

RESOLUTION NO. _____

A resolution appropriating a total of \$563,908 from the Metropolitan Government, acting by and through the Metropolitan Board of Health, to Meharry Medical College and approving a grant contract by and between the Metropolitan Government, acting by and through the Metropolitan Board of Health, and Meharry Medical College for the provision of food assistance, medical case management, mental health services, outpatient services, psychosocial services, and outreach services for participants in the Ryan White Part A program.

WHEREAS, Section 7-3-314 of the Tennessee Code Annotated states that metropolitan forms of government may provide financial assistance to nonprofit organizations in accordance with the guidelines of the Metropolitan Government; and,

WHEREAS, Section 5.04.070 of the Metropolitan Code of Laws provides that the Council may, by Resolution, appropriate funds for the financial aid of nonprofit organizations; and,

WHEREAS, Metropolitan Charter Section 10.104 provides that the Board of Health has the duty to contract for such services as will further the program and policies of the Board, subject to confirmation by Resolution of Council; and,

WHEREAS, Resolution No. RS2025-1084 approved a grant award of \$857,721 from the U.S. Department of Health and Human Services to the Metropolitan Board of Health to provide for the prevention, surveillance, diagnosis, and treatment of HIV/AIDS; and,

WHEREAS, The Metropolitan Government of Nashville and Davidson County, acting by and through the Metropolitan Board of Health, wishes to appropriate funding and contract with Meharry Medical College to provide food assistance, medical case management, mental health services, outpatient services, psychosocial services, and outreach services for participants in the Ryan White Part A program; and,

WHEREAS, it is to the benefit of the citizens of The Metropolitan Government of Nashville and Davidson County that this contract be approved.

NOW, THEREFORE, BE IT RESOLVED BY THE COUNCIL OF THE METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY:

Section 1. There is hereby appropriated Five Hundred Sixty-Three Thousand Nine Hundred and Eight Dollars (\$563,908) from the Metropolitan Government of Nashville and Davidson County, acting by and through the Metropolitan Board of Health, to Meharry Medical College for the purposes herein stated.

Section 2. The Metropolitan Government is hereby authorized to enter into a grant contract, attached hereto and incorporated herein, with Meharry Medical College for the amount provided herein and the purposes stated. Such contract shall specify the terms and conditions under which the grant funds are to be spent.

Section 3. That this resolution shall take effect from and after its adoption, the welfare of the Metropolitan Government of Nashville and Davidson County requiring it.

APPROVED FOR PROPER BUDGET PROCEDURES:

DocuSigned by:
Aaron Pratt
DB59844A2DE04C4...

Budget Officer

INTRODUCED BY:

Member(s) of Council

APPROVED AS TO AVAILABILITY OF FUNDS:

Signed by:
Jennifer Reed/mjr
62377A2A8742460...

Director of Finance

APPROVED AS TO FORM AND LEGALITY:

Signed by:
Matthew Garth
00F00922930044F...

Assistant Metropolitan Attorney

LEGISLATIVE TRACKING FORM

Filing for Council Meeting Date: 11/18/25

Resolution Ordinance

Contact/Prepared By: Brad Thompson

Date Prepared: 10/29/25

Title (Caption): Meharry Medical College Ryan White subgrant for the provision of Food Assistance, Medical Case Management, Mental

Health Services, Outpatient Services and Psychocial Services for participants in the Ryan White Part A program. Also, for the provision of

Outreach Services for participants in the Ryan White Part A MAI program. RS2025-1084

3/25- 2/26 38351137 38351037

Submitted to Planning Commission? N/A Yes-Date: _____ Proposal No: _____

Proposing Department: Health Requested By: Health

Affected Department(s): Health Affected Council District(s): all

Legislative Category (check one):

- | | | |
|---|---|--|
| <input type="checkbox"/> Bonds | <input checked="" type="checkbox"/> Contract Approval | <input type="checkbox"/> Intergovernmental Agreement |
| <input type="checkbox"/> Budget - Pay Plan | <input type="checkbox"/> Donation | <input type="checkbox"/> Lease |
| <input type="checkbox"/> Budget - 4% | <input type="checkbox"/> Easement Abandonment | <input type="checkbox"/> Maps |
| <input type="checkbox"/> Capital Improvements | <input type="checkbox"/> Easement Accept/Acquisition | <input type="checkbox"/> Master List A&E |
| <input type="checkbox"/> Capital Outlay Notes | <input type="checkbox"/> Grant | <input type="checkbox"/> Settlement of Claims/Lawsuits |
| <input type="checkbox"/> Code Amendment | <input type="checkbox"/> Grant Application | <input type="checkbox"/> Street/Highway Improvements |
| <input type="checkbox"/> Condemnation | <input type="checkbox"/> Improvement Acc. | <input type="checkbox"/> Other: _____ |

FINANCE Amount +/-: \$ <u>563,908.00</u> Funding Source: Capital Improvement Budget Capital Outlay Notes Departmental/Agency Budget Funds to Metro General Obligation Bonds Grant Increased Revenue Sources	Match: \$ _____ Judgments and Losses Local Government Investment Project Revenue Bonds Self-Insured Liability Solid Waste Reserve Unappropriated Fund Balance 4% Fund Other: _____ Date to Finance Director's Office: _____ APPROVED BY FINANCE DIRECTOR'S OFFICE: _____
Approved by OMB: _____ Approved by Finance/Accounts: _____ Approved by Div Grants Coordination: _____	

ADMINISTRATION	
Council District Member Sponsors: _____	
Council Committee Chair Sponsors: _____	
Approved by Administration: _____	Date: _____

DEPARTMENT OF LAW	
Date to Dept. of Law: _____	Approved by Department of Law: _____
Settlement Resolution/Memorandum Approved by: _____	
Date to Council: _____	For Council Meeting: _____ <input type="checkbox"/> E-mailed Clerk
<input type="checkbox"/> All Dept. Signatures <input type="checkbox"/> Copies <input type="checkbox"/> Backing <input type="checkbox"/> Legislative Summary <input type="checkbox"/> Settlement Memo <input type="checkbox"/> Clerk Letter <input type="checkbox"/> Ready to File	

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**GRANT CONTRACT
BETWEEN THE METROPOLITAN GOVERNMENT
OF NASHVILLE AND DAVIDSON COUNTY
AND
MEHARRY MEDICAL COLLEGE**

This Grant Contract issued and entered into pursuant to Resolution RS2025-_____ by and between the Metropolitan Government of Nashville and Davidson County ("Metro"), and Meharry Medical College, ("Recipient"), is for the provision of Ryan White Part A program services, as further defined in the "SCOPE OF PROGRAM" and detailed in this Grant Contract. Attachments A through I incorporated herein by reference.

A. SCOPE OF PROGRAM:

A.1. The Recipient will use the funds to provide the following Ryan White Part A program services:

a. Food Assistance

- i. Achieve an 85% viral suppression rate for Ryan White Part A - eligible clients.
- ii. Increase the retention rate of Ryan White Part A – eligible clients in care to 78%.
- iii. Provide 64 People Living With HIV ("PLWH") with food vouchers.

b. Medical Case Management

- i. Achieve an 85% viral suppression rate for Ryan White Part A - eligible clients.
- ii. Increase the retention rate of Ryan White Part A – eligible clients in care to 78%.
- iii. Provide 128 PLWH with medical case management assessments including service planning, monitoring, follow-up activities and treatment adherence counseling, based on identified need and acuity, administered by a social worker or other related human services professional.

c. Mental Health Services

- i. Achieve an 85% viral suppression rate for Ryan White Part A - eligible clients.
- ii. Increase the retention rate of Ryan White Part A – eligible clients in care to 78%.
- iii. Provide 19 PLWH with individual mental health treatment and counselling.
- iv. Provide 22 PLWH with mental health session administered by a clinical psychologist.
- v. Provide 16 PLWH with diagnostic evaluations and treatment provided by a psychiatrist.

d. Outpatient Services

- i. Achieve an 85% viral suppression rate for Ryan White Part A - eligible clients.
- ii. Increase the retention rate of Ryan White Part A – eligible clients in care to 78%.

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- iii. Provide comprehensive outpatient/ambulatory care to 96 individuals in all stages of HIV disease.
 - iv. Provide lab and diagnostic services to 96 individuals in all stages of HIV disease.
 - v. Provide 96 HIV positive clients with face-to-face medical care provided by a physician or nurse
- e. Psychosocial Services
- i. Achieve an 85% viral suppression rate for Ryan White Part A - eligible clients.
 - ii. Increase the retention rate of Ryan White Part A – eligible clients in care to 78%.
 - iii. Provide 128 PLWH with individual peer support.
- f. Minority AIDS Initiative – Outreach Services
- i. Achieve an 85% viral suppression rate for Ryan White Part A - eligible clients.
 - ii. Increase the retention rate of Ryan White Part A – eligible clients in care to 78%.
 - iii. Provide comprehensive outpatient/ambulatory care to 34 individuals in all stages of HIV disease.
 - iv. Provide lab and diagnostic services to 34 individuals in all stages of HIV disease.
 - v. Provide 34 HIV positive clients with face-to-face medical care provided by a physician or nurse.
- A.2. The Recipient shall ensure that eligible program participants are referred, encouraged and assisted in enrolling in other private and public benefits programs, including but not limited to, Housing Opportunities for Persons with AIDS, Section 8 Housing, Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, Women Infant & Children and other non-profit service programs.
- A.3. The Recipient shall ensure that eligible program participants are referred, encouraged and assisted in enrolling in other private and public health coverage programs, including but not limited to, Medicaid, Medicare, State Children’s Health Insurance Programs, and Private Insurance.
- A.4. The Recipient shall ensure billing and collection from private and public health coverage programs, including but not limited to, Medicaid, Medicare, State Children’s Health Insurance Programs, and Private Insurance, so that the Ryan White Program remains the payer of last resort.
- A.5. The Recipient shall utilize Program Income as required by section 28 of the Ryan White Part A Notice of Award for grant #H89HA11433-17 (RS2025-1084) and all applicable modifications and further explained in provision 45 CFR § 75.307(e)(2).
- A.6. The Recipient shall utilize the CAREWare information system for program reporting purposes and meet the standards and specifications in 45 CFR § 170, subpart B.

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- A.7. The Recipient must spend funds consistent with the Grant Spending Plan, attached and incorporated herein as **Attachment A**. The Recipient must collect data to evaluate the effectiveness of their services and must provide those results to Metro according to a mutually acceptable process and schedule, and when needed, upon request.
- A.8. The Recipient must comply with all quarterly reporting requirements. The Recipient must submit quarterly reports that contain the following:
 - Implementation Plans
 - Provider Data Import Report
 - Other data as requested.
- A.9. The Recipient will only utilize these grant funds for services the Recipient provides to documented residents of Cannon, Cheatham, Davidson, Dickson, Hickman, Macon, Robertson, Rutherford, Smith, Sumner, Trousdale, Williamson and Wilson Counties. Documentation of residency may be established with a recent utility bill; voter's registration card; driver's license or other government issued identification; current record from a school district showing an address; or affidavit by landlord; or affidavit by a nonprofit treatment, shelter, half-way house, or homeless assistance entity located in the named counties.
- A.10. The funds received through this contract are considered federal funds subject to the Single Audit Act, the related provisions of 45 CFR § 75 Health & Human Services ("HHS") Uniform Guidance, 2 CFR § 200.1 Definitions, 2 CFR § 200.313(e) Equipment Disposition, 2 CFR § 200.314(a) Supply Disposition, 2 CFR § 200.320 Micro-Purchase Threshold, 2 CFR § 200.333 Fixed Amount Subawards Amount, 2 CFR § 200.344 Closeout Provisions, 2 CFR § 200.414(f) Indirect Cost Rate Provisions, and 2 CFR § 200.501 Audit Provisions, the Ryan White Part A Notice of Award for grant #H89HA11433-17 (RS2025-1084) and all applicable modifications, the HIV/AIDS Bureau Policy Notices and Program Letters, and the HHS Ryan White Part A Manual.

B. GRANT CONTRACT TERM:

- B.1. **Grant Contract Term.** The term of this Grant will commence on the date filed with the Metropolitan Clerk after receiving all required Metro approvals and ending on February 28, 2026. Metro will have no obligation for services rendered by the Recipient that are not performed within this term, although it is understood that Recipient has provided services prior to the commencement of the term of this agreement and will be allowed to submit invoices and be paid for services rendered beginning March 1, 2025.

C. PAYMENT TERMS AND CONDITIONS:

- C.1. **Maximum Liability.** In no event will Metro's maximum liability under this Grant Contract exceed Five Hundred Sixty-Three Thousand Nine Hundred Eight dollars (\$563,908). The Grant Spending Plan will constitute the maximum amount provided to the Recipient by Metro for all of the Recipient's obligations hereunder. The Grant Spending Plan line items include, but are not limited to, all applicable taxes, fees, overhead, and all other direct and indirect costs incurred or to be incurred by the Recipient.

Subject to modification and amendments as provided in section D.2 of this agreement, this amount will constitute the Grant Amount and the entire compensation to be provided to the Recipient by Metro.

- C.2. **Payment Methodology.** The Recipient will only be compensated for actual costs based upon the Grant Spending Plan, not to exceed the maximum liability established in Section C.1

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Upon progress toward the completion of the work, as described in Section A of this Grant Contract, the Recipient shall submit invoices and any supporting documentation as requested by Metro to demonstrate that the funds are used as required by this Grant, prior to any payment for allowable costs. Such invoices shall be submitted no more often than monthly and indicate at a minimum the amount charged by Spending Plan line-item for the period invoiced, the amount charged by line-item to date, the total amount charged for the period invoiced, and the total amount charged under this Grant Contract to date.

Recipient must send all invoices to Metro Public Health Department, healthap@nashville.gov.

Final invoices for the contract period should be received by March 31, 2026. Any invoice not received by the deadline date will not be processed and all remaining grant funds will expire.

- C.3. **Annual Expenditure Report.** The Recipient must submit a final grant Annual Expenditure Report, to be received by Metro Public Health Department, within forty-five (45) days of the end of the Grant Contract. Said report must be in form and substance acceptable to Metro and must be prepared by a Certified Public Accounting Firm or the Chief Financial Officer of the Recipient Organization.
- C.4. **Payment of Invoice.** The payment of any invoice by Metro will not prejudice Metro's right to object to the invoice or any other related matter. Any payment by Metro will neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the costs included therein.
- C.5. **Unallowable Costs.** The Recipient's invoice may be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by Metro, on the basis of audits or monitoring conducted in accordance with the terms of this Grant Contract, to constitute unallowable costs. Any unallowable cost discovered after payment of the final invoice shall be returned by the Recipient to Metro within fifteen (15) days of notice.
- C.6. **Deductions.** Metro reserves the right to adjust any amounts which are or become due and payable to the Recipient by Metro under this or any Contract by deducting any amounts which are or become due and payable to Metro by the Recipient under this or any Contract.
- C.7. **Travel Compensation.** Payment to the Recipient for travel, meals, or lodging is subject to amounts and limitations specified in Metro's Travel Regulations and subject to the Grant Spending Plan.
- C.8. **Electronic Payment.** Metro requires as a condition of this contract that the Recipient have on file with Metro a completed and signed "ACH Form for Electronic Payment". If Recipient has not previously submitted the form to Metro or if Recipient's information has changed, Recipient will have thirty (30) days to complete, sign, and return the form. Thereafter, all payments to the Recipient, under this or any other contract the Recipient has with Metro, must be made electronically.
- D. **STANDARD TERMS AND CONDITIONS:**
 - D.1. **Required Approvals.** Metro is not bound by this Grant Contract until it is approved by the appropriate Metro representatives as indicated on the signature page of this Grant and approved by the Metropolitan Council.
 - D.2. **Modification and Amendment.** This Grant Contract may be modified only by a written amendment that has been approved in accordance with all Metro procedures and by appropriate legislation of the Metropolitan Council.

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- D.3. **Termination - Cause.** Metro shall have the right to terminate this Grant Contract immediately if Metro determines that Recipient, its employees or principals have engaged in conduct or violated any federal, state or local laws which affect the ability of Recipient to effectively provide services under this Grant Contract. Should the Recipient fail to properly perform its obligations under this Grant Contract or if the Recipient violates any terms of this Grant Contract, Metro will have the right to immediately terminate the Grant Contract and the Recipient must return to Metro any and all grant monies for services or programs under the grant not performed as of the termination date. The Recipient must also return to Metro any and all funds expended for purposes contrary to the terms of the Grant Contract. Such termination will not relieve the Recipient of any liability to Metro for damages sustained by virtue of any breach by the Recipient.
- D.4. **Termination - Notice.** Metro may terminate the Grant Contract without cause for any reason. Said termination shall not be deemed a breach of Contract by Metro. Metro shall give the Recipient at least thirty (30) days written notice before effective termination date.
- a. The Recipient shall be entitled to receive compensation for satisfactory, authorized service completed as of the effective termination date, but in no event shall Metro be liable to the Recipient for compensation for any service that has not been rendered.
- b. Upon such termination, the Recipient shall have no right to any actual general, special, incidental, consequential or any other damages whatsoever of any description or amount.
- D.5. **Termination - Funding.** The Grant Contract is subject to the appropriation and availability of local, State and/or Federal funds. In the event that the funds are not appropriated or are otherwise unavailable, Metro shall have the right to terminate the Grant Contract immediately upon written notice to the Recipient. Upon receipt of the written notice, the Recipient shall cease all work associated with the Grant Contract on or before the effective termination date specified in the written notice. Should such an event occur, the Recipient shall be entitled to compensation for all satisfactory and authorized services completed as of the effective termination date. The Recipient shall be responsible for repayment of any funds already received in excess of satisfactory and authorized services completed as of the effective termination date.
- D.6. **Subcontracting.** The Recipient shall not assign this Grant Contract or enter into a subcontract for any of the services performed under this Grant Contract without obtaining the prior written approval of Metro. Notwithstanding any use of approved Sub-Grantee, the Recipient will be considered the prime Recipient and will be responsible for all work performed.
- D.7. **Conflicts of Interest.** The Recipient warrants that no part of the total Grant Amount will be paid directly or indirectly to an employee or official of Metro as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Recipient in connection with any work contemplated or performed relative to this Grant Contract.
- D.8. **Nondiscrimination.** The Recipient hereby agrees, warrants, and assures that no person will be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Grant Contract or in the employment practices of the Recipient on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification which is in violation of applicable laws. The Recipient must, upon request, show proof of such nondiscrimination and must post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.
- D.9. **Records.** The Recipient must maintain documentation for all charges to Metro under this Grant Contract. The books, records, and documents of the Recipient, insofar as they relate to work performed or money received under this Grant Contract, must be maintained for a period of three (3) full years from the date of the final payment or until the Recipient engages a licensed independent public accountant to perform an audit of its activities. The books, records, and

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documents of the Recipient insofar as they relate to work performed or money received under this Grant Contract are subject to audit at any reasonable time and upon reasonable notice by Metro or its duly appointed representatives. Records must be maintained in accordance with the standards outlined in the Metro Non-Profit Grants Manual. The financial statements must be prepared in accordance with generally accepted accounting principles.

- D.10. **Monitoring.** The Recipient's activities conducted and records maintained pursuant to this Grant Contract are subject to monitoring and evaluation by The Metropolitan Office of Financial Accountability or Metro's duly appointed representatives. The Recipient must make all audit, accounting, or financial records, notes, and other documents pertinent to this grant available for review by the Metropolitan Office of Financial Accountability, Internal Audit or Metro's representatives, upon request, during normal working hours.
- D.11. **Reporting.** The Recipient must submit a Quarterly Program Report to be received by Metro Public Health Department, within thirty (30) days of the end of the quarter and a Final Program Report, to be received by Metro Public Health Department, within forty-five (45) days of the end of the Grant Contract. Said reports shall detail the outcome of the activities funded under this Grant Contract.
- D.12. **Strict Performance.** Failure by Metro to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this agreement is not a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Grant Contract is considered to be waived, modified, or deleted except by a written amendment by the appropriate parties as indicated on the signature page of this Grant.
- D.13. **Insurance.** The Recipient agrees to carry adequate public liability and other appropriate forms of insurance, and to pay all applicable taxes incident to this Grant Contract.
- D.14. **Metro Liability.** Metro will have no liability except as specifically provided in this Grant Contract.
- D.15. **Independent Contractor.** Nothing herein will in any way be construed or intended to create a partnership or joint venture between the Recipient and Metro or to create the relationship of principal and agent between or among the Recipient and Metro. The Recipient must not hold itself out in a manner contrary to the terms of this paragraph. Metro will not become liable for any representation, act, or omission of any other party contrary to the terms of this paragraph.
- D.16. **Indemnification and Hold Harmless.**
 - a. Recipient agrees to indemnify, defend, and hold harmless Metro, its officers, agents and employees from any claims, damages, penalties, costs and attorney fees for injuries or damages arising, in part or in whole, from the negligent or intentional acts or omissions of Recipient, its officers, employees and/or agents, including its sub or independent Grantees, in connection with the performance of the contract, and any claims, damages, penalties, costs and attorney fees arising from any failure of Recipient, its officers, employees and/or agents, including its sub or independent Grantees, to observe applicable laws, including, but not limited to, labor laws and minimum wage laws.
 - b. Metro will not indemnify, defend or hold harmless in any fashion the Recipient from any claims, regardless of any language in any attachment or other document that the Recipient may provide.
 - c. Recipient will pay Metro any expenses incurred as a result of Recipient's failure to fulfill any obligation in a professional and timely manner under this Contract.
 - d. Recipient's duties under this section will survive the termination or expiration of the grant.

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- D.17. **Force Majeure.** "Force Majeure Event" means fire, flood, earthquake, elements of nature or acts of God, wars, riots, civil disorders, rebellions or revolutions, acts of terrorism or any other similar cause beyond the reasonable control of the party. Except as provided in this Section, any failure or delay by a party in the performance of its obligations under this Grant Contract arising from a Force Majeure Event is not a breach under this Grant Contract. The non-performing party will be excused from performing those obligations directly affected by the Force Majeure Event, and only for as long as the Force Majeure Event continues, provided that the party continues to use diligent, good faith efforts to resume performance without delay. Recipient will promptly notify Metro within forty-eight (48) hours of any delay caused by a Force Majeure Event and will describe in reasonable detail the nature of the Force Majeure Event.
- D.18. **Iran Divestment Act.** In accordance with the Iran Divestment Act, Tennessee Code Annotated § 12-12-101 et seq., Recipient certifies that to the best of its knowledge and belief, neither Recipient nor any of its subcontractors are on the list created pursuant to Tennessee Code Annotated § 12-12-106. Misrepresentation may result in civil and criminal sanctions, including contract termination, debarment, or suspension from being a contractor or subcontractor under Metro contracts.
- D.19. **State, Local and Federal Compliance.** The Recipient agrees to comply with all applicable federal, state and local laws and regulations in the performance of this Grant Contract. Metro shall have the right to terminate this Grant Contract at any time for failure of Recipient to comply with applicable federal, state or local laws in connection with the performance of services under this Grant Contract.
- D.20. **Governing Law and Venue.** The validity, construction and effect of this Grant Contract and any and all extensions and/or modifications thereof will be governed by and construed in accordance with the laws of the State of Tennessee. The venue for legal action concerning this Grant Contract will be in the courts of Davidson County, Tennessee.
- D.21. **Completeness.** This Grant Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Grant Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.
- D.22. **Headings.** Section headings are for reference purposes only and will not be construed as part of this Grant Contract.
- D.23. **Severability.** In the event any provision of this Agreement is rendered invalid or unenforceable, said provision(s) hereof will be immediately void and may be renegotiated for the sole purpose of rectifying the error. The remainder of the provisions of this Agreement not in question shall remain in full force and effect.
- D.24. **Metro Interest in Equipment.** The Recipient will take legal title to all equipment and to all motor vehicles, hereinafter referred to as "equipment," purchased totally or in part with funds provided under this Grant Contract, subject to Metro's equitable interest therein, to the extent of its *pro rata* share, based upon Metro's contribution to the purchase price. "Equipment" is defined as an article of nonexpendable, tangible, personal property having a useful life of more than one year and an acquisition cost which equals or exceeds Five Thousand dollars (\$5,000).

The Recipient agrees to be responsible for the accountability, maintenance, management, and inventory of all property purchased totally or in part with funds provided under this Grant Contract. Upon termination of the Grant Contract, where a further contractual relationship is not entered into, or at any time during the term of the Grant Contract, the Recipient must request written

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approval from Metro for any proposed disposition of equipment purchased with Grant funds. All equipment must be disposed of in such a manner as parties may agree as appropriate and in accordance with any applicable federal, state or local laws or regulations.

- D.25. **Assignment—Consent Required.** The provisions of this contract will inure to the benefit of and will be binding upon the respective successors and assignees of the parties hereto. Except for the rights of money due to Recipient under this contract, neither this contract nor any of the rights and obligations of Recipient hereunder may be assigned or transferred in whole or in part without the prior written consent of Metro. Any such assignment or transfer will not release Recipient from its obligations hereunder. Notice of assignment of any rights to money due to Recipient under this Contract must be sent to the attention of the Metro Department of Finance.
- D.26. **Gratuities and Kickbacks.** It will be a breach of ethical standards for any person to offer, give or agree to give any employee or former employee, or for any employee or former employee to solicit, demand, accept or agree to accept from another person, a gratuity or an offer of employment in connection with any decision, approval, disapproval, recommendation, preparations of any part of a program requirement or a purchase request, influencing the content of any specification or procurement standard, rendering of advice, investigation, auditing or in any other advisory capacity in any proceeding or application, request for ruling, determination, claim or controversy in any proceeding or application, request for ruling, determination, claim or controversy or other particular matter, pertaining to any program requirement of a contract or subcontract or to any solicitation or proposal therefore. It will be a breach of ethical standards for any payment, gratuity or offer of employment to be made by or on behalf of a Sub-Grantee under a contract to the prime Grantee or higher tier Sub-Grantee or a person associated therewith, as an inducement for the award of a subcontract or order. Breach of the provisions of this paragraph is, in addition to a breach of this contract, a breach of ethical standards which may result in civil or criminal sanction and/or debarment or suspension from participation in Metropolitan Government contracts.
- D.27. **Communications and Contacts.** All instructions, notices, consents, demands, or other communications from the Recipient required or contemplated by this Grant Contract must be in writing and must be made by email transmission, or by first class mail, addressed to the respective party at the appropriate email or physical address as set forth below or to such other party, email, or address as may be hereafter specified by written notice.

Metro

For contract-related matters:
Metro Public Health Department
2500 Charlotte Avenue
Nashville, TN 37209
(615) 340-8900
Holly.Rice@nashville.gov

For inquiries regarding invoices:
Metro Public Health Department
2500 Charlotte Avenue
Nashville, TN 37209
(615) 340-5634
Nancy.Uribe@nashville.gov

Recipient

Meharry Medical College
Director
1005 DB Todd BLVD
Nashville, TN 37208

- D.28. **Lobbying.** The Recipient certifies, to the best of its knowledge and belief, that:
 - a. No federally appropriated funds have been paid or will be paid, by or on behalf of the Recipient, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, and entering into of any

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cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

- b. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this grant, loan, or cooperative agreement, the Recipient must complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- c. The Recipient will require that the language of this certification be included in the award documents for all sub-awards at all tiers (including sub-grants, subcontracts, and contracts under grants, loans, and cooperative agreements) and that all subcontractors of federally appropriated funds shall certify and disclose accordingly.

D.29. Certification Regarding Debarment and Convictions.

- a. Recipient certifies that Recipient, and its current and future principals:
 - i. are not presently debarred, suspended, or proposed for debarment from participation in any federal or state grant program;
 - ii. have not within a three (3) year period preceding this Grant Contract been convicted of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) grant;
 - iii. have not within a three (3) year period preceding this Grant Contract been convicted of embezzlement, obstruction of justice, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; and
 - iv. are not presently indicted or otherwise criminally charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in Sections D.29(a)(ii) and D.29(a)(iii) of this certification.
- b. Recipient shall provide immediate written notice to Metro if at any time Recipient learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals fall under any of the prohibitions of Section D.29(a).

D.30. Effective Date. This contract will not be binding upon the parties until it has been signed first by the Recipient and then by the authorized representatives of the Metropolitan Government and has been filed in the office of the Metropolitan Clerk. When it has been so signed and filed, this contract will be effective as of the date first written above.

D.31. Health Insurance Portability and Accountability Act. Metro and Recipient shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its accompanying regulations.

- a. Recipient warrants that it is familiar with the requirements of HIPAA and its accompanying regulations and will comply with all applicable HIPAA requirements in the course of this Agreement.
- b. Recipient warrants that it will cooperate with Metro, including cooperation and coordination with Metro privacy officials and other compliance officers required by HIPAA and its regulations, in the course of performance of this Agreement so that both parties will be in compliance with HIPAA.

Grant contract between the Metropolitan Government of Nashville and Davidson County and Meharry Medical College Contract # _____

- c. Recipient agrees to sign documents, including but not limited to Business Associate agreements, as required by HIPAA and that are reasonably necessary to keep Metro and Recipient in compliance with HIPAA. This provision shall not apply if information received by the Recipient from Metro under this Agreement is not "protected health information" as defined by HIPAA, or if HIPAA permits Recipient and Metro to receive such information without entering into a Business Associate agreement or signing another such document.

D.32. **Federal Funding Accountability and Transparency Act (FFATA).** This Grant Contract requires the Recipient to provide supplies or services that are funded in whole or in part by federal funds that are subject to FFATA. The Recipient is responsible for ensuring that all applicable FFATA requirements, including but not limited to those below, are met and that the Recipient provides information to the Metro as required.

The Recipient shall comply with the following:

a. Reporting of Total Compensation of the Recipient's Executives.

- i. The Recipient shall report the names and total compensation of each of its five most highly compensated executives for the Recipient's preceding completed fiscal year, if in the Recipient's preceding fiscal year, it received:
 - (1) Eighty percent (80%) or more of the Recipient's annual gross revenues from Federal procurement contracts and federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and
 - (2) Twenty-Five Million Dollars (\$25,000,000) or more in annual gross revenues from federal procurement contracts (and subcontracts), federal financial assistance subject to the Transparency Act (and subawards); and
 - (3) The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. § 78m(a), 78o(d)) or § 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at <http://www.sec.gov/answers/execomp.htm>).

As defined in 2 C.F.R. § 170.315, "Executive" means officers, managing partners, or any other employees in management positions.

- ii. Total compensation means the cash and noncash dollar value earned by the executive during the Recipient's preceding fiscal year and includes the following (for more information see 17 CFR § 229.402(c)(2)):
 - (1) Salary and bonus.
 - (2) Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.
 - (3) Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives and are available generally to all salaried employees.

Grant contract between the Metropolitan Government of Nashville and Davidson County and Meharry Medical College Contract # _____

- (4) Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.
 - (5) Above-market earnings on deferred compensation which is not tax qualified.
 - (6) Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds Ten Thousand dollars (\$10,000).
- b. The Recipient must report executive total compensation described above to Metro by the end of the month during which this Grant Contract is established.
 - c. If this Grant Contract is amended to extend its term, the Recipient must submit an executive total compensation report to the Metro by the end of the month in which the amendment to this Grant Contract becomes effective.
 - d. The Recipient will obtain a Unique Entity Identifier and maintain its number for the term of this Grant Contract. More information about obtaining a Unique Entity Identifier can be found at: <https://www.sam.gov>.

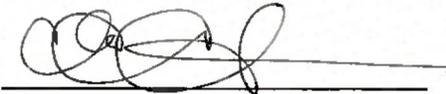
The Recipient's failure to comply with the above requirements is a material breach of this Grant Contract for which Metro may terminate this Grant Contract for cause. Metro will not be obligated to pay any outstanding invoice received from the Recipient unless and until the Recipient is in full compliance with the above requirements.

D.33. **Assistance Listing Number.** When applicable, the Recipient shall inform its licensed independent public accountant of the federal regulations that require compliance with the performance of an audit. This information shall consist of the following Assistance Listing Numbers:

- a. 93.914 HIV Emergency Relief Project Grants.

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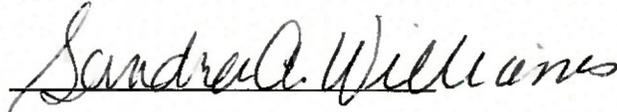
Grant contract between the Metropolitan Government of Nashville and Davidson County and Meharry Medical College Contract # _____

Recipient: 

By: Cynthia Clemons, MHA

Title: Senior Vice President & Chief Financial Officer

Sworn to and subscribed to before me, a Notary Public this 28th day of October, 2025, by Cynthia Clemons, the SVP & Chief Financial Officer of Contractor and duly authorized to execute this instrument on Contractor's behalf.

Notary Public: 

My Commission Expires: May 9, 2026



Grant contract between the Metropolitan Government of Nashville and Davidson County and Meharry Medical College Contract # _____

METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY

Signed by: Sanmi Aroka 10/29/2025
0872295CD81A4B1...
 Director, Metro Public Health Department Date

Signed by: Tené Hamilton Franklin 10/30/2025
BE8E0BBE14D14B0...
 Chair, Board of Health Date

APPROVED AS TO AVAILABILITY OF FUNDS:

Signed by: Jennifer Reed/Myw 11/3/2025
62377A2A8742469...
 Director, Department of Finance Date

Initial DH DS AP

APPROVED AS TO RISK AND INSURANCE:

DocuSigned by: Balagun Cobb 11/3/2025
888648F12FD741C...
 Director of Risk Management Services Date

APPROVED AS TO FORM AND LEGALITY:

Signed by: Matthew Garth 11/3/2025
66F69922939844F...
 Metropolitan Attorney Date

FILED:

 Metropolitan Clerk Date

Grant contract between the Metropolitan Government of Nashville and Davidson County and Meharry Medical College Contract # _____

Table of Contents of Attachments:

- A. Grant Spending Plan
- B. Business Associate Agreement
- C. Application
- D. Certificate of Assurance
- E. Non-Profit Grants Manual Receipt Acknowledgement
- F. Internal Revenue Service 501(c)(3) Tax-Exempt Organization Letter
- G. Non-Profit Charter and Tennessee Secretary of State Non-Profit Confirmation
- H. Independent Audit completed by Certified Public Accountant
- I. Certificate of Insurance

ATTACHMENT A

GRANT BUDGET

(BUDGET PAGE 1)

Meharry Rollup				
APPLICABLE PERIOD: The grant budget line-item amounts below shall be applicable only to expense incurred during the grant period.				
Object Line-item Reference	EXPENSE OBJECT LINE-ITEM CATEGORY ¹ (detail schedule(s) attached as applicable)	GRANT CONTRACT	GRANTEE MATCH ³	TOTAL PROJECT
1	Salaries ²	\$353,154.00	\$0.00	\$353,154.00
2	Benefits & Taxes	\$90,054.50	\$0.00	\$90,054.50
4, 15	Professional Fee/ Grant & Award ²	\$0.00	\$0.00	\$0.00
5	Supplies	\$0.00	\$0.00	\$0.00
6	Telephone	\$0.00	\$0.00	\$0.00
7	Postage & Shipping	\$0.00	\$0.00	\$0.00
8	Occupancy	\$0.00	\$0.00	\$0.00
9	Equipment Rental & Maintenance	\$0.00	\$0.00	\$0.00
10	Printing & Publications	\$0.00	\$0.00	\$0.00
11, 12	Travel/ Conferences & Meetings ²	\$0.00	\$0.00	\$0.00
13	Interest ²	\$0.00	\$0.00	\$0.00
14	Insurance	\$0.00	\$0.00	\$0.00
16	Specific Assistance To Individuals ²	\$0.00	\$0.00	\$0.00
17	Depreciation ²	\$0.00	\$0.00	\$0.00
18	Other Non-Personnel ²	\$69,524.50	\$0.00	\$69,524.50
20	Capital Purchase ²	\$0.00	\$0.00	\$0.00
22	Indirect Cost (10% of S&B)	\$51,175.00	\$0.00	\$51,175.00
24	In-Kind Expense	\$0.00	\$0.00	\$0.00
25	GRAND TOTAL	\$563,908.00	\$0.00	\$563,908.00

¹ Each expense object line-item shall be defined by the Department of Finance and Administration Policy 03, *Uniform Reporting Requirements and Cost Allocation Plans for Subrecipients of Federal and State Grant Monies, Appendix A*. (posted on the Internet at: <https://www.tn.gov/assets/entities/finance/attachments/policy3.pdf>).

² Applicable detail follows this page if line-item is funded.

³ A Grantee Match Requirement is detailed by this Grant Budget, and the maximum total amount reimbursable by the State pursuant to this Grant Contract, as detailed by the "Grant Contract" column above, shall be reduced by the amount of any Grantee failure to meet the Match Requirement.

ATTACHMENT A

GRANT BUDGET

(BUDGET PAGE 1)

Meharry Part A Rollup

APPLICABLE PERIOD: The grant budget line-item amounts below shall be applicable only to expense incurred during the grant period.

Object Line-item Reference	EXPENSE OBJECT LINE-ITEM CATEGORY ¹ (detail schedule(s) attached as applicable)	GRANT CONTRACT	GRANTEE MATCH ³	TOTAL PROJECT
1	Salaries ²	\$330,691.00	\$0.00	\$330,691.00
2	Benefits & Taxes	\$84,326.50	\$0.00	\$84,326.50
4, 15	Professional Fee/ Grant & Award ²	\$0.00	\$0.00	\$0.00
5	Supplies	\$0.00	\$0.00	\$0.00
6	Telephone	\$0.00	\$0.00	\$0.00
7	Postage & Shipping	\$0.00	\$0.00	\$0.00
8	Occupancy	\$0.00	\$0.00	\$0.00
9	Equipment Rental & Maintenance	\$0.00	\$0.00	\$0.00
10	Printing & Publications	\$0.00	\$0.00	\$0.00
11, 12	Travel/ Conferences & Meetings ²	\$0.00	\$0.00	\$0.00
13	Interest ²	\$0.00	\$0.00	\$0.00
14	Insurance	\$0.00	\$0.00	\$0.00
16	Specific Assistance To Individuals ²	\$0.00	\$0.00	\$0.00
17	Depreciation ²	\$0.00	\$0.00	\$0.00
18	Other Non-Personnel ²	\$69,524.50	\$0.00	\$69,524.50
20	Capital Purchase ²	\$0.00	\$0.00	\$0.00
22	Indirect Cost (10% of S&B)	\$48,356.00	\$0.00	\$48,356.00
24	In-Kind Expense	\$0.00	\$0.00	\$0.00
25	GRAND TOTAL	\$532,898.00	\$0.00	\$532,898.00

¹ Each expense object line-item shall be defined by the Department of Finance and Administration Policy 03, *Uniform Reporting Requirements and Cost Allocation Plans for Subrecipients of Federal and State Grant Monies, Appendix A*. (posted on the Internet at: <https://www.tn.gov/assets/entities/finance/attachments/policy3.pdf>).

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ATTACHMENT A

GRANT BUDGET

(BUDGET PAGE 1)

Meharry Food Assistance

APPLICABLE PERIOD: The grant budget line-item amounts below shall be applicable only to expense incurred during the grant period.

Object Line-item Reference	EXPENSE OBJECT LINE-ITEM CATEGORY ¹ (detail schedule(s) attached as applicable)	GRANT CONTRACT	GRANTEE MATCH ³	TOTAL PROJECT
1	Salaries ²	\$0.00	\$0.00	\$0.00
2	Benefits & Taxes	\$0.00	\$0.00	\$0.00
4, 15	Professional Fee/ Grant & Award ²	\$0.00	\$0.00	\$0.00
5	Supplies	\$0.00	\$0.00	\$0.00
6	Telephone	\$0.00	\$0.00	\$0.00
7	Postage & Shipping	\$0.00	\$0.00	\$0.00
8	Occupancy	\$0.00	\$0.00	\$0.00
9	Equipment Rental & Maintenance	\$0.00	\$0.00	\$0.00
10	Printing & Publications	\$0.00	\$0.00	\$0.00
11, 12	Travel/ Conferences & Meetings ²	\$0.00	\$0.00	\$0.00
13	Interest ²	\$0.00	\$0.00	\$0.00
14	Insurance	\$0.00	\$0.00	\$0.00
16	Specific Assistance To Individuals ²	\$0.00	\$0.00	\$0.00
17	Depreciation ²	\$0.00	\$0.00	\$0.00
18	Other Non-Personnel ²	\$7,680.00	\$0.00	\$7,680.00
20	Capital Purchase ²	\$0.00	\$0.00	\$0.00
22	Indirect Cost (10% of S&B)	\$768.00	\$0.00	\$768.00
24	In-Kind Expense	\$0.00	\$0.00	\$0.00
25	GRAND TOTAL	\$8,448.00	\$0.00	\$8,448.00

¹ Each expense object line-item shall be defined by the Department of Finance and Administration Policy 03, *Uniform Reporting Requirements and Cost Allocation Plans for Subrecipients of Federal and State Grant Monies, Appendix A*. (posted on the Internet at: <https://www.tn.gov/assets/entities/finance/attachments/policy3.pdf>).

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GRANT BUDGET LINE-ITEM DETAIL

(BUDGET PAGE 2)

SALARIES					AMOUNT
Name - Title	Salary	x	Percentage of Time	+ Longevity Bonus	
		x	100%	+	\$ -
		x	100%	+	\$ -
		x	100%	+	\$ -
		x	100%	+	\$ -
		x	100%	+	\$ -
ROUNDED TOTAL					\$ -

PROFESSIONAL FEE/ GRANT & AWARD	AMOUNT
ROUNDED TOTAL	\$ -

TRAVEL/ CONFERENCES & MEETINGS	AMOUNT
ROUNDED TOTAL	\$ -

SPECIFIC ASSISTANCE TO INDIVIDUALS	AMOUNT
ROUNDED TOTAL	\$ -

OTHER NON-PERSONNEL	AMOUNT
128 Food vouchers (gift cards) @ \$60 each	\$ 7,680.00
ROUNDED TOTAL	\$ 7,680.00

ATTACHMENT A

GRANT BUDGET

(BUDGET PAGE 1)

Meharry Medical Case Management

APPLICABLE PERIOD: The grant budget line-item amounts below shall be applicable only to expense incurred during the grant period.

Object Line-item Reference	EXPENSE OBJECT LINE-ITEM CATEGORY ¹ (detail schedule(s) attached as applicable)	GRANT CONTRACT	GRANTEE MATCH ³	TOTAL PROJECT
1	Salaries ²	\$58,880.00	\$0.00	\$58,880.00
2	Benefits & Taxes	\$15,014.00	\$0.00	\$15,014.00
4, 15	Professional Fee/ Grant & Award ²	\$0.00	\$0.00	\$0.00
5	Supplies	\$0.00	\$0.00	\$0.00
6	Telephone	\$0.00	\$0.00	\$0.00
7	Postage & Shipping	\$0.00	\$0.00	\$0.00
8	Occupancy	\$0.00	\$0.00	\$0.00
9	Equipment Rental & Maintenance	\$0.00	\$0.00	\$0.00
10	Printing & Publications	\$0.00	\$0.00	\$0.00
11, 12	Travel/ Conferences & Meetings ²	\$0.00	\$0.00	\$0.00
13	Interest ²	\$0.00	\$0.00	\$0.00
14	Insurance	\$0.00	\$0.00	\$0.00
16	Specific Assistance To Individuals ²	\$0.00	\$0.00	\$0.00
17	Depreciation ²	\$0.00	\$0.00	\$0.00
18	Other Non-Personnel ²	\$0.00	\$0.00	\$0.00
20	Capital Purchase ²	\$0.00	\$0.00	\$0.00
22	Indirect Cost (10% of S&B)	\$7,390.00	\$0.00	\$7,390.00
24	In-Kind Expense	\$0.00	\$0.00	\$0.00
25	GRAND TOTAL	\$81,284.00	\$0.00	\$81,284.00

¹ Each expense object line-item shall be defined by the Department of Finance and Administration Policy 03, *Uniform Reporting Requirements and Cost Allocation Plans for Subrecipients of Federal and State Grant Monies, Appendix A*. (posted on the Internet at: <https://www.tn.gov/assets/entities/finance/attachments/policy3.pdf>).

² Applicable detail follows this page if line-item is funded.

³ A Grantee Match Requirement is detailed by this Grant Budget, and the maximum total amount reimbursable by the State pursuant to this Grant Contract, as detailed by the "Grant Contract" column above, shall be reduced by the amount of any Grantee failure to meet the Match Requirement.

GRANT BUDGET LINE-ITEM DETAIL

(BUDGET PAGE 2)

SALARIES						AMOUNT
Name - Title	Salary	x	Percentage of Time	+	Longevity Bonus	
Ja'Rae Davenport	46000	x	64%	+	\$	29,440.00
Kaye Chavis	51000	x	58%	+	\$	29,440.01
		x	100%	+	\$	-
		x	100%	+	\$	-
ROUNDED TOTAL						\$ 58,900.00

PROFESSIONAL FEE/ GRANT & AWARD	AMOUNT
ROUNDED TOTAL	\$ -

TRAVEL/ CONFERENCES & MEETINGS	AMOUNT
ROUNDED TOTAL	\$ -

SPECIFIC ASSISTANCE TO INDIVIDUALS	AMOUNT
ROUNDED TOTAL	\$ -

OTHER NON-PERSONNEL	AMOUNT
	\$ -
ROUNDED TOTAL	\$ -

ATTACHMENT A

GRANT BUDGET

(BUDGET PAGE 1)

Meharry Mental Health

APPLICABLE PERIOD: The grant budget line-item amounts below shall be applicable only to expense incurred during the grant period.

Object Line-item Reference	EXPENSE OBJECT LINE-ITEM CATEGORY ¹ (detail schedule(s) attached as applicable)	GRANT CONTRACT	GRANTEE MATCH ³	TOTAL PROJECT
1	Salaries ²	\$ 126,711.00	\$0.00	\$126,711.00
2	Benefits & Taxes	\$32,312.00	\$0.00	\$32,312.00
4, 15	Professional Fee/ Grant & Award ²	\$0.00	\$0.00	\$0.00
5	Supplies	\$0.00	\$0.00	\$0.00
6	Telephone	\$0.00	\$0.00	\$0.00
7	Postage & Shipping	\$0.00	\$0.00	\$0.00
8	Occupancy	\$0.00	\$0.00	\$0.00
9	Equipment Rental & Maintenance	\$0.00	\$0.00	\$0.00
10	Printing & Publications	\$0.00	\$0.00	\$0.00
11, 12	Travel/ Conferences & Meetings ²	\$0.00	\$0.00	\$0.00
13	Interest ²	\$0.00	\$0.00	\$0.00
14	Insurance	\$0.00	\$0.00	\$0.00
16	Specific Assistance To Individuals ²	\$0.00	\$0.00	\$0.00
17	Depreciation ²	\$0.00	\$0.00	\$0.00
18	Other Non-Personnel ²	\$0.00	\$0.00	\$0.00
20	Capital Purchase ²	\$0.00	\$0.00	\$0.00
22	Indirect Cost (10% of S&B)	\$15,902.00	\$0.00	\$15,902.00
24	In-Kind Expense	\$0.00	\$0.00	\$0.00
25	GRAND TOTAL	\$174,925.00	\$0.00	\$174,925.00

¹ Each expense object line-item shall be defined by the Department of Finance and Administration Policy 03, *Uniform Reporting Requirements and Cost Allocation Plans for Subrecipients of Federal and State Grant Monies, Appendix A*. (posted on the Internet at: <https://www.tn.gov/assets/entities/finance/attachments/policy3.pdf>).

² Applicable detail follows this page if line-item is funded.

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GRANT BUDGET LINE-ITEM DETAIL

(BUDGET PAGE 2)

SALARIES						AMOUNT
Name - Title	Salary	x	Percentage of Time	+	Longevity Bonus	
Osamudien Osa-Edoh	221900	x	5%	+	\$	11,095.00
Erlete Ascencao	120000	x	75%	+	\$	90,000.00
Ronda Jennings	70000	X	36.60%	+	\$	25,616.00
		x	100%	+	\$	-
		x	100%	+	\$	-
ROUNDED TOTAL						\$ 126,700.00

PROFESSIONAL FEE/ GRANT & AWARD	AMOUNT
ROUNDED TOTAL	\$ -

TRAVEL/ CONFERENCES & MEETINGS	AMOUNT
ROUNDED TOTAL	\$ -

SPECIFIC ASSISTANCE TO INDIVIDUALS	AMOUNT
ROUNDED TOTAL	\$ -

OTHER NON-PERSONNEL	AMOUNT
	\$ -
ROUNDED TOTAL	\$ -

ATTACHMENT A

GRANT BUDGET

(BUDGET PAGE 1)

Meharry Outpatient

APPLICABLE PERIOD: The grant budget line-item amounts below shall be applicable only to expense incurred during the grant period.

Object Line-item Reference	EXPENSE OBJECT LINE-ITEM CATEGORY ¹ (detail schedule(s) attached as applicable)	GRANT CONTRACT	GRANTEE MATCH ³	TOTAL PROJECT
1	Salaries ²	\$98,900.00	\$0.00	\$98,900.00
2	Benefits & Taxes	\$25,219.50	\$0.00	\$25,219.50
4, 15	Professional Fee/ Grant & Award ²	\$0.00	\$0.00	\$0.00
5	Supplies	\$0.00	\$0.00	\$0.00
6	Telephone	\$0.00	\$0.00	\$0.00
7	Postage & Shipping	\$0.00	\$0.00	\$0.00
8	Occupancy	\$0.00	\$0.00	\$0.00
9	Equipment Rental & Maintenance	\$0.00	\$0.00	\$0.00
10	Printing & Publications	\$0.00	\$0.00	\$0.00
11, 12	Travel/ Conferences & Meetings ²	\$0.00	\$0.00	\$0.00
13	Interest ²	\$0.00	\$0.00	\$0.00
14	Insurance	\$0.00	\$0.00	\$0.00
16	Specific Assistance To Individuals ²	\$0.00	\$0.00	\$0.00
17	Depreciation ²	\$0.00	\$0.00	\$0.00
18	Other Non-Personnel ²	\$61,844.50	\$0.00	\$61,844.50
20	Capital Purchase ²	\$0.00	\$0.00	\$0.00
22	Indirect Cost (10% of S&B)	\$18,596.00	\$0.00	\$18,596.00
24	In-Kind Expense	\$0.00	\$0.00	\$0.00
25	GRAND TOTAL	\$204,560.00	\$0.00	\$204,560.00

¹ Each expense object line-item shall be defined by the Department of Finance and Administration Policy 03, *Uniform Reporting Requirements and Cost Allocation Plans for Subrecipients of Federal and State Grant Monies, Appendix A*. (posted on the Internet at: <https://www.tn.gov/assets/entities/finance/attachments/policy3.pdf>).

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GRANT BUDGET LINE-ITEM DETAIL

(BUDGET PAGE 2)

SALARIES						AMOUNT
Name - Title	Salary	x	Percentage of Time	+	Longevity Bonus	
Livette Johnson	200740	x	21%	+	\$	41,700.37
Sheena Simon	117832	x	25%	+	\$	29,458.13
Debra Simmons	55536	x	50%	+	\$	27,775.45
		x	100%	+	\$	-
		x	100%	+	\$	-
ROUNDED TOTAL						\$ 98,900.00

PROFESSIONAL FEE/ GRANT & AWARD	AMOUNT
ROUNDED TOTAL	\$ -

TRAVEL/ CONFERENCES & MEETINGS	AMOUNT
ROUNDED TOTAL	\$ -

SPECIFIC ASSISTANCE TO INDIVIDUALS	AMOUNT
ROUNDED TOTAL	\$ -

OTHER NON-PERSONNEL	AMOUNT
Labcorp	\$ 61,844.50
ROUNDED TOTAL	\$ 61,844.50

ATTACHMENT A

GRANT BUDGET

(BUDGET PAGE 1)

Meharry Psychosocial

APPLICABLE PERIOD: The grant budget line-item amounts below shall be applicable only to expense incurred during the grant period.

Object Line-item Reference	EXPENSE OBJECT LINE-ITEM CATEGORY ¹ (detail schedule(s) attached as applicable)	GRANT CONTRACT	GRANTEE MATCH ³	TOTAL PROJECT
1	Salaries ²	\$46,200.00	\$0.00	\$46,200.00
2	Benefits & Taxes	\$11,781.00	\$0.00	\$11,781.00
4, 15	Professional Fee/ Grant & Award ²	\$0.00	\$0.00	\$0.00
5	Supplies	\$0.00	\$0.00	\$0.00
6	Telephone	\$0.00	\$0.00	\$0.00
7	Postage & Shipping	\$0.00	\$0.00	\$0.00
8	Occupancy	\$0.00	\$0.00	\$0.00
9	Equipment Rental & Maintenance	\$0.00	\$0.00	\$0.00
10	Printing & Publications	\$0.00	\$0.00	\$0.00
11, 12	Travel/ Conferences & Meetings ²	\$0.00	\$0.00	\$0.00
13	Interest ²	\$0.00	\$0.00	\$0.00
14	Insurance	\$0.00	\$0.00	\$0.00
16	Specific Assistance To Individuals ²	\$0.00	\$0.00	\$0.00
17	Depreciation ²	\$0.00	\$0.00	\$0.00
18	Other Non-Personnel ²	\$0.00	\$0.00	\$0.00
20	Capital Purchase ²	\$0.00	\$0.00	\$0.00
22	Indirect Cost (10% of S&B)	\$5,700.00	\$0.00	\$5,700.00
24	In-Kind Expense	\$0.00	\$0.00	\$0.00
25	GRAND TOTAL	\$63,681.00	\$0.00	\$63,681.00

¹ Each expense object line-item shall be defined by the Department of Finance and Administration Policy 03, *Uniform Reporting Requirements and Cost Allocation Plans for Subrecipients of Federal and State Grant Monies, Appendix A*. (posted on the Internet at: <https://www.tn.gov/assets/entities/finance/attachments/policy3.pdf>).

² Applicable detail follows this page if line-item is funded.

³ A Grantee Match Requirement is detailed by this Grant Budget, and the maximum total amount reimbursable by the State pursuant to this Grant Contract, as detailed by the "Grant Contract" column above, shall be reduced by the amount of any Grantee failure to meet the Match Requirement.

ATTACHMENT A

GRANT BUDGET

(BUDGET PAGE 1)

Meharry MAI

APPLICABLE PERIOD: The grant budget line-item amounts below shall be applicable only to expense incurred during the grant period.

Object Line-item Reference	EXPENSE OBJECT LINE-ITEM CATEGORY ¹ (detail schedule(s) attached as applicable)	GRANT CONTRACT	GRANTEE MATCH ³	TOTAL PROJECT
1	Salaries ²	\$22,463.00	\$0.00	\$22,463.00
2	Benefits & Taxes	\$5,728.00	\$0.00	\$5,728.00
4, 15	Professional Fee/ Grant & Award ²	\$0.00	\$0.00	\$0.00
5	Supplies	\$0.00	\$0.00	\$0.00
6	Telephone	\$0.00	\$0.00	\$0.00
7	Postage & Shipping	\$0.00	\$0.00	\$0.00
8	Occupancy	\$0.00	\$0.00	\$0.00
9	Equipment Rental & Maintenance	\$0.00	\$0.00	\$0.00
10	Printing & Publications	\$0.00	\$0.00	\$0.00
11, 12	Travel/ Conferences & Meetings ²	\$0.00	\$0.00	\$0.00
13	Interest ²	\$0.00	\$0.00	\$0.00
14	Insurance	\$0.00	\$0.00	\$0.00
16	Specific Assistance To Individuals ²	\$0.00	\$0.00	\$0.00
17	Depreciation ²	\$0.00	\$0.00	\$0.00
18	Other Non-Personnel ²	\$0.00	\$0.00	\$0.00
20	Capital Purchase ²	\$0.00	\$0.00	\$0.00
22	Indirect Cost (10% of S&B)	\$2,819.00	\$0.00	\$2,819.00
24	In-Kind Expense	\$0.00	\$0.00	\$0.00
25	GRAND TOTAL	\$31,010.00	\$0.00	\$31,010.00

¹ Each expense object line-item shall be defined by the Department of Finance and Administration Policy 03, *Uniform Reporting Requirements and Cost Allocation Plans for Subrecipients of Federal and State Grant Monies, Appendix A*. (posted on the Internet at: <https://www.tn.gov/assets/entities/finance/attachments/policy3.pdf>).

² Applicable detail follows this page if line-item is funded.

³ A Grantee Match Requirement is detailed by this Grant Budget, and the maximum total amount reimbursable by the State pursuant to this Grant Contract, as detailed by the "Grant Contract" column above, shall be reduced by the amount of any Grantee failure to meet the Match Requirement.

GRANT BUDGET LINE-ITEM DETAIL

(BUDGET PAGE 2)

SALARIES						AMOUNT
Name - Title	Salary	x	Percentage of Time	+	Longevity Bonus	
Sheena Simon	117832	x	19%	+	\$	22,463.02
		x	100%	+	\$	-
ROUNDED TOTAL						\$ 22,500.00

PROFESSIONAL FEE/ GRANT & AWARD	AMOUNT
ROUNDED TOTAL	\$ -

TRAVEL/ CONFERENCES & MEETINGS	AMOUNT
ROUNDED TOTAL	\$ -

SPECIFIC ASSISTANCE TO INDIVIDUALS	AMOUNT
ROUNDED TOTAL	\$ -

OTHER NON-PERSONNEL	AMOUNT
	\$ -
ROUNDED TOTAL	\$ -

BUSINESS ASSOCIATE AGREEMENT

This agreement is initiated by and between **THE METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY (METRO)**, a metropolitan form government organized and existing under the laws and constitution of the State of Tennessee ("**Metro**" or "**Covered entity**") and **Meharry Medical College** ("**Business Associate**").

SECTION 1 – DEFINITIONS

- a. **Business Associate.** "Business Associate" shall generally have the same meaning as the term "Business Associate" in 45 CFR § 160.103, and in reference to the party to this agreement, shall mean **Meharry Medical College**.
- b. **Covered Entity.** "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR § 160.103, and in reference to the party to this agreement, shall mean **Metro**, which must fall under one of the following categories:
 - (1) A health plan.
 - (2) A health care clearinghouse.
 - (3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter.
- c. **Disclosure.** "Disclosure" means the release, transfer, provision of access to, or divulging in any manner of information outside the entity holding the information.
- d. **Electronic Media.** "Electronic Media" shall have the same meaning as set forth in 45 CFR § 160.103.
- e. **Employer.** "Employer" is defined as it is in 26 U.S.C. § 3401(d).
- f. **Genetic Information.** "Genetic Information" shall have the same meaning as set forth in 45 CFR § 160.103.
- g. **HITECH Standards.** "HITECH Standards" means the privacy, security and security Breach notification provisions under the Health Information Technology for Economic and Clinical Health (HITECH) Act, Final Rule of 2013, and any regulations promulgated thereunder.

- h. **Individual.** "Individual" shall have the same meaning as set forth in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
- i. **Person.** "Person" means a natural person, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.
- j. **Privacy Rule.** "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
- k. **Protected Health Information.** "Protected Health Information" or "PHI":
 - (1) Shall have the same meaning as set forth in 45 CFR § 160.103.
 - (2) Includes, as set forth in 45 CFR § 160.103, any information, *now also including genetic information*, whether oral or recorded in any form or medium, that:
 - (i) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
 - (ii) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.
- l. **Required By Law.** "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103.
- m. **Secretary.** "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
- n. **Security Rule.** "Security Rule" shall mean the Standards for Security of Individually Identifiable Health Information at 45 CFR part 160 and subparts A and C of part 164.
- o. **Subcontractor.** "Subcontractor" means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

- p. **Transaction.** "Transaction" shall have the same meaning as set forth in 45 CFR § 160.103.
- q. **Catch-all definition.** Terms used but not otherwise defined in this Agreement shall have the same meaning as the meaning ascribed to those terms in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology Act of 2009, as incorporated in the American Recovery and Reinvestment Act of 2009 ("HITECH Act"), implementing regulations at 45 Code of Federal regulations Parts 160-164 and any other current and future regulations promulgated under HIPAA or the HITECH Act.

SECTION 2 - OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

- a. **Permitted Uses of Protected Health Information.** Business Associate shall not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required by Law. Business Associate may: 1) use and disclose PHI to perform its obligations under its contract with Metro; (2) use PHI for the proper management and administration of Business Associate; and (3) disclose PHI for the proper management and administration of Business Associate, if such disclosure is required by law or such disclosure is authorized by Metro.
- b. **Safeguards.** Business Associate shall use appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement. Business Associate shall develop and implement policies and procedures that comply with the Privacy Rule, Security Rule, and the HITECH Act. The Business Associate must obtain satisfactory assurances that any subcontractor(s) will appropriately safeguard PHI.
- c. **Mitigation.** Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
- d. **Notice of Use or Disclosure, Security Incident or Breach.** Business Associate shall notify Metro of any use or disclosure of PHI by Business Associate not permitted by this Agreement, any Security Incident (as defined in 45 C.F.R. section 164.304) involving Electronic PHI, and any Breach of Protected Health Information within five (5) business days.

- (i) Business Associate shall provide the following information to Metro within ten (10) business days of discovery of a Breach except when despite all reasonable efforts by Business Associate to obtain the information required, circumstances beyond the control of the Business Associate necessitate additional time. Under such circumstances, Business Associate shall provide to Metro the following information as soon as possible and without unreasonable delay, but in no event later than thirty (30) calendar days from the date of discovery of a Breach:
 - (1) The date of the Breach;
 - (2) The date of the discovery of the Breach;
 - (3) A description of the types of PHI that were involved;
 - (4) identification of each individual whose PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed; and
 - (5) Any other details necessary to complete an assessment of the risk of harm to the Individual.
- (ii) Business Associate shall cooperate with Metro in investigating the breach and in meeting Metro's notification obligations under the HITECH Act and any other security breach notification laws.
- (iii) Business Associate agrees to pay actual costs for notification after a determination that the Breach is significant enough to warrant such measures.
- (iv) Business Associate agrees to establish procedures to investigate the Breach, mitigate losses, and protect against any future Breaches, and to provide a description of these procedures and the specific findings of the investigation to Metro in the time and manner reasonably requested by Metro.
- (v) Business Associate shall report to Metro any successful: (1) unauthorized access, use, disclosure, modification, or destruction of Electronic Protected Health Information; and (2) interference with Business Associate's information systems operations, of which Business Associate becomes aware.

- e. **Compliance of Agents.** Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Metro, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
- f. **Access.** Business Associate agrees to provide access, at the request of Metro, and in the time and manner designated by Metro, to Protected Health Information in a Designated Record Set, to Metro or, as directed by Metro, to an Individual, so that Metro may meet its access obligations under 45 CFR § 164.524, HIPAA and the HITECH Act.
- g. **Amendments.** Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that Metro directs or agrees at the request of Metro or an Individual, and in the time and manner designated by Metro, so that Metro may meet its amendment obligations under 45 CFR § 164.526, HIPAA and the HITECH Act.
- h. **Disclosure of Practices, Books, and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Metro available to Metro, or at the request of Metro to the Secretary, in a time and manner designated by Metro or the Secretary, for purposes of determining Metro's compliance with the HIPAA Privacy Regulations.
- i. **Accounting.** Business Associate shall provide documentation regarding any disclosures by Business Associate that would have to be included in an accounting of disclosures to an Individual under 45 CFR § 164.528 (including without limitation a disclosure permitted under 45 CFR § 164.512) and under the HITECH Act. Business Associate shall make the disclosure Information available to Metro within thirty (30) days of Metro's request for such disclosure Information to comply with an individual's request for disclosure accounting. If Business Associate is contacted directly by an individual based on information provided to the individual by Metro and as required by HIPAA, the HITECH Act or any accompanying regulations, Business Associate shall make such disclosure Information available directly to the individual.
- j. **Security of Electronic Protected Health Information.** Business Associate agrees to: (1) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of Metro; (2) ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; and (3) report to Metro any security incident of which it becomes aware.

- k. **Minimum Necessary.** Business Associate agrees to limit its uses and disclosures of, and requests for, PHI: (a) when practical, to the information making up a Limited Data Set; and (b) in all other cases subject to the requirements of 45 CFR 164.502(b), to the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.
- l. **Compliance with HITECH Standards.** Business Associate shall comply with the HITECH Standards as specified by law.
- m. **Compliance with Electronic Transactions and Code Set Standards:** If Business Associate conducts any Standard Transaction for, or on behalf, of Metro, Business Associate shall comply, and shall require any subcontractor or agent conducting such Standard Transaction to comply, with each applicable requirement of Title 45, Part 162 of the Code of Federal Regulations. Business Associate shall not enter into, or permit its subcontractor or agents to enter into, any Agreement in connection with the conduct of Standard Transactions for or on behalf of Metro that:
- (i) Changes the definition, Health Information condition, or use of a Health Information element or segment in a Standard;
 - (ii) Adds any Health Information elements or segments to the maximum defined Health Information Set;
 - (iii) Uses any code or Health Information elements that are either marked “not used” in the Standard’s Implementation Specification(s) or are not in the Standard’s Implementation Specifications(s); or
 - (iv) Changes the meaning or intent of the Standard’s Implementations Specification(s).
- n. **Indemnity.** Business Associate shall indemnify and hold harmless Metro, its officers, agents and employees from and against any claim, cause of action, liability, damage, cost or expense, including attorneys’ fees, arising out of or in connection with any non-permitted use or disclosure of Protected Health Information or other breach of this Agreement by Business Associate or any subcontractor or agent of the Business Associate.

SECTION 3 - OBLIGATIONS OF METRO

- a. Metro shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate’s use or disclosure of Protected Health Information.

- b. Metro shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Metro has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

SECTION 4 – TERM, TERMINATION AND RETURN OF PHI

- a. **Term.** The Term of this Agreement shall be effective when file in the office of the Metropolitan Clerk and shall terminate when all of the Protected Health Information provided by Metro to Business Associate, or created or received by Business Associate on behalf of Metro, is destroyed or returned to Metro, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this section. The maximum length of the effective term of the contract is sixty (60) months from the effective date.
- b. **Termination for Cause.** Upon Metro's knowledge of a material breach by Business Associate, Metro shall provide an opportunity for Business Associate to cure the breach or end the violation. Metro may terminate this Agreement between Metro and Business Associate if Business Associate does not cure the breach or end the violation within fourteen (14) days. In addition, Metro may immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not feasible.
- c. **Obligations on Termination.**
 - (i) Except as provided in subsection (ii), upon termination of this Agreement, for any reason, Business Associate shall return or destroy as determined by Metro, all Protected Health Information received from Metro, or created or received by Business Associate on behalf of Metro. This provision shall apply to Protected Health Information that is in the possession of subcontractor or agents of the Business Associate. Business Associate shall retain no copies of the Protected Health Information. Business Associate shall complete such return or destruction as promptly as possible, but no later than sixty (60) days following the termination or other conclusion of this Agreement. Within such sixty (60) day period, Business Associate shall certify on oath in writing to Metro that such return or destruction has been completed.

- (ii) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Metro notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information. If Metro does not agree that return or destruction of Protected Health Information is infeasible, subparagraph (i) shall apply. Business Associate shall complete these obligations as promptly as possible, but no later than sixty (60) days following the termination or other conclusion of this Agreement.

Section 5 – Miscellaneous

- a. **Regulatory References.** A reference in this Agreement to a section in HIPAA or the HITECH Act means the section as in effect or as amended, and for which compliance is required.
- b. **Amendment.** The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Metro to comply with the requirements of HIPAA or the HITECH Act and any applicable regulations in regard to such laws.
- c. **Survival.** The respective rights and obligations of Business Associate shall survive the termination of this Agreement.
- d. **Interpretation.** Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Metro to comply with HIPAA or the HITECH Act or any applicable regulations in regard to such laws.
- e. **Governing Law.** The validity, construction, and effect of this Agreement and any and all extensions and/or modifications thereof shall be governed by the laws of the State of Tennessee. Tennessee law shall govern regardless of any language in any attachment or other document that Business Associate may provide.
- f. **Venue.** Any action between the parties arising from this Agreement shall be maintained in the courts of Davidson County, Tennessee.

MEHARRY COMMUNITY WELLNESS CENTER

AMBULATORY/OUTPATIENT SERVICES

ORGANIZATION AND TEAM QUALIFICATIONS

I. ORGANIZATIONAL BACKGROUND

1. Describe in detail the background of your agency. Include the purpose of your organization, years of experience in providing services to People Living With HIV/AIDS (PLWHAs) and the years of providing these services (note if any HIV specific services are provided and/or if you currently collaborate with an HIV agency) and number of unduplicated persons served last year.

Purpose. Meharry Community Wellness Center (MCWC) strives to eliminate HIV health disparities in Nashville Transitional Grant Area (TGA) by promoting awareness, education, and training, transdisciplinary research, community partnership, and unfettered access to comprehensive, high-quality care.

Background. Meharry has been a leader in primary care medicine for over a century and HIV prevention and treatment since the beginning of the epidemic in 1981. Out of a growing need to expand access to culturally sensitive, comprehensive primary HIV care in the Nashville Transitional Grant Area (TGA), Dr. Vladimir Berthaud founded Meharry Community Wellness Center (MCWC) in 2005. MCWC has been a top-ranked Tennessee-designated AIDS Center of Excellence since 2006, and a Hepatitis Center of Excellence since 2016. Tennessee Health Department recognizes MCWC as a “national model for comprehensive HIV care among the underserved community”. Meharry has been providing mental health services to people living with HIV for over 40 years and Meharry Community Wellness Center had done so for 20 years.

Meharry Community Wellness Center provides 24/7 coverage for medical and dental services. Clients have easy access to one-stop, wrap around core and support services: HIV counseling and testing, PrEP/PEP, and primary HIV care; management of complex infectious diseases; women’s health services including reproductive health, Pap test/colposcopy; minor ambulatory surgery including proctoscopy, skin biopsy, wound care, pre- and postoperative management; psychiatry, clinical psychology, mental health therapy and drug counseling; Medication-Assisted Treatment (MAT), outpatient and residential treatment of substance use disorder; HIV Drug Assistance Program (HDAP), Insurance Assistance Program (IAP), on-site pharmacy services; housing assistance, medical transportation, and nutrition; legal aid, home and community-based health services, and referrals to specialty and community resources; comprehensive primary oral health including prophylaxis, dental hygiene, tooth extraction, root canal, cutting-edge prosthodontics, and oro-maxillo-facial surgery.

Our patient population has an alarming prevalence of severe tooth decay (60%) and severe periodontitis (30%). Meharry Community Wellness Center (MCWC) represents the only Tennessee clinic that offers unfettered access to fully integrated, comprehensive oral health

services for low-income PLWH regardless of their primary HIV care providers. The Tennessee Ryan White Dental Assistance Program (RWDAP) ran out of funding in April 2019 and left 1,800 clients with very limited or non-existing access to oral health services. Only 10% of our clients have dental insurance coverage and just 2% of them have adequate coverage. As of 2023, TennCare offers limited oral health benefits to eligible clients. So far, they have not referred any patients to our dental clinic. The dental clinic disposes of two state-of-the-art operatories, two intra-oral digital cameras, and one portable digital X-Ray, one lab, and one sterilization room. It applies breakthrough 3D technology to fabricate crowns, bridges, partial, and full dentures while the client is waiting. Meharry Community Wellness Center is among five health centers who dispose of this brand-new technology for fabricating full-mouth and partial denture in one visit in the United States. Special cases such as impacted molars, orthodontics, intra-oral abscesses, or deep-seated infections, are referred on site to Oro-Maxillo-Facial Surgery service at the Meharry School of Dentistry using program income to pay the discounted fees for these referrals.

Meharry Community Wellness Center had served 2,165 unduplicated clients since inception and 468 in 2024 including 77% Black or African American, 10% Hispanic/Latino, 25% female, and 46% MMSC. Our proportion of PWH with unmet housing needs (24.9%) represent about thrice the national average for PWH (8.4%) and twice the average for Ryan White clients nationwide (12.9%). Our clients bear an excess burden of poverty (53% below 100% federal poverty level), history of incarceration (20%), substance use and behavioral disorders (30%), uninsured (39%), cardiovascular diseases (30%), chronic lung diseases (35%), and diabetes (20%). Nonetheless, 85% of our clients had achieved viral load suppression (increased from 78.6% in 2021, 82.3% in 2022, and 83.3% in 2023), and 90% have CD4 cell count above 200 cells/mm³. Retention in care had increased from 70.47% in 2021 to 76.13% in 2023. However, cases of syphilis rose from 18.1% in 2021 to 22.5% in 2023, in line with the ongoing syphilis epidemic in the US. Only 7.5% of women had abnormal Pap test in 2023 as compared with 8.3% in 2021. As the sole clinic providing fully integrated state-of-the-art oral health services at no cost to people with HIV (PWH) in Tennessee regardless of their primary HIV provider, MCWC had served 650 clients in 2,689 units during past 16 years.

Under contractual agreement, MCWC had served about 600 inmates living with HIV (64% Black or African American) throughout all Tennessee prisons over 21 years. In 2006, we pioneered telemedicine between Meharry and Tennessee prisons. This collaboration contributed to raising clinic attendance from 50% to 90% and viral suppression, from baseline 30% to 90% in 2020.

MCWC had received uninterrupted grant funding from Ryan White Part B since 2002, HRSA Ryan White Part C since 2003, Ryan White Part A since 2008, and HOPWA since 2016. In order to stretch the Ryan White grant dollars, MCWC expends its program income to further project objectives in priority areas of unmet need, such as nutrition and medical transportation; oral health, ambulatory surgery, and women's health services; as well as coverage of

ambulatory/outpatient specialty services for management of comorbidities, and co-pays of prescription drugs for underinsured, low-income individuals with HIV. The dental clinic was built out of several competitive HRSA grants supplemented by program income.

The prospect for new funding remains grim because of a large budget shortfall in the Tennessee Ryan White B program that required across-the-board budget cuts leading to a reduction of our annual budget by \$76,510.50 since 2021-2022 and planned termination of Part B funding for Part A grantees in 2026. Our Part C grant has been on freeze under Executive Order and HRSA has not issued the 2025 grant award yet. Therefore, Ryan White Part A had become lifesaving for people living with HIV in Nashville TGA.

2. Describe in detail the current HIV counseling and testing capacity of your organization, and any existing collaborative arrangements with other organizations within your service area that provide HIV counseling and testing services.

Clients who are diagnosed HIV positive at Meharry Community Wellness Center are linked and enrolled in care immediately. The same policy applies to those who test HIV positive in the Emergency Department or outpatient clinics of Nashville General Hospital. Newly diagnosed people who are incarcerated in local jails are referred to MCWC and seen in less than a week. Inmates of Tennessee Department of Corrections are referred to the clinic on the day of their release for medical insurance enrollment and linkage to care. All other individuals with HIV referred to MCWC are given an initial appointment within 1-7 days

Meharry Community Wellness Center (MCWC) uses its program income to provide targeted HIV counseling and testing. In 2023, we tested 75 high-risk individuals and found seven (9.33%) HIV-positive people, as compared to <0.5% in the general population. All these newly identified persons with HIV were enrolled in care and started taking antiretroviral treatment (ART) before leaving the clinic. Medical providers, EIS Worker, and Medical Case Managers (MCM) educate clients about HIV risk behaviors and effective strategies to prevent HIV transmission at each patient visit, using audio-visual materials, interactive tablets, brochures, and multi-disciplinary intervention. They counsel every person with HIV (PWH) entering care about the implications of HIV infection, the benefits and potential side-effects of antiretroviral therapy (ART), risk reduction and disclosure to sexual and/or needle sharing partners. They reinforce risk reduction messages and encourage clients to have their partner(s) tested every 3-6 months and enroll in PrEP if they're not virally suppressed. We also invite persons with high-risk HIV behavior to participate in our ongoing clinical trials such as the landmark Purpose 2 study conducted at Meharry under the leadership of Dr. Berthaud as Principal Investigator. This trial showed that twice-yearly injection of lenacapavir resulted in 96% protection from HIV transmission in MSM, transgender men, and non-binary persons.

MCWC has a track record of collaboration for HIV counseling and testing with multiple local and extramural partners such as: Nashville General Hospital, the Meharry Elam Mental Health Center, the Meharry Medication-Assisted Treatment (MAT) clinic, and the Meharry Clinics;

Davidson County Sheriff Office, Tennessee Department of Corrections, United Neighborhood, Matthew Walker Comprehensive Health Center, Street Works, Nashville CARES, Vanderbilt University Medical Center, Ascension St Thomas Health, and Metropolitan Nashville Health Department; long-term care facilities like, Bordeaux Nursing Home and Whites Creek Nursing Home, as well as drug treatment centers (Cumberland, Samaritan), and Middle Tennessee Mental Health Institute.

3. Describe in detail how the proposed project fits with your agency’s mission and capabilities.

As an annual Tennessee-designated AIDS Center of Excellence since 2006, Meharry Community Wellness Center (MCWC) focuses on eliminating health inequities in HIV/AIDS, advancing HIV/AIDS awareness, transformative education, and transdisciplinary research, strengthening community outreach and partnership, and providing exceptional and compassionate health services. Our mission aligns with the overall mission of Meharry Medical College to empower diverse populations to improve the well-being of humankind. Our vision aligns with the vision of the National HIV/AIDS Strategy and the White House Ending-the-Epidemic Plan. Meharry has been providing mental health services to people living with HIV for over 40 years and Meharry Community Wellness Center had done so for 20 years. This proposed Mental Health project fits our mission and capabilities to address unmet need in outpatient/ambulatory care for underserved persons living with HIV in the Nashville Transitional Grant Area (TGA). Although Meharry Community Wellness Center serves the hardest-to-reach populations of persons with HIV in Middle Tennessee, as aforementioned, our retention in care had reached 76.13% in 2023. During the most recent decade, viral load suppression had substantially improved for all subpopulations, especially youth, young adults, and MSM, the risk categories with the highest incidence of HIV in our clinic (47.1% for MSM). In fact, MSM achieved the highest rate of viral suppression in 2024, a reflection of our cultural competence, coupled with non-judgmental, customer-friendly, and compassionate HIV care.

Viral Suppression by Subpopulation (%): 2015-2024			
Subpopulation	Year		
	2015	2019	2024
White	75.61	73.85	81.82
Black or African American	73.14	75.58	82.48
Hispanic/Latino	81.25	83.33	80.49
Youth (13-24)	51.85	74.19	80.00
25-34	63.22	71.57	84.38
35-54	76.52	74.88	79.79
55+	82.83	81.82	83.72
Women	72.00	77.39	79.81
Men	68.9	70.79	80.78
MSM	63.27	72.73	85.71

Source: CAREWare 230

4. Describe in detail how your background, mission and experience contribute to the ability of your organization to conduct the proposed project and meet the expectations of the program requirements. In addition, Metro Health may conduct pre-award on-site visits to determine if the contractor's facilities are appropriate for the services intended.

Meharry is the oldest provider of HIV care in Tennessee, dating back the beginning of the epidemic in 1981. Under the leadership of its Founding Executive Director, Dr. Vladimir Berthaud, Meharry Community Wellness Center (MCWC) had earned the annual designation of Tennessee AIDS Center of Excellence continuously since 2006 and grew exponentially, thanks to multiple funding streams including several Ryan White grants. MCWC had become a beacon of hope and comfort for persons with HIV, affected by stigma, discrimination, social injustice, and health inequities. For current grant year ending on February 28, 2025, our outpatient/ambulatory grant had already beaten the expectations of program requirements as illustrated by the projected number of clients to be served and the number of service units (projected number: 99/actual: 179 and projected units: 400/actual: 2480). A multidisciplinary team of experienced and highly-qualified staff provide person-centered, multidisciplinary, holistic health services of the highest quality. Daily patient surveys denote an average satisfaction rate of 95%. As a testament of our performance, HRSA had selected MCWC to host the first National Meeting on HIV in Rural Areas in 2019 and one of three US sites that conducted the Special Project of National Significance (SPNS), "Dissemination of Evidence-Informed Interventions: Peer Linkage and Re-engagement of Women of Color", 2016-2019. The Project-derived manual is available at: <https://www.targethiv.org/deii/deii-peer-linkage>.

II. Organization Capacity:

1. Provide copies of the following:

- Resume and job description of proposed Finance Manager
- Organizational chart for your agency; chart must clearly include the program components funded by Part A/MAI.
- Copies of most recent State Licensure or Accreditation for relevant services.
- Articles of Incorporation.
- Documentation of 501(c) 3 designation.
- Current State of Tennessee Charitable Solicitations Letter.
- System for Award Management (SAM) exclusion report.

All these documents are uploaded.

2. Describe agency's experience in administering federal, state and/or local government funds. Include funding source(s) and number of years administering those funds. Provide information for the following:

- **Agency restrictions from receiving federal funds or placed on restrictive measures in the last five years (e.g., increased reporting, increased monitoring visits), please explain.**

Meharry has no restrictions from receiving federal funds. It has never been placed on restrictive measures in the last five years or during its existence.

- **Corrective action plan(s) in the last three years from any funding source, please describe (include the name of the funder, overview of issues identified and the current status of addressing the identified issues and/or recommendations).**

In 2024, HRSA conducted a site visit and identified the following issues: documentation of coordination and linkages with CDC and Prevention-funded HIV testing and outreach services of federally qualified health centers in the service area; documentation of training for HIV care and treatment of all non-clinical staff, documentation of sexual practices of women; demonstration of full implementation of the time and effort policy and the caps on charges; and documentation for allocating program income according to each Ryan White Program grant. All these issues have been corrected except the time and effort policy. The Office of Grants and Contracts is updating the Workday system and recruiting additional personnel to ensure any issues related to time and effort are fixed soon.

- **Audit finding(s) in the last three years. Please describe an overview of issues identified and the current status of addressing the identified issues.**

In 2024, HRSA audited our Ryan White Part C EIS grant and identified the following issues: documentation of coordination and linkages with CDC and Prevention-funded HIV testing and outreach services of federally qualified health centers in the service area; documentation of training for HIV care and treatment of all non-clinical staff, documentation of sexual practices of women; demonstration of full implementation of the time and effort policy and cap on charges; and a clear policy for allocating program income according to each Ryan White Program grant. All these issues have been corrected except the time and effort policy. The Office of Grants and Contracts is updating Workday system and recruiting additional personnel to ensure any issues related to time and effort are quickly fixed.

- **If Contractor(s) is currently a Ryan White Part A provider, an administrative review will be conducted of the previous year's spending of grant funds and will be included as part of the score. If Contractor(s) is not a current Ryan White Part A provider, Contractor(s) must provide a letter of reference from a funder to include a description of Contractor's performance in spending allocated grant funds. This letter will be included as part of the score.**

Not applicable.

- **Submit copies of most recent A-122 Audit (for the last reporting year) conducted by an independent certified public accountant or 990 form, if not required by federal regulations to complete an A-122 Audit.**

An independent CPA firm, Crosslin Certified Public Accountants, had audited the accompanying consolidated financial statements of Meharry Medical College and Subsidiary (collectively the “College”), which comprise the consolidated statements of financial position as of June 30, 2023, and 2022, and the related consolidated statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the consolidated financial statements. In their opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the College as of June 30, 2023, and 2022, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America. (see Attachment: Most Recent Financial Audit, Final Consolidated A133 Financial Statement June 2023).

3. **Describe agency’s current system for collecting data on client demographics, service utilization and performance data. Include all software used to collect this data, staff resources for data collection and hardware resources.**

Staff resources. The Program Director, Dr. Berthaud, serves as Data Manager, assisted by biostatistician, Derek Wilus, MS. They perform duties such as quality management initiatives, data analysis, and dissemination of results, and staff training. The Program Director integrates all audits and performance evaluations into the overall strategic planning and Ryan White programs operations. He facilitates collaboration with statewide, local, and national quality improvement projects. Dirk Francis, Data Center and System Administrator for Meharry Office of Information Technology (OIT), manages the CAREWare server and maintains the software, while Lee Nelson, MBA, Health Information Technology Director, is responsible for managing E-Clinical Works (our electronic health record system) and interfacing with CAREWare (the primary source of data reports).

Data infrastructure. CAREWare™ forms the backbone of our robust information system. Our data repository relies on three separate layers of security. The CAREWare network connects to a dedicated server housed in a highly secure and restricted basement location in the Office of Information and Technology (OIT), monitored by video camera and on uninterrupted electric power supply 24/7. Meharry OIT has designated a qualified technician, Dirk Francis, to manage the CAREWare server in collaboration with MCWC Program Director.

Data operations. Since 2003, Meharry has been using Microsoft SQL server and the most recent CAREWare version as the primary tool for Ryan White data collection, HRSA-required performances measures and programmatic reports. All MCWC staff use CAREWare and enter data elements in real-time. MCWC had created over 180 customized reports in

CAREWare to facilitate data queries and special reports. Moreover, we had developed CAREWare instruments to describe the graphic time course of individual lab variables including CD4 cell count and viral load and designed a unique platform to capture social determinants of health, monitor and evaluate community health care delivery. We have modified CAREWare to allow for attachment of external medical, personal and legal records as well as patient's clinical documents including radiographs and intraoral pictures. MCWC had installed data quality and validity checks for duplicated, missing, discordant, and unknown key data elements to enhance accuracy of reports. A validity check is run prior to submission of reports. All HRSA-required reports including performance measures are readily available in CAREWare and can be created instantly. The Assistant Data Manager, Derek Wilus, MS, biostatistician, uses IBM SPSS or R Studio for more complex data analyses.

Data backup design. Meharry OIT backs up the data daily on extra-large capacity servers and digital tapes. Then, an independent contractor picks up the tapes daily and stores them away from the campus to safeguard them against major disasters and catastrophes such as floods, hurricanes, fire, and powerful earthquakes. The Program Director verifies that CAREWare posts daily messages to check the exact time of each data backup completion.

Original Data: The original data, also referred to as the live production data, resides on the HP Synergy Blade system, stored as a VM, with snapshots taken hourly, and stored on the Nimble CS5000. The snapshots are stored for 7 days.

Tier 1 Storage - The tier 1 backup occurs nightly and writes to a second Nimble array, the CS235. This data is stored for 90 days.

Tier 2 "off-site" Storage - Once weekly, the data is copied from the CS235 to a tape backup solution that is rotated off-site weekly. This data would be stored for 180 days.

Additional data safety and security procedures. Each Meharry desktop and laptop are configured to provide optimum security and reliability. OIT monitors each user's activities and downloads automatically the most recent security updates to all Meharry desktops connected to the network, daily, and screens all emails for SPAMs and phishing messages instantly. Meharry students and employees access the network with a personal username and secured password that is required to be changed regularly.

Software platforms. Meharry has adopted the electronic health records system, E-Clinical Works™, across the campus. The software suits for clinical notes, mobile applications, and Physician Quality Reporting Systems (PQRS). However, its capacity to generate customized reports is limited, complex, and provider-restricted, time-consuming, and costly. Medical providers enter their clinical notes and services in E-Clinical Works, also available on their smartphones app. LabCorp will export the lab tests results in E-Clinical Works as soon as they are available and alert the clinicians on critical values immediately. The HL7 platform and the "socket" allow for seamless export of LabCorp results into the CAREWare labs

section. External health records are either faxed or exported into E-Clinical Works using compatible electronic software. A patient portal is available in E-Clinical Works for better self-management and interaction with medical providers. The patient portal is also accessible via smartphone app. MCWC utilizes E-Clinical Works to submit third party billings and track service charges. Both E-Clinical Works and CAREWare are fully secure and HIPAA-compliant. MCWC staff attend mandatory training on compliance with HIPAA, federal and State, as well as Meharry regulations on patient personal health information. MCWC had developed a user-friendly iOS app that allows the quick calculation of odds for a person with HIV to achieve viral load suppression, based on our landmark publication in BMC Infectious Diseases in 2022.

4. Describe agency's system for managing fiscal and accounting responsibilities. Address the following:

- **Define who oversees this area, what staff is responsible for these activities.**
- **Identify what software is used to manage financial information.**
- **Describe the accounting system that is in place; and**
- **Describe the internal systems that are used to monitor grant expenditures and track, spend, and report program income generated by a federal award.**

Meharry Community Wellness Center (MCWC) had received uninterrupted grant funding from HRSA Part C EIS, Ryan White Part B, and Ryan White Part A for 21, 22, and 17 years, respectively. The Finance Manager, Zudi Takizala, MD, MPH, MBA, is uniquely qualified to oversee fiscal and accounting operations. She brings 21 years of experience in grant administration. In the past three years alone, she had successfully managed 18 public grants including 10 Ryan White grants. MCWC carries a current grant portfolio of about \$3,000,000.00 including grants from NIH/NIAID, HRSA, HOPWA, PEPFAR, and Ryan White Part A and B. Having managed thousands of Federal, State, and local grants and contracts for over 100 years, Meharry is strongly qualified to manage this project. To track and manage grants and contracts, the College uses an accrual method of accounting incorporated into the Banner software and Workday system. The Office of Grants and Contracts works closely with each program and department to assure that budget matters are appropriate and understood. Meharry retains a CPA firm to conduct annual audits and interim financial reports for program planning and implementation. All Meharry fiscal audits had no findings. Additionally, appropriate internal controls including an internal auditing process are in place and assist the College to anticipate and plan more effectively. The Department of Internal Medicine is primary responsible to oversee grant management and the delivery of clinical services. Meharry Medical Group (MMG) supervises the delivery of clinical services, performs billing, collection of charges, and tracking, and reporting of program income to the Project Director. The Office of

Human Resources oversees the hiring process, reviews job descriptions and proposed salaries, assists in background checks, job offers and staff training. The Compliance Office reviews contracts and agreements to ensure compliance with the law. The Office of Grants Management oversees Ryan White programs, ensures that current practices align with federal and State legislation, and that Ryan White funds are expended according to program budget, goals, and expectations. It works closely with MCWC and provides monthly grants expenditures reports to assure disbursements align with program goals and objectives. MCWC and the Office of Grants and Contracts hold monthly financial meetings with Ryan White Part A leadership. The Office of Finance verifies that MCWC manages Ryan White grants according to Generally Accepted Accounting Principles (GAAP). MCWC segregates Ryan White contracts, public, private, and other types of medical insurance in CAREWare to allow for easy tracking and accurate financial report using the service fees and units determined by Ryan White Part A Program. MCWC reinvests program income (billings collections from third-party payers and 340B pharmacy revenues) into overall budget to further program goals and objectives and cover ambulatory out-of-pocket expenses of low-income, underinsured clients. The Program Director reports the program income quarterly to Ryan White Part A and B. The Director of the Office of Grants and Contracts reports annual program income to HRSA via the Federal Financial Report (FFR).

5. Describe agency's process for completing program reports in a timely and accurate manner. Include descriptions of how responsibility for reporting is assigned to staff, how reports are reviewed for accuracy and who assures reports are completed on time.

MCWC staff enters data in CAREWare in real-time. The Program Director had created over 200 customized reports in CAREWare that allow for quick data analysis and reports, research advancement, and deeper understanding of program outcomes. These customized CAREWare reports also comprise data validation, quality checks, for duplicate, missing, and unknown data. CAREWare is able to create a list of all clients with missing/unknown, or duplicate data for the responsible staff to correct. Prior to submitting any reports, a quality check is run again to identify errors, warnings, and alerts needed to be fixed. All Ryan White required periodic reports and performance measures are embedded in CAREWare, i.e. Ryan White Service Report (RSR), Provider Data Export (PDE), program financial and service reports, etc.

III. Cultural and Linguistic Competency:

As a person closely affected by HIV himself, Dr. Berthaud has dedicated his professional career to improve and save the lives of people with HIV in New York, Tennessee, Latin America, Africa, and the Caribbean. He attributes high priority to cultural and linguistic competency. MCWC staff are trained in cultural competence, cultural humility, and trauma-informed care, and motivational interview. Six of our full-time staff are themselves people living with HIV for over 20 years. Sixty percent of our staff have been affected by HIV, and 70% live in the community

they are serving. Client feedback is obtained daily through anonymous satisfaction surveys and quarterly from the Consumer Advisory Board (CAB). The CAB Chair attends our weekly staff meetings, which reserves ample time for discussion of CAB concerns and the results of patient satisfaction surveys including corrective actions, implementation, and monitoring plan. MCWC leadership incorporates the final recommendations into program operations, specific projects, and/or grant applications. Educational materials are created according to the fifth-grade level based on health literacy research conducted at Meharry Community Wellness Center. Interpretation and translation services are readily available for all languages through a contractual agreement paid for by Meharry Medical College. All MCWC Medical Case Managers are well-trained College graduates, with at least a Master degree, and very familiar with underserved communities, HIV issues, and Ryan White programs.

IV. Collaboration:

- 1 Describe a plan for creating a new or improving an existing network to improve collaboration with HIV agencies that will link PLWHAs to HIV testing and HIV medical care and support services. If applicable, identify any collaborating organizations that will assist the applicant through HIV testing and linkage to HIV medical care and services.**

Linkage of newly identified clients: Patients who diagnose HIV positive in the emergency department (ED) at Nashville General Hospital (NGH), located on the Meharry campus, are linked and enrolled into care the same or next business day. HIV providers and Medical Case Managers follow newly diagnosed persons with HIV (PWH) admitted to NGH and coordinate their discharge disposition. Clients newly identified outside the Meharry campus are linked as soon as possible, preferably within less than 7 days. The Patient Service Representatives (insurance verification), the Community Health Workers (coaching and navigation), and the Medical Case Managers (insurance assistance and Ryan White eligibility) are responsible for rapid linkage.

MCWC organizes outreach events with local partners including Metropolitan Nashville Health Department to raise HIV awareness and promote testing. As member of Nashville PrEP Coalition, MCWC facilitates the rapid linkage of newly diagnosed persons. It also leverages its experience as a research site for the SPNS project targeting newly diagnosed and out-of-care women of color for linkage and retention to enhance engagement in care. As a pioneer of HIV telemedicine in TN prisons and HIV consultant for Davidson County jails since 2006, MCWC facilitates the transition of ex-offenders to rapid linkage and engagement upon their release in the community.

Main referral relationships and collaborations include the following: Nashville General Hospital (NGH), Meharry teaching hospital, where Dr. Berthaud serves as Director of Infectious Diseases and Dr. Livette Johnson co-chairs the Infection Prevention Committee; NGH refers PWH from Emergency Department, inpatient, and outpatient clinics; Meharry Elam Mental Health Center, Meharry Family Medicine and MAT Clinic, located right across the hall from MCWC, and Meharry Clinics constitute regular sources of mutual referrals; Davidson County Sheriff's Office refers inmates with HIV to MCWC since 2005, while Tennessee Department of Corrections

refers them for telemedicine consultation, a service established by Dr. Berthaud in 2006; Neighborhood Health, the largest FQHC in Davidson County, Ascension St Thomas Health (Dr. Berthaud maintains consultation privileges), and Metropolitan Nashville Health Department, the largest HIV testing center in Nashville, represent important referral sources. Metropolitan Development Housing Authority awarded a HOPWA grant for the provision of Short-Term, Rent, Mortgage, and Utilities assistance. Street Works and Nashville CARES provide medical case management, food and housing services including permanent placement and emergency shelters. Second Harvest provides low-cost preserved food for our pantry. Vanderbilt University Medical Center provides emergency, specialty ambulatory, and inpatient care for MCWC clients. Tennessee Health Department had contracted with Meharry for ambulatory/outpatient and medical case management services. They provide technical support to medical case managers and assist in linkage/reengagement of clients lost to care. Metropolitan Nashville Public Health Department (MNPHD) refers newly diagnosed HIV-positive and lost-to-care people, treats persons with latent and active tuberculosis, and coordinates STD management and control. Under MNPHD sponsorship, Meharry received a Part A grant for core and support services. Meharry Elam Mental Health Center collaborates with MCWC Therapist/Drug Counselor on outpatient and inpatient drug treatment, detoxification, and rehabilitation. Meharry and Vanderbilt had signed a Data Usage Agreement for expanding participation of minorities in clinical research through the NIH-funded TN Center for AIDS Research (TN-CFAR), a joint venture including Nashville CARES and TN Health Department.

- 2 Contractor(s) must demonstrate their commitment to work with or collaborate with organizations representing the HIV/AIDS community through a signed and dated letter of support or memoranda of agreement or understanding. The letter must specify example activities that each entity provides that will help connect high risk clients to HIV testing and services.**

Meharry has been providing mental health services to people living with HIV for over 40 years and Meharry Community Wellness Center (MCWC) had done the same for 20 consecutive years. MCWC had established a strong relationship with Meharry Elam Mental Health Center since inception. MCWC Mental Health services are always provided by a psychiatrist from the Elam Mental Health Center. The current psychiatrist is Dr. Osa-Edoh, Director of Elam Mental Health Center. Our Clinical Psychologist, Dr. Erlete Ascencao, worked at the Elam Center for over 12 years, and Ronda Jennings, the Therapist, worked there for two years. Elean Whitlow, Drug Counselor, and Trevon Kelley, Case Manager, both at Elam Center, were MCWC staff for two years. Meharry Community Wellness Center, Street Works, and Nashville CARES have a longstanding collaborative relationship. Dated signed letters that specify example activities that each entity provides that will help connect high risk clients to HIV testing and services are uploaded.

B. Reference Projects (10 Points) Service History & References:

- 1. If your agency currently provides this service(s) to the HIV/AIDS client population,**

describe the number of years you have provided this service and the funder of the service. Please provide a reference name and phone number.

Meharry Medical College has been providing ambulatory/outpatient services to persons with HIV since the initial outbreak in 1981, i.e., even before the virus was discovered. Meharry Community Wellness Center opened in 2005 with funding support from Ryan White Part B and Part C. Ryan White Part A support started right after Nashville became an Emerging Metropolitan Area (EMA) in 2008. However, TN Health Department will stop funding for recipients who receive Part A funding starting on April 2026. Our Part C grant has been on freeze under Executive Order and HRSA has not issued the 2025 grant award yet. Therefore, Ryan White Part A had become lifesaving for people living with HIV in Nashville TGA. Meharry Community Wellness Center has been recipient of Part C Minority AIDS Initiative (MAI) grant funding for Ambulatory/Outpatient Services since 2013 and of Part A MAI grant support since 2022.

For reference, we mention the name of our Part C EIS Project Officer
Christie Slay, MPA, MAEd, CHES, Public Health Analyst/Project Officer, Central
Branch, Division of Community HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, Rockville, MD 20857
Phone: 301.443.0504

2. If your agency does not currently provide service(s) to the HIV/AIDS client population, explain any related experience that would demonstrate the agency's competency in providing services to this population. Please provide a reference name and phone number.

Not applicable.

3. Describe any related experience that would demonstrate your agency's competency in providing HIV medical or support services to this population. Please provide a reference name and phone number. The file is limited to 5 pages and should be in PDF format entitled "Reference Projects."

The file labelled "Reference Projects" had been uploaded.

Here's the reference name and phone number:

Part C EIS Project Officer
Christie Slay, MPA, MAEd, CHES, Public Health Analyst/Project Officer,
Central Branch, Division of Community HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, Rockville, MD 20857
Phone: 301.443.0504

A. Project Approach and Process (30 Points)

I. Staffing:

Present in detail your organization's staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the number of time/hours per month being requested for each proposed staff position.

Ambulatory/Outpatient Services

Staffing Plan of Key Personnel				
Name	Roles	Responsibilities	Education/Training	Experience Part A FTE
Vladimir Berthaud, MD, MPH, FACP, FIDSA, DTMH, CPH	Project Director	Supervision of overall activities; HIV care and infectious diseases services	Board-certified in internal medicine, infectious diseases, public health, tropical medicine, and traveler's health.	International HIV expert with 39 years of experience in HIV care, research, training, teaching, program development, and implementation worldwide.
Zudi Takizala, MD, MPH, MBA	Finance Manager	Project management and CQI	Doctor of Medicine, with master's degree in public health and business	21 years of experience in management of \$30M in Federal, State, & local grants
Keisha Ashmeade Ed.D, MSPH, FNP, AHIVS	Clinic Manager	Manages clinic operations	HIV specialist and Board-certified NP	11 years of HIV care experience
Sheena S. Simon, DNP, APRN, NP-C	Primary HIV care provider	Comprehensive HIV management	Board-Certified Nurse Practitioner, specialized in prevention	22.44% FTE Six years of HIV care experience
Ethel Harris, DDS, MPH	Director of oral health services	Comprehensive oral care and prosthodontics	Meharry graduate, former Director of SEATC oral health	22 years of experience in oral health for PLWH
Ryan White Part A Staffing Plan				
Name	Roles	Responsibilities	Education/Training	Experience Part A FTE
Livette Johnson, MD	Infectious diseases management	HIV and specialty care	Meharry graduate, Board-certified in internal medicine	40% FTE

			and infectious diseases	35 years of experience and expertise in HIV care
Sheena S. Simon, DNP, APRN, NP-C	HIV care provider	Comprehensive HIV management	Board-Certified Nurse Practitioner, specialized in prevention	35% FTE Six years of HIV experience
Debra Simmons, LPN	Phlebotomist	Process laboratory specimens and perform nursing duties	Graduate of Baptist Hospital LPN School	50% FTE 9 years of experience serving PLWH
Maya Johnson, BS, MPH	Community Health Worker	Coaching, adherence counseling, patient navigation, community case management	MPH graduate from Meharry, with solid knowledge of SPSS, SAS, Redcap, GIS, and Microsoft environment	75% FTE One year of experience with PLWH
Tamiko Grimes	Community Health Worker	Coaching, adherence counseling, and patient navigation	Trained Peer Counselor and Community Health Worker	100% FTE 9 years of experience with PLWH
Osamudiamen Osa-Edoh, MD, MPH	Psychiatrist	Treatment of behavioral & substance use disorders	Board-certified psychiatrist, Director of substance use treatment at Meharry	15% FTE 10 years of experience with PLWH
Erlate Ascencao, PhD/PhD, HSP	Clinical Psychologist, Social Scientist	Specialized in HIV clinical psychology services	Doctor in Social Sciences and Clinical Psychology, Licensed Health Services Provider	100% FTE 22 years of experience with PLWH
Ronda Jennings, MA	Senior Medical Case Manager	HOPWA Case Manager, Mental health therapy and drug counseling	Master' degree in Clinical Counseling, Certified Alcohol and Drug Addiction Counselor	64.29% FTE 17 years of experience in medical case management and counseling with PLWH

JaRae Davenport, BS, MPH	Medical Case Manager	Medical case management services including treatment adherence	Master's degree in public health practice	100% Three years of experience in medical case management under Part A grant
Kaye Chavis, DBA	Medical Case Manager	Medical case management services including treatment adherence	Doctoral degree in Business Administration	90.02% 4 years of experience with PLWH and Ryan White Part A grant 23 years' MDHA experience

Qualifications of Key Personnel.

Vladimir Berthaud, MD, MPH, FACP, FIDSA, CPH, DTMH, is tenured professor of medicine, Director, Division of infectious diseases at Meharry Medical College and Nashville General Hospital and Founding Executive Director of Meharry Community Wellness Center. He completed his infectious diseases fellowship at Columbia University and Cornell University in New York. Dr. Berthaud has been a passionate advocate for PLWH and the recipient of numerous prestigious awards including IPRO's Outstanding Service to the Health Care Community Award for Quality Improvement in reducing Disparity for Adult Immunizations in New York State, Award for Outstanding Contribution to the Internal Medicine Training Program, Harlem Hospital/Columbia University College of Physicians & Surgeons, New York City Council Citation for Exemplary Service, National Library of Medicine/Marine Biological Laboratory, Fellowship Award in Medical Informatics, Nashville Business Journal, Award Honoring Superior Contributions to the Health Care Industry, Johnson & Johnson UCLA Healthcare Executive Management Award, Street Works Guiding Light Award, and Mahogany Honors Dwayne Jenkins Lifetime Achievement Award. Part C EIS Program Director for 20 years, Dr. Berthaud serves as Project Director/Principal Investigator for Meharry HIV Research and Training Facility, Mentor and Investigator for the NIH-funded U01-Practice-Based Research Integrating Multidisciplinary Experiences in Dental Schools (PRIMED), Associate Director of Clinical Discovery Core, for TN-CFAR, Clinical Lead for Meharry PEPFAR, and Program Director for HRSA-sponsored National HIV Residency Pathway Consortium. He has been a member of the Tennessee AIDS Centers of Excellence Committee since 2002. Other experiences include Train-of-Trainer Expert for the National HIV Curriculum, HIV Trainer for the National MTCT-Plus Program in Rwanda and Côte d'Ivoire, HIVAIDS Curriculum Developer for NIH/ACTG/HPTN in Latin America and the Caribbean and HIV Preceptor for IDSA International AIDS Training Program, HIV Curriculum Reviewer for CDC, and scientific advisor to CDC Program for TB Elimination, member of the National Board of Public Health Examiners, and of the National Board of Medical Examiners, Academic Advisor, UCLA School of Management, Community Health Improvement Program, and Member, American College of Physicians (ACP) Leadership Academy. Former member of the Leadership Conference and Admissions Liaison Officer, United States Military Academy at West Point, past Chair of The George W. Counts Interest Group of the Infectious Diseases

Society of America (IDSA), past member if IDSA Leadership Development Committee, Dr. Berthaud is a member of the American Board of Internal Medicine Infectious Diseases Task Force and Faculty of the IDSA Leadership Institute. He was a Lead Principal Investigator for the international Kid COVE Vaccine Trial. Dr. Berthaud is Endowed Professor of Medicine, with Adjunct appointment in Microbiology, Immunology, and Physiology. He is Academic Editor for PLOS ONE medical journal and the author of many peer-reviewed publications in impactful scientific journals. Dr. Berthaud is fluent in Spanish, French, English, and Creole.

Livette Johnson, MD. A native Nashvillian and a graduate of Meharry School of Medicine, Dr. Johnson completed her internal medicine residency training at Johns Hopkins University in Baltimore and her infectious diseases fellowship at Cornell University in New York. She holds Board certification in internal medicine and infectious diseases. Dr. Johnson is associate professor of medicine at Meharry Medical College and Vice Chair of Infection Prevention Committee at Nashville General Hospital. Dr. Johnson served as attending physician at Mount Sinai Hospital and Assistant Chief of Infectious Diseases at Metropolitan Hospital in New York. She brings a personal dedication to the care of populations living with HIV.

Zudi Takizala, MD, MPH, MBA. Doctor of Medicine with extensive experience in grant administration, financial management, and staff supervision, Dr. Takizala has a long record of collaboration with diverse internal and external stakeholders, community agencies, and Ryan White programs. She oversees clinical operations at Meharry Community Wellness Center. In the past three years, she had successfully managed 18 public grants including 10 Ryan White grants, and others from NIH, HOPWA, PCORI, Tennessee State and Metropolitan Nashville government.

Keisha Ashmeade, ANP, MSN, MSPH, Ed. D, AAHIVS, board-certified advanced nurse practitioner and certified HIV specialist, Dr. Ashmeade has been Clinical Manager of Meharry Community Wellness Center for seven years. She brings 10 years of experience in HIV primary care and seven years of teaching experience as Assistant Professor.

Ethel Harris, DDS, MPH, Director of Meharry Community Wellness Center's Oral Health Services, she holds joint Faculty appointment as Assistant Professor of Medicine and Dentistry at Meharry and serves as Clinical Investigator on the NIH-funded UO1 grant, "Practice-Based Research Integrating Multidisciplinary Experiences in Dental Schools". Dr. Harris served as Dental Director for the Southeast AIDS Education and Training Center (SEATC). She was born and raised in Nashville and she graduated from Meharry School of Dentistry.

If applicable, describe in detail the roles and responsibilities of any consultants and/or subcontractors will be used to conduct aspects of the proposed project.

This is not applicable.

II. Overview of Population:

Describe in detail the HIV/AIDS population in Davidson County. Describe in the detail the issues that interfere with identifying, engaging, and retaining PLWHAs in routine HIV testing and HIV services.

HIV/AIDS population in Davidson County.

Meharry Community Wellness Center stands at the epicenter of the HIV epidemic in Nashville, in the heart of Davidson County, more specifically, North Nashville, the neighborhood most densely populated in Blacks or African Americans (71%) where 1,933 of every 100,000 people are living with HIV as compared to 978.7 for Blacks in the remaining Nashville Transitional Grant Area (TGA). The TGA had an estimated population of 1,742,588 in 2019, accounting for 26.5% of the state's total population and 31% of the state's people living with HIV (PLWH). In the thirteen counties that make the Nashville Transitional Grant Area (TGA) including Davidson, non-Hispanic Blacks account for 54% of PLWH and in 2021, they represented 27% of Davidson County's population and 52.4% of PLWH. While about 39% of the Nashville TGA's population lives in Davidson County, 76.5% of the PLWH population reside in Davidson County. Of this PLWH population, 20% had been in jail and 42% were homeless/unstably housed at some point in the last year, and 40.2% did not have food to eat three or more days at some point in the last year. Fear of disclosure (50.6%) represents the number one barrier to accessing services (Metropolitan Nashville Health Department). In Nashville TGA, an estimated 17% of PLWH are unaware of their status. In 2020, 66% of newly diagnosed cases were linked to care in 30 days, 54% were retained, and 66% achieved viral suppression. Among Non-Hispanic Blacks, 64% were linked to care within 30 days, 54% were retained and 63% became virally suppressed, and they had the highest incidence of Chlamydia, gonorrhea, and syphilis. Meharry Community Wellness Center (MCWC) serves the most vulnerable and hardest-to-reach PLWH in Tennessee. In 2024, our program served 484 unduplicated clients. African Americans accounted for 77.06%, women 26.44% and MSM 42.35%. Our clients bear an excess burden of uninsured (39.25%), poverty (48.96% below 100% FPL), and history of incarceration (20%), homelessness (19.2%, higher than in Davidson's 13.6%), and substance use and behavioral disorders (30%). More than 70% of our clients did not graduate from high school. Our proportion of clients experiencing homelessness represents more than twice the national average for PLWH (8.4%) and is 50% greater than the national Ryan White average (12.9%). According to the Brookings Institution, North Nashville has an incarceration rate of 14%, by far the highest in the country, and 93% of those incarcerated are Blacks. Our patient population has an alarming prevalence of severe tooth decay (60%) and severe periodontitis (30%). Meharry Community Wellness Center (MCWC) represents the only Tennessee clinic that offers unfettered access to fully integrated, comprehensive oral health services for low-income PLWH regardless of their primary HIV care providers. The Tennessee Ryan White Dental Assistance Program (RWDAP) ran out of funding in April 2019 and left 1,800 clients with very limited or non-existing access to oral health services. Only 10% of our clients have dental insurance coverage and just 2% of them have adequate coverage. Since 2023, TennCare offers limited oral health benefits to eligible clients. So far, they have not referred any patients to our dental clinic. The prospect for new funding

remains grim because of a large budget shortfall in the Tennessee Ryan White B program that required across-the-board budget cuts leading to a reduction of our annual budget by \$76,510.50 since 2021-2022 and termination of funding for Part A grantees in 2026.

Issues that interfere with identifying, engaging, and retaining PLWHAs in routine HIV testing and HIV services.

Gaps in local services. Major gaps in MCWC/TGA HIV care continuum, retention, and viral suppression, can be attributed to high rates of incarceration (20%), homelessness (MCWC 19.2%; TGA 13.8%), and poverty (39.25% below 100% FPL), behavioral and substance use disorders (30%), and chronic comorbidities such as cancer, cardiovascular diseases, chronic kidney and lung diseases. Moreover, gaps in medical and dental insurance coverage, TennCare restrictions on the number of monthly prescriptions, and food shortage, lack of family support as well as stressful life events too often lead to poor treatment adherence and negative health outcomes such as HIV disease progression, exacerbation of comorbidities, frequent visits to specialty clinics, emergency department and admissions to the hospital, mental institutions, and drug treatment centers. Huge gaps persist in oral health, substance use disorders, medical transportation, and housing services.

Major Barriers to Care:

Incarceration: Of 516 inmates with HIV served by MCWC from 2003 to 2018, 64% were Black or African American and 66% aged 45-64. Stepwise implementation of telemedicine in 2006 led to increase in clinic attendance from 50% to 90% and viral suppression from 30% to 90% (Berthaud V. 2022 National Ryan White Conference). Of PLWH incarcerated in Davidson County jails, Non-Hispanic Blacks account for 71% and non-Hispanic Whites 29%. North Nashville has an incarceration rate of 14%, the highest in the country by far, and 93% of those incarcerated are Blacks. In other words, one in seven people who were born in the primary zip code of North Nashville between 1980 and 1986 went to jail or prison at some point in their lives. (Adams L, Nicholas T: Work and opportunity before and after incarceration. The Brookings Institution, March 2018). Twenty five percent of our patients reside in that neighborhood and 41% of them belong to this age group. MSM is still the most frequent means of exposure accounting for 37.5%, and IDU the second most reported exposure category among the jail population (22.1%). Heterosexual exposure accounts for 18.9% of PLWH in jail and MSM/IDU account for 6.3% of the cases; unreported exposure accounts for (15.1%). (Source: Nashville Metropolitan Health Department). Meharry Community Health Worker had established a strong collaborative relationship with Tennessee Department of Corrections (TDOC) and Davidson County Sheriff's Office (DSCO) for over 20 years. Persons with HIV who are incarcerated in DSCO are referred to MCWC for in-person care, while inmates of TDOC are seen by telemedicine.

Transportation: Public bus service in Nashville is extremely limited to some parts of downtown and very few stops in North and West Nashville. It nearly does not exist in South and East Nashville. Most of our patients resides far away from a bus stop. They require multiple transfers to come to the clinic or simply rely on a ride with a relative or a friend. The bus service makes short stops every hour between 8:00am and 4:30pm. There is no subway line in Nashville and Tennessee. MCWC had hired a full-time person to provide free round-trip medical transportation in the Transitional Grant Area (TGA).

Education: High school completion rate is 76% in Davidson County and 15% at MCWC.

Unemployment and poverty: 39.25% of Meharry clients had an annual income <100% FPL in 2023. Unemployment rate reached 60% and 30% were receiving Social Security Income.

Drug and alcohol: Addiction to drugs and alcohol remains a significant risk factor for poor nutrition and treatment adherence, bad health outcomes, incarceration, and homelessness. However, there are insufficient access points to drug detoxification and rehabilitation in Davidson County. Many offenders released on parole or probation cannot get into drug or alcohol treatment. Consequently, they are often re-incarcerated for parole or probation violation. Periodic mandatory report to parole or probation officer had become their major competing priority. Moreover, many African Americans had switched from injection drugs to cocaine snorting or smoking, without any available treatment option.

Housing is the utmost priority for persons addicted to drugs who are experiencing homelessness. As Nashville is becoming a major destination for relocation of businesses and people, affordable housing had become very scarce, while homelessness continues to rise. Aggressive gentrification further aggravates the shortage of affordable housing units. Moreover, the Department of Housing and Urban Development (HUD) had tightened requirements and narrowed their definition of homeless, which requires that clients be in a shelter for three days before being deemed eligible. Clients with criminal records, active addiction, and mental health issues are denied housing (both public and private); limited transitional, assisted living or group homes are available. Recently released convicts present other critical challenges such as limited access to employment, financial loans and social support. During the past five years, in Nashville, Tennessee, the trend of homelessness paralleled the economic growth curve that propelled a booming housing market. “Nearly 70% of Nashville ever-changing skyline wasn’t there 10 years ago” according to Nashville Chamber of Commerce. In April 2024, the median price for residential single-family homes in Nashville was more than \$500,000 for the first time. In the aftermath of the March 3, 2020, devastating tornado that destroyed numerous homes in North Nashville and the subsequent coronavirus pandemic, the number of displaced families grew exponentially. Most of the patients attending Meharry Community Wellness Center (MCWC) reside in North Nashville. Many of them lost their jobs in places such as hotels, restaurants, and factories due to local and state government-imposed “Stay-at-Home” and social distancing orders related to mitigation of the COVID-19 pandemic. The national economic downturn during the coronavirus pandemic exacerbated the homelessness crisis and widens the gaps in care and HIV health disparities. Our proportion of clients experiencing homelessness represents more than twice the national average for PLWH (8.4%) and is 50% greater than the national Ryan White average (12.9%).

Community environment: An often-forgotten barrier is the fact that 70% of our patients live in the same neighborhood and are very familiar with each other. Fear of disclosure of HIV status, stigma, and discrimination, prejudice, religious concerns, and misconceptions remain enormous barriers to accessing HIV care.

Barriers to reaching Tennessee’s disproportionately-impacted populations:

African-American MSM: lack of awareness, or misinformation about HIV transmission, prevention, and treatment; impact of homophobia on health-seeking behavior; lack of

access to health care generally; and denial of risk.

Young MSM: misperceptions about HIV risk; denial and complacency associated with being a late adolescent; difficulties comprehending the seriousness of HIV, coupled with rejection by family and friends.

High-risk heterosexuals: lack of perceived risk; poverty, limited access to health care and health information; acting as caregivers in families; and financial dependency on a partner.

Incarcerated: stigma (isolation & potential for violence due to HIV status); misinformation about HIV transmission, prevention, and treatment (situational sex/" gay for the stay"); and lack of awareness or access to testing and/or health care services upon release.

Ryan White Part C Minority AIDS Initiative Report.

- To recruit persons with HIV (PWH) of the MAI target population, MCWC conducted outreach activities at multiple events:

Nashville Mayor's Ending-the-Epidemic, PRIDE Day, Black PRIDE, World AIDS Day, National HIV Black Awareness Day, and HIV Testing Day, and The African Street Festival. MCWC also leverages its partnership with Tennessee Department of Corrections, Metro Health Department, Davidson County Sheriff Office, Nashville General Hospital, United Neighborhood Health Centers, and Street Works. The Program Director promotes HIV awareness on Fisk Radio program, Health Waves. In general, the positivity yield of HIV testing in Nashville/Davidson County during outreach activities is less than 1%.

- How targeted testing is done for PWH of the MAI target population, and positives identified.

MCWC focuses on partners of non-virally suppressed clients, persons with sexually transmitted infection(s), or those with risky sexual behavior. Thus, from 01/2023 to 8/2023, MCWC performed targeted HIV testing for 60 high-risk persons on-site. Six of them (8.3%) tested HIV-positive. They were enrolled in care and started on ART immediately.

- How identified positives are linked to and enrolled in care.

People who test HIV-positive in the clinic or on the Meharry campus are linked to care and started on ART the same day; those referred from outside the campus are seen as soon as possible, usually within less than a week. EIS Worker, Community Health Workers, and the Community Care Team are responsible for linkage of identified positives to care. The Community Care Team meet twice a week to discuss newly identified positives and facilitate engagement. Medical case managers and medical providers collaborate in identifying and enrolling new clients. Altogether, they arrange for medical transportation, inform about core and support services, and expectations at initial clinic visit.

- How the PWH are retained in care.

The Patient Service Representative and Community Health Workers contact clients one week and 24-72 hours prior to their scheduled clinic appointments. They reach out by phone, text message, or e-mail to those who missed their visits the same day and attempt to reschedule them, while trying to address the root causes of missed appointments. If these attempts are unsuccessful after one or two weeks, they will mail a certified letter of notification at the client's last address.

Medical case managers and HIV medical providers identify new and current clients at high risk for drop out-of-care and refer them to the Community Care Team. They analyze challenges, barriers, and facilitators to develop and implement a joint plan of care for

intensive adherence counseling, peer coaching, performance monitoring, and evaluation. Difficult cases are discussed at weekly staff meetings for broader input.

The Community Care Team reviews the out-of-care list and deploy all their effort to locate the client, reach out to their authorized contact persons, state prisons and jails, local hospitals and drug treatment centers, and homeless camps. Once they are unable to locate the client, they will arrange an in-person visit at their residence or their hangout places. If that fails, they will solicit assistance from the local and state Health Department as well as other community organizations. As a last-ditch effort, they will access the obit announcements.

Describe in detail:

- 1) The number of persons you plan to serve with the funding.**
- 2) The number of units of service you plan to provide by type of intervention (e.g., number of face-to-face contacts with clients and amount of time each client will be seen each year, number of educational sessions provided, number of contacts with gatekeepers); and**
- 3) the average amount of service a client is expected to receive each year (e.g., 2 face to face each year) and the amount of time that will be spent with gatekeepers (e.g., 3 hours/gatekeeper/year).**

With this funding, we propose to serve 150 persons with HIV, distributed as follows:

Male 76%; Female 24%

African American 80%; Caucasian: 19%; other 1%

Hispanic 10%

Age group: 13-24: 0.1%; 25-44: 54%; 45-64: 45%; 65+ 0.9%

They will receive 400 units of 15 minute each in face to face medical care provided by a Part A funded salaried physician or nurse practitioner and 2,000 units of lab and diagnostic services in the grant year.

III. Implementation Plan:

The importance of improving progress along the HIV care continuum is supported using scientific research that leads to the identification of best practices and evidence-based practices. The use of best practices/evidenced informed models is preferred for all services and as applicable/available.

Describe in detail any evidence bases or best practice models you will use to provide the service. Include a reference to the model's name and source of the best practice (e.g., "Healthy Living Project," CDC Evidence-Based Intervention-EBI).

<https://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html>

Ideally, interventions will be based upon proven outreach and engagement models; and/or adaptations of proven models; and /or novel models of outreach and engagement in care, particularly developed for the HIV/AIDS population.

Meharry Community Wellness Center will provide primary HIV care based on the latest Guidelines and Recommendations of the Department of Health and Human Services (DHHS) for prevention and treatment of HIV-associated opportunistic infections. These

Guidelines summarized the best evidence as assessed by a panel of national HIV experts. Moreover, our experience as one of the three national performance sites, for the HRSA-sponsored Special Project of National Significance (SPNS), “Dissemination of Evidence-Informed Interventions: Peer Linkage and Re-Engagement of HIV-Positive Women of Color” in 2016-2019 inspired the Community Care Team Model implemented by our program in 2020. The Manual is available at: <https://www.targethiv.org/deii/deii-peer-linkage>. Peer Linkage and Re-engagement of Women of Color with HIV. Rajabiun S., Marbach A., Fox J., Childs E., Sullivan M., Downes, A., Bryant H, Nortrup E., Berthaud V., Alexander L., Grimes T., et al. Dissemination of Evidence-Informed Interventions. Peer Linkage and Re-engagement of Women of Color Living with HIV (2020). Available at: <https://www.targethiv.org/deii/deii-peer-linkage>. The peer-reviewed manuscript is referred here: Serena Rajabiun, Janet J. Myers, Janet Goldberg, Karen Fortu, Marena Sullivan, Vladimir Berthaud, Rahab Wahome, and Howard J. Cabral. “Outcomes from the adaptation of an evidence-based Peer Linkage & Re-engagement: Intervention for Women of Color with HIV in three urban clinics”. AIDS and Behavior. October 05, 2021. PMID: 34609629.

For all Ryan White projects, Meharry Community Wellness Center also implements the most recent Standards of Care published by Tennessee Health Department Ryan White Part B Program and Metropolitan Nashville Health Department Ryan White Part A Program.

Retention strategies: To improve retention and viral suppression, Meharry Community Wellness Center (MCWC) had formed the Community Care Team, which meets twice weekly to discuss clients with incoming appointments, those who missed their recent clinic visits, and those lost to care. MCWC works diligently to schedule all of a client’s visits the same day. The Patient Service Representatives or the Community Health Workers contact the client one week and 24-48 hours before the appointment date to facilitate the clinic visit. They arrange for round-trip medical transportation, if needed. Those who missed their scheduled visits are contacted in less than 24 hours. If they are unable to reach a client by phone calls, text messages, e-mails, or letters, after 2 weeks, the Community Health Worker attempts to make a home visit. If that fails, they reach out to Nashville Health Department EIS Worker, Davidson County Sheriff Office and Tennessee Department of Corrections, the Coalition for the Homeless, drug treatment centers, mental health institutions, local hospitals, and nursing homes, for investigation. If these strategies fail after 6 months, the TN Health Department Disease Intervention Specialist (DIS) is alerted for further tracking efforts. Clients who miss more than two consecutive appointments receive intensified adherence counseling and coaching.

Targeted retention efforts toward subpopulations with poor health outcomes. The Community Health Workers and PSRs target MSM, women of color, and clients with challenging issues such as mental illnesses, substance use disorders, and pervasive stigma. The Medical Case Managers assist clients experiencing homelessness in permanent placement, prevention of eviction, and maintenance of stable housing. The HOPWA Case Manager assists clients with rent, mortgage, and utilities bills. The Community Health Workers provide clients with medical transportation, food services, and pharmacy management to facilitate clinic visits and medication adherence. The medical providers

coordinate with staff to facilitate joint clinic appointments. All clients are screened for behavioral and substance use disorders and those who screen positive are seen by the clinical psychologist, the psychiatrist, and/or the therapist/counselor.

Coordination of medical and support services for pregnant women.

An obstetrician-gynecologist with over 25 years of experience including 15 years at MCWC, Dr. Vernita Tucker, will manage pregnant women in the clinic in close coordination with medical providers and nurses during the entire prenatal, peripartum and postpartum period. All pregnant women will be offered ART, if not on yet, and counseled regarding the benefits and risks of ART during pregnancy for the woman, fetus, and newborn. Adherence to ART may decline in the postpartum period. Therefore, clinical and support staff caring for postpartum women on ART will stress adherence and evaluate specific facilitators and barriers. Two Meharry board-certified infectious diseases pediatricians, Dr. Shahana Choudhury and Dr. Christopher Keefer, will manage HIV-exposed babies. Prenatal and HIV care visits as well as neonatal and maternal medical visits will occur on the same day. Attention will be paid to nutrition, medical transportation, housing status, and medical insurance coverage.

Unmet need and HIV care continuum: In 2020, 66% of newly diagnosed people in Tennessee were linked to care within 30 days, compared to 64% in 2018; 54% were retained in care (same for non-Hispanic Blacks) and 66% achieved viral load suppression (63% for Non-Hispanic Blacks). In Nashville TGA, an estimated 17% of PLWH are unaware of their status. In 2020, 66% of newly diagnosed cases were linked to care in 30 days, 54% were retained, and 66% achieved viral suppression. Among Non-Hispanic Blacks, 64% were linked to care within 30 days, 54% were retained and 63% became virally suppressed. Among Non-Hispanic Black PLWH, there were significant differences in care retention by age group ($p < 0.0001$). The lowest rates of care retention in this subpopulation were found among 13-24-year old (44%) and 25-34-year-old (52%). Among Non-Hispanic Black PLWH, there were significant differences in viral suppression by age group ($p = 0.0009$). The lowest rates of viral suppression were found among 13-24-year old (51%), 35-44-year-old (57%), and 25-34-year-old (58%). In TN and the Nashville TGA, the Ryan White program represents the strongest contributor to successful outcomes along the HIV care continuum as shown in this figure. Source: TN Health Department sponsored presentation TN HIV Continuum of Care: Update, Peter F. Rebeiro, MHS, PhD. (September 24, 2015)

We examined the effect of homelessness on viral suppression between 2014-2019. Our retrospective study revealed that permanently/stably housed clients had a much higher proportion of viral suppression compared to unhoused clients. Among clients with viral load < 20 copies/mL, 78% were permanently housed and 22% homeless, while 74% of permanently/stably housed clients reached viral suppression and a smaller proportion of the homeless clients (54.7%) remained virally suppressed (Pearson's Chi-Square 25.171, $p < 0.001$). The multivariable logistic regression showed that permanent/stable housing (p -value < 0.001), higher frequency of CD4 count > 500 cells/mm³ (HIV infection, stage 1) (p -value < 0.001), age (p -value = 0.004), and FPL (p -value = 0.031) were strong predictors of viral suppression. As expected, patients living in permanent/stable housing had twice the chance of achieving viral suppression compared with those who were experiencing

homelessness [OR 2.08 (1.39-3.23), p-value <0.001]. Under the nonparametric assumption, the receiver operating characteristic (ROC) curve correctly predicted 72.3% of the primary outcome variable, viral suppression (AUC = 0.767; p-value < 0.001; 95% CI for AUC (0.73, 0.80). During the 5-year study period, 52 clients died. Of them, 16 (30.76%) were experiencing homelessness and 36 (69.23%) lived in stable housing, while 12.5% of the homeless and 61.12% of those in stable housing achieved viral suppression at the time of death (Berthaud V. et al. BMC Infectious Diseases, 2022; 22: 144). This seminal paper inspired the 2022 CDC Issue Brief, “The Role of Housing in Ending the HIV Epidemic” and a Human Resources and Services Administration (HRSA) Notice of Funding Opportunity for housing of PWH. The Infectious Diseases Society of America cited our paper in their special issue dedicated to homelessness and infectious diseases (Emily Mosites, Laura Hughes, and Jay C. Butler. Homelessness and Infectious Diseases: Understanding the Gaps and Defining a Public Health Approach: Introduction. The Journal of Infectious Diseases 2022;226(S3): S301–3).

IV. Best Practices:

Provide a clear and succinct description of the proposed project to implement an intervention model designed to create access to HIV testing, improve timely entry, engagement, and retention in quality HIV medical care for persons living with HIV infection.

Initial medical evaluation: The goals of the initial evaluation are to confirm the HIV diagnosis, obtain appropriate baseline historical and laboratory data, provide treatment adherence counseling, and ensure patient understanding about living with HIV, its modes and risks of transmission, and to initiate care as soon as possible as recommended by the Department of Health and Human Services (DHHS) under HIV primary care guidelines for prevention and treatment of HIV-associated opportunistic infections.

In the case of previously treated patients who present for an initial evaluation, it is critical to obtain a complete antiretroviral (ARV) history (including drug-resistance testing results, if available), preferably through the review of past medical records. Newly diagnosed patients shall also be asked about any prior use of ARV agents for prevention of HIV infection.

Follow-up visits: After the initial visit, patients deemed at high-risk for dropout and poor treatment adherence shall be followed at least biweekly for intensive case management, peer support, and close medical monitoring. Appointments will be spaced out at larger intervals once they are stabilized and virally suppressed. Stable patients shall be seen every 2-3 months during the first 2 years, then, every 4-6 months once their viral load had been suppressed for 2 consecutive years. Virally suppressed patients with CD4 count > 500 over 2 years can be seen once or twice a year. At each follow-up visit, the medical record shall be updated considering patient complaints, treatment adherence and medication tolerance, referrals, laboratory and procedures results, recent visits to emergency departments, hospitalizations, incarceration, homelessness, outpatient or residential drug treatment, family and personal life changes.

Describe the strategies you will use to identify and engage with key stakeholders recognized and trusted by the HIV/AIDS community; include the names of specific people and entities.

Describe the components of your intervention model and its specific strategies

that will:

- a) Increase awareness of HIV disease, with a focus on reaching persons at high risk for becoming infected with HIV disease.**
- b) Identification of high-risk persons who need but do not access regular HIV tests and how you will link those persons to HIV testing agencies; and**
- c) Identification of persons who are HIV positive but have never or who have dropped out of HIV medical care and services and how you will facilitate linking those persons with needed HIV services and care.**

Proposed interventions must address personal, financial, sociocultural, and structural barriers, especially stigma, that affect PLWHAs access to HIV testing and retention in HIV medical care and services. Define specific barriers that may be encountered by the population being served and discuss how your proposed interventions will positively address each of these barriers.

Meharry Community Wellness Center (MCWC) organizes outreach events with local partners including Metropolitan Nashville Health Department to raise HIV awareness and promote testing. As member of Nashville PrEP Coalition, MCWC facilitates the rapid linkage of newly diagnosed persons. It also leverages its experience as a research site for the SPNS project targeting newly diagnosed and out-of-care women of color for linkage and retention to enhance engagement in care. As a pioneer of HIV telemedicine in TN prisons and HIV consultant for Davidson County jails since 2006, MCWC facilitates the transition of ex-offenders to rapid linkage and engagement upon their release in the community.

Patients who diagnose HIV positive in the emergency department (ED) at Nashville General Hospital (NGH), located on the Meharry campus, are linked and enrolled into care the same or next business day. HIV providers and Medical Case Managers follow newly diagnosed persons with HIV (PWH) admitted to NGH and coordinate their discharge disposition. Clients newly identified outside the Meharry campus are linked as soon as possible, preferably within less than 7 days. The Patient Service Representatives (insurance verification), the Community Health Workers (coaching and navigation), and the Medical Case Managers (insurance assistance and Ryan White eligibility) are responsible for rapid linkage.

Community Care Team Model. To optimize patient care at multiple access points and shift from a disease-based model to truly patient-centered care, MCWC will implement the community care team model based on four tracking pathways, A, B, C and D.

A: Patients who attend clinic appointments regularly, maintain viral load suppression, and may have zero to low-level comorbidities and social determinants of health. (*Focus: prevention, health promotion, and reinforcement of adherence*)

B: Patients who are missing scheduled appointments (no-shows, walk-ins), do not maintain viral load suppression, and may experience rising levels of comorbidities and social determinants of health. (*Focus: increase adherence counseling, health education, and rapid intervention, and identify, and address emerging risk factors for adverse outcomes*)

C: Patients who do not attend clinic appointments regularly, may have variable levels of viral

load suppression and comorbidities, and high levels of challenging social determinants of health impacting treatment adherence, the HIV care continuum, and overall health and wellness, and representing greatest life priorities. (*Focus: intensive medical case management and peer support, ensure unfettered access to clinical and support services, and collaborate with community agencies to prevent critical progression*)

D: Patients who may not attend clinic appointments regularly and have variable levels of viral load suppression, and may be facing high levels of chronic diseases that are becoming higher health priorities than HIV, and have variable levels of social determinants of health.

(*Focus: coordination of multispecialty services and referrals, and disease education*).

The Community Care Team (CCT) will implement an HIV service delivery model that will facilitate patient tracking, peer-to-peer support, differentiated case management, improve retention, viral load, and health outcomes. The CCT will strive to track clients at their ever-changing points-of-contact, particularly the hard-to-reach, highly vulnerable, and marginalized individuals, and those who are struggling with adverse social determinants of health, HIV disease progression and significant comorbidities. In fact, the results of our pilot study showed the following viral suppressions: **100% for Pathway A, 78% for B, 43% for C, and 65% for D.** (*Berthaud V, Special Presentation, 2020 National Ryan White Meeting*).

Strategies to improve care transition focus on inmates, youth living with HIV and hospitalized patients who are HIV positive. Meharry infectious diseases specialists serve as HIV consultants for TN Department of Corrections and Davidson County Sheriff's Office. At the time of consultation, they will identify inmates ready to transition into the community and initiate the contact between prison or jail personnel and MCWC staff such as PSR, EIS Worker, Community Health Workers, Therapist/Drug Counselor, and Medical Case Managers, to coordinate transitional services, with the intent to schedule the first clinic appointment on the same day of release or within one week. Meharry infectious diseases physicians will follow all persons with HIV hospitalized at Nashville General Hospital and coordinate their discharge and linkage to care in close collaboration with hospital physicians, nurses, and case managers and MCWC staff. They will also coordinate the care of their patients who are admitted to another acute or long-term care facility. The Community Health Workers will follow clients hospitalized in other medical facilities and share authorized health information with outside providers to ensure continuity in care. They will coach youth living with HIV and help them navigate the HIV service delivery system.

Coordination of medical and support services for pregnant women.

An obstetrician-gynecologist with over 25 years of experience including 15 years at MCWC, Dr. Vernita Tucker, will manage pregnant women in the clinic in close coordination with medical providers and nurses during the entire prenatal, peripartum and postpartum period. All pregnant women will be offered ART, if not on yet, and counseled regarding the benefits and risks of ART during pregnancy for the woman, fetus, and newborn. Adherence to ART may decline in the postpartum period. Therefore, clinical and support staff caring for postpartum women on ART will stress adherence and evaluate specific facilitators and barriers. Two Meharry board-certified infectious diseases pediatricians, Dr. Shahana Choudhury and Dr. Christopher Keefer, will manage HIV-exposed babies. Prenatal and HIV care visits as well as neonatal and maternal medical visits will occur on the same day. Attention will be paid to

nutrition, medical transportation, housing status, and medical insurance coverage. Meharry Community Wellness Center collaborates with diverse stakeholders to identify persons who are HIV positive but have never or who have dropped out of HIV medical care and services and facilitate linking those persons with needed HIV services and care: Nashville General Hospital (NGH), Meharry teaching hospital, where Dr. Berthaud serves as Director of Infectious Diseases and Dr. Livette Johnson co-chairs the Infection Prevention Committee. They work closely with hospital staff to identify patient who are out of HIV care and re-engage them immediately. Inpatient referrals are seen the same day and outpatient referrals are seen in less than a week. A Medical Case Manager and a Community Health Worker will introduce themselves to the hospitalized patient with HIV to educate them about our HIV program and expectations at initial clinic visit. They will coordinate patient discharge with medical providers and Case Managers and arrange for those who are eligible for commercial medical insurance, TennCare, Medicare, or VA insurance initiate the enrollment process as soon as possible. They will inform those deemed eligible for Ryan White insurance coverage about the program requirements, policies, and procedures. The same process is applied to all other referring partners as circumstances allow. NGH refers PWH from Emergency Department, inpatient, and outpatient clinics; Meharry Elam Mental Health Center, Meharry Family Medicine and MAT Clinic, located right across the hall from MCWC, and Meharry Clinics constitute regular sources of mutual referrals; Davidson County Sheriff's Office refers inmates with HIV to MCWC since 2005, while Tennessee Department of Corrections refers them for telemedicine consultation, a service established by Dr. Berthaud in 2006; Neighborhood Health, the largest FQHC in Davidson County, Ascension St Thomas Health (Dr. Berthaud maintains consultation privileges), and Metropolitan Nashville Health Department, the largest HIV testing center in Nashville, represent important referral sources. Metropolitan Development Housing Authority awarded a HOPWA grant for the provision of Short-Term, Rent, Mortgage, and Utilities assistance. Street Works and Nashville CARES provide medical case management, food and housing services including permanent placement and emergency shelters. Second Harvest provides low-cost preserved food for our pantry. Vanderbilt University Medical Center provides emergency, specialty ambulatory, and inpatient care for MCWC clients. Tennessee Health Department had contracted with Meharry for ambulatory/outpatient and medical case management services. They provide technical support to medical case managers and assist in linkage/reengagement of clients lost to care. Metropolitan Nashville Public Health Department (MNPHD) refers newly diagnosed HIV-positive and lost-to-care people, treats persons with latent and active tuberculosis, and coordinates STD management and control. Meharry Elam Mental Health Center collaborates with MCWC Therapist/Drug Counselor on outpatient and inpatient drug treatment, detoxification, and rehabilitation. Dr. Osa-Edoh, the Part A funded psychiatrist, is also the Director of the Drug Treatment Program at Elam Center.

Service Specific Questions:**1. Service Model**

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of your proposed project. Include all aspects of planning, implementation, and evaluation, listing the role of everyone involved in activity.

2. Work Plan

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of your proposed project. Include all aspects of planning, implementation, and evaluation, listing the role of everyone involved in each activity.

The work plan should include clearly written:

- 1. Goals**
- 2. Objectives that are specific, time-framed, and measurable**
- 3. Action steps**
- 4. Staff responsible for each action step; and**
- 5. Anticipated dates of completion.**

Please note that goals for the work plan are to be written for the first year of the grant. Discuss any challenges that are likely to be encountered in planning and implementing the project’s activities described in the work plan and describe realistic and appropriate approaches to be used to resolve these challenges.

Work Plan

Goals	Objectives	Action Steps	Anticipated Date of Completion	Responsible Staff
Increase viral suppression	85% viral suppression by end of Year 1	Periodic viral load monitoring as per DHHS guidelines Monitor treatment adherence Monitor health complications and chronic comorbidities	End of Year 1	Medical providers Medical providers, Medical Case Managers, Community Health Workers
Increase retention in care	78% retention in care by end of Year 1	Early identification of clients at high-risk for dropout and treatment failure Provide intensive coaching and case management	End of Year 1 End of Year 1	Medical providers Medical Case Managers Community Health Workers Medical providers

		Monitor and evaluate barriers, challenges, and facilitators to treatment adherence and clinic attendance	End of Year 1	Community Health Workers Therapist Medical providers Mental Health Therapist Psychiatrist Clinical Psychologist
		Facilitate access to treatment of behavioral and substance use disorders, medical transportation, housing and food services	End of Year 1	Therapist Community Health Workers
		Track clients who missed clinic appointments weekly	End of Year 1	Community Health Workers Medical Case Managers
		Collaborate with community-based organizations, local and state health departments, and correctional facilities	End of Year 1	Community Health Workers Medical Case Managers

Aggregate measures of viral suppression and retention are already incorporated in the HRSA-required Performance Measures section of CAREWare. We have customized the system to measure viral load for subpopulations.

Challenges and Resolutions		
Challenges	Approaches for Resolutions	Barriers

Homelessness	HOPWA grant for Short-Term Rent, Mortgage, and Utilities (STRMU) does not match explosive real estate costs in the TGA.	Many of our clients experiencing homelessness are excluded from public housing because of restrictive housing policies and limited HOPWA funding.
Limited transportation service	Medical transportation service provided by program income.	Limited or inexistent public transportation.
Food shortage	Raise Part A Food Voucher card from \$20 to \$60 to adjust for inflationary cost. Program income-supported Food Pantry with unrestricted access in collaboration with Second Harvest.	Lack of job skills & education, unemployment, and poverty, exacerbate food shortage.
High rate of incarceration	Clinical psychologist, psychiatrist, therapist/drug counselor address behavioral and substance use disorders and relapse, and the roots of incarceration.	Limited access points for substance use treatment; high rate of drug charges, incarceration, and recidivism.

Our landmark paper was the first to highlight the negative effect of homelessness on HIV viral suppression and mortality in Middle Tennessee and its potential challenges to ending the HIV epidemic. (Vladimir Berthaud; Livette Johnson; Ronda Jennings et al. “The Effect of Homelessness on Viral Suppression in an Underserved Metropolitan Area of Middle Tennessee: Potential Implications for Ending the HIV Epidemic”. BMC Infectious Diseases. 2022 Feb 10; 22: 144). This retrospective analysis reveals that permanently/stably housed clients had a much higher proportion of viral suppression compared to their unhoused counterparts. Among clients with viral load <20 copies/mL, 78% were permanently housed and 22% unhoused. This seminal paper inspired the 2022 CDC Issue Brief, “The Role of Housing in Ending the HIV Epidemic” and a Human Resources and Services Administration (HRSA) Notice of Funding Opportunity for housing of PWH. The Infectious Diseases Society of America cited our paper in their special issue dedicated to homelessness and infectious diseases (Emily Mosites, Laura Hughes, and Jay C. Butler. Homelessness and Infectious Diseases: Understanding the Gaps and Defining a Public Health Approach: Introduction. The Journal of Infectious Diseases 2022;226(S3): S301–3).

B. Budget (35 Points)

Complete the entire Budget Spreadsheet attachment (excel version) which describes how your will use the funds to provide the service requested in the scope of work for this solicitation. Include detailed information about the number and type of staff your firm will fund, staffing costs and other specific costs associated with providing the service. Contractor(s) will be allowed to budget up to 10% for administrative costs, including indirect charges.

Leaving blanks on any of the Budget Spreadsheets and/or not following the provided format may result in your proposal being deemed non-responsive.

The entire Budget Spreadsheet attachment has been completed and uploaded.

ORGANIZATION AND TEAM QUALIFICATIONS

I. ORGANIZATIONAL BACKGROUND

1. Describe in detail the background of your agency. Include the purpose of your organization, years of experience in providing services to People Living With HIV/AIDS (PLWHAs) and the years of providing these services (note if any HIV specific services are provided and/or if you currently collaborate with an HIV agency) and number of unduplicated persons served last year.

Purpose. Meharry Community Wellness Center (MCWC) strives to eliminate HIV health disparities in Nashville Transitional Grant Area (TGA) by promoting awareness, education, and training, transdisciplinary research, community partnership, and unfettered access to comprehensive, high-quality care.

Background. Meharry has been a leader in primary care medicine for over a century and HIV prevention and treatment since the beginning of the epidemic in 1981. Out of a growing need to expand access to culturally sensitive, comprehensive primary HIV care in the Nashville Transitional Grant Area (TGA), Dr. Vladimir Berthaud founded Meharry Community Wellness Center (MCWC) in 2005. MCWC has been a top-ranked Tennessee-designated AIDS Center of Excellence since 2006, and a Hepatitis Center of Excellence since 2016. Tennessee Health Department recognizes MCWC as a “national model for comprehensive HIV care among the underserved community”. Meharry has been providing mental health services to people living with HIV for over 40 years and Meharry Community Wellness Center had done so for 20 years. MCWC provided food services under Ryan White Part B program for about five years. Our current food services (food coupons) are funded by Ryan White Part A since 2015 and our program income in collaboration with Second Harvest for the past five years (food pantry).

Meharry Community Wellness Center provides 24/7 coverage for medical and dental services. Clients have easy access to one-stop, wrap around core and support services: HIV counseling and testing, PrEP/PEP, and primary HIV care; management of complex infectious diseases; women’s health services including reproductive health, Pap test/colposcopy; minor ambulatory surgery including proctoscopy, skin biopsy, wound care, pre- and postoperative management; psychiatry, clinical psychology, mental health therapy and drug counseling; Medication-Assisted Treatment (MAT), outpatient and residential treatment of substance use disorder; HIV Drug Assistance Program (HDAP), Insurance Assistance Program (IAP), on-site pharmacy services; housing assistance, medical transportation, and nutrition; legal aid, home and community-based health services, and referrals to specialty and community resources; comprehensive primary oral health including prophylaxis, dental hygiene, tooth extraction, root canal, cutting-edge prosthodontics, and oro-maxillo-facial surgery.

Our patient population has an alarming prevalence of severe tooth decay (60%) and severe periodontitis (30%). Meharry Community Wellness Center (MCWC) represents the only Tennessee clinic that offers unfettered access to fully integrated, comprehensive oral health services for low-income PLWH regardless of their primary HIV care providers. The Tennessee Ryan White Dental Assistance Program (RWDAP) ran out of funding in April 2019 and left 1,800 clients with very limited or non-existing access to oral health services. Only 10% of our clients have dental insurance coverage and just 2% of them have adequate coverage. As of 2023, TennCare offers limited oral health benefits to eligible clients. So far, they have not referred any patients to our dental clinic. The dental clinic disposes of two state-of-the-art operatories, two intra-oral digital cameras, and one portable digital X-Ray, one lab, and one sterilization room. It applies breakthrough 3D technology to fabricate crowns, bridges, partial, and full dentures while the client is waiting. Meharry Community Wellness Center is among five health centers who dispose of this brand-new technology for fabricating full-mouth and partial denture in one visit in the United States. Special cases such as impacted molars, orthodontics, intra-oral abscesses, or deep-seated infections, are referred on site to Oro-Maxillo-Facial Surgery service at the Meharry School of Dentistry using program income to pay the discounted fees for these referrals.

Meharry Community Wellness Center had served 2,165 unduplicated clients since inception and 468 in 2024 including 77% Black or African American, 10% Hispanic/Latino, 25% female, and 46% MMSC. Our proportion of PWH with unmet housing needs (24.9%) represent about thrice the national average for PWH (8.4%) and twice the average for Ryan White clients nationwide (12.9%). Our clients bear an excess burden of poverty (53% below 100% federal poverty level), history of incarceration (20%), substance use and behavioral disorders (30%), uninsured (39%), cardiovascular diseases (30%), chronic lung diseases (35%), and diabetes (20%). Nonetheless, 85% of our clients had achieved viral load suppression (increased from 78.6% in 2021, 82.3% in 2022, and 83.3% in 2023), and 90% have CD4 cell count above 200 cells/mm³. Retention in care had increased from 70.47% in 2021 to 76.13% in 2023. However, cases of syphilis rose from 18.1% in 2021 to 22.5% in 2023, in line with the ongoing syphilis epidemic in the US. Only 7.5% of women had abnormal Pap test in 2023 as compared with 8.3% in 2021. As the sole clinic providing fully integrated state-of-the-art oral health services at no cost to people with HIV (PWH) in Tennessee regardless of their primary HIV provider, MCWC had served 650 clients in 2,689 units during past 16 years.

Under contractual agreement, MCWC had served about 600 inmates living with HIV (64% Black or African American) throughout all Tennessee prisons over 21 years. In 2006, we pioneered telemedicine between Meharry and Tennessee prisons. This collaboration contributed to raising clinic attendance from 50% to 90% and viral suppression, from baseline 30% to 90% in 2020.

MCWC had received uninterrupted grant funding from Ryan White Part B since 2002, HRSA Ryan White Part C since 2003, Ryan White Part A since 2008, and HOPWA since 2016. In order

to stretch the Ryan White grant dollars, MCWC expends its program income to further project objectives in priority areas of unmet need, such as nutrition and medical transportation; oral health, ambulatory surgery, and women's health services; as well as coverage of ambulatory/outpatient specialty services for management of comorbidities, and co-pays of prescription drugs for underinsured, low-income individuals with HIV. The dental clinic was built out of several competitive HRSA grants supplemented by program income.

The prospect for new funding remains grim because of a large budget shortfall in the Tennessee Ryan White B program that required across-the-board budget cuts leading to a reduction of our annual budget by \$76,510.50 since 2021-2022 and planned termination of Part B funding for Part A grantees in 2026. Our Part C grant has been on freeze under Executive Order and HRSA has not issued the 2025 grant award yet. Therefore, Ryan White Part A had become lifesaving for people living with HIV in Nashville TGA.

2. Describe in detail the current HIV counseling and testing capacity of your organization, and any existing collaborative arrangements with other organizations within your service area that provide HIV counseling and testing services.

Clients who are diagnosed HIV positive at Meharry Community Wellness Center are linked and enrolled in care immediately. The same policy applies to those who test HIV positive in the Emergency Department or outpatient clinics of Nashville General Hospital. Newly diagnosed people who are incarcerated in local jails are referred to MCWC and seen in less than a week. Inmates of Tennessee Department of Corrections are referred to the clinic on the day of their release for medical insurance enrollment and linkage to care. All other individuals with HIV referred to MCWC are given an initial appointment within 1-7 days

Meharry Community Wellness Center (MCWC) uses its program income to provide targeted HIV counseling and testing. In 2023, we tested 75 high-risk individuals and found seven (9.33%) HIV-positive people, as compared to <0.5% in the general population. All these newly identified persons with HIV were enrolled in care and started taking antiretroviral treatment (ART) before leaving the clinic. Medical providers, EIS Worker, and Medical Case Managers (MCM) educate clients about HIV risk behaviors and effective strategies to prevent HIV transmission at each patient visit, using audio-visual materials, interactive tablets, brochures, and multi-disciplinary intervention. They counsel every person with HIV (PWH) entering care about the implications of HIV infection, the benefits and potential side-effects of antiretroviral therapy (ART), risk reduction and disclosure to sexual and/or needle sharing partners. They reinforce risk reduction messages and encourage clients to have their partner(s) tested every 3-6 months and enroll in PrEP if they're not virally suppressed. We also invite persons with high-risk HIV behavior to participate in our ongoing clinical trials such as the landmark Purpose 2 study conducted at Meharry under the leadership of Dr. Berthaud as Principal Investigator. This trial showed that twice-yearly injection of lenacapavir resulted in 96% protection from HIV transmission in MSM, transgender men, and non-binary persons.

MCWC has a track record of collaboration for HIV counseling and testing with multiple local and extramural partners such as: Nashville General Hospital, the Meharry Elam Mental Health Center, the Meharry Medication-Assisted Treatment (MAT) clinic, and the Meharry Clinics; Davidson County Sheriff Office, Tennessee Department of Corrections, United Neighborhood, Matthew Walker Comprehensive Health Center, Street Works, Nashville CARES, Vanderbilt University Medical Center, Ascension St Thomas Health, and Metropolitan Nashville Health Department; long-term care facilities like, Bordeaux Nursing Home and Whites Creek Nursing Home, as well as drug treatment centers (Cumberland, Samaritan), and Middle Tennessee Mental Health Institute.

3. Describe in detail how the proposed project fits with your agency’s mission and capabilities.

As an annual Tennessee-designated AIDS Center of Excellence since 2006, Meharry Community Wellness Center (MCWC) focuses on eliminating health inequities in HIV/AIDS, advancing HIV/AIDS awareness, transformative education, and transdisciplinary research, strengthening community outreach and partnership, and providing exceptional and compassionate health services. Our mission aligns with the overall mission of Meharry Medical College to empower diverse populations to improve the well-being of humankind. Our vision aligns with the vision of the National HIV/AIDS Strategy and the White House Ending-the-Epidemic Plan. Meharry has been providing mental health services to people living with HIV for over 40 years and Meharry Community Wellness Center had done so for 20 years. This proposed Mental Health project fits our mission and capabilities to address unmet need in outpatient/ambulatory care for underserved persons living with HIV in the Nashville Transitional Grant Area (TGA). Although Meharry Community Wellness Center serves the hardest-to-reach populations of persons with HIV in Middle Tennessee, as aforementioned, our retention in care had reached 76.13% in 2023. During the most recent decade, viral load suppression had substantially improved for all subpopulations, especially youth, young adults, and MSM, the risk categories with the highest incidence of HIV in our clinic (47.1% for MSM). In fact, MSM achieved the highest rate of viral suppression in 2024, a reflection of our cultural competence, coupled with non-judgmental, customer-friendly, and compassionate HIV care.

Viral Suppression by Subpopulation (%): 2015-2024			
Subpopulation	Year		
	2015	2019	2024
White	75.61	73.85	81.82
Black or African American	73.14	75.58	82.48
Hispanic/Latino	81.25	83.33	80.49
Youth (13-24)	51.85	74.19	80.00
25-34	63.22	71.57	84.38
35-54	76.52	74.88	79.79
55+	82.83	81.82	83.72

Women	72.00	77.39	79.81
Men	68.9	70.79	80.78
MSM	63.27	72.73	85.71

Source: CAREWare 230

4. Describe in detail how your background, mission and experience contribute to the ability of your organization to conduct the proposed project and meet the expectations of the program requirements. In addition, Metro Health may conduct pre-award on-site visits to determine if the contractor’s facilities are appropriate for the services intended.

Meharry is the oldest provider of HIV care in Tennessee, dating back the beginning of the epidemic in 1981. Under the leadership of its Founding Executive Director, Dr. Vladimir Berthaud, Meharry Community Wellness Center (MCWC) had earned the annual designation of Tennessee AIDS Center of Excellence continuously since 2006 and grew exponentially, thanks to multiple funding streams including several Ryan White grants. MCWC had become a beacon of hope and comfort for persons with HIV, affected by stigma, discrimination, social injustice, and health inequities. For current grant year ending on February 28, 2025, our outpatient/ambulatory grant had already beaten the expectations of program requirements as illustrated by the projected number of clients to be served and the number of service units (projected number: 99/actual: 179 and projected units: 400/actual: 2480) and our Part A food coupons are quickly exhausted. A multidisciplinary team of experienced and highly-qualified staff provide person-centered, multidisciplinary, holistic health services of the highest quality. Daily patient surveys denote an average satisfaction rate of 95%. As a testament of our performance, HRSA had selected MCWC to host the first National Meeting on HIV in Rural Areas in 2019 and one of three US sites that conducted the Special Project of National Significance (SPNS), “Dissemination of Evidence-Informed Interventions: Peer Linkage and Re-engagement of Women of Color”, 2016-2019. The Project-derived manual is available at: <https://www.targethiv.org/deii/deii-peer-linkage>.

II. Organization Capacity:

1. Provide copies of the following:

- Resume and job description of proposed Finance Manager
- Organizational chart for your agency; chart must clearly include the program components funded by Part A/MAI.
- Copies of most recent State Licensure or Accreditation for relevant services.
- Articles of Incorporation.
- Documentation of 501(c) 3 designation.
- Current State of Tennessee Charitable Solicitations Letter.

- System for Award Management (SAM) exclusion report.

All these documents are uploaded.

2. Describe agency's experience in administering federal, state and/or local government funds. Include funding source(s) and number of years administering those funds. Provide information for the following:

- **Agency restrictions from receiving federal funds or placed on restrictive measures in the last five years (e.g., increased reporting, increased monitoring visits), please explain.**

Meharry has no restrictions from receiving federal funds. It has never been placed on restrictive measures in the last five years or during its existence.

- **Corrective action plan(s) in the last three years from any funding source, please describe (include the name of the funder, overview of issues identified and the current status of addressing the identified issues and/or recommendations).**

In 2024, HRSA conducted a site visit and identified the following issues: documentation of coordination and linkages with CDC and Prevention-funded HIV testing and outreach services of federally qualified health centers in the service area; documentation of training for HIV care and treatment of all non-clinical staff, documentation of sexual practices of women; demonstration of full implementation of the time and effort policy and the caps on charges; and documentation for allocating program income according to each Ryan White Program grant. All these issues have been corrected except the time and effort policy. The Office of Grants and Contracts is updating the Workday system and recruiting additional personnel to ensure any issues related to time and effort are fixed soon.

- **Audit finding(s) in the last three years. Please describe an overview of issues identified and the current status of addressing the identified issues.**

In 2024, HRSA audited our Ryan White Part C EIS grant and identified the following issues: documentation of coordination and linkages with CDC and Prevention-funded HIV testing and outreach services of federally qualified health centers in the service area; documentation of training for HIV care and treatment of all non-clinical staff, documentation of sexual practices of women; demonstration of full implementation of the time and effort policy and cap on charges; and a clear policy for allocating program income according to each Ryan White Program grant. All these issues have been corrected except the time and effort policy. The Office of Grants and Contracts is updating Workday system and recruiting additional personnel to ensure any issues related to time and effort are quickly fixed.

- **If Contractor(s) is currently a Ryan White Part A provider, an administrative review will be conducted of the previous year's spending of grant funds and will be included as part of the score. If Contractor(s) is not a current Ryan White Part A provider,**

Contractor(s) must provide a letter of reference from a funder to include a description of Contractor's performance in spending allocated grant funds. This letter will be included as part of the score.

Not applicable.

- **Submit copies of most recent A-122 Audit (for the last reporting year) conducted by an independent certified public accountant or 990 form, if not required by federal regulations to complete an A-122 Audit.**

An independent CPA firm, Crosslin Certified Public Accountants, had audited the accompanying consolidated financial statements of Meharry Medical College and Subsidiary (collectively the "College"), which comprise the consolidated statements of financial position as of June 30, 2023, and 2022, and the related consolidated statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the consolidated financial statements. In their opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the College as of June 30, 2023, and 2022, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America. (see Attachment: Most Recent Financial Audit, Final Consolidated A133 Financial Statement June 2023).

3. Describe agency's current system for collecting data on client demographics, service utilization and performance data. Include all software used to collect this data, staff resources for data collection and hardware resources.

Staff resources. The Program Director, Dr. Berthaud, serves as Data Manager, assisted by biostatistician, Derek Wilus, MS. They perform duties such as quality management initiatives, data analysis, and dissemination of results, and staff training. The Program Director integrates all audits and performance evaluations into the overall strategic planning and Ryan White programs operations. He facilitates collaboration with statewide, local, and national quality improvement projects. Dirk Francis, Data Center and System Administrator for Meharry Office of Information Technology (OIT), manages the CAREWare server and maintains the software, while Lee Nelson, MBA, Health Information Technology Director, is responsible for managing E-Clinical Works (our electronic health record system) and interfacing with CAREWare (the primary source of data reports).

Data infrastructure. CAREWare™ forms the backbone of our robust information system. Our data repository relies on three separate layers of security. The CAREWare network connects to a dedicated server housed in a highly secure and restricted basement location in the Office of Information and Technology (OIT), monitored by video camera and on uninterrupted electric power supply 24/7. Meharry OIT has designated a qualified technician, Dirk Francis, to manage the CAREWare server in collaboration with MCWC Program Director.

Data operations. Since 2003, Meharry has been using Microsoft SQL server and the most recent CAREWare version as the primary tool for Ryan White data collection, HRSA-required performances measures and programmatic reports. All MCWC staff use CAREWare and enter data elements in real-time. MCWC had created over 180 customized reports in CAREWare to facilitate data queries and special reports. Moreover, we had developed CAREWare instruments to describe the graphic time course of individual lab variables including CD4 cell count and viral load and designed a unique platform to capture social determinants of health, monitor and evaluate community health care delivery. We have modified CAREWare to allow for attachment of external medical, personal and legal records as well as patient's clinical documents including radiographs and intraoral pictures. MCWC had installed data quality and validity checks for duplicated, missing, discordant, and unknown key data elements to enhance accuracy of reports. A validity check is run prior to submission of reports. All HRSA-required reports including performance measures are readily available in CAREWare and can be created instantly. The Assistant Data Manager, Derek Wilus, MS, biostatistician, uses IBM SPSS or R Studio for more complex data analyses.

Data backup design. Meharry OIT backs up the data daily on extra-large capacity servers and digital tapes. Then, an independent contractor picks up the tapes daily and stores them away from the campus to safeguard them against major disasters and catastrophes such as floods, hurricanes, fire, and powerful earthquakes. The Program Director verifies that CAREWare posts daily messages to check the exact time of each data backup completion. Original Data: The original data, also referred to as the live production data, resides on the HP Synergy Blade system, stored as a VM, with snapshots taken hourly, and stored on the Nimble CS5000. The snapshots are stored for 7 days.

Tier 1 Storage - The tier 1 backup occurs nightly and writes to a second Nimble array, the CS235. This data is stored for 90 days.

Tier 2 "off-site" Storage - Once weekly, the data is copied from the CS235 to a tape backup solution that is rotated off-site weekly. This data would be stored for 180 days.

Additional data safety and security procedures. Each Meharry desktop and laptop are configured to provide optimum security and reliability. OIT monitors each user's activities and downloads automatically the most recent security updates to all Meharry desktops connected to the network, daily, and screens all emails for SPAMs and phishing messages instantly. Meharry students and employees access the network with a personal username and secured password that is required to be changed regularly.

Software platforms. Meharry has adopted the electronic health records system, E-Clinical Works™, across the campus. The software suits for clinical notes, mobile applications, and Physician Quality Reporting Systems (PQRS). However, its capacity to generate customized reports is limited, complex, and provider-restricted, time-consuming, and costly. Medical providers enter their clinical notes and services in E-Clinical Works, also available on their

smartphones app. LabCorp will export the lab tests results in E-Clinical Works as soon as they are available and alert the clinicians on critical values immediately. The HL7 platform and the “socket” allow for seamless export of LabCorp results into the CAREWare labs section. External health records are either faxed or exported into E-Clinical Works using compatible electronic software. A patient portal is available in E-Clinical Works for better self-management and interaction with medical providers. The patient portal is also accessible via smartphone app. MCWC utilizes E-Clinical Works to submit third party billings and track service charges. Both E-Clinical Works and CAREWare are fully secure and HIPAA-compliant. MCWC staff attend mandatory training on compliance with HIPAA, federal and State, as well as Meharry regulations on patient personal health information. MCWC had developed a user-friendly iOS app that allows the quick calculation of odds for a person with HIV to achieve viral load suppression, based on our landmark publication in BMC Infectious Diseases in 2022.

4. Describe agency’s system for managing fiscal and accounting responsibilities. Address the following:

- **Define who oversees this area, what staff is responsible for these activities.**
- **Identify what software is used to manage financial information.**
- **Describe the accounting system that is in place; and**
- **Describe the internal systems that are used to monitor grant expenditures and track, spend, and report program income generated by a federal award.**

Meharry Community Wellness Center (MCWC) had received uninterrupted grant funding from HRSA Part C EIS, Ryan White Part B, and Ryan White Part A for 21, 22, and 17 years, respectively. The Finance Manager, Zudi Takizala, MD, MPH, MBA, is uniquely qualified to oversee fiscal and accounting operations. She brings 21 years of experience in grant administration. In the past three years alone, she had successfully managed 18 public grants including 10 Ryan White grants. MCWC carries a current grant portfolio of about \$3,000,000.00 including grants from NIH/NIAID, HRSA, HOPWA, PEPFAR, and Ryan White Part A and B. Having managed thousands of Federal, State, and local grants and contracts for over 100 years, Meharry is strongly qualified to manage this project. To track and manage grants and contracts, the College uses an accrual method of accounting incorporated into the Banner software and Workday system. The Office of Grants and Contracts works closely with each program and department to assure that budget matters are appropriate and understood. Meharry retains a CPA firm to conduct annual audits and interim financial reports for program planning and implementation. All Meharry fiscal audits had no findings. Additionally, appropriate internal controls including an internal auditing process are in place and assist the College to anticipate and plan more effectively. The Department of Internal Medicine is primary responsible to

oversee grant management and the delivery of clinical services. Meharry Medical Group (MMG) supervises the delivery of clinical services, performs billing, collection of charges, and tracking, and reporting of program income to the Project Director. The Office of Human Resources oversees the hiring process, reviews job descriptions and proposed salaries, assists in background checks, job offers and staff training. The Compliance Office reviews contracts and agreements to ensure compliance with the law. The Office of Grants Management oversees Ryan White programs, ensures that current practices align with federal and State legislation, and that Ryan White funds are expended according to program budget, goals, and expectations. It works closely with MCWC and provides monthly grants expenditures reports to assure disbursements align with program goals and objectives. MCWC and the Office of Grants and Contracts hold monthly financial meetings with Ryan White Part A leadership. The Office of Finance verifies that MCWC manages Ryan White grants according to Generally Accepted Accounting Principles (GAAP). MCWC segregates Ryan White contracts, public, private, and other types of medical insurance in CAREWare to allow for easy tracking and accurate financial report using the service fees and units determined by Ryan White Part A Program. MCWC reinvests program income (billings collections from third-party payers and 340B pharmacy revenues) into overall budget to further program goals and objectives and cover ambulatory out-of-pocket expenses of low-income, underinsured clients. The Program Director reports the program income quarterly to Ryan White Part A and B. The Director of the Office of Grants and Contracts reports annual program income to HRSA via the Federal Financial Report (FFR).

5. Describe agency's process for completing program reports in a timely and accurate manner. Include descriptions of how responsibility for reporting is assigned to staff, how reports are reviewed for accuracy and who assures reports are completed on time.

MCWC staff enters data in CAREWare in real-time. The Program Director had created over 200 customized reports in CAREWare that allow for quick data analysis and reports, research advancement, and deeper understanding of program outcomes. These customized CAREWare reports also comprise data validation, quality checks, for duplicate, missing, and unknown data. CAREWare is able to create a list of all clients with missing/unknown, or duplicate data for the responsible staff to correct. Prior to submitting any reports, a quality check is run again to identify errors, warnings, and alerts needed to be fixed. All Ryan White required periodic reports and performance measures are embedded in CAREWare, i.e. Ryan White Service Report (RSR), Provider Data Export (PDE), program financial and service reports, etc.

III. Cultural and Linguistic Competency:

As a person closely affected by HIV himself, Dr. Berthaud has dedicated his professional career to improve and save the lives of people with HIV in New York, Tennessee, Latin America, Africa, and the Caribbean. He attributes high priority to cultural and linguistic competency. MCWC

staff are trained in cultural competence, cultural humility, and trauma-informed care, and motivational interview. Six of our full-time staff are themselves people living with HIV for over 20 years. Sixty percent of our staff have been affected by HIV, and 70% live in the community they are serving. Client feedback is obtained daily through anonymous satisfaction surveys and quarterly from the Consumer Advisory Board (CAB). The CAB Chair attends our weekly staff meetings, which reserves ample time for discussion of CAB concerns and the results of patient satisfaction surveys including corrective actions, implementation, and monitoring plan. MCWC leadership incorporates the final recommendations into program operations, specific projects, and/or grant applications. Educational materials are created according to the fifth-grade level based on health literacy research conducted at Meharry Community Wellness Center. Interpretation and translation services are readily available for all languages through a contractual agreement paid for by Meharry Medical College. All MCWC Medical Case Managers are well-trained College graduates, with at least a Master degree, and very familiar with underserved communities, HIV issues, and Ryan White programs.

IV. Collaboration:

- 1 Describe a plan for creating a new or improving an existing network to improve collaboration with HIV agencies that will link PLWHAs to HIV testing and HIV medical care and support services. If applicable, identify any collaborating organizations that will assist the applicant through HIV testing and linkage to HIV medical care and services.**

Linkage of newly identified clients: Patients who diagnose HIV positive in the emergency department (ED) at Nashville General Hospital (NGH), located on the Meharry campus, are linked and enrolled into care the same or next business day. HIV providers and Medical Case Managers follow newly diagnosed persons with HIV (PWH) admitted to NGH and coordinate their discharge disposition. Clients newly identified outside the Meharry campus are linked as soon as possible, preferably within less than 7 days. The Patient Service Representatives (insurance verification), the Community Health Workers (coaching and navigation), and the Medical Case Managers (insurance assistance and Ryan White eligibility) are responsible for rapid linkage.

MCWC organizes outreach events with local partners including Metropolitan Nashville Health Department to raise HIV awareness and promote testing. As member of Nashville PrEP Coalition, MCWC facilitates the rapid linkage of newly diagnosed persons. It also leverages its experience as a research site for the SPNS project targeting newly diagnosed and out-of-care women of color for linkage and retention to enhance engagement in care. As a pioneer of HIV telemedicine in TN prisons and HIV consultant for Davidson County jails since 2006, MCWC facilitates the transition of ex-offenders to rapid linkage and engagement upon their release in the community.

Main referral relationships and collaborations include the following: Nashville General Hospital (NGH), Meharry teaching hospital, where Dr. Berthaud serves as Director of Infectious Diseases and Dr. Livette Johnson co-chairs the Infection Prevention Committee; NGH refers PWH from

Emergency Department, inpatient, and outpatient clinics; Meharry Elam Mental Health Center, Meharry Family Medicine and MAT Clinic, located right across the hall from MCWC, and Meharry Clinics constitute regular sources of mutual referrals; Davidson County Sheriff's Office refers inmates with HIV to MCWC since 2005, while Tennessee Department of Corrections refers them for telemedicine consultation, a service established by Dr. Berthaud in 2006; Neighborhood Health, the largest FQHC in Davidson County, Ascension St Thomas Health (Dr. Berthaud maintains consultation privileges), and Metropolitan Nashville Health Department, the largest HIV testing center in Nashville, represent important referral sources. Metropolitan Development Housing Authority awarded a HOPWA grant for the provision of Short-Term, Rent, Mortgage, and Utilities assistance. Street Works and Nashville CARES provide medical case management, food and housing services including permanent placement and emergency shelters. Second Harvest provides low-cost preserved food for our pantry. Vanderbilt University Medical Center provides emergency, specialty ambulatory, and inpatient care for MCWC clients. Tennessee Health Department had contracted with Meharry for ambulatory/outpatient and medical case management services. They provide technical support to medical case managers and assist in linkage/reengagement of clients lost to care. Metropolitan Nashville Public Health Department (MNPHD) refers newly diagnosed HIV-positive and lost-to-care people, treats persons with latent and active tuberculosis, and coordinates STD management and control. Under MNPHD sponsorship, Meharry received a Part A grant for core and support services. Meharry Elam Mental Health Center collaborates with MCWC Therapist/Drug Counselor on outpatient and inpatient drug treatment, detoxification, and rehabilitation. Meharry and Vanderbilt had signed a Data Usage Agreement for expanding participation of minorities in clinical research through the NIH-funded TN Center for AIDS Research (TN-CFAR), a joint venture including Nashville CARES and TN Health Department.

- 2 Contractor(s) must demonstrate their commitment to work with or collaborate with organizations representing the HIV/AIDS community through a signed and dated letter of support or memoranda of agreement or understanding. The letter must specify example activities that each entity provides that will help connect high risk clients to HIV testing and services.**

Meharry Community Wellness Center (MCWC) has been provided food services (food coupons) under Ryan White Part A grant since 2015 and food pantry service under our program income in collaboration with Second Harvest for the past five years. Meharry Community Wellness Center, Street Works, and Nashville CARES have a longstanding collaborative relationship. MCWC clients can also access food services at Nashville CARES and Street Works. Those who are also patients of Nashville General Hospital can access their fresh and hot meals. Dated signed letters that specify example activities that each entity provides that will help connect high risk clients to HIV testing and services are uploaded.

B. Reference Projects (10 Points) Service History & References:

- 1. If your agency currently provides this service(s) to the HIV/AIDS client population,**

describe the number of years you have provided this service and the funder of the service. Please provide a reference name and phone number.

Meharry Medical College has been providing ambulatory/outpatient services to persons with HIV since the initial outbreak in 1981, i.e., even before the virus was discovered. Meharry Community Wellness Center opened in 2005 with funding support from Ryan White Part B and Part C. Ryan White Part A support started right after Nashville became an Emerging Metropolitan Area (EMA) in 2008. However, TN Health Department will stop funding for recipients who receive Part A funding starting on April 2026. Our Part C grant has been on freeze under Executive Order and HRSA has not issued the 2025 grant award yet. Therefore, Ryan White Part A had become lifesaving for people living with HIV in Nashville TGA. Meharry Community Wellness Center has been recipient of Part C Minority AIDS Initiative (MAI) grant funding for Ambulatory/Outpatient Services since 2013 and of Part A MAI grant support since 2022. Meharry Community Wellness Center (MCWC) has been provided **food services** (food coupons) under Ryan White Part A grant since 2015 and food pantry service under our program income in collaboration with Second Harvest for the past five years.

For reference, we mention the name of our Part C EIS Project Officer
Christie Slay, MPA, MAEd, CHES, Public Health Analyst/Project Officer, Central
Branch, Division of Community HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, Rockville, MD 20857
Phone: 301.443.0504

2. If your agency does not currently provide service(s) to the HIV/AIDS client population, explain any related experience that would demonstrate the agency's competency in providing services to this population. Please provide a reference name and phone number.

Not applicable.

3. Describe any related experience that would demonstrate your agency's competency in providing HIV medical or support services to this population. Please provide a reference name and phone number. The file is limited to 5 pages and should be in PDF format entitled "Reference Projects."

The file labelled "Reference Projects" had been uploaded.

Here's the reference name and phone number:

Part C EIS Project Officer
Christie Slay, MPA, MAEd, CHES, Public Health Analyst/Project Officer,
Central Branch, Division of Community HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, Rockville, MD 20857

Phone: 301.443.0504

A. Project Approach and Process (30 Points)

I. Staffing:

Present in detail your organization's staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the number of time/hours per month being requested for each proposed staff position.

Ambulatory/Outpatient Services

Staffing Plan of Key Personnel				
Name	Roles	Responsibilities	Education/Training	Experience Part A FTE
Vladimir Berthaud, MD, MPH, FACP, FIDSA, DTMH, CPH	Project Director	Supervision of overall activities; HIV care and infectious diseases services	Board-certified in internal medicine, infectious diseases, public health, tropical medicine, and traveler's health.	International HIV expert with 39 years of experience in HIV care, research, training, teaching, program development, and implementation worldwide.
Zudi Takizala, MD, MPH, MBA	Finance Manager	Project management and CQI	Doctor of Medicine, with master's degree in public health and business	21 years of experience in management of \$30M in Federal, State, & local grants
Keisha Ashmeade Ed.D, MSPH, FNP, AHIVS	Clinic Manager	Manages clinic operations	HIV specialist and Board-certified NP	11 years of HIV care experience
Sheena S. Simon, DNP, APRN, NP-C	Primary HIV care provider	Comprehensive HIV management	Board-Certified Nurse Practitioner, specialized in prevention	22.44% FTE Six years of HIV care experience
Ethel Harris, DDS, MPH	Director of oral health services	Comprehensive oral care and prosthodontics	Meharry graduate, former Director of SEATC oral health	22 years of experience in oral health for PLWH
Ryan White Part A Staffing Plan				
Name	Roles	Responsibilities	Education/Training	Experience Part A FTE

Livette Johnson, MD	Infectious diseases management	HIV and specialty care	Meharry graduate, Board-certified in internal medicine and infectious diseases	40% FTE 35 years of experience and expertise in HIV care
Sheena S. Simon, DNP, APRN, NP-C	HIV care provider	Comprehensive HIV management	Board-Certified Nurse Practitioner, specialized in prevention	35% FTE Six years of HIV experience
Debra Simmons, LPN	Phlebotomist	Process laboratory specimens and perform nursing duties	Graduate of Baptist Hospital LPN School	50% FTE 9 years of experience serving PLWH
Maya Johnson, BS, MPH	Community Health Worker	Coaching, adherence counseling, patient navigation, community case management	MPH graduate from Meharry, with solid knowledge of SPSS, SAS, Redcap, GIS, and Microsoft environment	75% FTE One year of experience with PLWH
Tamiko Grimes	Community Health Worker	Coaching, adherence counseling, and patient navigation	Trained Peer Counselor and Community Health Worker	100% FTE 9 years of experience with PLWH
Osamudiamen Osa-Edoh, MD, MPH	Psychiatrist	Treatment of behavioral & substance use disorders	Board-certified psychiatrist, Director of substance use treatment at Meharry	15% FTE 10 years of experience with PLWH
Erlete Ascencao, PhD/PhD, HSP	Clinical Psychologist, Social Scientist	Specialized in HIV clinical psychology services	Doctor in Social Sciences and Clinical Psychology, Licensed Health Services Provider	100% FTE 22 years of experience with PLWH
Ronda Jennings, MA	Senior Medical Case Manager	HOPWA Case Manager, Mental health therapy and drug counseling	Master' degree in Clinical Counseling, Certified Alcohol and Drug Addiction Counselor	64.29% FTE 17 years of experience in medical case management and

				counseling with PLWH
JaRae Davenport, BS, MPH	Medical Case Manager	Medical case management services including treatment adherence	Master’s degree in public health practice	100% Three years of experience in medical case management under Part A grant
Kaye Chavis, DBA	Medical Case Manager	Medical case management services including treatment adherence	Doctoral degree in Business Administration	90.02% 4 years of experience with PLWH and Ryan White Part A grant 23 years’ MDHA experience

Qualifications of Key Personnel.

Vladimir Berthaud, MD, MPH, FACP, FIDSA, CPH, DTMH, is tenured professor of medicine, Director, Division of infectious diseases at Meharry Medical College and Nashville General Hospital and Founding Executive Director of Meharry Community Wellness Center. He completed his infectious diseases fellowship at Columbia University and Cornell University in New York. Dr. Berthaud has been a passionate advocate for PLWH and the recipient of numerous prestigious awards including IPRO’s Outstanding Service to the Health Care Community Award for Quality Improvement in reducing Disparity for Adult Immunizations in New York State, Award for Outstanding Contribution to the Internal Medicine Training Program, Harlem Hospital/Columbia University College of Physicians & Surgeons, New York City Council Citation for Exemplary Service, National Library of Medicine/Marine Biological Laboratory, Fellowship Award in Medical Informatics, Nashville Business Journal, Award Honoring Superior Contributions to the Health Care Industry, Johnson & Johnson UCLA Healthcare Executive Management Award, Street Works Guiding Light Award, and Mahogany Honors Dwayne Jenkins Lifetime Achievement Award. Part C EIS Program Director for 20 years, Dr. Berthaud serves as Project Director/Principal Investigator for Meharry HIV Research and Training Facility, Mentor and Investigator for the NIH-funded U01-Practice-Based Research Integrating Multidisciplinary Experiences in Dental Schools (PRIMED), Associate Director of Clinical Discovery Core, for TN-CFAR, Clinical Lead for Meharry PEPFAR, and Program Director for HRSA-sponsored National HIV Residency Pathway Consortium. He has been a member of the Tennessee AIDS Centers of Excellence Committee since 2002. Other experiences include Train-of-Trainer Expert for the National HIV Curriculum, HIV Trainer for the National MTCT-Plus Program in Rwanda and Côte d’Ivoire, HIVAIDS Curriculum Developer for NIH/ACTG/HPTN in Latin America and the Caribbean and HIV Preceptor for IDSA International AIDS Training Program, HIV Curriculum Reviewer for CDC, and scientific advisor to CDC Program for TB Elimination, member of the National Board of Public Health Examiners, and of the National Board of Medical Examiners, Academic Advisor, UCLA School of Management, Community Health Improvement Program, and Member, American College of Physicians (ACP) Leadership Academy. Former member of

the Leadership Conference and Admissions Liaison Officer, United States Military Academy at West Point, past Chair of The George W. Counts Interest Group of the Infectious Diseases Society of America (IDSA), past member of IDSA Leadership Development Committee, Dr. Berthaud is a member of the American Board of Internal Medicine Infectious Diseases Task Force and Faculty of the IDSA Leadership Institute. He was a Lead Principal Investigator for the international Kid COVE Vaccine Trial. Dr. Berthaud is Endowed Professor of Medicine, with Adjunct appointment in Microbiology, Immunology, and Physiology. He is Academic Editor for PLOS ONE medical journal and the author of many peer-reviewed publications in impactful scientific journals. Dr. Berthaud is fluent in Spanish, French, English, and Creole.

Livette Johnson, MD. A native Nashvillian and a graduate of Meharry School of Medicine, Dr. Johnson completed her internal medicine residency training at Johns Hopkins University in Baltimore and her infectious diseases fellowship at Cornell University in New York. She holds Board certification in internal medicine and infectious diseases. Dr. Johnson is associate professor of medicine at Meharry Medical College and Vice Chair of Infection Prevention Committee at Nashville General Hospital. Dr. Johnson served as attending physician at Mount Sinai Hospital and Assistant Chief of Infectious Diseases at Metropolitan Hospital in New York. She brings a personal dedication to the care of populations living with HIV.

Zudi Takizala, MD, MPH, MBA. Doctor of Medicine with extensive experience in grant administration, financial management, and staff supervision, Dr. Takizala has a long record of collaboration with diverse internal and external stakeholders, community agencies, and Ryan White programs. She oversees clinical operations at Meharry Community Wellness Center. In the past three years, she has successfully managed 18 public grants including 10 Ryan White grants, and others from NIH, HOPWA, PCORI, Tennessee State and Metropolitan Nashville government.

Keisha Ashmeade, ANP, MSN, MSPH, Ed. D, AAHIVS, board-certified advanced nurse practitioner and certified HIV specialist, Dr. Ashmeade has been Clinical Manager of Meharry Community Wellness Center for seven years. She brings 10 years of experience in HIV primary care and seven years of teaching experience as Assistant Professor.

Ethel Harris, DDS, MPH, Director of Meharry Community Wellness Center's Oral Health Services, she holds joint Faculty appointment as Assistant Professor of Medicine and Dentistry at Meharry and serves as Clinical Investigator on the NIH-funded UO1 grant, "Practice-Based Research Integrating Multidisciplinary Experiences in Dental Schools". Dr. Harris served as Dental Director for the Southeast AIDS Education and Training Center (SEATC). She was born and raised in Nashville and she graduated from Meharry School of Dentistry.

If applicable, describe in detail the roles and responsibilities of any consultants and/or subcontractors will be used to conduct aspects of the proposed project.

This is not applicable.

II. Overview of Population:

Describe in detail the HIV/AIDS population in Davidson County. Describe in the detail the issues that interfere with identifying, engaging, and retaining PLWHAs in routine HIV testing and HIV services.

HIV/AIDS population in Davidson County.

Meharry Community Wellness Center stands at the epicenter of the HIV epidemic in Nashville, in the heart of Davidson County, more specifically, North Nashville, the neighborhood most densely populated in Blacks or African Americans (71%) where 1,933 of every 100,000 people are living with HIV as compared to 978.7 for Blacks in the remaining Nashville Transitional Grant Area (TGA). The TGA had an estimated population of 1,742,588 in 2019, accounting for 26.5% of the state's total population and 31% of the state's people living with HIV (PLWH). In the thirteen counties that make the Nashville Transitional Grant Area (TGA) including Davidson, non-Hispanic Blacks account for 54% of PLWH and in 2021, they represented 27% of Davidson County's population and 52.4% of PLWH. While about 39% of the Nashville TGA's population lives in Davidson County, 76.5% of the PLWH population reside in Davidson County. Of this PLWH population, 20% had been in jail and 42% were homeless/unstably housed at some point in the last year, and 40.2% did not have food to eat three or more days at some point in the last year. Fear of disclosure (50.6%) represents the number one barrier to accessing services (Metropolitan Nashville Health Department). In Nashville TGA, an estimated 17% of PLWH are unaware of their status. In 2020, 66% of newly diagnosed cases were linked to care in 30 days, 54% were retained, and 66% achieved viral suppression. Among Non-Hispanic Blacks, 64% were linked to care within 30 days, 54% were retained and 63% became virally suppressed, and they had the highest incidence of Chlamydia, gonorrhea, and syphilis. Meharry Community Wellness Center (MCWC) serves the most vulnerable and hardest-to-reach PLWH in Tennessee. In 2024, our program served 484 unduplicated clients. African Americans accounted for 77.06%, women 26.44% and MSM 42.35%. Our clients bear an excess burden of uninsured (39.25%), poverty (48.96% below 100% FPL), and history of incarceration (20%), homelessness (19.2%, higher than in Davidson's 13.6%), and substance use and behavioral disorders (30%). More than 70% of our clients did not graduate from high school. Our proportion of clients experiencing homelessness represents more than twice the national average for PLWH (8.4%) and is 50% greater than the national Ryan White average (12.9%). According to the Brookings Institution, North Nashville has an incarceration rate of 14%, by far the highest in the country, and 93% of those incarcerated are Blacks. Our patient population has an alarming prevalence of severe tooth decay (60%) and severe periodontitis (30%). Meharry Community Wellness Center (MCWC) represents the only Tennessee clinic that offers unfettered access to fully integrated, comprehensive oral health services for low-income PLWH regardless of their primary HIV care providers. The Tennessee Ryan White Dental Assistance Program (RWDAP) ran out of funding in April 2019 and left 1,800 clients with very limited or non-existing access to oral health services. Only 10% of our clients have dental insurance coverage and just 2% of them have adequate

coverage. Since 2023, TennCare offers limited oral health benefits to eligible clients. So far, they have not referred any patients to our dental clinic. The prospect for new funding remains grim because of a large budget shortfall in the Tennessee Ryan White B program that required across-the-board budget cuts leading to a reduction of our annual budget by \$76,510.50 since 2021-2022 and termination of funding for Part A grantees in 2026.

Issues that interfere with identifying, engaging, and retaining PLWHAs in routine HIV testing and HIV services.

Gaps in local services. Major gaps in MCWC/TGA HIV care continuum, retention, and viral suppression, can be attributed to high rates of incarceration (20%), homelessness (MCWC 19.2%; TGA 13.8%), and poverty (39.25% below 100% FPL), behavioral and substance use disorders (30%), and chronic comorbidities such as cancer, cardiovascular diseases, chronic kidney and lung diseases. Moreover, gaps in medical and dental insurance coverage, TennCare restrictions on the number of monthly prescriptions, and food shortage, lack of family support as well as stressful life events too often lead to poor treatment adherence and negative health outcomes such as HIV disease progression, exacerbation of comorbidities, frequent visits to specialty clinics, emergency department and admissions to the hospital, mental institutions, and drug treatment centers. Huge gaps persist in oral health, substance use disorders, medical transportation, and housing services.

Major Barriers to Care:

Incarceration: Of 516 inmates with HIV served by MCWC from 2003 to 2018, 64% were Black or African American and 66% aged 45-64. Stepwise implementation of telemedicine in 2006 led to increase in clinic attendance from 50% to 90% and viral suppression from 30% to 90% (Berthaud V. 2022 National Ryan White Conference). Of PLWH incarcerated in Davidson County jails, Non-Hispanic Blacks account for 71% and non-Hispanic Whites 29%. North Nashville has an incarceration rate of 14%, the highest in the country by far, and 93% of those incarcerated are Blacks. In other words, one in seven people who were born in the primary zip code of North Nashville between 1980 and 1986 went to jail or prison at some point in their lives. (Adams L, Nicholas T: Work and opportunity before and after incarceration. The Brookings Institution, March 2018). Twenty five percent of our patients reside in that neighborhood and 41% of them belong to this age group. MSM is still the most frequent means of exposure accounting for 37.5%, and IDU the second most reported exposure category among the jail population (22.1%). Heterosexual exposure accounts for 18.9% of PLWH in jail and MSM/IDU account for 6.3% of the cases; unreported exposure accounts for (15.1%). (Source: Nashville Metropolitan Health Department). Meharry Community Health Worker had established a strong collaborative relationship with Tennessee Department of Corrections (TDOC) and Davidson County Sheriff's Office (DSCO) for over 20 years. Persons with HIV who are incarcerated in DSCO are referred to MCWC for in-person care, while inmates of TDOC are seen by telemedicine.

Transportation: Public bus service in Nashville is extremely limited to some parts of downtown and very few stops in North and West Nashville. It nearly does not exist in South and East Nashville. Most of our patients resides far away from a bus stop. They require multiple transfers to come to the clinic or simply rely on a ride with a relative or a friend. The bus service makes short stops every hour between 8:00am and 4:30pm. There is no

subway line in Nashville and Tennessee. MCWC had hired a full-time person to provide free round-trip medical transportation in the Transitional Grant Area (TGA).

Education: High school completion rate is 76% in Davidson County and 15% at MCWC.

Unemployment and poverty: 39.25% of Meharry clients had an annual income <100% FPL in 2023. Unemployment rate reached 60% and 30% were receiving Social Security Income. Drug and alcohol: Addiction to drugs and alcohol remains a significant risk factor for poor nutrition and treatment adherence, bad health outcomes, incarceration, and homelessness. However, there are insufficient access points to drug detoxification and rehabilitation in Davidson County. Many offenders released on parole or probation cannot get into drug or alcohol treatment. Consequently, they are often re-incarcerated for parole or probation violation. Periodic mandatory report to parole or probation officer had become their major competing priority. Moreover, many African Americans had switched from injection drugs to cocaine snorting or smoking, without any available treatment option.

Housing is the utmost priority for persons addicted to drugs who are experiencing homelessness. As Nashville is becoming a major destination for relocation of businesses and people, affordable housing had become very scarce, while homelessness continues to rise. Aggressive gentrification further aggravates the shortage of affordable housing units. Moreover, the Department of Housing and Urban Development (HUD) had tightened requirements and narrowed their definition of homeless, which requires that clients be in a shelter for three days before being deemed eligible. Clients with criminal records, active addiction, and mental health issues are denied housing (both public and private); limited transitional, assisted living or group homes are available. Recently released convicts present other critical challenges such as limited access to employment, financial loans and social support. During the past five years, in Nashville, Tennessee, the trend of homelessness paralleled the economic growth curve that propelled a booming housing market. “Nearly 70% of Nashville ever-changing skyline wasn’t there 10 years ago” according to Nashville Chamber of Commerce. In April 2024, the median price for residential single-family homes in Nashville was more than \$500,000 for the first time. In the aftermath of the March 3, 2020, devastating tornado that destroyed numerous homes in North Nashville and the subsequent coronavirus pandemic, the number of displaced families grew exponentially. Most of the patients attending Meharry Community Wellness Center (MCWC) reside in North Nashville. Many of them lost their jobs in places such as hotels, restaurants, and factories due to local and state government-imposed “Stay-at-Home” and social distancing orders related to mitigation of the COVID-19 pandemic. The national economic downturn during the coronavirus pandemic exacerbated the homelessness crisis and widens the gaps in care and HIV health disparities. Our proportion of clients experiencing homelessness represents more than twice the national average for PLWH (8.4%) and is 50% greater than the national Ryan White average (12.9%).

Community environment: An often-forgotten barrier is the fact that 70% of our patients live in the same neighborhood and are very familiar with each other. Fear of disclosure of HIV status, stigma, and discrimination, prejudice, religious concerns, and misconceptions remain enormous barriers to accessing HIV care.

Barriers to reaching Tennessee’s disproportionately-impacted populations:

African-American MSM: lack of awareness, or misinformation about HIV transmission, prevention, and treatment; impact of homophobia on health-seeking behavior; lack of access to health care generally; and denial of risk.

Young MSM: misperceptions about HIV risk; denial and complacency associated with being a late adolescent; difficulties comprehending the seriousness of HIV, coupled with rejection by family and friends.

High-risk heterosexuals: lack of perceived risk; poverty, limited access to health care and health information; acting as caregivers in families; and financial dependency on a partner.

Incarcerated: stigma (isolation & potential for violence due to HIV status); misinformation about HIV transmission, prevention, and treatment (situational sex/" gay for the stay"); and lack of awareness or access to testing and/or health care services upon release.

Ryan White Part C Minority AIDS Initiative Report.

- To recruit persons with HIV (PWH) of the MAI target population, MCWC conducted outreach activities at multiple events:

Nashville Mayor's Ending-the-Epidemic, PRIDE Day, Black PRIDE, World AIDS Day, National HIV Black Awareness Day, and HIV Testing Day, and The African Street Festival. MCWC also leverages its partnership with Tennessee Department of Corrections, Metro Health Department, Davidson County Sheriff Office, Nashville General Hospital, United Neighborhood Health Centers, and Street Works. The Program Director promotes HIV awareness on Fisk Radio program, Health Waves. In general, the positivity yield of HIV testing in Nashville/Davidson County during outreach activities is less than 1%.

- How targeted testing is done for PWH of the MAI target population, and positives identified.

MCWC focuses on partners of non-virally suppressed clients, persons with sexually transmitted infection(s), or those with risky sexual behavior. Thus, from 01/2023 to 8/2023, MCWC performed targeted HIV testing for 60 high-risk persons on-site. Six of them (8.3%) tested HIV-positive. They were enrolled in care and started on ART immediately.

- How identified positives are linked to and enrolled in care.

People who test HIV-positive in the clinic or on the Meharry campus are linked to care and started on ART the same day; those referred from outside the campus are seen as soon as possible, usually within less than a week. EIS Worker, Community Health Workers, and the Community Care Team are responsible for linkage of identified positives to care. The Community Care Team meet twice a week to discuss newly identified positives and facilitate engagement. Medical case managers and medical providers collaborate in identifying and enrolling new clients. Altogether, they arrange for medical transportation, inform about core and support services, and expectations at initial clinic visit.

- How the PWH are retained in care.

The Patient Service Representative and Community Health Workers contact clients one week and 24-72 hours prior to their scheduled clinic appointments. They reach out by phone, text message, or e-mail to those who missed their visits the same day and attempt to reschedule them, while trying to address the root causes of missed appointments. If these attempts are unsuccessful after one or two weeks, they will mail a certified letter of notification at the client's last address.

Medical case managers and HIV medical providers identify new and current clients at high

risk for drop out-of-care and refer them to the Community Care Team. They analyze challenges, barriers, and facilitators to develop and implement a joint plan of care for intensive adherence counseling, peer coaching, performance monitoring, and evaluation. Difficult cases are discussed at weekly staff meetings for broader input.

The Community Care Team reviews the out-of-care list and deploy all their effort to locate the client, reach out to their authorized contact persons, state prisons and jails, local hospitals and drug treatment centers, and homeless camps. Once they are unable to locate the client, they will arrange an in-person visit at their residence or their hangout places. If that fails, they will solicit assistance from the local and state Health Department as well as other community organizations. As a last-ditch effort, they will access the obit announcements.

Describe in detail:

- 1) The number of persons you plan to serve with the funding.**
- 2) The number of units of service you plan to provide by type of intervention (e.g., number of face-to-face contacts with clients and amount of time each client will be seen each year, number of educational sessions provided, number of contacts with gatekeepers); and**
- 3) the average amount of service a client is expected to receive each year (e.g., 2 face to face each year) and the amount of time that will be spent with gatekeepers (e.g., 3 hours/gatekeeper/year).**

With this funding, we propose to serve 100 persons with HIV, distributed as follows:

Male 76%; Female 24%

African American 80%; Caucasian: 19%; other 1%

Hispanic 10%

Age group: 13-24: 0.1%; 25-44: 54%; 45-64: 45%; 65+ 0.9%

They will receive 600 units of service at \$20 each, in face to face food service provided by a Part A funded Medical Case Manager in the grant year.

III. Implementation Plan:

The importance of improving progress along the HIV care continuum is supported using scientific research that leads to the identification of best practices and evidence-based practices. The use of best practices/evidenced informed models is preferred for all services and as applicable/available.

Describe in detail any evidence bases or best practice models you will use to provide the service. Include a reference to the model's name and source of the best practice (e.g., "Healthy Living Project," CDC Evidence-Based Intervention-EBI).

<https://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html>

Ideally, interventions will be based upon proven outreach and engagement models; and/or adaptations of proven models; and /or novel models of outreach and engagement in care, particularly developed for the HIV/AIDS population.

Meharry Community Wellness Center will provide primary HIV care based on the latest Guidelines and Recommendations of the Department of Health and Human Services

(DHHS) for prevention and treatment of HIV-associated opportunistic infections. These Guidelines summarized the best evidence as assessed by a panel of national HIV experts. Moreover, our experience as one of the three national performance sites, for the HRSA-sponsored Special Project of National Significance (SPNS), “Dissemination of Evidence-Informed Interventions: Peer Linkage and Re-Engagement of HIV-Positive Women of Color” in 2016-2019 inspired the Community Care Team Model implemented by our program in 2020. The Manual is available at: <https://www.targethiv.org/deii/deii-peer-linkage>. Peer Linkage and Re-engagement of Women of Color with HIV. Rajabiun S., Marbach A., Fox J., Childs E., Sullivan M., Downes, A., Bryant H, Nortrup E., Berthaud V., Alexander L., Grimes T., et al. Dissemination of Evidence-Informed Interventions. Peer Linkage and Re-engagement of Women of Color Living with HIV (2020). Available at: <https://www.targethiv.org/deii/deii-peer-linkage>. The peer-reviewed manuscript is referred here: Serena Rajabiun, Janet J. Myers, Janet Goldberg, Karen Fortu, Marena Sullivan, Vladimir Berthaud, Rahab Wahome, and Howard J. Cabral. “Outcomes from the adaptation of an evidence-based Peer Linkage & Re-engagement: Intervention for Women of Color with HIV in three urban clinics”. AIDS and Behavior. October 05, 2021. PMID: 34609629.

For all Ryan White projects, Meharry Community Wellness Center also implements the most recent Standards of Care published by Tennessee Health Department Ryan White Part B Program and Metropolitan Nashville Health Department Ryan White Part A Program.

Retention strategies: To improve retention and viral suppression, Meharry Community Wellness Center (MCWC) had formed the Community Care Team, which meets twice weekly to discuss clients with incoming appointments, those who missed their recent clinic visits, and those lost to care. MCWC works diligently to schedule all of a client’s visits the same day. The Patient Service Representatives or the Community Health Workers contact the client one week and 24-48 hours before the appointment date to facilitate the clinic visit. They arrange for round-trip medical transportation, if needed. Those who missed their scheduled visits are contacted in less than 24 hours. If they are unable to reach a client by phone calls, text messages, e-mails, or letters, after 2 weeks, the Community Health Worker attempts to make a home visit. If that fails, they reach out to Nashville Health Department EIS Worker, Davidson County Sheriff Office and Tennessee Department of Corrections, the Coalition for the Homeless, drug treatment centers, mental health institutions, local hospitals, and nursing homes, for investigation. If these strategies fail after 6 months, the TN Health Department Disease Intervention Specialist (DIS) is alerted for further tracking efforts. Clients who miss more than two consecutive appointments receive intensified adherence counseling and coaching.

Targeted retention efforts toward subpopulations with poor health outcomes. The Community Health Workers and PSRs target MSM, women of color, and clients with challenging issues such as mental illnesses, substance use disorders, and pervasive stigma. The Medical Case Managers assist clients experiencing homelessness in permanent placement, prevention of eviction, and maintenance of stable housing. The HOPWA Case Manager assists clients with rent, mortgage, and utilities bills. The Community Health Workers provide clients with medical transportation, food services, and pharmacy

management to facilitate clinic visits and medication adherence. The medical providers coordinate with staff to facilitate joint clinic appointments. All clients are screened for behavioral and substance use disorders and those who screen positive are seen by the clinical psychologist, the psychiatrist, and/or the therapist/counselor.

Coordination of medical and support services for pregnant women.

An obstetrician-gynecologist with over 25 years of experience including 15 years at MCWC, Dr. Vernita Tucker, will manage pregnant women in the clinic in close coordination with medical providers and nurses during the entire prenatal, peripartum and postpartum period. All pregnant women will be offered ART, if not on yet, and counseled regarding the benefits and risks of ART during pregnancy for the woman, fetus, and newborn. Adherence to ART may decline in the postpartum period. Therefore, clinical and support staff caring for postpartum women on ART will stress adherence and evaluate specific facilitators and barriers. Two Meharry board-certified infectious diseases pediatricians, Dr. Shahana Choudhury and Dr. Christopher Keefer, will manage HIV-exposed babies. Prenatal and HIV care visits as well as neonatal and maternal medical visits will occur on the same day. Attention will be paid to nutrition, medical transportation, housing status, and medical insurance coverage.

Unmet need and HIV care continuum: In 2020, 66% of newly diagnosed people in Tennessee were linked to care within 30 days, compared to 64% in 2018; 54% were retained in care (same for non-Hispanic Blacks) and 66% achieved viral load suppression (63% for Non-Hispanic Blacks). In Nashville TGA, an estimated 17% of PLWH are unaware of their status. In 2020, 66% of newly diagnosed cases were linked to care in 30 days, 54% were retained, and 66% achieved viral suppression. Among Non-Hispanic Blacks, 64% were linked to care within 30 days, 54% were retained and 63% became virally suppressed. Among Non-Hispanic Black PLWH, there were significant differences in care retention by age group ($p < 0.0001$). The lowest rates of care retention in this subpopulation were found among 13-24-year old (44%) and 25-34-year-old (52%). Among Non-Hispanic Black PLWH, there were significant differences in viral suppression by age group ($p = 0.0009$). The lowest rates of viral suppression were found among 13-24-year old (51%), 35-44-year-old (57%), and 25-34-year-old (58%). In TN and the Nashville TGA, the Ryan White program represents the strongest contributor to successful outcomes along the HIV care continuum as shown in this figure. Source: TN Health Department sponsored presentation TN HIV Continuum of Care: Update, Peter F. Rebeiro, MHS, PhD. (September 24, 2015)

We examined the effect of homelessness on viral suppression between 2014-2019. Our retrospective study revealed that permanently/stably housed clients had a much higher proportion of viral suppression compared to unhoused clients. Among clients with viral load < 20 copies/mL, 78% were permanently housed and 22% homeless, while 74% of permanently/stably housed clients reached viral suppression and a smaller proportion of the homeless clients (54.7%) remained virally suppressed (Pearson's Chi-Square 25.171, $p < 0.001$). The multivariable logistic regression showed that permanent/stable housing (p -value < 0.001), higher frequency of CD4 count > 500 cells/mm³ (HIV infection, stage 1) (p -value < 0.001), age (p -value = 0.004), and FPL (p -value = 0.031) were strong predictors of viral suppression. As expected, patients living in permanent/stable housing had twice the

chance of achieving viral suppression compared with those who were experiencing homelessness [OR 2.08 (1.39-3.23), p-value <0.001]. Under the nonparametric assumption, the receiver operating characteristic (ROC) curve correctly predicted 72.3% of the primary outcome variable, viral suppression (AUC = 0.767; p-value < 0.001; 95% CI for AUC (0.73, 0.80). During the 5-year study period, 52 clients died. Of them, 16 (30.76%) were experiencing homelessness and 36 (69.23%) lived in stable housing, while 12.5% of the homeless and 61.12% of those in stable housing achieved viral suppression at the time of death (Berthaud V. et al. BMC Infectious Diseases, 2022; 22: 144). This seminal paper inspired the 2022 CDC Issue Brief, “The Role of Housing in Ending the HIV Epidemic” and a Human Resources and Services Administration (HRSA) Notice of Funding Opportunity for housing of PWH. The Infectious Diseases Society of America cited our paper in their special issue dedicated to homelessness and infectious diseases (Emily Mosites, Laura Hughes, and Jay C. Butler. Homelessness and Infectious Diseases: Understanding the Gaps and Defining a Public Health Approach: Introduction. The Journal of Infectious Diseases 2022;226(S3): S301–3).

IV. Best Practices:

Provide a clear and succinct description of the proposed project to implement an intervention model designed to create access to HIV testing, improve timely entry, engagement, and retention in quality HIV medical care for persons living with HIV infection.

The primary objective of the Food Voucher program is to serve eligible Ryan White Part A clients based on their nutritional and socio-economic status. The medical providers conduct clinical evaluation, nutritional education and adherence assessment to determine medically eligible patients. Their weight is monitored at each clinic visit and serum albumin measured twice a year.

Data is entered in CAREWare for periodic reports and feedback using a note template. Nutritional brochures and educational videos are widely available in the clinic.

The Medical Case Manager performs the intake to determine financial and geographic eligibility, assist in application for food stamps and develop a care plan. Clients are informed about good nutrition, restrictions on food items, and required to bring their original receipts for each food voucher received. Their socio-economic status and food stamps application are reassessed prior to issuing any subsequent food cards.

Moreover, clients are also informed on the availability of comprehensive oral health services in the clinic to sustain optimal nutrition. The Medical Case Manager will evaluate all available nutritional resources in the community for linkages and patients’ referrals and will be responsible for storing, distributing and tracking the food cards. Food cards will be secured in locked cabinets behind double locked doors. Clients are required to acknowledge and sign every food card received and their understanding and agreement with the food voucher policy.

Nonetheless the Food Voucher program stands far from meeting the need of our clients. In response to this acute food shortage, MCWC has been using its program income to implement and operate its food pantry for the past five years. The food pantry offers a great variety of

nutritious foods and supplements, constantly replenished in partnership with Second Harvest. Our staff also facilitate access to hot meals at Nashville General Hospital for needy clients. In order to improve the health and well-being of medically underserved and low-income clients, Meharry Community Wellness Center (MCWC) draws from its program income to fill gaps in core and support services: patient service representative, comprehensive oral health services, and women's health care, on-site ambulatory surgery, pharmacy assistance, medical transportation, housing, and the food pantry.

Describe the strategies you will use to identify and engage with key stakeholders recognized and trusted by the HIV/AIDS community; include the names of specific people and entities.

Describe the components of your intervention model and its specific strategies that will:

- a) Increase awareness of HIV disease, with a focus on reaching persons at high risk for becoming infected with HIV disease.**
- b) Identification of high-risk persons who need but do not access regular HIV tests and how you will link those persons to HIV testing agencies; and**
- c) Identification of persons who are HIV positive but have never or who have dropped out of HIV medical care and services and how you will facilitate linking those persons with needed HIV services and care.**

Proposed interventions must address personal, financial, sociocultural, and structural barriers, especially stigma, that affect PLWHAs access to HIV testing and retention in HIV medical care and services. Define specific barriers that may be encountered by the population being served and discuss how your proposed interventions will positively address each of these barriers.

Meharry Community Wellness Center (MCWC) organizes outreach events with local partners including Metropolitan Nashville Health Department to raise HIV awareness and promote testing. As member of Nashville PrEP Coalition, MCWC facilitates the rapid linkage of newly diagnosed persons. It also leverages its experience as a research site for the SPNS project targeting newly diagnosed and out-of-care women of color for linkage and retention to enhance engagement in care. As a pioneer of HIV telemedicine in TN prisons and HIV consultant for Davidson County jails since 2006, MCWC facilitates the transition of ex-offenders to rapid linkage and engagement upon their release in the community.

Patients who diagnose HIV positive in the emergency department (ED) at Nashville General Hospital (NGH), located on the Meharry campus, are linked and enrolled into care the same or next business day. HIV providers and Medical Case Managers follow newly diagnosed persons with HIV (PWH) admitted to NGH and coordinate their discharge disposition. Clients newly identified outside the Meharry campus are linked as soon as possible, preferably within less than 7 days. The Patient Service Representatives (insurance verification), the Community Health Workers (coaching and navigation), and the Medical Case Managers (insurance assistance and Ryan White eligibility) are responsible for rapid linkage.

Community Care Team Model. To optimize patient care at multiple access points and shift from a disease-based model to truly patient-centered care, MCWC will implement the community care team model based on four tracking pathways, A, B, C and D.

A: Patients who attend clinic appointments regularly, maintain viral load suppression, and may have zero to low-level comorbidities and social determinants of health. (*Focus: prevention, health promotion, and reinforcement of adherence*)

B: Patients who are missing scheduled appointments (no-shows, walk-ins), do not maintain viral load suppression, and may experience rising levels of comorbidities and social determinants of health. (*Focus: increase adherence counseling, health education, and rapid intervention, and identify, and address emerging risk factors for adverse outcomes*)

C: Patients who do not attend clinic appointments regularly, may have variable levels of viral load suppression and comorbidities, and high levels of challenging social determinants of health impacting treatment adherence, the HIV care continuum, and overall health and wellness, and representing greatest life priorities. (*Focus: intensive medical case management and peer support, ensure unfettered access to clinical and support services, and collaborate with community agencies to prevent critical progression*)

D: Patients who may not attend clinic appointments regularly and have variable levels of viral load suppression, and may be facing high levels of chronic diseases that are becoming higher health priorities than HIV, and have variable levels of social determinants of health. (*Focus: coordination of multispecialty services and referrals, and disease education*).

The Community Care Team (CCT) will implement an HIV service delivery model that will facilitate patient tracking, peer-to-peer support, differentiated case management, improve retention, viral load, and health outcomes. The CCT will strive to track clients at their ever-changing points-of-contact, particularly the hard-to-reach, highly vulnerable, and marginalized individuals, and those who are struggling with adverse social determinants of health, HIV disease progression and significant comorbidities. In fact, the results of our pilot study showed the following viral suppressions: **100% for Pathway A, 78% for B, 43% for C, and 65% for D.** (*Berthaud V, Special Presentation, 2020 National Ryan White Meeting*).

Strategies to improve care transition focus on inmates, youth living with HIV and hospitalized patients who are HIV positive. Meharry infectious diseases specialists serve as HIV consultants for TN Department of Corrections and Davidson County Sheriff's Office. At the time of consultation, they will identify inmates ready to transition into the community and initiate the contact between prison or jail personnel and MCWC staff such as PSR, EIS Worker, Community Health Workers, Therapist/Drug Counselor, and Medical Case Managers, to coordinate transitional services, with the intent to schedule the first clinic appointment on the same day of release or within one week. Meharry infectious diseases physicians will follow all persons with HIV hospitalized at Nashville General Hospital and coordinate their discharge and linkage to care in close collaboration with hospital physicians, nurses, and case managers and MCWC staff. They will also coordinate the care of their patients who are admitted to another acute or long-term care facility. The Community Health Workers will follow clients hospitalized in other medical facilities and share authorized health information with outside providers to ensure continuity in care. They will coach youth living with HIV and help them navigate the HIV service

delivery system.

Coordination of medical and support services for pregnant women.

An obstetrician-gynecologist with over 25 years of experience including 15 years at MCWC, Dr. Vernita Tucker, will manage pregnant women in the clinic in close coordination with medical providers and nurses during the entire prenatal, peripartum and postpartum period. All pregnant women will be offered ART, if not on yet, and counseled regarding the benefits and risks of ART during pregnancy for the woman, fetus, and newborn. Adherence to ART may decline in the postpartum period. Therefore, clinical and support staff caring for postpartum women on ART will stress adherence and evaluate specific facilitators and barriers. Two Meharry board-certified infectious diseases pediatricians, Dr. Shahana Choudhury and Dr. Christopher Keefer, will manage HIV-exposed babies. Prenatal and HIV care visits as well as neonatal and maternal medical visits will occur on the same day. Attention will be paid to nutrition, medical transportation, housing status, and medical insurance coverage.

Meharry Community Wellness Center collaborates with diverse stakeholders to identify persons who are HIV positive but have never or who have dropped out of HIV medical care and services and facilitate linking those persons with needed HIV services and care: Nashville General Hospital (NGH), Meharry teaching hospital, where Dr. Berthaud serves as Director of Infectious Diseases and Dr. Livette Johnson co-chairs the Infection Prevention Committee. They work closely with hospital staff to identify patient who are out of HIV care and re-engage them immediately. Inpatient referrals are seen the same day and outpatient referrals are seen in less than a week. A Medical Case Manager and a Community Health Worker will introduce themselves to the hospitalized patient with HIV to educate them about our HIV program and expectations at initial clinic visit. They will coordinate patient discharge with medical providers and Case Managers and arrange for those who are eligible for commercial medical insurance, TennCare, Medicare, or VA insurance initiate the enrollment process as soon as possible. They will inform those deemed eligible for Ryan White insurance coverage about the program requirements, policies, and procedures. The same process is applied to all other referring partners as circumstances allow. NGH refers PWH from Emergency Department, inpatient, and outpatient clinics; Meharry Elam Mental Health Center, Meharry Family Medicine and MAT Clinic, located right across the hall from MCWC, and Meharry Clinics constitute regular sources of mutual referrals; Davidson County Sheriff's Office refers inmates with HIV to MCWC since 2005, while Tennessee Department of Corrections refers them for telemedicine consultation, a service established by Dr. Berthaud in 2006; Neighborhood Health, the largest FQHC in Davidson County, Ascension St Thomas Health (Dr. Berthaud maintains consultation privileges), and Metropolitan Nashville Health Department, the largest HIV testing center in Nashville, represent important referral sources. Metropolitan Development Housing Authority awarded a HOPWA grant for the provision of Short-Term, Rent, Mortgage, and Utilities assistance. Street Works and Nashville CARES provide medical case management, food and housing services including permanent placement and emergency shelters. Second Harvest provides low-cost preserved food for our pantry. Vanderbilt University Medical Center provides emergency, specialty ambulatory, and inpatient care for MCWC clients. Tennessee Health Department had contracted with Meharry for ambulatory/outpatient and medical case management services. They provide technical support to medical case managers and assist in linkage/reengagement of clients lost to care. Metropolitan Nashville Public Health Department (MNPHD) refers newly

diagnosed HIV-positive and lost-to-care people, treats persons with latent and active tuberculosis, and coordinates STD management and control. Meharry Elam Mental Health Center collaborates with MCWC Therapist/Drug Counselor on outpatient and inpatient drug treatment, detoxification, and rehabilitation. Dr. Osa-Edoh, the Part A funded psychiatrist, is also the Director of the Drug Treatment Program at Elam Center.

Service Specific Questions:

1. Service Model

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of your proposed project. Include all aspects of planning, implementation, and evaluation, listing the role of everyone involved in activity.

2. Work Plan

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of your proposed project. Include all aspects of planning, implementation, and evaluation, listing the role of everyone involved in each activity.

The work plan should include clearly written:

- 1. Goals**
- 2. Objectives that are specific, time-framed, and measurable**
- 3. Action steps**
- 4. Staff responsible for each action step; and**
- 5. Anticipated dates of completion.**

Please note that goals for the work plan are to be written for the first year of the grant. Discuss any challenges that are likely to be encountered in planning and implementing the project’s activities described in the work plan and describe realistic and appropriate approaches to be used to resolve these challenges.

Work Plan

Goals	Objectives	Action Steps	Anticipated Date of Completion	Responsible Staff
Increase viral suppression	85% viral suppression by end of Year 1	Periodic viral load monitoring as per DHHS guidelines Monitor treatment adherence Monitor health complications and chronic comorbidities	End of Year 1	Medical providers Medical providers, Medical Case Managers, Community

				Health Workers
Increase retention in care	78% retention in care by end of Year 1	Early identification of clients at high-risk for dropout and treatment failure	End of Year 1	Medical providers Medical Case Managers Community Health Workers
		Provide intensive coaching and case management	End of Year 1	Medical providers Community Health Workers Therapist
		Monitor and evaluate barriers, challenges, and facilitators to treatment adherence and clinic attendance	End of Year 1	Medical providers Mental Health Therapist Psychiatrist Clinical Psychologist
		Facilitate access to treatment of behavioral and substance use disorders, medical transportation, housing and food services	End of Year 1	Therapist Community Health Workers
		Track clients who missed clinic appointments weekly	End of Year 1	Community Health Workers

		Collaborate with community-based organizations, local and state health departments, and correctional facilities	End of Year 1	Medical Case Managers Community Health Workers Medical Case Managers
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Aggregate measures of viral suppression and retention are already incorporated in the HRSA-required Performance Measures section of CAREWare. We have customized the system to measure viral load for subpopulations.

Challenges and Resolutions		
Challenges	Approaches for Resolutions	Barriers
Homelessness	HOPWA grant for Short-Term Rent, Mortgage, and Utilities (STRMU) does not match explosive real estate costs in the TGA.	Many of our clients experiencing homelessness are excluded from public housing because of restrictive housing policies and limited HOPWA funding.
Limited transportation service	Medical transportation service provided by program income.	Limited or inexistent public transportation.
Food shortage	Raise Part A Food Voucher card from \$20 to \$60 to adjust for inflationary cost. Program income-supported Food Pantry with unrestricted access in collaboration with Second Harvest.	Lack of job skills & education, unemployment, and poverty, exacerbate food shortage.
High rate of incarceration	Clinical psychologist, psychiatrist, therapist/drug counselor address behavioral and substance use disorders and relapse, and the roots of incarceration.	Limited access points for substance use treatment; high rate of drug charges, incarceration, and recidivism.

Our landmark paper was the first to highlight the negative effect of homelessness on HIV viral suppression and mortality in Middle Tennessee and its potential challenges to ending the HIV epidemic. (Vladimir Berthaud; Livette Johnson; Ronda Jennings et al. “The Effect of Homelessness on Viral Suppression in an Underserved Metropolitan Area of Middle Tennessee: Potential Implications for Ending the HIV Epidemic”. BMC Infectious Diseases. 2022 Feb 10; 22: 144). This retrospective analysis reveals that permanently/stably housed clients had a much higher proportion of viral suppression compared to their unhoused counterparts. Among clients with viral load <20 copies/mL, 78% were permanently housed and 22% unhoused. This seminal paper inspired the 2022 CDC Issue Brief, “The Role of Housing in Ending the HIV Epidemic” and a Human Resources and Services Administration (HRSA) Notice of Funding Opportunity for housing of PWH. The Infectious Diseases Society of America cited our paper in their special issue dedicated to homelessness and infectious diseases (Emily Mosites, Laura Hughes, and Jay C. Butler. Homelessness and Infectious Diseases: Understanding the Gaps and Defining a Public Health Approach: Introduction. The Journal of Infectious Diseases 2022;226(S3): S301–3).

B. Budget (35 Points)

Complete the entire Budget Spreadsheet attachment (excel version) which describes how you will use the funds to provide the service requested in the scope of work for this solicitation. Include detailed information about the number and type of staff your firm will fund, staffing costs and other specific costs associated with providing the service. Contractor(s) will be allowed to budget up to 10% for administrative costs, including indirect charges.

Leaving blanks on any of the Budget Spreadsheets and/or not following the provided format may result in your proposal being deemed non-responsive.

The entire Budget Spreadsheet attachment has been completed and uploaded.

MEHARRY COMMUNITY WELLNESS CENTER

MEDICAL CASE MANAGEMENT SERVICES

ORGANIZATION AND TEAM QUALIFICATIONS

I. ORGANIZATIONAL BACKGROUND

1. Describe in detail the background of your agency. Include the purpose of your organization, years of experience in providing services to People Living With HIV/AIDS (PLWHAs) and the years of providing these services (note if any HIV specific services are provided and/or if you currently collaborate with an HIV agency) and number of unduplicated persons served last year.

Purpose. Meharry Community Wellness Center (MCWC) strives to eliminate HIV health disparities in Nashville Transitional Grant Area (TGA) by promoting awareness, education, and training, transdisciplinary research, community partnership, and unfettered access to comprehensive, high-quality care.

Background. Meharry has been a leader in primary care medicine for over a century and HIV prevention and treatment since the beginning of the epidemic in 1981. Out of a growing need to expand access to culturally sensitive, comprehensive primary HIV care in the Nashville Transitional Grant Area (TGA), Dr. Vladimir Berthaud founded Meharry Community Wellness Center (MCWC) in 2005. MCWC has been a top-ranked Tennessee-designated AIDS Center of Excellence since 2006, and a Hepatitis Center of Excellence since 2016. Tennessee Health Department recognizes MCWC as a “national model for comprehensive HIV care among the underserved community”. **Meharry has been providing medical case management services to people living with HIV for 22 years.**

Meharry Community Wellness Center provides 24/7 coverage for medical and dental services. Clients have easy access to one-stop, wrap around core and support services: HIV counseling and testing, PrEP/PEP, and primary HIV care; management of complex infectious diseases; women’s health services including reproductive health, Pap test/colposcopy; minor ambulatory surgery including proctoscopy, skin biopsy, wound care, pre- and postoperative management; psychiatry, clinical psychology, mental health therapy and drug counseling; Medication-Assisted Treatment (MAT), outpatient and residential treatment of substance use disorder; HIV Drug Assistance Program (HDAP), Insurance Assistance Program (IAP), on-site pharmacy services; housing assistance, medical transportation, and nutrition; legal aid, home and community-based health services, and referrals to specialty and community resources; comprehensive primary oral health including prophylaxis, dental hygiene, tooth extraction, root canal, cutting-edge prosthodontics, and oro-maxillo-facial surgery.

Our patient population has an alarming prevalence of severe tooth decay (60%) and severe periodontitis (30%). Meharry Community Wellness Center (MCWC) represents the only Tennessee clinic that offers unfettered access to fully integrated, comprehensive oral health

services for low-income PLWH regardless of their primary HIV care providers. The Tennessee Ryan White Dental Assistance Program (RWDAP) ran out of funding in April 2019 and left 1,800 clients with very limited or non-existing access to oral health services. Only 10% of our clients have dental insurance coverage and just 2% of them have adequate coverage. As of 2023, TennCare offers limited oral health benefits to eligible clients. So far, they have not referred any patients to our dental clinic. The dental clinic disposes of two state-of-the-art operatories, two intra-oral digital cameras, and one portable digital X-Ray, one lab, and one sterilization room. It applies breakthrough 3D technology to fabricate crowns, bridges, partial, and full dentures while the client is waiting. Meharry Community Wellness Center is among five health centers who dispose of this brand-new technology for fabricating full-mouth and partial denture in one visit in the United States. Special cases such as impacted molars, orthodontics, intra-oral abscesses, or deep-seated infections, are referred on site to Oro-Maxillo-Facial Surgery service at the Meharry School of Dentistry using program income to pay the discounted fees for these referrals.

Meharry Community Wellness Center had served 2,165 unduplicated clients since inception and 468 in 2024 including 77% Black or African American, 10% Hispanic/Latino, 25% female, and 46% MMSC. Our proportion of PWH with unmet housing needs (24.9%) represent about thrice the national average for PWH (8.4%) and twice the average for Ryan White clients nationwide (12.9%). Our clients bear an excess burden of poverty (53% below 100% federal poverty level), history of incarceration (20%), substance use and behavioral disorders (30%), uninsured (39%), cardiovascular diseases (30%), chronic lung diseases (35%), and diabetes (20%). Nonetheless, 85% of our clients had achieved viral load suppression (increased from 78.6% in 2021, 82.3% in 2022, and 83.3% in 2023), and 90% have CD4 cell count above 200 cells/mm³. Retention in care had increased from 70.47% in 2021 to 76.13% in 2023. However, cases of syphilis rose from 18.1% in 2021 to 22.5% in 2023, in line with the ongoing syphilis epidemic in the US. Only 7.5% of women had abnormal Pap test in 2023 as compared with 8.3% in 2021. As the sole clinic providing fully integrated state-of-the-art oral health services at no cost to people with HIV (PWH) in Tennessee regardless of their primary HIV provider, MCWC had served 650 clients in 2,689 units during past 16 years.

Under contractual agreement, MCWC had served about 600 inmates living with HIV (64% Black or African American) throughout all Tennessee prisons over 21 years. In 2006, we pioneered telemedicine between Meharry and Tennessee prisons. This collaboration contributed to raising clinic attendance from 50% to 90% and viral suppression, from baseline 30% to 90% in 2020.

MCWC had received uninterrupted grant funding from Ryan White Part B since 2002, HRSA Ryan White Part C since 2003, Ryan White Part A since 2008, and HOPWA since 2016. In order to stretch the Ryan White grant dollars, MCWC expends its program income to further project objectives in priority areas of unmet need, such as nutrition and medical transportation; oral health, ambulatory surgery, and women's health services; as well as coverage of

ambulatory/outpatient specialty services for management of comorbidities, and co-pays of prescription drugs for underinsured, low-income individuals with HIV. The dental clinic was built out of several competitive HRSA grants supplemented by program income.

The prospect for new funding remains grim because of a large budget shortfall in the Tennessee Ryan White B program that required across-the-board budget cuts leading to a reduction of our annual budget by \$76,510.50 since 2021-2022 and planned termination of Part B funding for Part A grantees in 2026. Our Part C grant has been on freeze under Executive Order and HRSA has not issued the 2025 grant award yet. Therefore, Ryan White Part A had become lifesaving for people living with HIV in Nashville TGA.

2. Describe in detail the current HIV counseling and testing capacity of your organization, and any existing collaborative arrangements with other organizations within your service area that provide HIV counseling and testing services.

Clients who are diagnosed HIV positive at Meharry Community Wellness Center are linked and enrolled in care immediately. The same policy applies to those who test HIV positive in the Emergency Department or outpatient clinics of Nashville General Hospital. Newly diagnosed people who are incarcerated in local jails are referred to MCWC and seen in less than a week. Inmates of Tennessee Department of Corrections are referred to the clinic on the day of their release for medical insurance enrollment and linkage to care. All other individuals with HIV referred to MCWC are given an initial appointment within 1-7 days

Meharry Community Wellness Center (MCWC) uses its program income to provide targeted HIV counseling and testing. In 2023, we tested 75 high-risk individuals and found seven (9.33%) HIV-positive people, as compared to <0.5% in the general population. All these newly identified persons with HIV were enrolled in care and started taking antiretroviral treatment (ART) before leaving the clinic. Medical providers, EIS Worker, and Medical Case Managers (MCM) educate clients about HIV risk behaviors and effective strategies to prevent HIV transmission at each patient visit, using audio-visual materials, interactive tablets, brochures, and multi-disciplinary intervention. They counsel every person with HIV (PWH) entering care about the implications of HIV infection, the benefits and potential side-effects of antiretroviral therapy (ART), risk reduction and disclosure to sexual and/or needle sharing partners. They reinforce risk reduction messages and encourage clients to have their partner(s) tested every 3-6 months and enroll in PrEP if they're not virally suppressed. We also invite persons with high-risk HIV behavior to participate in our ongoing clinical trials such as the landmark Purpose 2 study conducted at Meharry under the leadership of Dr. Berthaud as Principal Investigator. This trial showed that twice-yearly injection of lenacapavir resulted in 96% protection from HIV transmission in MSM, transgender men, and non-binary persons.

MCWC has a track record of collaboration for HIV counseling and testing with multiple local and extramural partners such as: Nashville General Hospital, the Meharry Elam Mental Health Center, the Meharry Medication-Assisted Treatment (MAT) clinic, and the Meharry Clinics;

Davidson County Sheriff Office, Tennessee Department of Corrections, United Neighborhood, Matthew Walker Comprehensive Health Center, Street Works, Nashville CARES, Vanderbilt University Medical Center, Ascension St Thomas Health, and Metropolitan Nashville Health Department; long-term care facilities like, Bordeaux Nursing Home and Whites Creek Nursing Home, as well as drug treatment centers (Cumberland, Samaritan), and Middle Tennessee Mental Health Institute.

3. Describe in detail how the proposed project fits with your agency’s mission and capabilities.

As an annual Tennessee-designated AIDS Center of Excellence since 2006, Meharry Community Wellness Center (MCWC) focuses on eliminating health inequities in HIV/AIDS, advancing HIV/AIDS awareness, transformative education, and transdisciplinary research, strengthening community outreach and partnership, and providing exceptional and compassionate health services. Our mission aligns with the overall mission of Meharry Medical College to empower diverse populations to improve the well-being of humankind. Our vision aligns with the vision of the National HIV/AIDS Strategy and the White House Ending-the-Epidemic Plan. **Meharry has been providing medical case management services to people living with HIV for 22 years.** This proposed Medical Case Management project fits our mission and capabilities to address unmet need in outpatient/ambulatory care for underserved persons living with HIV in the Nashville Transitional Grant Area (TGA). Although Meharry Community Wellness Center serves the hardest-to-reach populations of persons with HIV in Middle Tennessee, as aforementioned, our retention in care had reached 76.13% in 2023. During the most recent decade, viral load suppression had substantially improved for all subpopulations, especially youth, young adults, and MSM, the risk categories with the highest incidence of HIV in our clinic (47.1% for MSM). In fact, MSM achieved the highest rate of viral suppression in 2024, a reflection of our cultural competence, coupled with non-judgmental, customer-friendly, and compassionate HIV care.

Viral Suppression by Subpopulation (%): 2015-2024			
Subpopulation	Year		
	2015	2019	2024
White	75.61	73.85	81.82
Black or African American	73.14	75.58	82.48
Hispanic/Latino	81.25	83.33	80.49
Youth (13-24)	51.85	74.19	80.00
25-34	63.22	71.57	84.38
35-54	76.52	74.88	79.79
55+	82.83	81.82	83.72
Women	72.00	77.39	79.81
Men	68.9	70.79	80.78
MSM	63.27	72.73	85.71

Source: CAREWare 230

4. Describe in detail how your background, mission and experience contribute to the ability of your organization to conduct the proposed project and meet the expectations of the program requirements. In addition, Metro Health may conduct pre-award on-site visits to determine if the contractor's facilities are appropriate for the services intended.

Meharry is the oldest provider of HIV care in Tennessee, dating back the beginning of the epidemic in 1981. Under the leadership of its Founding Executive Director, Dr. Vladimir Berthaud, Meharry Community Wellness Center (MCWC) had earned the annual designation of Tennessee AIDS Center of Excellence continuously since 2006 and grew exponentially, thanks to multiple funding streams including several Ryan White grants. MCWC had become a beacon of hope and comfort for persons with HIV, affected by stigma, discrimination, social injustice, and health inequities. For current grant year ending on February 28, 2025, our outpatient/ambulatory grant had already beaten the expectations of program requirements as illustrated by the projected number of clients to be served and the number of service units (projected number: 99/actual: 179 and projected units: 400/actual: 2480). A multidisciplinary team of experienced and highly-qualified staff provide person-centered, multidisciplinary, holistic health services of the highest quality. Daily patient surveys denote an average satisfaction rate of 95%. As a testament of our performance, HRSA had selected MCWC to host the first National Meeting on HIV in Rural Areas in 2019 and one of three US sites that conducted the Special Project of National Significance (SPNS), "Dissemination of Evidence-Informed Interventions: Peer Linkage and Re-engagement of Women of Color", 2016-2019. The Project-derived manual is available at: <https://www.targethiv.org/deii/deii-peer-linkage>.

II. Organization Capacity:

1. Provide copies of the following:

- Resume and job description of proposed Finance Manager
- Organizational chart for your agency; chart must clearly include the program components funded by Part A/MAI.
- Copies of most recent State Licensure or Accreditation for relevant services.
- Articles of Incorporation.
- Documentation of 501(c) 3 designation.
- Current State of Tennessee Charitable Solicitations Letter.
- System for Award Management (SAM) exclusion report.

All these documents are uploaded.

2. Describe agency's experience in administering federal, state and/or local government funds. Include funding source(s) and number of years administering those funds. Provide information for the following:

- **Agency restrictions from receiving federal funds or placed on restrictive measures in the last five years (e.g., increased reporting, increased monitoring visits), please explain.**

Meharry has no restrictions from receiving federal funds. It has never been placed on restrictive measures in the last five years or during its existence.

- **Corrective action plan(s) in the last three years from any funding source, please describe (include the name of the funder, overview of issues identified and the current status of addressing the identified issues and/or recommendations).**

In 2024, HRSA conducted a site visit and identified the following issues: documentation of coordination and linkages with CDC and Prevention-funded HIV testing and outreach services of federally qualified health centers in the service area; documentation of training for HIV care and treatment of all non-clinical staff, documentation of sexual practices of women; demonstration of full implementation of the time and effort policy and the caps on charges; and documentation for allocating program income according to each Ryan White Program grant. All these issues have been corrected except the time and effort policy. The Office of Grants and Contracts is updating the Workday system and recruiting additional personnel to ensure any issues related to time and effort are fixed soon.

- **Audit finding(s) in the last three years. Please describe an overview of issues identified and the current status of addressing the identified issues.**

In 2024, HRSA audited our Ryan White Part C EIS grant and identified the following issues: documentation of coordination and linkages with CDC and Prevention-funded HIV testing and outreach services of federally qualified health centers in the service area; documentation of training for HIV care and treatment of all non-clinical staff, documentation of sexual practices of women; demonstration of full implementation of the time and effort policy and cap on charges; and a clear policy for allocating program income according to each Ryan White Program grant. All these issues have been corrected except the time and effort policy. The Office of Grants and Contracts is updating Workday system and recruiting additional personnel to ensure any issues related to time and effort are quickly fixed.

- **If Contractor(s) is currently a Ryan White Part A provider, an administrative review will be conducted of the previous year's spending of grant funds and will be included as part of the score. If Contractor(s) is not a current Ryan White Part A provider, Contractor(s) must provide a letter of reference from a funder to include a description of Contractor's performance in spending allocated grant funds. This letter will be included as part of the score.**

Not applicable.

- **Submit copies of most recent A-122 Audit (for the last reporting year) conducted by an independent certified public accountant or 990 form, if not required by federal regulations to complete an A-122 Audit.**

An independent CPA firm, Crosslin Certified Public Accountants, had audited the accompanying consolidated financial statements of Meharry Medical College and Subsidiary (collectively the “College”), which comprise the consolidated statements of financial position as of June 30, 2023, and 2022, and the related consolidated statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the consolidated financial statements. In their opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the College as of June 30, 2023, and 2022, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America. (see Attachment: Most Recent Financial Audit, Final Consolidated A133 Financial Statement June 2023).

3. **Describe agency’s current system for collecting data on client demographics, service utilization and performance data. Include all software used to collect this data, staff resources for data collection and hardware resources.**

Staff resources. The Program Director, Dr. Berthaud, serves as Data Manager, assisted by biostatistician, Derek Wilus, MS. They perform duties such as quality management initiatives, data analysis, and dissemination of results, and staff training. The Program Director integrates all audits and performance evaluations into the overall strategic planning and Ryan White programs operations. He facilitates collaboration with statewide, local, and national quality improvement projects. Dirk Francis, Data Center and System Administrator for Meharry Office of Information Technology (OIT), manages the CAREWare server and maintains the software, while Lee Nelson, MBA, Health Information Technology Director, is responsible for managing E-Clinical Works (our electronic health record system) and interfacing with CAREWare (the primary source of data reports).

Data infrastructure. CAREWare™ forms the backbone of our robust information system. Our data repository relies on three separate layers of security. The CAREWare network connects to a dedicated server housed in a highly secure and restricted basement location in the Office of Information and Technology (OIT), monitored by video camera and on uninterrupted electric power supply 24/7. Meharry OIT has designated a qualified technician, Dirk Francis, to manage the CAREWare server in collaboration with MCWC Program Director.

Data operations. Since 2003, Meharry has been using Microsoft SQL server and the most recent CAREWare version as the primary tool for Ryan White data collection, HRSA-required performances measures and programmatic reports. All MCWC staff use CAREWare and enter data elements in real-time. MCWC had created over 180 customized reports in

CAREWare to facilitate data queries and special reports. Moreover, we had developed CAREWare instruments to describe the graphic time course of individual lab variables including CD4 cell count and viral load and designed a unique platform to capture social determinants of health, monitor and evaluate community health care delivery. We have modified CAREWare to allow for attachment of external medical, personal and legal records as well as patient's clinical documents including radiographs and intraoral pictures. MCWC had installed data quality and validity checks for duplicated, missing, discordant, and unknown key data elements to enhance accuracy of reports. A validity check is run prior to submission of reports. All HRSA-required reports including performance measures are readily available in CAREWare and can be created instantly. The Assistant Data Manager, Derek Wilus, MS, biostatistician, uses IBM SPSS or R Studio for more complex data analyses.

Data backup design. Meharry OIT backs up the data daily on extra-large capacity servers and digital tapes. Then, an independent contractor picks up the tapes daily and stores them away from the campus to safeguard them against major disasters and catastrophes such as floods, hurricanes, fire, and powerful earthquakes. The Program Director verifies that CAREWare posts daily messages to check the exact time of each data backup completion.

Original Data: The original data, also referred to as the live production data, resides on the HP Synergy Blade system, stored as a VM, with snapshots taken hourly, and stored on the Nimble CS5000. The snapshots are stored for 7 days.

Tier 1 Storage - The tier 1 backup occurs nightly and writes to a second Nimble array, the CS235. This data is stored for 90 days.

Tier 2 "off-site" Storage - Once weekly, the data is copied from the CS235 to a tape backup solution that is rotated off-site weekly. This data would be stored for 180 days.

Additional data safety and security procedures. Each Meharry desktop and laptop are configured to provide optimum security and reliability. OIT monitors each user's activities and downloads automatically the most recent security updates to all Meharry desktops connected to the network, daily, and screens all emails for SPAMs and phishing messages instantly. Meharry students and employees access the network with a personal username and secured password that is required to be changed regularly.

Software platforms. Meharry has adopted the electronic health records system, E-Clinical Works™, across the campus. The software suits for clinical notes, mobile applications, and Physician Quality Reporting Systems (PQRS). However, its capacity to generate customized reports is limited, complex, and provider-restricted, time-consuming, and costly. Medical providers enter their clinical notes and services in E-Clinical Works, also available on their smartphones app. LabCorp will export the lab tests results in E-Clinical Works as soon as they are available and alert the clinicians on critical values immediately. The HL7 platform and the "socket" allow for seamless export of LabCorp results into the CAREWare labs

section. External health records are either faxed or exported into E-Clinical Works using compatible electronic software. A patient portal is available in E-Clinical Works for better self-management and interaction with medical providers. The patient portal is also accessible via smartphone app. MCWC utilizes E-Clinical Works to submit third party billings and track service charges. Both E-Clinical Works and CAREWare are fully secure and HIPAA-compliant. MCWC staff attend mandatory training on compliance with HIPAA, federal and State, as well as Meharry regulations on patient personal health information. MCWC had developed a user-friendly iOS app that allows the quick calculation of odds for a person with HIV to achieve viral load suppression, based on our landmark publication in BMC Infectious Diseases in 2022.

4. Describe agency's system for managing fiscal and accounting responsibilities. Address the following:

- **Define who oversees this area, what staff is responsible for these activities.**
- **Identify what software is used to manage financial information.**
- **Describe the accounting system that is in place; and**
- **Describe the internal systems that are used to monitor grant expenditures and track, spend, and report program income generated by a federal award.**

Meharry Community Wellness Center (MCWC) had received uninterrupted grant funding from HRSA Part C EIS, Ryan White Part B, and Ryan White Part A for 21, 22, and 17 years, respectively. The Finance Manager, Zudi Takizala, MD, MPH, MBA, is uniquely qualified to oversee fiscal and accounting operations. She brings 21 years of experience in grant administration. In the past three years alone, she had successfully managed 18 public grants including 10 Ryan White grants. MCWC carries a current grant portfolio of about \$3,000,000.00 including grants from NIH/NIAID, HRSA, HOPWA, PEPFAR, and Ryan White Part A and B. Having managed thousands of Federal, State, and local grants and contracts for over 100 years, Meharry is strongly qualified to manage this project. To track and manage grants and contracts, the College uses an accrual method of accounting incorporated into the Banner software and Workday system. The Office of Grants and Contracts works closely with each program and department to assure that budget matters are appropriate and understood. Meharry retains a CPA firm to conduct annual audits and interim financial reports for program planning and implementation. All Meharry fiscal audits had no findings. Additionally, appropriate internal controls including an internal auditing process are in place and assist the College to anticipate and plan more effectively. The Department of Internal Medicine is primary responsible to oversee grant management and the delivery of clinical services. Meharry Medical Group (MMG) supervises the delivery of clinical services, performs billing, collection of charges, and tracking, and reporting of program income to the Project Director. The Office of

Human Resources oversees the hiring process, reviews job descriptions and proposed salaries, assists in background checks, job offers and staff training. The Compliance Office reviews contracts and agreements to ensure compliance with the law. The Office of Grants Management oversees Ryan White programs, ensures that current practices align with federal and State legislation, and that Ryan White funds are expended according to program budget, goals, and expectations. It works closely with MCWC and provides monthly grants expenditures reports to assure disbursements align with program goals and objectives. MCWC and the Office of Grants and Contracts hold monthly financial meetings with Ryan White Part A leadership. The Office of Finance verifies that MCWC manages Ryan White grants according to Generally Accepted Accounting Principles (GAAP). MCWC segregates Ryan White contracts, public, private, and other types of medical insurance in CAREWare to allow for easy tracking and accurate financial report using the service fees and units determined by Ryan White Part A Program. MCWC reinvests program income (billings collections from third-party payers and 340B pharmacy revenues) into overall budget to further program goals and objectives and cover ambulatory out-of-pocket expenses of low-income, underinsured clients. The Program Director reports the program income quarterly to Ryan White Part A and B. The Director of the Office of Grants and Contracts reports annual program income to HRSA via the Federal Financial Report (FFR).

5. Describe agency's process for completing program reports in a timely and accurate manner. Include descriptions of how responsibility for reporting is assigned to staff, how reports are reviewed for accuracy and who assures reports are completed on time.

MCWC staff enters data in CAREWare in real-time. The Program Director had created over 200 customized reports in CAREWare that allow for quick data analysis and reports, research advancement, and deeper understanding of program outcomes. These customized CAREWare reports also comprise data validation, quality checks, for duplicate, missing, and unknown data. CAREWare is able to create a list of all clients with missing/unknown, or duplicate data for the responsible staff to correct. Prior to submitting any reports, a quality check is run again to identify errors, warnings, and alerts needed to be fixed. All Ryan White required periodic reports and performance measures are embedded in CAREWare, i.e. Ryan White Service Report (RSR), Provider Data Export (PDE), program financial and service reports, etc.

III. Cultural and Linguistic Competency:

As a person closely affected by HIV himself, Dr. Berthaud has dedicated his professional career to improve and save the lives of people with HIV in New York, Tennessee, Latin America, Africa, and the Caribbean. He attributes high priority to cultural and linguistic competency. MCWC staff are trained in cultural competence, cultural humility, and trauma-informed care, and motivational interview. Six of our full-time staff are themselves people living with HIV for over 20 years. Sixty percent of our staff have been affected by HIV, and 70% live in the community

they are serving. Client feedback is obtained daily through anonymous satisfaction surveys and quarterly from the Consumer Advisory Board (CAB). The CAB Chair attends our weekly staff meetings, which reserves ample time for discussion of CAB concerns and the results of patient satisfaction surveys including corrective actions, implementation, and monitoring plan. MCWC leadership incorporates the final recommendations into program operations, specific projects, and/or grant applications. Educational materials are created according to the fifth-grade level based on health literacy research conducted at Meharry Community Wellness Center. Interpretation and translation services are readily available for all languages through a contractual agreement paid for by Meharry Medical College. **All MCWC Medical Case Managers are well-trained College graduates, with at least a Master degree, and very familiar with underserved communities, HIV issues, and Ryan White programs.**

IV. Collaboration:

- 1 Describe a plan for creating a new or improving an existing network to improve collaboration with HIV agencies that will link PLWHAs to HIV testing and HIV medical care and support services. If applicable, identify any collaborating organizations that will assist the applicant through HIV testing and linkage to HIV medical care and services.**

Linkage of newly identified clients: Patients who diagnose HIV positive in the emergency department (ED) at Nashville General Hospital (NGH), located on the Meharry campus, are linked and enrolled into care the same or next business day. HIV providers and Medical Case Managers follow newly diagnosed persons with HIV (PWH) admitted to NGH and coordinate their discharge disposition. Clients newly identified outside the Meharry campus are linked as soon as possible, preferably within less than 7 days. The Patient Service Representatives (insurance verification), the Community Health Workers (coaching and navigation), and the Medical Case Managers (insurance assistance and Ryan White eligibility) are responsible for rapid linkage.

MCWC organizes outreach events with local partners including Metropolitan Nashville Health Department to raise HIV awareness and promote testing. As member of Nashville PrEP Coalition, MCWC facilitates the rapid linkage of newly diagnosed persons. It also leverages its experience as a research site for the SPNS project targeting newly diagnosed and out-of-care women of color for linkage and retention to enhance engagement in care. As a pioneer of HIV telemedicine in TN prisons and HIV consultant for Davidson County jails since 2006, MCWC facilitates the transition of ex-offenders to rapid linkage and engagement upon their release in the community.

Main referral relationships and collaborations include the following: Nashville General Hospital (NGH), Meharry teaching hospital, where Dr. Berthaud serves as Director of Infectious Diseases and Dr. Livette Johnson co-chairs the Infection Prevention Committee; NGH refers PWH from Emergency Department, inpatient, and outpatient clinics; Meharry Elam Mental Health Center, Meharry Family Medicine and MAT Clinic, located right across the hall from MCWC, and Meharry Clinics constitute regular sources of mutual referrals; Davidson County Sheriff's Office refers inmates with HIV to MCWC since 2005, while Tennessee Department of Corrections

refers them for telemedicine consultation, a service established by Dr. Berthaud in 2006; Neighborhood Health, the largest FQHC in Davidson County, Ascension St Thomas Health (Dr. Berthaud maintains consultation privileges), and Metropolitan Nashville Health Department, the largest HIV testing center in Nashville, represent important referral sources. Metropolitan Development Housing Authority awarded a HOPWA grant for the provision of Short-Term, Rent, Mortgage, and Utilities assistance. Street Works and Nashville CARES provide medical case management, food and housing services including permanent placement and emergency shelters. Second Harvest provides low-cost preserved food for our pantry. Vanderbilt University Medical Center provides emergency, specialty ambulatory, and inpatient care for MCWC clients. Tennessee Health Department had contracted with Meharry for ambulatory/outpatient and medical case management services. They provide technical support to medical case managers and assist in linkage/reengagement of clients lost to care. Metropolitan Nashville Public Health Department (MNPHD) refers newly diagnosed HIV-positive and lost-to-care people, treats persons with latent and active tuberculosis, and coordinates STD management and control. Under MNPHD sponsorship, Meharry received a Part A grant for core and support services. Meharry Elam Mental Health Center collaborates with MCWC Therapist/Drug Counselor on outpatient and inpatient drug treatment, detoxification, and rehabilitation. Meharry and Vanderbilt had signed a Data Usage Agreement for expanding participation of minorities in clinical research through the NIH-funded TN Center for AIDS Research (TN-CFAR), a joint venture including Nashville CARES and TN Health Department.

- 2 Contractor(s) must demonstrate their commitment to work with or collaborate with organizations representing the HIV/AIDS community through a signed and dated letter of support or memoranda of agreement or understanding. The letter must specify example activities that each entity provides that will help connect high risk clients to HIV testing and services.**

Meharry Community Wellness Center, Street Works, and Nashville CARES have a longstanding collaborative relationship. Dated signed letters that specify example activities that each entity provides that will help connect high risk clients to HIV testing and services are uploaded.

B. Reference Projects (10 Points) Service History & References:

- 1. If your agency currently provides this service(s) to the HIV/AIDS client population, describe the number of years you have provided this service and the funder of the service. Please provide a reference name and phone number.**

Meharry Medical College has been providing ambulatory/outpatient services to persons with HIV since the initial outbreak in 1981, i.e., even before the virus was discovered. Meharry Community Wellness Center opened in 2005 with funding support from Ryan White Part B and Part C. Ryan White Part A support started right after Nashville became an Emerging Metropolitan Area (EMA) in 2008. However, TN Health Department will stop funding for recipients who receive Part A funding

starting on April 2026. Our Part C grant has been on freeze under Executive Order and HRSA has not issued the 2025 grant award yet. Therefore, Ryan White Part A had become lifesaving for people living with HIV in Nashville TGA. Meharry Community Wellness Center has been recipient of Part C Minority AIDS Initiative (MAI) grant funding for Ambulatory/Outpatient Services since 2013 and of Part A MAI grant support since 2022.

For reference, we mention the name of our Part C EIS Project Officer
Christie Slay, MPA, MAEd, CHES, Public Health Analyst/Project Officer, Central
Branch, Division of Community HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, Rockville, MD 20857
Phone: 301.443.0504

- 2. If your agency does not currently provide service(s) to the HIV/AIDS client population, explain any related experience that would demonstrate the agency's competency in providing services to this population. Please provide a reference name and phone number.**

Not applicable.

- 3. Describe any related experience that would demonstrate your agency's competency in providing HIV medical or support services to this population. Please provide a reference name and phone number. The file is limited to 5 pages and should be in PDF format entitled "Reference Projects."**

The file labelled "Reference Projects" had been uploaded.

Here's the reference name and phone number:

Part C EIS Project Officer

Christie Slay, MPA, MAEd, CHES, Public Health Analyst/Project Officer,
Central Branch, Division of Community HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration

5600 Fishers Lane, Rockville, MD 20857

Phone: 301.443.0504

A. Project Approach and Process (30 Points)

I. Staffing:

Present in detail your organization's staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the number of time/hours per month being requested for each proposed staff position.

Staffing Plan of Key Personnel				
Name	Roles	Responsibilities	Education/Training	Experience Part A FTE
Vladimir Berthaud, MD, MPH, FACP, FIDSA, DTMH, CPH	Project Director	Supervision of overall activities; HIV care and infectious diseases services	Board-certified in internal medicine, infectious diseases, public health, tropical medicine, and traveler’s health.	International HIV expert with 39 years of experience in HIV care, research, training, teaching, program development, and implementation worldwide.
Zudi Takizala, MD, MPH, MBA	Finance Manager	Project management and CQI	Doctor of Medicine, with master’s degree in public health and business	21 years of experience in management of \$30M in Federal, State, & local grants
Keisha Ashmeade Ed.D, MSPH, FNP, AHIVS	Clinic Manager	Manages clinic operations	HIV specialist and Board-certified NP	11 years of HIV care experience
Sheena S. Simon, DNP, APRN, NP-C	Primary HIV care provider	Comprehensive HIV management	Board-Certified Nurse Practitioner, specialized in prevention	22.44% FTE Six years of HIV care experience
Ethel Harris, DDS, MPH	Director of oral health services	Comprehensive oral care and prosthodontics	Meharry graduate, former Director of SEATC oral health	22 years of experience in oral health for PLWH
Ryan White Part A Staffing Plan				
Name	Roles	Responsibilities	Education/Training	Experience Part A FTE
Livette Johnson, MD	Infectious diseases management	HIV and specialty care	Meharry graduate, Board-certified in internal medicine and infectious diseases	40% FTE 35 years of experience and expertise in HIV care
Sheena S. Simon, DNP, APRN, NP-C	HIV care provider	Comprehensive HIV management	Board-Certified Nurse Practitioner, specialized in prevention	35% FTE Six years of HIV experience

Debra Simmons, LPN	Phlebotomist	Process laboratory specimens and perform nursing duties	Graduate of Baptist Hospital LPN School	50% FTE 9 years of experience serving PLWH
Maya Johnson, BS, MPH	Community Health Worker	Coaching, adherence counseling, patient navigation, community case management	MPH graduate from Meharry, with solid knowledge of SPSS, SAS, Redcap, GIS, and Microsoft environment	75% FTE One year of experience with PLWH
Tamiko Grimes	Community Health Worker	Coaching, adherence counseling, and patient navigation	Trained Peer Counselor and Community Health Worker	100% FTE 9 years of experience with PLWH
Osamudiamen Osa-Edoh, MD, MPH	Psychiatrist	Treatment of behavioral & substance use disorders	Board-certified psychiatrist, Director of substance use treatment at Meharry	15% FTE 10 years of experience with PLWH
Erlete Ascencao, PhD/PhD, HSP	Clinical Psychologist, Social Scientist	Specialized in HIV clinical psychology services	Doctor in Social Sciences and Clinical Psychology, Licensed Health Services Provider	100% FTE 22 years of experience with PLWH
Ronda Jennings, MA	Senior Medical Case Manager	HOPWA Case Manager, Mental health therapy and drug counseling	Master' degree in Clinical Counseling, Certified Alcohol and Drug Addiction Counselor	64.29% FTE 17 years of experience in medical case management and counseling with PLWH
JaRae Davenport, BS, MPH	Medical Case Manager	Medical case management services including treatment adherence	Master's degree in public health practice	100% Three years of experience in medical case management under Part A grant

<p>Kaye Chavis, DBA</p>	<p>Medical Case Manager</p>	<p>Medical case management services including treatment adherence</p>	<p>Doctoral degree in Business Administration</p>	<p>90.02% 4 years of experience with PLWH and Ryan White Part A grant 23 years' MDHA experience</p>
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Qualifications of Key Personnel.

Vladimir Berthaud, MD, MPH, FACP, FIDSA, CPH, DTMH, is tenured professor of medicine, Director, Division of infectious diseases at Meharry Medical College and Nashville General Hospital and Founding Executive Director of Meharry Community Wellness Center. He completed his infectious diseases fellowship at Columbia University and Cornell University in New York. Dr. Berthaud has been a passionate advocate for PLWH and the recipient of numerous prestigious awards including IPRO’s Outstanding Service to the Health Care Community Award for Quality Improvement in reducing Disparity for Adult Immunizations in New York State, Award for Outstanding Contribution to the Internal Medicine Training Program, Harlem Hospital/Columbia University College of Physicians & Surgeons, New York City Council Citation for Exemplary Service, National Library of Medicine/Marine Biological Laboratory, Fellowship Award in Medical Informatics, Nashville Business Journal, Award Honoring Superior Contributions to the Health Care Industry, Johnson & Johnson UCLA Healthcare Executive Management Award, Street Works Guiding Light Award, and Mahogany Honors Dwayne Jenkins Lifetime Achievement Award. Part C EIS Program Director for 20 years, Dr, Berthaud serves as Project Director/Principal Investigator for Meharry HIV Research and Training Facility, Mentor and Investigator for the NIH-funded U01-Practice-Based Research Integrating Multidisciplinary Experiences in Dental Schools (PRIMED), Associate Director of Clinical Discovery Core, for TN-CFAR, Clinical Lead for Meharry PEPFAR, and Program Director for HRSA-sponsored National HIV Residency Pathway Consortium. He has been a member of the Tennessee AIDS Centers of Excellence Committee since 2002. Other experiences include Train-of-Trainer Expert for the National HIV Curriculum, HIV Trainer for the National MTCT-Plus Program in Rwanda and Côte d’Ivoire, HIVAIDS Curriculum Developer for NIH/ACTG/HPTN in Latin America and the Caribbean and HIV Preceptor for IDSA International AIDS Training Program, HIV Curriculum Reviewer for CDC, and scientific advisor to CDC Program for TB Elimination, member of the National Board of Public Health Examiners, and of the National Board of Medical Examiners, Academic Advisor, UCLA School of Management, Community Health Improvement Program, and Member, American College of Physicians (ACP) Leadership Academy. Former member of the Leadership Conference and Admissions Liaison Officer, United States Military Academy at West Point, past Chair of The George W. Counts Interest Group of the Infectious Diseases Society of America (IDSA), past member if IDSA Leadership Development Committee, Dr. Berthaud is a member of the American Board of Internal Medicine Infectious Diseases Task Force and Faculty of the IDSA Leadership Institute. He was a Lead Principal Investigator for the international Kid COVE Vaccine Trial. Dr. Berthaud is Endowed Professor of Medicine, with Adjunct appointment in Microbiology, Immunology, and Physiology. He is Academic

Editor for PLOS ONE medical journal and the author of many peer-reviewed publications in impactful scientific journals. Dr. Berthaud is fluent in Spanish, French, English, and Creole.

Livette Johnson, MD. A native Nashvillian and a graduate of Meharry School of Medicine, Dr. Johnson completed her internal medicine residency training at Johns Hopkins University in Baltimore and her infectious diseases fellowship at Cornell University in New York. She holds Board certification in internal medicine and infectious diseases. Dr. Johnson is associate professor of medicine at Meharry Medical College and Vice Chair of Infection Prevention Committee at Nashville General Hospital. Dr. Johnson served as attending physician at Mount Sinai Hospital and Assistant Chief of Infectious Diseases at Metropolitan Hospital in New York. She brings a personal dedication to the care of populations living with HIV.

Zudi Takizala, MD, MPH, MBA. Doctor of Medicine with extensive experience in grant administration, financial management, and staff supervision, Dr. Takizala has a long record of collaboration with diverse internal and external stakeholders, community agencies, and Ryan White programs. She oversees clinical operations at Meharry Community Wellness Center. In the past three years, she had successfully managed 18 public grants including 10 Ryan White grants, and others from NIH, HOPWA, PCORI, Tennessee State and Metropolitan Nashville government.

Keisha Ashmeade, ANP, MSN, MSPH, Ed. D, AAHIVS, board-certified advanced nurse practitioner and certified HIV specialist, Dr. Ashmeade has been Clinical Manager of Meharry Community Wellness Center for seven years. She brings 10 years of experience in HIV primary care and seven years of teaching experience as Assistant Professor.

If applicable, describe in detail the roles and responsibilities of any consultants and/or subcontractors will be used to conduct aspects of the proposed project.

This is not applicable.

II. Overview of Population:

Describe in detail the HIV/AIDS population in Davidson County. Describe in the detail the issues that interfere with identifying, engaging, and retaining PLWHAs in routine HIV testing and HIV services.

HIV/AIDS population in Davidson County.

Meharry Community Wellness Center stands at the epicenter of the HIV epidemic in Nashville, in the heart of Davidson County, more specifically, North Nashville, the neighborhood most densely populated in Blacks or African Americans (71%) where 1,933 of every 100,000 people are living with HIV as compared to 978.7 for Blacks in the remaining Nashville Transitional Grant Area (TGA). The TGA had an estimated population of 1,742,588 in 2019, accounting for 26.5% of the state's total population and 31% of the state's people living with HIV (PLWH). In the thirteen counties that make the Nashville Transitional Grant Area (TGA) including Davidson, non-Hispanic Blacks account for 54% of PLWH and in 2021,

they represented 27% of Davidson County's population and 52.4% of PLWH. While about 39% of the Nashville TGA's population lives in Davidson County, 76.5% of the PLWH population reside in Davidson County. Of this PLWH population, 20% had been in jail and 42% were homeless/unstably housed at some point in the last year, and 40.2% did not have food to eat three or more days at some point in the last year. Fear of disclosure (50.6%) represents the number one barrier to accessing services (Metropolitan Nashville Health Department). In Nashville TGA, an estimated 17% of PLWH are unaware of their status. In 2020, 66% of newly diagnosed cases were linked to care in 30 days, 54% were retained, and 66% achieved viral suppression. Among Non-Hispanic Blacks, 64% were linked to care within 30 days, 54% were retained and 63% became virally suppressed, and they had the highest incidence of Chlamydia, gonorrhea, and syphilis. Meharry Community Wellness Center (MCWC) serves the most vulnerable and hardest-to-reach PLWH in Tennessee. In 2024, our program served 484 unduplicated clients. African Americans accounted for 77.06%, women 26.44% and MSM 42.35%. Our clients bear an excess burden of uninsured (39.25%), poverty (48.96% below 100% FPL), and history of incarceration (20%), homelessness (19.2%, higher than in Davidson's 13.6%), and substance use and behavioral disorders (30%). More than 70% of our clients did not graduate from high school. Our proportion of clients experiencing homelessness represents more than twice the national average for PLWH (8.4%) and is 50% greater than the national Ryan White average (12.9%). According to the Brookings Institution, North Nashville has an incarceration rate of 14%, by far the highest in the country, and 93% of those incarcerated are Blacks. Our patient population has an alarming prevalence of severe tooth decay (60%) and severe periodontitis (30%). Meharry Community Wellness Center (MCWC) represents the only Tennessee clinic that offers unfettered access to fully integrated, comprehensive oral health services for low-income PLWH regardless of their primary HIV care providers. The Tennessee Ryan White Dental Assistance Program (RWDAP) ran out of funding in April 2019 and left 1,800 clients with very limited or non-existing access to oral health services. Only 10% of our clients have dental insurance coverage and just 2% of them have adequate coverage. Since 2023, TennCare offers limited oral health benefits to eligible clients. So far, they have not referred any patients to our dental clinic. The prospect for new funding remains grim because of a large budget shortfall in the Tennessee Ryan White B program that required across-the-board budget cuts leading to a reduction of our annual budget by \$76,510.50 since 2021-2022 and termination of funding for Part A grantees in 2026.

Issues that interfere with identifying, engaging, and retaining PLWHAs in routine HIV testing and HIV services.

Gaps in local services. Major gaps in MCWC/TGA HIV care continuum, retention, and viral suppression, can be attributed to high rates of incarceration (20%), homelessness (MCWC 19.2%; TGA 13.8%), and poverty (39.25% below 100% FPL), behavioral and substance use disorders (30%), and chronic comorbidities such as cancer, cardiovascular diseases, chronic kidney and lung diseases. Moreover, gaps in medical and dental insurance coverage, TennCare restrictions on the number of monthly prescriptions, and food shortage, lack of family support as well as stressful life events too often lead to poor treatment adherence and negative health outcomes such as HIV disease progression, exacerbation of co-

morbidities, frequent visits to specialty clinics, emergency department and admissions to the hospital, mental institutions, and drug treatment centers. Huge gaps persist in oral health, substance use disorders, medical transportation, and housing services.

Major Barriers to Care:

Incarceration: Of 516 inmates with HIV served by MCWC from 2003 to 2018, 64% were Black or African American and 66% aged 45-64. Stepwise implementation of telemedicine in 2006 led to increase in clinic attendance from 50% to 90% and viral suppression from 30% to 90% (Berthaud V. 2022 National Ryan White Conference). Of PLWH incarcerated in Davidson County jails, Non-Hispanic Blacks account for 71% and non-Hispanic Whites 29%. North Nashville has an incarceration rate of 14%, the highest in the country by far, and 93% of those incarcerated are Blacks. In other words, one in seven people who were born in the primary zip code of North Nashville between 1980 and 1986 went to jail or prison at some point in their lives. (Adams L, Nicholas T: Work and opportunity before and after incarceration. The Brookings Institution, March 2018). Twenty five percent of our patients reside in that neighborhood and 41% of them belong to this age group. MSM is still the most frequent means of exposure accounting for 37.5%, and IDU the second most reported exposure category among the jail population (22.1%). Heterosexual exposure accounts for 18.9% of PLWH in jail and MSM/IDU account for 6.3% of the cases; unreported exposure accounts for (15.1%). (Source: Nashville Metropolitan Health Department). Meharry Community Health Worker had established a strong collaborative relationship with Tennessee Department of Corrections (TDOC) and Davidson County Sheriff's Office (DSCO) for over 20 years. Persons with HIV who are incarcerated in DSCO are referred to MCWC for in-person care, while inmates of TDOC are seen by telemedicine.

Transportation: Public bus service in Nashville is extremely limited to some parts of downtown and very few stops in North and West Nashville. It nearly does not exist in South and East Nashville. Most of our patients resides far away from a bus stop. They require multiple transfers to come to the clinic or simply rely on a ride with a relative or a friend. The bus service makes short stops every hour between 8:00am and 4:30pm. There is no subway line in Nashville and Tennessee. MCWC had hired a full-time person to provide free round-trip medical transportation in the Transitional Grant Area (TGA).

Education: High school completion rate is 76% in Davidson County and 15% at MCWC.

Unemployment and poverty: 39.25% of Meharry clients had an annual income <100% FPL in 2023. Unemployment rate reached 60% and 30% were receiving Social Security Income. Drug and alcohol: Addiction to drugs and alcohol remains a significant risk factor for poor nutrition and treatment adherence, bad health outcomes, incarceration, and homelessness. However, there are insufficient access points to drug detoxification and rehabilitation in Davidson County. Many offenders released on parole or probation cannot get into drug or alcohol treatment. Consequently, they are often re-incarcerated for parole or probation violation. Periodic mandatory report to parole or probation officer had become their major competing priority. Moreover, many African Americans had switched from injection drugs to cocaine snorting or smoking, without any available treatment option.

Housing is the utmost priority for persons addicted to drugs who are experiencing homelessness. As Nashville is becoming a major destination for relocation of businesses

and people, affordable housing had become very scarce, while homelessness continues to rise. Aggressive gentrification further aggravates the shortage of affordable housing units. Moreover, the Department of Housing and Urban Development (HUD) had tightened requirements and narrowed their definition of homeless, which requires that clients be in a shelter for three days before being deemed eligible. Clients with criminal records, active addiction, and mental health issues are denied housing (both public and private); limited transitional, assisted living or group homes are available. Recently released convicts present other critical challenges such as limited access to employment, financial loans and social support. During the past five years, in Nashville, Tennessee, the trend of homelessness paralleled the economic growth curve that propelled a booming housing market. “Nearly 70% of Nashville ever-changing skyline wasn’t there 10 years ago” according to Nashville Chamber of Commerce. In April 2024, the median price for residential single-family homes in Nashville was more than \$500,000 for the first time. In the aftermath of the March 3, 2020, devastating tornado that destroyed numerous homes in North Nashville and the subsequent coronavirus pandemic, the number of displaced families grew exponentially. Most of the patients attending Meharry Community Wellness Center (MCWC) reside in North Nashville. Many of them lost their jobs in places such as hotels, restaurants, and factories due to local and state government-imposed “Stay-at-Home” and social distancing orders related to mitigation of the COVID-19 pandemic. The national economic downturn during the coronavirus pandemic exacerbated the homelessness crisis and widens the gaps in care and HIV health disparities. Our proportion of clients experiencing homelessness represents more than twice the national average for PLWH (8.4%) and is 50% greater than the national Ryan White average (12.9%).

Community environment: An often-forgotten barrier is the fact that 70% of our patients live in the same neighborhood and are very familiar with each other. Fear of disclosure of HIV status, stigma, and discrimination, prejudice, religious concerns, and misconceptions remain enormous barriers to accessing HIV care.

Barriers to reaching Tennessee’s disproportionately-impacted populations:

African-American MSM: lack of awareness, or misinformation about HIV transmission, prevention, and treatment; impact of homophobia on health-seeking behavior; lack of access to health care generally; and denial of risk.

Young MSM: misperceptions about HIV risk; denial and complacency associated with being a late adolescent; difficulties comprehending the seriousness of HIV, coupled with rejection by family and friends.

High-risk heterosexuals: lack of perceived risk; poverty, limited access to health care and health information; acting as caregivers in families; and financial dependency on a partner.

Incarcerated: stigma (isolation & potential for violence due to HIV status); misinformation about HIV transmission, prevention, and treatment (situational sex/” gay for the stay”); and lack of awareness or access to testing and/or health care services upon release.

Ryan White Part C Minority AIDS Initiative Report.

- To recruit persons with HIV (PWH) of the MAI target population, MCWC conducted outreach activities at multiple events:

Nashville Mayor’s Ending-the-Epidemic, PRIDE Day, Black PRIDE, World AIDS Day, National HIV Black Awareness Day, and HIV Testing Day, and The African Street Festival. MCWC also

leverages its partnership with Tennessee Department of Corrections, Metro Health Department, Davidson County Sheriff Office, Nashville General Hospital, United Neighborhood Health Centers, and Street Works. The Program Director promotes HIV awareness on Fisk Radio program, Health Waves. In general, the positivity yield of HIV testing in Nashville/Davidson County during outreach activities is less than 1%.

- How targeted testing is done for PWH of the MAI target population, and positives identified.

MCWC focuses on partners of non-virally suppressed clients, persons with sexually transmitted infection(s), or those with risky sexual behavior. Thus, from 01/2023 to 8/2023, MCWC performed targeted HIV testing for 60 high-risk persons on-site. Six of them (8.3%) tested HIV-positive. They were enrolled in care and started on ART immediately.

- How identified positives are linked to and enrolled in care.

People who test HIV-positive in the clinic or on the Meharry campus are linked to care and started on ART the same day; those referred from outside the campus are seen as soon as possible, usually within less than a week. EIS Worker, Community Health Workers, and the Community Care Team are responsible for linkage of identified positives to care. The Community Care Team meet twice a week to discuss newly identified positives and facilitate engagement. Medical case managers and medical providers collaborate in identifying and enrolling new clients. Altogether, they arrange for medical transportation, inform about core and support services, and expectations at initial clinic visit.

- How the PWH are retained in care.

The Patient Service Representative and Community Health Workers contact clients one week and 24-72 hours prior to their scheduled clinic appointments. They reach out by phone, text message, or e-mail to those who missed their visits the same day and attempt to reschedule them, while trying to address the root causes of missed appointments. If these attempts are unsuccessful after one or two weeks, they will mail a certified letter of notification at the client's last address.

Medical case managers and HIV medical providers identify new and current clients at high risk for drop out-of-care and refer them to the Community Care Team. They analyze challenges, barriers, and facilitators to develop and implement a joint plan of care for intensive adherence counseling, peer coaching, performance monitoring, and evaluation. Difficult cases are discussed at weekly staff meetings for broader input.

The Community Care Team reviews the out-of-care list and deploy all their effort to locate the client, reach out to their authorized contact persons, state prisons and jails, local hospitals and drug treatment centers, and homeless camps. Once they are unable to locate the client, they will arrange an in-person visit at their residence or their hangout places. If that fails, they will solicit assistance from the local and state Health Department as well as other community organizations. As a last-ditch effort, they will access the obit announcements.

Describe in detail:

- 1) The number of persons you plan to serve with the funding.**
- 2) The number of units of service you plan to provide by type of intervention (e.g., number of face-to-face contacts with clients and amount of time each client will be seen each year, number of educational sessions provided, number of contacts with**

gatekeepers); and

3) the average amount of service a client is expected to receive each year (e.g., 2 face to face each year) and the amount of time that will be spent with gatekeepers (e.g., 3 hours/gatekeeper/year).

With this Medical Case Management funding, we propose to serve 200 persons with HIV, distributed as follows:

Male 76%; Female 24%

African American 80%; Caucasian: 19%; other 1%

Hispanic 10%

Age group: 13-24: 0.1%; 25-44: 54%; 45-64: 45%; 65+ 0.9%

They will receive 800 units of service of 15 minutes each in face to face medical case management provided by a Part A funded salaried and credentialed Medical Case Manager.

III. Implementation Plan:

The importance of improving progress along the HIV care continuum is supported using scientific research that leads to the identification of best practices and evidence-based practices. The use of best practices/evidenced informed models is preferred for all services and as applicable/available.

Describe in detail any evidence bases or best practice models you will use to provide the service. Include a reference to the model's name and source of the best practice (e.g., "Healthy Living Project," CDC Evidence-Based Intervention-EBI).

<https://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html>

Ideally, interventions will be based upon proven outreach and engagement models; and/or adaptations of proven models; and /or novel models of outreach and engagement in care, particularly developed for the HIV/AIDS population.

Meharry Community Wellness Center follows the most recent Standards of Care for Medical Case Management set by TN Health Department Part B and Metropolitan Nashville Health Department Part A Program. All MCWC Medical Case Managers must be trained and approved by the State before they start serving clients. Afterwards, they attend the statewide Medical Case Managers' Conference, Update Meetings organized by United Way of Nashville and Middle Tennessee, and the Annual Ryan White Part B Meeting. The Ryan White Part A Program is always available for technical assistance, in-person or virtually.

Moreover, our experience as one of the three national performance sites, for the HRSA-sponsored Special Project of National Significance (SPNS), "Dissemination of Evidence-Informed Interventions: Peer Linkage and Re-Engagement of HIV-Positive Women of Color" in 2016-2019 inspired the Community Care Team Model implemented by our program in 2020. The Manual is available at: <https://www.targethiv.org/deii/deii-peer-linkage>.

Peer Linkage and Re-engagement of Women of Color with HIV. Rajabiun S., Marbach A., Fox J., Childs E., Sullivan M., Downes, A., Bryant H, Nortrup E., Berthaud V., Alexander L., Grimes T., et al. Dissemination of Evidence-Informed Interventions. Peer Linkage and Re-

engagement of Women of Color Living with HIV (2020). Available at: <https://www.targethiv.org/deii/deii-peer-linkage>. The peer-reviewed manuscript is referred here: Serena Rajabiun, Janet J. Myers, Janet Goldberg, Karen Fortu, Marena Sullivan, Vladimir Berthaud, Rahab Wahome, and Howard J. Cabral. "Outcomes from the adaptation of an evidence-based Peer Linkage & Re-engagement: Intervention for Women of Color with HIV in three urban clinics". AIDS and Behavior. October 05, 2021. PMID: 34609629.

Retention strategies: To improve retention and viral suppression, Meharry Community Wellness Center (MCWC) had formed the Community Care Team, which meets twice weekly to discuss clients with incoming appointments, those who missed their recent clinic visits, and those lost to care. MCWC works diligently to schedule all of a client's visits the same day. The Patient Service Representatives or the Community Health Workers contact the client one week and 24-48 hours before the appointment date to facilitate the clinic visit. They arrange for round-trip medical transportation, if needed. Those who missed their scheduled visits are contacted in less than 24 hours. If they are unable to reach a client by phone calls, text messages, e-mails, or letters, after 2 weeks, the Community Health Worker attempts to make a home visit. If that fails, they reach out to Nashville Health Department EIS Worker, Davidson County Sheriff Office and Tennessee Department of Corrections, the Coalition for the Homeless, drug treatment centers, mental health institutions, local hospitals, and nursing homes, for investigation. If these strategies fail after 6 months, the TN Health Department Disease Intervention Specialist (DIS) is alerted for further tracking efforts. Clients who miss more than two consecutive appointments receive intensified adherence counseling and coaching.

Targeted retention efforts toward subpopulations with poor health outcomes. The Community Health Workers and PSRs target MSM, women of color, and clients with challenging issues such as mental illnesses, substance use disorders, and pervasive stigma. The Medical Case Managers assist clients experiencing homelessness in permanent placement, prevention of eviction, and maintenance of stable housing. The HOPWA Case Manager assists clients with rent, mortgage, and utilities bills. The Community Health Workers provide clients with medical transportation, food services, and pharmacy management to facilitate clinic visits and medication adherence. The medical providers coordinate with staff to facilitate joint clinic appointments. All clients are screened for behavioral and substance use disorders and those who screen positive are seen by the clinical psychologist, the psychiatrist, and/or the therapist/counselor.

Coordination of medical and support services for pregnant women.

An obstetrician-gynecologist with over 25 years of experience including 15 years at MCWC, Dr. Vernita Tucker, will manage pregnant women in the clinic in close coordination with medical providers and nurses during the entire prenatal, peripartum and postpartum period. All pregnant women will be offered ART, if not on yet, and counseled regarding the benefits and risks of ART during pregnancy for the woman, fetus, and newborn. Adherence to ART may decline in the postpartum period. Therefore, clinical and support staff caring for postpartum women on ART will stress adherence and evaluate specific facilitators and barriers. Two Meharry board-certified infectious diseases pediatricians, Dr. Shahana Choudhury and Dr. Christopher Keefer, will manage HIV-exposed babies. Prenatal and HIV

care visits as well as neonatal and maternal medical visits will occur on the same day. Attention will be paid to nutrition, medical transportation, housing status, and medical insurance coverage.

Unmet need and HIV care continuum: In 2020, 66% of newly diagnosed people in Tennessee were linked to care within 30 days, compared to 64% in 2018; 54% were retained in care (same for non-Hispanic Blacks) and 66% achieved viral load suppression (63% for Non-Hispanic Blacks). In Nashville TGA, an estimated 17% of PLWH are unaware of their status. In 2020, 66% of newly diagnosed cases were linked to care in 30 days, 54% were retained, and 66% achieved viral suppression. Among Non-Hispanic Blacks, 64% were linked to care within 30 days, 54% were retained and 63% became virally suppressed. Among Non-Hispanic Black PLWH, there were significant differences in care retention by age group ($p < 0.0001$). The lowest rates of care retention in this subpopulation were found among 13-24-year old (44%) and 25-34-year-old (52%). Among Non-Hispanic Black PLWH, there were significant differences in viral suppression by age group ($p = 0.0009$). The lowest rates of viral suppression were found among 13-24-year old (51%), 35-44-year-old (57%), and 25-34-year-old (58%). In TN and the Nashville TGA, the Ryan White program represents the strongest contributor to successful outcomes along the HIV care continuum as shown in this figure. Source: TN Health Department sponsored presentation TN HIV Continuum of Care: Update, Peter F. Rebeiro, MHS, PhD. (September 24, 2015)

We examined the effect of homelessness on viral suppression between 2014-2019. Our retrospective study revealed that permanently/stably housed clients had a much higher proportion of viral suppression compared to unhoused clients. Among clients with viral load < 20 copies/mL, 78% were permanently housed and 22% homeless, while 74% of permanently/stably housed clients reached viral suppression and a smaller proportion of the homeless clients (54.7%) remained virally suppressed (Pearson's Chi-Square 25.171, $p < 0.001$). The multivariable logistic regression showed that permanent/stable housing (p -value < 0.001), higher frequency of CD4 count > 500 cells/mm³ (HIV infection, stage 1) (p -value < 0.001), age (p -value = 0.004), and FPL (p -value = 0.031) were strong predictors of viral suppression. As expected, patients living in permanent/stable housing had twice the chance of achieving viral suppression compared with those who were experiencing homelessness [OR 2.08 (1.39-3.23), p -value < 0.001]. Under the nonparametric assumption, the receiver operating characteristic (ROC) curve correctly predicted 72.3% of the primary outcome variable, viral suppression (AUC = 0.767; p -value < 0.001 ; 95% CI for AUC (0.73, 0.80). During the 5-year study period, 52 clients died. Of them, 16 (30.76%) were experiencing homelessness and 36 (69.23%) lived in stable housing, while 12.5% of the homeless and 61.12% of those in stable housing achieved viral suppression at the time of death (Berthaud V. et al. BMC Infectious Diseases, 2022; 22: 144). This seminal paper inspired the 2022 CDC Issue Brief, "The Role of Housing in Ending the HIV Epidemic" and a Human Resources and Services Administration (HRSA) Notice of Funding Opportunity for housing of PWH. The Infectious Diseases Society of America cited our paper in their special issue dedicated to homelessness and infectious diseases (Emily Mosites, Laura Hughes, and Jay C. Butler. Homelessness and Infectious Diseases: Understanding the Gaps and Defining a Public Health Approach: Introduction. The Journal of Infectious Diseases 2022;226(S3):

S301–3).

IV. Best Practices:

Provide a clear and succinct description of the proposed project to implement an intervention model designed to create access to HIV testing, improve timely entry, engagement, and retention in quality HIV medical care for persons living with HIV infection.

Medical Case Management (MCM) including treatment adherence is a focused case management activity designed to insure adequate access to basic outpatient HIV/AIDS related medical services for low-income clients without adequate healthcare coverage and to insure Ryan White funds are ALWAYS utilized as payor of last resort. MCM services, as appropriate for HIV/AIDS patients, consist of the following functions:

Assist eligible PLWH in applying for Ryan White programs as appropriate or for all possible third-party payor programs; with a primary focus of maintaining the cost of care, whenever possible, in the private sector. When the private sector is not an option in a particular patient's circumstance, the focus of intervention will be to seek healthcare coverage within any eligible publicly funded program (i.e., TennCare, Medicare, VA, and Ryan White as a last resort).

Assist eligible patients in accessing health related services, which are not provided by a private or public healthcare policy and/or by the Grantee (including, but not limited to, nutritional counseling, dental care, home health services, etc.).

Coordinate with appropriate regional Consortia and various community-based organizations, to link eligible patients with services that can assist with social support needs such as transportation, food services and housing.

Encourage community service providers to participate in the Medical Services Program as a designated provider for the Ryan White Medical Services Fee Schedule.

Key Medical Case Management activities include:

1. Initial assessment of service needs:
 - Medical Case Managers review process for new clients to ensure that intake and assessment are completed within the first week and insure that documentation of completion is identifiable in paper or electronic chart.
 - Medical Case Managers have prepared an intake packet that includes registration form, patient's privacy, rights and responsibilities forms, and consent form for release of information.
 - Medical Case Managers review patient schedules two weeks in advance and check with Patient Service Representative of any schedule changes.
 - Medical Case Management Supervisor assign patients to Part A Medical Case Managers by alphabetical order.
 - Medical Case Management Supervisor conducts chart review at the weekly medical case management meeting on Thursdays to ensure that intakes and assessments are completed on time.

- Once an incomplete intake/assessment is identified, the Medical Case Manager or his/her designee contacts the patient for another appointment as soon as possible.
2. Development of a comprehensive, individualized service plan
 - Medical Case Managers review process to ensure that every client has signed and reviewed a plan of care and that the plan is easily identifiable in the paper chart.
 - Medical Case Managers implement a uniform filing system of paper charts so that key documents are identically filed by Medical Case Managers and Mental Health Therapist/Substance Use Counselor.
 - Medical Case Managers implement a uniform naming system for all case management and other notes based on the contents of the note.
 - Medical Case Managers perform weekly systematic chart reviews.
 3. Coordination of services required to implement the plan
 - Medical Case Managers participate in bi-weekly staff meetings to discuss barriers to access services and identify solutions for resolution of challenges
 - Medical Case Managers participate in bi-weekly multidisciplinary case conference to ensure better coordination of services
 - Medical Case Managers lead weekly retention meetings to track clients who missed their schedule appointments, who are hospitalized, incarcerated, institutionalized, or lost to follow-up.
 - Medical Case Managers work closely with all medical providers, Patient Service Representatives, Substance Abuse Counselor, Community Health Workers, and Referral Specialist to ensure patients have unfettered access to a continuum of coordinated services that meet their needs as described in the signed care plan.
 - Medical Case Managers coordinate outreach with EIS Workers of Tennessee Health Department and Metropolitan Nashville Health Department to locate and re-engage hard-to-reach clients
 4. Client monitoring to assess the efficacy of the plan
 - Medical Case Managers insure that patient needs are met and services are documented and reflect Medical Case Managers' efforts to follow up on client care plan.
 - Medical Case Managers generate a check list of socio-demographic data and coordinated services including medical and support services.
 - Medical Case Managers do chart review at their weekly medical case management meeting to verify that the check list is complete and reflects the care plan.
 - Medical Case Managers participate in Continuous Quality Improvement projects and weekly team meetings.
 5. Periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services.
 - This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
 - Medical Case Managers review process for re-assessment to ensure that face-to-face re-assessments are completed every 6 months and insure that documentation of completion is clearly identifiable in paper or electronic chart

- Medical Case Managers insert the re-assessment due date in the care plan both in CAREWare and paper chart.
- Medical Case Managers utilize a disenrollment template in CAREWare when clients are no longer eligible for Part A services or fail to re-certify.
- Medical Case Managers create a list of due dates on an EXCEL spreadsheet for monthly review.
- Medical Case Managers contact patients by mail and phone 30 days in advance to remind them of all required documents for re-assessment and to schedule an appointment quickly.
- Medical Case Managers do chart review at their case management meeting on Thursdays to ensure that re-assessments are completed on time.

PROCEDURE:

In order to ensure the highest quality Medical Case Management services are delivered to MCWC patients, two forms of review and supervision will be provided to all MCMs at the MCWC.

Clinical Supervision:

All Medical Case Managers will meet with their supervisor, the licensed Clinical Psychologist and Social Scientist, weekly. Prior to these supervision meetings one MCM will be responsible for completing the case-presentation outline, as well as opening the reviewed patient's CAREWare file. During these meetings one MCM weekly will present a patient they are currently working with using the aforementioned outline. Particular focus will be placed on the MCM both delivering the services and completing the key activities described above in the definitions section, as well as maintaining appropriate patient notes in the CAREWare system. All MCMs will rotate through as presenters, and will receive feedback from each other as well as the clinical supervisor during these meetings. Should deficiencies be noted in either service delivery or MCM record keeping a corrective plan will be developed by the MCM responsible for the patient and the clinical supervisor. After one week the MCM and clinical supervisor will meet to ensure the corrections to care or charting are complete, and these meetings will continue until the deficiency is corrected.

Chart Review:

On a monthly basis the clinical supervisor will randomly select ten patient files and review of both the paper file and CAREWare. Files will be reviewed to ensure they are in accordance with Ryan White funding guidelines for appropriate charting, as well as other information pertinent to providing optimal care to the patients at the MCWC.

The supervisor will use the checklist of file elements to review the chart. Again, should deficiencies be noted, the Medical Case Manager who serves this patient will be asked to correct the file and the supervisor will review with the Medical Case Manager the following week. Should additional deficiencies be noted this process will continue until the deficiencies are corrected.

Insurance Eligibility Policies and Procedures.

Purpose. The purpose of this policy is to establish eligibility guidelines and procedures to be utilized when verifying HIV status, identification, residency, and income for Ryan White

Program clients at Meharry Community Wellness Center, while ensuring that the Ryan White HIV/AIDS Program always remains a payor of last resort.

Meharry Community Wellness Center had developed Insurance Eligibility Policies and Procedures in accordance with policy clarification notice (PCN) 21-02 and Ryan White Part B Standards of Care for Medical Case Management. All Medical Case Managers are trained, approved, and monitored by Ryan White Part B Program. Ryan White Part A Program provides additional training, approval, and monitoring. These Policies and procedures will be updated continuously as per the latest recommendations of Human Resources and Services Administration (HRSA) and Tennessee Department of Health Part B program.

Eligibility Determination. In determining eligibility, all program applications must be fully completed and signed by the client and Medical Case Manager (MCM). All required supporting documentation (written verification of HIV positive status, residency, and income) must be verified by the MCM before submitting the application in the Ryan White Eligibility System (RWES). All documentation should be maintained in the client's file for review purposes. A copy of the "Participant Release of Information and Client Rights and Responsibilities" statement must be signed every year; it may be necessary to read the statement to the client.

In addition, all clients participating in a Ryan White Part B program must recertify eligibility at a minimum of every 6 months. Recertification can be done through mail, by phone or in person using the Self Attestation form. Recertification using the Self Attestation cannot be done consecutively. Any updated information received during this contact (income, residency, etc.) must be updated in the Ryan White Eligibility System. Client contact with the MCM regarding Ryan White Part B programs must be documented.

Eligibility is further based on the applicant's willingness to work with his/her Case Manager to apply for all other possibilities of third-party coverage (i.e., TennCare, eligible private coverage through employer, etc.) Persistent failure to cooperate in such is grounds for termination/suspension from Ryan White Part B assistance programs.

HIV Status. All RWHAP clients have a documented diagnosis of HIV, CD4 count, and viral load in CAREWare and E-Clinical Works. Their HIV diagnosis can also be verified on the State Ryan White Eligibility System (RWES).

Low-Income. The Medical Case Manager determines low-income status based on Modified Adjusted Gross Income. To be deemed eligible for coverage by the Ryan White Part B Program in Tennessee, a client must show proof of a household income of less than or equal to 400% of the currently established Federal Poverty Level Guidelines. One of the following items of the documentation needed to determine income:

- I) At a minimum, two consecutive pay stubs (i.e., weekly, bi-weekly, monthly) showing income before taxes and deductions.
- II) One pay stub with a year to date can be used if within 30 days.
- III) W-2 form. (Can only be used until January 31st of the following year).
- IV) If self-employed, client can use the previous year income tax form until May 1st of the current year.
- V) Food stamp letter can be used for income determination proof.

VI) Housing documentation, such as Section 8 letter, may be used for the purposes of determining income and residency.

VII) Letter of Support can be handwritten if it contains the following elements:

- a. Applicant name.
- b. Applicant address.
- c. Support provider's name
- d. Support provider's address if different.
- e. Support provider's signature and date signed.
- f. Support providers telephone number
- g. Support provider's relation to applicant.

VIII) If applicant/client is legally separated, the spouse can write a letter of support (if applicable and circumstances indicate one spouse is supporting the applicant). Legal documentation must also be supplied as further proof of separation.

IX) A signed and dated employer statement on company letterhead (if applicable) stating name of applicant, providing income information, (i.e., defining pay period, salary per pay period, rate of hourly pay, number of hours normally worked per pay period, etc.), a phone number and whether applicant is currently receiving or is eligible to receive health benefits from employer.

X) For fixed income applicants, a letter or benefits statement from originating source, showing the amount of benefits and frequency received (Social Security, Private Disability, Retirement, Unemployment, etc.).

XI) Letter from the Department of Human Services (DHS), showing calculated income (and frequency received) and/or resources.

XII) Statement of Direct Deposit, clearly identifying the source, if the gross income is reflected.

XIII) For applicants who have zero income, a Confirmation of Support Letter from whoever is providing their food, clothing, and housing. It is recommended that the Case Manager use the Letter of Support Form found in Appendix F in the Case Management Manual. All other letters of support must contain the following elements: Applicant's name, address and signature with date. Person providing supports' name, address, telephone number, relationship to the client and signature with date. The MCM may also satisfy this requirement by completing the Acknowledgement of Support Letter, stating that he/she has personal knowledge that the client has no income, e.g., a homeless person.

Residency. To be deemed eligible for coverage by Ryan White Services Programs, a recipient must provide one proof of residency documentation. Residency documentation cannot be older than 60 days from time of certification or recertification.

Proof of Residency (Client must provide one of the following documents)

- a) Current bank statement (internet bank statements are acceptable only if taken to the local bank, stamped, and dated by teller as active account. Checks and checkbook information are not acceptable).
- b) A valid (non-expired) Tennessee driver's license or Tennessee State issued ID or voter registration card can be used for proof of residency. Address must match the address used on any documentation used for proof of income.

- c) Food stamp documentation can be used for proof of residency if the address matches the proof of income documentation.
- d) Current paycheck/check stub, work ID or badge, if address is included.
- e) Current automobile, life, or health insurance policy (wallet cards cannot be accepted).
- f) Official government documents issued annually (e.g., food stamp or Social Security letter) can be used for the proof of residency and income for enrollment and recertification.
- g) Current driver's license/ID issued by Tennessee Department of Safety to a parent, legal guardian, or spouse of applicant.
- h) Current Tennessee motor vehicle registration or title.
- i) Receipt for personal property or real estate taxes paid within the last year.
- j) In case of student enrolled in public or private school in this state, student may provide a photo student ID and acceptable documentation from the Dean or Bursar Office that the student lives on campus.
- k) Current mortgage or rental lease agreement in recipient's name.
- l) Current Tennessee utility bill (landline telephone, electric, water, gas, cable, etc.) in recipient's name and address.
- m) Current employer verification of residence address or letter from employer if it is on company letterhead with original signature. If employer does not have letterhead, then signature of employer must be notarized.
- n) Letter from a verifiable homeless shelter or community center serving homeless individuals with clear identification and verification of residency Letter of Support
- o) Mail postmarked within the last 60 days and delivered to recipient's street address.
- p) Property Tax Receipt or W-2 form for previous year
- q) Unemployment Document with Address
- r) Prison records (if recently released)
- s) Contact the ADAP Director or Coordinator for any exceptions.

Payor of Last Resort. By statute, the RWHAP funds may not be used for any item or service "for which payment has been made or can reasonably be expected to be made" by another payment source (Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1) and 2671(i) of the Public Health Service (PHS) Act.). This means that the recipient must make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. The recipient should ensure that eligibility for other funding sources (e.g., Medicaid, CHIP, ACA, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance, etc.) is consistently assessed and enrollment is vigorously pursued, to extend finite RWHAP grant resources to new clients and/or needed services. If this process is going to take some time, the Medical Case Manager then escorts client to the Office of Financial Assistance at Meharry Medical Group (MMG) or Nashville General Hospital (NGH) to enroll in the indigent care program.

Best Practices to Promote Continuity of Services and Care. Meharry Community Wellness Center (MCWC) will adopt the following best practices recommended by Policy Clarification Notice 21-02 to promote continuity of services and care in the RWHAP.

- Conduct periodic checks to identify any potential changes that may affect eligibility, and require clients to report any such changes.

- Use electronic data sources (e.g., Medicaid enrollment, state tax filings, enrollment and eligibility information collected from health care marketplaces) to collect and verify client eligibility information, such as income and health care coverage (that includes income limitations), when possible. MCWC will first use available data sources to confirm client eligibility before requesting additional information from the client. If the RWHAP client still meets the eligibility criteria based on recent, reliable, available data, recipients and subrecipients may renew that client's eligibility without requesting additional information from the individual.
- Identify opportunities to streamline eligibility determination policies and procedures across service categories and RWHAP parts within the service area. In addition, MCWC will develop data sharing strategies with other RWHAP recipients and relevant entities to reduce administrative burden across programs.

Describe the strategies you will use to identify and engage with key stakeholders recognized and trusted by the HIV/AIDS community; include the names of specific people and entities.

Describe the components of your intervention model and its specific strategies that will:

- a) Increase awareness of HIV disease, with a focus on reaching persons at high risk for becoming infected with HIV disease.**
- b) Identification of high-risk persons who need but do not access regular HIV tests and how you will link those persons to HIV testing agencies; and**
- c) Identification of persons who are HIV positive but have never or who have dropped out of HIV medical care and services and how you will facilitate linking those persons with needed HIV services and care.**

Proposed interventions must address personal, financial, sociocultural, and structural barriers, especially stigma, that affect PLWHAs access to HIV testing and retention in HIV medical care and services. Define specific barriers that may be encountered by the population being served and discuss how your proposed interventions will positively address each of these barriers.

Meharry Community Wellness Center (MCWC) organizes outreach events with local partners including Metropolitan Nashville Health Department to raise HIV awareness and promote testing. As member of Nashville PrEP Coalition, MCWC facilitates the rapid linkage of newly diagnosed persons. It also leverages its experience as a research site for the SPNS project targeting newly diagnosed and out-of-care women of color for linkage and retention to enhance engagement in care. As a pioneer of HIV telemedicine in TN prisons and HIV consultant for Davidson County jails since 2006, MCWC facilitates the transition of ex-offenders to rapid linkage and engagement upon their release in the community.

Patients who diagnose HIV positive in the emergency department (ED) at Nashville General Hospital (NGH), located on the Meharry campus, are linked and enrolled into care the same or next business day. HIV providers and Medical Case Managers follow newly diagnosed persons

with HIV (PWH) admitted to NGH and coordinate their discharge disposition. Clients newly identified outside the Meharry campus are linked as soon as possible, preferably within less than 7 days. The Patient Service Representatives (insurance verification), the Community Health Workers (coaching and navigation), and the Medical Case Managers (insurance assistance and Ryan White eligibility) are responsible for rapid linkage.

Community Care Team Model. To optimize patient care at multiple access points and shift from a disease-based model to truly patient-centered care, MCWC will implement the community care team model based on four tracking pathways, A, B, C and D.

A: Patients who attend clinic appointments regularly, maintain viral load suppression, and may have zero to low-level comorbidities and social determinants of health. (*Focus: prevention, health promotion, and reinforcement of adherence*)

B: Patients who are missing scheduled appointments (no-shows, walk-ins), do not maintain viral load suppression, and may experience rising levels of comorbidities and social determinants of health. (*Focus: increase adherence counseling, health education, and rapid intervention, and identify, and address emerging risk factors for adverse outcomes*)

C: Patients who do not attend clinic appointments regularly, may have variable levels of viral load suppression and comorbidities, and high levels of challenging social determinants of health impacting treatment adherence, the HIV care continuum, and overall health and wellness, and representing greatest life priorities. (*Focus: intensive medical case management and peer support, ensure unfettered access to clinical and support services, and collaborate with community agencies to prevent critical progression*)

D: Patients who may not attend clinic appointments regularly and have variable levels of viral load suppression, and may be facing high levels of chronic diseases that are becoming higher health priorities than HIV, and have variable levels of social determinants of health.

(*Focus: coordination of multispecialty services and referrals, and disease education*).

The Community Care Team (CCT) will implement an HIV service delivery model that will facilitate patient tracking, peer-to-peer support, differentiated case management, improve retention, viral load, and health outcomes. The CCT will strive to track clients at their ever-changing points-of-contact, particularly the hard-to-reach, highly vulnerable, and marginalized individuals, and those who are struggling with adverse social determinants of health, HIV disease progression and significant comorbidities. In fact, the results of our pilot study showed the following viral suppressions: **100% for Pathway A, 78% for B, 43% for C, and 65% for D.** (*Berthaud V, Special Presentation, 2020 National Ryan White Meeting*).

Strategies to improve care transition focus on inmates, youth living with HIV and hospitalized patients who are HIV positive. Meharry infectious diseases specialists serve as HIV consultants for TN Department of Corrections and Davidson County Sheriff's Office. At the time of consultation, they will identify inmates ready to transition into the community and initiate the contact between prison or jail personnel and MCWC staff such as PSR, EIS Worker, Community Health Workers, Therapist/Drug Counselor, and Medical Case Managers, to coordinate transitional services, with the intent to schedule the first clinic appointment on the same day of release or within one week. Meharry infectious diseases physicians will follow all persons with HIV hospitalized at Nashville General Hospital and coordinate their discharge and linkage to

care in close collaboration with hospital physicians, nurses, and case managers and MCWC staff. They will also coordinate the care of their patients who are admitted to another acute or long-term care facility. The Community Health Workers will follow clients hospitalized in other medical facilities and share authorized health information with outside providers to ensure continuity in care. They will coach youth living with HIV and help them navigate the HIV service delivery system.

Coordination of medical and support services for pregnant women.

An obstetrician-gynecologist with over 25 years of experience including 15 years at MCWC, Dr. Vernita Tucker, will manage pregnant women in the clinic in close coordination with medical providers and nurses during the entire prenatal, peripartum and postpartum period. All pregnant women will be offered ART, if not on yet, and counseled regarding the benefits and risks of ART during pregnancy for the woman, fetus, and newborn. Adherence to ART may decline in the postpartum period. Therefore, clinical and support staff caring for postpartum women on ART will stress adherence and evaluate specific facilitators and barriers. Two Meharry board-certified infectious diseases pediatricians, Dr. Shahana Choudhury and Dr. Christopher Keefer, will manage HIV-exposed babies. Prenatal and HIV care visits as well as neonatal and maternal medical visits will occur on the same day. Attention will be paid to nutrition, medical transportation, housing status, and medical insurance coverage.

Meharry Community Wellness Center collaborates with diverse stakeholders to identify persons who are HIV positive but have never or who have dropped out of HIV medical care and services and facilitate linking those persons with needed HIV services and care: Nashville General Hospital (NGH), Meharry teaching hospital, where Dr. Berthaud serves as Director of Infectious Diseases and Dr. Livette Johnson co-chairs the Infection Prevention Committee. They work closely with hospital staff to identify patient who are out of HIV care and re-engage them immediately. Inpatient referrals are seen the same day and outpatient referrals are seen in less than a week. A Medical Case Manager and a Community Health Worker will introduce themselves to the hospitalized patient with HIV to educate them about our HIV program and expectations at initial clinic visit. They will coordinate patient discharge with medical providers and Case Managers and arrange for those who are eligible for commercial medical insurance, TennCare, Medicare, or VA insurance initiate the enrollment process as soon as possible. They will inform those deemed eligible for Ryan White insurance coverage about the program requirements, policies, and procedures. The same process is applied to all other referring partners as circumstances allow. NGH refers PWH from Emergency Department, inpatient, and outpatient clinics; Meharry Elam Mental Health Center, Meharry Family Medicine and MAT Clinic, located right across the hall from MCWC, and Meharry Clinics constitute regular sources of mutual referrals; Davidson County Sheriff's Office refers inmates with HIV to MCWC since 2005, while Tennessee Department of Corrections refers them for telemedicine consultation, a service established by Dr. Berthaud in 2006; Neighborhood Health, the largest FQHC in Davidson County, Ascension St Thomas Health (Dr. Berthaud maintains consultation privileges), and Metropolitan Nashville Health Department, the largest HIV testing center in Nashville, represent important referral sources. Metropolitan Development Housing Authority awarded a HOPWA grant for the provision of Short-Term, Rent, Mortgage, and Utilities assistance. Street Works and Nashville CARES provide medical case management, food and housing services including permanent placement and emergency shelters. Second Harvest provides low-cost

preserved food for our pantry. Vanderbilt University Medical Center provides emergency, specialty ambulatory, and inpatient care for MCWC clients. Tennessee Health Department had contracted with Meharry for ambulatory/outpatient and medical case management services. They provide technical support to medical case managers and assist in linkage/reengagement of clients lost to care. Metropolitan Nashville Public Health Department (MNPHD) refers newly diagnosed HIV-positive and lost-to-care people, treats persons with latent and active tuberculosis, and coordinates STD management and control. Meharry Elam Mental Health Center collaborates with MCWC Therapist/Drug Counselor on outpatient and inpatient drug treatment, detoxification, and rehabilitation. Dr. Osa-Edoh, the Part A funded psychiatrist, is also the Director of the Drug Treatment Program at Elam Center.

Service Specific Questions:

1. Service Model

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of your proposed project. Include all aspects of planning, implementation, and evaluation, listing the role of everyone involved in activity.

2. Work Plan

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of your proposed project. Include all aspects of planning, implementation, and evaluation, listing the role of everyone involved in each activity.

The work plan should include clearly written:

- 1. Goals**
- 2. Objectives that are specific, time-framed, and measurable**
- 3. Action steps**
- 4. Staff responsible for each action step; and**
- 5. Anticipated dates of completion.**

Please note that goals for the work plan are to be written for the first year of the grant. Discuss any challenges that are likely to be encountered in planning and implementing the project's activities described in the work plan and describe realistic and appropriate approaches to be used to resolve these challenges.

Work Plan

Goals	Objectives	Action Steps	Anticipated Date of Completion	Responsible Staff
Increase viral suppression	85% viral suppression by end of Year 1	<p>Periodic viral load monitoring as per DHHS guidelines</p> <p>Monitor treatment adherence</p> <p>Monitor health complications and chronic comorbidities</p>	End of Year 1	<p>Medical providers</p> <p>Medical providers, Medical Case Managers, Community Health Workers</p>
Increase retention in care	78% retention in care by end of Year 1	<p>Early identification of clients at high-risk for dropout and treatment failure</p> <p>Provide intensive coaching and case management</p> <p>Monitor and evaluate barriers, challenges, and facilitators to treatment adherence and clinic attendance</p> <p>Facilitate access to treatment of behavioral and substance use disorders, medical transportation,</p>	<p>End of Year 1</p> <p>End of Year 1</p> <p>End of Year 1</p> <p>End of Year 1</p>	<p>Medical providers Medical Case Managers Community Health Workers</p> <p>Medical providers Community Health Workers Therapist</p> <p>Medical providers Mental Health Therapist Psychiatrist Clinical Psychologist</p> <p>Therapist Community Health Workers</p>

		housing and food services		
		Track clients who missed clinic appointments weekly	End of Year 1	Community Health Workers Medical Case Managers
		Collaborate with community-based organizations, local and state health departments, and correctional facilities	End of Year 1	Community Health Workers Medical Case Managers

Aggregate measures of viral suppression and retention are already incorporated in the HRSA-required Performance Measures section of CAREWare. We have customized the system to measure viral load for subpopulations.

Challenges and Resolutions		
Challenges	Approaches for Resolutions	Barriers
Homelessness	HOPWA grant for Short-Term Rent, Mortgage, and Utilities (STRMU) does not match explosive real estate costs in the TGA.	Many of our clients experiencing homelessness are excluded from public housing because of restrictive housing policies and limited HOPWA funding.
Limited transportation service	Medical transportation service provided by program income.	Limited or in-existent public transportation.
Food shortage	Raise Part A Food Voucher card from \$20 to \$60 to adjust for inflationary cost. Program income-supported Food Pantry with unrestricted access in collaboration with Second Harvest.	Lack of job skills & education, unemployment, and poverty, exacerbate food shortage.

High rate of incarceration	Clinical psychologist, psychiatrist, therapist/drug counselor address behavioral and substance use disorders and relapse, and the roots of incarceration.	Limited access points for substance use treatment; high rate of drug charges, incarceration, and recidivism.
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Our landmark paper was the first to highlight the negative effect of homelessness on HIV viral suppression and mortality in Middle Tennessee and its potential challenges to ending the HIV epidemic. (Vladimir Berthaud; Livette Johnson; Ronda Jennings et al. “The Effect of Homelessness on Viral Suppression in an Underserved Metropolitan Area of Middle Tennessee: Potential Implications for Ending the HIV Epidemic”. BMC Infectious Diseases. 2022 Feb 10; 22: 144). This retrospective analysis reveals that permanently/stably housed clients had a much higher proportion of viral suppression compared to their unhoused counterparts. Among clients with viral load <20 copies/mL, 78% were permanently housed and 22% unhoused. This seminal paper inspired the 2022 CDC Issue Brief, “The Role of Housing in Ending the HIV Epidemic” and a Human Resources and Services Administration (HRSA) Notice of Funding Opportunity for housing of PWH. The Infectious Diseases Society of America cited our paper in their special issue dedicated to homelessness and infectious diseases (Emily Mosites, Laura Hughes, and Jay C. Butler. Homelessness and Infectious Diseases: Understanding the Gaps and Defining a Public Health Approach: Introduction. The Journal of Infectious Diseases 2022;226(S3): S301–3).

B. Budget (35 Points)

Complete the entire Budget Spreadsheet attachment (excel version) which describes how you will use the funds to provide the service requested in the scope of work for this solicitation. Include detailed information about the number and type of staff your firm will fund, staffing costs and other specific costs associated with providing the service. Contractor(s) will be allowed to budget up to 10% for administrative costs, including indirect charges.

Leaving blanks on any of the Budget Spreadsheets and/or not following the provided format may result in your proposal being deemed non-responsive.

The entire Budget Spreadsheet attachment has been completed and uploaded.

MEHARRY COMMUNITY WELLNESS CENTER

MENTAL HEALTH

ORGANIZATION AND TEAM QUALIFICATIONS

I. ORGANIZATIONAL BACKGROUND

1. Describe in detail the background of your agency. Include the purpose of your organization, years of experience in providing services to People Living With HIV/AIDS (PLWHAs) and the years of providing these services (note if any HIV specific services are provided and/or if you currently collaborate with an HIV agency) and number of unduplicated persons served last year.

Purpose. Meharry Community Wellness Center (MCWC) strives to eliminate HIV health disparities in Nashville Transitional Grant Area (TGA) by promoting awareness, education, and training, transdisciplinary research, community partnership, and unfettered access to comprehensive, high-quality care.

Background. Meharry has been a leader in primary care medicine for over a century and HIV prevention and treatment since the beginning of the epidemic in 1981. Out of a growing need to expand access to culturally sensitive, comprehensive primary HIV care in the Nashville Transitional Grant Area (TGA), Dr. Vladimir Berthaud founded Meharry Community Wellness Center (MCWC) in 2005. MCWC has been a top-ranked Tennessee-designated AIDS Center of Excellence since 2006, and a Hepatitis Center of Excellence since 2016. Tennessee Health Department recognizes MCWC as a “national model for comprehensive HIV care among the underserved community”. **Meharry has been providing mental health services to people living with HIV for over 40 years and Meharry Community Wellness Center had done so for 20 years.**

Meharry Community Wellness Center provides 24/7 coverage for medical and dental services. Clients have easy access to one-stop, wrap around core and support services: HIV counseling and testing, PrEP/PEP, and primary HIV care; management of complex infectious diseases; women’s health services including reproductive health, Pap test/colposcopy; minor ambulatory surgery including proctoscopy, skin biopsy, wound care, pre- and postoperative management; psychiatry, clinical psychology, mental health therapy and drug counseling; Medication-Assisted Treatment (MAT), outpatient and residential treatment of substance use disorder; HIV Drug Assistance Program (HDAP), Insurance Assistance Program (IAP), on-site pharmacy services; housing assistance, medical transportation, and nutrition; legal aid, home and community-based health services, and referrals to specialty and community resources; comprehensive primary oral health including prophylaxis, dental hygiene, tooth extraction, root canal, cutting-edge prosthodontics, and oro-maxillo-facial surgery.

Our patient population has an alarming prevalence of severe tooth decay (60%) and severe periodontitis (30%). Meharry Community Wellness Center (MCWC) represents the only

Tennessee clinic that offers unfettered access to fully integrated, comprehensive oral health services for low-income PLWH regardless of their primary HIV care providers. The Tennessee Ryan White Dental Assistance Program (RWDAP) ran out of funding in April 2019 and left 1,800 clients with very limited or non-existing access to oral health services. Only 10% of our clients have dental insurance coverage and just 2% of them have adequate coverage. As of 2023, TennCare offers limited oral health benefits to eligible clients. So far, they have not referred any patients to our dental clinic. The dental clinic disposes of two state-of-the-art operatories, two intra-oral digital cameras, and one portable digital X-Ray, one lab, and one sterilization room. It applies breakthrough 3D technology to fabricate crowns, bridges, partial, and full dentures while the client is waiting. Meharry Community Wellness Center is among five health centers who dispose of this brand-new technology for fabricating full-mouth and partial denture in one visit in the United States. Special cases such as impacted molars, orthodontics, intra-oral abscesses, or deep-seated infections, are referred on site to Oro-Maxillo-Facial Surgery service at the Meharry School of Dentistry using program income to pay the discounted fees for these referrals.

Meharry Community Wellness Center had served 2,165 unduplicated clients since inception and 468 in 2024 including 77% Black or African American, 10% Hispanic/Latino, 25% female, and 46% MMSC. Our proportion of PWH with unmet housing needs (24.9%) represent about thrice the national average for PWH (8.4%) and twice the average for Ryan White clients nationwide (12.9%). Our clients bear an excess burden of poverty (53% below 100% federal poverty level), history of incarceration (20%), substance use and behavioral disorders (30%), uninsured (39%), cardiovascular diseases (30%), chronic lung diseases (35%), and diabetes (20%). Nonetheless, 85% of our clients had achieved viral load suppression (increased from 78.6% in 2021, 82.3% in 2022, and 83.3% in 2023), and 90% have CD4 cell count above 200 cells/mm³. Retention in care had increased from 70.47% in 2021 to 76.13% in 2023. However, cases of syphilis rose from 18.1% in 2021 to 22.5% in 2023, in line with the ongoing syphilis epidemic in the US. Only 7.5% of women had abnormal Pap test in 2023 as compared with 8.3% in 2021. As the sole clinic providing fully integrated state-of-the-art oral health services at no cost to people with HIV (PWH) in Tennessee regardless of their primary HIV provider, MCWC had served 650 clients in 2,689 units during past 16 years.

Under contractual agreement, MCWC had served about 600 inmates living with HIV (64% Black or African American) throughout all Tennessee prisons over 21 years. In 2006, we pioneered telemedicine between Meharry and Tennessee prisons. This collaboration contributed to raising clinic attendance from 50% to 90% and viral suppression, from baseline 30% to 90% in 2020.

MCWC had received uninterrupted grant funding from Ryan White Part B since 2002, HRSA Ryan White Part C since 2003, Ryan White Part A since 2008, and HOPWA since 2016. In order to stretch the Ryan White grant dollars, MCWC expends its program income to further project objectives in priority areas of unmet need, such as nutrition and medical transportation; oral

health, ambulatory surgery, and women's health services; as well as coverage of ambulatory/outpatient specialty services for management of comorbidities, and co-pays of prescription drugs for underinsured, low-income individuals with HIV. The dental clinic was built out of several competitive HRSA grants supplemented by program income.

The prospect for new funding remains grim because of a large budget shortfall in the Tennessee Ryan White B program that required across-the-board budget cuts leading to a reduction of our annual budget by \$76,510.50 since 2021-2022 and planned termination of Part B funding for Part A grantees in 2026. Our Part C grant has been on freeze under Executive Order and HRSA has not issued the 2025 grant award yet. Therefore, Ryan White Part A had become lifesaving for people living with HIV in Nashville TGA.

2. Describe in detail the current HIV counseling and testing capacity of your organization, and any existing collaborative arrangements with other organizations within your service area that provide HIV counseling and testing services.

Clients who are diagnosed HIV positive at Meharry Community Wellness Center are linked and enrolled in care immediately. The same policy applies to those who test HIV positive in the Emergency Department or outpatient clinics of Nashville General Hospital. Newly diagnosed people who are incarcerated in local jails are referred to MCWC and seen in less than a week. Inmates of Tennessee Department of Corrections are referred to the clinic on the day of their release for medical insurance enrollment and linkage to care. All other individuals with HIV referred to MCWC are given an initial appointment within 1-7 days

Meharry Community Wellness Center (MCWC) uses its program income to provide targeted HIV counseling and testing. In 2023, we tested 75 high-risk individuals and found seven (9.33%) HIV-positive people, as compared to <0.5% in the general population. All these newly identified persons with HIV were enrolled in care and started taking antiretroviral treatment (ART) before leaving the clinic. Medical providers, EIS Worker, and Medical Case Managers (MCM) educate clients about HIV risk behaviors and effective strategies to prevent HIV transmission at each patient visit, using audio-visual materials, interactive tablets, brochures, and multi-disciplinary intervention. They counsel every person with HIV (PWH) entering care about the implications of HIV infection, the benefits and potential side-effects of antiretroviral therapy (ART), risk reduction and disclosure to sexual and/or needle sharing partners. They reinforce risk reduction messages and encourage clients to have their partner(s) tested every 3-6 months and enroll in PrEP if they're not virally suppressed. We also invite persons with high-risk HIV behavior to participate in our ongoing clinical trials such as the landmark Purpose 2 study conducted at Meharry under the leadership of Dr. Berthaud as Principal Investigator. This trial showed that twice-yearly injection of lenacapavir resulted in 96% protection from HIV transmission in MSM, transgender men, and non-binary persons.

MCWC has a track record of collaboration for HIV counseling and testing with multiple local and extramural partners such as: Nashville General Hospital, the Meharry Elam Mental Health

Center, the Meharry Medication-Assisted Treatment (MAT) clinic, and the Meharry Clinics; Davidson County Sheriff Office, Tennessee Department of Corrections, United Neighborhood, Matthew Walker Comprehensive Health Center, Street Works, Nashville CARES, Vanderbilt University Medical Center, Ascension St Thomas Health, and Metropolitan Nashville Health Department; long-term care facilities like, Bordeaux Nursing Home and Whites Creek Nursing Home, as well as drug treatment centers (Cumberland, Samaritan), and Middle Tennessee Mental Health Institute.

3. Describe in detail how the proposed project fits with your agency’s mission and capabilities.

As an annual Tennessee-designated AIDS Center of Excellence since 2006, Meharry Community Wellness Center (MCWC) focuses on eliminating health inequities in HIV/AIDS, advancing HIV/AIDS awareness, transformative education, and transdisciplinary research, strengthening community outreach and partnership, and providing exceptional and compassionate health services. Our mission aligns with the overall mission of Meharry Medical College to empower diverse populations to improve the well-being of humankind. Our vision aligns with the vision of the National HIV/AIDS Strategy and the White House Ending-the-Epidemic Plan. Meharry has been providing mental health services to people living with HIV for over 40 years and Meharry Community Wellness Center had done so for 20 years. This proposed Mental Health project fits our mission and capabilities to address unmet need in outpatient/ambulatory care for underserved persons living with HIV in the Nashville Transitional Grant Area (TGA). Although Meharry Community Wellness Center serves the hardest-to-reach populations of persons with HIV in Middle Tennessee, as aforementioned, our retention in care had reached 76.13% in 2023. During the most recent decade, viral load suppression had substantially improved for all subpopulations, especially youth, young adults, and MSM, the risk categories with the highest incidence of HIV in our clinic (47.1% for MSM). In fact, MSM achieved the highest rate of viral suppression in 2024, a reflection of our cultural competence, coupled with non-judgmental, customer-friendly, and compassionate HIV care.

Viral Suppression by Subpopulation (%): 2015-2024			
Subpopulation	Year		
	2015	2019	2024
White	75.61	73.85	81.82
Black or African American	73.14	75.58	82.48
Hispanic/Latino	81.25	83.33	80.49
Youth (13-24)	51.85	74.19	80.00
25-34	63.22	71.57	84.38
35-54	76.52	74.88	79.79
55+	82.83	81.82	83.72
Women	72.00	77.39	79.81
Men	68.9	70.79	80.78

MSM	63.27	72.73	85.71
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Source: CAREWare 230

4. Describe in detail how your background, mission and experience contribute to the ability of your organization to conduct the proposed project and meet the expectations of the program requirements. In addition, Metro Health may conduct pre-award on-site visits to determine if the contractor's facilities are appropriate for the services intended.

Meharry is the oldest provider of HIV care in Tennessee, dating back the beginning of the epidemic in 1981. Under the leadership of its Founding Executive Director, Dr. Vladimir Berthaud, Meharry Community Wellness Center (MCWC) had earned the annual designation of Tennessee AIDS Center of Excellence continuously since 2006 and grew exponentially, thanks to multiple funding streams including several Ryan White grants. MCWC had become a beacon of hope and comfort for persons with HIV, affected by stigma, discrimination, social injustice, and health inequities. For current grant year ending on February 28, 2025, our mental health grant had already beaten the expectations of program requirements as illustrated by the projected number of clients to be served and the number of service units (projected number: 24/actual: 95 and projected units: 42/actual: 1623). A multidisciplinary team of experienced and highly-qualified staff provide person-centered, multidisciplinary, holistic health services of the highest quality. Daily patient surveys denote an average satisfaction rate of 95%. As a testament of our performance, HRSA had selected MCWC to host the first National Meeting on HIV in Rural Areas in 2019 and one of three US sites that conducted the Special Project of National Significance (SPNS), "Dissemination of Evidence-Informed Interventions: Peer Linkage and Re-engagement of Women of Color", 2016-2019. The Project-derived manual is available at: <https://www.targethiv.org/deii/deii-peer-linkage>.

II. Organization Capacity:

1. Provide copies of the following:

- Resume and job description of proposed Finance Manager
- Organizational chart for your agency; chart must clearly include the program components funded by Part A/MAI.
- Copies of most recent State Licensure or Accreditation for relevant services.
- Articles of Incorporation.
- Documentation of 501(c) 3 designation.
- Current State of Tennessee Charitable Solicitations Letter.
- System for Award Management (SAM) exclusion report.

All these documents are uploaded.

2. Describe agency's experience in administering federal, state and/or local government funds. Include funding source(s) and number of years administering those funds. Provide information for the following:

- **Agency restrictions from receiving federal funds or placed on restrictive measures in the last five years (e.g., increased reporting, increased monitoring visits), please explain.**

Meharry has no restrictions from receiving federal funds. It has never been placed on restrictive measures in the last five years or during its existence.

- **Corrective action plan(s) in the last three years from any funding source, please describe (include the name of the funder, overview of issues identified and the current status of addressing the identified issues and/or recommendations).**

In 2024, HRSA conducted a site visit and identified the following issues: documentation of coordination and linkages with CDC and Prevention-funded HIV testing and outreach services of federally qualified health centers in the service area; documentation of training for HIV care and treatment of all non-clinical staff, documentation of sexual practices of women; demonstration of full implementation of the time and effort policy and the caps on charges; and documentation for allocating program income according to each Ryan White Program grant. All these issues have been corrected except the time and effort policy. The Office of Grants and Contracts is updating the Workday system and recruiting additional personnel to ensure any issues related to time and effort are fixed soon.

- **Audit finding(s) in the last three years. Please describe an overview of issues identified and the current status of addressing the identified issues.**

In 2024, HRSA audited our Ryan White Part C EIS grant and identified the following issues: documentation of coordination and linkages with CDC and Prevention-funded HIV testing and outreach services of federally qualified health centers in the service area; documentation of training for HIV care and treatment of all non-clinical staff, documentation of sexual practices of women; demonstration of full implementation of the time and effort policy and cap on charges; and a clear policy for allocating program income according to each Ryan White Program grant. All these issues have been corrected except the time and effort policy. The Office of Grants and Contracts is updating Workday system and recruiting additional personnel to ensure any issues related to time and effort are quickly fixed.

- **If Contractor(s) is currently a Ryan White Part A provider, an administrative review will be conducted of the previous year's spending of grant funds and will be included as part of the score. If Contractor(s) is not a current Ryan White Part A provider, Contractor(s) must provide a letter of reference from a funder to include a description of Contractor's performance in spending allocated grant funds. This letter will be included as part of the score.**

Not applicable.

- **Submit copies of most recent A-122 Audit (for the last reporting year) conducted by an independent certified public accountant or 990 form, if not required by federal regulations to complete an A-122 Audit.**

An independent CPA firm, Crosslin Certified Public Accountants, had audited the accompanying consolidated financial statements of Meharry Medical College and Subsidiary (collectively the “College”), which comprise the consolidated statements of financial position as of June 30, 2023, and 2022, and the related consolidated statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the consolidated financial statements. In their opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the College as of June 30, 2023, and 2022, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America. (see Attachment: Most Recent Financial Audit, Final Consolidated A133 Financial Statement June 2023).

3. **Describe agency’s current system for collecting data on client demographics, service utilization and performance data. Include all software used to collect this data, staff resources for data collection and hardware resources.**

Staff resources. The Program Director, Dr. Berthaud, serves as Data Manager, assisted by biostatistician, Derek Wilus, MS. They perform duties such as quality management initiatives, data analysis, and dissemination of results, and staff training. The Program Director integrates all audits and performance evaluations into the overall strategic planning and Ryan White programs operations. He facilitates collaboration with statewide, local, and national quality improvement projects. Dirk Francis, Data Center and System Administrator for Meharry Office of Information Technology (OIT), manages the CAREWare server and maintains the software, while Lee Nelson, MBA, Health Information Technology Director, is responsible for managing E-Clinical Works (our electronic health record system) and interfacing with CAREWare (the primary source of data reports).

Data infrastructure. CAREWare™ forms the backbone of our robust information system. Our data repository relies on three separate layers of security. The CAREWare network connects to a dedicated server housed in a highly secure and restricted basement location in the Office of Information and Technology (OIT), monitored by video camera and on uninterrupted electric power supply 24/7. Meharry OIT has designated a qualified technician, Dirk Francis, to manage the CAREWare server in collaboration with MCWC Program Director.

Data operations. Since 2003, Meharry has been using Microsoft SQL server and the most recent CAREWare version as the primary tool for Ryan White data collection, HRSA-required performances measures and programmatic reports. All MCWC staff use CAREWare and enter data elements in real-time. MCWC had created over 180 customized reports in

CAREWare to facilitate data queries and special reports. Moreover, we had developed CAREWare instruments to describe the graphic time course of individual lab variables including CD4 cell count and viral load and designed a unique platform to capture social determinants of health, monitor and evaluate community health care delivery. We have modified CAREWare to allow for attachment of external medical, personal and legal records as well as patient's clinical documents including radiographs and intraoral pictures. MCWC had installed data quality and validity checks for duplicated, missing, discordant, and unknown key data elements to enhance accuracy of reports. A validity check is run prior to submission of reports. All HRSA-required reports including performance measures are readily available in CAREWare and can be created instantly. The Assistant Data Manager, Derek Wilus, MS, biostatistician, uses IBM SPSS or R Studio for more complex data analyses.

Data backup design. Meharry OIT backs up the data daily on extra-large capacity servers and digital tapes. Then, an independent contractor picks up the tapes daily and stores them away from the campus to safeguard them against major disasters and catastrophes such as floods, hurricanes, fire, and powerful earthquakes. The Program Director verifies that CAREWare posts daily messages to check the exact time of each data backup completion.

Original Data: The original data, also referred to as the live production data, resides on the HP Synergy Blade system, stored as a VM, with snapshots taken hourly, and stored on the Nimble CS5000. The snapshots are stored for 7 days.

Tier 1 Storage - The tier 1 backup occurs nightly and writes to a second Nimble array, the CS235. This data is stored for 90 days.

Tier 2 "off-site" Storage - Once weekly, the data is copied from the CS235 to a tape backup solution that is rotated off-site weekly. This data would be stored for 180 days.

Additional data safety and security procedures. Each Meharry desktop and laptop are configured to provide optimum security and reliability. OIT monitors each user's activities and downloads automatically the most recent security updates to all Meharry desktops connected to the network, daily, and screens all emails for SPAMs and phishing messages instantly. Meharry students and employees access the network with a personal username and secured password that is required to be changed regularly.

Software platforms. Meharry has adopted the electronic health records system, E-Clinical Works™, across the campus. The software suits for clinical notes, mobile applications, and Physician Quality Reporting Systems (PQRS). However, its capacity to generate customized reports is limited, complex, and provider-restricted, time-consuming, and costly. Medical providers enter their clinical notes and services in E-Clinical Works, also available on their smartphones app. LabCorp will export the lab tests results in E-Clinical Works as soon as they are available and alert the clinicians on critical values immediately. The HL7 platform and the "socket" allow for seamless export of LabCorp results into the CAREWare labs

section. External health records are either faxed or exported into E-Clinical Works using compatible electronic software. A patient portal is available in E-Clinical Works for better self-management and interaction with medical providers. The patient portal is also accessible via smartphone app. MCWC utilizes E-Clinical Works to submit third party billings and track service charges. Both E-Clinical Works and CAREWare are fully secure and HIPAA-compliant. MCWC staff attend mandatory training on compliance with HIPAA, federal and State, as well as Meharry regulations on patient personal health information. MCWC had developed a user-friendly iOS app that allows the quick calculation of odds for a person with HIV to achieve viral load suppression, based on our landmark publication in BMC Infectious Diseases in 2022.

4. Describe agency's system for managing fiscal and accounting responsibilities. Address the following:

- **Define who oversees this area, what staff is responsible for these activities.**
- **Identify what software is used to manage financial information.**
- **Describe the accounting system that is in place; and**
- **Describe the internal systems that are used to monitor grant expenditures and track, spend, and report program income generated by a federal award.**

Meharry Community Wellness Center (MCWC) had received uninterrupted grant funding from HRSA Part C EIS, Ryan White Part B, and Ryan White Part A for 21, 22, and 17 years, respectively. The Finance Manager, Zudi Takizala, MD, MPH, MBA, is uniquely qualified to oversee fiscal and accounting operations. She brings 21 years of experience in grant administration. In the past three years alone, she had successfully managed 18 public grants including 10 Ryan White grants. MCWC carries a current grant portfolio of about \$3,000,000.00 including grants from NIH/NIAID, HRSA, HOPWA, PEPFAR, and Ryan White Part A and B. Having managed thousands of Federal, State, and local grants and contracts for over 100 years, Meharry is strongly qualified to manage this project. To track and manage grants and contracts, the College uses an accrual method of accounting incorporated into the Banner software and Workday system. The Office of Grants and Contracts works closely with each program and department to assure that budget matters are appropriate and understood. Meharry retains a CPA firm to conduct annual audits and interim financial reports for program planning and implementation. All Meharry fiscal audits had no findings. Additionally, appropriate internal controls including an internal auditing process are in place and assist the College to anticipate and plan more effectively. The Department of Internal Medicine is primary responsible to oversee grant management and the delivery of clinical services. Meharry Medical Group (MMG) supervises the delivery of clinical services, performs billing, collection of charges, and tracking, and reporting of program income to the Project Director. The Office of

Human Resources oversees the hiring process, reviews job descriptions and proposed salaries, assists in background checks, job offers and staff training. The Compliance Office reviews contracts and agreements to ensure compliance with the law. The Office of Grants Management oversees Ryan White programs, ensures that current practices align with federal and State legislation, and that Ryan White funds are expended according to program budget, goals, and expectations. It works closely with MCWC and provides monthly grants expenditures reports to assure disbursements align with program goals and objectives. MCWC and the Office of Grants and Contracts hold monthly financial meetings with Ryan White Part A leadership. The Office of Finance verifies that MCWC manages Ryan White grants according to Generally Accepted Accounting Principles (GAAP). MCWC segregates Ryan White contracts, public, private, and other types of medical insurance in CAREWare to allow for easy tracking and accurate financial report using the service fees and units determined by Ryan White Part A Program. MCWC reinvests program income (billings collections from third-party payers and 340B pharmacy revenues) into overall budget to further program goals and objectives and cover ambulatory out-of-pocket expenses of low-income, underinsured clients. The Program Director reports the program income quarterly to Ryan White Part A and B. The Director of the Office of Grants and Contracts reports annual program income to HRSA via the Federal Financial Report (FFR).

5. Describe agency's process for completing program reports in a timely and accurate manner. Include descriptions of how responsibility for reporting is assigned to staff, how reports are reviewed for accuracy and who assures reports are completed on time.

MCWC staff enters data in CAREWare in real-time. The Program Director had created over 200 customized reports in CAREWare that allow for quick data analysis and reports, research advancement, and deeper understanding of program outcomes. These customized CAREWare reports also comprise data validation, quality checks, for duplicate, missing, and unknown data. CAREWare is able to create a list of all clients with missing/unknown, or duplicate data for the responsible staff to correct. Prior to submitting any reports, a quality check is run again to identify errors, warnings, and alerts needed to be fixed. All Ryan White required periodic reports and performance measures are embedded in CAREWare, i.e. Ryan White Service Report (RSR), Provider Data Export (PDE), program financial and service reports, etc.

III. Cultural and Linguistic Competency:

As a person closely affected by HIV himself, Dr. Berthaud has dedicated his professional career to improve and save the lives of people with HIV in New York, Tennessee, Latin America, Africa, and the Caribbean. He attributes high priority to cultural and linguistic competency. MCWC staff are trained in cultural competence, cultural humility, and trauma-informed care, and motivational interview. Six of our full-time staff are themselves people living with HIV for over 20 years. Sixty percent of our staff have been affected by HIV, and 70% live in the community

they are serving. Client feedback is obtained daily through anonymous satisfaction surveys and quarterly from the Consumer Advisory Board (CAB). The CAB Chair attends our weekly staff meetings, which reserves ample time for discussion of CAB concerns and the results of patient satisfaction surveys including corrective actions, implementation, and monitoring plan. MCWC leadership incorporates the final recommendations into program operations, specific projects, and/or grant applications. Educational materials are created according to the fifth-grade level based on health literacy research conducted at Meharry Community Wellness Center. Interpretation and translation services are readily available for all languages through a contractual agreement paid for by Meharry Medical College. All MCWC Medical Case Managers are well-trained College graduates, with at least a Master degree, and very familiar with underserved communities, HIV issues, and Ryan White programs.

IV. Collaboration:

- 1 Describe a plan for creating a new or improving an existing network to improve collaboration with HIV agencies that will link PLWHAs to HIV testing and HIV medical care and support services. If applicable, identify any collaborating organizations that will assist the applicant through HIV testing and linkage to HIV medical care and services.**

Linkage of newly identified clients: Patients who diagnose HIV positive in the emergency department (ED) at Nashville General Hospital (NGH), located on the Meharry campus, are linked and enrolled into care the same or next business day. HIV providers and Medical Case Managers follow newly diagnosed persons with HIV (PWH) admitted to NGH and coordinate their discharge disposition. Clients newly identified outside the Meharry campus are linked as soon as possible, preferably within less than 7 days. The Patient Service Representatives (insurance verification), the Community Health Workers (coaching and navigation), and the Medical Case Managers (insurance assistance and Ryan White eligibility) are responsible for rapid linkage.

MCWC organizes outreach events with local partners including Metropolitan Nashville Health Department to raise HIV awareness and promote testing. As member of Nashville PrEP Coalition, MCWC facilitates the rapid linkage of newly diagnosed persons. It also leverages its experience as a research site for the SPNS project targeting newly diagnosed and out-of-care women of color for linkage and retention to enhance engagement in care. As a pioneer of HIV telemedicine in TN prisons and HIV consultant for Davidson County jails since 2006, MCWC facilitates the transition of ex-offenders to rapid linkage and engagement upon their release in the community.

Main referral relationships and collaborations include the following: Nashville General Hospital (NGH), Meharry teaching hospital, where Dr. Berthaud serves as Director of Infectious Diseases and Dr. Livette Johnson co-chairs the Infection Prevention Committee; NGH refers PWH from Emergency Department, inpatient, and outpatient clinics; Meharry Elam Mental Health Center, Meharry Family Medicine and MAT Clinic, located right across the hall from MCWC, and Meharry Clinics constitute regular sources of mutual referrals; Davidson County Sheriff's Office refers inmates with HIV to MCWC since 2005, while Tennessee Department of Corrections

refers them for telemedicine consultation, a service established by Dr. Berthaud in 2006; Neighborhood Health, the largest FQHC in Davidson County, Ascension St Thomas Health (Dr. Berthaud maintains consultation privileges), and Metropolitan Nashville Health Department, the largest HIV testing center in Nashville, represent important referral sources. Metropolitan Development Housing Authority awarded a HOPWA grant for the provision of Short-Term, Rent, Mortgage, and Utilities assistance. Street Works and Nashville CARES provide medical case management, food and housing services including permanent placement and emergency shelters. Second Harvest provides low-cost preserved food for our pantry. Vanderbilt University Medical Center provides emergency, specialty ambulatory, and inpatient care for MCWC clients. Tennessee Health Department had contracted with Meharry for ambulatory/outpatient and medical case management services. They provide technical support to medical case managers and assist in linkage/reengagement of clients lost to care. Metropolitan Nashville Public Health Department (MNPHD) refers newly diagnosed HIV-positive and lost-to-care people, treats persons with latent and active tuberculosis, and coordinates STD management and control. Under MNPHD sponsorship, Meharry received a Part A grant for core and support services. Meharry Elam Mental Health Center collaborates with MCWC Therapist/Drug Counselor on outpatient and inpatient drug treatment, detoxification, and rehabilitation. Meharry and Vanderbilt had signed a Data Usage Agreement for expanding participation of minorities in clinical research through the NIH-funded TN Center for AIDS Research (TN-CFAR), a joint venture including Nashville CARES and TN Health Department.

- 2 Contractor(s) must demonstrate their commitment to work with or collaborate with organizations representing the HIV/AIDS community through a signed and dated letter of support or memoranda of agreement or understanding. The letter must specify example activities that each entity provides that will help connect high risk clients to HIV testing and services.**

Meharry has been providing mental health services to people living with HIV for over 40 years and Meharry Community Wellness Center (MCWC) had done the same for 20 consecutive years. MCWC had established a strong relationship with Meharry Elam Mental Health Center since inception. MCWC Mental Health services are always provided by a psychiatrist from the Elam Mental Health Center. The current psychiatrist is Dr. Osa-Edoh, Director of Elam Mental Health Center. Our Clinical Psychologist, Dr. Erlete Ascencao, worked at the Elam Center for over 12 years, and Ronda Jennings, the Therapist, worked there for two years. Elean Whitlow, Drug Counselor, and Trevon Kelley, Case Manager, both at Elam Center, were MCWC staff for two years. Meharry Community Wellness Center, Street Works, and Nashville CARES have a longstanding collaborative relationship. Dated signed letters that specify example activities that each entity provides that will help connect high risk clients to HIV testing and services are uploaded.

B. Reference Projects (10 Points) Service History & References:

- 1. If your agency currently provides this service(s) to the HIV/AIDS client population,**

describe the number of years you have provided this service and the funder of the service. Please provide a reference name and phone number.

Meharry Medical College has been providing ambulatory/outpatient and mental health services to persons with HIV since the initial outbreak in 1981, i.e., even before the virus was discovered. Meharry Community Wellness Center (MCWC) opened in 2005 with funding support from Ryan White Part B and Part C to provide mental health and ambulatory/outpatient services. Ryan White Part A support started right after Nashville became an Emerging Metropolitan Area (EMA) in 2008. However, TN Health Department will terminate funding for grantees who receive Part A funding, starting in April 2026. Our Part C grant has been on freeze under Executive Order and HRSA has not issued the 2025 grant award yet. Therefore, Ryan White Part A funding had become lifesaving for people living with HIV in Nashville TGA.

For reference, we mention the name of our Part C EIS Project Officer
Christie Slay, MPA, MAEd, CHES, Public Health Analyst/Project Officer, Central
Branch, Division of Community HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, Rockville, MD 20857
Phone: 301.443.0504

2. If your agency does not currently provide service(s) to the HIV/AIDS client population, explain any related experience that would demonstrate the agency's competency in providing services to this population. Please provide a reference name and phone number.

Not applicable.

3. Describe any related experience that would demonstrate your agency's competency in providing HIV medical or support services to this population. Please provide a reference name and phone number. The file is limited to 5 pages and should be in PDF format entitled "Reference Projects."

The file labelled "Reference Projects" had been uploaded.

Here's the reference name and phone number:

Part C EIS Project Officer
Christie Slay, MPA, MAEd, CHES, Public Health Analyst/Project Officer,
Central Branch, Division of Community HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, Rockville, MD 20857
Phone: 301.443.0504

A. Project Approach and Process (30 Points)

I. Staffing:

Present in detail your organization's staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the number of time/hours per month being requested for each proposed staff position.

Mental Health Services

Staffing Plan of Key Personnel

Staffing Plan of Key Personnel				
Name	Roles	Responsibilities	Education/Training	Experience Part A FTE
Vladimir Berthaud, MD, MPH, FACP, FIDSA, DTMH, CPH	Project Director	Supervision of overall activities; HIV care and infectious diseases services	Board-certified in internal medicine, infectious diseases, public health, tropical medicine, and traveler's health.	International HIV expert with 39 years of experience in HIV care, research, training, teaching, program development, and implementation worldwide.
Zudi Takizala, MD, MPH, MBA	Finance Manager	Project management and CQI	Doctor of Medicine, with master's degree in public health and business	21 years of experience in management of \$30M in Federal, State, & local grants
Keisha Ashmeade Ed.D, MSPH, FNP, AHIVS	Clinic Manager	Manages clinic operations	HIV specialist and Board-certified NP	11 years of HIV care experience
Sheena S. Simon, DNP, APRN, NP-C	Primary HIV care provider	Comprehensive HIV management	Board-Certified Nurse Practitioner, specialized in prevention	22.44% FTE Six years of HIV care experience
Ethel Harris, DDS, MPH	Director of oral health services	Comprehensive oral care and prosthodontics	Meharry graduate, former Director of SEATC oral health	22 years of experience in oral health for PLWH
Ryan White Part A Staffing Plan				
Name	Roles	Responsibilities	Education/Training	Experience Part A FTE
Livette Johnson, MD	Infectious diseases management	HIV and specialty care	Meharry graduate, Board-certified in internal medicine	40% FTE

			and infectious diseases	35 years of experience and expertise in HIV care
Sheena S. Simon, DNP, APRN, NP-C	HIV care provider	Comprehensive HIV management	Board-Certified Nurse Practitioner, specialized in prevention	35% FTE Six years of HIV experience
Debra Simmons, LPN	Phlebotomist	Process laboratory specimens and perform nursing duties	Graduate of Baptist Hospital LPN School	50% FTE 9 years of experience serving PLWH
Maya Johnson, BS, MPH	Community Health Worker	Coaching, adherence counseling, patient navigation, community case management	MPH graduate from Meharry, with solid knowledge of SPSS, SAS, Redcap, GIS, and Microsoft environment	75% FTE One year of experience with PLWH
Tamiko Grimes	Community Health Worker	Coaching, adherence counseling, and patient navigation	Trained Peer Counselor and Community Health Worker	100% FTE 9 years of experience with PLWH
Osamudiamen Osa-Edoh, MD, MPH	Psychiatrist	Treatment of behavioral & substance use disorders	Board-certified psychiatrist, Director of substance use treatment at Meharry	15% FTE 10 years of experience with PLWH
Erlate Ascencao, PhD/PhD, HSP	Clinical Psychologist, Social Scientist	Specialized in HIV clinical psychology services	Doctor in Social Sciences and Clinical Psychology, Licensed Health Services Provider	100% FTE 22 years of experience with PLWH
Ronda Jennings, MA	Senior Medical Case Manager	HOPWA Case Manager, Mental health therapy and drug counseling	Master' degree in Clinical Counseling, Certified Alcohol and Drug	64.29% FTE 17 years of experience in medical case management and

			Addiction Counselor	counseling with PLWH
JaRae Davenport, BS, MPH	Medical Case Manager	Medical case management services including treatment adherence	Master’s degree in public health practice	100% Three years of experience in medical case management under Part A grant
Kaye Chavis, DBA	Medical Case Manager	Medical case management services including treatment adherence	Doctoral degree in Business Administration	90.02% 4 years of experience with PLWH and Ryan White Part A grant 23 years’ MDHA experience

Qualifications of Key Personnel.

Vladimir Berthaud, MD, MPH, FACP, FIDSA, CPH, DTMH, is tenured professor of medicine, Director, Division of infectious diseases at Meharry Medical College and Nashville General Hospital and Founding Executive Director of Meharry Community Wellness Center. He completed his infectious diseases fellowship at Columbia University and Cornell University in New York. Dr. Berthaud has been a passionate advocate for PLWH and the recipient of numerous prestigious awards including IPRO’s Outstanding Service to the Health Care Community Award for Quality Improvement in reducing Disparity for Adult Immunizations in New York State, Award for Outstanding Contribution to the Internal Medicine Training Program, Harlem Hospital/Columbia University College of Physicians & Surgeons, New York City Council Citation for Exemplary Service, National Library of Medicine/Marine Biological Laboratory, Fellowship Award in Medical Informatics, Nashville Business Journal, Award Honoring Superior Contributions to the Health Care Industry, Johnson & Johnson UCLA Healthcare Executive Management Award, Street Works Guiding Light Award, and Mahogany Honors Dwayne Jenkins Lifetime Achievement Award. Part C EIS Program Director for 20 years, Dr. Berthaud serves as Project Director/Principal Investigator for Meharry HIV Research and Training Facility, Mentor and Investigator for the NIH-funded U01-Practice-Based Research Integrating Multidisciplinary Experiences in Dental Schools (PRIMED), Associate Director of Clinical Discovery Core, for TN-CFAR, Clinical Lead for Meharry PEPFAR, and Program Director for HRSA-sponsored National HIV Residency Pathway Consortium. He has been a member of the Tennessee AIDS Centers of Excellence Committee since 2002. Other experiences include Train-of-Trainer Expert for the National HIV Curriculum, HIV Trainer for the National MTCT-Plus Program in Rwanda and Côte d’Ivoire, HIVAIDS Curriculum Developer for NIH/ACTG/HPTN in Latin America and the Caribbean and HIV Preceptor for IDSA International AIDS Training Program, HIV Curriculum Reviewer for CDC, and scientific advisor to CDC Program for TB Elimination, member of the National Board of Public Health Examiners, and of the National Board of Medical Examiners, Academic Advisor, UCLA School of Management, Community Health Improvement Program, and Member, American College of Physicians (ACP) Leadership Academy. Former member of

the Leadership Conference and Admissions Liaison Officer, United States Military Academy at West Point, past Chair of The George W. Counts Interest Group of the Infectious Diseases Society of America (IDSA), past member of IDSA Leadership Development Committee, Dr. Berthaud is a member of the American Board of Internal Medicine Infectious Diseases Task Force and Faculty of the IDSA Leadership Institute. He was a Lead Principal Investigator for the international Kid COVE Vaccine Trial. Dr. Berthaud is Endowed Professor of Medicine, with Adjunct appointment in Microbiology, Immunology, and Physiology. He is Academic Editor for PLOS ONE medical journal and the author of many peer-reviewed publications in impactful scientific journals. Dr. Berthaud is fluent in Spanish, French, English, and Creole.

Livette Johnson, MD. A native Nashvillian and a graduate of Meharry School of Medicine, Dr. Johnson completed her internal medicine residency training at Johns Hopkins University in Baltimore and her infectious diseases fellowship at Cornell University in New York. She holds Board certification in internal medicine and infectious diseases. Dr. Johnson is associate professor of medicine at Meharry Medical College and Vice Chair of Infection Prevention Committee at Nashville General Hospital. Dr. Johnson served as attending physician at Mount Sinai Hospital and Assistant Chief of Infectious Diseases at Metropolitan Hospital in New York. She brings a personal dedication to the care of PLWH.

Zudi Takizala, MD, MPH, MBA. Doctor of Medicine with extensive experience in grant administration, financial management, and staff supervision, Dr. Takizala has a long record of collaboration with diverse internal and external stakeholders, community agencies, and Ryan White programs. She oversees clinical operations at Meharry Community Wellness Center. In the past three years, she has successfully managed 18 public grants including 10 Ryan White grants, and others from NIH, HOPWA, PCORI, Tennessee State and Metropolitan Nashville government.

Keisha Ashmeade, ANP, MSN, MSPH, Ed. D, AAHIVS, board-certified advanced nurse practitioner and certified HIV specialist, Dr. Ashmeade has been Clinical Manager of Meharry Community Wellness Center for seven years. She brings 10 years of experience in HIV primary care and seven years of teaching experience as Assistant Professor.

Osamudiamen Osa-Edoh, MD, MPH is American Board-certified psychiatrist, Director of Meharry Elam Mental Health Center. He is quite familiar with behavioral and substance use disorders among people with HIV.

Erlete Ascencao, PhD/PhD, HSP, Clinical Psychologist and Social Scientist, nationally recognized as multicultural expert, and trainer for TN Health Department and Tennessee State University graduate studies in Clinical Psychology, fluent in English, Spanish, and Portuguese. She supervises the Medical Case Managers and the Therapist weekly and participates in the Community Care Team meetings twice a week. She is the recipient of many prestigious VA awards for quality performance.

Ronda Jennings MA, BS, Senior Medical Case Manager and Therapist/Drug Counselor,

former Program Director at Street Works and Administrator at Elam Mental Health Center, brings 16 years of experience working with people living with HIV.

If applicable, describe in detail the roles and responsibilities of any consultants and/or subcontractors will be used to conduct aspects of the proposed project.

This is not applicable.

II. Overview of Population:

Describe in detail the HIV/AIDS population in Davidson County. Describe in the detail the issues that interfere with identifying, engaging, and retaining PLWHAs in routine HIV testing and HIV services.

HIV/AIDS population in Davidson County.

Meharry Community Wellness Center stands at the epicenter of the HIV epidemic in Nashville, in the heart of Davidson County, more specifically, North Nashville, the neighborhood most densely populated in Blacks or African Americans (71%) where 1,933 of every 100,000 people are living with HIV as compared to 978.7 for Blacks in the remaining Nashville Transitional Grant Area (TGA). The TGA had an estimated population of 1,742,588 in 2019, accounting for 26.5% of the state's total population and 31% of the state's people living with HIV (PLWH). In the thirteen counties that make the Nashville Transitional Grant Area (TGA) including Davidson, non-Hispanic Blacks account for 54% of PLWH and in 2021, they represented 27% of Davidson County's population and 52.4% of PLWH. While about 39% of the Nashville TGA's population lives in Davidson County, 76.5% of the PLWH population reside in Davidson County. Of this PLWH population, 20% had been in jail and 42% were homeless/unstably housed at some point in the last year, and 40.2% did not have food to eat three or more days at some point in the last year. Fear of disclosure (50.6%) represents the number one barrier to accessing services (Metropolitan Nashville Health Department). In Nashville TGA, an estimated 17% of PLWH are unaware of their status. In 2020, 66% of newly diagnosed cases were linked to care in 30 days, 54% were retained, and 66% achieved viral suppression. Among Non-Hispanic Blacks, 64% were linked to care within 30 days, 54% were retained and 63% became virally suppressed, and they had the highest incidence of Chlamydia, gonorrhea, and syphilis. Meharry Community Wellness Center (MCWC) serves the most vulnerable and hardest-to-reach PLWH in Tennessee. In 2024, our program served 484 unduplicated clients. African Americans accounted for 77.06%, women 26.44% and MSM 42.35%. Our clients bear an excess burden of uninsured (39.25%), poverty (48.96% below 100% FPL), and history of incarceration (20%), homelessness (19.2%, higher than in Davidson's 13.6%), and substance use and behavioral disorders (30%). More than 70% of our clients did not graduate from high school. Our proportion of clients experiencing homelessness represents more than twice the national average for PLWH (8.4%) and is 50% greater than the national Ryan White average (12.9%). According to the Brookings Institution, North Nashville has an incarceration rate of 14%, by far the highest in the country, and 93% of those incarcerated are Blacks. Our patient population has an alarming prevalence of severe tooth decay (60%) and severe

periodontitis (30%). Meharry Community Wellness Center (MCWC) represents the only Tennessee clinic that offers unfettered access to fully integrated, comprehensive oral health services for low-income PLWH regardless of their primary HIV care providers. The Tennessee Ryan White Dental Assistance Program (RWDAP) ran out of funding in April 2019 and left 1,800 clients with very limited or non-existing access to oral health services. Only 10% of our clients have dental insurance coverage and just 2% of them have adequate coverage. Since 2023, TennCare offers limited oral health benefits to eligible clients. So far, they have not referred any patients to our dental clinic. The prospect for new funding remains grim because of a large budget shortfall in the Tennessee Ryan White B program that required across-the-board budget cuts leading to a reduction of our annual budget by \$76,510.50 since 2021-2022 and termination of funding for Part A grantees in 2026.

Issues that interfere with identifying, engaging, and retaining PLWHAs in routine HIV testing and HIV services.

Gaps in local services. Major gaps in MCWC/TGA HIV care continuum, retention, and viral suppression, can be attributed to high rates of incarceration (20%), homelessness (MCWC 19.2%; TGA 13.8%), and poverty (39.25% below 100% FPL), behavioral and substance use disorders (30%), and chronic comorbidities such as cancer, cardiovascular diseases, chronic kidney and lung diseases. Moreover, gaps in medical and dental insurance coverage, TennCare restrictions on the number of monthly prescriptions, and food shortage, lack of family support as well as stressful life events too often lead to poor treatment adherence and negative health outcomes such as HIV disease progression, exacerbation of comorbidities, frequent visits to specialty clinics, emergency department and admissions to the hospital, mental institutions, and drug treatment centers. Huge gaps persist in oral health, substance use disorders, medical transportation, and housing services.

Major Barriers to Care:

Incarceration: Of 516 inmates with HIV served by MCWC from 2003 to 2018, 64% were Black or African American and 66% aged 45-64. Stepwise implementation of telemedicine in 2006 led to increase in clinic attendance from 50% to 90% and viral suppression from 30% to 90% (Berthaud V. 2022 National Ryan White Conference). Of PLWH incarcerated in Davidson County jails, Non-Hispanic Blacks account for 71% and non-Hispanic Whites 29%. North Nashville has an incarceration rate of 14%, the highest in the country by far, and 93% of those incarcerated are Blacks. In other words, one in seven people who were born in the primary zip code of North Nashville between 1980 and 1986 went to jail or prison at some point in their lives. (Adams L, Nicholas T: Work and opportunity before and after incarceration. The Brookings Institution, March 2018). Twenty five percent of our patients reside in that neighborhood and 41% of them belong to this age group. MSM is still the most frequent means of exposure accounting for 37.5%, and IDU the second most reported exposure category among the jail population (22.1%). Heterosexual exposure accounts for 18.9% of PLWH in jail and MSM/IDU account for 6.3% of the cases; unreported exposure accounts for (15.1%). (Source: Nashville Metropolitan Health Department). Meharry Community Health Worker had established a strong collaborative relationship with Tennessee Department of Corrections (TDOC) and Davidson County Sheriff's Office (DSCO) for over 20 years. Persons with HIV who are incarcerated in DSCO are referred to MCWC for

in-person care, while inmates of TDOC are seen by telemedicine.

Transportation: Public bus service in Nashville is extremely limited to some parts of downtown and very few stops in North and West Nashville. It nearly does not exist in South and East Nashville. Most of our patients resides far away from a bus stop. They require multiple transfers to come to the clinic or simply rely on a ride with a relative or a friend. The bus service makes short stops every hour between 8:00am and 4:30pm. There is no subway line in Nashville and Tennessee. MCWC had hired a full-time person to provide free round-trip medical transportation in the Transitional Grant Area (TGA).

Education: High school completion rate is 76% in Davidson County and 15% at MCWC.

Unemployment and poverty: 39.25% of Meharry clients had an annual income <100% FPL in 2023. Unemployment rate reached 60% and 30% were receiving Social Security Income. Drug and alcohol: Addiction to drugs and alcohol remains a significant risk factor for poor nutrition and treatment adherence, bad health outcomes, incarceration, and homelessness. However, there are insufficient access points to drug detoxification and rehabilitation in Davidson County. Many offenders released on parole or probation cannot get into drug or alcohol treatment. Consequently, they are often re-incarcerated for parole or probation violation. Periodic mandatory report to parole or probation officer had become their major competing priority. Moreover, many African Americans had switched from injection drugs to cocaine snorting or smoking, without any available treatment option.

Housing is the utmost priority for persons addicted to drugs who are experiencing homelessness. As Nashville is becoming a major destination for relocation of businesses and people, affordable housing had become very scarce, while homelessness continues to rise. Aggressive gentrification further aggravates the shortage of affordable housing units. Moreover, the Department of Housing and Urban Development (HUD) had tightened requirements and narrowed their definition of homeless, which requires that clients be in a shelter for three days before being deemed eligible. Clients with criminal records, active addiction, and mental health issues are denied housing (both public and private); limited transitional, assisted living or group homes are available. Recently released convicts present other critical challenges such as limited access to employment, financial loans and social support. During the past five years, in Nashville, Tennessee, the trend of homelessness paralleled the economic growth curve that propelled a booming housing market. "Nearly 70% of Nashville ever-changing skyline wasn't there 10 years ago" according to Nashville Chamber of Commerce. In April 2024, the median price for residential single-family homes in Nashville was more than \$500,000 for the first time. In the aftermath of the March 3, 2020, devastating tornado that destroyed numerous homes in North Nashville and the subsequent coronavirus pandemic, the number of displaced families grew exponentially. Most of the patients attending Meharry Community Wellness Center (MCWC) reside in North Nashville. Many of them lost their jobs in places such as hotels, restaurants, and factories due to local and state government-imposed "Stay-at-Home" and social distancing orders related to mitigation of the COVID-19 pandemic. The national economic downturn during the coronavirus pandemic exacerbated the homelessness crisis and widens the gaps in care and HIV health disparities. Our proportion of clients experiencing homelessness represents more than twice the national average for PLWH (8.4%) and is 50% greater than

the national Ryan White average (12.9%).

Community environment: An often-forgotten barrier is the fact that 70% of our patients live in the same neighborhood and are very familiar with each other. Fear of disclosure of HIV status, stigma, and discrimination, prejudice, religious concerns, and misconceptions remain enormous barriers to accessing HIV care.

Barriers to reaching Tennessee's disproportionately-impacted populations:

African-American MSM: lack of awareness, or misinformation about HIV transmission, prevention, and treatment; impact of homophobia on health-seeking behavior; lack of access to health care generally; and denial of risk.

Young MSM: misperceptions about HIV risk; denial and complacency associated with being a late adolescent; difficulties comprehending the seriousness of HIV, coupled with rejection by family and friends.

High-risk heterosexuals: lack of perceived risk; poverty, limited access to health care and health information; acting as caregivers in families; and financial dependency on a partner.

Incarcerated: stigma (isolation & potential for violence due to HIV status); misinformation about HIV transmission, prevention, and treatment (situational sex/" gay for the stay"); and lack of awareness or access to testing and/or health care services upon release.

Ryan White Part C Minority AIDS Initiative Report.

- To recruit persons with HIV (PWH) of the MAI target population, MCWC conducted outreach activities at multiple events:

Nashville Mayor's Ending-the-Epidemic, PRIDE Day, Black PRIDE, World AIDS Day, National HIV Black Awareness Day, and HIV Testing Day, and The African Street Festival. MCWC also leverages its partnership with Tennessee Department of Corrections, Metro Health Department, Davidson County Sheriff Office, Nashville General Hospital, United Neighborhood Health Centers, and Street Works. The Program Director promotes HIV awareness on Fisk Radio program, Health Waves. In general, the positivity yield of HIV testing in Nashville/Davidson County during outreach activities is less than 1%.

- How targeted testing is done for PWH of the MAI target population, and positives identified.

MCWC focuses on partners of non-virally suppressed clients, persons with sexually transmitted infection(s), or those with risky sexual behavior. Thus, from 01/2023 to 8/2023, MCWC performed targeted HIV testing for 60 high-risk persons on-site. Six of them (8.3%) tested HIV-positive. They were enrolled in care and started on ART immediately.

- How identified positives are linked to and enrolled in care.

People who test HIV-positive in the clinic or on the Meharry campus are linked to care and started on ART the same day; those referred from outside the campus are seen as soon as possible, usually within less than a week. EIS Worker, Community Health Workers, and the Community Care Team are responsible for linkage of identified positives to care. The Community Care Team meet twice a week to discuss newly identified positives and facilitate engagement. Medical case managers and medical providers collaborate in identifying and enrolling new clients. Altogether, they arrange for medical transportation, inform about core and support services, and expectations at initial clinic visit.

- How the PWH are retained in care.

The Patient Service Representative and Community Health Workers contact clients one

week and 24-72 hours prior to their scheduled clinic appointments. They reach out by phone, text message, or e-mail to those who missed their visits the same day and attempt to reschedule them, while trying to address the root causes of missed appointments. If these attempts are unsuccessful after one or two weeks, they will mail a certified letter of notification at the client's last address.

Medical case managers and HIV medical providers identify new and current clients at high risk for drop out-of-care and refer them to the Community Care Team. They analyze challenges, barriers, and facilitators to develop and implement a joint plan of care for intensive adherence counseling, peer coaching, performance monitoring, and evaluation. Difficult cases are discussed at weekly staff meetings for broader input.

The Community Care Team reviews the out-of-care list and deploy all their effort to locate the client, reach out to their authorized contact persons, state prisons and jails, local hospitals and drug treatment centers, and homeless camps. Once they are unable to locate the client, they will arrange an in-person visit at their residence or their hangout places. If that fails, they will solicit assistance from the local and state Health Department as well as other community organizations. As a last-ditch effort, they will access the obit announcements.

Describe in detail:

- 1) The number of persons you plan to serve with the funding.**
- 2) The number of units of service you plan to provide by type of intervention (e.g., number of face-to-face contacts with clients and amount of time each client will be seen each year, number of educational sessions provided, number of contacts with gatekeepers); and**
- 3) the average amount of service a client is expected to receive each year (e.g., 2 face to face each year) and the amount of time that will be spent with gatekeepers (e.g., 3 hours/gatekeeper/year).**

With this funding, we propose that 25 persons with HIV will receive face-to-face psychiatric care, 35 will receive face-to-face clinical psychology services, and 30 will receive therapy, yielding a total of 90 unduplicated clients. Demographic distribution is as follows:

Male 76%; Female 24%

African American 79%; Caucasian: 19%; Hispanic 2%

Age group: 13-24: 0.1%; 25-44: 54%; 45-64: 45%; 65+ 0.9%

They will receive 1260 units of service of 15 minute each in face-to-face mental health care provided by a Part A funded salaried physician, a Clinical Psychologist, and a Therapist/Counselor, in the grant year.

III. Implementation Plan:

The importance of improving progress along the HIV care continuum is supported using scientific research that leads to the identification of best practices and evidence-based practices. The use of best practices/evidenced informed models is preferred for all services and as applicable/available.

Describe in detail any evidence bases or best practice models you will use to provide the

service. Include a reference to the model's name and source of the best practice (e.g., "Healthy Living Project," CDC Evidence-Based Intervention-EBI).

<https://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html>

Ideally, interventions will be based upon proven outreach and engagement models; and/or adaptations of proven models; and /or novel models of outreach and engagement in care, particularly developed for the HIV/AIDS population.

Meharry Community Wellness Center will provide psychiatric services according to the American Board of Psychiatry and Neurology Guidelines and Recommendations. The clinical psychology services will be delivered as per the Standards of American Psychological Association (APA), HIV/AIDS Office of Psychologists' Education (HOPE). Therapy and drug counseling will follow HRSA, Part B, and Part A Standards of Care. Moreover, our experience as one of the three national performance sites, for the HRSA-sponsored Special Project of National Significance (SPNS), "Dissemination of Evidence-Informed Interventions: Peer Linkage and Re-Engagement of HIV-Positive Women of Color" in 2016-2019 inspired the Community Care Team Model implemented by our program in 2020. The Manual is available at: <https://www.targetshiv.org/deii/deii-peer-linkage>.

Peer Linkage and Re-engagement of Women of Color with HIV. Rajabiun S., Marbach A., Fox J., Childs E., Sullivan M., Downes, A., Bryant H, Nortrup E., Berthaud V., Alexander L., Grimes T., et al. Dissemination of Evidence-Informed Interventions. Peer Linkage and Re-engagement of Women of Color Living with HIV (2020). Available at: <https://www.targetshiv.org/deii/deii-peer-linkage>. The peer-reviewed manuscript is referred here: Serena Rajabiun, Janet J. Myers, Janet Goldberg, Karen Fortu, Marena Sullivan, Vladimir Berthaud, Rahab Wahome, and Howard J. Cabral. "Outcomes from the adaptation of an evidence-based Peer Linkage & Re-engagement: Intervention for Women of Color with HIV in three urban clinics". AIDS and Behavior. October 05, 2021. PMID: 34609629.

For all Ryan White projects, Meharry Community Wellness Center also implements the most recent Standards of Care published by Tennessee Health Department Ryan White Part B Program and Metropolitan Nashville Health Department Ryan White Part A Program.

Retention strategies: To improve retention and viral suppression, Meharry Community Wellness Center (MCWC) had formed the Community Care Team, which meets twice weekly to discuss clients with incoming appointments, those who missed their recent clinic visits, and those lost to care. MCWC works diligently to schedule all of a client's visits the same day. The Patient Service Representatives or the Community Health Workers contact the client one week and 24-48 hours before the appointment date to facilitate the clinic visit. They arrange for round-trip medical transportation, if needed. Those who missed their scheduled visits are contacted in less than 24 hours. If they are unable to reach a client by phone calls, text messages, e-mails, or letters, after 2 weeks, the Community Health Worker attempts to make a home visit. If that fails, they reach out to Nashville Health Department EIS Worker, Davidson County Sheriff Office and Tennessee Department of Corrections, the Coalition for the Homeless, drug treatment centers, mental health institutions, local hospitals, and nursing homes, for investigation. If these strategies fail

after 6 months, the TN Health Department Disease Intervention Specialist (DIS) is alerted for further tracking efforts. Clients who miss more than two consecutive appointments receive intensified adherence counseling and coaching.

Targeted retention efforts toward subpopulations with poor health outcomes. The Community Health Workers and PSRs target MSM, women of color, and clients with challenging issues such as mental illnesses, substance use disorders, and pervasive stigma. The Medical Case Managers assist clients experiencing homelessness in permanent placement, prevention of eviction, and maintenance of stable housing. The HOPWA Case Manager assists clients with rent, mortgage, and utilities bills. The Community Health Workers provide clients with medical transportation, food services, and pharmacy management to facilitate clinic visits and medication adherence. The medical providers coordinate with staff to facilitate joint clinic appointments. All clients are screened for behavioral and substance use disorders and those who screen positive are seen by the clinical psychologist, the psychiatrist, and/or the therapist/counselor.

Coordination of medical and support services for pregnant women.

An obstetrician-gynecologist with over 25 years of experience including 15 years at MCWC, Dr. Vernita Tucker, will manage pregnant women in the clinic in close coordination with medical providers and nurses during the entire prenatal, peripartum and postpartum period. All pregnant women will be offered ART, if not on yet, and counseled regarding the benefits and risks of ART during pregnancy for the woman, fetus, and newborn. Adherence to ART may decline in the postpartum period. Therefore, clinical and support staff caring for postpartum women on ART will stress adherence and evaluate specific facilitators and barriers. Two Meharry board-certified infectious diseases pediatricians, Dr. Shahana Choudhury and Dr. Christopher Keefer, will manage HIV-exposed babies. Prenatal and HIV care visits as well as neonatal and maternal medical visits will occur on the same day. Attention will be paid to nutrition, medical transportation, housing status, and medical insurance coverage.

Unmet need and HIV care continuum: In 2020, 66% of newly diagnosed people in Tennessee were linked to care within 30 days, compared to 64% in 2018; 54% were retained in care (same for non-Hispanic Blacks) and 66% achieved viral load suppression (63% for Non-Hispanic Blacks). In Nashville TGA, an estimated 17% of PLWH are unaware of their status. In 2020, 66% of newly diagnosed cases were linked to care in 30 days, 54% were retained, and 66% achieved viral suppression. Among Non-Hispanic Blacks, 64% were linked to care within 30 days, 54% were retained and 63% became virally suppressed. Among Non-Hispanic Black PLWH, there were significant differences in care retention by age group ($p < 0.0001$). The lowest rates of care retention in this subpopulation were found among 13-24-year old (44%) and 25-34-year-old (52%). Among Non-Hispanic Black PLWH, there were significant differences in viral suppression by age group ($p = 0.0009$). The lowest rates of viral suppression were found among 13-24-year old (51%), 35-44-year-old (57%), and 25-34-year-old (58%). In TN and the Nashville TGA, the Ryan White program represents the strongest contributor to successful outcomes along the HIV care continuum as shown in this figure. Source: TN Health Department sponsored presentation TN HIV Continuum of Care: Update, Peter F. Rebeiro, MHS, PhD. (September 24, 2015)

We examined the effect of homelessness on viral suppression between 2014-2019. Our retrospective study revealed that permanently/stably housed clients had a much higher proportion of viral suppression compared to unhoused clients. Among clients with viral load <20 copies/mL, 78% were permanently housed and 22% homeless, while 74% of permanently/stably housed clients reached viral suppression and a smaller proportion of the homeless clients (54.7%) remained virally suppressed (Pearson's Chi-Square 25.171, $p < 0.001$). The multivariable logistic regression showed that permanent/stable housing (p -value < 0.001), higher frequency of CD4 count > 500 cells/mm³ (HIV infection, stage 1) (p -value < 0.001), age (p -value = 0.004), and FPL (p -value = 0.031) were strong predictors of viral suppression. As expected, patients living in permanent/stable housing had twice the chance of achieving viral suppression compared with those who were experiencing homelessness [OR 2.08 (1.39-3.23), p -value < 0.001]. Under the nonparametric assumption, the receiver operating characteristic (ROC) curve correctly predicted 72.3% of the primary outcome variable, viral suppression (AUC = 0.767; p -value < 0.001 ; 95% CI for AUC (0.73, 0.80). During the 5-year study period, 52 clients died. Of them, 16 (30.76%) were experiencing homelessness and 36 (69.23%) lived in stable housing, while 12.5% of the homeless and 61.12% of those in stable housing achieved viral suppression at the time of death (Berthaud V. et al. BMC Infectious Diseases, 2022; 22: 144). This seminal paper inspired the 2022 CDC Issue Brief, "The Role of Housing in Ending the HIV Epidemic" and a Human Resources and Services Administration (HRSA) Notice of Funding Opportunity for housing of PWH. The Infectious Diseases Society of America cited our paper in their special issue dedicated to homelessness and infectious diseases (Emily Mosites, Laura Hughes, and Jay C. Butler. Homelessness and Infectious Diseases: Understanding the Gaps and Defining a Public Health Approach: Introduction. The Journal of Infectious Diseases 2022;226(S3): S301-3).

IV. Best Practices:

Provide a clear and succinct description of the proposed project to implement an intervention model designed to create access to HIV testing, improve timely entry, engagement, and retention in quality HIV medical care for persons living with HIV infection.

Initial medical evaluation: The goals of the initial evaluation are to confirm the HIV diagnosis, obtain appropriate baseline historical and laboratory data, provide treatment adherence counseling, and ensure patient understanding about living with HIV, its modes and risks of transmission, and to initiate care as soon as possible as recommended by the Department of Health and Human Services (DHHS) under HIV primary care guidelines for prevention and treatment of HIV-associated opportunistic infections.

In the case of previously treated patients who present for an initial evaluation, it is critical to obtain a complete antiretroviral (ARV) history (including drug-resistance testing results, if available), preferably through the review of past medical records. Newly diagnosed patients shall also be asked about any prior use of ARV agents for prevention of HIV infection.

Follow-up visits: After the initial visit, patients deemed at high-risk for dropout and poor treatment adherence shall be followed at least biweekly for intensive case management, peer support, and close medical monitoring. Appointments will be spaced out at larger intervals

once they are stabilized and virally suppressed. Stable patients shall be seen every 2-3 months during the first 2 years, then, every 4-6 months once their viral load had been suppressed for 2 consecutive years. Virally suppressed patients with CD4 count > 500 over 2 years can be seen once or twice a year. At each follow-up visit, the medical record shall be updated considering patient complaints, treatment adherence and medication tolerance, referrals, laboratory and procedures results, recent visits to emergency departments, hospitalizations, incarceration, homelessness, outpatient or residential drug treatment, family and personal life changes.

Describe the strategies you will use to identify and engage with key stakeholders recognized and trusted by the HIV/AIDS community; include the names of specific people and entities.

Describe the components of your intervention model and its specific strategies that will:

- a) **Increase awareness of HIV disease, with a focus on reaching persons at high risk for becoming infected with HIV disease.**
- b) **Identification of high-risk persons who need but do not access regular HIV tests and how you will link those persons to HIV testing agencies; and**
- c) **Identification of persons who are HIV positive but have never or who have dropped out of HIV medical care and services and how you will facilitate linking those persons with needed HIV services and care.**

Proposed interventions must address personal, financial, sociocultural, and structural barriers, especially stigma, that affect PLWHAs access to HIV testing and retention in HIV medical care and services. Define specific barriers that may be encountered by the population being served and discuss how your proposed interventions will positively address each of these barriers.

Meharry Community Wellness Center (MCWC) organizes outreach events with local partners including Metropolitan Nashville Health Department to raise HIV awareness and promote testing. As member of Nashville PrEP Coalition, MCWC facilitates the rapid linkage of newly diagnosed persons. It also leverages its experience as a research site for the SPNS project targeting newly diagnosed and out-of-care women of color for linkage and retention to enhance engagement in care. As a pioneer of HIV telemedicine in TN prisons and HIV consultant for Davidson County jails since 2006, MCWC facilitates the transition of ex-offenders to rapid linkage and engagement upon their release in the community.

Patients who diagnose HIV positive in the emergency department (ED) at Nashville General Hospital (NGH), located on the Meharry campus, are linked and enrolled into care the same or next business day. HIV providers and Medical Case Managers follow newly diagnosed persons with HIV (PWH) admitted to NGH and coordinate their discharge disposition. Clients newly identified outside the Meharry campus are linked as soon as possible, preferably within less than 7 days. The Patient Service Representatives (insurance verification), the Community Health Workers (coaching and navigation), and the Medical Case Managers (insurance assistance and Ryan White eligibility) are responsible for rapid linkage.

Community Care Team Model. To optimize patient care at multiple access points and shift from a disease-based model to truly patient-centered care, MCWC will implement the community care team model based on four tracking pathways, A, B, C and D.

A: Patients who attend clinic appointments regularly, maintain viral load suppression, and may have zero to low-level comorbidities and social determinants of health. (*Focus: prevention, health promotion, and reinforcement of adherence*)

B: Patients who are missing scheduled appointments (no-shows, walk-ins), do not maintain viral load suppression, and may experience rising levels of comorbidities and social determinants of health. (*Focus: increase adherence counseling, health education, and rapid intervention, and identify, and address emerging risk factors for adverse outcomes*)

C: Patients who do not attend clinic appointments regularly, may have variable levels of viral load suppression and comorbidities, and high levels of challenging social determinants of health impacting treatment adherence, the HIV care continuum, and overall health and wellness, and representing greatest life priorities. (*Focus: intensive medical case management and peer support, ensure unfettered access to clinical and support services, and collaborate with community agencies to prevent critical progression*)

D: Patients who may not attend clinic appointments regularly and have variable levels of viral load suppression, and may be facing high levels of chronic diseases that are becoming higher health priorities than HIV, and have variable levels of social determinants of health.

(*Focus: coordination of multispecialty services and referrals, and disease education*).

The Community Care Team (CCT) will implement an HIV service delivery model that will facilitate patient tracking, peer-to-peer support, differentiated case management, improve retention, viral load, and health outcomes. The CCT will strive to track clients at their ever-changing points-of-contact, particularly the hard-to-reach, highly vulnerable, and marginalized individuals, and those who are struggling with adverse social determinants of health, HIV disease progression and significant comorbidities. In fact, the results of our pilot study showed the following viral suppressions: **100% for Pathway A, 78% for B, 43% for C, and 65% for D.** (*Berthaud V, Special Presentation, 2020 National Ryan White Meeting*).

Strategies to improve care transition focus on inmates, youth living with HIV and hospitalized patients who are HIV positive. Meharry infectious diseases specialists serve as HIV consultants for TN Department of Corrections and Davidson County Sheriff's Office. At the time of consultation, they will identify inmates ready to transition into the community and initiate the contact between prison or jail personnel and MCWC staff such as PSR, EIS Worker, Community Health Workers, Therapist/Drug Counselor, and Medical Case Managers, to coordinate transitional services, with the intent to schedule the first clinic appointment on the same day of release or within one week. Meharry infectious diseases physicians will follow all persons with HIV hospitalized at Nashville General Hospital and coordinate their discharge and linkage to care in close collaboration with hospital physicians, nurses, and case managers and MCWC staff. They will also coordinate the care of their patients who are admitted to another acute or long-term care facility. The Community Health Workers will follow clients hospitalized in other medical facilities and share authorized health information with outside providers to ensure continuity in care. They will coach youth living with HIV and help them navigate the HIV service delivery system.

Coordination of medical and support services for pregnant women.

An obstetrician-gynecologist with over 25 years of experience including 15 years at MCWC, Dr. Vernita Tucker, will manage pregnant women in the clinic in close coordination with medical providers and nurses during the entire prenatal, peripartum and postpartum period. All pregnant women will be offered ART, if not on yet, and counseled regarding the benefits and risks of ART during pregnancy for the woman, fetus, and newborn. Adherence to ART may decline in the postpartum period. Therefore, clinical and support staff caring for postpartum women on ART will stress adherence and evaluate specific facilitators and barriers. Two Meharry board-certified infectious diseases pediatricians, Dr. Shahana Choudhury and Dr. Christopher Keefer, will manage HIV-exposed babies. Prenatal and HIV care visits as well as neonatal and maternal medical visits will occur on the same day. Attention will be paid to nutrition, medical transportation, housing status, and medical insurance coverage.

Meharry Community Wellness Center collaborates with diverse stakeholders to identify persons who are HIV positive but have never or who have dropped out of HIV medical care and services and facilitate linking those persons with needed HIV services and care: Nashville General Hospital (NGH), Meharry teaching hospital, where Dr. Berthaud serves as Director of Infectious Diseases and Dr. Livette Johnson co-chairs the Infection Prevention Committee. They work closely with hospital staff to identify patient who are out of HIV care and re-engage them immediately. Inpatient referrals are seen the same day and outpatient referrals are seen in less than a week. A Medical Case Manager and a Community Health Worker will introduce themselves to the hospitalized patient with HIV to educate them about our HIV program and expectations at initial clinic visit. They will coordinate patient discharge with medical providers and Case Managers and arrange for those who are eligible for commercial medical insurance, TennCare, Medicare, or VA insurance initiate the enrollment process as soon as possible. They will inform those deemed eligible for Ryan White insurance coverage about the program requirements, policies, and procedures. The same process is applied to all other referring partners as circumstances allow. NGH refers PWH from Emergency Department, inpatient, and outpatient clinics; Meharry Elam Mental Health Center, Meharry Family Medicine and MAT Clinic, located right across the hall from MCWC, and Meharry Clinics constitute regular sources of mutual referrals; Davidson County Sheriff's Office refers inmates with HIV to MCWC since 2005, while Tennessee Department of Corrections refers them for telemedicine consultation, a service established by Dr. Berthaud in 2006; Neighborhood Health, the largest FQHC in Davidson County, Ascension St Thomas Health (Dr. Berthaud maintains consultation privileges), and Metropolitan Nashville Health Department, the largest HIV testing center in Nashville, represent important referral sources. Metropolitan Development Housing Authority awarded a HOPWA grant for the provision of Short-Term, Rent, Mortgage, and Utilities assistance. Street Works and Nashville CARES provide medical case management, food and housing services including permanent placement and emergency shelters. Second Harvest provides low-cost preserved food for our pantry. Vanderbilt University Medical Center provides emergency, specialty ambulatory, and inpatient care for MCWC clients. Tennessee Health Department had contracted with Meharry for ambulatory/outpatient and medical case management services. They provide technical support to medical case managers and assist in linkage/reengagement of clients lost to care. Metropolitan Nashville Public Health Department (MNPHD) refers newly diagnosed HIV-positive and lost-to-care people, treats persons with latent and active

tuberculosis, and coordinates STD management and control. Meharry Elam Mental Health Center collaborates with MCWC Therapist/Drug Counselor on outpatient and inpatient drug treatment, detoxification, and rehabilitation. Dr. Osa-Edoh, the Part A funded psychiatrist, is also the Director of the Drug Treatment Program at Elam Center.

Service Specific Questions:

1. Service Model

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of your proposed project. Include all aspects of planning, implementation, and evaluation, listing the role of everyone involved in activity.

2. Work Plan

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of your proposed project. Include all aspects of planning, implementation, and evaluation, listing the role of everyone involved in each activity.

The work plan should include clearly written:

- 1. Goals**
- 2. Objectives that are specific, time-framed, and measurable**
- 3. Action steps**
- 4. Staff responsible for each action step; and**
- 5. Anticipated dates of completion.**

Please note that goals for the work plan are to be written for the first year of the grant. Discuss any challenges that are likely to be encountered in planning and implementing the project’s activities described in the work plan and describe realistic and appropriate approaches to be used to resolve these challenges.

Work Plan

Goals	Objectives	Action Steps	Anticipated Date of Completion	Responsible Staff
Increase viral suppression	85% viral suppression by end of Year 1	Periodic viral load monitoring as per DHHS guidelines Monitor treatment adherence Monitor health complications and chronic comorbidities	End of Year 1	Medical providers Medical providers, Medical Case Managers, Community Health Workers

Increase retention in care	78% retention in care by end of Year 1	Early identification of clients at high-risk for dropout and treatment failure	End of Year 1	Medical providers Medical Case Managers Community Health Workers
		Provide intensive coaching and case management	End of Year 1	Medical providers Community Health Workers Therapist
		Monitor and evaluate barriers, challenges, and facilitators to treatment adherence and clinic attendance	End of Year 1	Medical providers Mental Health Therapist Psychiatrist Clinical Psychologist
		Facilitate access to treatment of behavioral and substance use disorders, medical transportation, housing and food services	End of Year 1	Therapist Community Health Workers
		Track clients who missed clinic appointments weekly	End of Year 1	Community Health Workers Medical Case Managers
		Collaborate with community-based organizations, local and state health departments, and correctional facilities	End of Year 1	Community Health Workers Medical Case Managers

Aggregate measures of viral suppression and retention are already incorporated in the HRSA-required Performance Measures section of CAREWare. We have customized the system to measure viral load for subpopulations.

Challenges and Resolutions		
Challenges	Approaches for Resolutions	Barriers
Homelessness	HOPWA grant for Short-Term Rent, Mortgage, and Utilities (STRMU) does not match explosive real estate costs in the TGA.	Many of our clients experiencing homelessness are excluded from public housing because of restrictive housing policies and limited HOPWA funding.
Limited transportation service	Medical transportation service provided by program income.	Limited or inexistent public transportation.
Food shortage	Raise Part A Food Voucher card from \$20 to \$60 to adjust for inflationary cost. Program income-supported Food Pantry with unrestricted access in collaboration with Second Harvest.	Lack of job skills & education, unemployment, and poverty, exacerbate food shortage.
High rate of incarceration	Clinical psychologist, psychiatrist, therapist/drug counselor address behavioral and substance use disorders and relapse, and the roots of incarceration.	Limited access points for substance use treatment; high rate of drug charges, incarceration, and recidivism.

Our landmark paper was the first to highlight the negative effect of homelessness on HIV viral suppression and mortality in Middle Tennessee and its potential challenges to ending the HIV epidemic. (Vladimir Berthaud; Livette Johnson; Ronda Jennings et al. “The Effect of Homelessness on Viral Suppression in an Underserved Metropolitan Area of Middle Tennessee: Potential Implications for Ending the HIV Epidemic”. BMC Infectious Diseases. 2022 Feb 10; 22: 144). This retrospective analysis reveals that permanently/stably housed clients had a much higher proportion of viral suppression compared to their unhoused counterparts. Among clients with viral load <20 copies/mL, 78% were permanently housed and 22% unhoused. This seminal

paper inspired the 2022 CDC Issue Brief, “The Role of Housing in Ending the HIV Epidemic” and a Human Resources and Services Administration (HRSA) Notice of Funding Opportunity for housing of PWH. The Infectious Diseases Society of America cited our paper in their special issue dedicated to homelessness and infectious diseases (Emily Mosites, Laura Hughes, and Jay C. Butler. Homelessness and Infectious Diseases: Understanding the Gaps and Defining a Public Health Approach: Introduction. The Journal of Infectious Diseases 2022;226(S3): S301–3).

B. Budget (35 Points)

Complete the entire Budget Spreadsheet attachment (excel version) which describes how you will use the funds to provide the service requested in the scope of work for this solicitation. Include detailed information about the number and type of staff your firm will fund, staffing costs and other specific costs associated with providing the service. Contractor(s) will be allowed to budget up to 10% for administrative costs, including indirect charges.

Leaving blanks on any of the Budget Spreadsheets and/or not following the provided format may result in your proposal being deemed non-responsive.

The entire Budget Spreadsheet attachment has been completed and uploaded.

MEHARRY COMMUNITY WELLNESS CENTER

PSYCHOSOCIAL SERVICES

ORGANIZATION AND TEAM QUALIFICATIONS

I. ORGANIZATIONAL BACKGROUND

1. Describe in detail the background of your agency. Include the purpose of your organization, years of experience in providing services to People Living With HIV/AIDS (PLWHAs) and the years of providing these services (note if any HIV specific services are provided and/or if you currently collaborate with an HIV agency) and number of unduplicated persons served last year.

Purpose. Meharry Community Wellness Center (MCWC) strives to eliminate HIV health disparities in Nashville Transitional Grant Area (TGA) by promoting awareness, education, and training, transdisciplinary research, community partnership, and unfettered access to comprehensive, high-quality care.

Background. Meharry has been a leader in primary care medicine for over a century and HIV prevention and treatment since the beginning of the epidemic in 1981. Out of a growing need to expand access to culturally sensitive, comprehensive primary HIV care in the Nashville Transitional Grant Area (TGA), Dr. Vladimir Berthaud founded Meharry Community Wellness Center (MCWC) in 2005. MCWC has been a top-ranked Tennessee-designated AIDS Center of Excellence since 2006, and a Hepatitis Center of Excellence since 2016. Tennessee Health Department recognizes MCWC as a “national model for comprehensive HIV care among the underserved community”.

Meharry Community Wellness Center provides 24/7 coverage for medical and dental services. Clients have easy access to one-stop, wrap around core and support services: HIV counseling and testing, PrEP/PEP, and primary HIV care; management of complex infectious diseases; women’s health services including reproductive health, Pap test/colposcopy; minor ambulatory surgery including proctoscopy, skin biopsy, wound care, pre- and postoperative management; psychiatry, clinical psychology, mental health therapy and drug counseling; Medication-Assisted Treatment (MAT), outpatient and residential treatment of substance use disorder; HIV Drug Assistance Program (HDAP), Insurance Assistance Program (IAP), on-site pharmacy services; housing assistance, medical transportation, and nutrition; legal aid, home and community-based health services, and referrals to specialty and community resources; comprehensive primary oral health including prophylaxis, dental hygiene, tooth extraction, root canal, cutting-edge prosthodontics, and oro-maxillo-facial surgery.

Our patient population has an alarming prevalence of severe tooth decay (60%) and severe periodontitis (30%). Meharry Community Wellness Center (MCWC) represents the only Tennessee clinic that offers unfettered access to fully integrated, comprehensive oral health services for low-income PLWH regardless of their primary HIV care providers. The Tennessee

Ryan White Dental Assistance Program (RWDAP) ran out of funding in April 2019 and left 1,800 clients with very limited or non-existing access to oral health services. Only 10% of our clients have dental insurance coverage and just 2% of them have adequate coverage. As of 2023, TennCare offers limited oral health benefits to eligible clients. So far, they have not referred any patients to our dental clinic. The dental clinic disposes of two state-of-the-art operatories, two intra-oral digital cameras, and one portable digital X-Ray, one lab, and one sterilization room. It applies breakthrough 3D technology to fabricate crowns, bridges, partial, and full dentures while the client is waiting. Meharry Community Wellness Center is among five health centers who dispose of this brand-new technology for fabricating full-mouth and partial denture in one visit in the United States. Special cases such as impacted molars, orthodontics, intra-oral abscesses, or deep-seated infections, are referred on site to Oro-Maxillo-Facial Surgery service at the Meharry School of Dentistry using program income to pay the discounted fees for these referrals.

Meharry Community Wellness Center had served 2,165 unduplicated clients since inception and 468 in 2024 including 77% Black or African American, 10% Hispanic/Latino, 25% female, and 46% MMSC. Our proportion of PWH with unmet housing needs (24.9%) represent about thrice the national average for PWH (8.4%) and twice the average for Ryan White clients nationwide (12.9%). Our clients bear an excess burden of poverty (53% below 100% federal poverty level), history of incarceration (20%), substance use and behavioral disorders (30%), uninsured (39%), cardiovascular diseases (30%), chronic lung diseases (35%), and diabetes (20%). Nonetheless, 85% of our clients had achieved viral load suppression (increased from 78.6% in 2021, 82.3% in 2022, and 83.3% in 2023), and 90% have CD4 cell count above 200 cells/mm³. Retention in care had increased from 70.47% in 2021 to 76.13% in 2023. However, cases of syphilis rose from 18.1% in 2021 to 22.5% in 2023, in line with the ongoing syphilis epidemic in the US. Only 7.5% of women had abnormal Pap test in 2023 as compared with 8.3% in 2021. As the sole clinic providing fully integrated state-of-the-art oral health services at no cost to people with HIV (PWH) in Tennessee regardless of their primary HIV provider, MCWC had served 650 clients in 2,689 units during past 16 years.

Under contractual agreement, MCWC had served about 600 inmates living with HIV (64% Black or African American) throughout all Tennessee prisons over 21 years. In 2006, we pioneered telemedicine between Meharry and Tennessee prisons. This collaboration contributed to raising clinic attendance from 50% to 90% and viral suppression, from baseline 30% to 90% in 2020.

MCWC had received uninterrupted grant funding from Ryan White Part B since 2002, HRSA Ryan White Part C since 2003, Ryan White Part A since 2008, and HOPWA since 2016. In order to stretch the Ryan White grant dollars, MCWC expends its program income to further project objectives in priority areas of unmet need, such as nutrition and medical transportation; oral health, ambulatory surgery, and women's health services; as well as coverage of ambulatory/outpatient specialty services for management of comorbidities, and co-pays of

prescription drugs for underinsured, low-income individuals with HIV. The dental clinic was built out of several competitive HRSA grants supplemented by program income.

The prospect for new funding remains grim because of a large budget shortfall in the Tennessee Ryan White B program that required across-the-board budget cuts leading to a reduction of our annual budget by \$76,510.50 since 2021-2022 and planned termination of Part B funding for Part A grantees in 2026. Our Part C grant has been on freeze under Executive Order and HRSA has not issued the 2025 grant award yet. Therefore, Ryan White Part A had become lifesaving for people living with HIV in Nashville TGA.

2. Describe in detail the current HIV counseling and testing capacity of your organization, and any existing collaborative arrangements with other organizations within your service area that provide HIV counseling and testing services.

Clients who are diagnosed HIV positive at Meharry Community Wellness Center are linked and enrolled in care immediately. The same policy applies to those who test HIV positive in the Emergency Department or outpatient clinics of Nashville General Hospital. Newly diagnosed people who are incarcerated in local jails are referred to MCWC and seen in less than a week. Inmates of Tennessee Department of Corrections are referred to the clinic on the day of their release for medical insurance enrollment and linkage to care. All other individuals with HIV referred to MCWC are given an initial appointment within 1-7 days

Meharry Community Wellness Center (MCWC) uses its program income to provide targeted HIV counseling and testing. In 2023, we tested 75 high-risk individuals and found seven (9.33%) HIV-positive people, as compared to <0.5% in the general population. All these newly identified persons with HIV were enrolled in care and started taking antiretroviral treatment (ART) before leaving the clinic. Medical providers, EIS Worker, and Medical Case Managers (MCM) educate clients about HIV risk behaviors and effective strategies to prevent HIV transmission at each patient visit, using audio-visual materials, interactive tablets, brochures, and multi-disciplinary intervention. They counsel every person with HIV (PWH) entering care about the implications of HIV infection, the benefits and potential side-effects of antiretroviral therapy (ART), risk reduction and disclosure to sexual and/or needle sharing partners. They reinforce risk reduction messages and encourage clients to have their partner(s) tested every 3-6 months and enroll in PrEP if they're not virally suppressed. We also invite persons with high-risk HIV behavior to participate in our ongoing clinical trials such as the landmark Purpose 2 study conducted at Meharry under the leadership of Dr. Berthaud as Principal Investigator. This trial showed that twice-yearly injection of lenacapavir resulted in 96% protection from HIV transmission in MSM, transgender men, and non-binary persons.

MCWC has a track record of collaboration for HIV counseling and testing with multiple local and extramural partners such as: Nashville General Hospital, the Meharry Elam Mental Health Center, the Meharry Medication-Assisted Treatment (MAT) clinic, and the Meharry Clinics; Davidson County Sheriff Office, Tennessee Department of Corrections, United Neighborhood,

Matthew Walker Comprehensive Health Center, Street Works, Nashville CARES, Vanderbilt University Medical Center, Ascension St Thomas Health, and Metropolitan Nashville Health Department; long-term care facilities like, Bordeaux Nursing Home and Whites Creek Nursing Home, as well as drug treatment centers (Cumberland, Samaritan), and Middle Tennessee Mental Health Institute.

3. Describe in detail how the proposed project fits with your agency’s mission and capabilities.

As an annual Tennessee-designated AIDS Center of Excellence since 2006, Meharry Community Wellness Center (MCWC) focuses on eliminating health inequities in HIV/AIDS, advancing HIV/AIDS awareness, transformative education, and transdisciplinary research, strengthening community outreach and partnership, and providing exceptional and compassionate health services. Our mission aligns with the overall mission of Meharry Medical College to empower diverse populations to improve the well-being of humankind. Our vision aligns with the vision of the National HIV/AIDS Strategy and the White House Ending-the-Epidemic Plan. This proposed project fits our mission and capabilities to address unmet need in outpatient/ambulatory care for underserved persons living with HIV in the Nashville Transitional Grant Area (TGA). Although Meharry Community Wellness Center serves the hardest-to-reach populations of persons with HIV in Middle Tennessee, as aforementioned, our retention in care had reached 76.13% in 2023. During the most recent decade, viral load suppression had substantially improved for all subpopulations, especially youth, young adults, and MSM, the risk categories with the highest incidence of HIV in our clinic (47.1% for MSM). In fact, MSM achieved the highest rate of viral suppression in 2024, a reflection of our cultural competence, coupled with non-judgmental, customer-friendly, and compassionate HIV care.

Viral Suppression by Subpopulation (%): 2015-2024			
Subpopulation	Year		
	2015	2019	2024
White	75.61	73.85	81.82
Black or African American	73.14	75.58	82.48
Hispanic/Latino	81.25	83.33	80.49
Youth (13-24)	51.85	74.19	80.00
25-34	63.22	71.57	84.38
35-54	76.52	74.88	79.79
55+	82.83	81.82	83.72
Women	72.00	77.39	79.81
Men	68.9	70.79	80.78
MSM	63.27	72.73	85.71

Source: CAREWare 230

4. Describe in detail how your background, mission and experience contribute to the ability of your organization to conduct the proposed project and meet the expectations of the program

requirements. In addition, Metro Health may conduct pre-award on-site visits to determine if the contractor's facilities are appropriate for the services intended.

Meharry is the oldest provider of HIV care in Tennessee, dating back the beginning of the epidemic in 1981. Under the leadership of its Founding Executive Director, Dr. Vladimir Berthaud, Meharry Community Wellness Center (MCWC) had earned the annual designation of Tennessee AIDS Center of Excellence continuously since 2006 and grew exponentially, thanks to multiple funding streams including several Ryan White grants. MCWC had become a beacon of hope and comfort for persons with HIV, affected by stigma, discrimination, social injustice, and health inequities. For current grant year ending on February 28, 2025, our outpatient/ambulatory grant had already beaten the expectations of program requirements as illustrated by the projected number of clients to be served and the number of service units (projected number: 99/actual: 179 and projected units: 400/actual: 2480). A multidisciplinary team of experienced and highly-qualified staff provide person-centered, multidisciplinary, holistic health services of the highest quality. Daily patient surveys denote an average satisfaction rate of 95%. As a testament of our performance, HRSA had selected MCWC to host the first National Meeting on HIV in Rural Areas in 2019 and one of three US sites that conducted the Special Project of National Significance (SPNS), "Dissemination of Evidence-Informed Interventions: Peer Linkage and Re-engagement of Women of Color", 2016-2019. The Project-derived manual is available at: <https://www.targethiv.org/deii/deii-peer-linkage>.

II. Organization Capacity:

1. Provide copies of the following:

- Resume and job description of proposed Finance Manager
- Organizational chart for your agency; chart must clearly include the program components funded by Part A/MAI.
- Copies of most recent State Licensure or Accreditation for relevant services.
- Articles of Incorporation.
- Documentation of 501(c) 3 designation.
- Current State of Tennessee Charitable Solicitations Letter.
- System for Award Management (SAM) exclusion report.

All these documents are uploaded.

2. **Describe agency's experience in administering federal, state and/or local government funds. Include funding source(s) and number of years administering those funds. Provide information for the following:**

- **Agency restrictions from receiving federal funds or placed on restrictive measures in the last five years (e.g., increased reporting, increased monitoring visits), please explain.**

Meharry has no restrictions from receiving federal funds. It has never been placed on restrictive measures in the last five years or during its existence.

- **Corrective action plan(s) in the last three years from any funding source, please describe (include the name of the funder, overview of issues identified and the current status of addressing the identified issues and/or recommendations).**

In 2024, HRSA conducted a site visit and identified the following issues: documentation of coordination and linkages with CDC and Prevention-funded HIV testing and outreach services of federally qualified health centers in the service area; documentation of training for HIV care and treatment of all non-clinical staff, documentation of sexual practices of women; demonstration of full implementation of the time and effort policy and the caps on charges; and documentation for allocating program income according to each Ryan White Program grant. All these issues have been corrected except the time and effort policy. The Office of Grants and Contracts is updating the Workday system and recruiting additional personnel to ensure any issues related to time and effort are fixed soon.

- **Audit finding(s) in the last three years. Please describe an overview of issues identified and the current status of addressing the identified issues.**

In 2024, HRSA audited our Ryan White Part C EIS grant and identified the following issues: documentation of coordination and linkages with CDC and Prevention-funded HIV testing and outreach services of federally qualified health centers in the service area; documentation of training for HIV care and treatment of all non-clinical staff, documentation of sexual practices of women; demonstration of full implementation of the time and effort policy and cap on charges; and a clear policy for allocating program income according to each Ryan White Program grant. All these issues have been corrected except the time and effort policy. The Office of Grants and Contracts is updating Workday system and recruiting additional personnel to ensure any issues related to time and effort are quickly fixed.

- **If Contractor(s) is currently a Ryan White Part A provider, an administrative review will be conducted of the previous year's spending of grant funds and will be included as part of the score. If Contractor(s) is not a current Ryan White Part A provider, Contractor(s) must provide a letter of reference from a funder to include a description of Contractor's performance in spending allocated grant funds. This letter will be included as part of the score.**

Not applicable.

- **Submit copies of most recent A-122 Audit (for the last reporting year) conducted by an**

independent certified public accountant or 990 form, if not required by federal regulations to complete an A-122 Audit.

An independent CPA firm, Crosslin Certified Public Accountants, had audited the accompanying consolidated financial statements of Meharry Medical College and Subsidiary (collectively the “College”), which comprise the consolidated statements of financial position as of June 30, 2023, and 2022, and the related consolidated statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the consolidated financial statements. In their opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the College as of June 30, 2023, and 2022, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America. (see Attachment: Most Recent Financial Audit, Final Consolidated A133 Financial Statement June 2023).

3. Describe agency’s current system for collecting data on client demographics, service utilization and performance data. Include all software used to collect this data, staff resources for data collection and hardware resources.

Staff resources. The Program Director, Dr. Berthaud, serves as Data Manager, assisted by biostatistician, Derek Wilus, MS. They perform duties such as quality management initiatives, data analysis, and dissemination of results, and staff training. The Program Director integrates all audits and performance evaluations into the overall strategic planning and Ryan White programs operations. He facilitates collaboration with statewide, local, and national quality improvement projects. Dirk Francis, Data Center and System Administrator for Meharry Office of Information Technology (OIT), manages the CAREWare server and maintains the software, while Lee Nelson, MBA, Health Information Technology Director, is responsible for managing E-Clinical Works (our electronic health record system) and interfacing with CAREWare (the primary source of data reports).

Data infrastructure. CAREWare™ forms the backbone of our robust information system. Our data repository relies on three separate layers of security. The CAREWare network connects to a dedicated server housed in a highly secure and restricted basement location in the Office of Information and Technology (OIT), monitored by video camera and on uninterrupted electric power supply 24/7. Meharry OIT has designated a qualified technician, Dirk Francis, to manage the CAREWare server in collaboration with MCWC Program Director.

Data operations. Since 2003, Meharry has been using Microsoft SQL server and the most recent CAREWare version as the primary tool for Ryan White data collection, HRSA-required performances measures and programmatic reports. All MCWC staff use CAREWare and enter data elements in real-time. MCWC had created over 180 customized reports in CAREWare to facilitate data queries and special reports. Moreover, we had developed CAREWare instruments to describe the graphic time course of individual lab variables

including CD4 cell count and viral load and designed a unique platform to capture social determinants of health, monitor and evaluate community health care delivery. We have modified CAREWare to allow for attachment of external medical, personal and legal records as well as patient's clinical documents including radiographs and intraoral pictures. MCWC had installed data quality and validity checks for duplicated, missing, discordant, and unknown key data elements to enhance accuracy of reports. A validity check is run prior to submission of reports. All HRSA-required reports including performance measures are readily available in CAREWare and can be created instantly. The Assistant Data Manager, Derek Wilus, MS, biostatistician, uses IBM SPSS or R Studio for more complex data analyses.

Data backup design. Meharry OIT backs up the data daily on extra-large capacity servers and digital tapes. Then, an independent contractor picks up the tapes daily and stores them away from the campus to safeguard them against major disasters and catastrophes such as floods, hurricanes, fire, and powerful earthquakes. The Program Director verifies that CAREWare posts daily messages to check the exact time of each data backup completion.

Original Data: The original data, also referred to as the live production data, resides on the HP Synergy Blade system, stored as a VM, with snapshots taken hourly, and stored on the Nimble CS5000. The snapshots are stored for 7 days.

Tier 1 Storage - The tier 1 backup occurs nightly and writes to a second Nimble array, the CS235. This data is stored for 90 days.

Tier 2 "off-site" Storage - Once weekly, the data is copied from the CS235 to a tape backup solution that is rotated off-site weekly. This data would be stored for 180 days.

Additional data safety and security procedures. Each Meharry desktop and laptop are configured to provide optimum security and reliability. OIT monitors each user's activities and downloads automatically the most recent security updates to all Meharry desktops connected to the network, daily, and screens all emails for SPAMs and phishing messages instantly. Meharry students and employees access the network with a personal username and secured password that is required to be changed regularly.

Software platforms. Meharry has adopted the electronic health records system, E-Clinical Works™, across the campus. The software suits for clinical notes, mobile applications, and Physician Quality Reporting Systems (PQRS). However, its capacity to generate customized reports is limited, complex, and provider-restricted, time-consuming, and costly. Medical providers enter their clinical notes and services in E-Clinical Works, also available on their smartphones app. LabCorp will export the lab tests results in E-Clinical Works as soon as they are available and alert the clinicians on critical values immediately. The HL7 platform and the "socket" allow for seamless export of LabCorp results into the CAREWare labs section. External health records are either faxed or exported into E-Clinical Works using compatible electronic software. A patient portal is available in E-Clinical Works for better

self-management and interaction with medical providers. The patient portal is also accessible via smartphone app. MCWC utilizes E-Clinical Works to submit third party billings and track service charges. Both E-Clinical Works and CAREWare are fully secure and HIPAA-compliant. MCWC staff attend mandatory training on compliance with HIPAA, federal and State, as well as Meharry regulations on patient personal health information. MCWC had developed a user-friendly iOS app that allows the quick calculation of odds for a person with HIV to achieve viral load suppression, based on our landmark publication in BMC Infectious Diseases in 2022.

4. Describe agency's system for managing fiscal and accounting responsibilities. Address the following:

- **Define who oversees this area, what staff is responsible for these activities.**
- **Identify what software is used to manage financial information.**
- **Describe the accounting system that is in place; and**
- **Describe the internal systems that are used to monitor grant expenditures and track, spend, and report program income generated by a federal award.**

Meharry Community Wellness Center (MCWC) had received uninterrupted grant funding from HRSA Part C EIS, Ryan White Part B, and Ryan White Part A for 21, 22, and 17 years, respectively. The Finance Manager, Zudi Takizala, MD, MPH, MBA, is uniquely qualified to oversee fiscal and accounting operations. She brings 21 years of experience in grant administration. In the past three years alone, she had successfully managed 18 public grants including 10 Ryan White grants. MCWC carries a current grant portfolio of about \$3,000,000.00 including grants from NIH/NIAID, HRSA, HOPWA, PEPFAR, and Ryan White Part A and B. Having managed thousands of Federal, State, and local grants and contracts for over 100 years, Meharry is strongly qualified to manage this project. To track and manage grants and contracts, the College uses an accrual method of accounting incorporated into the Banner software and Workday system. The Office of Grants and Contracts works closely with each program and department to assure that budget matters are appropriate and understood. Meharry retains a CPA firm to conduct annual audits and interim financial reports for program planning and implementation. All Meharry fiscal audits had no findings. Additionally, appropriate internal controls including an internal auditing process are in place and assist the College to anticipate and plan more effectively. The Department of Internal Medicine is primary responsible to oversee grant management and the delivery of clinical services. Meharry Medical Group (MMG) supervises the delivery of clinical services, performs billing, collection of charges, and tracking, and reporting of program income to the Project Director. The Office of Human Resources oversees the hiring process, reviews job descriptions and proposed salaries, assists in background checks, job offers and staff training. The Compliance Office

reviews contracts and agreements to ensure compliance with the law. The Office of Grants Management oversees Ryan White programs, ensures that current practices align with federal and State legislation, and that Ryan White funds are expended according to program budget, goals, and expectations. It works closely with MCWC and provides monthly grants expenditures reports to assure disbursements align with program goals and objectives. MCWC and the Office of Grants and Contracts hold monthly financial meetings with Ryan White Part A leadership. The Office of Finance verifies that MCWC manages Ryan White grants according to Generally Accepted Accounting Principles (GAAP). MCWC segregates Ryan White contracts, public, private, and other types of medical insurance in CAREWare to allow for easy tracking and accurate financial report using the service fees and units determined by Ryan White Part A Program. MCWC reinvests program income (billings collections from third-party payers and 340B pharmacy revenues) into overall budget to further program goals and objectives and cover ambulatory out-of-pocket expenses of low-income, underinsured clients. The Program Director reports the program income quarterly to Ryan White Part A and B. The Director of the Office of Grants and Contracts reports annual program income to HRSA via the Federal Financial Report (FFR).

5. Describe agency's process for completing program reports in a timely and accurate manner. Include descriptions of how responsibility for reporting is assigned to staff, how reports are reviewed for accuracy and who assures reports are completed on time.

MCWC staff enters data in CAREWare in real-time. The Program Director had created over 200 customized reports in CAREWare that allow for quick data analysis and reports, research advancement, and deeper understanding of program outcomes. These customized CAREWare reports also comprise data validation, quality checks, for duplicate, missing, and unknown data. CAREWare is able to create a list of all clients with missing/unknown, or duplicate data for the responsible staff to correct. Prior to submitting any reports, a quality check is run again to identify errors, warnings, and alerts needed to be fixed. All Ryan White required periodic reports and performance measures are embedded in CAREWare, i.e. Ryan White Service Report (RSR), Provider Data Export (PDE), program financial and service reports, etc.

III. Cultural and Linguistic Competency:

As a person closely affected by HIV himself, Dr. Berthaud has dedicated his professional career to improve and save the lives of people with HIV in New York, Tennessee, Latin America, Africa, and the Caribbean. He attributes high priority to cultural and linguistic competency. MCWC staff are trained in cultural competence, cultural humility, and trauma-informed care, and motivational interview. Six of our full-time staff are themselves people living with HIV for over 20 years. Sixty percent of our staff have been affected by HIV, and 70% live in the community they are serving. Client feedback is obtained daily through anonymous satisfaction surveys and quarterly from the Consumer Advisory Board (CAB). The CAB Chair attends our weekly staff

meetings, which reserves ample time for discussion of CAB concerns and the results of patient satisfaction surveys including corrective actions, implementation, and monitoring plan. MCWC leadership incorporates the final recommendations into program operations, specific projects, and/or grant applications. Educational materials are created according to the fifth-grade level based on health literacy research conducted at Meharry Community Wellness Center. Interpretation and translation services are readily available for all languages through a contractual agreement paid for by Meharry Medical College.

IV. Collaboration:

- 1 Describe a plan for creating a new or improving an existing network to improve collaboration with HIV agencies that will link PLWHAs to HIV testing and HIV medical care and support services. If applicable, identify any collaborating organizations that will assist the applicant through HIV testing and linkage to HIV medical care and services.**

Linkage of newly identified clients: Patients who diagnose HIV positive in the emergency department (ED) at Nashville General Hospital (NGH), located on the Meharry campus, are linked and enrolled into care the same or next business day. HIV providers and Medical Case Managers follow newly diagnosed persons with HIV (PWH) admitted to NGH and coordinate their discharge disposition. Clients newly identified outside the Meharry campus are linked as soon as possible, preferably within less than 7 days. The Patient Service Representatives (insurance verification), the Community Health Workers (coaching and navigation), and the Medical Case Managers (insurance assistance and Ryan White eligibility) are responsible for rapid linkage.

MCWC organizes outreach events with local partners including Metropolitan Nashville Health Department to raise HIV awareness and promote testing. As member of Nashville PrEP Coalition, MCWC facilitates the rapid linkage of newly diagnosed persons. It also leverages its experience as a research site for the SPNS project targeting newly diagnosed and out-of-care women of color for linkage and retention to enhance engagement in care. As a pioneer of HIV telemedicine in TN prisons and HIV consultant for Davidson County jails since 2006, MCWC facilitates the transition of ex-offenders to rapid linkage and engagement upon their release in the community.

Main referral relationships and collaborations include the following: Nashville General Hospital (NGH), Meharry teaching hospital, where Dr. Berthaud serves as Director of Infectious Diseases and Dr. Livette Johnson co-chairs the Infection Prevention Committee; NGH refers PWH from Emergency Department, inpatient, and outpatient clinics; Meharry Elam Mental Health Center, Meharry Family Medicine and MAT Clinic, located right across the hall from MCWC, and Meharry Clinics constitute regular sources of mutual referrals; Davidson County Sheriff's Office refers inmates with HIV to MCWC since 2005, while Tennessee Department of Corrections refers them for telemedicine consultation, a service established by Dr. Berthaud in 2006; Neighborhood Health, the largest FQHC in Davidson County, Ascension St Thomas Health (Dr. Berthaud maintains consultation privileges), and Metropolitan Nashville Health Department, the largest HIV testing center in Nashville, represent important referral sources. Metropolitan

Development Housing Authority awarded a HOPWA grant for the provision of Short-Term, Rent, Mortgage, and Utilities assistance. Street Works and Nashville CARES provide medical case management, food and housing services including permanent placement and emergency shelters. Second Harvest provides low-cost preserved food for our pantry. Vanderbilt University Medical Center provides emergency, specialty ambulatory, and inpatient care for MCWC clients. Tennessee Health Department had contracted with Meharry for ambulatory/outpatient and medical case management services. They provide technical support to medical case managers and assist in linkage/reengagement of clients lost to care. Metropolitan Nashville Public Health Department (MNPHD) refers newly diagnosed HIV-positive and lost-to-care people, treats persons with latent and active tuberculosis, and coordinates STD management and control. Under MNPHD sponsorship, Meharry received a Part A grant for core and support services. Meharry Elam Mental Health Center collaborates with MCWC Therapist/Drug Counselor on outpatient and inpatient drug treatment, detoxification, and rehabilitation. Meharry and Vanderbilt had signed a Data Usage Agreement for expanding participation of minorities in clinical research through the NIH-funded TN Center for AIDS Research (TN-CFAR), a joint venture including Nashville CARES and TN Health Department.

- 2 Contractor(s) must demonstrate their commitment to work with or collaborate with organizations representing the HIV/AIDS community through a signed and dated letter of support or memoranda of agreement or understanding. The letter must specify example activities that each entity provides that will help connect high risk clients to HIV testing and services.**

Meharry Community Wellness Center, Street Works, and Nashville CARES have a longstanding collaborative relationship. Dated signed letters that specify example activities that each entity provides that will help connect high risk clients to HIV testing and services are uploaded.

B. Reference Projects (10 Points) Service History & References:

- 1. If your agency currently provides this service(s) to the HIV/AIDS client population, describe the number of years you have provided this service and the funder of the service. Please provide a reference name and phone number.**

Meharry Medical College has been providing ambulatory/outpatient services to persons with HIV since the initial outbreak in 1981, i.e., even before the virus was discovered. Meharry Community Wellness Center opened in 2005 with funding support from Ryan White Part B and Part C. Ryan White Part A support started right after Nashville became an Emerging Metropolitan Area (EMA) in 2008. However, TN Health Department will stop funding for recipients who receive Part A funding starting on April 2026. Our Part C grant has been on freeze under Executive Order and HRSA has not issued the 2025 grant award yet. Therefore, Ryan White Part A had become lifesaving for people living with HIV in Nashville TGA. Meharry Community Wellness Center has been recipient of Part C Minority AIDS Initiative

(MAI) grant funding for Ambulatory/Outpatient Services since 2013 and of Part A MAI grant support since 2022.

For reference, we mention the name of our Part C EIS Project Officer
Christie Slay, MPA, MAEd, CHES, Public Health Analyst/Project Officer, Central
Branch, Division of Community HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, Rockville, MD 20857
Phone: 301.443.0504

- 2. If your agency does not currently provide service(s) to the HIV/AIDS client population, explain any related experience that would demonstrate the agency's competency in providing services to this population. Please provide a reference name and phone number.**

Not applicable.

- 3. Describe any related experience that would demonstrate your agency's competency in providing HIV medical or support services to this population. Please provide a reference name and phone number. The file is limited to 5 pages and should be in PDF format entitled "Reference Projects."**

The file labelled "Reference Projects" had been uploaded.
Here's the reference name and phone number:

Part C EIS Project Officer
Christie Slay, MPA, MAEd, CHES, Public Health Analyst/Project Officer,
Central Branch, Division of Community HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, Rockville, MD 20857
Phone: 301.443.0504

A. Project Approach and Process (30 Points)

I. Staffing:

Present in detail your organization's staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the number of time/hours per month being requested for each proposed staff position.

Minority AIDS Initiative (MAI) for Ambulatory/Outpatient Services

Staffing Plan of Key Personnel

Staffing Plan of Key Personnel				
Name	Roles	Responsibilities	Education/Training	Experience Part A FTE

Vladimir Berthaud, MD, MPH, FACP, FIDSA, DTMH, CPH	Project Director	Supervision of overall activities; HIV care and infectious diseases services	Board-certified in internal medicine, infectious diseases, public health, tropical medicine, and traveler's health.	International HIV expert with 39 years of experience in HIV care, research, training, teaching, program development, and implementation worldwide.
Zudi Takizala, MD, MPH, MBA	Finance Manager	Project management and CQI	Doctor of Medicine, with master's degree in public health and business	21 years of experience in management of \$30M in Federal, State, & local grants
Keisha Ashmeade Ed.D, MSPH, FNP, AHIVS	Clinic Manager	Manages clinic operations	HIV specialist and Board-certified NP	11 years of HIV care experience
Sheena S. Simon, DNP, APRN, NP-C	Primary HIV care provider	Comprehensive HIV management	Board-Certified Nurse Practitioner, specialized in prevention	22.44% FTE Six years of HIV care experience
Ethel Harris, DDS, MPH	Director of oral health services	Comprehensive oral care and prosthodontics	Meharry graduate, former Director of SEATC oral health	22 years of experience in oral health for PLWH
Ryan White Part A Staffing Plan				
Name	Roles	Responsibilities	Education/Training	Experience Part A FTE
Livette Johnson, MD	Infectious diseases management	HIV and specialty care	Meharry graduate, Board-certified in internal medicine and infectious diseases	40% FTE 35 years of experience and expertise in HIV care
Sheena S. Simon, DNP, APRN, NP-C	HIV care provider	Comprehensive HIV management	Board-Certified Nurse Practitioner, specialized in prevention	35% FTE Six years of HIV experience
Debra Simmons, LPN	Phlebotomist	Process laboratory specimens and perform nursing duties	Graduate of Baptist Hospital LPN School	50% FTE 9 years of experience serving PLWH

Maya Johnson, BS, MPH	Community Health Worker	Coaching, adherence counseling, patient navigation, community case management	MPH graduate from Meharry, with solid knowledge of SPSS, SAS, Redcap, GIS, and Microsoft environment	75% FTE One year of experience with PLWH
Tamiko Grimes	Community Health Worker	Coaching, adherence counseling, and patient navigation	Trained Peer Counselor and Community Health Worker	100% FTE 9 years of experience with PLWH
Osamudiamen Osa-Edoh, MD, MPH	Psychiatrist	Treatment of behavioral & substance use disorders	Board-certified psychiatrist, Director of substance use treatment at Meharry	15% FTE 10 years of experience with PLWH
Erlete Ascencao, PhD/PhD, HSP	Clinical Psychologist, Social Scientist	Specialized in HIV clinical psychology services	Doctor in Social Sciences and Clinical Psychology, Licensed Health Services Provider	100% FTE 22 years of experience with PLWH
Ronda Jennings, MA	Senior Medical Case Manager	HOPWA Case Manager, Mental health therapy and drug counseling	Master' degree in Clinical Counseling, Certified Alcohol and Drug Addiction Counselor	64.29% FTE 17 years of experience in medical case management and counseling with PLWH
JaRae Davenport, BS, MPH	Medical Case Manager	Medical case management services including treatment adherence	Master's degree in public health practice	100% Three years of experience in medical case management under Part A grant
Kaye Chavis, DBA	Medical Case Manager	Medical case management services including treatment adherence	Doctoral degree in Business Administration	90.02% 4 years of experience with PLWH and Ryan White Part A grant 23 years' MDHA experience

Qualifications of Key Personnel.

Vladimir Berthaud, MD, MPH, FACP, FIDSA, CPH, DTMH, is tenured professor of medicine, Director, Division of infectious diseases at Meharry Medical College and Nashville General Hospital and Founding Executive Director of Meharry Community Wellness Center. He completed his infectious diseases fellowship at Columbia University and Cornell University in New York. Dr. Berthaud has been a passionate advocate for PLWH and the recipient of numerous prestigious awards including IPRO's Outstanding Service to the Health Care Community Award for Quality Improvement in reducing Disparity for Adult Immunizations in New York State, Award for Outstanding Contribution to the Internal Medicine Training Program, Harlem Hospital/Columbia University College of Physicians & Surgeons, New York City Council Citation for Exemplary Service, National Library of Medicine/Marine Biological Laboratory, Fellowship Award in Medical Informatics, Nashville Business Journal, Award Honoring Superior Contributions to the Health Care Industry, Johnson & Johnson UCLA Healthcare Executive Management Award, Street Works Guiding Light Award, and Mahogany Honors Dwayne Jenkins Lifetime Achievement Award. Part C EIS Program Director for 20 years, Dr. Berthaud serves as Project Director/Principal Investigator for Meharry HIV Research and Training Facility, Mentor and Investigator for the NIH-funded U01-Practice-Based Research Integrating Multidisciplinary Experiences in Dental Schools (PRIMED), Associate Director of Clinical Discovery Core, for TN-CFAR, Clinical Lead for Meharry PEPFAR, and Program Director for HRSA-sponsored National HIV Residency Pathway Consortium. He has been a member of the Tennessee AIDS Centers of Excellence Committee since 2002. Other experiences include Train-of-Trainer Expert for the National HIV Curriculum, HIV Trainer for the National MTCT-Plus Program in Rwanda and Côte d'Ivoire, HIVAIDS Curriculum Developer for NIH/ACTG/HPTN in Latin America and the Caribbean and HIV Preceptor for IDSA International AIDS Training Program, HIV Curriculum Reviewer for CDC, and scientific advisor to CDC Program for TB Elimination, member of the National Board of Public Health Examiners, and of the National Board of Medical Examiners, Academic Advisor, UCLA School of Management, Community Health Improvement Program, and Member, American College of Physicians (ACP) Leadership Academy. Former member of the Leadership Conference and Admissions Liaison Officer, United States Military Academy at West Point, past Chair of The George W. Counts Interest Group of the Infectious Diseases Society of America (IDSA), past member of IDSA Leadership Development Committee, Dr. Berthaud is a member of the American Board of Internal Medicine Infectious Diseases Task Force and Faculty of the IDSA Leadership Institute. He was a Lead Principal Investigator for the international Kid COVE Vaccine Trial. Dr. Berthaud is Endowed Professor of Medicine, with Adjunct appointment in Microbiology, Immunology, and Physiology. He is Academic Editor for PLOS ONE medical journal and the author of many peer-reviewed publications in impactful scientific journals. Dr. Berthaud is fluent in Spanish, French, English, and Creole.

Livette Johnson, MD. A native Nashvillian and a graduate of Meharry School of Medicine, Dr. Johnson completed her internal medicine residency training at Johns Hopkins University in Baltimore and her infectious diseases fellowship at Cornell University in New York. She holds Board certification in internal medicine and infectious diseases. Dr. Johnson is

associate professor of medicine at Meharry Medical College and Vice Chair of Infection Prevention Committee at Nashville General Hospital. Dr. Johnson served as attending physician at Mount Sinai Hospital and Assistant Chief of Infectious Diseases at Metropolitan Hospital in New York. She brings a personal dedication to the care of populations living with HIV.

Zudi Takizala, MD, MPH, MBA. Doctor of Medicine with extensive experience in grant administration, financial management, and staff supervision, Dr. Takizala has a long record of collaboration with diverse internal and external stakeholders, community agencies, and Ryan White programs. She oversees clinical operations at Meharry Community Wellness Center. In the past three years, she had successfully managed 18 public grants including 10 Ryan White grants, and others from NIH, HOPWA, PCORI, Tennessee State and Metropolitan Nashville government.

Keisha Ashmeade, ANP, MSN, MSPH, Ed. D, AAHIVS, board-certified advanced nurse practitioner and certified HIV specialist, Dr. Ashmeade has been Clinical Manager of Meharry Community Wellness Center for seven years. She brings 10 years of experience in HIV primary care and seven years of teaching experience as Assistant Professor.

Ethel Harris, DDS, MPH, Director of Meharry Community Wellness Center's Oral Health Services, she holds joint Faculty appointment as Assistant Professor of Medicine and Dentistry at Meharry and serves as Clinical Investigator on the NIH-funded UO1 grant, "Practice-Based Research Integrating Multidisciplinary Experiences in Dental Schools". Dr. Harris served as Dental Director for the Southeast AIDS Education and Training Center (SEATC). She was born and raised in Nashville and she graduated from Meharry School of Dentistry.

If applicable, describe in detail the roles and responsibilities of any consultants and/or subcontractors will be used to conduct aspects of the proposed project.

This is not applicable.

II. Overview of Population:

Describe in detail the HIV/AIDS population in Davidson County. Describe in the detail the issues that interfere with identifying, engaging, and retaining PLWHAs in routine HIV testing and HIV services.

HIV/AIDS population in Davidson County.

Meharry Community Wellness Center stands at the epicenter of the HIV epidemic in Nashville, in the heart of Davidson County, more specifically, North Nashville, the neighborhood most densely populated in Blacks or African Americans (71%) where 1,933 of every 100,000 people are living with HIV as compared to 978.7 for Blacks in the remaining Nashville Transitional Grant Area (TGA). The TGA had an estimated population of 1,742,588 in 2019, accounting for 26.5% of the state's total population and 31% of the state's people

living with HIV (PLWH). In the thirteen counties that make the Nashville Transitional Grant Area (TGA) including Davidson, non-Hispanic Blacks account for 54% of PLWH and in 2021, they represented 27% of Davidson County's population and 52.4% of PLWH. While about 39% of the Nashville TGA's population lives in Davidson County, 76.5% of the PLWH population reside in Davidson County. Of this PLWH population, 20% had been in jail and 42% were homeless/unstably housed at some point in the last year, and 40.2% did not have food to eat three or more days at some point in the last year. Fear of disclosure (50.6%) represents the number one barrier to accessing services (Metropolitan Nashville Health Department). In Nashville TGA, an estimated 17% of PLWH are unaware of their status. In 2020, 66% of newly diagnosed cases were linked to care in 30 days, 54% were retained, and 66% achieved viral suppression. Among Non-Hispanic Blacks, 64% were linked to care within 30 days, 54% were retained and 63% became virally suppressed, and they had the highest incidence of Chlamydia, gonorrhea, and syphilis. Meharry Community Wellness Center (MCWC) serves the most vulnerable and hardest-to-reach PLWH in Tennessee. In 2024, our program served 484 unduplicated clients. African Americans accounted for 77.06%, women 26.44% and MSM 42.35%. Our clients bear an excess burden of uninsured (39.25%), poverty (48.96% below 100% FPL), and history of incarceration (20%), homelessness (19.2%, higher than in Davidson's 13.6%), and substance use and behavioral disorders (30%). More than 70% of our clients did not graduate from high school. Our proportion of clients experiencing homelessness represents more than twice the national average for PLWH (8.4%) and is 50% greater than the national Ryan White average (12.9%). According to the Brookings Institution, North Nashville has an incarceration rate of 14%, by far the highest in the country, and 93% of those incarcerated are Blacks. Our patient population has an alarming prevalence of severe tooth decay (60%) and severe periodontitis (30%). Meharry Community Wellness Center (MCWC) represents the only Tennessee clinic that offers unfettered access to fully integrated, comprehensive oral health services for low-income PLWH regardless of their primary HIV care providers. The Tennessee Ryan White Dental Assistance Program (RWDAP) ran out of funding in April 2019 and left 1,800 clients with very limited or non-existing access to oral health services. Only 10% of our clients have dental insurance coverage and just 2% of them have adequate coverage. Since 2023, TennCare offers limited oral health benefits to eligible clients. So far, they have not referred any patients to our dental clinic. The prospect for new funding remains grim because of a large budget shortfall in the Tennessee Ryan White B program that required across-the-board budget cuts leading to a reduction of our annual budget by \$76,510.50 since 2021-2022 and termination of funding for Part A grantees in 2026.

Issues that interfere with identifying, engaging, and retaining PLWHAs in routine HIV testing and HIV services.

Gaps in local services. Major gaps in MCWC/TGA HIV care continuum, retention, and viral suppression, can be attributed to high rates of incarceration (20%), homelessness (MCWC 19.2%; TGA 13.8%), and poverty (39.25% below 100% FPL), behavioral and substance use disorders (30%), and chronic comorbidities such as cancer, cardiovascular diseases, chronic kidney and lung diseases. Moreover, gaps in medical and dental insurance coverage, TennCare restrictions on the number of monthly prescriptions, and food shortage, lack of

family support as well as stressful life events too often lead to poor treatment adherence and negative health outcomes such as HIV disease progression, exacerbation of co-morbidities, frequent visits to specialty clinics, emergency department and admissions to the hospital, mental institutions, and drug treatment centers. Huge gaps persist in oral health, substance use disorders, medical transportation, and housing services.

Major Barriers to Care:

Incarceration: Of 516 inmates with HIV served by MCWC from 2003 to 2018, 64% were Black or African American and 66% aged 45-64. Stepwise implementation of telemedicine in 2006 led to increase in clinic attendance from 50% to 90% and viral suppression from 30% to 90% (Berthaud V. 2022 National Ryan White Conference). Of PLWH incarcerated in Davidson County jails, Non-Hispanic Blacks account for 71% and non-Hispanic Whites 29%. North Nashville has an incarceration rate of 14%, the highest in the country by far, and 93% of those incarcerated are Blacks. In other words, one in seven people who were born in the primary zip code of North Nashville between 1980 and 1986 went to jail or prison at some point in their lives. (Adams L, Nicholas T: Work and opportunity before and after incarceration. The Brookings Institution, March 2018). Twenty five percent of our patients reside in that neighborhood and 41% of them belong to this age group. MSM is still the most frequent means of exposure accounting for 37.5%, and IDU the second most reported exposure category among the jail population (22.1%). Heterosexual exposure accounts for 18.9% of PLWH in jail and MSM/IDU account for 6.3% of the cases; unreported exposure accounts for (15.1%). (Source: Nashville Metropolitan Health Department). Meharry Community Health Worker had established a strong collaborative relationship with Tennessee Department of Corrections (TDOC) and Davidson County Sheriff's Office (DSCO) for over 20 years. Persons with HIV who are incarcerated in DSCO are referred to MCWC for in-person care, while inmates of TDOC are seen by telemedicine.

Transportation: Public bus service in Nashville is extremely limited to some parts of downtown and very few stops in North and West Nashville. It nearly does not exist in South and East Nashville. Most of our patients resides far away from a bus stop. They require multiple transfers to come to the clinic or simply rely on a ride with a relative or a friend. The bus service makes short stops every hour between 8:00am and 4:30pm. There is no subway line in Nashville and Tennessee. MCWC had hired a full-time person to provide free round-trip medical transportation in the Transitional Grant Area (TGA).

Education: High school completion rate is 76% in Davidson County and 15% at MCWC.

Unemployment and poverty: 39.25% of Meharry clients had an annual income <100% FPL in 2023. Unemployment rate reached 60% and 30% were receiving Social Security Income. Drug and alcohol: Addiction to drugs and alcohol remains a significant risk factor for poor nutrition and treatment adherence, bad health outcomes, incarceration, and homelessness. However, there are insufficient access points to drug detoxification and rehabilitation in Davidson County. Many offenders released on parole or probation cannot get into drug or alcohol treatment. Consequently, they are often re-incarcerated for parole or probation violation. Periodic mandatory report to parole or probation officer had become their major competing priority. Moreover, many African Americans had switched from injection drugs to cocaine snorting or smoking, without any available treatment option.

Housing is the utmost priority for persons addicted to drugs who are experiencing homelessness. As Nashville is becoming a major destination for relocation of businesses and people, affordable housing had become very scarce, while homelessness continues to rise. Aggressive gentrification further aggravates the shortage of affordable housing units. Moreover, the Department of Housing and Urban Development (HUD) had tightened requirements and narrowed their definition of homeless, which requires that clients be in a shelter for three days before being deemed eligible. Clients with criminal records, active addiction, and mental health issues are denied housing (both public and private); limited transitional, assisted living or group homes are available. Recently released convicts present other critical challenges such as limited access to employment, financial loans and social support. During the past five years, in Nashville, Tennessee, the trend of homelessness paralleled the economic growth curve that propelled a booming housing market. “Nearly 70% of Nashville ever-changing skyline wasn’t there 10 years ago” according to Nashville Chamber of Commerce. In April 2024, the median price for residential single-family homes in Nashville was more than \$500,000 for the first time. In the aftermath of the March 3, 2020, devastating tornado that destroyed numerous homes in North Nashville and the subsequent coronavirus pandemic, the number of displaced families grew exponentially. Most of the patients attending Meharry Community Wellness Center (MCWC) reside in North Nashville. Many of them lost their jobs in places such as hotels, restaurants, and factories due to local and state government-imposed “Stay-at-Home” and social distancing orders related to mitigation of the COVID-19 pandemic. The national economic downturn during the coronavirus pandemic exacerbated the homelessness crisis and widens the gaps in care and HIV health disparities. Our proportion of clients experiencing homelessness represents more than twice the national average for PLWH (8.4%) and is 50% greater than the national Ryan White average (12.9%).

Community environment: An often-forgotten barrier is the fact that 70% of our patients live in the same neighborhood and are very familiar with each other. Fear of disclosure of HIV status, stigma, and discrimination, prejudice, religious concerns, and misconceptions remain enormous barriers to accessing HIV care.

Barriers to reaching Tennessee’s disproportionately-impacted populations:

African-American MSM: lack of awareness, or misinformation about HIV transmission, prevention, and treatment; impact of homophobia on health-seeking behavior; lack of access to health care generally; and denial of risk.

Young MSM: misperceptions about HIV risk; denial and complacency associated with being a late adolescent; difficulties comprehending the seriousness of HIV, coupled with rejection by family and friends.

High-risk heterosexuals: lack of perceived risk; poverty, limited access to health care and health information; acting as caregivers in families; and financial dependency on a partner.

Incarcerated: stigma (isolation & potential for violence due to HIV status); misinformation about HIV transmission, prevention, and treatment (situational sex/” gay for the stay”); and lack of awareness or access to testing and/or health care services upon release.

Ryan White Part C Minority AIDS Initiative Report.

- To recruit persons with HIV (PWH) of the MAI target population, MCWC conducted outreach activities at multiple events:

Nashville Mayor's Ending-the-Epidemic, PRIDE Day, Black PRIDE, World AIDS Day, National HIV Black Awareness Day, and HIV Testing Day, and The African Street Festival. MCWC also leverages its partnership with Tennessee Department of Corrections, Metro Health Department, Davidson County Sheriff Office, Nashville General Hospital, United Neighborhood Health Centers, and Street Works. The Program Director promotes HIV awareness on Fisk Radio program, Health Waves. In general, the positivity yield of HIV testing in Nashville/Davidson County during outreach activities is less than 1%.

- How targeted testing is done for PWH of the MAI target population, and positives identified.

MCWC focuses on partners of non-virally suppressed clients, persons with sexually transmitted infection(s), or those with risky sexual behavior. Thus, from 01/2023 to 8/2023, MCWC performed targeted HIV testing for 60 high-risk persons on-site. Six of them (8.3%) tested HIV-positive. They were enrolled in care and started on ART immediately.

- How identified positives are linked to and enrolled in care.

People who test HIV-positive in the clinic or on the Meharry campus are linked to care and started on ART the same day; those referred from outside the campus are seen as soon as possible, usually within less than a week. EIS Worker, Community Health Workers, and the Community Care Team are responsible for linkage of identified positives to care. The Community Care Team meet twice a week to discuss newly identified positives and facilitate engagement. Medical case managers and medical providers collaborate in identifying and enrolling new clients. Altogether, they arrange for medical transportation, inform about core and support services, and expectations at initial clinic visit.

- How the PWH are retained in care.

The Patient Service Representative and Community Health Workers contact clients one week and 24-72 hours prior to their scheduled clinic appointments. They reach out by phone, text message, or e-mail to those who missed their visits the same day and attempt to reschedule them, while trying to address the root causes of missed appointments. If these attempts are unsuccessful after one or two weeks, they will mail a certified letter of notification at the client's last address.

Medical case managers and HIV medical providers identify new and current clients at high risk for drop out-of-care and refer them to the Community Care Team. They analyze challenges, barriers, and facilitators to develop and implement a joint plan of care for intensive adherence counseling, peer coaching, performance monitoring, and evaluation. Difficult cases are discussed at weekly staff meetings for broader input.

The Community Care Team reviews the out-of-care list and deploy all their effort to locate the client, reach out to their authorized contact persons, state prisons and jails, local hospitals and drug treatment centers, and homeless camps. Once they are unable to locate the client, they will arrange an in-person visit at their residence or their hangout places. If that fails, they will solicit assistance from the local and state Health Department as well as other community organizations. As a last-ditch effort, they will access the obit announcements.

Describe in detail:

- 1) The number of persons you plan to serve with the funding.**
- 2) The number of units of service you plan to provide by type of intervention (e.g.,**

number of face-to-face contacts with clients and amount of time each client will be seen each year, number of educational sessions provided, number of contacts with gatekeepers); and

3) the average amount of service a client is expected to receive each year (e.g., 2 face to face each year) and the amount of time that will be spent with gatekeepers (e.g., 3 hours/gatekeeper/year).

With this funding, we propose to serve 200 persons with HIV, distributed as follows:

Male 76%; Female 24%

African American 80%; Caucasian: 19%; other 1%

Hispanic 10%

Age group: 13-24: 0.1%; 25-44: 54%; 45-64: 45%; 65+ 0.9%

They will provide 500 units of 15 minute each in face to face medical care and 300 units in non-face to face service provided by two Part A funded salaried Community Health Workers in the grant year.

III. Implementation Plan:

The importance of improving progress along the HIV care continuum is supported using scientific research that leads to the identification of best practices and evidence-based practices. The use of best practices/evidenced informed models is preferred for all services and as applicable/available.

Describe in detail any evidence bases or best practice models you will use to provide the service. Include a reference to the model's name and source of the best practice (e.g., "Healthy Living Project," CDC Evidence-Based Intervention-EBI).

<https://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html>

Ideally, interventions will be based upon proven outreach and engagement models; and/or adaptations of proven models; and /or novel models of outreach and engagement in care, particularly developed for the HIV/AIDS population.

Meharry Community Wellness Center will provide primary HIV care based on the latest Guidelines and Recommendations of the Department of Health and Human Services (DHHS) for prevention and treatment of HIV-associated opportunistic infections. These Guidelines summarized the best evidence as assessed by a panel of national HIV experts. Moreover, our experience as one of the three national performance sites, for the HRSA-sponsored Special Project of National Significance (SPNS), "Dissemination of Evidence-Informed Interventions: Peer Linkage and Re-Engagement of HIV-Positive Women of Color" in 2016-2019 inspired the Community Care Team Model implemented by our program in 2020. The Manual is available at: <https://www.targethiv.org/deii/deii-peer-linkage>.

Peer Linkage and Re-engagement of Women of Color with HIV. Rajabiun S., Marbach A., Fox J., Childs E., Sullivan M., Downes, A., Bryant H, Nortrup E., Berthaud V., Alexander L., Grimes T., et al. Dissemination of Evidence-Informed Interventions. Peer Linkage and Re-engagement of Women of Color Living with HIV (2020). Available at:

<https://www.targethiv.org/deii/deii-peer-linkage>. The peer-reviewed manuscript is referred here: Serena Rajabiun, Janet J. Myers, Janet Goldberg, Karen Fortu, Marena

Sullivan, Vladimir Berthaud, Rahab Wahome, and Howard J. Cabral. "Outcomes from the adaptation of an evidence-based Peer Linkage & Re-engagement: Intervention for Women of Color with HIV in three urban clinics". *AIDS and Behavior*. October 05, 2021. PMID: 34609629.

For all Ryan White projects, Meharry Community Wellness Center also implements the most recent Standards of Care published by Tennessee Health Department Ryan White Part B Program and Metropolitan Nashville Health Department Ryan White Part A Program.

Retention strategies: To improve retention and viral suppression, Meharry Community Wellness Center (MCWC) had formed the Community Care Team, which meets twice weekly to discuss clients with incoming appointments, those who missed their recent clinic visits, and those lost to care. MCWC works diligently to schedule all of a client's visits the same day. The Patient Service Representatives or the Community Health Workers contact the client one week and 24-48 hours before the appointment date to facilitate the clinic visit. They arrange for round-trip medical transportation, if needed. Those who missed their scheduled visits are contacted in less than 24 hours. If they are unable to reach a client by phone calls, text messages, e-mails, or letters, after 2 weeks, the Community Health Worker attempts to make a home visit. If that fails, they reach out to Nashville Health Department EIS Worker, Davidson County Sheriff Office and Tennessee Department of Corrections, the Coalition for the Homeless, drug treatment centers, mental health institutions, local hospitals, and nursing homes, for investigation. If these strategies fail after 6 months, the TN Health Department Disease Intervention Specialist (DIS) is alerted for further tracking efforts. Clients who miss more than two consecutive appointments receive intensified adherence counseling and coaching.

Targeted retention efforts toward subpopulations with poor health outcomes. The Community Health Workers and PSRs target MSM, women of color, and clients with challenging issues such as mental illnesses, substance use disorders, and pervasive stigma. The Medical Case Managers assist clients experiencing homelessness in permanent placement, prevention of eviction, and maintenance of stable housing. The HOPWA Case Manager assists clients with rent, mortgage, and utilities bills. The Community Health Workers provide clients with medical transportation, food services, and pharmacy management to facilitate clinic visits and medication adherence. The medical providers coordinate with staff to facilitate joint clinic appointments. All clients are screened for behavioral and substance use disorders and those who screen positive are seen by the clinical psychologist, the psychiatrist, and/or the therapist/counselor.

Coordination of medical and support services for pregnant women.

An obstetrician-gynecologist with over 25 years of experience including 15 years at MCWC, Dr. Vernita Tucker, will manage pregnant women in the clinic in close coordination with medical providers and nurses during the entire prenatal, peripartum and postpartum period. All pregnant women will be offered ART, if not on yet, and counseled regarding the benefits and risks of ART during pregnancy for the woman, fetus, and newborn. Adherence to ART may decline in the postpartum period. Therefore, clinical and support staff caring for postpartum women on ART will stress adherence and evaluate specific facilitators and barriers. Two Meharry board-certified infectious diseases pediatricians, Dr. Shahana

Choudhury and Dr. Christopher Keefer, will manage HIV-exposed babies. Prenatal and HIV care visits as well as neonatal and maternal medical visits will occur on the same day. Attention will be paid to nutrition, medical transportation, housing status, and medical insurance coverage.

Unmet need and HIV care continuum: In 2020, 66% of newly diagnosed people in Tennessee were linked to care within 30 days, compared to 64% in 2018; 54% were retained in care (same for non-Hispanic Blacks) and 66% achieved viral load suppression (63% for Non-Hispanic Blacks). In Nashville TGA, an estimated 17% of PLWH are unaware of their status. In 2020, 66% of newly diagnosed cases were linked to care in 30 days, 54% were retained, and 66% achieved viral suppression. Among Non-Hispanic Blacks, 64% were linked to care within 30 days, 54% were retained and 63% became virally suppressed. Among Non-Hispanic Black PLWH, there were significant differences in care retention by age group ($p < 0.0001$). The lowest rates of care retention in this subpopulation were found among 13-24-year old (44%) and 25-34-year-old (52%). Among Non-Hispanic Black PLWH, there were significant differences in viral suppression by age group ($p = 0.0009$). The lowest rates of viral suppression were found among 13-24-year old (51%), 35-44-year-old (57%), and 25-34-year-old (58%). In TN and the Nashville TGA, the Ryan White program represents the strongest contributor to successful outcomes along the HIV care continuum as shown in this figure. Source: TN Health Department sponsored presentation TN HIV Continuum of Care: Update, Peter F. Rebeiro, MHS, PhD. (September 24, 2015)

We examined the effect of homelessness on viral suppression between 2014-2019. Our retrospective study revealed that permanently/stably housed clients had a much higher proportion of viral suppression compared to unhoused clients. Among clients with viral load < 20 copies/mL, 78% were permanently housed and 22% homeless, while 74% of permanently/stably housed clients reached viral suppression and a smaller proportion of the homeless clients (54.7%) remained virally suppressed (Pearson's Chi-Square 25.171, $p < 0.001$). The multivariable logistic regression showed that permanent/stable housing (p -value < 0.001), higher frequency of CD4 count > 500 cells/mm³ (HIV infection, stage 1) (p -value < 0.001), age (p -value = 0.004), and FPL (p -value = 0.031) were strong predictors of viral suppression. As expected, patients living in permanent/stable housing had twice the chance of achieving viral suppression compared with those who were experiencing homelessness [OR 2.08 (1.39-3.23), p -value < 0.001]. Under the nonparametric assumption, the receiver operating characteristic (ROC) curve correctly predicted 72.3% of the primary outcome variable, viral suppression (AUC = 0.767; p -value < 0.001 ; 95% CI for AUC (0.73, 0.80). During the 5-year study period, 52 clients died. Of them, 16 (30.76%) were experiencing homelessness and 36 (69.23%) lived in stable housing, while 12.5% of the homeless and 61.12% of those in stable housing achieved viral suppression at the time of death (Berthaud V. et al. BMC Infectious Diseases, 2022; 22: 144). This seminal paper inspired the 2022 CDC Issue Brief, "The Role of Housing in Ending the HIV Epidemic" and a Human Resources and Services Administration (HRSA) Notice of Funding Opportunity for housing of PWH. The Infectious Diseases Society of America cited our paper in their special issue dedicated to homelessness and infectious diseases (Emily Mosites, Laura Hughes, and Jay C. Butler. Homelessness and Infectious Diseases: Understanding the Gaps and Defining

a Public Health Approach: Introduction. The Journal of Infectious Diseases 2022;226(S3): S301–3).

IV. Best Practices:

Provide a clear and succinct description of the proposed project to implement an intervention model designed to create access to HIV testing, improve timely entry, engagement, and retention in quality HIV medical care for persons living with HIV infection.

Initial medical evaluation: The goals of the initial evaluation are to confirm the HIV diagnosis, obtain appropriate baseline historical and laboratory data, provide treatment adherence counseling, and ensure patient understanding about living with HIV, its modes and risks of transmission, and to initiate care as soon as possible as recommended by the Department of Health and Human Services (DHHS) under HIV primary care guidelines for prevention and treatment of HIV-associated opportunistic infections.

In the case of previously treated patients who present for an initial evaluation, it is critical to obtain a complete antiretroviral (ARV) history (including drug-resistance testing results, if available), preferably through the review of past medical records. Newly diagnosed patients shall also be asked about any prior use of ARV agents for prevention of HIV infection.

Follow-up visits: After the initial visit, patients deemed at high-risk for dropout and poor treatment adherence shall be followed at least biweekly for intensive case management, peer support, and close medical monitoring. Appointments will be spaced out at larger intervals once they are stabilized and virally suppressed. Stable patients shall be seen every 2-3 months during the first 2 years, then, every 4-6 months once their viral load had been suppressed for 2 consecutive years. Virally suppressed patients with CD4 count > 500 over 2 years can be seen once or twice a year. At each follow-up visit, the medical record shall be updated considering patient complaints, treatment adherence and medication tolerance, referrals, laboratory and procedures results, recent visits to emergency departments, hospitalizations, incarceration, homelessness, outpatient or residential drug treatment, family and personal life changes.

Describe the strategies you will use to identify and engage with key stakeholders recognized and trusted by the HIV/AIDS community; include the names of specific people and entities.

Describe the components of your intervention model and its specific strategies that will:

- a) **Increase awareness of HIV disease, with a focus on reaching persons at high risk for becoming infected with HIV disease.**
- b) **Identification of high-risk persons who need but do not access regular HIV tests and how you will link those persons to HIV testing agencies; and**
- c) **Identification of persons who are HIV positive but have never or who have dropped out of HIV medical care and services and how you will facilitate linking those persons with needed HIV services and care.**

Proposed interventions must address personal, financial, sociocultural, and structural barriers, especially stigma, that affect PLWHAs access to HIV testing and retention in HIV medical care and services. Define specific barriers that may be

encountered by the population being served and discuss how your proposed interventions will positively address each of these barriers.

Meharry Community Wellness Center (MCWC) organizes outreach events with local partners including Metropolitan Nashville Health Department to raise HIV awareness and promote testing. As member of Nashville PrEP Coalition, MCWC facilitates the rapid linkage of newly diagnosed persons. It also leverages its experience as a research site for the SPNS project targeting newly diagnosed and out-of-care women of color for linkage and retention to enhance engagement in care. As a pioneer of HIV telemedicine in TN prisons and HIV consultant for Davidson County jails since 2006, MCWC facilitates the transition of ex-offenders to rapid linkage and engagement upon their release in the community.

Patients who diagnose HIV positive in the emergency department (ED) at Nashville General Hospital (NGH), located on the Meharry campus, are linked and enrolled into care the same or next business day. HIV providers and Medical Case Managers follow newly diagnosed persons with HIV (PWH) admitted to NGH and coordinate their discharge disposition. Clients newly identified outside the Meharry campus are linked as soon as possible, preferably within less than 7 days. The Patient Service Representatives (insurance verification), the Community Health Workers (coaching and navigation), and the Medical Case Managers (insurance assistance and Ryan White eligibility) are responsible for rapid linkage.

Community Care Team Model. To optimize patient care at multiple access points and shift from a disease-based model to truly patient-centered care, MCWC will implement the community care team model based on four tracking pathways, A, B, C and D.

A: Patients who attend clinic appointments regularly, maintain viral load suppression, and may have zero to low-level comorbidities and social determinants of health. (*Focus: prevention, health promotion, and reinforcement of adherence*)

B: Patients who are missing scheduled appointments (no-shows, walk-ins), do not maintain viral load suppression, and may experience rising levels of comorbidities and social determinants of health. (*Focus: increase adherence counseling, health education, and rapid intervention, and identify, and address emerging risk factors for adverse outcomes*)

C: Patients who do not attend clinic appointments regularly, may have variable levels of viral load suppression and comorbidities, and high levels of challenging social determinants of health impacting treatment adherence, the HIV care continuum, and overall health and wellness, and representing greatest life priorities. (*Focus: intensive medical case management and peer support, ensure unfettered access to clinical and support services, and collaborate with community agencies to prevent critical progression*)

D: Patients who may not attend clinic appointments regularly and have variable levels of viral load suppression, and may be facing high levels of chronic diseases that are becoming higher health priorities than HIV, and have variable levels of social determinants of health. (*Focus: coordination of multispecialty services and referrals, and disease education*).

The Community Care Team (CCT) will implement an HIV service delivery model that will facilitate patient tracking, peer-to-peer support, differentiated case management, improve retention, viral load, and health outcomes. The CCT will strive to track clients at their ever-

changing points-of-contact, particularly the hard-to-reach, highly vulnerable, and marginalized individuals, and those who are struggling with adverse social determinants of health, HIV disease progression and significant comorbidities. In fact, the results of our pilot study showed the following viral suppressions: **100% for Pathway A, 78% for B, 43% for C, and 65% for D.** (*Berthaud V, Special Presentation, 2020 National Ryan White Meeting*).

Strategies to improve care transition focus on inmates, youth living with HIV and hospitalized patients who are HIV positive. Meharry infectious diseases specialists serve as HIV consultants for TN Department of Corrections and Davidson County Sheriff's Office. At the time of consultation, they will identify inmates ready to transition into the community and initiate the contact between prison or jail personnel and MCWC staff such as PSR, EIS Worker, Community Health Workers, Therapist/Drug Counselor, and Medical Case Managers, to coordinate transitional services, with the intent to schedule the first clinic appointment on the same day of release or within one week. Meharry infectious diseases physicians will follow all persons with HIV hospitalized at Nashville General Hospital and coordinate their discharge and linkage to care in close collaboration with hospital physicians, nurses, and case managers and MCWC staff. They will also coordinate the care of their patients who are admitted to another acute or long-term care facility. The Community Health Workers will follow clients hospitalized in other medical facilities and share authorized health information with outside providers to ensure continuity in care. They will coach youth living with HIV and help them navigate the HIV service delivery system.

Coordination of medical and support services for pregnant women.

An obstetrician-gynecologist with over 25 years of experience including 15 years at MCWC, Dr. Vernita Tucker, will manage pregnant women in the clinic in close coordination with medical providers and nurses during the entire prenatal, peripartum and postpartum period. All pregnant women will be offered ART, if not on yet, and counseled regarding the benefits and risks of ART during pregnancy for the woman, fetus, and newborn. Adherence to ART may decline in the postpartum period. Therefore, clinical and support staff caring for postpartum women on ART will stress adherence and evaluate specific facilitators and barriers. Two Meharry board-certified infectious diseases pediatricians, Dr. Shahana Choudhury and Dr. Christopher Keefer, will manage HIV-exposed babies. Prenatal and HIV care visits as well as neonatal and maternal medical visits will occur on the same day. Attention will be paid to nutrition, medical transportation, housing status, and medical insurance coverage.

Meharry Community Wellness Center collaborates with diverse stakeholders to identify persons who are HIV positive but have never or who have dropped out of HIV medical care and services and facilitate linking those persons with needed HIV services and care: Nashville General Hospital (NGH), Meharry teaching hospital, where Dr. Berthaud serves as Director of Infectious Diseases and Dr. Livette Johnson co-chairs the Infection Prevention Committee. They work closely with hospital staff to identify patient who are out of HIV care and re-engage them immediately. Inpatient referrals are seen the same day and outpatient referrals are seen in less than a week. A Medical Case Manager and a Community Health Worker will introduce themselves to the hospitalized patient with HIV to educate them about our HIV program and expectations at initial clinic visit. They will coordinate patient discharge with medical providers

and Case Managers and arrange for those who are eligible for commercial medical insurance, TennCare, Medicare, or VA insurance initiate the enrollment process as soon as possible. They will inform those deemed eligible for Ryan White insurance coverage about the program requirements, policies, and procedures. The same process is applied to all other referring partners as circumstances allow. NGH refers PWH from Emergency Department, inpatient, and outpatient clinics; Meharry Elam Mental Health Center, Meharry Family Medicine and MAT Clinic, located right across the hall from MCWC, and Meharry Clinics constitute regular sources of mutual referrals; Davidson County Sheriff's Office refers inmates with HIV to MCWC since 2005, while Tennessee Department of Corrections refers them for telemedicine consultation, a service established by Dr. Berthaud in 2006; Neighborhood Health, the largest FQHC in Davidson County, Ascension St Thomas Health (Dr. Berthaud maintains consultation privileges), and Metropolitan Nashville Health Department, the largest HIV testing center in Nashville, represent important referral sources. Metropolitan Development Housing Authority awarded a HOPWA grant for the provision of Short-Term, Rent, Mortgage, and Utilities assistance. Street Works and Nashville CARES provide medical case management, food and housing services including permanent placement and emergency shelters. Second Harvest provides low-cost preserved food for our pantry. Vanderbilt University Medical Center provides emergency, specialty ambulatory, and inpatient care for MCWC clients. Tennessee Health Department had contracted with Meharry for ambulatory/outpatient and medical case management services. They provide technical support to medical case managers and assist in linkage/reengagement of clients lost to care. Metropolitan Nashville Public Health Department (MNPHD) refers newly diagnosed HIV-positive and lost-to-care people, treats persons with latent and active tuberculosis, and coordinates STD management and control. Meharry Elam Mental Health Center collaborates with MCWC Therapist/Drug Counselor on outpatient and inpatient drug treatment, detoxification, and rehabilitation. Dr. Osa-Edoh, the Part A funded psychiatrist, is also the Director of the Drug Treatment Program at Elam Center.

Service Specific Questions:

1. Service Model

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of your proposed project. Include all aspects of planning, implementation, and evaluation, listing the role of everyone involved in activity.

2. Work Plan

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of your proposed project. Include all aspects of planning, implementation, and evaluation, listing the role of everyone involved in each activity.

The work plan should include clearly written:

- 1. Goals**
- 2. Objectives that are specific, time-framed, and measurable**
- 3. Action steps**
- 4. Staff responsible for each action step; and**
- 5. Anticipated dates of completion.**

Please note that goals for the work plan are to be written for the first year of the grant. Discuss any challenges that are likely to be encountered in planning and implementing the project’s activities described in the work plan and describe realistic and appropriate approaches to be used to resolve these challenges.

Work Plan

Goals	Objectives	Action Steps	Anticipated Date of Completion	Responsible Staff
Increase viral suppression	85% viral suppression by end of Year 1	Periodic viral load monitoring as per DHHS guidelines Monitor treatment adherence Monitor health complications and chronic comorbidities	End of Year 1	Medical providers Medical providers, Medical Case Managers, Community Health Workers
Increase retention in care	78% retention in care by end of Year 1	Early identification of clients at high-risk for dropout and treatment failure Provide intensive coaching and case management Monitor and evaluate barriers, challenges, and facilitators to treatment adherence and clinic attendance	End of Year 1 End of Year 1 End of Year 1	Medical providers Medical Case Managers Community Health Workers Medical providers Community Health Workers Therapist Medical providers Mental Health Therapist Psychiatrist

		Facilitate access to treatment of behavioral and substance use disorders, medical transportation, housing and food services	End of Year 1	Clinical Psychologist Therapist Community Health Workers
		Track clients who missed clinic appointments weekly	End of Year 1	Community Health Workers Medical Case Managers
		Collaborate with community-based organizations, local and state health departments, and correctional facilities	End of Year 1	Community Health Workers Medical Case Managers

Aggregate measures of viral suppression and retention are already incorporated in the HRSA-required Performance Measures section of CAREWare. We have customized the system to measure viral load for subpopulations.

Challenges and Resolutions		
Challenges	Approaches for Resolutions	Barriers
Homelessness	HOPWA grant for Short-Term Rent, Mortgage, and Utilities (STRMU) does not match explosive real estate costs in the TGA.	Many of our clients experiencing homelessness are excluded from public housing because of restrictive housing policies and limited HOPWA funding.
Limited transportation service	Medical transportation service provided by program income.	Limited or in-existent public transportation.

<p>Food shortage</p>	<p>Raise Part A Food Voucher card from \$20 to \$60 to adjust for inflationary cost.</p> <p>Program income-supported Food Pantry with unrestricted access in collaboration with Second Harvest.</p>	<p>Lack of job skills & education, unemployment, and poverty, exacerbate food shortage.</p>
<p>High rate of incarceration</p>	<p>Clinical psychologist, psychiatrist, therapist/drug counselor address behavioral and substance use disorders and relapse, and the roots of incarceration.</p>	<p>Limited access points for substance use treatment; high rate of drug charges, incarceration, and recidivism.</p>

Our landmark paper was the first to highlight the negative effect of homelessness on HIV viral suppression and mortality in Middle Tennessee and its potential challenges to ending the HIV epidemic. (Vladimir Berthaud; Livette Johnson; Ronda Jennings et al. “The Effect of Homelessness on Viral Suppression in an Underserved Metropolitan Area of Middle Tennessee: Potential Implications for Ending the HIV Epidemic”. BMC Infectious Diseases. 2022 Feb 10; 22: 144). This retrospective analysis reveals that permanently/stably housed clients had a much higher proportion of viral suppression compared to their unhoused counterparts. Among clients with viral load <20 copies/mL, 78% were permanently housed and 22% unhoused. This seminal paper inspired the 2022 CDC Issue Brief, “The Role of Housing in Ending the HIV Epidemic” and a Human Resources and Services Administration (HRSA) Notice of Funding Opportunity for housing of PWH. The Infectious Diseases Society of America cited our paper in their special issue dedicated to homelessness and infectious diseases (Emily Mosites, Laura Hughes, and Jay C. Butler. Homelessness and Infectious Diseases: Understanding the Gaps and Defining a Public Health Approach: Introduction. The Journal of Infectious Diseases 2022;226(S3): S301–3).

B. Budget (35 Points)

Complete the entire Budget Spreadsheet attachment (excel version) which describes how your will use the funds to provide the service requested in the scope of work for this solicitation. Include detailed information about the number and type of staff your firm will fund, staffing costs and other specific costs associated with providing the service. Contractor(s) will be allowed to budget up to 10% for administrative costs, including indirect charges.

Leaving blanks on any of the Budget Spreadsheets and/or not following the provided format may result in your proposal being deemed non-responsive.

The entire Budget Spreadsheet attachment has been completed and uploaded.

MEHARRY COMMUNITY WELLNESS CENTER

MAI SERVICES

ORGANIZATION AND TEAM QUALIFICATIONS

I. ORGANIZATIONAL BACKGROUND

1. Describe in detail the background of your agency. Include the purpose of your organization, years of experience in providing services to People Living With HIV/AIDS (PLWHAs) and the years of providing these services (note if any HIV specific services are provided and/or if you currently collaborate with an HIV agency) and number of unduplicated persons served last year.

Purpose. Meharry Community Wellness Center (MCWC) strives to eliminate HIV health disparities in Nashville Transitional Grant Area (TGA) by promoting awareness, education, and training, transdisciplinary research, community partnership, and unfettered access to comprehensive, high-quality care.

Background. Meharry has been a leader in primary care medicine for over a century and HIV prevention and treatment since the beginning of the epidemic in 1981. Out of a growing need to expand access to culturally sensitive, comprehensive primary HIV care in the Nashville Transitional Grant Area (TGA), Dr. Vladimir Berthaud founded Meharry Community Wellness Center (MCWC) in 2005. MCWC has been a top-ranked Tennessee-designated AIDS Center of Excellence since 2006, and a Hepatitis Center of Excellence since 2016. Tennessee Health Department recognizes MCWC as a “national model for comprehensive HIV care among the underserved community”.

Meharry Community Wellness Center provides 24/7 coverage for medical and dental services. Clients have easy access to one-stop, wrap around core and support services: HIV counseling and testing, PrEP/PEP, and primary HIV care; management of complex infectious diseases; women’s health services including reproductive health, Pap test/colposcopy; minor ambulatory surgery including proctoscopy, skin biopsy, wound care, pre- and postoperative management; psychiatry, clinical psychology, mental health therapy and drug counseling; Medication-Assisted Treatment (MAT), outpatient and residential treatment of substance use disorder; HIV Drug Assistance Program (HDAP), Insurance Assistance Program (IAP), on-site pharmacy services; housing assistance, medical transportation, and nutrition; legal aid, home and community-based health services, and referrals to specialty and community resources; comprehensive primary oral health including prophylaxis, dental hygiene, tooth extraction, root canal, cutting-edge prosthodontics, and oro-maxillo-facial surgery.

Our patient population has an alarming prevalence of severe tooth decay (60%) and severe periodontitis (30%). Meharry Community Wellness Center (MCWC) represents the only Tennessee clinic that offers unfettered access to fully integrated, comprehensive oral health services for low-income PLWH regardless of their primary HIV care providers. The Tennessee

Ryan White Dental Assistance Program (RWDAP) ran out of funding in April 2019 and left 1,800 clients with very limited or non-existing access to oral health services. Only 10% of our clients have dental insurance coverage and just 2% of them have adequate coverage. As of 2023, TennCare offers limited oral health benefits to eligible clients. So far, they have not referred any patients to our dental clinic. The dental clinic disposes of two state-of-the-art operatories, two intra-oral digital cameras, and one portable digital X-Ray, one lab, and one sterilization room. It applies breakthrough 3D technology to fabricate crowns, bridges, partial, and full dentures while the client is waiting. Meharry Community Wellness Center is among five health centers who dispose of this brand-new technology for fabricating full-mouth and partial denture in one visit in the United States. Special cases such as impacted molars, orthodontics, intra-oral abscesses, or deep-seated infections, are referred on site to Oro-Maxillo-Facial Surgery service at the Meharry School of Dentistry using program income to pay the discounted fees for these referrals.

Meharry Community Wellness Center had served 2,165 unduplicated clients since inception and 468 in 2024 including 77% Black or African American, 10% Hispanic/Latino, 25% female, and 46% MMSC. Our proportion of PWH with unmet housing needs (24.9%) represent about thrice the national average for PWH (8.4%) and twice the average for Ryan White clients nationwide (12.9%). Our clients bear an excess burden of poverty (53% below 100% federal poverty level), history of incarceration (20%), substance use and behavioral disorders (30%), uninsured (39%), cardiovascular diseases (30%), chronic lung diseases (35%), and diabetes (20%). Nonetheless, 85% of our clients had achieved viral load suppression (increased from 78.6% in 2021, 82.3% in 2022, and 83.3% in 2023), and 90% have CD4 cell count above 200 cells/mm³. Retention in care had increased from 70.47% in 2021 to 76.13% in 2023. However, cases of syphilis rose from 18.1% in 2021 to 22.5% in 2023, in line with the ongoing syphilis epidemic in the US. Only 7.5% of women had abnormal Pap test in 2023 as compared with 8.3% in 2021. As the sole clinic providing fully integrated state-of-the-art oral health services at no cost to people with HIV (PWH) in Tennessee regardless of their primary HIV provider, MCWC had served 650 clients in 2,689 units during past 16 years.

Under contractual agreement, MCWC had served about 600 inmates living with HIV (64% Black or African American) throughout all Tennessee prisons over 21 years. In 2006, we pioneered telemedicine between Meharry and Tennessee prisons. This collaboration contributed to raising clinic attendance from 50% to 90% and viral suppression, from baseline 30% to 90% in 2020.

MCWC had received uninterrupted grant funding from Ryan White Part B since 2002, HRSA Ryan White Part C since 2003, Ryan White Part A since 2008, and HOPWA since 2016. In order to stretch the Ryan White grant dollars, MCWC expends its program income to further project objectives in priority areas of unmet need, such as nutrition and medical transportation; oral health, ambulatory surgery, and women's health services; as well as coverage of ambulatory/outpatient specialty services for management of comorbidities, and co-pays of

prescription drugs for underinsured, low-income individuals with HIV. The dental clinic was built out of several competitive HRSA grants supplemented by program income.

The prospect for new funding remains grim because of a large budget shortfall in the Tennessee Ryan White B program that required across-the-board budget cuts leading to a reduction of our annual budget by \$76,510.50 since 2021-2022 and planned termination of Part B funding for Part A grantees in 2026. Our Part C grant has been on freeze under Executive Order and HRSA has not issued the 2025 grant award yet. Therefore, Ryan White Part A had become lifesaving for people living with HIV in Nashville TGA.

2. Describe in detail the current HIV counseling and testing capacity of your organization, and any existing collaborative arrangements with other organizations within your service area that provide HIV counseling and testing services.

Clients who are diagnosed HIV positive at Meharry Community Wellness Center are linked and enrolled in care immediately. The same policy applies to those who test HIV positive in the Emergency Department or outpatient clinics of Nashville General Hospital. Newly diagnosed people who are incarcerated in local jails are referred to MCWC and seen in less than a week. Inmates of Tennessee Department of Corrections are referred to the clinic on the day of their release for medical insurance enrollment and linkage to care. All other individuals with HIV referred to MCWC are given an initial appointment within 1-7 days

Meharry Community Wellness Center (MCWC) uses its program income to provide targeted HIV counseling and testing. In 2023, we tested 75 high-risk individuals and found seven (9.33%) HIV-positive people, as compared to <0.5% in the general population. All these newly identified persons with HIV were enrolled in care and started taking antiretroviral treatment (ART) before leaving the clinic. Medical providers, EIS Worker, and Medical Case Managers (MCM) educate clients about HIV risk behaviors and effective strategies to prevent HIV transmission at each patient visit, using audio-visual materials, interactive tablets, brochures, and multi-disciplinary intervention. They counsel every person with HIV (PWH) entering care about the implications of HIV infection, the benefits and potential side-effects of antiretroviral therapy (ART), risk reduction and disclosure to sexual and/or needle sharing partners. They reinforce risk reduction messages and encourage clients to have their partner(s) tested every 3-6 months and enroll in PrEP if they're not virally suppressed. We also invite persons with high-risk HIV behavior to participate in our ongoing clinical trials such as the landmark Purpose 2 study conducted at Meharry under the leadership of Dr. Berthaud as Principal Investigator. This trial showed that twice-yearly injection of lenacapavir resulted in 96% protection from HIV transmission in MSM, transgender men, and non-binary persons.

MCWC has a track record of collaboration for HIV counseling and testing with multiple local and extramural partners such as: Nashville General Hospital, the Meharry Elam Mental Health Center, the Meharry Medication-Assisted Treatment (MAT) clinic, and the Meharry Clinics; Davidson County Sheriff Office, Tennessee Department of Corrections, United Neighborhood,

Matthew Walker Comprehensive Health Center, Street Works, Nashville CARES, Vanderbilt University Medical Center, Ascension St Thomas Health, and Metropolitan Nashville Health Department; long-term care facilities like, Bordeaux Nursing Home and Whites Creek Nursing Home, as well as drug treatment centers (Cumberland, Samaritan), and Middle Tennessee Mental Health Institute.

3. Describe in detail how the proposed project fits with your agency’s mission and capabilities.

As an annual Tennessee-designated AIDS Center of Excellence since 2006, Meharry Community Wellness Center (MCWC) focuses on eliminating health inequities in HIV/AIDS, advancing HIV/AIDS awareness, transformative education, and transdisciplinary research, strengthening community outreach and partnership, and providing exceptional and compassionate health services. Our mission aligns with the overall mission of Meharry Medical College to empower diverse populations to improve the well-being of humankind. Our vision aligns with the vision of the National HIV/AIDS Strategy and the White House Ending-the-Epidemic Plan. This proposed project fits our mission and capabilities to address unmet need in outpatient/ambulatory care for underserved persons living with HIV in the Nashville Transitional Grant Area (TGA). Although Meharry Community Wellness Center serves the hardest-to-reach populations of persons with HIV in Middle Tennessee, as aforementioned, our retention in care had reached 76.13% in 2023. During the most recent decade, viral load suppression had substantially improved for all subpopulations, especially youth, young adults, and MSM, the risk categories with the highest incidence of HIV in our clinic (47.1% for MSM). In fact, MSM achieved the highest rate of viral suppression in 2024, a reflection of our cultural competence, coupled with non-judgmental, customer-friendly, and compassionate HIV care.

Viral Suppression by Subpopulation (%): 2015-2024			
Subpopulation	Year		
	2015	2019	2024
White	75.61	73.85	81.82
Black or African American	73.14	75.58	82.48
Hispanic/Latino	81.25	83.33	80.49
Youth (13-24)	51.85	74.19	80.00
25-34	63.22	71.57	84.38
35-54	76.52	74.88	79.79
55+	82.83	81.82	83.72
Women	72.00	77.39	79.81
Men	68.9	70.79	80.78
MSM	63.27	72.73	85.71

Source: CAREWare 230

4. Describe in detail how your background, mission and experience contribute to the ability of your organization to conduct the proposed project and meet the expectations of the program

requirements. In addition, Metro Health may conduct pre-award on-site visits to determine if the contractor's facilities are appropriate for the services intended.

Meharry is the oldest provider of HIV care in Tennessee, dating back the beginning of the epidemic in 1981. Under the leadership of its Founding Executive Director, Dr. Vladimir Berthaud, Meharry Community Wellness Center (MCWC) had earned the annual designation of Tennessee AIDS Center of Excellence continuously since 2006 and grew exponentially, thanks to multiple funding streams including several Ryan White grants. MCWC had become a beacon of hope and comfort for persons with HIV, affected by stigma, discrimination, social injustice, and health inequities. For current grant year ending on February 28, 2025, our outpatient/ambulatory grant had already beaten the expectations of program requirements as illustrated by the projected number of clients to be served and the number of service units (projected number: 99/actual: 179 and projected units: 400/actual: 2480). A multidisciplinary team of experienced and highly-qualified staff provide person-centered, multidisciplinary, holistic health services of the highest quality. Daily patient surveys denote an average satisfaction rate of 95%. As a testament of our performance, HRSA had selected MCWC to host the first National Meeting on HIV in Rural Areas in 2019 and one of three US sites that conducted the Special Project of National Significance (SPNS), "Dissemination of Evidence-Informed Interventions: Peer Linkage and Re-engagement of Women of Color", 2016-2019. The Project-derived manual is available at: <https://www.targethiv.org/deii/deii-peer-linkage>.

II. Organization Capacity:

1. Provide copies of the following:

- Resume and job description of proposed Finance Manager
- Organizational chart for your agency; chart must clearly include the program components funded by Part A/MAI.
- Copies of most recent State Licensure or Accreditation for relevant services.
- Articles of Incorporation.
- Documentation of 501(c) 3 designation.
- Current State of Tennessee Charitable Solicitations Letter.
- System for Award Management (SAM) exclusion report.

All these documents are uploaded.

2. **Describe agency's experience in administering federal, state and/or local government funds. Include funding source(s) and number of years administering those funds. Provide information for the following:**

- **Agency restrictions from receiving federal funds or placed on restrictive measures in the last five years (e.g., increased reporting, increased monitoring visits), please explain.**

Meharry has no restrictions from receiving federal funds. It has never been placed on restrictive measures in the last five years or during its existence.

- **Corrective action plan(s) in the last three years from any funding source, please describe (include the name of the funder, overview of issues identified and the current status of addressing the identified issues and/or recommendations).**

In 2024, HRSA conducted a site visit and identified the following issues: documentation of coordination and linkages with CDC and Prevention-funded HIV testing and outreach services of federally qualified health centers in the service area; documentation of training for HIV care and treatment of all non-clinical staff, documentation of sexual practices of women; demonstration of full implementation of the time and effort policy and the caps on charges; and documentation for allocating program income according to each Ryan White Program grant. All these issues have been corrected except the time and effort policy. The Office of Grants and Contracts is updating the Workday system and recruiting additional personnel to ensure any issues related to time and effort are fixed soon.

- **Audit finding(s) in the last three years. Please describe an overview of issues identified and the current status of addressing the identified issues.**

In 2024, HRSA audited our Ryan White Part C EIS grant and identified the following issues: documentation of coordination and linkages with CDC and Prevention-funded HIV testing and outreach services of federally qualified health centers in the service area; documentation of training for HIV care and treatment of all non-clinical staff, documentation of sexual practices of women; demonstration of full implementation of the time and effort policy and cap on charges; and a clear policy for allocating program income according to each Ryan White Program grant. All these issues have been corrected except the time and effort policy. The Office of Grants and Contracts is updating Workday system and recruiting additional personnel to ensure any issues related to time and effort are quickly fixed.

- **If Contractor(s) is currently a Ryan White Part A provider, an administrative review will be conducted of the previous year's spending of grant funds and will be included as part of the score. If Contractor(s) is not a current Ryan White Part A provider, Contractor(s) must provide a letter of reference from a funder to include a description of Contractor's performance in spending allocated grant funds. This letter will be included as part of the score.**

Not applicable.

- **Submit copies of most recent A-122 Audit (for the last reporting year) conducted by an**

independent certified public accountant or 990 form, if not required by federal regulations to complete an A-122 Audit.

An independent CPA firm, Crosslin Certified Public Accountants, had audited the accompanying consolidated financial statements of Meharry Medical College and Subsidiary (collectively the “College”), which comprise the consolidated statements of financial position as of June 30, 2023, and 2022, and the related consolidated statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the consolidated financial statements. In their opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the College as of June 30, 2023, and 2022, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America. (see Attachment: Most Recent Financial Audit, Final Consolidated A133 Financial Statement June 2023).

3. Describe agency’s current system for collecting data on client demographics, service utilization and performance data. Include all software used to collect this data, staff resources for data collection and hardware resources.

Staff resources. The Program Director, Dr. Berthaud, serves as Data Manager, assisted by biostatistician, Derek Wilus, MS. They perform duties such as quality management initiatives, data analysis, and dissemination of results, and staff training. The Program Director integrates all audits and performance evaluations into the overall strategic planning and Ryan White programs operations. He facilitates collaboration with statewide, local, and national quality improvement projects. Dirk Francis, Data Center and System Administrator for Meharry Office of Information Technology (OIT), manages the CAREWare server and maintains the software, while Lee Nelson, MBA, Health Information Technology Director, is responsible for managing E-Clinical Works (our electronic health record system) and interfacing with CAREWare (the primary source of data reports).

Data infrastructure. CAREWare™ forms the backbone of our robust information system. Our data repository relies on three separate layers of security. The CAREWare network connects to a dedicated server housed in a highly secure and restricted basement location in the Office of Information and Technology (OIT), monitored by video camera and on uninterrupted electric power supply 24/7. Meharry OIT has designated a qualified technician, Dirk Francis, to manage the CAREWare server in collaboration with MCWC Program Director.

Data operations. Since 2003, Meharry has been using Microsoft SQL server and the most recent CAREWare version as the primary tool for Ryan White data collection, HRSA-required performances measures and programmatic reports. All MCWC staff use CAREWare and enter data elements in real-time. MCWC had created over 180 customized reports in CAREWare to facilitate data queries and special reports. Moreover, we had developed CAREWare instruments to describe the graphic time course of individual lab variables

including CD4 cell count and viral load and designed a unique platform to capture social determinants of health, monitor and evaluate community health care delivery. We have modified CAREWare to allow for attachment of external medical, personal and legal records as well as patient's clinical documents including radiographs and intraoral pictures. MCWC had installed data quality and validity checks for duplicated, missing, discordant, and unknown key data elements to enhance accuracy of reports. A validity check is run prior to submission of reports. All HRSA-required reports including performance measures are readily available in CAREWare and can be created instantly. The Assistant Data Manager, Derek Wilus, MS, biostatistician, uses IBM SPSS or R Studio for more complex data analyses.

Data backup design. Meharry OIT backs up the data daily on extra-large capacity servers and digital tapes. Then, an independent contractor picks up the tapes daily and stores them away from the campus to safeguard them against major disasters and catastrophes such as floods, hurricanes, fire, and powerful earthquakes. The Program Director verifies that CAREWare posts daily messages to check the exact time of each data backup completion.

Original Data: The original data, also referred to as the live production data, resides on the HP Synergy Blade system, stored as a VM, with snapshots taken hourly, and stored on the Nimble CS5000. The snapshots are stored for 7 days.

Tier 1 Storage - The tier 1 backup occurs nightly and writes to a second Nimble array, the CS235. This data is stored for 90 days.

Tier 2 "off-site" Storage - Once weekly, the data is copied from the CS235 to a tape backup solution that is rotated off-site weekly. This data would be stored for 180 days.

Additional data safety and security procedures. Each Meharry desktop and laptop are configured to provide optimum security and reliability. OIT monitors each user's activities and downloads automatically the most recent security updates to all Meharry desktops connected to the network, daily, and screens all emails for SPAMs and phishing messages instantly. Meharry students and employees access the network with a personal username and secured password that is required to be changed regularly.

Software platforms. Meharry has adopted the electronic health records system, E-Clinical Works™, across the campus. The software suits for clinical notes, mobile applications, and Physician Quality Reporting Systems (PQRS). However, its capacity to generate customized reports is limited, complex, and provider-restricted, time-consuming, and costly. Medical providers enter their clinical notes and services in E-Clinical Works, also available on their smartphones app. LabCorp will export the lab tests results in E-Clinical Works as soon as they are available and alert the clinicians on critical values immediately. The HL7 platform and the "socket" allow for seamless export of LabCorp results into the CAREWare labs section. External health records are either faxed or exported into E-Clinical Works using compatible electronic software. A patient portal is available in E-Clinical Works for better

self-management and interaction with medical providers. The patient portal is also accessible via smartphone app. MCWC utilizes E-Clinical Works to submit third party billings and track service charges. Both E-Clinical Works and CAREWare are fully secure and HIPAA-compliant. MCWC staff attend mandatory training on compliance with HIPAA, federal and State, as well as Meharry regulations on patient personal health information. MCWC had developed a user-friendly iOS app that allows the quick calculation of odds for a person with HIV to achieve viral load suppression, based on our landmark publication in BMC Infectious Diseases in 2022.

4. Describe agency's system for managing fiscal and accounting responsibilities. Address the following:

- **Define who oversees this area, what staff is responsible for these activities.**
- **Identify what software is used to manage financial information.**
- **Describe the accounting system that is in place; and**
- **Describe the internal systems that are used to monitor grant expenditures and track, spend, and report program income generated by a federal award.**

Meharry Community Wellness Center (MCWC) had received uninterrupted grant funding from HRSA Part C EIS, Ryan White Part B, and Ryan White Part A for 21, 22, and 17 years, respectively. The Finance Manager, Zudi Takizala, MD, MPH, MBA, is uniquely qualified to oversee fiscal and accounting operations. She brings 21 years of experience in grant administration. In the past three years alone, she had successfully managed 18 public grants including 10 Ryan White grants. MCWC carries a current grant portfolio of about \$3,000,000.00 including grants from NIH/NIAID, HRSA, HOPWA, PEPFAR, and Ryan White Part A and B. Having managed thousands of Federal, State, and local grants and contracts for over 100 years, Meharry is strongly qualified to manage this project. To track and manage grants and contracts, the College uses an accrual method of accounting incorporated into the Banner software and Workday system. The Office of Grants and Contracts works closely with each program and department to assure that budget matters are appropriate and understood. Meharry retains a CPA firm to conduct annual audits and interim financial reports for program planning and implementation. All Meharry fiscal audits had no findings. Additionally, appropriate internal controls including an internal auditing process are in place and assist the College to anticipate and plan more effectively. The Department of Internal Medicine is primarily responsible to oversee grant management and the delivery of clinical services. Meharry Medical Group (MMG) supervises the delivery of clinical services, performs billing, collection of charges, and tracking, and reporting of program income to the Project Director. The Office of Human Resources oversees the hiring process, reviews job descriptions and proposed salaries, assists in background checks, job offers and staff training. The Compliance Office

reviews contracts and agreements to ensure compliance with the law. The Office of Grants Management oversees Ryan White programs, ensures that current practices align with federal and State legislation, and that Ryan White funds are expended according to program budget, goals, and expectations. It works closely with MCWC and provides monthly grants expenditures reports to assure disbursements align with program goals and objectives. MCWC and the Office of Grants and Contracts hold monthly financial meetings with Ryan White Part A leadership. The Office of Finance verifies that MCWC manages Ryan White grants according to Generally Accepted Accounting Principles (GAAP). MCWC segregates Ryan White contracts, public, private, and other types of medical insurance in CAREWare to allow for easy tracking and accurate financial report using the service fees and units determined by Ryan White Part A Program. MCWC reinvests program income (billings collections from third-party payers and 340B pharmacy revenues) into overall budget to further program goals and objectives and cover ambulatory out-of-pocket expenses of low-income, underinsured clients. The Program Director reports the program income quarterly to Ryan White Part A and B. The Director of the Office of Grants and Contracts reports annual program income to HRSA via the Federal Financial Report (FFR).

5. Describe agency's process for completing program reports in a timely and accurate manner. Include descriptions of how responsibility for reporting is assigned to staff, how reports are reviewed for accuracy and who assures reports are completed on time.

MCWC staff enters data in CAREWare in real-time. The Program Director had created over 200 customized reports in CAREWare that allow for quick data analysis and reports, research advancement, and deeper understanding of program outcomes. These customized CAREWare reports also comprise data validation, quality checks, for duplicate, missing, and unknown data. CAREWare is able to create a list of all clients with missing/unknown, or duplicate data for the responsible staff to correct. Prior to submitting any reports, a quality check is run again to identify errors, warnings, and alerts needed to be fixed. All Ryan White required periodic reports and performance measures are embedded in CAREWare, i.e. Ryan White Service Report (RSR), Provider Data Export (PDE), program financial and service reports, etc.

III. Cultural and Linguistic Competency:

As a person closely affected by HIV himself, Dr. Berthaud has dedicated his professional career to improve and save the lives of people with HIV in New York, Tennessee, Latin America, Africa, and the Caribbean. He attributes high priority to cultural and linguistic competency. MCWC staff are trained in cultural competence, cultural humility, and trauma-informed care, and motivational interview. Six of our full-time staff are themselves people living with HIV for over 20 years. Sixty percent of our staff have been affected by HIV, and 70% live in the community they are serving. Client feedback is obtained daily through anonymous satisfaction surveys and quarterly from the Consumer Advisory Board (CAB). The CAB Chair attends our weekly staff

meetings, which reserves ample time for discussion of CAB concerns and the results of patient satisfaction surveys including corrective actions, implementation, and monitoring plan. MCWC leadership incorporates the final recommendations into program operations, specific projects, and/or grant applications. Educational materials are created according to the fifth-grade level based on health literacy research conducted at Meharry Community Wellness Center. Interpretation and translation services are readily available for all languages through a contractual agreement paid for by Meharry Medical College.

IV. Collaboration:

- 1 Describe a plan for creating a new or improving an existing network to improve collaboration with HIV agencies that will link PLWHAs to HIV testing and HIV medical care and support services. If applicable, identify any collaborating organizations that will assist the applicant through HIV testing and linkage to HIV medical care and services.**

Linkage of newly identified clients: Patients who diagnose HIV positive in the emergency department (ED) at Nashville General Hospital (NGH), located on the Meharry campus, are linked and enrolled into care the same or next business day. HIV providers and Medical Case Managers follow newly diagnosed persons with HIV (PWH) admitted to NGH and coordinate their discharge disposition. Clients newly identified outside the Meharry campus are linked as soon as possible, preferably within less than 7 days. The Patient Service Representatives (insurance verification), the Community Health Workers (coaching and navigation), and the Medical Case Managers (insurance assistance and Ryan White eligibility) are responsible for rapid linkage.

MCWC organizes outreach events with local partners including Metropolitan Nashville Health Department to raise HIV awareness and promote testing. As member of Nashville PrEP Coalition, MCWC facilitates the rapid linkage of newly diagnosed persons. It also leverages its experience as a research site for the SPNS project targeting newly diagnosed and out-of-care women of color for linkage and retention to enhance engagement in care. As a pioneer of HIV telemedicine in TN prisons and HIV consultant for Davidson County jails since 2006, MCWC facilitates the transition of ex-offenders to rapid linkage and engagement upon their release in the community.

Main referral relationships and collaborations include the following: Nashville General Hospital (NGH), Meharry teaching hospital, where Dr. Berthaud serves as Director of Infectious Diseases and Dr. Livette Johnson co-chairs the Infection Prevention Committee; NGH refers PWH from Emergency Department, inpatient, and outpatient clinics; Meharry Elam Mental Health Center, Meharry Family Medicine and MAT Clinic, located right across the hall from MCWC, and Meharry Clinics constitute regular sources of mutual referrals; Davidson County Sheriff's Office refers inmates with HIV to MCWC since 2005, while Tennessee Department of Corrections refers them for telemedicine consultation, a service established by Dr. Berthaud in 2006; Neighborhood Health, the largest FQHC in Davidson County, Ascension St Thomas Health (Dr. Berthaud maintains consultation privileges), and Metropolitan Nashville Health Department, the largest HIV testing center in Nashville, represent important referral sources. Metropolitan

Development Housing Authority awarded a HOPWA grant for the provision of Short-Term, Rent, Mortgage, and Utilities assistance. Street Works and Nashville CARES provide medical case management, food and housing services including permanent placement and emergency shelters. Second Harvest provides low-cost preserved food for our pantry. Vanderbilt University Medical Center provides emergency, specialty ambulatory, and inpatient care for MCWC clients. Tennessee Health Department had contracted with Meharry for ambulatory/outpatient and medical case management services. They provide technical support to medical case managers and assist in linkage/reengagement of clients lost to care. Metropolitan Nashville Public Health Department (MNPHD) refers newly diagnosed HIV-positive and lost-to-care people, treats persons with latent and active tuberculosis, and coordinates STD management and control. Under MNPHD sponsorship, Meharry received a Part A grant for core and support services. Meharry Elam Mental Health Center collaborates with MCWC Therapist/Drug Counselor on outpatient and inpatient drug treatment, detoxification, and rehabilitation. Meharry and Vanderbilt had signed a Data Usage Agreement for expanding participation of minorities in clinical research through the NIH-funded TN Center for AIDS Research (TN-CFAR), a joint venture including Nashville CARES and TN Health Department.

- 2 Contractor(s) must demonstrate their commitment to work with or collaborate with organizations representing the HIV/AIDS community through a signed and dated letter of support or memoranda of agreement or understanding. The letter must specify example activities that each entity provides that will help connect high risk clients to HIV testing and services.**

Meharry Community Wellness Center, Street Works, and Nashville CARES have a longstanding collaborative relationship. Dated signed letters that specify example activities that each entity provides that will help connect high risk clients to HIV testing and services are uploaded.

B. Reference Projects (10 Points) Service History & References:

- 1. If your agency currently provides this service(s) to the HIV/AIDS client population, describe the number of years you have provided this service and the funder of the service. Please provide a reference name and phone number.**

Meharry Medical College has been providing ambulatory/outpatient services to persons with HIV since the initial outbreak in 1981, i.e., even before the virus was discovered. Meharry Community Wellness Center opened in 2005 with funding support from Ryan White Part B and Part C. Ryan White Part A support started right after Nashville became an Emerging Metropolitan Area (EMA) in 2008. However, TN Health Department will stop funding for recipients who receive Part A funding starting on April 2026. Our Part C grant has been on freeze under Executive Order and HRSA has not issued the 2025 grant award yet. Therefore, Ryan White Part A had become lifesaving for people living with HIV in Nashville TGA. Meharry Community Wellness Center has been recipient of Part C Minority AIDS Initiative

(MAI) grant funding for Ambulatory/Outpatient Services since 2013 and of Part A MAI grant support since 2022.

For reference, we mention the name of our Part C EIS Project Officer
Christie Slay, MPA, MAEd, CHES, Public Health Analyst/Project Officer, Central
Branch, Division of Community HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, Rockville, MD 20857
Phone: 301.443.0504

- 2. If your agency does not currently provide service(s) to the HIV/AIDS client population, explain any related experience that would demonstrate the agency's competency in providing services to this population. Please provide a reference name and phone number.**

Not applicable.

- 3. Describe any related experience that would demonstrate your agency's competency in providing HIV medical or support services to this population. Please provide a reference name and phone number. The file is limited to 5 pages and should be in PDF format entitled "Reference Projects."**

The file labelled "Reference Projects" had been uploaded.
Here's the reference name and phone number:

Part C EIS Project Officer
Christie Slay, MPA, MAEd, CHES, Public Health Analyst/Project Officer,
Central Branch, Division of Community HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, Rockville, MD 20857
Phone: 301.443.0504

A. Project Approach and Process (30 Points)

I. Staffing:

Present in detail your organization's staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the number of time/hours per month being requested for each proposed staff position.

Minority AIDS Initiative (MAI) for Ambulatory/Outpatient Services

Staffing Plan of Key Personnel

Staffing Plan of Key Personnel				
Name	Roles	Responsibilities	Education/Training	Experience Part A FTE

Vladimir Berthaud, MD, MPH, FACP, FIDSA, DTMH, CPH	Project Director	Supervision of overall activities; HIV care and infectious diseases services	Board-certified in internal medicine, infectious diseases, public health, tropical medicine, and traveler's health.	International HIV expert with 39 years of experience in HIV care, research, training, teaching, program development, and implementation worldwide.
Zudi Takizala, MD, MPH, MBA	Finance Manager	Project management and CQI	Doctor of Medicine, with master's degree in public health and business	21 years of experience in management of \$30M in Federal, State, & local grants
Keisha Ashmeade Ed.D, MSPH, FNP, AHIVS	Clinic Manager	Manages clinic operations	HIV specialist and Board-certified NP	11 years of HIV care experience
Sheena S. Simon, DNP, APRN, NP-C	Primary HIV care provider	Comprehensive HIV management	Board-Certified Nurse Practitioner, specialized in prevention	22.44% FTE Six years of HIV care experience
Ethel Harris, DDS, MPH	Director of oral health services	Comprehensive oral care and prosthodontics	Meharry graduate, former Director of SEATC oral health	22 years of experience in oral health for PLWH
Ryan White Part A Staffing Plan				
Name	Roles	Responsibilities	Education/Training	Experience Part A FTE
Livette Johnson, MD	Infectious diseases management	HIV and specialty care	Meharry graduate, Board-certified in internal medicine and infectious diseases	40% FTE 35 years of experience and expertise in HIV care
Sheena S. Simon, DNP, APRN, NP-C	HIV care provider	Comprehensive HIV management	Board-Certified Nurse Practitioner, specialized in prevention	35% FTE Six years of HIV experience
Debra Simmons, LPN	Phlebotomist	Process laboratory specimens and perform nursing duties	Graduate of Baptist Hospital LPN School	50% FTE 9 years of experience serving PLWH

Maya Johnson, BS, MPH	Community Health Worker	Coaching, adherence counseling, patient navigation, community case management	MPH graduate from Meharry, with solid knowledge of SPSS, SAS, Redcap, GIS, and Microsoft environment	75% FTE One year of experience with PLWH
Tamiko Grimes	Community Health Worker	Coaching, adherence counseling, and patient navigation	Trained Peer Counselor and Community Health Worker	100% FTE 9 years of experience with PLWH
Osamudiamen Osa-Edoh, MD, MPH	Psychiatrist	Treatment of behavioral & substance use disorders	Board-certified psychiatrist, Director of substance use treatment at Meharry	15% FTE 10 years of experience with PLWH
Erlete Ascencao, PhD/PhD, HSP	Clinical Psychologist, Social Scientist	Specialized in HIV clinical psychology services	Doctor in Social Sciences and Clinical Psychology, Licensed Health Services Provider	100% FTE 22 years of experience with PLWH
Ronda Jennings, MA	Senior Medical Case Manager	HOPWA Case Manager, Mental health therapy and drug counseling	Master' degree in Clinical Counseling, Certified Alcohol and Drug Addiction Counselor	64.29% FTE 17 years of experience in medical case management and counseling with PLWH
JaRae Davenport, BS, MPH	Medical Case Manager	Medical case management services including treatment adherence	Master's degree in public health practice	100% Three years of experience in medical case management under Part A grant
Kaye Chavis, DBA	Medical Case Manager	Medical case management services including treatment adherence	Doctoral degree in Business Administration	90.02% 4 years of experience with PLWH and Ryan White Part A grant 23 years' MDHA experience

Qualifications of Key Personnel.

Vladimir Berthaud, MD, MPH, FACP, FIDSA, CPH, DTMH, is tenured professor of medicine, Director, Division of infectious diseases at Meharry Medical College and Nashville General Hospital and Founding Executive Director of Meharry Community Wellness Center. He completed his infectious diseases fellowship at Columbia University and Cornell University in New York. Dr. Berthaud has been a passionate advocate for PLWH and the recipient of numerous prestigious awards including IPRO's Outstanding Service to the Health Care Community Award for Quality Improvement in reducing Disparity for Adult Immunizations in New York State, Award for Outstanding Contribution to the Internal Medicine Training Program, Harlem Hospital/Columbia University College of Physicians & Surgeons, New York City Council Citation for Exemplary Service, National Library of Medicine/Marine Biological Laboratory, Fellowship Award in Medical Informatics, Nashville Business Journal, Award Honoring Superior Contributions to the Health Care Industry, Johnson & Johnson UCLA Healthcare Executive Management Award, Street Works Guiding Light Award, and Mahogany Honors Dwayne Jenkins Lifetime Achievement Award. Part C EIS Program Director for 20 years, Dr. Berthaud serves as Project Director/Principal Investigator for Meharry HIV Research and Training Facility, Mentor and Investigator for the NIH-funded U01-Practice-Based Research Integrating Multidisciplinary Experiences in Dental Schools (PRIMED), Associate Director of Clinical Discovery Core, for TN-CFAR, Clinical Lead for Meharry PEPFAR, and Program Director for HRSA-sponsored National HIV Residency Pathway Consortium. He has been a member of the Tennessee AIDS Centers of Excellence Committee since 2002. Other experiences include Train-of-Trainer Expert for the National HIV Curriculum, HIV Trainer for the National MTCT-Plus Program in Rwanda and Côte d'Ivoire, HIVAIDS Curriculum Developer for NIH/ACTG/HPTN in Latin America and the Caribbean and HIV Preceptor for IDSA International AIDS Training Program, HIV Curriculum Reviewer for CDC, and scientific advisor to CDC Program for TB Elimination, member of the National Board of Public Health Examiners, and of the National Board of Medical Examiners, Academic Advisor, UCLA School of Management, Community Health Improvement Program, and Member, American College of Physicians (ACP) Leadership Academy. Former member of the Leadership Conference and Admissions Liaison Officer, United States Military Academy at West Point, past Chair of The George W. Counts Interest Group of the Infectious Diseases Society of America (IDSA), past member of IDSA Leadership Development Committee, Dr. Berthaud is a member of the American Board of Internal Medicine Infectious Diseases Task Force and Faculty of the IDSA Leadership Institute. He was a Lead Principal Investigator for the international Kid COVE Vaccine Trial. Dr. Berthaud is Endowed Professor of Medicine, with Adjunct appointment in Microbiology, Immunology, and Physiology. He is Academic Editor for PLOS ONE medical journal and the author of many peer-reviewed publications in impactful scientific journals. Dr. Berthaud is fluent in Spanish, French, English, and Creole.

Livette Johnson, MD. A native Nashvillian and a graduate of Meharry School of Medicine, Dr. Johnson completed her internal medicine residency training at Johns Hopkins University in Baltimore and her infectious diseases fellowship at Cornell University in New York. She holds Board certification in internal medicine and infectious diseases. Dr. Johnson is

associate professor of medicine at Meharry Medical College and Vice Chair of Infection Prevention Committee at Nashville General Hospital. Dr. Johnson served as attending physician at Mount Sinai Hospital and Assistant Chief of Infectious Diseases at Metropolitan Hospital in New York. She brings a personal dedication to the care of populations living with HIV.

Zudi Takizala, MD, MPH, MBA. Doctor of Medicine with extensive experience in grant administration, financial management, and staff supervision, Dr. Takizala has a long record of collaboration with diverse internal and external stakeholders, community agencies, and Ryan White programs. She oversees clinical operations at Meharry Community Wellness Center. In the past three years, she had successfully managed 18 public grants including 10 Ryan White grants, and others from NIH, HOPWA, PCORI, Tennessee State and Metropolitan Nashville government.

Keisha Ashmeade, ANP, MSN, MSPH, Ed. D, AAHIVS, board-certified advanced nurse practitioner and certified HIV specialist, Dr. Ashmeade has been Clinical Manager of Meharry Community Wellness Center for seven years. She brings 10 years of experience in HIV primary care and seven years of teaching experience as Assistant Professor.

Ethel Harris, DDS, MPH, Director of Meharry Community Wellness Center's Oral Health Services, she holds joint Faculty appointment as Assistant Professor of Medicine and Dentistry at Meharry and serves as Clinical Investigator on the NIH-funded UO1 grant, "Practice-Based Research Integrating Multidisciplinary Experiences in Dental Schools". Dr. Harris served as Dental Director for the Southeast AIDS Education and Training Center (SEATC). She was born and raised in Nashville and she graduated from Meharry School of Dentistry.

If applicable, describe in detail the roles and responsibilities of any consultants and/or subcontractors will be used to conduct aspects of the proposed project.

This is not applicable.

II. Overview of Population:

Describe in detail the HIV/AIDS population in Davidson County. Describe in the detail the issues that interfere with identifying, engaging, and retaining PLWHAs in routine HIV testing and HIV services.

HIV/AIDS population in Davidson County.

Meharry Community Wellness Center stands at the epicenter of the HIV epidemic in Nashville, in the heart of Davidson County, more specifically, North Nashville, the neighborhood most densely populated in Blacks or African Americans (71%) where 1,933 of every 100,000 people are living with HIV as compared to 978.7 for Blacks in the remaining Nashville Transitional Grant Area (TGA). The TGA had an estimated population of 1,742,588 in 2019, accounting for 26.5% of the state's total population and 31% of the state's people

living with HIV (PLWH). In the thirteen counties that make the Nashville Transitional Grant Area (TGA) including Davidson, non-Hispanic Blacks account for 54% of PLWH and in 2021, they represented 27% of Davidson County's population and 52.4% of PLWH. While about 39% of the Nashville TGA's population lives in Davidson County, 76.5% of the PLWH population reside in Davidson County. Of this PLWH population, 20% had been in jail and 42% were homeless/unstably housed at some point in the last year, and 40.2% did not have food to eat three or more days at some point in the last year. Fear of disclosure (50.6%) represents the number one barrier to accessing services (Metropolitan Nashville Health Department). In Nashville TGA, an estimated 17% of PLWH are unaware of their status. In 2020, 66% of newly diagnosed cases were linked to care in 30 days, 54% were retained, and 66% achieved viral suppression. Among Non-Hispanic Blacks, 64% were linked to care within 30 days, 54% were retained and 63% became virally suppressed, and they had the highest incidence of Chlamydia, gonorrhea, and syphilis. Meharry Community Wellness Center (MCWC) serves the most vulnerable and hardest-to-reach PLWH in Tennessee. In 2024, our program served 484 unduplicated clients. African Americans accounted for 77.06%, women 26.44% and MSM 42.35%. Our clients bear an excess burden of uninsured (39.25%), poverty (48.96% below 100% FPL), and history of incarceration (20%), homelessness (19.2%, higher than in Davidson's 13.6%), and substance use and behavioral disorders (30%). More than 70% of our clients did not graduate from high school. Our proportion of clients experiencing homelessness represents more than twice the national average for PLWH (8.4%) and is 50% greater than the national Ryan White average (12.9%). According to the Brookings Institution, North Nashville has an incarceration rate of 14%, by far the highest in the country, and 93% of those incarcerated are Blacks. Our patient population has an alarming prevalence of severe tooth decay (60%) and severe periodontitis (30%). Meharry Community Wellness Center (MCWC) represents the only Tennessee clinic that offers unfettered access to fully integrated, comprehensive oral health services for low-income PLWH regardless of their primary HIV care providers. The Tennessee Ryan White Dental Assistance Program (RWDAP) ran out of funding in April 2019 and left 1,800 clients with very limited or non-existing access to oral health services. Only 10% of our clients have dental insurance coverage and just 2% of them have adequate coverage. Since 2023, TennCare offers limited oral health benefits to eligible clients. So far, they have not referred any patients to our dental clinic. The prospect for new funding remains grim because of a large budget shortfall in the Tennessee Ryan White B program that required across-the-board budget cuts leading to a reduction of our annual budget by \$76,510.50 since 2021-2022 and termination of funding for Part A grantees in 2026.

Issues that interfere with identifying, engaging, and retaining PLWHAs in routine HIV testing and HIV services.

Gaps in local services. Major gaps in MCWC/TGA HIV care continuum, retention, and viral suppression, can be attributed to high rates of incarceration (20%), homelessness (MCWC 19.2%; TGA 13.8%), and poverty (39.25% below 100% FPL), behavioral and substance use disorders (30%), and chronic comorbidities such as cancer, cardiovascular diseases, chronic kidney and lung diseases. Moreover, gaps in medical and dental insurance coverage, TennCare restrictions on the number of monthly prescriptions, and food shortage, lack of

family support as well as stressful life events too often lead to poor treatment adherence and negative health outcomes such as HIV disease progression, exacerbation of co-morbidities, frequent visits to specialty clinics, emergency department and admissions to the hospital, mental institutions, and drug treatment centers. Huge gaps persist in oral health, substance use disorders, medical transportation, and housing services.

Major Barriers to Care:

Incarceration: Of 516 inmates with HIV served by MCWC from 2003 to 2018, 64% were Black or African American and 66% aged 45-64. Stepwise implementation of telemedicine in 2006 led to increase in clinic attendance from 50% to 90% and viral suppression from 30% to 90% (Berthaud V. 2022 National Ryan White Conference). Of PLWH incarcerated in Davidson County jails, Non-Hispanic Blacks account for 71% and non-Hispanic Whites 29%. North Nashville has an incarceration rate of 14%, the highest in the country by far, and 93% of those incarcerated are Blacks. In other words, one in seven people who were born in the primary zip code of North Nashville between 1980 and 1986 went to jail or prison at some point in their lives. (Adams L, Nicholas T: Work and opportunity before and after incarceration. The Brookings Institution, March 2018). Twenty five percent of our patients reside in that neighborhood and 41% of them belong to this age group. MSM is still the most frequent means of exposure accounting for 37.5%, and IDU the second most reported exposure category among the jail population (22.1%). Heterosexual exposure accounts for 18.9% of PLWH in jail and MSM/IDU account for 6.3% of the cases; unreported exposure accounts for (15.1%). (Source: Nashville Metropolitan Health Department). Meharry Community Health Worker had established a strong collaborative relationship with Tennessee Department of Corrections (TDOC) and Davidson County Sheriff's Office (DSCO) for over 20 years. Persons with HIV who are incarcerated in DSCO are referred to MCWC for in-person care, while inmates of TDOC are seen by telemedicine.

Transportation: Public bus service in Nashville is extremely limited to some parts of downtown and very few stops in North and West Nashville. It nearly does not exist in South and East Nashville. Most of our patients resides far away from a bus stop. They require multiple transfers to come to the clinic or simply rely on a ride with a relative or a friend. The bus service makes short stops every hour between 8:00am and 4:30pm. There is no subway line in Nashville and Tennessee. Incarceration: Of 516 inmates with HIV served by MCWC from 2003 to 2018, 64% were Black or African American and 66% aged 45-64. Stepwise implementation of telemedicine in 2006 led to increase in clinic attendance from 50% to 90% and viral suppression from 30% to 90% (Berthaud V. 2022 National Ryan White Conference). Of PLWH incarcerated in Davidson County jails, Non-Hispanic Blacks account for 71% and non-Hispanic Whites 29%. North Nashville has an incarceration rate of 14%, the highest in the country by far, and 93% of those incarcerated are Blacks. In other words, one in seven people who were born in the primary zip code of North Nashville between 1980 and 1986 went to jail or prison at some point in their lives. (Adams L, Nicholas T: Work and opportunity before and after incarceration. The Brookings Institution, March 2018). Twenty five percent of our patients reside in that neighborhood and 41% of them belong to this age group. MSM is still the most frequent means of exposure accounting for 37.5%, and IDU the second most reported exposure category among the jail population (22.1%). Heterosexual exposure accounts for 18.9% of PLWH in jail and MSM/IDU account for 6.3%

of the cases; unreported exposure accounts for (15.1%). (Source: Nashville Metropolitan Health Department). MCWC had hired a full-time person to provide free round-trip medical transportation in the Transitional Grant Area (TGA).

Education: High school completion rate is 76% in Davidson County and 15% at MCWC.

Unemployment and poverty: 39.25% of Meharry clients had an annual income <100% FPL in 2023. Unemployment rate reached 60% and 30% were receiving Social Security Income. Drug and alcohol: Addiction to drugs and alcohol remains a significant risk factor for poor nutrition and treatment adherence, bad health outcomes, incarceration, and homelessness. However, there are insufficient access points to drug detoxification and rehabilitation in Davidson County. Many offenders released on parole or probation cannot get into drug or alcohol treatment. Consequently, they are often re-incarcerated for parole or probation violation. Periodic mandatory report to parole or probation officer had become their major competing priority. Moreover, many African Americans had switched from injection drugs to cocaine snorting or smoking, without any available treatment option.

Housing is the utmost priority for persons addicted to drugs who are experiencing homelessness. As Nashville is becoming a major destination for relocation of businesses and people, affordable housing had become very scarce, while homelessness continues to rise. Aggressive gentrification further aggravates the shortage of affordable housing units. Moreover, the Department of Housing and Urban Development (HUD) had tightened requirements and narrowed their definition of homeless, which requires that clients be in a shelter for three days before being deemed eligible. Clients with criminal records, active addiction, and mental health issues are denied housing (both public and private); limited transitional, assisted living or group homes are available. Recently released convicts present other critical challenges such as limited access to employment, financial loans and social support. During the past five years, in Nashville, Tennessee, the trend of homelessness paralleled the economic growth curve that propelled a booming housing market. “Nearly 70% of Nashville ever-changing skyline wasn’t there 10 years ago” according to Nashville Chamber of Commerce. In April 2024, the median price for residential single-family homes in Nashville was more than \$500,000 for the first time. In the aftermath of the March 3, 2020, devastating tornado that destroyed numerous homes in North Nashville and the subsequent coronavirus pandemic, the number of displaced families grew exponentially. Most of the patients attending Meharry Community Wellness Center (MCWC) reside in North Nashville. Many of them lost their jobs in places such as hotels, restaurants, and factories due to local and state government-imposed “Stay-at-Home” and social distancing orders related to mitigation of the COVID-19 pandemic. The national economic downturn during the coronavirus pandemic exacerbated the homelessness crisis and widens the gaps in care and HIV health disparities. Our proportion of clients experiencing homelessness represents more than twice the national average for PLWH (8.4%) and is 50% greater than the national Ryan White average (12.9%).

Community environment: An often-forgotten barrier is the fact that 70% of our patients live in the same neighborhood and are very familiar with each other. Fear of disclosure of HIV status, stigma, and discrimination, prejudice, religious concerns, and misconceptions remain enormous barriers to accessing HIV care.

Barriers to reaching Tennessee's disproportionately-impacted populations:

African-American MSM: lack of awareness, or misinformation about HIV transmission, prevention, and treatment; impact of homophobia on health-seeking behavior; lack of access to health care generally; and denial of risk.

Young MSM: misperceptions about HIV risk; denial and complacency associated with being a late adolescent; difficulties comprehending the seriousness of HIV, coupled with rejection by family and friends.

High-risk heterosexuals: lack of perceived risk; poverty, limited access to health care and health information; acting as caregivers in families; and financial dependency on a partner.

Incarcerated: stigma (isolation & potential for violence due to HIV status); misinformation about HIV transmission, prevention, and treatment (situational sex/" gay for the stay"); and lack of awareness or access to testing and/or health care services upon release.

Ryan White Part C Minority AIDS Initiative Report.

- To recruit persons with HIV (PWH) of the MAI target population, MCWC conducted outreach activities at multiple events:

Nashville Mayor's Ending-the-Epidemic, PRIDE Day, Black PRIDE, World AIDS Day, National HIV Black Awareness Day, and HIV Testing Day, and The African Street Festival. MCWC also leverages its partnership with Tennessee Department of Corrections, Metro Health Department, Davidson County Sheriff Office, Nashville General Hospital, United Neighborhood Health Centers, and Street Works. The Program Director promotes HIV awareness on Fisk Radio program, Health Waves. In general, the positivity yield of HIV testing in Nashville/Davidson County during outreach activities is less than 1%.

- How targeted testing is done for PWH of the MAI target population, and positives identified.

MCWC focuses on partners of non-virally suppressed clients, persons with sexually transmitted infection(s), or those with risky sexual behavior. Thus, from 01/2023 to 8/2023, MCWC performed targeted HIV testing for 60 high-risk persons on-site. Six of them (8.3%) tested HIV-positive. They were enrolled in care and started on ART immediately.

- How identified positives are linked to and enrolled in care.

People who test HIV-positive in the clinic or on the Meharry campus are linked to care and started on ART the same day; those referred from outside the campus are seen as soon as possible, usually within less than a week. EIS Worker, Community Health Workers, and the Community Care Team are responsible for linkage of identified positives to care. The Community Care Team meet twice a week to discuss newly identified positives and facilitate engagement. Medical case managers and medical providers collaborate in identifying and enrolling new clients. Altogether, they arrange for medical transportation, inform about core and support services, and expectations at initial clinic visit.

- How the PWH are retained in care.

The Patient Service Representative and Community Health Workers contact clients one week and 24-72 hours prior to their scheduled clinic appointments. They reach out by phone, text message, or e-mail to those who missed their visits the same day and attempt to reschedule them, while trying to address the root causes of missed appointments. If these attempts are unsuccessful after one or two weeks, they will mail a certified letter of notification at the client's last address.

Medical case managers and HIV medical providers identify new and current clients at high risk for drop out-of-care and refer them to the Community Care Team. They analyze challenges, barriers, and facilitators to develop and implement a joint plan of care for intensive adherence counseling, peer coaching, performance monitoring, and evaluation. Difficult cases are discussed at weekly staff meetings for broader input.

The Community Care Team reviews the out-of-care list and deploy all their effort to locate the client, reach out to their authorized contact persons, state prisons and jails, local hospitals and drug treatment centers, and homeless camps. Once they are unable to locate the client, they will arrange an in-person visit at their residence or their hangout places. If that fails, they will solicit assistance from the local and state Health Department as well as other community organizations. As a last-ditch effort, they will access the obit announcements.

Describe in detail:

- 1) The number of persons you plan to serve with the funding.**
- 2) The number of units of service you plan to provide by type of intervention (e.g., number of face-to-face contacts with clients and amount of time each client will be seen each year, number of educational sessions provided, number of contacts with gatekeepers); and**
- 3) the average amount of service a client is expected to receive each year (e.g., 2 face to face each year) and the amount of time that will be spent with gatekeepers (e.g., 3 hours/gatekeeper/year).**

With this funding, we propose to serve 50 persons with HIV, distributed as follows:

Male 76%; Female 24%

African American 80%; Caucasian: 19%; other 1%

Hispanic 10%

Age group: 13-24: 0.1%; 25-44: 54%; 45-64: 45%; 65+ 0.9%

They will receive 100 units of 15 minutes each in face to face medical care provided by a Part A funded salaried nurse practitioner, Sheena Simon, and 400 units of lab and diagnostic services in the grant year.

III. Implementation Plan:

The importance of improving progress along the HIV care continuum is supported using scientific research that leads to the identification of best practices and evidence-based practices. The use of best practices/evidenced informed models is preferred for all services and as applicable/available.

Describe in detail any evidence bases or best practice models you will use to provide the service. Include a reference to the model's name and source of the best practice (e.g., "Healthy Living Project," CDC Evidence-Based Intervention-EBI).

<https://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html>

Ideally, interventions will be based upon proven outreach and engagement models; and/or adaptations of proven models; and /or novel models of outreach and engagement in care, particularly developed for the HIV/AIDS population.

Meharry Community Wellness Center will provide primary HIV care based on the latest Guidelines and Recommendations of the Department of Health and Human Services (DHHS) for prevention and treatment of HIV-associated opportunistic infections. These Guidelines summarized the best evidence as assessed by a panel of national HIV experts. Moreover, our experience as one of the three national performance sites, for the HRSA-sponsored Special Project of National Significance (SPNS), "Dissemination of Evidence-Informed Interventions: Peer Linkage and Re-Engagement of HIV-Positive Women of Color" in 2016-2019 inspired the Community Care Team Model implemented by our program in 2020. The Manual is available at: <https://www.targetshiv.org/deii/deii-peer-linkage>. Peer Linkage and Re-engagement of Women of Color with HIV. Rajabiun S., Marbach A., Fox J., Childs E., Sullivan M., Downes, A., Bryant H, Nortrup E., Berthaud V., Alexander L., Grimes T., et al. Dissemination of Evidence-Informed Interventions. Peer Linkage and Re-engagement of Women of Color Living with HIV (2020). Available at: <https://www.targetshiv.org/deii/deii-peer-linkage>. The peer-reviewed manuscript is referred here: Serena Rajabiun, Janet J. Myers, Janet Goldberg, Karen Fortu, Marena Sullivan, Vladimir Berthaud, Rahab Wahome, and Howard J. Cabral. "Outcomes from the adaptation of an evidence-based Peer Linkage & Re-engagement: Intervention for Women of Color with HIV in three urban clinics". AIDS and Behavior. October 05, 2021. PMID: 34609629.

For all Ryan White projects, Meharry Community Wellness Center also implements the most recent Standards of Care published by Tennessee Health Department Ryan White Part B Program and Metropolitan Nashville Health Department Ryan White Part A Program.

Retention strategies: To improve retention and viral suppression, Meharry Community Wellness Center (MCWC) had formed the Community Care Team, which meets twice weekly to discuss clients with incoming appointments, those who missed their recent clinic visits, and those lost to care. MCWC works diligently to schedule all of a client's visits the same day. The Patient Service Representatives or the Community Health Workers contact the client one week and 24-48 hours before the appointment date to facilitate the clinic visit. They arrange for round-trip medical transportation, if needed. Those who missed their scheduled visits are contacted in less than 24 hours. If they are unable to reach a client by phone calls, text messages, e-mails, or letters, after 2 weeks, the Community Health Worker attempts to make a home visit. If that fails, they reach out to Nashville Health Department EIS Worker, Davidson County Sheriff Office and Tennessee Department of Corrections, the Coalition for the Homeless, drug treatment centers, mental health institutions, local hospitals, and nursing homes, for investigation. If these strategies fail after 6 months, the TN Health Department Disease Intervention Specialist (DIS) is alerted for further tracking efforts. Clients who miss more than two consecutive appointments receive intensified adherence counseling and coaching.

Targeted retention efforts toward subpopulations with poor health outcomes. The Community Health Workers and PSRs target MSM, women of color, and clients with challenging issues such as mental illnesses, substance use disorders, and pervasive stigma. The Medical Case Managers assist clients experiencing homelessness in permanent placement, prevention of eviction, and maintenance of stable housing. The HOPWA Case

Manager assists clients with rent, mortgage, and utilities bills. The Community Health Workers provide clients with medical transportation, food services, and pharmacy management to facilitate clinic visits and medication adherence. The medical providers coordinate with staff to facilitate joint clinic appointments. All clients are screened for behavioral and substance use disorders and those who screen positive are seen by the clinical psychologist, the psychiatrist, and/or the therapist/counselor.

Coordination of medical and support services for pregnant women.

An obstetrician-gynecologist with over 25 years of experience including 15 years at MCWC, Dr. Vernita Tucker, will manage pregnant women in the clinic in close coordination with medical providers and nurses during the entire prenatal, peripartum and postpartum period. All pregnant women will be offered ART, if not on yet, and counseled regarding the benefits and risks of ART during pregnancy for the woman, fetus, and newborn. Adherence to ART may decline in the postpartum period. Therefore, clinical and support staff caring for postpartum women on ART will stress adherence and evaluate specific facilitators and barriers. Two Meharry board-certified infectious diseases pediatricians, Dr. Shahana Choudhury and Dr. Christopher Keefer, will manage HIV-exposed babies. Prenatal and HIV care visits as well as neonatal and maternal medical visits will occur on the same day. Attention will be paid to nutrition, medical transportation, housing status, and medical insurance coverage.

Unmet need and HIV care continuum: In 2020, 66% of newly diagnosed people in Tennessee were linked to care within 30 days, compared to 64% in 2018; 54% were retained in care (same for non-Hispanic Blacks) and 66% achieved viral load suppression (63% for Non-Hispanic Blacks). In Nashville TGA, an estimated 17% of PLWH are unaware of their status. In 2020, 66% of newly diagnosed cases were linked to care in 30 days, 54% were retained, and 66% achieved viral suppression. Among Non-Hispanic Blacks, 64% were linked to care within 30 days, 54% were retained and 63% became virally suppressed. Among Non-Hispanic Black PLWH, there were significant differences in care retention by age group ($p < 0.0001$). The lowest rates of care retention in this subpopulation were found among 13-24-year old (44%) and 25-34-year-old (52%). Among Non-Hispanic Black PLWH, there were significant differences in viral suppression by age group ($p = 0.0009$). The lowest rates of viral suppression were found among 13-24-year old (51%), 35-44-year-old (57%), and 25-34-year-old (58%). In TN and the Nashville TGA, the Ryan White program represents the strongest contributor to successful outcomes along the HIV care continuum as shown in this figure. Source: TN Health Department sponsored presentation TN HIV Continuum of Care: Update, Peter F. Rebeiro, MHS, PhD. (September 24, 2015)

We examined the effect of homelessness on viral suppression between 2014-2019. Our retrospective study revealed that permanently/stably housed clients had a much higher proportion of viral suppression compared to unhoused clients. Among clients with viral load < 20 copies/mL, 78% were permanently housed and 22% homeless, while 74% of permanently/stably housed clients reached viral suppression and a smaller proportion of the homeless clients (54.7%) remained virally suppressed (Pearson's Chi-Square 25.171, $p < 0.001$). The multivariable logistic regression showed that permanent/stable housing (p -value < 0.001), higher frequency of CD4 count > 500 cells/mm³ (HIV infection, stage 1) (p -

value < 0.001), age (p-value = 0.004), and FPL (p-value = 0.031) were strong predictors of viral suppression. As expected, patients living in permanent/stable housing had twice the chance of achieving viral suppression compared with those who were experiencing homelessness [OR 2.08 (1.39-3.23), p-value <0.001]. Under the nonparametric assumption, the receiver operating characteristic (ROC) curve correctly predicted 72.3% of the primary outcome variable, viral suppression (AUC = 0.767; p-value < 0.001; 95% CI for AUC (0.73, 0.80). During the 5-year study period, 52 clients died. Of them, 16 (30.76%) were experiencing homelessness and 36 (69.23%) lived in stable housing, while 12.5% of the homeless and 61.12% of those in stable housing achieved viral suppression at the time of death (Berthaud V. et al. BMC Infectious Diseases, 2022; 22: 144). This seminal paper inspired the 2022 CDC Issue Brief, “The Role of Housing in Ending the HIV Epidemic” and a Human Resources and Services Administration (HRSA) Notice of Funding Opportunity for housing of PWH. The Infectious Diseases Society of America cited our paper in their special issue dedicated to homelessness and infectious diseases (Emily Mosites, Laura Hughes, and Jay C. Butler. Homelessness and Infectious Diseases: Understanding the Gaps and Defining a Public Health Approach: Introduction. The Journal of Infectious Diseases 2022;226(S3): S301–3).

IV. Best Practices:

Provide a clear and succinct description of the proposed project to implement an intervention model designed to create access to HIV testing, improve timely entry, engagement, and retention in quality HIV medical care for persons living with HIV infection.

Initial medical evaluation: The goals of the initial evaluation are to confirm the HIV diagnosis, obtain appropriate baseline historical and laboratory data, provide treatment adherence counseling, and ensure patient understanding about living with HIV, its modes and risks of transmission, and to initiate care as soon as possible as recommended by the Department of Health and Human Services (DHHS) under HIV primary care guidelines for prevention and treatment of HIV-associated opportunistic infections.

In the case of previously treated patients who present for an initial evaluation, it is critical to obtain a complete antiretroviral (ARV) history (including drug-resistance testing results, if available), preferably through the review of past medical records. Newly diagnosed patients shall also be asked about any prior use of ARV agents for prevention of HIV infection.

Follow-up visits: After the initial visit, patients deemed at high-risk for dropout and poor treatment adherence shall be followed at least biweekly for intensive case management, peer support, and close medical monitoring. Appointments will be spaced out at larger intervals once they are stabilized and virally suppressed. Stable patients shall be seen every 2-3 months during the first 2 years, then, every 4-6 months once their viral load had been suppressed for 2 consecutive years. Virally suppressed patients with CD4 count > 500 over 2 years can be seen once or twice a year. At each follow-up visit, the medical record shall be updated considering patient complaints, treatment adherence and medication tolerance, referrals, laboratory and procedures results, recent visits to emergency departments, hospitalizations, incarceration, homelessness, outpatient or residential drug treatment, family and personal life changes.

Describe the strategies you will use to identify and engage with key stakeholders

recognized and trusted by the HIV/AIDS community; include the names of specific people and entities.

Describe the components of your intervention model and its specific strategies that will:

- a) Increase awareness of HIV disease, with a focus on reaching persons at high risk for becoming infected with HIV disease.**
- b) Identification of high-risk persons who need but do not access regular HIV tests and how you will link those persons to HIV testing agencies; and**
- c) Identification of persons who are HIV positive but have never or who have dropped out of HIV medical care and services and how you will facilitate linking those persons with needed HIV services and care.**

Proposed interventions must address personal, financial, sociocultural, and structural barriers, especially stigma, that affect PLWHAs access to HIV testing and retention in HIV medical care and services. Define specific barriers that may be encountered by the population being served and discuss how your proposed interventions will positively address each of these barriers.

Meharry Community Wellness Center (MCWC) organizes outreach events with local partners including Metropolitan Nashville Health Department to raise HIV awareness and promote testing. As member of Nashville PrEP Coalition, MCWC facilitates the rapid linkage of newly diagnosed persons. It also leverages its experience as a research site for the SPNS project targeting newly diagnosed and out-of-care women of color for linkage and retention to enhance engagement in care. As a pioneer of HIV telemedicine in TN prisons and HIV consultant for Davidson County jails since 2006, MCWC facilitates the transition of ex-offenders to rapid linkage and engagement upon their release in the community.

Patients who diagnose HIV positive in the emergency department (ED) at Nashville General Hospital (NGH), located on the Meharry campus, are linked and enrolled into care the same or next business day. HIV providers and Medical Case Managers follow newly diagnosed persons with HIV (PWH) admitted to NGH and coordinate their discharge disposition. Clients newly identified outside the Meharry campus are linked as soon as possible, preferably within less than 7 days. The Patient Service Representatives (insurance verification), the Community Health Workers (coaching and navigation), and the Medical Case Managers (insurance assistance and Ryan White eligibility) are responsible for rapid linkage.

Strategies to improve care transition focus on inmates, youth living with HIV and hospitalized patients who are HIV positive. Meharry infectious diseases specialists serve as HIV consultants for TN Department of Corrections and Davidson County Sheriff's Office. At the time of consultation, they will identify inmates ready to transition into the community and initiate the contact between prison or jail personnel and MCWC staff such as PSR, EIS Worker, Community Health Workers, Therapist/Drug Counselor, and Medical Case Managers, to coordinate transitional services, with the intent to schedule the first clinic appointment on the same day of release or within one week. Meharry infectious diseases physicians will follow all persons with

HIV hospitalized at Nashville General Hospital and coordinate their discharge and linkage to care in close collaboration with hospital physicians, nurses, and case managers and MCWC staff. They will also coordinate the care of their patients who are admitted to another acute or long-term care facility. The Community Health Workers will follow clients hospitalized in other medical facilities and share authorized health information with outside providers to ensure continuity in care. They will coach youth living with HIV and help them navigate the HIV service delivery system.

Meharry Community Wellness Center collaborates with diverse stakeholders to identify persons who are HIV positive but have never or who have dropped out of HIV medical care and services and facilitate linking those persons with needed HIV services and care: Nashville General Hospital (NGH), Meharry teaching hospital, where Dr. Berthaud serves as Director of Infectious Diseases and Dr. Livette Johnson co-chairs the Infection Prevention Committee. They work closely with hospital staff to identify patient who are out of HIV care and re-engage them immediately. Inpatient referrals are seen the same day and outpatient referrals are seen in less than a week. A Medical Case Manager and a Community Health Worker will introduce themselves to the hospitalized patient with HIV to educate them about our HIV program and expectations at initial clinic visit. They will coordinate patient discharge with medical providers and Case Managers and arrange for those who are eligible for commercial medical insurance, TennCare, Medicare, or VA insurance initiate the enrollment process as soon as possible. They will inform those deemed eligible for Ryan White insurance coverage about the program requirements, policies, and procedures. The same process is applied to all other referring partners as circumstances allow. NGH refers PWH from Emergency Department, inpatient, and outpatient clinics; Meharry Elam Mental Health Center, Meharry Family Medicine and MAT Clinic, located right across the hall from MCWC, and Meharry Clinics constitute regular sources of mutual referrals; Davidson County Sheriff's Office refers inmates with HIV to MCWC since 2005, while Tennessee Department of Corrections refers them for telemedicine consultation, a service established by Dr. Berthaud in 2006; Neighborhood Health, the largest FQHC in Davidson County, Ascension St Thomas Health (Dr. Berthaud maintains consultation privileges), and Metropolitan Nashville Health Department, the largest HIV testing center in Nashville, represent important referral sources. Metropolitan Development Housing Authority awarded a HOPWA grant for the provision of Short-Term, Rent, Mortgage, and Utilities assistance. Street Works and Nashville CARES provide medical case management, food and housing services including permanent placement and emergency shelters. Second Harvest provides low-cost preserved food for our pantry. Vanderbilt University Medical Center provides emergency, specialty ambulatory, and inpatient care for MCWC clients. Tennessee Health Department had contracted with Meharry for ambulatory/outpatient and medical case management services. They provide technical support to medical case managers and assist in linkage/reengagement of clients lost to care. Metropolitan Nashville Public Health Department (MNPHD) refers newly diagnosed HIV-positive and lost-to-care people, treats persons with latent and active tuberculosis, and coordinates STD management and control. Meharry Elam Mental Health Center collaborates with MCWC Therapist/Drug Counselor on outpatient and inpatient drug treatment, detoxification, and rehabilitation. Dr. Osa-Edoh, the Part A funded psychiatrist, is also the Director of the Drug Treatment Program at Elam Center.

Service Specific Questions:

1. Service Model

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of your proposed project. Include all aspects of planning, implementation, and evaluation, listing the role of everyone involved in activity.

2. Work Plan

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of your proposed project. Include all aspects of planning, implementation, and evaluation, listing the role of everyone involved in each activity.

The work plan should include clearly written:

- 1. Goals**
- 2. Objectives that are specific, time-framed, and measurable**
- 3. Action steps**
- 4. Staff responsible for each action step; and**
- 5. Anticipated dates of completion.**

Please note that goals for the work plan are to be written for the first year of the grant. Discuss any challenges that are likely to be encountered in planning and implementing the project’s activities described in the work plan and describe realistic and appropriate approaches to be used to resolve these challenges.

Work Plan

Goals	Objectives	Action Steps	Anticipated Date of Completion	Responsible Staff
Increase viral suppression	85% viral suppression by end of Year 1	Periodic viral load monitoring as per DHHS guidelines Monitor treatment adherence Monitor health complications and chronic comorbidities	End of Year 1	Medical providers Medical providers, Medical Case Managers, Community Health Workers

Increase retention in care	78% retention in care by end of Year 1	Early identification of clients at high-risk for dropout and treatment failure	End of Year 1	Medical providers Medical Case Managers Community Health Workers
		Provide intensive coaching and case management	End of Year 1	Medical providers Community Health Workers Therapist
		Monitor and evaluate barriers, challenges, and facilitators to treatment adherence and clinic attendance	End of Year 1	Medical providers Mental Health Therapist Psychiatrist Clinical Psychologist
		Facilitate access to treatment of behavioral and substance use disorders, medical transportation, housing and food services	End of Year 1	Therapist Community Health Workers
		Track clients who missed clinic appointments weekly	End of Year 1	Community Health Workers Medical Case Managers
		Collaborate with community-based organizations, local and state health departments, and correctional facilities	End of Year 1	Community Health Workers Medical Case Managers

Aggregate measures of viral suppression and retention are already incorporated in the HRSA-required Performance Measures section of CAREWare. We have customized the system to measure viral load for subpopulations.

Challenges and Resolutions		
Challenges	Approaches for Resolutions	Barriers
Homelessness	HOPWA grant for Short-Term Rent, Mortgage, and Utilities (STRMU) does not match explosive real estate costs in the TGA.	Many of our clients experiencing homelessness are excluded from public housing because of restrictive housing policies and limited HOPWA funding.
Limited transportation service	Medical transportation service provided by program income.	Limited or inexistent public transportation.
Food shortage	Raise Part A Food Voucher card from \$20 to \$60 to adjust for inflationary cost. Program income-supported Food Pantry with unrestricted access in collaboration with Second Harvest.	Lack of job skills & education, unemployment, and poverty, exacerbate food shortage.
High rate of incarceration	Clinical psychologist, psychiatrist, therapist/drug counselor address behavioral and substance use disorders and relapse, and the roots of incarceration.	Limited access points for substance use treatment; high rate of drug charges, incarceration, and recidivism.

Our landmark paper was the first to highlight the negative effect of homelessness on HIV viral suppression and mortality in Middle Tennessee and its potential challenges to ending the HIV epidemic. (Vladimir Berthaud; Livette Johnson; Ronda Jennings et al. “The Effect of Homelessness on Viral Suppression in an Underserved Metropolitan Area of Middle Tennessee: Potential Implications for Ending the HIV Epidemic”. BMC Infectious Diseases. 2022 Feb 10; 22: 144). This retrospective analysis reveals that permanently/stably housed clients had a much higher proportion of viral suppression compared to their unhoused counterparts. Among clients with viral load <20 copies/mL, 78% were permanently housed and 22% unhoused. This seminal

paper inspired the 2022 CDC Issue Brief, “The Role of Housing in Ending the HIV Epidemic” and a Human Resources and Services Administration (HRSA) Notice of Funding Opportunity for housing of PWH. The Infectious Diseases Society of America cited our paper in their special issue dedicated to homelessness and infectious diseases (Emily Mosites, Laura Hughes, and Jay C. Butler. Homelessness and Infectious Diseases: Understanding the Gaps and Defining a Public Health Approach: Introduction. The Journal of Infectious Diseases 2022;226(S3): S301–3).

B. Budget (35 Points)

Complete the entire Budget Spreadsheet attachment (excel version) which describes how you will use the funds to provide the service requested in the scope of work for this solicitation. Include detailed information about the number and type of staff your firm will fund, staffing costs and other specific costs associated with providing the service. Contractor(s) will be allowed to budget up to 10% for administrative costs, including indirect charges.

Leaving blanks on any of the Budget Spreadsheets and/or not following the provided format may result in your proposal being deemed non-responsive.

The entire Budget Spreadsheet attachment has been completed and uploaded.



METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY

Department of Finance
700 President Ronald Reagan Way, STE 201
Nashville, Tennessee 37210

**Metropolitan Government of Nashville and Davidson County
Recipient of Metro Grant Funding
Certifications of Assurance**

December 30, 2024

As a condition of receipt of this funding, the Recipient assures that it will comply fully with the provisions of the following laws.

- The Americans with Disabilities Act (ADA) of 1990, 42 U.S.C. Section 12116;
- Title VI of the Civil Rights Act of 1964, as amended which prohibits discrimination on the basis of race, color, and national origin;
- Section 504 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination against qualified individuals with disabilities;

CERTIFICATION REGARDING LOBBYING - Certification for Contracts, Grants, Loans, and Cooperative Agreements

By accepting this funding, the signee hereby certifies, to the best of his or her knowledge and belief, that:

- a. No federally appropriated funds have been paid or will be paid, by or on behalf of the Recipient, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, and entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
- b. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this grant, loan, or cooperative agreement, the Recipient shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- c. The Recipient shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including sub-grants, subcontracts, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients of federally appropriated funds shall certify and disclose accordingly.

Signature of Authorized Representative

Name: Vladimir Berthaud MD

Title: Executive Director

Agency Name: Meharry Community Wellness Center

Date: February 10, 2025



Department of Finance
700 President Ronald Reagan Way, STE 201
Nashville, Tennessee 37210

**Metropolitan Government of Nashville and Davidson County
Recipient of Metro Grant Funding
Non-Profit Grants Manual Receipt Acknowledgement**

December 30, 2024

As a condition of receipt of this funding, the recipient acknowledges the following:

- Receipt of the Non-Profit Grants Manual, updated February 2, 2023, issued by the Division of Grants and Accountability. Electronic version can be located at the following: [Non-Profit Grant Resources](#)
- The recipient has read, understands and hereby affirms that the agency will adhere to the requirements and expectations outlined within the Non-Profit Grants Manual.
- The recipient understands that if the organization has any questions regarding the Non-Profit Grants Manual or its content, they will consult with the Metro department that awarded their grant.

**Note to Organizations: Please read the Non-Profits Grants Manual carefully to ensure that you understand the requirements and expectations before signing this document.*



Signature of Authorized Representative
Name: Vladimir Berthaud MD
Title: Executive Director
Agency Name: Meharry Community Wellness Center
Date: February 10, 2025

Internal Revenue Service

Department of the Treasury

District Director
Baltimore District

31 Hopkins Plaza, Baltimore, Md. 21201

▷ May 16, 1996

MEHARRY MEDICAL COLLEGE
1005 D B TODD BLVD
NASHVILLE, TN 37208

P.O. Box 13163, Room 817
Baltimore, MD 21203

Employer Identification Number:
62-0488046

Person to Contact:
EP/EO Tax Examiner

Telephone Number:
(410) 962-6058

Dear Sir/Madam:

This is in response to your inquiry dated January 9, 1996, requesting a copy of the letter which granted tax exempt status to the above named organization.

Our records show that the organization was granted exemption from Federal Income Tax under section 501(c)(3) of the Internal Revenue Code effective September, 1937. We have also determined that the organization is not a private foundation because it is described in section(s) 509(a)(1) and 170(b)(1)(A)(ii).

Donors may deduct contributions to you under section 170 of the Code.

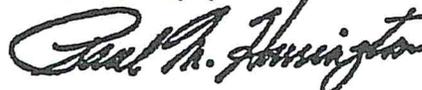
As of January 1, 1984, you are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of \$100 or more you pay to each of your employees during the calendar year. You are not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

You are required to file Form 990, Return of Organization Exempt from Income Tax, only if your gross receipts each year are normally more than \$25,000. However, if you receive a Form 990 package in the mail, please file the return even if you do not exceed the gross receipts test. If you are not required to file, simply attach the label provided, check the box in the heading to indicate that your annual gross receipts are normally \$25,000 or less, and sign the return.

A copy of our letter certifying the status of the organization is not available, however, this letter may be used to verify your tax-exempt status.

Because this letter could help resolve any questions about your exempt status, it should be kept in your permanent records.

Sincerely yours,



Paul M. Harrington
District Director

**AMENDED AND RESTATED CHARTER
OF MEHARRY MEDICAL COLLEGE**

Pursuant to the provisions of Tennessee Code Annotated Section 48-60-106 and Section 48-60-106, the undersigned Corporation adopts the following amendment and restatement of its charter:

1. The name of the Corporation is Meharry Medical College.
2. The Corporation is a nonprofit, public benefit corporation.
3. The Corporation shall have perpetual duration.
4. The address of the principal office of the Corporation shall be 1005 Dr. D.B. Todd Jr. Boulevard, Nashville, Tennessee 37208, Davidson County. The Corporation may establish branches in any other county in the State of Tennessee.
5. The name and street address of its registered agent in the State of Tennessee shall be Corporate Secretary, Meharry Medical College, Office of the President, 1005 Dr. D.B. Todd Jr. Boulevard, Nashville, Tennessee 37208.
6. The Corporation will have no capital stock, and will not be conducted for pecuniary gain, or profit to anyone, but its purpose will be to give, promote and extend instruction, education and training of medical, dental, and graduate students, residents, fellows and physicians for the delivery of high-quality patient care and the conduct of medical, dental and other scientific research and study in related branches of learning.
7. The Corporation shall be managed, its affairs conducted, and its powers exercised by a Board of Trustees. There shall be a representative of the United Methodist Episcopal Church serving on the Board of Trustees.
8. The Corporation shall have the power to acquire both real and personal property by purchase, exchange, devise, gift or donation, and to hold, use or invest same in such way and manner as may tend to promote the objectives of said Corporation; and to carry out all purposes set forth in this Charter, including the right to lend on security approved by it, or to otherwise invest any and all funds which may be received by it as endowment; provided, however, that all property, real or personal, that may be purchased or otherwise acquired by the Corporation, shall be received, used, kept, maintained and disposed of for the purposes set forth in this Charter.
9. The Corporation shall have the power (but shall not be required) to have a seal which it may alter at pleasure (if no common seal, then the signature of the name of the corporation by any duly authorized officer shall be legal and binding), to sue and be sued under the corporate name; to keep and maintain order and discipline among its student body and on its campus; to make any and all contracts with reference to acquisition, management, control, encumbrance, sale, or disposition of its property not contrary to the laws of the State of Tennessee or the United States of America; and to appoint such subordinate officers and agents in addition to a president

and secretary or treasurer, as the business of the Corporation may require as set forth in the Corporation's bylaws, as amended from time to time; and to designate the name of said officers and fix the compensation of said officers.

10. The Corporation shall have authority to give or provide for instruction in medicine and dentistry and related branches of learning, and in such connection shall have the authority to establish or acquire such schools, departments and faculties as it may deem proper; and in connection with the medical school maintained by it, to establish, or acquire and maintain such hospitals, dispensaries, and training schools for nurses as may be necessary or useful in connection therewith.

11. The Corporation shall have the power and authority to prescribe the course of study and the degrees of proficiency therein necessary to graduate in any school or department, or under any faculty created, maintained, or controlled by it, and to grant such diplomas or certificates to graduates or students in any of such schools or departments, or affiliated colleges or under any such faculty as it may deem proper, and to confer such degrees upon such graduates as may be appropriate, and such as are conferred by other colleges or universities maintaining or controlling similar schools of instruction and learning; also, to grant honorary degrees to persons distinguished for learning, ability and character in their respective vocations.

12. The Corporation shall also have power to make and adopt all such bylaws, rules and regulations as may seem to it necessary or proper for the management, control and conduct of the affairs and property of the Corporation, and said bylaws, rules and regulations so adopted shall be binding on said Corporation until amended in the manner and form prescribed therein for their amendment; provided, none of said bylaws, rules or regulations shall be contrary to any provisions in this Charter. The Corporation shall also have all other such powers of authority as are conferred upon nonprofit corporations by the laws of the State of Tennessee.

13. Notwithstanding any other provision of this Charter, the Corporation will not carry on any other activities not permitted to be carried on by a corporation exempt from Federal income tax under Sections 501(c)(3) of the Internal Revenue Code of 1986 or the corresponding provision of any future United States internal revenue law and Section 170(c)(2) of the Internal Revenue Code of 1986, or corresponding provision of any future United States internal revenue law.

14. The Corporation is organized exclusively for religious, charitable, education, and scientific purposes, including in such purposes, the making of distributions to organizations that qualify as exempt organizations under Section 501(c) of the Internal Revenue Code of 1986 (or corresponding provision of any future United States internal revenue law). No part of the net earnings of the Corporation shall inure to the benefit of or be distributable to its trustees, officers, or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth above.

15. Except as expressly provided by law, no person who is serving or has served as a member of the Board of Trustees shall have any personal liability to the Corporation or to any third party

for monetary damages, breach of duty or care, or other duty as a member of the Board of Trustees; provided that this provision shall not eliminate or limit the liability of any such person:

- a. For any appropriation, in violation of his or her duties, of any business opportunity of the Corporation;
- b. For acts of omission not in good faith or which involve intentional misconduct or a knowing violation of law; or
- c. For any transaction from which such person derived an improper personal benefit.

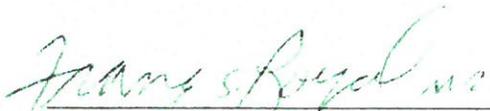
The limitation of liability hereby conferred shall be in addition to and not in lieu of all other limitation, immunities, and indemnities conferred by law (including Tennessee Code Annotated Sections 48-58-501 through 509 or any successor provisions), this Charter and the bylaws of the Corporation.

16. The Corporation has no members. No persons other than the Board of Trustees are required for approval of this Amended and Restated Charter.

17. The Board of Trustees may at any time voluntarily dissolve the corporation by a conveyance of its assets and property to one or more organizations which themselves are exempt as organizations described in Sections 501(c) and 170(c)(2) of the Internal Revenue Code of 1986 in the State of Tennessee or as designated in the bylaws, provided the Corporation first provides for all corporate debts and obligations.

IN WITNESS WHEREOF, the Board of Trustees of Meharry Medical College has adopted this Amended and Restated Charter effective the date of filing by the Secretary of the State of Tennessee.

UN 4-19-05



Frank Royal, M.D.

Chairman of the Board of Trustees



Leilani Boulware, Esq.

Corporate Secretary

Details



MEHARRY MEDICAL COLLEGE

1005 D. B. TODD JR. BLVD NASHVILLE TN 37208

Office of General Counsel

(615) 327-6724

No Website

Status: Active

CO Number: CO3632

Registration Date: 07/06/1999

Financials (1)

Officers (3)



Charity Events (0)



Secretary of State Tre Hargett

Tre Hargett was elected by the Tennessee General Assembly to serve as Tennessee's 37th secretary of state in 2009 and re-elected in 2013, 2017, 2021, and 2025. Secretary Hargett is the chief executive officer of the Department of State with oversight of more than 300 employees. He also serves on 16 boards and commissions, on two of which he is the presiding member. The services and oversight found in the Secretary of State's office reach every department and agency in state government.



Details



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[Title VI Information](#)

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MEHARRY MEDICAL COLLEGE

Entity Type: Nonprofit Corporation

Formed in: TENNESSEE

Term of Duration: Perpetual

Religious Type: Non-Religious

Benefit Type: Public Benefit Corporation

Status: Active

Control Number: 000078454

Initial Filing Date: 10/13/1915 4:30:00 PM

Fiscal Ending Month: June

AR Due Date: 10/01/2025

Registered Agent

IVANETTA DAVIS SAMUELS
1005 DR DB TODD JR BLVD
NASHVILLE, TN 37208

Principal Office Address

1005 DR DB TODD JR BLVD
NASHVILLE, TN 37208-3501

Mailing Address

1005 DR DB TODD JR BLVD
NASHVILLE, TN 37208-3501

AR Standing: Good	RA Standing: Good	Other Standing: Good	Revenue Standing: N/A
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History (51) ^			
Type	Date	Tracking Number	Change History
2024 Annual Report for MEHARRY MEDICAL COLLEGE	10/2/2024 4:35:12 PM	B1630-4505	
2023 Annual Report for MEHARRY MEDICAL COLLEGE	12/19/2023 3:05:25 PM	B1480-7998	
Notice of Determination for MEHARRY MEDICAL COLLEGE	12/5/2023 1:40:32 AM	B1449-3784	
System Amendment for MEHARRY MEDICAL COLLEGE	10/3/2023 2:17:02 AM		
2022 Annual Report for MEHARRY MEDICAL COLLEGE	10/17/2022 4:28:10 PM	B1291-7276	
System Amendment for MEHARRY MEDICAL COLLEGE	10/4/2022 2:14:00 AM		
2021 Annual Report for MEHARRY MEDICAL COLLEGE	9/13/2021 11:36:00 AM	B1093-8276	
2020 Annual Report for MEHARRY MEDICAL COLLEGE	9/14/2020 10:27:32 AM	B0921-7770	

2019 Annual Report for MEHARRY MEDICAL COLLEGE	10/28/2019 12:22:14 PM	B0775-2233	
System Amendment for MEHARRY MEDICAL COLLEGE	10/2/2019 1:40:25 AM		
2018 Annual Report for MEHARRY MEDICAL COLLEGE	10/18/2018 1:45:08 PM	B0610-1286	
System Amendment for MEHARRY MEDICAL COLLEGE	10/2/2018 1:40:34 AM		
2017 Annual Report for MEHARRY MEDICAL COLLEGE	10/2/2017 3:38:44 PM	B0447-2173	
System Amendment for MEHARRY MEDICAL COLLEGE	10/2/2017 1:40:38 AM		
2016 Annual Report for MEHARRY MEDICAL COLLEGE	9/26/2016 2:26:46 PM	B0300-1989	
2015 Annual Report for MEHARRY MEDICAL COLLEGE	12/9/2015 1:43:50 PM	B0174-3810	
Notice of Determination for MEHARRY MEDICAL COLLEGE	12/3/2015 3:00:31 AM	B0169-8759	
System Amendment for MEHARRY MEDICAL COLLEGE	10/2/2015 3:06:06 AM		
2014 Annual Report for MEHARRY MEDICAL COLLEGE	9/3/2014 12:14:14 PM	A0263-2413	<ul style="list-style-type: none"> ○ Principal Address 1 changed from: 1005 D B TODD BLVD to: 1005 DF DB TODD JR BLVD ○ Principal Postal Code changed from: 37208 to: 37208-3501
2013 Annual Report for MEHARRY MEDICAL COLLEGE	8/22/2013 3:51:35 PM	A0200-1330	
Registered Agent Change (by Entity) for MEHARRY MEDICAL COLLEGE	7/11/2013 4:32:35 PM	A0192-0378	<ul style="list-style-type: none"> ○ Registered Agent First Name changed from: BENJAMIN to: IVANETT/ ○ Registered Agent Last Name changed from: RAWLINS ESQ to: SAMUELS ○ Registered Agent Middle Name changed from: No Value to: DAVIS
2012 Annual Report for MEHARRY MEDICAL COLLEGE	12/7/2012 3:27:15 PM	A0146-3027	
Notice of Determination for MEHARRY MEDICAL COLLEGE	12/4/2012 3:00:12 AM	A0146-1488	

System Amendment for MEHARRY MEDICAL COLLEGE	10/2/2012 3:02:49 AM		
2011 Annual Report for MEHARRY MEDICAL COLLEGE	8/1/2011 8:00:00 AM	A0087-0041	
2010 Annual Report for MEHARRY MEDICAL COLLEGE	12/7/2010 8:00:00 AM	A0049-2212	
Notice of Determination for MEHARRY MEDICAL COLLEGE	12/1/2010 3:00:13 AM	A0049-0629	
System Amendment for MEHARRY MEDICAL COLLEGE	10/2/2010 3:03:58 AM		
2009 Annual Report for MEHARRY MEDICAL COLLEGE	8/20/2009 12:04:21 AM	6586-0840	o Mail Address Changed
2008 Annual Report for MEHARRY MEDICAL COLLEGE	9/3/2008 12:04:24 AM	6372-1270	
2007 Annual Report for MEHARRY MEDICAL COLLEGE	10/1/2007 12:14:32 AM	6135-2220	
Registered Agent Change (by Entity) for MEHARRY MEDICAL COLLEGE	8/23/2007 12:00:25 AM	6117-1105	o Registered Agent Changed
2006 Annual Report for MEHARRY MEDICAL COLLEGE	9/29/2006 12:05:13 AM	5869-0608	
2005 Annual Report for MEHARRY MEDICAL COLLEGE	9/30/2005 12:03:49 AM	5573-1336	
Amended and Restated Formation Documents for MEHARRY MEDICAL COLLEGE	4/19/2005 12:00:10 AM	5436-2279	
2004 Annual Report for MEHARRY MEDICAL COLLEGE	9/30/2004 12:04:32 AM	5246-1678	o Registered Agent Changed
2003 Annual Report for MEHARRY MEDICAL COLLEGE	10/1/2003 12:03:44 AM	4924-1424	
2002 Annual Report for MEHARRY MEDICAL COLLEGE	10/29/2002 12:02:55 AM	4636-0917	
2001 Annual Report for MEHARRY MEDICAL COLLEGE	7/31/2001 12:03:53 AM	4262-0975	o Mail Address Changed

2000 Annual Report for MEHARRY MEDICAL COLLEGE	8/14/2000 12:02:49 AM	3975-0178	
CMS Annual Report Update for MEHARRY MEDICAL COLLEGE	1/31/2000 12:02:36 AM	3813-0270	<ul style="list-style-type: none"> ○ Registered Agent Physical Address Change ○ Registered Agent Changed ○ Mail Address Changed
Notice of Determination for MEHARRY MEDICAL COLLEGE	12/17/1999 12:04:39 AM	ROLL 3772	
CMS Annual Report Update for MEHARRY MEDICAL COLLEGE	11/25/1992 12:02:56 AM	2596-1114	<ul style="list-style-type: none"> ○ Fiscal Year Close Changed
Notice of Determination for MEHARRY MEDICAL COLLEGE	4/20/1990 12:06:30 AM	ROLL 1732	
Registered Agent Change (by Entity) for MEHARRY MEDICAL COLLEGE	10/24/1988 12:00:35 AM	1010-0720	<ul style="list-style-type: none"> ○ Registered Agent Changed
Registered Agent Change (by Entity) for MEHARRY MEDICAL COLLEGE	10/29/1985 12:00:33 AM	573 01032	<ul style="list-style-type: none"> ○ Registered Agent Physical Address Change ○ Registered Agent Changed
Application for Reinstatement for MEHARRY MEDICAL COLLEGE	10/29/1985 12:00:32 AM	573 01513	
Articles of Amendment for MEHARRY MEDICAL COLLEGE	10/29/1985 12:00:31 AM	573 01031	<ul style="list-style-type: none"> ○ Principal Address Changed
Administrative Amendment for MEHARRY MEDICAL COLLEGE	10/28/1985 12:00:44 AM	573 01482	<ul style="list-style-type: none"> ○ Mail Address Changed
Dissolution/Revocation - Administrative for MEHARRY MEDICAL COLLEGE	8/23/1985 12:11:10 AM	561 00610	
Initial Filing for MEHARRY MEDICAL COLLEGE	10/13/1915 12:00:00 AM	B007P0248	

MEHARRY MEDICAL COLLEGE
CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

MEHARRY MEDICAL COLLEGE

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Independent Auditor's Report

The Board of Trustees
Meharry Medical College
Nashville, Tennessee

Opinion

We have audited the accompanying consolidated financial statements of Meharry Medical College and Subsidiary (collectively the "College"), which comprise the consolidated statements of financial position as of June 30, 2024 and 2023, and the related consolidated statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the College as of June 30, 2024 and 2023, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the College and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the College's ability to continue as a going concern within one year after the date that the consolidated financial statements are available to be issued.



The Board of Trustees
Meharry Medical College

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with generally accepted auditing standards and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the College's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the College's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Crosslin, PLLC

Nashville, Tennessee
April 29, 2025

MEHARRY MEDICAL COLLEGE
CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

ASSETS

	June 30,	
	2024	2023
Cash and cash equivalents	\$ 26,517,848	\$ 25,436,900
Accounts receivable, less allowance for credit losses of \$6,171,737 and \$2,645,554 for 2024 and 2023, respectively	57,814,063	47,696,652
Student loans receivables, less allowance for credit losses of \$137,791 and \$128,019 for 2024 and 2023, respectively	9,871,541	6,150,768
Contributions receivable, net	35,786,433	11,274,513
Investments	194,423,173	180,709,219
Investment in real estate	16,165,376	17,074,614
Investment in affiliates	1,095,457	-
Plant facilities, net of accumulated depreciation	157,506,451	154,593,073
Right-of-use assets - leases	13,399,055	1,881,266
Deferred charges	379,178	758,355
Funds held by trustees	10,372,450	7,085,236
Other assets, including net pension assets	1,977,554	1,334,695
Total assets	\$ 525,308,579	\$ 453,995,291

LIABILITIES AND NET ASSETS

Notes payable to banks	\$ 12,078,712	\$ 17,518,527
Accounts payable	7,126,254	5,582,266
Accrued liabilities	4,289,439	6,129,441
Deferred revenue	17,899,747	12,294,670
Bonds payable, net	61,239,819	59,904,564
Finance lease liability	10,279,474	-
Operating lease liability	3,103,023	1,881,266
Government advances for student loans	4,106,457	4,544,944
Funds held in trust for others	1,931,508	1,042,927
Total liabilities	122,054,433	108,898,605
Net assets:		
Without donor restrictions:		
Undesignated	122,883,933	117,102,189
Funded pension liability	1,907,569	1,277,299
Unrealized loss on interest rate swap agreement	(24,032)	(89,417)
Prefunding of debt service resulting from refinancings	(2,559,822)	(2,811,975)
Total net assets without restrictions	122,207,648	115,478,096
With donor restrictions	281,046,498	229,618,590
Total net assets	403,254,146	345,096,686
Total liabilities and net assets	\$ 525,308,579	\$ 453,995,291

See accompanying notes to consolidated financial statements.

MEHARRY MEDICAL COLLEGE
CONSOLIDATED STATEMENTS OF ACTIVITIES

	Year Ended June 30,	
	2024	2023
Changes in net assets without restrictions:		
Operating revenue:		
Tuition and fees	\$ 55,195,579	\$ 48,546,706
Less College funded scholarships	(9,988,285)	(9,581,623)
Net tuition and fees	45,207,294	38,965,083
Government grants and contracts	77,486,545	73,220,998
Private gifts, grants, and contracts	3,726,181	3,112,051
Sales and services of educational departments	2,168,495	1,191,972
Other sources	9,677,085	6,870,333
Health services division	20,598,264	27,557,601
Net assets released from restrictions and reclassifications	18,315,798	44,536,839
Total operating revenue	177,179,662	195,454,877
Operating expenses:		
Instruction	32,382,179	33,367,690
Research	22,451,058	22,669,728
Public service	23,302,091	24,134,367
Academic support	27,651,927	28,366,028
Student services	5,859,602	5,290,336
Institutional support	31,938,149	49,567,864
Health services division	27,593,052	28,166,180
Total operating expenses	171,178,058	191,562,193
Increase in net assets without donor restrictions from operating activities	6,001,604	3,892,684
Nonoperating Items:		
Change in net minimum pension liability	630,270	339,066
Change in market value of interest rate swap agreement	65,385	308,301
Total nonoperating items	695,655	647,367
Increase in net assets without donor restrictions before provision for income taxes	6,697,259	4,540,051
Income tax benefit	32,294	32,294
Increase in net assets without donor restrictions	6,729,553	4,572,345
Changes in net assets with donor restrictions:		
Private gifts, grants, and contracts	49,083,367	29,918,825
Income on long-term investments, net	7,091,742	6,386,819
Net gain on investments	13,568,596	11,987,483
Net assets released from restrictions and reclassifications	(18,315,798)	(44,536,839)
Increase in net assets with donor restrictions	51,427,907	3,756,288
Increase in net assets	58,157,460	8,328,633
Net assets at beginning of year	345,096,686	336,768,053
Net assets at end of year	\$ 403,254,146	\$ 345,096,686

See accompanying notes to consolidated financial statements.

MEHARRY MEDICAL COLLEGE
 CONSOLIDATED STATEMENT OF FUNCTIONAL EXPENSES
 YEAR ENDED JUNE 30, 2024

	<u>Instruction</u>	<u>Research</u>	<u>Public Service</u>	<u>Academic Support</u>	<u>Student Services</u>	<u>Institutional Support</u>	<u>Plant O/M</u>	<u>Health Services</u>	<u>Total</u>
Salaries and benefits	\$ 25,750,361	\$11,906,414	\$13,998,342	\$15,208,478	\$2,145,835	\$18,750,748	\$ 186,000	\$16,438,779	\$ 104,384,957
Supplies	2,361,472	1,846,355	548,351	3,592,005	167,111	1,298,356	397,467	450,718	10,661,835
Utilities and communication	9,129	9,813	6,946	161,302	134	761,119	3,250,278	25,607	4,224,328
Travel	566,222	490,118	290,097	1,213,928	74,331	533,745	1,290	69,040	3,238,771
Equipment related expenses	129,847	840,709	278,434	655,624	1,778	4,899,478	73,805	124,221	7,003,896
Contractual services	1,726,406	3,473,071	10,163,874	5,211,436	224,046	10,386,704	5,548,410	3,395,475	40,129,422
Interest and related costs	-	-	-	-	-	2,888,142	-	-	2,888,142
Other, transfers and indirect costs	1,838,742	3,884,578	(1,983,953)	1,609,154	3,246,367	(7,580,143)	(9,457,250)	7,089,212	(1,353,293)
Total	<u>\$32,382,179</u>	<u>\$22,451,058</u>	<u>\$23,302,091</u>	<u>\$27,651,927</u>	<u>\$5,859,602</u>	<u>\$31,938,149</u>	<u>\$ -</u>	<u>\$27,593,052</u>	<u>\$171,178,058</u>

See accompanying notes to consolidated financial statements.

MEHARRY MEDICAL COLLEGE
CONSOLIDATED STATEMENT OF FUNCTIONAL EXPENSES
YEAR ENDED JUNE 30, 2023

	Instruction	Research	Public Service	Academic Support	Student Services	Institutional Support	Plant O/M	Health Services	Total
Salaries and benefits	\$ 25,054,548	\$11,007,108	\$13,208,990	\$13,923,920	\$1,816,846	\$19,273,472	\$ -	\$18,972,845	\$ 103,257,729
Supplies	1,516,139	1,549,766	678,046	4,806,596	93,866	1,269,527	505,891	598,286	11,018,117
Utilities and communication	3,791	231	19,343	38,169	9,704	547,713	3,560,246	28,153	4,207,350
Travel	354,888	258,269	342,717	933,490	33,893	581,844	-	46,678	2,551,779
Equipment related expenses	7,393	1,661,133	236,966	664,577	12,750	6,355,017	4,670	676,202	9,618,708
Contractual services	1,327,293	5,002,932	6,639,635	3,660,934	295,701	11,501,463	4,719,832	3,540,911	36,688,701
Interest and related costs	-	-	-	-	-	1,854,670	-	-	1,854,670
Other, transfers and indirect costs	5,103,638	3,190,289	3,008,670	4,338,342	3,027,576	8,184,158	(8,790,639)	4,303,105	22,365,139
Total	\$33,367,690	\$22,669,728	\$24,134,367	\$28,366,028	\$5,290,336	\$49,567,864	\$ -	\$28,166,180	\$191,562,193

See accompanying notes to consolidated financial statements.

MEHARRY MEDICAL COLLEGE
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended June 30,	
	2024	2023
Cash flows from operating activities:		
Increase in net assets	\$ 58,157,460	\$ 8,328,633
Adjustments to reconcile increase in net assets provided by operating activities:		
Depreciation and amortization	10,543,468	8,315,815
Contributions restricted for long-term investment	(4,142,069)	(1,693,946)
Net realized and unrealized (gain) loss on long-term investments	(13,568,596)	(11,987,483)
Change in allowances for credit losses	3,526,103	(1,127,561)
Changes in:		
Accounts receivable, net	(13,643,514)	(26,575,182)
Contributions receivable, net	(24,511,920)	85,705
Deferred charges	379,177	379,178
Other assets	(641,859)	(360,211)
Accounts payable	1,543,988	(531,477)
Accrued liabilities	(1,840,002)	(2,326,064)
Income tax payable	-	(870,670)
Deferred revenue	5,605,077	926,676
Funds held in trust for others	888,581	(450,337)
Net cash provided by (used in) operating activities	<u>22,295,894</u>	<u>(27,886,924)</u>
Cash flows from investing activities:		
Acquisition of plant facilities equipment	(10,472,181)	(30,948,017)
Student loans receivable, net	(3,720,773)	264,731
Sales of investments, net of purchases	(445,604)	1,814,813
Investment in affiliates	(1,095,457)	-
Change in funds held by trustees	(3,287,214)	(2,718,959)
Net cash used in investing activities	<u>(19,021,229)</u>	<u>(31,587,432)</u>
Cash flows from financing activities:		
Proceeds from contributions restricted for long-term investment	4,142,069	1,693,946
Change in government advances for student loans	(438,487)	(573,729)
Payment of bond issuance costs	-	-
Proceeds from issuance of note payable	2,000,000	6,000,000
Principal repayments of notes payable	(7,439,816)	(1,439,816)
Proceeds from issuance of bonds	5,545,048	30,306,594
Payments on finance lease liabilities	(1,720,526)	-
Principal repayment of bonds	(4,282,005)	(3,522,598)
Net cash (used in) provided by financing activities	<u>(2,193,717)</u>	<u>32,464,397</u>
Net increase (decrease) in cash and cash equivalents	1,080,948	(27,009,959)
Cash and cash equivalents at beginning of year	<u>25,436,900</u>	<u>52,446,859</u>
Cash and cash equivalents at end of year	<u>\$ 26,517,848</u>	<u>\$ 25,436,900</u>
Supplemental cash flow information:		
Cash paid for interest	<u>\$ 2,146,570</u>	<u>\$ 1,912,474</u>
Cash paid for amounts included in the measurement of operating lease liabilities	<u>\$ 1,175,651</u>	<u>\$ 553,736</u>
Cash paid for amounts included in the measurement of finance lease liabilities	<u>\$ 979,336</u>	<u>\$ -</u>
ROU assets obtained in exchange for operating lease liabilities	<u>\$ 2,181,040</u>	<u>\$ 2,340,672</u>
ROU assets obtained in exchange for finance lease liabilities lease liabilities	<u>\$ 12,000,000</u>	<u>\$ -</u>

See accompanying notes to consolidated financial statements.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

A. ORGANIZATION AND PURPOSE

Meharry Medical College (the “College”) is a fully accredited, private college committed to training health care professionals and leaders in many medical and health related fields. The College exists to provide an excellent education in the health sciences, while maintaining a center of excellence for the practice and delivery of health care, and the conduct of both basic and clinical research.

MMCV, Inc., a Tennessee corporation, is a for-profit wholly owned subsidiary of the College formed to seek and perform opportunities and projects that align with the mission of the College, but that are not considered core activities of the College.

Meharry Real Estate Foundation, Inc. (the “Foundation”), a not-for-profit organized as a 501(c)(3) to accept certain contributions on behalf of the College. There was no activity for the Foundation in fiscal year 2024.

B. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation and Accounting

The consolidated financial statements of the College have been prepared on the accrual basis of accounting and in accordance with the accounting principles generally accepted in the United States of America.

The consolidated financial statements include the operations of the College and its wholly owned subsidiaries, MMCV, Inc. and Meharry Real Estate Foundation, Inc. All significant intercompany activity has been eliminated in consolidation.

To ensure observance of limitations and restrictions placed on the use of resources available, the College maintains its accounts in accordance with the principles and practices of fund accounting. Fund accounting is the procedure by which resources for various purposes are classified for accounting purposes into funds that are maintained in accordance with activities or objectives of the College.

The College classifies its support, revenue, expenses, gains and losses into two net asset categories differentiated based on the existence or absence of donor-imposed restrictions. Net assets of the College and changes therein are classified as follows:

Net Assets Without Donor Restrictions are free of donor-imposed restrictions and may be designated for specific purposes by action of the Board of Trustees or may otherwise be limited by contractual agreements with outside parties. Support, revenue, gains, and losses that are not restricted by donors are included in this classification. Expenses are reported as decreases in this classification.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

B. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - Continued

Net Assets With Donor Restrictions are subject to stipulations imposed by donors and grantors. Some donor restrictions are temporary in nature; those restrictions will be met by actions of the College or by the passage of time. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity but may permit the College to use or expend part or all of the income derived from the donated assets. Net assets with donor restrictions that are held in perpetuity include the College's permanent endowment funds.

Use of Estimates in the Preparation of Financial Statements

Judgment and estimation are exercised by management in certain areas of the preparation of the consolidated financial statements. The more significant areas include the recovery period for plant facilities, the allocation of certain operating and maintenance expenses to functional categories, the collection of contributions receivable, and the valuation of receivables including the allowances for contractual adjustments and credit losses on accounts receivable. Management believes that such estimates have been based on reasonable assumptions and that such estimates are adequate; however, actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include cash and highly liquid investments with original maturities of three months or less. Certain cash equivalents are also included in investments as they are awaiting investment.

Inventories

Inventories consisting of supplies are stated at the lower of cost (first-in, first-out) or market (net realizable value).

Accounts Receivable

The College records accounts receivable at their estimated net realizable value. An allowance for credit losses is recorded based upon management's estimate of uncollectible accounts determined by analysis of specific balances and a general reserve based upon aging of outstanding balances. Past due balances are charged against the allowance when they are determined to be uncollectible. The College evaluates the need for an allowance for credit losses based upon factors surrounding the credit risk of the specific students or patients, historical trends, macroeconomic data, supportable forecasts, and other information available.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

B. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - Continued

Student Loans Receivable

Student loans receivable are carried at unpaid principal balances, less an allowance for credit losses. The allowance for credit losses is increased by charges to income and decreased by charge-offs (net of recoveries). Management's periodic evaluation of the adequacy of the allowance is based on various loan program requirements, the College's historical loan loss experience, specific impaired loans, adverse situations that may affect the borrower's ability to repay, estimated value of any underlying collateral, and current economic conditions. Loans are considered impaired if full principal or interest payments are not anticipated in accordance with the contractual terms. The College's practice is to charge off any loan or portion of a loan when the loan is determined by management to be uncollectible due to the borrower's failure to meet repayment terms, the borrower's deteriorating or deteriorated financial condition, the depreciation of the underlying collateral, or for other reasons.

Investments

Investments in equity securities with readily determinable fair value and all investments in debt securities are reported at fair value with gains and losses included in the consolidated statements of activities. Works of art, historical treasures, and similar assets held as part of collections are reported at the fair or appraisal value at the date of acquisition or contribution, respectively.

The estimated fair value of certain alternative investments, such as private equity interests, is determined by reference to the net asset values allocated to the College at the measurement date. The College believes the carrying amount of these financial instruments is a reasonable estimate of fair value. Because alternative investments are not readily marketable, their estimated value is subject to uncertainty and, therefore, may differ from the value that would have been used had a ready market for such investments existed. Such difference could be material.

Investment in the hospital facility is based upon the estimated fair value of the facility, which equates to the discounted payments to be received from the 30-year lease of the facility. The investment is being depreciated on a straight-line basis over the estimated useful life of the facility and equipment which range from ten to forty years.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

B. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - Continued

Life Income and Gift Annuities

The College's split interest agreements with donors consist primarily of irrevocable charitable remainder trusts for which the College serves as trustee. Assets held in these trusts are included in investments. Contribution revenues are recognized at the dates the trusts are established after recording liabilities for the present value of the estimated future payments to be made to the donors and/or other beneficiaries. The liabilities are adjusted annually for changes in the value of the assets, accretion of the discount and other changes in the estimate of future benefits.

Plant Facilities

Plant facilities are stated at cost or estimated fair value at dates of gifts, less accumulated depreciation, computed on the straight-line basis over the estimated useful lives of the various assets, which range from 5 years to 50 years. Depreciation, operation and maintenance charges are allocated to appropriate functional expense categories. Plant disposals are removed from the records at time of disposal. The College lifts restrictions on contributions for long-lived assets at the time the assets are acquired.

Leases

The College determines whether an arrangement is or contains a lease at lease inception. Under ASC 842, a contract is (or contains) a lease if it conveys the right to control the use of an identified asset for a period of time in exchange for consideration. Control is defined under the standard as having both the right to obtain substantially all of the economic benefits from use of the asset and the right to direct the use of the asset.

On the commencement date, operating leases are recorded as operating lease right-of-use ("ROU") assets and operating lease liabilities in the statements of financial position. Finance leases are recorded as equipment and finance lease liabilities in the statements of financial position.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

B. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - Continued

ROU assets represent the College's right to use an underlying asset for the lease term, and lease liabilities represent the College's contractual obligation to make lease payments. The lease liability is measured as the present value of the lease payments over the lease term using either the rate implicit in the lease, if it is determinable, or the College's incremental borrowing rate if the implicit rate is not determinable. ROU assets are calculated as the present value of the remaining lease payments plus unamortized initial direct costs and prepayments of rent, less any unamortized lease incentives received. Lease terms may include renewal or extension options to the extent they are reasonably certain to be exercised. For operating leases, lease expense is recognized on a straight-line basis over the lease term. For finance leases, amortization of the asset is recognized on a straight-line basis over the useful life of the underlying asset and interest on the lease liability is recognized over the lease term. The College has elected not to recognize a ROU asset and lease liability for leases with an initial term of 12 months or less but includes the expense associated with short-term leases in lease expense in the statements of activities.

ROU assets are assessed for impairment in accordance with the College's long-lived asset policy. Management reassesses lease classification and remeasures ROU assets and lease liabilities when a lease is modified and that modification is not accounted for as a separate new lease or upon certain other events that require reassessment in accordance with ASC 842.

Debt Issuance Costs

Costs incurred in connection with the issuance of the College's bonds and notes payable have been capitalized and are being amortized using the straight-line method, which approximates the interest method, over the term of the related bonds and notes. The College presents debt issuance cost as a direct deduction from the carrying amount of the related liability. The College recognized amortization on debt issuance costs of \$71,287 and \$73,115 during 2024 and 2023, respectively. In addition, during fiscal years 2024 and 2023, the College did not incur any additional debt issuance costs for issuance of bonds.

Deferred Charges

Deferred charges consist of educational program costs specifically related to unrecognized tuition, which are expensed as the program occurs.

Deferred Revenue

Early fall registration revenue and expenditures are deferred and are reported within the fiscal year in which the activities are completed.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

B. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - Continued

Derivative Financial Instruments

The College employs derivatives in the form of interest rate swap agreements to manage market risk associated with outstanding variable-rate debt. Derivative financial instruments are reported at fair value with any resulting change in fair value recognized as a nonoperating item in the consolidated statements of activities.

Government Advances for Student Loans

Funds provided by the United States government under the Federal Perkins and Health Professions Student Loan programs are loaned to qualified students and may be reloaned after collection. These funds are ultimately refundable to the government and are therefore recorded as liabilities. Under federal law, the authority for schools to make new Perkins loans ended on September 30, 2017, with final disbursements permitted through June 30, 2018.

Contributions

The College reports gifts of cash and other assets as support with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor time or purpose restrictions are reclassified to net assets without donor restrictions and reported in the consolidated statements of activities as net assets released from restrictions. However, donor-restricted contributions whose restrictions are met in the same reporting period as received are reported in the consolidated statements of activities as contributions without donor restrictions. Expenses are reported as decreases in net assets without donor restrictions. Restrictions on gifts to acquire long-lived assets are considered met in the period in which the assets are acquired or placed in service.

Contributions, including unconditional promises to give, are recognized as support in the period received. Conditional promises to give are not recognized until the conditions on which they depend are substantially met. Contributions of assets other than cash are recorded at their estimated fair value at the date of the gift. Contributions to be received after one year are discounted at a rate commensurate with the risk involved. Amortization of the discount is recorded as additional contribution revenue and used in accordance with donor-imposed restrictions, if any, on the contributions. An allowance is made for uncollectible contributions based upon management's judgment and analysis of the creditworthiness of the donors, past collection experience and other relevant factors.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

B. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - Continued

Revenue from Contracts with Customers

The College's primary sources of revenues from contracts with customers are from tuition, fees, and services and sales of educational departments and the health services division.

In accordance with the adoption of Accounting Standards Update ("ASU") 2014-09, *Revenues from Contracts with Customers*, the College identifies a contract for revenue recognition when there is approval and commitment from both parties, the rights of the parties and payment terms are identified, the contract has commercial substance and the collectability of the consideration is probable. The College evaluates each contract to determine the number of distinct performance obligations in the contract, which requires the use of judgment. Performance obligations are determined based on the nature of the services provided by the College.

Tuition and fees are derived from academic services rendered by the College, as well as from related educational resources that the College provides to its students. The College recognizes revenue for academic services pro-rata over the applicable academic period. Scholarships provided to students by the College are reflected as a reduction of gross tuition and fees. Tuition and fees received in advance of services performed are considered contract liabilities and recorded as deferred revenue in the statements of financial position.

Included in health services division revenue and sales and services of educational departments are amounts from the Meharry Medical Group, various clinics operated by the College and the Lloyd C. Elam Mental Health Center. The College recognizes revenue from these services and sales at the point in time services are rendered or sales occur. The College has agreements with third-party payors that provide for payments to the College at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, per diem payments and capitation. Such revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Contractual adjustments are accrued on an estimated basis in the period that the related services are rendered and adjusted in future periods as final settlements are determined.

The College's accounts receivable represent unconditional rights to consideration from its contracts with customers. Typically, once a customer is invoiced for tuition, fees, and health services and sales, payment is due immediately. The College does not have any contract assets. The College had no costs that were capitalized to obtain or to fulfill a contract with a student.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

B. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - Continued

Program Services

The College's primary program services are instruction, research, health services, and public service. Expenses reported as academic support, student services, and institutional support are incurred in support of these primary program services. Institutional support includes fundraising expenses of \$4,175,440 and \$3,391,074 in 2024 and 2023, respectively. For purposes of reporting fundraising expenses, the College includes those fundraising costs incurred by its Development Office as well as an estimate of payroll-related expenditures incurred by members of management in fundraising activities.

Income Taxes

The College and the Foundation have received determination letters from the Internal Revenue service indicating it is exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code (the "Code"); whereby only unrelated business income, as defined by Section 512(a)(1) of the Code, is subject to federal income tax. The College and the Foundation are not classified as a private foundation.

The College's wholly owned subsidiary, MMCV, Inc., is subject to federal and state income taxes. The College provides for income taxes based on Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") Topic 740 *Income Taxes*, which requires recognition of deferred tax liabilities and assets for the expected future tax consequences attributable to differences between financial statement carrying amounts of existing assets and liabilities and their respective tax basis. The College provides a valuation allowance for deferred tax assets when it is determined that it is more likely than not that the deferred tax assets will not be utilized. No such valuation allowance was record at June 30, 2024 or 2023. See Note T.

The College and its subsidiaries account for the effect of any uncertain tax positions based on a more likely than not threshold to the recognition of the tax positions being sustained based on the technical merits of the position under examination by the applicable taxing authority. If a tax position or positions are deemed to result in uncertainties of those positions, any unrecognized tax benefit is estimated based on a cumulative probability assessment that aggregates the estimated tax liability for all uncertain tax positions.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

B. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - Continued

Fair Value Measurements

Assets and liabilities recorded at fair value in the consolidated statements of financial position are categorized based on the level of judgment associated with the inputs used to measure their fair value (Note P). Level inputs are defined by ASC 820, *Fair Value Measurements* are as follows:

Level 1 - Values are unadjusted quoted prices for identical assets and liabilities in active markets accessible at the measurement date.

Level 2 - Inputs include quoted prices for similar assets or liabilities in active markets, quoted prices from those willing to trade in markets that are not active, or other inputs that are observable or can be corroborated by market data for the term of the instrument. Such inputs include market interest rates and volatilities, spreads and yield curves.

Level 3 - Certain inputs are unobservable (supported by little or no market activity) and significant to the fair value measurement. Unobservable inputs reflect the College's best estimate of what hypothetical market participants would use to determine a transaction price for the asset or liability at the reporting date.

Functional Expenses

Costs of providing the College's programs are reported in the Statement of Activities on a functional basis. Program expenses include costs directly associated with the program and other indirect costs determined to benefit that program. The statement of functional expenses presents the details of natural classification of expenses by these functional categories. These costs have been allocated between functional categories based on estimates made by management.

Newly Adopted Accounting Pronouncements

In June 2016, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2016-13, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments* ("ASU 2016-13" or "ASC 326"). ASU 2016-13 revises the accounting requirements related to the measurement of credit losses and requires organizations to measure all expected credit losses for financial assets based on historical experience, current conditions, and reasonable and supportable forecasts about collectability. Assets must be presented in the financial statements at the net amount expected to be collected.

On July 1, 2023, the College adopted the new accounting standard and all of the applicable related amendments using the modified retrospective method. The adoption did not have an impact on the University's consolidated statement of financial position and, therefore, a cumulative effect adjustment to retained earnings was not recorded. The College does not expect ASC 326 to have a significant impact on its financial condition or results of operations on an ongoing basis.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

C. LIQUIDITY AND AVAILABILITY OF RESOURCES

The table below represents financial assets available for general expenditures within one year at June 30, 2024 and 2023.

	<u>2024</u>	<u>2023</u>
Financial assets at year-end		
Cash and cash equivalents	\$ 26,517,848	\$ 25,436,900
Accounts receivable, net	57,814,063	47,696,652
Contributions receivable, net	35,786,433	11,274, 513
Student loan receivables, net	9,871,541	6,150,768
Investments	210,588,549	197,783,833
Funds held by trustees	<u>10,372,450</u>	<u>7,085,236</u>
Total financial assets at year-end	<u>350,950,884</u>	<u>295,427,902</u>
Less amounts not available to meet general expenditures within one year		
Restricted funds held by trustees	(10,372,450)	(7,085,235)
Student loans receivable, net Restricted by donors with purpose and/or time restrictions	(9,871,541)	(6,150,768)
Restricted by the Board for endowment	(114,503,245)	(67,217,406)
Restricted by donors to be held in perpetuity	(10,675,096)	(10,675,096)
	<u>(166,543,253)</u>	<u>(162,401,184)</u>
Total amounts not available to meet general expenditures within one year	<u>(311,965,585)</u>	<u>(253,529,690)</u>
Financial assets available to meet general expenditures within one year	<u>\$ 38,985,299</u>	<u>\$ 41,898,212</u>

The College regularly monitors the liquidity required to meet its operating needs and other contractual commitments, while also striving to maximize the investment of its available funds. The College has various sources of liquidity at its disposal, including cash and cash equivalents, marketable debt and equity securities, as well as a line of credit. For purposes of analyzing resources available to meet general expenditures over a 12-month period, the College considers all expenditures related to its ongoing mission-related activities as well as the conduct of services undertaken to support those activities to be general expenditures.

MEHARRY MEDICAL COLLEGE
 NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
 JUNE 30, 2024 AND 2023

C. LIQUIDITY AND AVAILABILITY OF RESOURCES - Continued

Student loans receivable are not considered to be available to meet general expenditures because principal and interest on these loans are used solely to make new loans or is due back to the federal government.

The College maintains certain assets that are board-designated for endowment as disclosed in Note S. Although the College does not expect to utilize board designated net assets in excess of the budgeted spending policy to meet general expenditures, they could be made available, if necessary, subject to further action by the Board of Trustees.

In addition to financial assets available to meet general expenditures over the next twelve months, the College operates with a balanced budget and anticipates collecting sufficient revenue to cover general expenditures not covered by donor-restricted resources.

D. ACCOUNTS RECEIVABLE

Accounts receivable consist of the following at June 30, 2024 and 2023:

	<u>2024</u>	<u>2023</u>
Receivable from grantors	\$31,267,199	\$17,670,310
Professional services receivable, net of allowance of \$3,758,336 and \$339,008 at June 30, 2024 and 2023, respectively	4,770,130	5,602,499
Patient receivables, net of contractual and credit loss allowances of \$1,727,907 and \$778,308 at June 30, 2024 and 2023, respectively	3,010,456	1,657,138
Student accounts receivable, net of allowance of \$685,494 and \$1,528,238 at June 30, 2024 and 2023, respectively	12,475,232	14,061,346
Other accounts receivable	<u>6,291,046</u>	<u>8,705,359</u>
Total accounts receivable, net	<u>\$57,814,063</u>	<u>\$47,696,652</u>

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

E. CONTRIBUTIONS RECEIVABLE

The College includes unconditional promises to give as contributions receivable in accordance with the provisions of ASC 958, *Not-for-Profit Entities*.

	<u>2024</u>	<u>2023</u>
Unconditional promises to give	\$ 39,714,268	\$ 12,160,497
Less unamortized discount at 5%	<u>(3,927,835)</u>	<u>(885,984)</u>
Unconditional promise to give, net	<u>\$ 35,786,433</u>	<u>\$ 11,274,513</u>
Amounts due in:		
Less than one year	\$ 11,491,194	\$ 7,285,497
Two to five years	<u>28,223,074</u>	<u>4,875,000</u>
	<u>\$ 39,714,268</u>	<u>\$ 12,160,497</u>

At June 30, 2024 and 2023, the College had also received bequest intentions and certain other conditional promises to give. These intentions and conditional promises to give are not recognized as assets and, if they are received, they will generally be restricted for specific purposes stipulated by the donors, primarily for faculty support, scholarships, or general operating support of a particular department or division of the College.

The College receives contributed services from alumni and other volunteers who assist in fundraising efforts through their participation in various fundraising drives. The value of such services, which the College considers not practicable to estimate, has not been recognized in the consolidated statements of activities.

F. STUDENT LOANS RECEIVABLE

Student loans receivable at June 30, 2024 and 2023, consisted of the following:

	<u>2024</u>	<u>2023</u>
Notes receivable - students	\$ 10,009,332	\$ 6,278,787
Less allowance for credit losses	<u>(137,791)</u>	<u>(128,019)</u>
	<u>\$ 9,871,541</u>	<u>\$ 6,150,768</u>

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

F. STUDENT LOANS RECEIVABLE - Continued

The College makes uncollateralized loans to students based on financial needs presented by the student. Student loans are funded through government loan programs or institutional resources. Upon graduation, the students have a grace period on government loans, at which time the loan will also begin accruing interest. Loan amounts are repaid through a third party billing service. Student loans are considered past due when payment has not been received in over 30 days. At June 30, 2024 and 2023, student loans represented 1.88% and 1.40%, respectively, of total assets.

The allowance for credit losses is established based on prior collection experience and current economic factors which, in management's judgment, could influence the ability of loan recipients to repay the amounts per the loan terms. Loan balances are written off only when they are deemed to be permanently uncollectible.

G. INVESTMENTS

Investments at June 30, 2024 and 2023, are summarized below at fair value:

	<u>2024</u>	<u>2023</u>
Marketable securities:		
Cash equivalents	\$ 1,091,138	\$ 1,070,655
Mutual funds	47,491	41,847
Common stocks	167,456,622	155,331,612
Bonds	8,989,846	8,966,430
Hedge funds	6,302,421	8,543,362
Other	<u>10,535,655</u>	<u>6,755,311</u>
Total investments	<u>\$194,423,173</u>	<u>\$180,709,219</u>
Investment in real estate, net of accumulated depreciation	<u>\$16,165,376</u>	<u>\$17,074,614</u>

Mutual funds for 2024 and 2023 are comprised solely of fixed income securities.

The College's investments are substantially all permanently restricted endowment funds. The investment in real estate is comprised of the College's net investment in hospital facilities, which are leased to the Metropolitan Government of Nashville and Davidson County (the Metropolitan Government) to house the operations of the Metropolitan Government's Nashville General Hospital. The thirty-year lease with the Metropolitan Government began in December 1994 and provides for rent payments of \$4,000,000 per year through November 2024. The Metropolitan Government has also agreed to pay an additional amount of rent annually from June 2023 through June 2027. The annual rent amount for 2024 and 2023 was \$6,475,500 and \$6,300,000, respectively.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

H. INVESTMENT IN AFFILIATES

In fiscal year 2024, the College's wholly owned subsidiary, MMCV, Inc. invested in several health companies to further expand and collaborate with medical partners. These affiliates are as follows:

Cost Method Investments

MMCV, Inc. purchased Shotel Medical, Inc. common stock for \$100,000 during fiscal year 2024 for an approximate investment of 13%. The common stock is convertible to preferred stock or other capital stock of the Company if certain terms are met.

Rocket Doctor, Inc. shares were purchased for \$200,000 during fiscal year 2024 for an approximate 5% investment.

These investments have been accounted for under the cost method.

Equity Method Investments

MMCV, Inc. purchased 490,000 founding shares of Meharry Medical College Consolidated Clinical Laboratories (MMCCCL) during fiscal year 2024 for \$445,457 which represents an approximate 49% investment.

180,000 shares preferred stock of Heal90, Inc. was purchased for \$350,000 during fiscal year 2024 for an approximately 30% investment.

The College accounts for the investments using the equity method. As of June 30, 2024, there was no activity for either investment, as operations for the companies began in fiscal year 2025.

The College evaluates the carrying value of its investments on at least an annual basis and more frequently if events occur or circumstances change that would likely reduce the fair value below its carrying amount. No impairment allowance was considered necessary at June 30, 2024.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

I. PLANT FACILITIES

Plant facilities consist of the following at June 30, 2024 and 2023:

	<u>2024</u>	<u>2023</u>
Land and land improvements	\$ 11,047,162	\$ 9,296,012
Buildings and building improvements	230,393,724	174,455,002
Equipment	60,717,390	57,632,459
Art	433,194	433,194
Library and visual aids	4,336,197	4,262,147
Construction in progress	<u>2,713,015</u>	<u>52,821,502</u>
	309,640,682	298,900,316
Less accumulated depreciation	<u>(152,134,231)</u>	<u>(144,307,243)</u>
Plant facilities, net	<u>\$ 157,506,451</u>	<u>\$ 154,593,073</u>

Plant operations and maintenance expenditures of \$9,457,250 and \$8,790,639 for the fiscal years ended June 30, 2024 and 2023, respectively, are allocated among functional expenses based on square footage percentages.

Depreciation expense was \$8,739,714 and \$8,242,680 for 2024 and 2023, respectively (of which \$909,250 in 2024 and 2023, was depreciation on the College's investment in real estate), is allocated among the various functional expense categories.

Estimated costs to complete construction in progress at June 30, 2024 is approximately \$6,105,000 and is primarily related to the construction of the Living Learning Center and renovation and capital repairs related to certain other campus facilities.

J. NOTES PAYABLE TO BANKS

The College has a \$10,000,000 revolving line of credit with a financial institution. All accrued interest shall be paid on the first (1st) day of each quarter and the principal balance and all unpaid accrued interest shall be due on the maturity date, May 1, 2025. Interest accrues at the SOFR rate plus 1.5% on the first (1st) day of each calendar month. As of June 30, 2024 and 2023, the outstanding balance on the line of credit was \$2,000,000 and \$6,000,000, respectively.

MEHARRY MEDICAL COLLEGE
 NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
 JUNE 30, 2024 AND 2023

J. NOTES PAYABLE TO BANKS - Continued

In May 2021, the College entered into a term loan agreement with a financial institution for \$14,398,160, the proceeds of which were used to retire and consolidate outstanding debt. The note is payable in 20 semi-annual principal installments of \$719,908, beginning August 1, 2021 with a final payment due February 1, 2031. Interest at a note 2.5% is due monthly beginning July 1, 2021 with a final payment of any outstanding interest due February 1, 2031. The note payable is collateralized by certain property of the College. The outstanding balance of the note payable was \$10,078,712 and \$11,518,527 as of June 30, 2024 and 2023, respectively.

The notes payable contain certain restrictive covenants, including a minimum debt service coverage ratio. The College was in compliance with the covenants and ratios at June 30, 2024.

Maturities of notes payable and the revolving line of credit at June 30, 2024, are as follows:

<u>Year Ending June 30,</u>	<u>Amount</u>
2025	\$ 3,439,816
2026	1,439,816
2027	1,439,816
2028	1,439,816
2029	1,439,816
Thereafter	<u>2,879,632</u>
	<u>\$12,078,712</u>

K. BONDS PAYABLE

Bonds payable consist of the following at June 30, 2024 and 2023:

	<u>2024</u>	<u>2023</u>
Future Advance Project Funding Bonds,		
Series A 2022-1	\$ 37,685,101	\$ 32,140,053
Series A 2020-3	8,972,410	9,402,640
Series A 2020-4	11,613,465	11,895,241
Revenue Bonds, Series 2009	<u>3,755,000</u>	<u>7,325,000</u>
	62,025,976	60,762,934
Less: Unamortized debt issuance costs (Note B)	<u>(786,157)</u>	<u>(858,370)</u>
Total bonds payable, net	<u>\$ 61,239,819</u>	<u>\$ 59,904,564</u>

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

K. BONDS PAYABLE - Continued

On December 3, 2009, the College issued Adjustable Rate Revenue Refunding Bond, Series 2009 (Series 2009 Bonds), in the amount of \$17,025,000 through the Health and Educational Facilities Board of the Metropolitan Government of Nashville and Davidson County, Tennessee. These bonds are collateralized by a letter of credit. Under the terms of the bond indenture, the proceeds were used to refinance \$17,025,000 of the outstanding Series 1996 Revenue Bonds. The Series 2009 Bonds bear interest as determined weekly by the Remarketing Agent (0.24% at June 30, 2024).

On August 19, 2020, the College entered into a capital project loan agreement in the form of Future Advance Project Funding Bond Series (A 2020-3 and A 2020-4) in an amount not to exceed \$48,500,000 (\$10,000,000 for Series A 2020-3 and \$38,500,000 for Series A 2020-4). This funding was financed through the U.S. Department of Education's Capital Financing Program via Rice Capital Access Program, LLC. The loan proceeds are to be used for the construction of the Living Learning Center and various other campus projects. Under the terms of the loan agreements, capitalized interest through November 1, 2022 and the first monthly payment, was due on May 1, 2023. The Series A 2020-3 loan is a 20 year fixed rate loan to mature on March 1, 2040. The Series A 2020-4 loan is a 30 year fixed rate loan to mature on March 1, 2050. During the construction phase, the rates are based on U.S. Treasury yields prevailing at the dates of each advance plus applicable federal financing bank and designated bonding fees. The interest on the Series A 2020-3 Bonds is fixed, equal to the 20 year Federal Financing Bank rate + 22.5 basis points at the date of each advance. The interest on the Series A 2020-4 Bonds is fixed, equal to the 30-year Federal Financing Bank rate + 22.5 basis points at the date of each advance. The trustee handling the bond issue, held sinking funds totaling \$2,842,257 and \$2,869,179 at June 30, 2024 and 2023, respectively, that are to be applied to the debt obligation as payments become due.

In March 2022, the College entered into a capital project loan agreement in the form of Future Advance Project Funding Bond Series (A 2022-1) in an amount not to exceed \$39,750,000. This funding was financed through the U.S. Department of Education's Capital Financing Program via Rice Capital Access Program, LLC. The loan proceeds are to be used for the construction of the Living Learning Center and various other campus projects. Under the terms of the loan agreements, capitalized interest through November 1, 2023 and the first monthly payment, was due on September 1, 2023. The loan is a 30 year fixed rate loan to mature on March 1, 2052. During the construction phase, the rates are based on U.S. Treasury yields prevailing at the dates of each advance plus applicable federal financing bank and designated bonding fees. The interest is fixed, equal to the 30-year Federal Financing Bank rate + 22.5 basis points at the date of each advance. The trustee handling the bond issue, held sinking funds totaling \$4,924,365 and \$1,636,931 at June 30, 2024 and 2023, respectively, that are to be applied to the debt obligation as payments become due.

MEHARRY MEDICAL COLLEGE
 NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
 JUNE 30, 2024 AND 2023

K. BONDS PAYABLE - Continued

The bond issues contain certain restrictive covenants, including a minimum debt service coverage ratio. As of June 30, 2024 and 2023, the College was in compliance with all restrictive covenants including the minimum debt service coverage ratio.

The aggregate scheduled principal maturities of bonds payable at June 30, 2024, are as follows:

Revenue Year Ending Ending June 30,	<u>Future Advance Project Funding</u>			Revenue Bonds Series 2009	<u>Total</u>
	<u>A 2022-1</u>	<u>A 2020-3</u>	<u>A 2020-4</u>		
2025	\$ -	\$ 356,310	\$ 290,949	\$3,755,000	\$ 4,402,259
2026	357,636	368,578	297,532	-	1,023,746
2027	736,060	381,269	304,264	-	1,421,593
2028	764,675	394,396	311,149	-	1,470,220
2029	794,402	407,976	318,189	-	1,520,567
2030 and thereafter	<u>35,032,328</u>	<u>7,063,882</u>	<u>10,091,383</u>	-	<u>52,187,593</u>
Total bonds payable	<u>\$37,685,101</u>	<u>\$8,972,411</u>	<u>\$11,613,466</u>	<u>\$3,755,000</u>	<u>\$62,025,978</u>

L. INTEREST RATE SWAP ARRANGEMENTS

To manage variable interest rate exposure for its debt portfolio, in December 2009, the College entered into a interest rate swap arrangement with a major financial institution. The total original notional amount was \$17,025,000 for this swap arrangement, with the remaining notional amount at June 30, 2024 and 2023 totaling \$3,755,000 and \$7,325,000, respectively. The swap notional amount will gradually decline, corresponding to the principal amortization of the College's Series 2009 bonds. The arrangement for the Series 2009 bonds is scheduled to expire in December 2024. The College pays a fixed rate of 4.70% under the remaining arrangement.

As of June 30, 2024 and 2023, the estimated fair value loss of the Series 2009 bond swap arrangement was \$24,032 and \$89,417, and is included in accrued liabilities and as a component of unrestricted net assets.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

M. LEASES

The College leases office space and certain equipment under operating leases expiring in various years through fiscal 2031. The College also has a finance lease for software expiring in fiscal year 2033. No renewal options are provided for in the above operating leases. In the normal course of business, operating leases are generally renewed or replaced by other leases.

Finance lease right-of-use assets are included in plant facilities in the consolidated statements of financial position. Total cost and accumulated depreciation of finance lease right-of-use assets were \$12,000,000 and \$1,235,524, respectively, at June 30, 2024.

The components of lease expense are as follows:

	<u>December 31,</u>	
	<u>2024</u>	<u>2023</u>
Operating lease expense	\$1,211,660	\$619,650
Finance Lease Expense		
Amortization of ROU Assets	\$1,235,524	-
Interest on lease liabilities	<u>393,206</u>	<u>-</u>
	<u>\$2,840,390</u>	<u>\$619,650</u>

Additional supplemental information regarding assumptions for leases is as follows:

	<u>December 31,</u>	
	<u>2024</u>	<u>2023</u>
Weighted-average remaining lease term (years)		
Operating leases	5.04	2.59
Finance leases	8.33	-
Weighted-average discount rate		
Operating leases	8.17%	8.44%
Finance leases	3.60%	-

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

M. LEASES - Continued

As of December 31, 2024, the maturity of the operating lease liabilities is as follows:

<u>Maturity</u>	<u>Operating</u>	<u>Finance</u>
2024	\$ 935,136	\$ 1,463,184
2025	756,276	1,463,184
2026	617,514	1,463,184
2027	408,288	1,463,184
2028	418,740	1,463,184
Thereafter	<u>657,171</u>	<u>4,573,242</u>
Total undiscounted cash flows	3,793,125	11,889,162
Less: present value discount	<u>(690,102)</u>	<u>(1,609,688)</u>
Total operating lease liabilities	<u>\$ 3,103,023</u>	<u>\$ 10,279,474</u>

N. EMPLOYEE BENEFIT PLANS

The College sponsors multiple plans which cover substantially all employees of the College. The details of the plans are as follows:

403(b) Meharry Medical College Defined Contribution Plan

The Plan is a defined contribution plan which covers substantially all employees except those in the residency programs. Union and non-union employees are eligible to participate upon reaching the age of eighteen, and are eligible to receive matching contributions upon reaching the age of twenty-one and completing one year of service. The Plan is funded by employee contributions which may not exceed the Internal Revenue Service annual limitations (\$22,500 and \$23,000 for individuals less than age 50 for calendar years 2023 and 2024, respectively; and \$30,000 and \$30,500 for individuals age 50 and older for calendar years 2023 and 2024, respectively).

The College provides a matching contribution to the non-union employees at a rate equal to 100% of their elective deferral up to 5% of their compensation, not to exceed \$14,500. The College has the discretion to vary the contribution rate.

The employer expense under this plan for the years ended June 30, 2024 and 2023 amounted to \$2,123,913 and \$2,052,658, respectively.

MEHARRY MEDICAL COLLEGE
 NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
 JUNE 30, 2024 AND 2023

N. EMPLOYEE BENEFIT PLANS - Continued

Retirement Income Plan

This noncontributory defined benefit retirement plan that covers only union eligible employees was frozen by an amendment adopted January 1, 2009. Pursuant to ASC 715 *Compensation - Retirement Benefits*, the College recognizes in its consolidated statements of financial position the over-funded or under-funded status of the defined benefit retirement plan.

The status of the plan at June 30, 2024 and 2023, was as follows:

	2024	2023
Change in benefit obligation:		
Projected benefit obligation at beginning of year	\$ 3,619,594	\$ 3,921,182
Service cost	30,997	36,051
Interest cost	162,281	213,914
Loss (gain) due to plan experience	(219,863)	46,129
Settlements	(394,690)	(573,584)
Actual benefit disbursements	(15,359)	(24,098)
 Projected benefit obligation at the end of year	 3,182,960	 3,619,594
Change in plan assets:		
Fair value of plan asset at beginning of year	4,896,893	4,859,415
Actual contributions	-	200,000
Actual benefit disbursements and settlements	(15,359)	(24,098)
Settlements	(394,690)	(573,584)
Actual return on plan assets	603,685	435,160
 Fair value of plan assets at end of year	 5,090,529	 4,896,893
Funded status:		
Net pension asset, included in other assets in the statements of activities	\$ 1,907,569	\$ 1,277,299
Key assumptions:		
Rate of compensation increase	5.00%	5.00%
Discount rate	7.50%	7.50%
Expected long-term return on plan assets	7.50%	7.50%

MEHARRY MEDICAL COLLEGE
 NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
 JUNE 30, 2024 AND 2023

N. EMPLOYEE BENEFIT PLANS - Continued

The College’s expected long-term return on plan assets assumption is based on a periodic review and modeling of the plans’ asset allocation and liability structure over a long-term horizon. Expectations of returns for each asset class are the most important of the assumptions used in the review and modeling and are based on comprehensive reviews of historical data and economical/financial market theory. The expected long-term rate of return on assets was selected from within the reasonable range of rates determined by (a) historical returns, net of inflation, for the asset classes covered by the investment policy, and (b) projections of inflation over the long term period during which benefits are payable to plan participants.

The College’s investment policy includes various guidelines and procedures designed to ensure assets are invested in a manner necessary to meet expected future benefits earned by participants. The investment guidelines consider a broad range of economic conditions. Central to the policy are target allocation ranges by major asset categories.

The objectives of the target allocations are to maintain investment portfolios that diversify risk through prudent asset allocation parameters, achieve asset returns that meet or exceed the plans’ actuarial assumptions, and achieve asset returns that are competitive with like institutions employing similar investment strategies.

The investment policy is periodically reviewed by the College and a designated third-party fiduciary for investment matters. The policy is established and administered in a manner so as to comply at all times with applicable government regulations.

The College expects to contribute \$200,000 to its pension plan in the year ended June 30, 2024.

The following pension benefit payments, which reflect expected future services and participants electing life annuities at retirement age 65, as appropriate, are expected to be paid for the plan years ended June 30:

2025	\$130,717
2026	198,610
2027	185,027
2028	286,349
2029	281,151
2030 to 2034	509,761

If lump sum payouts are elected they can materially accelerate cash benefit payments estimated above.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

O. NET ASSETS

The refunding of debt service amounts shown as a reduction of net assets without donor restrictions resulted from refinancing transactions in 1997 and 1999, and represents the loss recognized under accounting principles generally accepted in the United States of America to enact the refinancing. This component of net assets without donor restrictions is being amortized into net assets without donor restrictions available for operations over the lives of the related bond issues.

Net assets with donor purpose and/or time restrictions totaling \$114,503,245 and \$67,217,406 as of June 30, 2024 and 2023, respectively, are primarily available for scholarships and instruction and research.

Net assets with donor restrictions that are perpetual totaling \$166,543,253 and \$162,401,184 as of June 30, 2024 and 2023, respectively, consist primarily of perpetual endowment funds, scholarships, instruction and research funds as directed by the donor.

Net assets with donor restrictions of \$18,315,798 and \$44,536,839 for the years ended June 30, 2024 and 2023, respectively were released from donor restrictions by incurring expenses satisfying the restricted purposes or by occurrence of other events specified by the donors.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

P. FAIR VALUES OF FINANCIAL INSTRUMENTS

Required disclosures concerning the estimated fair value of financial instruments are presented below. The estimated fair value amounts have been determined based on the College's assessment of available market information and appropriate valuation methodologies. The following table summarizes required fair value disclosures and measurements at June 30, 2024 and 2023 for the assets measured at fair value on a recurring basis under ASC 820 *Fair Value Measurements*:

<u>June 30, 2024</u>	<u>Carrying Amount</u>	<u>ASC 825 Estimated Fair Value</u>	<u>Assets/Liabilities Measured at Fair Value</u>	<u>Fair Value Measurements Using</u>		
				<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
Assets:						
Investments:						
Cash equivalents	\$ 1,091,138	\$ 1,091,138	\$ 1,091,138	\$ 1,091,138	\$ -	\$ -
Mutual funds	47,491	47,491	47,491	47,491	-	-
Common stocks	167,456,622	167,456,622	167,456,622	167,456,622	-	-
Bonds	8,989,846	-	-	-	8,989,846	-
Other	10,535,655	-	-	10,535,655	-	-
Liabilities:						
Bonds payable	62,025,976	62,025,976	-	-	-	-
Note payable	12,078,712	12,078,712	-	-	-	-
Lease liabilities	13,382,497	13,382,497	-	-	-	-
Interest rate swap	24,032	24,032	24,032	-	24,032	-
June 30, 2023						
<u>June 30, 2023</u>	<u>Carrying Amount</u>	<u>ASC 825 Estimated Fair Value</u>	<u>Assets/Liabilities Measured at Fair Value</u>	<u>Fair Value Measurements Using</u>		
				<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
Assets:						
Investments:						
Cash equivalents	\$ 1,070,655	\$ 1,070,655	\$ 1,070,655	\$ 1,070,655	\$ -	\$ -
Mutual funds	41,847	41,847	41,847	41,847	-	-
Common stocks	155,331,612	155,331,612	155,331,612	155,331,612	-	-
Bonds	8,966,430	-	-	-	8,966,430	-
Other	6,755,311	-	-	6,755,311	-	-
Liabilities:						
Bonds payable	60,762,934	60,762,934	-	-	-	-
Note payable	17,518,527	17,518,527	-	-	-	-
Lease liabilities	1,881,266	1,881,266	-	-	-	-
Interest rate swap	89,417	89,417	89,417	-	89,417	-

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

P. FAIR VALUES OF FINANCIAL INSTRUMENTS - Continued

The following methods and assumptions were used to estimate the fair value of each class of financial instrument:

Cash and Cash Equivalents and Funds Held by Trustees

Cash is reflected at carrying value, which is considered its fair value.

Accounts and Student Loans Receivable

Accounts receivable consist primarily of receivables from grantor agencies, professional and patient receivables and other short-term receivables. The student loans receivable of \$5,585,143 and \$6,150,768 at June 30, 2024 and 2023, respectively, consist principally of government loan programs and are not readily marketable. The College has estimated their fair value to be the carrying value.

Contributions receivable

Contribution receivable are recorded at net present value as discussed in Notes B and E, which approximates their fair value.

Investments

The fair value of investments, as disclosed in Note G has been calculated based on quoted market prices, where available, and certain other Level 2 inputs. The College has certain investments in hedge funds that invest in multi-faceted, domestic and international companies operating in various industries. Each hedge fund employs its own strategies in determining investment opportunities. The fair values of these investments are estimated at the net asset value per share of the investments, using the practical expedient, and are therefore not required to be included in the fair value hierarchy table. Hedge funds valued at net asset value as of June 30, 2024 and 2023 were \$6,302,421 and \$8,543,362, respectively.

Accounts Payable, Accrued Liabilities, and Deferred Revenues

The carrying value of these items approximates fair value due to the short-term nature of the obligations.

Bonds Payable and Notes Payable

The bonds and notes payable reflected in the consolidated financial statements bear interest at floating rates and fixed rates. The carrying value of these debt instruments will differ from their fair value depending on current market rates. The fair value was estimated by calculating the net present value of the future payment stream using the current market interest rate.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

P. FAIR VALUES OF FINANCIAL INSTRUMENTS - Continued

Interest Rate Swap Agreements

Fair value has been estimated as the difference between the estimated future interest payments at contractual variable rates and expected future variable rates as of June 30, 2024 and 2023, respectively, and fixed interest rates specified in the related swap agreements, discounted to present value.

The fair value estimates presented herein are based on pertinent information available to management as of June 30, 2024 and 2023, respectively. Although management is not aware of any factors that would significantly affect the estimated fair value amounts, such amounts have not been comprehensively revalued for purposes of the consolidated financial statements since that date, and current estimates of fair value may differ significantly from the amounts presented herein.

Q. COMMITMENTS AND CONTINGENT LIABILITIES

Certain revenues, particularly Federal and state grants and contracts, are subject to adjustments based upon review by the granting agencies. Management does not anticipate that adjustments, if any, arising from such reviews would have a material effect on the consolidated financial statements.

The College is a defendant in lawsuits arising from time to time in the normal course of business. Management and legal counsel are of the opinion that insurance coverage is sufficient to satisfy any judgment or settlement liability.

R. CONCENTRATIONS OF CREDIT RISK

The College, in connection with its activities, grants credit that involves, to varying degrees, elements of risk. The maximum accounting loss from credit risk is limited to the amounts that are recognized in the accompanying consolidated statements of financial position as accounts receivable at June 30, 2024 and 2023.

Financial instruments which potentially subject the College to concentrations of credit risk consist principally of cash and investments held by the College and certain investment institutions. Cash at June 30, 2024 and 2023 includes demand deposits at high quality financial institutions. The deposits are exposed to credit risk to the extent they exceed federally insured limits. The exposure to concentrations of credit risk relative to securities is dependent on the College's investment objectives and policies.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

S. ENDOWMENT

The College's endowment consists of individual donor-restricted funds established for a variety of purposes and includes both donor-restricted endowment funds and funds designated by the Board of Trustees to function as endowments. As required by Generally Accepted Accounting Principles, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

Interpretation of Relevant Law

The Board of Trustees of Meharry Medical College has interpreted the applicable state laws as requiring the preservation of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the College classifies as net assets with donor restrictions that are perpetual in nature (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in net assets with donor restrictions that are perpetual in nature is classified as net assets with donor purpose and/or time restrictions until those amounts are appropriated for expenditure by the College in a manner consistent with the standard of prudence prescribed by applicable state laws. In accordance with applicable state laws, the College considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

- the duration and preservation of the fund;
- the purposes of the College and the donor-restricted endowment fund;
- general economic conditions;
- the possible effect of inflation and deflation;
- the expected total return from income and the appreciation of investments;
- other resources of the College; and
- the investment policies of the College

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

S. ENDOWMENT - Continued

Changes in Endowment Net Assets

	<u>Without Donor Restrictions</u>	<u>With Donor Restrictions</u>		<u>Total</u>
		<u>Temporarily in Nature</u>	<u>Perpetual in Nature</u>	
<i>Endowment net assets,</i> June 30, 2022	\$10,675,096	\$ 5,628,284	\$ 165,879,749	\$ 182,183,129
Investment return:				
Investment income	-	5,272,571	-	5,272,571
Net depreciation (realized and unrealized)	-	<u>11,987,483</u>	-	<u>11,987,483</u>
Total investment return	<u>-</u>	<u>17,260,054</u>	<u>-</u>	<u>17,260,054</u>
Contributions	<u>-</u>	<u>-</u>	<u>1,689,946</u>	<u>1,689,946</u>
Appropriation of endowment assets for expenditure	-	(9,207,279)	-	(9,207,279)
Reclassifications/transfers	<u>-</u>	<u>590,539</u>	<u>(5,290,539)</u>	<u>(4,700,000)</u>
<i>Endowment net assets,</i> June 30, 2023	10,675,096	14,271,598	162,279,156	187,225,850
Investment return:				
Investment income	-	6,043,100	-	6,043,100
Net appreciation (realized and unrealized)	-	<u>13,568,596</u>	-	<u>13,568,596</u>
Total investment return	<u>-</u>	<u>19,611,696</u>	<u>-</u>	<u>19,611,696</u>
Contributions	<u>-</u>	<u>-</u>	<u>4,142,069</u>	<u>4,142,069</u>
Appropriation of endowment assets for expenditure	<u>-</u>	<u>(9,967,212)</u>	<u>-</u>	<u>(9,967,212)</u>
<i>Endowment net assets,</i> June 30, 2024	<u>\$10,675,096</u>	<u>\$ 23,916,082</u>	<u>\$ 166,421,225</u>	<u>\$ 201,012,403</u>

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

S. ENDOWMENT - Continued

Return Objectives and Risk Parameters

The College has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the College must hold in perpetuity or for a donor-specified period(s). Under this policy, as approved by the Board of Trustees, the endowment assets are invested in a manner that is intended to produce on average, over a period of five years, a total rate of return between 4% to 6% per year. Actual returns in any given year may vary from this amount.

Strategies Employed for Achieving Objectives

To satisfy its long-term rate-of-return objectives, the College relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The College targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

Spending Policy and How the Investment Objectives Relate to Spending Policy

The College's objective is to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term as well as to provide additional real growth through new gifts and investment return. The Board of Trustees has decided that a prudent spending policy provides up to 4.5% of the market value of the Endowment Funds to the College for annual operating needs. To smooth out the short-term fluctuations in market prices, a three-year moving average of market value is used.

T. INCOME TAXES

MMCV, Inc. had an income tax benefit of \$32,294 for the year ended June 30, 2024 and 2023, respectively, consisting of federal and state tax benefits of \$22,488 and \$9,806, respectively. There were no temporary differences giving rise to deferred tax assets or deferred tax liabilities as of June 30, 2024 and 2023.

The College has determined that there are no significant tax positions that result in uncertainty requiring recognition as of and for the years ended June 30, 2024 and 2023. The College recognizes interest and penalties accrued related to any unrecognized tax benefits in other expenses. During the years ended June 30, 2024 and 2023, the College recognized no interest and penalties related to unrecognized tax benefits.

MEHARRY MEDICAL COLLEGE
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

U. RELATED PARTY TRANSACTIONS

In accordance with the U.S. Department of Education's regulations, specifically 34 CFR§ 668.23(d)(1), the College is required to disclose quantitatively all related party transactions. There are no related party transactions for disclosure for the years ending June 30, 2024 and 2023, respectively.

V. SUBSEQUENT EVENTS

The College has evaluated subsequent events through April 29, 2024, the issuance date of the College's consolidated financial statements, and has determined that there are no subsequent events that require disclosure.

AGENCY CUSTOMER ID: CN101377738

LOC #: Atlanta



ADDITIONAL REMARKS SCHEDULE

Page 2 of 2

AGENCY MARSH USA, LLC.		NAMED INSURED Meharry Medical College Office of the General Counsel 1027 D.B. Todd Blvd. Lyttle Hall Suite 317 Nashville, TN 37208	
POLICY NUMBER		EFFECTIVE DATE:	
CARRIER	NAIC CODE		

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

SEXUAL ABUSE & MOLESTATION LIABILITY

Carrier: Beazley Excess and Surplus Insurance Inc
 Policy: D30F93250501
 Effective: 07/01/2025
 Expiration: 07/01/2026
 Limits
 Annual Aggregate (Each Victim): \$5,000,000
 Annual Aggregate (All Victims): \$5,000,000
 SIR Each Victim: \$250,000

CYBER RISK

Carrier: ACE American Insurance Company
 Policy: D95755690
 Effective: 12/13/2024
 Expiration: 12/13/2025
 Limit (Each Incident/Aggregate): \$5,000,000
 SIR : \$150,000