# Request for Proposals

**Public Health Solutions**
**On behalf of**
**New York City Department of Health and Mental Hygiene**
**Bureau of Hepatitis, HIV, and STI**

## Ending the Epidemic (ETE) in New York City: The Undetectables Viral Load Suppression Program and Crystal Methamphetamine Harm Reduction Services

**Solicitation #: 2022.01.HIV.01.01**

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**For a copy of this Request for Proposals, please go to:**
***https://healthsolutions.bonfirehub.com/portal/?tab=openOpportunities***

## Table 1. Basic Information

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|---|---|
| **RFP Release Date** | **January 12, 2022** |
| **Proposal Due Date** | **February 23, 2022; 3pm ET** |
| **RFP Contact** | **James Bello, Public Health Solutions**<br>**RFP Email: ETE2RFP@healthsolutions.org** |
| **Pre-Proposal Conference Webinar** | **January 26, 2022, 10am-11:30am ET**<br>Attendance at the Pre-Proposal Conference Webinar is not mandatory; however, those organizations interested in submitting a proposal are strongly encouraged to attend.<br>To join the Pre-Proposal Conference Webinar via Zoom, please register in advance by using the link below.<br>**Registration Link: *https://us02web.zoom.us/webinar/register/WN_dUjfOTJOQBybEyjsvV3uog***<br>After registering, you will receive a Zoom confirmation email containing instructions for joining the Pre-Proposal Conference Webinar. |
| **Funding Source** | The funding source is City Tax Levy (CTL) Ending the Epidemic (ETE) funding to the New York City (NYC) Department of Health and Mental Hygiene (Health Department).<br>Public Health Solutions (PHS) has entered into an agreement with the Health Department for PHS to administer certain HIV-related subaward agreements for the Bureau of Hepatitis, HIV, and STI (BHHS). |
| **Anticipated Subaward Term** | The anticipated subaward start date is **July 1, 2022**. Subrecipients will receive a subaward for a term of up to three years, with up to two subsequent renewal options of three years each, for a total term not to exceed nine years. All subawards and subsequent continuations are contingent on the availability of funds, successful performance of contractual subaward terms, and continued need for services.<br>Organizations whose proposals are deemed fundable but not initially given a subaward due to funding limitations may receive a subaward later if additional funds become available. |

**Anticipated Funding, Payment Structure, and Expected Caseload**

Total Anticipated Funding Amount: $3,118,052 annually across all service categories. However, the Health Department reserves the right to increase/decrease the total funding amount depending on funding availability.

| Service Category | Anticipated Funding Amount | Anticipated Number of Subawards |
|---|---|---|
| **Service Category 1: The Undetectables Viral Load Suppression Program** | $1,610,000 | 7-9 |
| **Service Category 2: The Undetectables Viral Load Suppression Peer Learning Network** | $460,996 | 2-3 |
| **Service Category 3: Crystal Methamphetamine Harm Reduction Services** | $1,047,056 | 3 |

Payment Structure:

- During the first six-months of the subaward (anticipated to be 7/1/22-12/31/22), subrecipients will be reimbursed for the completion of program start-up milestones. These deliverables are subject to change and will be finalized during contract negotiations and during activities.

| **Program Start-up Milestones** | | |
|---|---|---|
| **Deliverable** | **Applicable Service Categories** | **Description** |
| Initial Staffing Status Report | All | Report on direct service staff and supervisory program staff in place at the beginning of the contract period and vacant positions to be filled (with target dates). |
| Grievance Procedure | All | Development of Grievance Procedure for Clients. |
| 50% of Program Staff Hired | All | Achieved when 50% of program staff are hired. |
| 100% of Program Staff Hired | All | Achieved when 100% of program staff are hired. |
| 50% of Required Training Completed by Program Staff | All | Achieved when 50% of required trainings are completed by program staff. |
| Organizational Readiness Assessment & Program Implementation Plan | Category 1 | Completion of Organizational Readiness Assessment and Development of Undetectables Program Implementation Plan with Technical Assistance provider. |
| Program Implementation Plan | Category 2 | Update Undetectables Program Implementation Plan with Technical Assistance provider. |
| Consumer Engagement | Category 3 | Conduct consumer engagement activity (CAG, satisfaction survey, participation in quality management committee or other) as described in the Scope of Services. |
| Quality Management Plan | All | A plan to manage program quality and guide quality improvement activities for the program. |
| Service Delivery Begins | All | Enroll 1st client in the program and begin service delivery |
| Monthly Program Narrative Report | All | Submission of complete Monthly Program Narrative Reports (ePNRs) (@2% per month for 6 months). |

| | | |
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| Reconciled Data Submission | All | Complete and reconciled data submission for all services provided during the first contract year using Monthly Itemization Report (MIR) to verify service data reported. Contractor must notify DOHMH of any technical issues reporting services. |

- During the second six-months of the subaward (anticipated 1/1/23-6/30/23) and subsequent 12-month budget periods (July-June), subrecipients will be reimbursed annually for costs against expenditures detailed in the line-item budget for up to 80% of the annual maximum payable amount (MPA). Payment for the remainder of the annual MPA will be contingent upon meeting milestones for monthly data entry (up to 20% of the annual MPA paid as a deliverable).

| **Data Reporting Milestones (Years 2 & 3)** | | |
|---|---|---|
| **Deliverable** | **Applicable Service Categories** | **Description** |
| 6-month Reconciled Data Submission | All | Complete and reconciled data submission for all services provided during the first six months of the contract year using Monthly Itemization Report (MIR) to verify service data reported. Contractor must notify DOHMH of any technical issues reporting services. |
| 12-month Reconciled Data Submission | All | Complete and reconciled data submission for all services provided during the second six months of the contract year using Monthly Itemization Report (MIR) to verify service data reported. Contractor must notify DOHMH of any technical issues reporting services. |

Expected Caseload:

**Service Category 1: The Undetectables Viral Load Suppression Program**

| | **YEAR 1** | | **YEARS 2 & 3** | |
|---|---|---|---|---|
| **Estimated Annual MPA** | **Caseload** | **% MPA allocated to financial incentives** | **Caseload** | **% MPA allocated to financial incentives** |
| $200,000 - $240,000 | 50-150 clients | 10-25% | 150-250 clients | 15-30% |

**Service Category 2: The Undetectables Viral Load Suppression Peer Learning**

| | **YEAR 1** | | **YEARS 2 & 3** | |
|---|---|---|---|---|
| **Estimated Annual MPA** | **Caseload** | **% MPA allocated to financial incentives** | **Caseload** | **% MPA allocated to financial incentives** |
| $150,000 - $230,000 | 150-250 clients | 25-40% | 150-250 clients | 25-45% |

**Service Category 3: Crystal Methamphetamine Harm Reduction Services**

| **Estimated Annual MPA** | **YEAR 1 Minimum # of clients** | **YEARS 2 & 3 Minimum # of clients** |
|---|---|---|
| $300,000 - $500,000 | 30-80 | 45-100 |

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| **Minimum Applicant Eligibility Requirements** | Organizations applying for funding must meet all the following requirements:<br>• Be legally incorporated by the New York State Department of State as a not-for-profit corporation;<br>• Have federal tax-exempt status under Section 501 (c)(3) of the Internal Revenue Code; and<br>• Operate a brick-and-mortar site in one of the five boroughs of New York City.<br>Organizations applying for Service Category 1 or 2 must also meet the following requirement:<br>• Submit Article 28 documenting that the applicant is licensed to provide HIV medical care (i.e., prescribe ART and monitor viral load) or submit a written agreement (e.g., memorandum of understanding) with a licensed provider of HIV primary care.<br>*Non-profit organizations are prohibited from serving as pass-through entities to for-profit organizations.* |
| **Required Documents** | Applicants must submit the following documents:<br>• Attachment A: Structured Proposal Form *(template provided; must be submitted in MS Word)*<br>• Attachment B: Budget Template *(template provided; must be submitted in MS Excel)*<br>• Attachment C1-2: ETE Service Projection Template-SC1 & SC2 UND *(template provided; must be submitted in MS Excel)* ***OR*** Attachment C3: ETE Service Projection Template-SC3 MTH *(template provided; must be submitted in MS Excel)*<br>• Attachment D: Organization and Program Information *(template provided; must be submitted in MS Excel),* including the following tabs:<br>i. Information Cover Sheet<br>ii. Organization Eligibility<br>iii. Government Funding Sources<br>iv. Proposed Program Staff<br>v. Unduplicated Clients<br>vi. Proposed Geographic Area<br>vii. Service Site Locations<br>viii. Program Hours and Days of Operations<br>• Attachment E: Program Organizational Chart *(no template provided)*<br>• Attachment F: Curricula Vitae or Resumes of Key Staff *(no template provided)*<br>• Attachment G: Linkage Agreement (LA) / Memorandum of Understanding (MOU) / Memorandum of Agreement (MOA) with collaborative partner organization(s), *if any (no template provided)*<br>• Attachment H: Board of Directors' Statement Template *(template provided)*<br>• *Internal Revenue Service 501(c)(3) Determination Letter<br>• *New York State Certificate of Incorporation<br>• *Current Board of Directors List<br>• *Article 28 License, *if applying for Service Category 1 or Service Category 2,* to document that the applicant is licensed to provide HIV medical care (i.e., prescribe ART and monitor viral load) ***OR*** a written agreement (e.g., memorandum of understanding) with a licensed provider of HIV primary care.<br>• *Most recent audited Annual Financial Statement; if total expenditures associated with federal funding exceed $750,000 a year, a Single Audit Report is required |

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|---|---|
| | *Note that you <u>may</u> transmit the documents which are marked with an asterisk (*), to Public Health Solutions via the NYC HHS Accelerator, New York City's contracting information system for health and human services. Organizations registered with the NYC HHS Accelerator must designate Public Health Solutions as a funder authorized to download their administrative documents. (Download the instructions, "Sharing Documents to PHS in the Document Vault" from the PHS Procurement Portal.)*<br>*For more information on the NYC HHS Accelerator and to register, go to:*<br>***https://www1.nyc.gov/site/mocs/systems/about-go-to-hhs-accelerator.page*** |
| **Other Requirement(s)** | • Awarded agencies will be required to have a valid Vendor Number in the New York City Financial Management System (FMS). Applicants that do not have an FMS Vendor Number may obtain one by completing the Payee Information Portal (PIP) Activation process at:<br>***https://a127-pip.nyc.gov/webapp/PRDPCW/SelfService***<br>• The selected applicants will be required to provide their Vendor Number to PHS at the time of award notification. |
| **Questions Regarding this RFP** | • Questions regarding this RFP must be submitted via the PHS Procurement Portal by **January 27, 2022, 5pm ET**:<br>***https://healthsolutions.bonfirehub.com/portal/?tab=openOpportunities***<br>• Select the "View Opportunity" button for this RFP. From the Project Details page click the "Ask a Question" button which will prompt you to the "Opportunity Q&A" tab. Click on "Start a new Opportunity Q&A" to begin the process of submitting your questions. For more information on how to ask a question through the PHS Procurement Portal please visit: *https://support.gobonfire.com/hc/en-us/articles/115015333227-How-do-I-contact-the-Project-Owner-*<br>• Responses to questions from the Pre-Proposal Conference Webinar, as well as questions submitted via the PHS Procurement Portal by the questions deadline date, may be addressed in a supplement to the RFP.<br>• The Supplement will be posted on the PHS Procurement Portal:<br>***https://healthsolutions.bonfirehub.com/portal/?tab=openOpportunities***<br>• An email notification will be sent to all individuals who download this RFP, submitted questions to the PHS Procurement Portal and/or registered/attended the Pre-Proposal Conference Webinar. Please note that not all written inquiries will receive written responses. *Note that PHS and the Health Department may not respond to questions received after January 27, 2022.*<br>• All inquiries concerning this RFP, from the date of issuance until the subawards notifications, must be submitted via the PHS Procurement Portal. *Organizations are advised that no contact related to this RFP is permitted with any other staff of PHS or the Health Department*. |
| **Notice of Intent to Respond (Intent to Bid)** | • The Notice of Intent to Respond form is not mandatory; however, applicants interested in responding to this RFP are strongly urged to submit the intent by the due date so that PHS may be better able to plan for the proposal evaluation process. The Notice of Intent can be submitted by visiting the RFP page in the PHS Procurement Portal and selecting "Yes" in the Intent to Bid tab, ***https://healthsolutions.bonfirehub.com/portal/?tab=openOpportunities***<br>• The Notice of Intent should be submitted no later than **February 16, 2022**. |

## Proposal Submission Instructions

**To Download the RFP documents, visit the 'NEW' Public Health Solutions (PHS) Procurement Portal*:**

**https://healthsolutions.bonfirehub.com/portal/?tab=openOpportunities**

1. On the "Open Public Opportunities" tab, select the "View Opportunity" button to the right of the appropriate RFP.
2. Scroll down to the segment titled "Supporting Documentation" and click on the "Download" button to all the RFP documents you wish to download.

**Note: To view the Opportunity (aka RFP) and download the RFP documents you must be registered and logged into to your PHS Procurement Portal Account. If you already have an existing Vendor Account with Bonfire, you do not need to register for a new account to access PHS RFPs or submit proposals to PHS.*

**How to Register as a Vendor in the 'NEW' PHS Procurement Portal**

To use the PHS Procurement Portal, you must first *Register for a New Vendor Account*:

**https://healthsolutions.bonfirehub.com/portal/?tab=login**

- Step 1: Account Confirmation (*required*)
  - Fill out all listed fields and click on Create Account. If the account was created successfully you will see a "Success" message.
  - To continue with the registration process, check your email inbox for confirmation. Open the email and click on the "Complete your registration" button, where a new page will open prompting you to create a password.
- Step 2: Account Information (*required*)
  - Fill out all required (marked with an asterisk) fields.
- Step 3: Documentation (*optional*)
- Step 4: Commodity Codes (*optional*)
- Step 5: Complete Registration (required)

*Note: Any optional steps can also be completed after registration.*

**To Submit Proposal via the 'NEW' PHS Procurement Portal:**

All the documents listed in the Required Documents section in Basic Information must be completed and submitted via the PHS Procurement Portal by the proposal due date and time.

To submit a proposal:

1. Navigate to the 'Open Public Opportunities' tab and select the 'View Opportunity' button to the right of the appropriate RFP.
2. Scroll down to the segment titled 'Submission'. Indicate 'Yes' to the question asking for your intention to bid on this opportunity. Click 'Submit'.
3. After confirmation, the 'Prepare' Tab will open. Since the PHS Procurement Portal is a new procurement system, it is recommended to watch the accompanying video for a quick overview of the submission process. When you are ready, select 'Prepare Your Submission'.
4. On the Submission page, upload the required documents and submit and finalize your proposal.

*Note: After the 'RFP Close Date', you will be unable to modify your proposal and uploaded documents.*

Designated individual documents can be uploaded and/or elected to be shared via HHS Accelerator *(such as the IRS 501(c)(3) Determination Letter; NYS Certificate of Incorporation; Board of Directors List; and/or Annual Financial Statement)*. Required submission method for each document is indicated in the PHS Procurement Portal.

*You should NOT send a copy of your proposal or submit via email. Use of the PHS Procurement Portal is REQUIRED. Proposals delivered as hard copy or email will NOT be considered as submitted.*

Please be aware that uploading a proposal will involve multiple files representing different required proposal documents. Please allow sufficient time to check that you have included all necessary digital file attachments. *Please ensure that you have a working login, and familiarize yourself with the PHS Procurement Portal, at least one week before the proposal submission deadline.*

*Note that proposals received after the Proposal Due Date may be deemed non-responsive and not eligible for further review.*

*It is the responsibility of the submitting organization to ensure delivery of the proposal to Public Health Solutions via the PHS Procurement Portal by the submission deadline. A confirmation of receipt of the proposal submission will be sent by email. Note that the email confirmation is confirming the delivery and receipt of the proposal submission and is* ***not*** *a confirmation that the proposal submission is complete or responsive.*

*All communication (e.g., submitting a question, indicating a notice of intent to submit, etc.) will all be conducted via the PHS Procurement Portal.*

**Proposal Format Requirements**

Applicants are expected to adhere to the following formatting requirements:

1. Each document of the proposal should be titled using the following naming convention: *Applicant Name_Document Title_ETE RFP*.
2. Proposal documents should be submitted in the format specified in the RFP *(e.g., Budget in MS Excel; etc.)*.
3. Structured Proposal Form sections include a maximum word count.
4. Structured Proposal Form should be a 1.08-spaced, except for any required tables and any included supportive charts, which may be single-spaced.
5. Minimum font size is Calibri 11-point except for any required tables and any included supportive charts, which may use a font no smaller than 10-point.
6. Each page of the Structured Proposal Form, including attachments, should be consecutively numbered.
7. The Structured Proposal Form should remain in the same sequence and format as provided; questions should not be renumbered or reordered; the text of the question may be omitted.
8. Each page of the proposal should include as a header or footer the name of the organization submitting the proposal.

## Section 1 – Program Background

The mission of the New York City Department of Health and Mental Hygiene (Health Department) is to protect and promote the health of all New York City (NYC) residents. Central to this mission is addressing health inequities due to racism, sexism, homophobia, transphobia, and poverty to achieve racial equity and social justice. The efforts of the Health Department's Bureau of Hepatitis, HIV, and STIs (BHHS) are also centered on racial equity and social justice in its mission to improve the lives of New Yorkers by ending transmission, illness, stigma, and inequities related to viral hepatitis, HIV, and sexually transmitted infections.

The Health Department coordinates NYC's response to the HIV epidemic. This includes HIV testing initiatives; prevention, care and treatment programming; surveillance; training and technical assistance; policy advocacy; community engagement; social marketing; and racial equity and social justice initiatives. Building upon the New York State Blueprint for Ending the Epidemic, and aligning with the U.S. Department of Health and Human Services' 2019 Ending the HIV Epidemic: A Plan for America, the Health Department's 2020 NYC Ending the Epidemic Plan includes five strategies to reduce the number of new HIV infections and improve the health and well-being of New Yorkers with HIV.

- **Strategy 1:** Increase the number of people who know their HIV status by diagnosing HIV infection as early as possible, promoting routine testing within health care facilities, and scaling up testing options in nonclinical settings.
- **Strategy 2:** Prevent new HIV infections by increasing access to effective prevention interventions, including PrEP, emergency post-exposure prophylaxis (PEP), condoms, harm reduction and supportive services.
- **Strategy 3:** Improve viral suppression and other health outcomes for people with HIV by optimizing medication adherence and access to care, improving coordination of clinical and supportive services, and increasing access to immediate antiretroviral treatment (iART).
- **Strategy 4:** Enhance methods to identify and intervene on HIV transmission networks to better support people and communities at increased risk of exposure.
- **Strategy 5:** In all strategies, utilize an intersectional, strengths-based, anti-stigma and community-driven approach to mitigate racism, sexism, homophobia, transphobia, and other systems of oppression that create and exacerbate HIV-related health inequities.

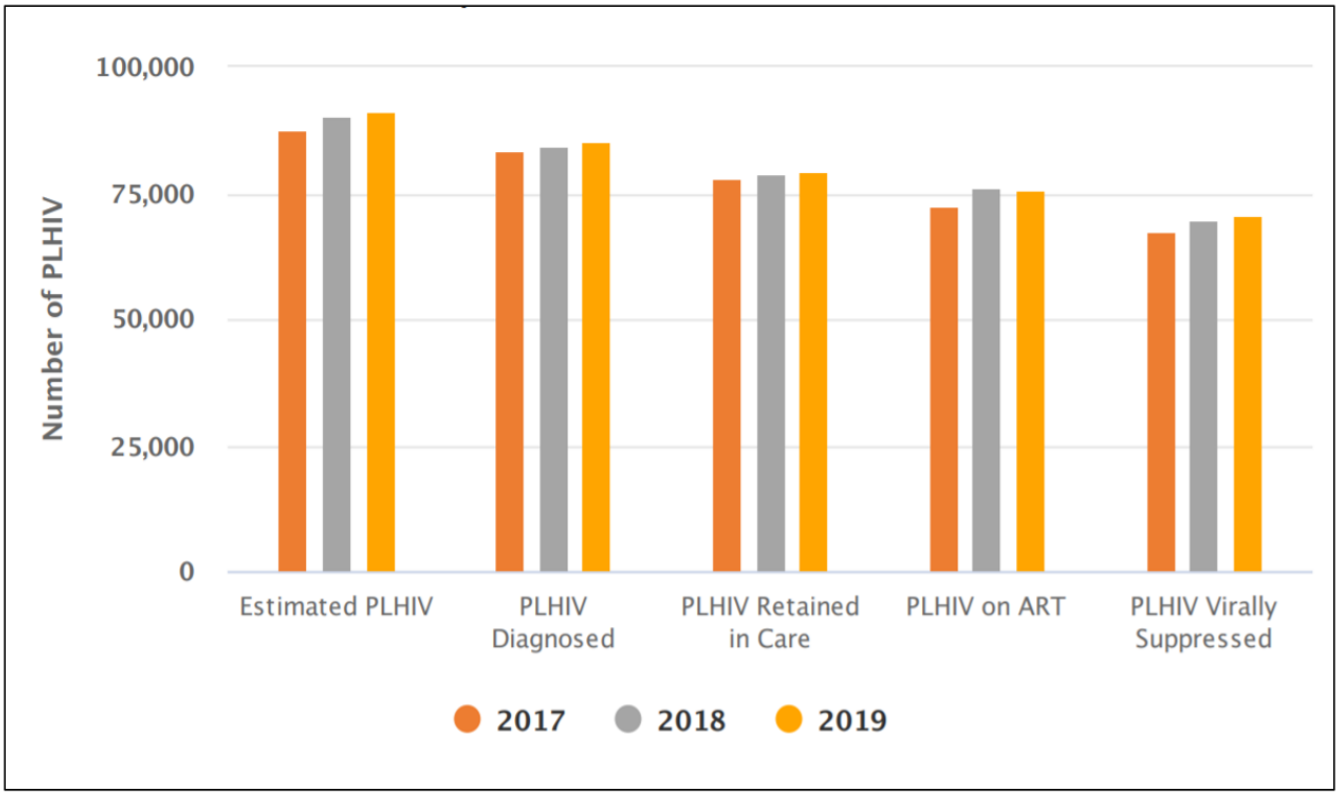
Directly addressing strategies 2 and 3, and framed by strategy 5, the Health Department is funding two program models with City Tax Levy Ending the Epidemic funds. The programs described in this RFP have been designed based on evidence-based interventions to facilitate timely linkage and engagement in HIV prevention and treatment services.

BHHS supports clinical and non-clinical community and hospital medical organizations throughout NYC to meet the needs of the over 129,000 people with HIV (PWH) as well as those vulnerable to contracting HIV.[1] Efforts to reduce transmission have resulted in steady declines in new HIV diagnoses. In 2020, 1,396

[1] New York City Department of Health and Mental Hygiene, HIV Epidemiology Program. HIV Surveillance Annual Report, 2020. https://www1.nyc.gov/assets/doh/downloads/pdf/dires/hiv-surveillance-annualreport-2020.pdf. Accessed December 1, 2021.

new HIV diagnoses were reported in NYC—a 21% reduction since 2019 and 76% reduction since 2001.[2] As a jurisdiction with a mature epidemic, the annual increase in the number of PWH has slowed over the past decade or more, as new diagnoses have declined more rapidly every year, and HIV-related mortality rates have significantly declined due to more sophisticated care and treatment strategies resulting in improved health outcomes. PWH who take HIV medicine as prescribed and maintain an undetectable viral load (<200 copies/mL) not only experience improved health and well-being themselves, they cannot transmit HIV to sexual partners.[3]

**Figure 1. New York City HIV Care Continuum, 2017-2019**




Source: New York City, Fast-Track Cities, Global Web Portal, Ending the HIV, TB, HBV, and HCV Epidemics. https://www.fasttrackcities.org/datavisualization/new-york. Accessed July 19, 2021.

Although we have seen significant improvement in HIV-related care outcomes over the years, HIV remains a significant public health challenge, with gaps across the HIV care continuum. Since 2017, the proportion of PWH in NYC who are on ART and virally suppressed (<200 copies/mL) has increased slightly, but nearly a quarter (23%) remain unsuppressed (see Figure 1) and inequities persist. In 2018, in the New York Eligible Metropolitan Area, among young cisgender men who have sex with men (YMSM) aged 13 to 29 years living with HIV, only 67% of Black YMSM were virally suppressed compared to 75% of white YMSM

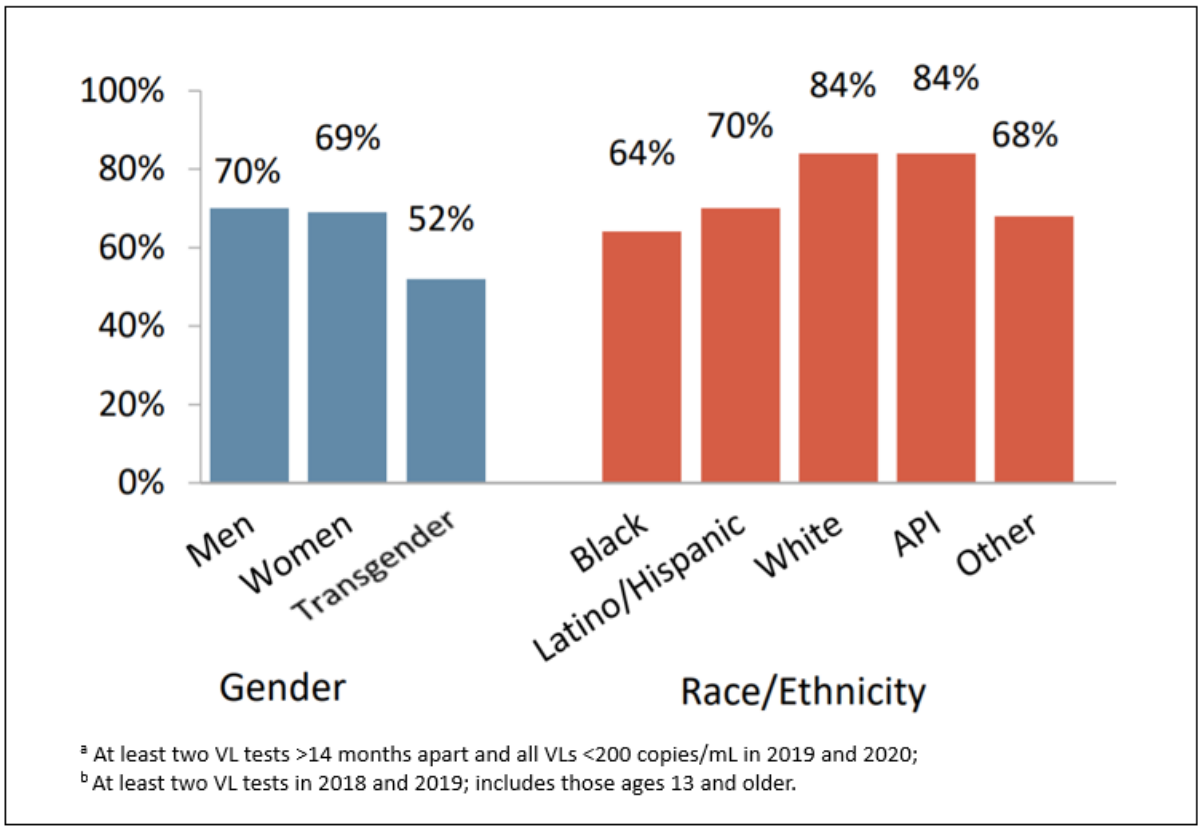
[2] New York City Department of Health and Mental Hygiene, HIV Epidemiology Program. HIV Surveillance Annual Report, 2020. https://www1.nyc.gov/assets/doh/downloads/pdf/dires/hiv-surveillance-annualreport-2020.pdf. Accessed December 1, 2021.
[3] Centers for Disease Control and Prevention. (2020). Evidence of HIV Treatment and Viral Suppression in Preventing the Sexual Transmission of HIV. https://www.cdc.gov/hiv/pdf/risk/art/cdc-hiv-art-viral-suppression.pdf. Accessed October 1, 2021.

and 72% of Latino YMSM. Among cisgender women living with HIV, viral suppression (VS) was lower among Black cisgender women (73%) when compared to white (77%) and Latina cisgender women (78%). Similarly, among transgender women living with HIV, VS was lowest among Black transgender women (64%) compared to white (71%) and Latina transgender women (72%).[4] In 2020, PWH living in high poverty neighborhoods in NYC were least likely to be virally suppressed.[5] Disparities are starker when assessing sustained viral suppression and HIV-related mortality. Among people established in HIV medical care in 2020, only 64% of Black people and 70% of Latinos had sustained VS compared to 84% of white people; only 52% of transgender people had sustained VS compared to 69% of cisgender women and 70% of cisgender men (see Figure 2).[6] In 2019, among women living with HIV, Black and Latina women experienced the lowest survival probabilities and markedly higher numbers of deaths than white and Asian/Pacific Islander women.[7] As such, BHHS has identified populations to prioritize for the provision of tailored, equitable services to bridge gaps in health outcomes among populations that have historically and are currently being left behind in our progress toward ending the HIV epidemic in NYC. These populations include PWH who identify as Black and/or Hispanic/Latino cisgender women; transgender women; youth, ages 13-29; older adults, ages 50+; and cisgender men who have sex with men (MSM).

Among cisgender men and transgender people who have sex with men, a contributing factor to HIV incidence is crystal methamphetamine use. In one study, when compared to individuals who did not report use of the drug, participants who reported taking methamphetamine over the course of the study had a fourfold increase in the odds of HIV seroconversion.[8] Limited research indicates that holistic approaches that address social and psychosocial stressors as well as the physical and biological aspects of methamphetamine addiction are necessary, as opposed to focusing solely on individual behavior.[9]

[4] New York State Department of Health, Bureau of HIV/AIDS Epidemiology, data as of 6/26/20.
[5] New York City Department of Health and Mental Hygiene, HIV Surveillance Data, Unmet Need Framework. 2020
[6] New York City Department of Health and Mental Hygiene, HIV Epidemiology Program. HIV Surveillance Annual Report, 2020.
[7] HIV Epidemiology Program. *HIV Surveillance Annual Report, 2019.* New York City Department of Health and Mental Hygiene: New York, NY. December 2020.
[8] Grov C, et al. (2020). The Crisis We Are Not Talking About: One-in-Three Annual HIV Seroconversions Among Sexual and Gender Minorities Were Persistent Methamphetamine Users. *JAIDS*. 85(3): 272-279.
[9] Halkitis PN, Levy MD, Moreira AD, Ferrusi CN. (2014). Crystal Methamphetamine Use and HIV Transmission Among Gay and Bisexual Men. *Current Addiction Reports*. (1): 206–213.

**Figure 2. Sustained viral suppression[a] among people established in HIV medical care[b], NYC 2020**




[a] At least two VL tests >14 months apart and all VLs <200 copies/mL in 2019 and 2020;
[b] At least two VL tests in 2018 and 2019; includes those ages 13 and older.

Source: New York City Department of Health and Mental Hygiene, HIV Epidemiology Program. (2020). HIV Surveillance Annual Report. https://www1.nyc.gov/assets/doh/downloads/pdf/dires/hiv-surveillance-annualreport-2020.pdf. Accessed December 1, 2021.

**Structural Racism and Health Inequities in HIV Care and Treatment**

Racism is the systematic subjugation of members of targeted racial groups, who hold less socio-political power and/or are racialized as non-White, to uphold White supremacy. Racism is supported and maintained, both implicitly and explicitly, by institutional structures and policies, cultural norms and values, and individual behaviors.[10] As people of color disproportionately suffer the brunt of the HIV epidemic in the United States, HIV is a racial justice issue as well as a public health issue. For people of color living with HIV, racial discrimination diminishes the quality of medical care received. Discrimination and socio-economic factors linked to race create additional obstacles to accessing the quality health care, housing, and education necessary for HIV treatment and prevention.[11]

[10] Key Equity Terms & Concepts: A Glossary for Shared Understanding. *Center for the Study of Social Policy: Ideas into Action.* September 2019. www.cssp.org.
[11] Racial Justice. *The Center for HIV Law & Policy*.

- **Healthcare Quality and Access**
  Systemic racism, bias, and discrimination in healthcare settings can directly affect health through poor health care. It is essential to understand the broad context within which health-care systems operate, including the potentially disparate settings in which healthcare professionals and their patients reside. Residential segregation systematically shapes healthcare access, use, and quality at the neighborhood, healthcare system, provider, and individual levels. The socioeconomic disadvantage resulting from systematic disinvestment in public and private sectors renders it difficult to attract primary care providers and specialists to predominantly Black neighborhoods. Likewise, health-promoting resources are inadequately invested into these neighborhoods. Healthcare infrastructure and services are inequitably distributed, resulting in predominantly Black neighborhoods having lower-quality facilities with fewer clinicians than those in other neighborhoods.[12]

- **Addressing Structural Racism to Advance Health Equity**
  Structural racism has developed over centuries and is deeply embedded in systems of care. Understanding and effectively addressing racial inequities is essential to advancing community health outcomes and achieving broader public health goals, including Ending the HIV Epidemic and the Health Department's Race to Justice Initiative. Therefore, this Request for Proposals (RFP) aims to seek proposals from organizations with this understanding and demonstrate the ability and willingness to incorporate health equity into their work to eliminate disparities and improve the health of all groups.

- **Race to Justice Statement of Support**
  Years of racist policies and unjust practices among institutions, including many City institutions, have led to worse health outcomes in communities of color than in White communities. The NYC Department of Health launched the Race to Justice internal reform effort to help staff learn what they can do to better address racial health gaps and improve health outcomes for all New Yorkers.[13] To learn more, please visit Race to Justice.

- **Community Input Processes**
  Consistent with the Health Department's Race to Justice Initiative and best practices for program planning, program planners ensured community representation in the development of this RFP. At the onset of the RFP development process, the Health Department hosted community forums for community stakeholders, including existing providers and consumers of the services of the current programs that are described in this RFP. They gave voice to the data and provided critical testimony about community needs which became core to the services included in this RFP. Their collective input was used to generate the service model and framework.

[12] Bailey ZD, Krieger N, Agenor M, Graves J, Linos N, Bassett MT. (2017). Structural racism and health inequities in the USA: evidence and interventions. *Lancet*. 389:1453-63.
[13] Race to Justice. The New York City Department of Health and Mental Hygiene. https://www1.nyc.gov/site/doh/health/health-topics/race-to-justice.page. Accessed May 17, 2021.

**Service Category Descriptions**

Programs outlined in this RFP draw upon effective, evidence-based strategies that have been shown to improve health outcomes and contribute to ending the HIV epidemic. The Health Department is seeking proposals for three service categories designed to respond to the unique needs of New Yorkers through strategies to improve engagement and re-engagement in care, initiation of antiretroviral treatment (ART), coordination of care, treatment adherence, and ultimately, HIV outcomes. BHHS HIV Care and Treatment Program (CTP) is committed to strategic leveraging of resources and expects organizations that are awarded funding through this RFP to demonstrate the ability to leverage existing partnerships and funding sources other than those provided by the Health Department to ensure program sustainability for the target population to be served under this RFP.

***Service Category 1: The Undetectables Viral Load Suppression Program***

This service category is based on The Undetectables, a pilot project[14] that was initially developed, implemented, and evaluated by Housing Works Community Healthcare, a community-based organization in NYC providing comprehensive clinical and non-clinical services to PWH. The Undetectables was designed to address HIV-related stigma, support retention in care, and increase viral load suppression (VLS) among clients with multiple psychosocial cofactors that are traditionally associated with poor VLS outcomes (e.g., unstable housing, substance use disorder, mental illness). As part of its ETE initiative, the Health Department funded a citywide scale-up of The Undetectables VLS Program by contracting with seven agencies to implement The Undetectables Program over a six-year period beginning in 2016. More information about The Undetectables can be found at https://liveundetectable.org.

The Undetectables Program is a multi-level approach to support HIV treatment adherence and VLS comprised of:

1. Organizational culture transformation to focus on achieving "VLS for All," including trainings for all levels of staff to understand the importance of VLS for individual and community health;
2. An innovative anti-stigma social marketing campaign that promotes the importance of achieving viral suppression for both maintaining the health of people living with HIV and preventing new infections;[15]
    - The campaign emphasizes the importance of maintaining an undetectable viral load for individual health and to prevent HIV transmission to sexual partners, a message known as Undetectable = Untransmittable (U=U).[16]
3. The Undetectables Toolkit to guide integration of the program into existing HIV care management programs, that includes:
    - Assessment of clients' needs;
    - Case conferencing, ideally with the client present;[17]

[14] Ghose T, Shubert V, Poitevien V, Choudhori S, Gross R. (2019) Effectiveness of a viral load suppression intervention for highly vulnerable people living with HIV. *AIDS Behav.* 23(9):2443-2452.
[15] Noar SM, Palmgreen P, Chabot M, Dobransky N, Zimmerman RS. (2009). A 10-year systematic review of HIV/AIDS mass communication campaigns: Have we made progress*? J Health Commun.* 14: 15-42.
[16] Prevention Access Campaign. Undetectable=Untransmittable. https://www.preventionaccess.org/undetectable. Published July 2016. Updated April 15, 2021.
[17] Kushel MB, et al. (2006). Case management is associated with improved antiretroviral adherence and CD4+ cell counts in homeless and marginally housed individuals with HIV infection. *Clin Infect Dis.* 43(2) :234-242.

- Client-centered ART adherence care planning;[18]
- Individual ART adherence counseling, based on the principles of Motivational Interviewing or other evidence-based/informed model;[19]
- Group ART adherence counseling, based on the principles of Cognitive Behavioral Therapy or other evidence-based/informed model (optional);[20]
- Adherence devices (e.g., pillboxes, text message reminders);[21]
- Modified directly observed therapy (mDOT);[22]
- Referral to services to address adherence barriers;
- Peer education and support (optional);[23]
- Quarterly $100 unrestricted gift cards that are provided to clients who have new quarterly lab work showing a viral load <200 copies.[24,25,26]

**Program Objectives**

- Improve ART adherence
- Improve retention in HIV medical care
- Provide prompt linkage to social support services
- Achieve and maintain viral load suppression (defined as a viral load test with <200 copies)

**Priority Populations**

People with HIV who are experiencing individual or structural barriers to ART adherence and VLS, including:

- Poverty;[27]

[18] Irvine MK, et al. (2015) Improvements in HIV Care Engagement and Viral Load Suppression Following Enrollment in a Comprehensive HIV Care Coordination Program. Clin Infect Dis. 60(2): 298–310.
[19] Parsons JT, et al. (2007). Motivational interviewing and cognitive-behavioral intervention to improve HIV medication adherence among hazardous drinkers: a randomized controlled trial. *J Aquir Immune Defic Syndr.* 46(4) : 443-450.
[20] Safren SA, et al. (2012). Cognitive behavioral therapy for adherence and depression (CBT-AD) in HIV-infected injection drug users: a randomized controlled trial. *J Consult Clin Psychol.* 80(3): 404-15.
[21] Petersen ML, et al. (2006). Pillbox organizers are associated with improved adherence to HIV antiretroviral therapy and viral suppression: a marginal structural model analysis. *Clin Infect Dis.* 45(7) :908-815.
[22] Macalino GE, et al. (2007). A randomized clinical trial of community-based directly observed therapy as an adherence intervention for HAART among substance users. *AIDS.* 21(11):1473-1477.
[23] Deering KN, et al. (2009). Piloting a peer-driven intervention model to increase access and adherence to antiretroviral therapy and HIV care among street-entrenched HIV-positive women in Vancouver. *AIDS Patient Care STDS.* 23(8):603-609.
[24] Bassett, IV, Wilson D, Taaffe J, Freedberg K. (2015). Financial incentives to improve progression through the HIV treatment cascade. *Curr Opin HIV AIDS.* 10(6):451-463.
[25] DeFulioa A & Silvermana K. (2012). The use of incentives to reinforce medication adherence. *Preventive Med.* 55(Suppl): S86–S94.
[26] Gambone, GF, Feldman MB, Thomas-Ferraioli AY, Shubert V, Ghose T. (2019) Integrating financial incentives for viral load suppression into HIV care coordination programs: considerations for development and implementation. *J Public Health Manag Pract.* [published online ahead of print (July 24, 2019)].
[27] Dasgupta S, et al. (2021). Barriers to HIV care by viral suppression status among US adults with HIV: findings from the Centers for Disease Control and Prevention Medical Monitoring Project. *J Assoc Nurses AIDS Care*. 32(5);561-568.

- Current, recent, or history of homelessness/housing instability;[28,29]
- Current or history of serious mental illness (SMI);[30]
- Cognitive impairment;
- Current or history of substance use disorder (SUD);[31]
- Food insecurity;[32,33]
- Current or history of trauma/violence; [34]
- Engagement in sex work;[35]
- Recent incarceration (past 12-months)[36]

**Client Eligibility**

To enroll in the program, clients must be:

- Living with HIV; AND
- Experiencing at least one of the individual or structural barriers listed under Priority Populations (above); AND
- Receiving HIV care management and HIV primary care services provided by the applicant OR receiving HIV care management provided by the applicant and HIV primary care services provided under a written agreement with the HIV care management program (per the terms described in Section 2.A., Organizational Experience, page 21).

***Note: Programs may <u>not</u> limit participation in the program to clients who are not virally suppressed at the time of enrollment.***

[28] Palepu A, et al. (2011). Homelessness and adherence to antiretroviral therapy among a cohort of HIV-infected injection drug users. J Urban Health. 88(3):545-555.

[29] Rintamaki LS, et al. (2006). Social stigma concerns and HIV medication adherence. *AIDS Patient Care and STDs*. 20(5): 359-368.

[30] Baligh R, et al. (2015). Health outcomes of HIV-infected people with mental illness. *AIDS Behav*. (19): 1491–1500.

[31] Lucas GM, et al. (2002). Longitudinal assessment of the effects of drug and alcohol abuse on HIV-1 treatment outcomes in an urban clinic. *AIDS*. 16(5):767-774.

[32] Feldman M, Alexy ER, Thomas JA, Gambone GF, Irvine MK. (2015) *J Acquir Immune Defic Syndr.* 69(3):329-37.

[33] Young S, et al. (2014). A review of the role of food insecurity in adherence to care and treatment among adult and pediatric populations living with HIV and AIDS. *AIDS Behav*. 18 Suppl 5: S505-15.

[34] Whetten K, et al. (2008). Trauma, mental health, distrust, and stigma among HIV-positive persons: implications for effective care. *Psychosom Med.* 70(5):531-538. 4

[35] Duff P, et al. (2016). Barriers to Viral Suppression Among Female Sex Workers: Role of Structural and Intimate Partner Dynamics. *J Acquir Immune Defic Syndr.* 73(1): 83–90.

[36] Erickson M, et al. (2020). Recent Incarceration as a Primary Barrier to Virologic Suppression Among Women Living with HIV: Results from a Longitudinal Community-Based Cohort in a Canadian Setting. AIDS and Behav. (24): 1243–1251.

***Service Category 2*: The Undetectables Viral Load Suppression Peer Learning Network**

This service category builds on the successful city-wide scale-up of The Undetectables by creating a Peer Learning Network of experienced implementors of The Undetectables VLS Program. Agencies with at least five consecutive years of experience implementing The Undetectables will collaborate with The Undetectables Technical Assistance Provider and Health Department to share lessons learned from their organization's experience with new implementors.

The Undetectables was initially developed, implemented, and evaluated by Housing Works Community Healthcare,[14] a community-based organization in NYC providing comprehensive clinical and non-clinical services to PWH. The Undetectables was designed to address HIV-related stigma, support retention in care, and increase viral load suppression (VLS) among clients with multiple psychosocial cofactors that are traditionally associated with poor VLS outcomes (e.g., unstable housing, substance use disorder, mental illness). As part of its ETE initiative, the Health Department funded a citywide scale-up of The Undetectables VLS Program by contracting with seven agencies to implement The Undetectables Program over a six-year period beginning in 2016. More information about The Undetectables can be found at https://liveundetectable.org.

The Undetectables Program is a multi-level approach to support HIV treatment adherence and VLS comprised of:

1. Organizational culture transformation to focus on achieving "VLS for All," including trainings for all levels of staff to understand the importance of VLS for individual and community health;
2. An innovative anti-stigma social marketing campaign that promotes the importance of achieving viral suppression for both maintaining the health of people living with HIV and preventing new infections;[15]
    - The campaign emphasizes the importance of maintaining an undetectable viral load for individual health and to prevent HIV transmission to sexual partners, a message known as Undetectable = Untransmittable (U=U). [16]
3. The Undetectables Toolkit to guide integration of the program into existing HIV care management programs, that includes:
    - Assessment of clients' needs;
    - Case conferencing, ideally with the client present;[17]
    - Client-centered ART adherence care planning;[18]
    - Individual ART adherence counseling, based on the principles of Motivational Interviewing or other evidence-based/informed model;[19]
    - Group ART adherence counseling, based on the principles of Cognitive Behavioral Therapy or other evidence-based/informed model (optional);[20]
    - Adherence devices (e.g., pillboxes, text message reminders);[21]
    - Modified directly observed therapy (mDOT);[22]
    - Referral to services to address adherence barriers;
    - Peer education and support (optional);[23]

- Quarterly $100 unrestricted gift cards that are provided to clients who have new quarterly lab work showing a viral load <200 copies.[24,25,26]

**Program Objectives**

- Improve ART adherence
- Improve retention in HIV medical care
- Provide prompt linkage to social support services
- Achieve and maintain viral load suppression (defined as a viral load test with <200 copies)
- Increased network of providers with capacity to carry out The Undetectables VLS Program.

**Priority Populations**

People with HIV who are experiencing individual or structural barriers to ART adherence and VLS, including:

- Poverty;[27]
- Current, recent, or history of homelessness/housing instability;[28,29]
- Current or history of serious mental illness (SMI);[30]
- Cognitive impairment;
- Current or history of substance use disorder (SUD);[31]
- Food insecurity;[32,33]
- Current or history of trauma/violence;[34]
- Engagement in sex work;[35]
- Recent incarceration (past 12-months)[46]

**Client Eligibility**

To enroll in the program, clients must be:

- Living with HIV; AND
- Experiencing at least one of the individual or structural barriers listed under Priority Populations (above); AND
- Receiving HIV care management and HIV primary care services provided by the applicant OR receiving HIV care management provided by the applicant and HIV primary care services provided under a written agreement with the HIV care management program (per the terms described in Section 2.A., Organizational Experience, page 21).

***Note: Programs may <u>not</u> limit participation in the program to clients who are not virally suppressed at the time of enrollment.***

***<u>Service Category 3:</u> Crystal Methamphetamine Harm Reduction Services***

Substance use is a co-factor at every stage of HIV (from transmission through treatment). It may contribute to elevated viral load, accelerated disease progression and mortality, and is associated with reduced adherence to ART. Crystal methamphetamine use increases the risk for HIV transmission and acquisition by lowering sexual inhibition and inducing confidence to engage in sexual activity for long periods of time. It also encourages needle sharing that can more easily facilitate transmission of HIV and hepatitis viruses.[37] Crystal methamphetamine use not only increases behavioral risks for HIV but also acts as an immunosuppressant, decreasing CD4 levels and allowing for more virus to get into cells. Crystal methamphetamine users, particularly because of the drug's long high, often fail to maintain a treatment regimen, causing their viral load to increase.[38] Users of crystal methamphetamine may find it difficult to find help reducing harm from drug use due to a lack of awareness of available resources and alienation from health and service systems driven by stigma, trauma, and fear.

Harm reduction is a set of practical strategies for reducing the negative consequences associated with drug use. It incorporates a spectrum of strategies (from safer use to managed use to abstinence) to meet drug users "where they're at" while addressing conditions of use along with the use itself.[39] Reducing the harms associated with methamphetamine use requires increasing access to a combination of evidence-informed services, including: effective means of preventing or treating HIV; harm reduction services and education; effective substance use counseling; mutual support services; and the treatment of depression, anxiety, psychosis and other factors that may result from or drive methamphetamine use. Pre-exposure prophylaxis (PrEP) for HIV-negative persons and antiretroviral treatment for PWH offer biomedical prevention that, when offered alongside behavioral and structural interventions such as counseling and education, serve as important tools in combination HIV prevention. For users of crystal meth, biomedical strategies also offer practical benefits over reliance solely on condoms for HIV protection because, taken routinely, they do not require action at the time of sexual activity.[40]

BHHS is seeking proposals for programs designed by community-based organizations and clinics that will expand access to harm reduction and supportive services for New Yorkers who use crystal methamphetamine, including people vulnerable to or living with HIV.

Under this RFP, funded services and components may include:

- Targeted outreach to reach those who may benefit from the program and bring them in for services;
- Drop-in safe spaces for participants to "come down" from use;
- Counseling;
- Contingency management or other evidence-based approaches to addressing use of crystal methamphetamine;
- Health education;

[37] Yeon P, Albrecht H. (2007). Crystal Meth and HIV/AIDS: The Perfect Storm? *NEJM Journal Watch.* Accessed July 19, 2021. https://www.jwatch.org/ac200712030000001/2007/12/03/crystal-meth-and-hiv-aids-perfect-storm

[38] Methamphetamine and HIV. HRSA Care Action. June 2009. https://hab.hrsa.gov/sites/default/files/hab/Publications/careactionnewsletter/june2009.pdf. Accessed July 19, 2021.

[39] Adapted from Harm Reduction Coalition: https://harmreduction.org/about-us/principles-of-harm-reduction/

[40] Hammoud MA, et al. (2020). Biomedical HIV protection among gay and bisexual men who use crystal methamphetamine. *AIDS Behav.* (24): 1400–1413.

- Navigation to help 1) HIV-negative users access PrEP and other needed services and 2) HIV-positive users to support treatment engagement and adherence. Navigation may facilitate access to:
  - Medication assisted treatment/pharmacotherapy to reduce dependence on methamphetamine and/or manage withdrawal symptoms
  - Other medical services such as:
    - Primary care
    - STI and hepatitis C testing and treatment
    - Vaccination for:
      - Hepatitis A and B
      - Human papillomavirus
      - Meningococcal disease
      - Pneumococcal disease
      - Influenza
      - COVID-19
    - PEP
    - Psychiatric services including evaluation, ongoing treatment, and management of psychotropic medications to treat the depression, anxiety, and psychosis that may be associated with methamphetamine use.

**Program Objectives**

- Improve access to culturally responsive treatment and harm reduction services for HIV-negative and HIV-positive New Yorkers who use methamphetamine, particularly for cisgender men who have sex with men, transgender persons who have sex with men, and people of color
- Increase the proportion of HIV-negative clients using methamphetamine who are:
  - educated about PrEP and PEP and
  - taking PrEP
- Increase the proportion of HIV-positive clients using methamphetamine who are engaged in care and reach viral load suppression
- Increase the proportion of clients who are linked to primary care, STI and hepatitis C testing and treatment, and other needed services.

**Priority Populations**

Active users of methamphetamine (defined as any use within the past 12 months) including:

- Cisgender men and transgender persons who have sex with men;
- People of color;
- Both HIV-negative and HIV-positive persons.

**Client Eligibility**

To enroll in the program, clients must:

- Report using methamphetamine within the past 12 months.

## Section 2–Program Expectations and Proposal Instructions

Only one proposal per applicant may be submitted per service category; however, an applicant may not apply to both Service Categories 1 and 2. Only one subaward may be made per applicant per service category.

**A. Organizational Experience** *(25 points)*

**1. *Program Expectations***

a. **All Service Categories Program Expectations**

*The Applicant should have demonstrated experience (minimum 2 years):*

i. meeting the needs of the populations specified in this RFP;

ii. identifying and addressing barriers to care related to systemic and institutional racism and other structural factors.

iii. ensuring that principles of health equity, as outlined above and by the American Public Health Association (APHA Advancing Health Equity link), are practiced within the organization to promote reductions in health disparities.

iv. addressing, either directly or through referral, the needs of clients with physical, behavioral, psychosocial, or sensory impairments.

v. coordinating care and linking clients to co-located medical and social support services **OR** to other service providers through established Linkage Agreements (LA), Memoranda of Understanding (MOU), or Memoranda of Agreement (MOA). Clients should be able to access services the same day as the referral. *Agreements must be in place before subawards can be executed. Awarded applicants who fail to furnish agreements at the time of subaward execution may forfeit their subaward.*

b. **Service Category 1 Program Expectations**

In addition to the expectations listed for All Service Categories above, applicants for Service Category 1 should also have demonstrated experience equivalent to:

i. 2 or more years of experience working with PWH who experience the individual and structural barriers to HIV treatment adherence (e.g., homelessness/unstable housing, food insecurity, mental illness) outlined in this RFP.

ii. 2 or more years of experience providing HIV care management services that include ART adherence support and connection to non-medical support services that help clients address barriers to adherence.

- HIV care management services: The applicant must have the capacity to provide all services in The Undetectables Toolkit (except for those services marked "optional" on Table 2, page 25). HIV care management programs include but are not limited to Ryan White-funded Care Coordination Program, Ryan White-funded Retention and Adherence Program, and Health Home Care Coordination. Applicants may propose integrating The Undetectables Program into other equivalent established HIV care management programs.
- HIV primary care: *At the time of proposal submission*, the applicant must provide HIV medical care (Article 28) or have a written agreement (e.g.,

memorandum of understanding) with a provider of HIV primary care to provide HIV care management as part of an integrated care team and to collaboratively implement the program, including case conferencing and service planning with primary care provider and care management staff.

c. **Service Category 2 Program Expectations**

In addition to the expectations listed for All Service Categories above, applicants for Service Category 2 should also have demonstrated experience equivalent to:

i. a minimum of 5 consecutive years of experience implementing The Undetectables VLS Program with the Priority Populations outlined in the RFP and a commitment to share lessons learned with new programs.

- HIV care management services: The applicant must have the capacity to provide all services in The Undetectables Toolkit (except for those services marked "optional" on Table 2, page 25). HIV care management programs include but are not limited to Ryan White-funded Care Coordination Program, Ryan White-funded Retention and Adherence Program, and Health Home Care Coordination. Applicants may propose integrating The Undetectables Program into other equivalent established HIV care management programs.
- HIV primary care: *At the time of proposal submission*, the applicant must provide HIV medical care (Article 28) or have a written agreement (e.g., memorandum of understanding) with a provider of HIV primary care to provide HIV care management as part of an integrated care team and to collaboratively implement the program, including case conferencing and service planning with care management staff.

d. **Service Category 3 Program Expectations**

In addition to the expectations listed for All Service Categories above, applicants for Service Category 3 should also have demonstrated experience equivalent to:

i. 2 or more years of experience working with people who use crystal methamphetamine;

ii. 2 or more years of experience working with PWH with behavioral health challenges.

**2. Proposal Instructions**

Complete the relevant section of the Structured Proposal Form - Attachment A.

**3. Evaluation**

This section is worth up to 25 points in the Proposal Evaluation and will be evaluated based on the extent to which the applicant responds comprehensively to the questions on the Structured Proposal Form.

*For All Service Categories:*

- Applicants who provide referrals with same-day service (whether co-located, available elsewhere in the organization, or available through referrals to under terms of an agreement) will receive higher proposal scores.

*For Service Category 1:*

- Applicants with more than 5 years of experience working with PWH who experience the individual and structural barriers to HIV treatment adherence outlined in this RFP will receive higher proposal scores.
- Applicants with more than 5 years of experience providing HIV care management services that include ART adherence support and connection to non-medical support services that help clients address barriers to adherence will receive higher proposal scores.

*For Service Category 2:* Applicants must have a minimum of 5 consecutive years of experience implementing The Undetectables VLS Program with the Priority Populations outlined in the RFP.

*For Service Category 3:*

- Applicants with more than 5 years of experience working with people who use crystal methamphetamine will receive higher proposal scores.
- Applicants with more than 5 years of experience working with PWH with behavioral health challenges will receive higher proposal scores.

**B. Proposed Program Approach** *(35 points)*

***Service Category 1: The Undetectables Viral Load Suppression Program***

**1. Project Expectations**

*Under the program framework, the Subrecipient will:*

a. Ensure Program Coordinator completes all trainings in The Undetectables five-part training series, provided by the contracted Undetectables Technical Assistance Provider, during the first year of the subcontract. Additional staff are encouraged to participate in the training series. Case managers who work with clients enrolled in the program must complete the "Case Management for VLS" training within the first year of the program.
   i. Participate in The Undetectables Viral Load Suppression Consortium[41] of stakeholders through quarterly roundtable discussions and other community stakeholder meetings.

b. Collaborate with the contracted Undetectables Technical Assistance Provider to complete the Organizational Readiness Assessment, identify program needs, and develop the Program Implementation Plan during the start-up period.

c. Transform organizational culture to focus on achieving "Viral Load Suppression for All," including trainings by the Program Coordinator for all levels of staff to understand the importance of VLS for individual and community health.

[41] The Undetectables Viral Load Suppression Consortium is a group of content experts and stakeholders who have been working to adapt and disseminate The Undetectables program model. Participants include clinicians, evaluators, program implementation staff, and providers of HIV care and care management services.

d. Implement a social marketing campaign using the materials provided by the contracted Undetectables Technical Assistance Provider which can be tailored to each individual agency. Additionally, subrecipients may develop materials internally with approval from the Health Department.

e. Obtain buy-in from your organization's existing HIV care management program leadership and staff to integrate The Undetectables Program (including all required services as well as any optional services in Table 1) into existing service delivery and collaboratively implement the program.

f. Conduct outreach and in-reach (including the use of social media) to enroll clients who meet the definition under ***Priority Populations*** (pages 15-16) using the caseload parameters outlined on page 4 as a guide.

g. Integrate The Undetectables Toolkit (page 14) into existing HIV care management programs by working closely with existing HIV care management staff to ensure timely assessments and delivery of evidence-based adherence support tools in the toolkit.

    i. Conduct case conferences that include the HIV primary care provider and HIV care manager. The client's participation in the case conference is strongly encouraged.

    ii. Drawing on the comprehensive assessment process and using motivational interviewing, collaborate with the client to develop an ART adherence care plan to set goals for their participation in the program, services to be provided by program staff, and action steps to be taken to achieve service plan goals.

        - Specific tools in The Undetectables Toolkit will be incorporated into the care plan based on assessments, care planning, and case conferencing.
        - Format and frequency of care plan updates is determined by the existing HIV care management program (e.g., Ryan White Care Coordination, Ryan-White Retention and Adherence Program, Health Homes Care Coordination). However, every client should be regularly assessed to evaluate progress toward achieving goals, changing needs, strengths, and challenges to inform care plan updates or case closure.

    iii. Provide evidence-based, trauma-informed, and client-centered tools in The Undetectables Toolkit, as outlined in this RFP, to promote treatment adherence and support clients' health and well-being.

    iv. Complete a reassessment of the client's health, psychosocial status and service needs every six months to inform care plan updates or case closure.

h. Ensure collection of timely lab results for all clients and timely distribution of financial incentives (i.e., $100 unrestricted gift card that is not specific to a single retailer) to clients for achieving or maintaining viral load suppression (<200 copies/mL) up to four times per year with new quarterly lab work. To receive an incentive, new labs must be dated at least 90 days since the labs that resulted in the previous incentive.

    i. Obtain client's recent HIV lab results at the time of enrollment to establish a baseline viral load. ***If lab results are more than three months old at the time of enrollment, new labs should be ordered within one week of enrollment to establish a baseline viral load***.

**Table 2: Service to be delivered under *Service Category 1 (The Undetectables Viral Load Suppression Program Services)* and *Service Category 2 (The Undetectables VLS Peer Learning Network)***

| PHS Code | Service Type | Service Description | Service Standard | Staff Responsible | Required / Optional |
|---|---|---|---|---|---|
| **Planning and Assessment** | | | | | |
| **115** | **Intake Assessment** | Initial assessment of health, psychosocial status and service needs to facilitate plan development. May include:<br>• Documenting eligibility for services and obtaining information for program enrollment<br>• Gathering demographic data, HIV diagnosis information, insurance coverage information, involvement in criminal justice system<br>• Evaluating financial and housing status, substance use, mental health, risk behavior, and general health and well-being | Intake assessment must be completed within 45 days of program enrollment. | Program Coordinator | Required |
| **225** | **Care/Service Plan Development** | Development of a client-centered service plan in response to the initial comprehensive assessment, listing client's goals for participation in the program, the actions that both the client and program staff will take to achieve goals, program services that will be delivered and service frequency. | Initial service plan must be completed within 45 days before or after program enrollment. All plans must be personalized to reflect each client's individual needs. | Case Manager | Required |
| **076** | **Reassessment** | Follow up assessment to re-evaluate and record client eligibility, engagement in care and services, emerging health and service needs, progress towards achieving service plan goals, substance use, mental health, and risk behaviors. Re-assessment facilitates service plan updates. | Reassessment must occur at least every six months. | Program Coordinator | Required |
| **Treatment Adherence** | | | | | |
| **239** | **Treatment Adherence** | One-to-one therapeutic counseling to address adherence to psychiatric, as well as HIV, treatment. Sessions may cover education about treatment options, barriers to adherence, strategies to | No additional service standard | Case Manager | Required |

| PHS Code | Service Type | Service Description | Service Standard | Staff Responsible | Required / Optional |
|---|---|---|---|---|---|
| | **Counseling (Individual)** | improve adherence, drug interactions and the managing side effects. | | | |
| **P89** | **Treatment Adherence Counseling (Group)** | Group therapeutic counseling to address adherence to psychiatric as well as HIV, treatment. Sessions may cover education about treatment options, barriers to adherence, strategies to improve adherence, drug interactions and the managing side effects. | No additional service standard | Case Manager | Optional |
| **Financial Services** | | | | | |
| **Q17** | **Incentive** | Reward to recognize or motivate achievement. | Must be in the form of an unrestricted noncash gift card equal to $100 distributed quarterly upon the receipt of a lab report showing a viral load <200 copies/mL. A client may receive the incentive up to four times per year. | Program Coordinator | Required |
| **Directly Observed Therapy** | | | | | |
| **N86** | **Modified Directly Observed Therapy (mDOT)** | Observing client administer medication to themselves at their home, in the field or program site according to service plan. | May be conducted by telephone or videoconference. | Case Manager; Other Care Management Staff | Required |
| **Service Coordination** | | | | | |
| **N83, N84** | **Case Conference** | Discussions with a primary care provider or HIV specialist to jointly assess and evaluate clients, coordinate services, and assess progress toward care/service plan goals. May also include patient and other service providers such as patient navigators, pharmacists, behavioral health providers and other members of the care team. | Initial case conferences with health care providers must be conducted within 45 days of program enrollment. Patient attendance recommended. May be conducted by telephone or videoconference. | Case Manager | Required |

**2. Proposal Instructions**

Complete relevant section of the Structured Proposal Form - Attachment A.

**3. Evaluation**

This section is worth a maximum of 35 points in the Proposal Evaluation and will be evaluated based on the extent to which the applicant responds comprehensively to the questions on the Structured Proposal Form.

- Applicants that propose to provide optional services **(see Table 2,** page 25) will receive a higher score.

***Service Category 2: The Undetectables Viral Load Suppression Peer Learning Network***

**1. Project Expectations**

*Under the program framework, the Subrecipient will:*

a. Ensure Program Coordinator completes all trainings in The Undetectables five-part training series, provided by the contracted Undetectables Technical Assistance Provider, during the first year of the subcontract. Additional staff are encouraged to participate in the training series. Case managers who work with clients enrolled in the program must complete the "Case Management for VLS" training within the first year of the program. *Staff who completed trainings in the past are exempt but encouraged to participate as a refresher and share lessons learned during trainings, when relevant.*

   i. Participate in The Undetectables Viral Load Suppression Consortium of stakeholders through quarterly roundtable discussions and other community stakeholder meetings.

   ii. As experienced implementors of this program, subrecipients will collaborate with the contracted Undetectables Technical Assistance Provider to plan roundtables and contribute their own implementation and quality improvement strategies as well as lessons learned during discussions and group activities.

   iii. Each subrecipient will co-facilitate at least one roundtable with the contracted Undetectables Technical Assistance Provider per year.

b. Collaborate with the contracted Undetectables Technical Assistance Provider to identify program needs and update the Program Implementation Plan during the start-up period.

c. Maintain an organizational culture focused on achieving "Viral Load Suppression for All," including trainings by the Program Coordinator for all levels of staff to understand the importance of VLS for individual and community health, as needed.

d. Implement a social marketing campaign using the materials provided by the contracted Undetectables Technical Assistance Provider which can be tailored to each individual agency. Additionally, subrecipients may develop materials internally with approval from the Health Department.

e. Obtain buy-in from your organization's existing HIV care management program leadership and staff to continue collaborative implementation of The Undetectables Program (including all required services as well as any optional services in Table 1).

f. Conduct outreach and in-reach (including the use of social media) to enroll clients who meet the definition under ***Priority Populations*** (page 18) using the caseload parameters outlined on page 4 as a guide.

    i. *Optional:* Programs may expand enrollment and implementation (e.g., expand to additional agency sites, to a specific sub-population within the priority population, to an additional HIV care management program).

g. Integrate The Undetectables Toolkit into existing HIV care management programs by working closely with existing HIV care management staff to ensure timely assessments, and delivery of evidence-based adherence support tools in the toolkit.

    i. Conduct case conferences that include the HIV primary care provider and HIV care manager. The client's participation in the case conference is strongly encouraged.

    ii. Drawing on the comprehensive assessment process and using motivational interviewing, collaborate with the client to develop an ART adherence care plan to set goals for their participation in the program, services to be provided by program staff, and action steps to be taken to achieve service plan goals.

        - Specific tools in The Undetectables Toolkit will be incorporated into the care plan based on assessments, care planning, and case conferencing.
        - Format and frequency of care plan updates is determined by the existing HIV care management program (e.g., Ryan White Care Coordination, Ryan-White Retention and Adherence Program, Health Homes Care Coordination). However, every client should be regularly assessed to evaluate progress toward achieving goals, changing needs, strengths, and challenges to inform care plan updates or case closure.

    iii. Provide evidence-based, trauma-informed, and client-centered tools in The Undetectables Toolkit, as outlined in this RFP, to promote treatment adherence and support clients' health and well-being.

    iv. Completing a reassessment of the client's health, psychosocial status and service needs every six months to inform care plan updates or case closure.

h. Ensure collection of timely lab results for all clients and timely distribution of financial incentives (i.e., $100 unrestricted gift card that is not specific to a single retailer) to clients for achieving or maintaining viral load suppression (<200 copies/mL) up to four times per year with new quarterly lab work. To receive an incentive, new labs must be dated at least 90 days since the labs that resulted in the previous incentive.

    i. Obtain client's recent HIV lab results at the time of enrollment to establish a baseline viral load. ***If lab results are more than three months old at the time of enrollment, new labs should be ordered within one week of enrollment to establish a baseline viral load***.

**2. Proposal Instructions**

Complete relevant section of the Structured Proposal Form – Attachment A.

**3. Evaluation**

This section is worth a maximum of 35 points in the Proposal Evaluation and will be evaluated based on the extent to which the applicant responds comprehensively to the questions on the Structured Proposal Form.

- Applicants that propose to provide optional services **(see Table 2,** page 25) will receive a higher score.
- Applicants that describe how they plan to expand the program within their organization (e.g., implementation at additional locations, integrating into additional HIV care management program(s), engaging new sub-population) will receive a higher score.

***Service Category 3: Crystal Methamphetamine Harm Reduction Services***

**1. Project Expectations**

*Under the program framework, the Subrecipient will:*

a. Employ multiple methods of outreach and recruitment—including use of social media, in-person outreach in areas of known crystal methamphetamine use, and general education—to enroll clients who meet the definition under ***Priority Populations*** (page 20) using the caseload parameters outlined on page 4 as a guide.

b. Follow an evidence-based/informed approach to deliver services that are client-centered, non-judgmental, guided by harm reduction principles, trauma-informed, and tailored to the populations outlined in the RFP. The use incentives to recognize program participation, achievement of milestones in their service plans, or sobriety may also be utilized.

c. Implement initial assessment, reassessment, and service planning with enrolled clients, including:

   i. Conduct a comprehensive assessment at intake of health, psychosocial status, and service needs.

   ii. Re-assess each client at least every six months to evaluate progress toward achieving goals as well as emerging needs, strengths, and challenges to inform service plan updates or case closure.

   iii. Drawing on the comprehensive assessment process and using motivational interviewing, collaborate with the client to develop a service plan to set SMART (specific, measurable, appropriate, realistic, and time-bound) goals for their participation in the program, services to be provided by program staff, and action steps to be taken to achieve service plan goals.

   iv. *Optional:* Programs may outline a comprehensive plan to meet quarterly with clients to obtain feedback and collaborate on program quality improvement.

d. Provide high quality evidence-based counseling and health education to address trauma and stigma, build skills, promote self-management, and encourage healthy decision-making both individually and in groups.

e. Coordinate all levels of medical and behavioral health care, as needed. This includes ensuring linkage to and engagement in needed clinical and social services as identified in assessments and reassessments. This may include linkages to internal organization services and/or providing referrals to partner programs and organizations for needed medical or specialty care services, mental health services, substance use services, health care coordination services, HIV care/prevention services (including PrEP/PEP) and other social support services when identified as needed.

    i. Applicants providing PrEP and PEP must be a New York State PrEP AP provider as well as licensed to prescribe the medication. Applicants that do not directly provide this service but propose to provide it as part of the program through referral under an MOU must demonstrate that the clinical provider is a New York State PrEP AP provider at the time of proposal submission.

**Table 3: Services to be delivered under *Service Category 3 (Crystal Methamphetamine Harm Reduction Services)***

| PHS Code | Service Type | Service Description | Service Standard | Staff Responsible | Required/Optional |
|---|---|---|---|---|---|
| **Outreach** | | | | | |
| **545** | **Targeted Case Finding** | Activities undertaken to identify and engage face-to-face with those who meet the eligibility criteria for the program. Includes outreach in settings where target population is known to reside or congregate as well as in-reach to eligible clients within the organization. | Targeted case finding is an event that must be at least 2 hours in duration AND reach at least 10 people OR result in obtaining contact information from at least 3 participants for program enrollment. | Patient Navigator | Required |
| **Planning and Assessment** | | | | | |
| **115** | **Intake Assessment** | Initial assessment of health, psychosocial status and service needs to facilitate plan development. May include:<br>• Documenting eligibility for services and obtaining information for program enrollment<br>• Gathering demographic data, HIV diagnosis information, insurance coverage information, involvement in criminal justice system<br>• Evaluating financial and housing status, substance use, mental health, risk behavior, and general health and well-being | Intake assessment must be completed within 45 days of program enrollment. | Case Manager | Required |
| **225** | **Service Plan Development** | Development of a client-centered service plan in response to the initial comprehensive assessment, listing client's goals for participation in the program, the actions that both the client and program staff will take to achieve goals, program services that will be delivered and service frequency. | Initial service plan must be completed within 45 days of program enrollment. All plans must be personalized to reflect each client's individual needs. Each goal should have at least one objective/ action step that describes what the client will do to meet the goal and at least one objective/ action step that describes what the program will do to help the client meet the goal. | Case Manager | Required |
| **076** | **Reassessment** | Follow up assessment to re-evaluate and record client eligibility, engagement in care and services, emerging health and service needs, progress towards achieving | Reassessment must occur at least every six months. | Case Manager | Required |

| PHS Code | Service Type | Service Description | Service Standard | Staff Responsible | Required/Optional |
|---|---|---|---|---|---|
| | | service plan goals, substance use, mental health, and risk behaviors. Re-assessment facilitates service plan updates. | | | |
| **226** | **Service Plan Update** | Review of service plan to evaluate progress toward achieving goals and make revisions in response to the reassessment or emerging needs. | Service plans must be updated at least every six months within 30 days of reassessment. | Case Manager | Required |
| **AOD Services** | | | | | |
| **049** | **AOD Counseling (Individual)** | One-to-one therapeutic counseling to address substance use, abuse, and harm reduction. Counseling may cover education, skill building, sexual behavior, recovery readiness, living skills, adherence to care and treatment, provider/patient relationship, secondary prevention, and tobacco use among other topics. Counseling modalities include, but are not limited to, motivational interviewing, cognitive behavioral therapy, and contingency management. | No additional standard. | Counselor | Required |
| **P87** | **AOD Counseling (Group)** | Group therapeutic counseling to address substance use, abuse, and harm reduction. Counseling may cover education, skill building, sexual behavior, recovery readiness, living skills, adherence to care and treatment, provider/patient relationship, secondary prevention, and tobacco use among other topics. Counseling modalities include, but are not limited to, motivational interviewing, cognitive behavioral therapy, and contingency management. | Groups must have at least 3 participants. At least 1 participant must be enrolled in the program. | Counselor | Required |
| **239** | **Overdose Prevention Training (Individual)** | One-to-one overdose prevention education and training. Session includes dispensing or prescribing naloxone (Narcan) or providing information about how to obtain naloxone from a pharmacy or another source. | No additional standard | Any staff member trained to provide the service | Optional |
| **Q12** | **Overdose Prevention Training (Group)** | Group overdose prevention education and training. Session includes dispensing or prescribing naloxone (Narcan) or providing information about how to obtain naloxone from a pharmacy or another source. | Groups must have at least 3 participants. At least 1 participant must be enrolled in the program. | Any staff member trained to provide the service | Optional |

| PHS Code | Service Type | Service Description | Service Standard | Staff Responsible | Required/Optional |
|---|---|---|---|---|---|
| **Mental Health Services** | | | | | |
| **050** | **Mental Health Counseling (Individual)** | One-to-one psychotherapeutic counseling session conducted to address a diagnosed mental health condition. | Each session is at least 45 minutes. | Mental health services: Licensed Mental Health Clinician | Required |
| **P88** | **Mental Health Counseling (Group)** | Group psychotherapeutic counseling session conducted to address a diagnosed mental health condition. | Each session is at least 60 minutes. Groups must have at least 3 participants. At least 1 participant must be enrolled in the program. | Mental health services: Licensed Mental Health Clinician | Required |
| **Navigation** | | | | | |
| **P85** | **Client Assistance** | Administrative activities and tasks associated with helping client gain access to health care, supportive services, housing, entitlements and benefits, and other needed services. Activities may occur with the client or on their behalf and include compiling documentation to demonstrate eligibility for services, assisting with the completion of forms and other necessary paperwork, calling to make appointments, and other administrative tasks required to connect the client to needed services. | No additional standard | Patient Navigator | Required |
| **030** | **Accompaniment** | Accompanying client to health and supportive service appointments. Service may be initiated from the client's home, program site or another location, including the site of the appointment. Service may include:<br>• navigating transportation systems with clients<br>• accompanying clients to help them locate the site of service, gain entrance, and check in and out | Type 1: Delivering the service requires staff to use transportation.<br>Type 2: Delivering the service does not require staff to use transportation. | Patient Navigator | Required |

| PHS Code | Service Type | Service Description | Service Standard | Staff Responsible | Required/Optional |
|---|---|---|---|---|---|
| | | • language interpretation (where permitted), emotional support, coaching, and advocacy during the appointment | | | |
| **P55** | **Client Engagement** | Activities to remind clients of upcoming appointments for services provided by the program. Includes both phone calls and face-to-face reminders. | Type 1: When service is delivered by phone, text message, or email message, program staff must achieve contact with the client. Voicemails, text messages and email messages that do not receive a response do not meet the standard for Client Engagement.<br>Type 2: Client engagement services delivered in the field meet the standard even when clients are unable to be found. | Patient Navigator | Required |
| **P69** | **Linkage to Services** | Verification that a client attended an appointment or followed through on a referral to initiate a relationship with a provider of supportive services or healthcare services following a referral from program staff. This includes but is not limited to harm reduction services; services that address clients' basic needs (e.g., food, shelter, and hygiene products/facilities); employment services; legal services; psycho-education counseling; substance abuse counseling; dental care; and specialty care (e.g., gynecology, oncology). | Attendance must be verified. If client attends unaccompanied, program may verify through contact with provider or patient self-report. | Patient Navigator | Required |
| **TBA** | **Provision of PrEP / PEP** | Internal linkage to PrEP or PEP via prescription or direct distribution of starter kit (PEP). Provider should link uninsured clients to programs or services that provide medications free of charge or assist with coverage. A list of resources will be provided upon award. | No additional standard | Case Manager | Required |
| **P29** | **Coordination with Service Providers** | Direct communication with other service providers with whom a client is shared to inform service planning, coordinate services, avoid duplication of effort and collaboratively support engagement in care and treatment. | No additional standard | Patient Navigator | Required |

| PHS Code | Service Type | Service Description | Service Standard | Staff Responsible | Required/Optional |
|---|---|---|---|---|---|
| **P56** | **Outreach for Client Re-engagement** | Activities to locate an enrolled client who, without providing prior notification, has missed an appointment for health or supportive services. Activities may include phone calls, letters, text messages, emails or in-person visits to the client's residence or other locations the client is known to frequent. | This service is reportable only in the 90 days following the most recent missed appointment. If the client is not reachable within 90 days of that missed appointment, their enrollment should be closed (though it may be re-opened if/when the client is found again). | Patient Navigator | Required |
| **Health Education** | | | | | |
| **221** | **Health Education (Individual)** | One-to-one educational session covering one or more health promotion topics in response to client's needs and interests. Sessions follow a semi-structured format and may cover HIV biology, care management, communication with providers, substance use, behavioral health, social support, harm reduction, wellness, adherence to care and treatment and other areas. | No additional standard | Patient Navigator | Required |
| **Q20** | **Health Education (Group)** | Group educational session covering one or more health promotion topics. Sessions follow a semi-structured format and may cover HIV biology, care management, communication with providers, substance use, behavioral health, social support, harm reduction, wellness, adherence to care and treatment and other areas. | Groups must have at least 3 participants and at least 1 participant must be enrolled in the program. | Case Manager | Required |

**2. Proposal Instructions**

Complete relevant section of the Structured Proposal Form – Attachment A.

**3. Evaluation**

This section is worth a maximum of 35 points in the Proposal Evaluation and will be evaluated based on the extent to which the applicant responds comprehensively to the questions on the Structured Proposal Form.

- Applicants that propose to provide optional services **(see Table 3,** page 31) will receive a higher score.
- Applicants that outline a comprehensive plan to meet quarterly with clients to obtain feedback and collaborate on program quality improvement will receive a higher score.

## C. Organizational Structure and Staffing Plan *(20 points)*

**1. Program Expectations**

**Organizational Structure**

*For Service Category 1: The Undetectables Viral Load Suppression Program,* the Subrecipient should:

a. Outline a plan to begin operation of the proposed program within six months of subcontract term start date integrating this program into the organization's existing programs and services. In the plan, the applicant must describe:
   i. How the proposed program aligns with the organization's history and mission;
   ii. The organizational, programmatic, managerial, and financial systems in place to perform the services described in this RFP within six months of subcontract term start date.

*For Service Category 2: The Undetectables VLS Peer Learning Network,* the Subrecipient should

a. Outline a plan to maintain operation of The Undetectables, that includes assessing existing Undetectables clients for case closure or continued enrollment in the program.

*For Service Category 3: Crystal Methamphetamine Harm Reduction Services*, the Subrecipient should:

a. Outline a plan to begin operation of the proposed program within six months of subcontract term start date integrating this program into the organization's existing programs and services. In the plan, the applicant must describe:
   iii. How the proposed program aligns with the organization's history and mission;
   iv. The organizational, programmatic, managerial, and financial systems in place to perform the services described in this RFP within six months of subcontract term start date.

**Staffing Plan**

*For all Service Categories, the Subrecipient should:*

a. Develop and implement a staffing plan to ensure delivery and oversight of all program services, data management, and subcontract award management and reporting. The staffing plan should include a description of how the applicant will fill vacancies as well as cover for vacancies to ensure service continuity.

b. Implement recruitment and advancement policies and procedures to promote employment and retention of those who are representative of the priority populations being served through this RFP and who provide services in the languages preferred by the clients they serve. *Those who are representative share the demographic characteristics of those served by the program (e.g. gender, sexual orientation, or race/ethnicity) or aspects of their lived experiences.* Such staff may be employed as peer workers or in any role for which they are qualified.

c. Ensure that staff for this program are trained and competent in cultural responsiveness, motivational interviewing, and other content and skills pertinent to the services provided. Training requirements will be finalized when subcontracts are executed.

*For Service Category 3: Crystal Methamphetamine Harm Reduction Services*, the applicant should complete the staffing table in the corresponding section of the structured proposal form.

- ***Optional:*** For positions that will be filled by existing staff, the applicant may opt to report whether staff have NYS AI Peer Certification or share any of the characteristics that are representative of the priority populations for the program: history of using crystal meth or other stimulants; history of using drugs while engaging in sex; or MSM or LGBTQ.

**Program Staffing:**

*For Service Category 1: The Undetectables Viral Load Suppression Program:*

a. **Program Coordinator is a required program position;** up to 1.0 FTE may be covered under the program's budget.

   Function: With the support of the contracted Undetectables Technical Assistance Provider, this individual will be responsible for coordinating the implementation of all components of The Undetectables Program at the funded agency, including completion of the Organizational Readiness Assessment and the Program Implementation Plan, training of all relevant staff on The Undetectables program model, and social marketing development and distribution. Responsible for ensuring case managers deliver all services in The Undetectables Toolkit to clients based on client need. Responsible for ensuring that Undetectables program enrollment, timely intake assessment, semi-annual reassessments, and complete documentation of services and viral load lab reports occurs.

   Recommended qualifications: Experience relevant to carry out functions of the position. May be demonstrated by associate's degree or higher, years of experience, or training in case management, organizational development, practice transformation, or other applicable topics.

b. **Data Specialist is a required program position;** up to 1.0 FTE may be covered under the program's budget**.**

Function: Collect and enter Undetectables data into eSHARE and other systems as needed. Ensure accuracy and completeness of data, establishing protocols, providing internal status reports, managing data, and assuring quality.

Recommended qualifications: N/A

c. **Case Manager –** While subrecipients must integrate The Undetectables into their existing HIV care management programs, they *may* opt to cover a case manager (up to 1.0 FTE) under the budget of the proposed program to provide additional support for implementation.

Function: Conduct Undetectables program enrollment, intake assessments, and reassessments, as needed. Deliver services in The Undetectables Toolkit to clients based on assessments, case conferences, and care planning. Routinely communicate and collaborate with HIV primary care providers and other medical and non-medical support service providers who are engaged with the client.

Recommended qualifications: Training in assessment, service planning, motivational interviewing, psychoeducation (e.g. mental health first aid), care coordination, case conferencing, monitoring and follow-up. May be demonstrated by a degree in counseling, CASAC or similar certification, training certificates of completion, or years of experience providing case management or similar work

*For Service Category 2: The Undetectables Viral Load Suppression Peer Learning Network:*

a. **Program Coordinator is a required program position;** up to 1.0 FTE may be covered under the program's budget.

Function: With the support of the contracted Undetectables Technical Assistance Provider, this individual will be responsible for coordinating the implementation of all components of The Undetectables Program at the funded agency, including updating the Program Implementation Plan, training of all relevant staff on The Undetectables program model, and social marketing development and distribution. Responsible for ensuring case managers deliver all services in The Undetectables Toolkit to clients based on client need. Responsible for ensuring that Undetectables program enrollment, timely intake assessment, semi-annual reassessments, and complete documentation of services and viral load lab reports occurs. Responsible for participating in the planning and co-facilitating of roundtable discussions with the contracted Undetectables Technical Assistance Provider.

Recommended Qualifications: Experience relevant to carry out functions of the position. May be demonstrated by associate's degree or higher, years of experience, or training in case management, organizational development, practice transformation, or other applicable topics.

b. **Data Specialist is a required program position;** up to 1.0 FTE may be covered under the program's budget.

Function: Collect and enter Undetectables data into eSHARE and other systems as needed. Ensure accuracy and completeness of data, establishing protocols, providing internal status reports, managing data, and assuring quality.

Recommended qualifications: N/A

c. **Case Manager –** While subrecipients must integrate The Undetectables into their existing HIV care management programs, they *may* opt to cover a case manager (up to 1.0 FTE) under the budget of the proposed program to provide additional support for implementation.

Function: Conduct Undetectables program enrollment, intake assessments, and reassessments, as needed. Deliver services in The Undetectables Toolkit to clients based on assessments, case conferences, and care planning. Routinely communicate and collaborate with HIV primary care providers and other medical and non-medical support service providers who are engaged with the client.

Recommended qualifications: Training in assessment, service planning, motivational interviewing, psychoeducation (e.g. mental health first aid), care coordination, case conferencing, monitoring and follow-up. May be demonstrated by a degree in counseling, CASAC or similar certification, training certificates of completion, or years of experience providing case management or similar work.

*For Service Category 3: Crystal Methamphetamine Harm Reduction Services:*

a. **Case Manager is a required program position;** up to 1.0 FTE may be covered under the program's budget.

Function: Conduct comprehensive assessment and regular reassessments. Guide service planning and updates. Routinely communicate and collaborate with health care providers and other medical and non-medical support service providers who are engaged with the client. Facilitate linkages to support and medical services. Help clients obtain coverage for needed care (e.g., Medicaid, health insurance exchange/marketplace, PrEP assistance programs, etc.).

Recommended qualifications: Training in assessment, service planning, motivational interviewing, psychoeducation (e.g. mental health first aid), care coordination, case conferencing, monitoring and follow-up. May be demonstrated by a degree in counseling, CASAC or similar certification, training certificates of completion, or years of experience providing case management or similar work.

b. **Mental Health Provider is a required program position;** up to 1.0 FTE may be covered under the program's budget.

Function: Conduct individual counseling and group counseling and support sessions. Coordinate care in partnership with the case manager. Conduct clinical supervision.

Required qualifications: Must be licensed to provide mental health counseling services and have experience delivering services and providing mental health care to those who use substances. While not an exhaustive list, the following are examples of professionals who may be qualified to provide services under the program:

- Mental Health Counselors
- Psychoanalysts
- Psychiatric Nurse Practitioners
- Psychologist
- Licensed Master Social Worker (LMSW) or Licensed Clinical Social Worker (LCSW)

c. **Data Specialist is a required program position;** up to 1.0 FTE may be covered under the program's budget.

Function: Collect and enter data into eSHARE and other systems as needed. Ensure accuracy and completeness of data, establishing protocols, providing internal status reports, managing data, and assuring quality.

Recommended qualifications: N/A

d. **Patient Navigator –** Programs must provide patient navigation services. However, the functions of the position may be carried out other qualified program staff who provide direct client services: case manager, mental health provider, substance use counselor. Programs that opt to staff the proposed program with a patient navigator may cover up to 1.0 FTE under the program's budget.

Functions: Conduct outreach and case finding. Help clients navigate systems to obtain needed health and social services. Deliver health education, provide coaching, and role model. Reach out to clients who disengage from the program to check on their well-being and address barriers to care.

Recommended qualifications: a staff person who, in their professional role, draws on life experiences shared by the clients they serve and who is trained in coaching, setting boundaries, motivational interviewing. May be demonstrated by training certificates of completion, years of experience providing case management or similar work, or NYS AIDS Institute Peer Worker certification (completed or in progress).

e. **Substance Use Counselor –** Programs must provide substance use counseling services. However, the functions of the position may be carried out other qualified program staff who provide direct client services: case manager or mental health provider. Programs that opt to staff the proposed program with a substance use counselor may cover up to 1.0 FTE under the program's budget.

Functions: Conduct intake assessments, individual counseling sessions and group counseling sessions. Conduct care coordination activities in partnership with the case manager.

Required qualifications: Credentialed alcoholism and substance abuse counselor (CASAC) or CASAC in training (CASAC-T).

**2. Proposal Instructions**

a. Complete the relevant section of the Structured Proposal Form – Attachment A.

b. Complete Staffing Plan Table in Attachment D.

c. Attach an organization chart to show where the proposed project will fit into the organization's structure.

**3. Evaluation**

This section is worth a maximum of 20 points in the Proposal Evaluation and will be evaluated based on the extent to which the applicant responds comprehensively to questions on the Structured Proposal Form.

- *For Service Category 3*: Applicants that will employ existing staff who have NYS AIDS Institute Peer Certification or share specified characteristics with the priority populations will receive a higher score.

**D. Confidentiality, Privacy, and Data Security** *(5 points)*

**1. All Service Categories Program Expectations**

a. Subrecipients will have policies and procedures in place to ensure client confidentiality and data security in compliance with all applicable local, state, and federal laws and regulations, including but not limited to HIPAA.

**2. Proposal Instructions**

Complete the Confidentiality section of the Structured Proposal Form - Attachment A.

**3. Evaluation**

This section is worth a maximum of 5 points in the Proposal Evaluation and will be evaluated based on the extent to which the applicant responds comprehensively to questions on the Structured Proposal Form.

**E. Program Monitoring and Evaluation, Data Management, and Reporting** *(5 points)*

**1. All Service Categories Program Expectations**

*The Subrecipient will:*

a. Implement protocols to collect, analyze, and report all required client-level and project data, ensure quality, evaluate program performance, and engage in continuous quality improvement.

i. Maintain records for each enrolled client including but not limited to client full name, date of birth, sex assigned at birth, gender identity, race, ethnicity, income, housing status, ZIP code of residence, HIV status, HIV risk factors, and ART prescription status.

ii. Identify staff, by title, who are responsible for maintaining documentation and according to written policies and procedures.

iii. Document a process for ensuring consistency and accuracy of data collection.

iv. Describe the steps from service delivery to documentation and data entry into the required reporting system (currently eSHARE).

v. Record and report client-level and service-level data in the required reporting system (eSHARE) by the 15th of every month (representing all clients/services in the prior month), for the duration of the subcontract, including assessment, program service, and clinical data.

b. Regularly seek and report feedback from clients about the quality of services and collaborate with clients to improve program quality.

*For Service Categories 1 and 2:*

In addition to the expectations listed for all service categories, applicants for Service Categories 1 and 2 should:

a. Have access to an electronic medical record (eMR), either internally or through a written agreement (e.g., memorandum of understanding) so that client records showing engagement in care and laboratory reports are accessible to The Undetectables program staff.

*For Service Category 3:*

In addition to the expectations listed for all service categories, applicants for Service Category 3 should:

a. Have a process for the internal documentation of services and the quality management of reporting service delivery.

**2. Proposal Instructions**

Complete the Program Monitoring, Data Management, and Reporting section of the Structured Proposal Form - Attachment A.

**3. Evaluation**

This section is worth a maximum of 5 points in the Proposal Evaluation and will be evaluated based on the extent to which the applicant responds comprehensively to the questions on the Structured Proposal Form.

**F. Budget Management** *(10 points)*

**1. All Service Categories Budget Expectations**

(See **Table 1, Basic Information,** pages 2-6 of this RFP for available funding, number of awards, and award ranges)

a. Applicants should demonstrate the capacity to manage budgets and monitor expenditures, ensuring that costs reported for reimbursement are accurate and allowable.

i. *For Service Categories 1 and 2*: The applicant must have demonstrated capacity to deliver financial incentives to clients including written policies and procedures for ensuring that the incentives are secured, tracked, and distributed appropriately to prevent loss or theft.

ii. *For Service Category 3*: The applicant must have demonstrated capacity to deliver incentives encouraging client participation in program services and/or as part of

contingency management participation. Examples of these incentives may include financial (including monetary certificates/vouchers), material items, and transportation reimbursement or compensation. Capacity includes written policies and procedures for ensuring that the incentives are secured, tracked, and distributed appropriately to prevent loss or theft.

b. The subrecipient will develop and implement a budget that is consistent with the provision of services for the selected service category and the number of clients served. Applicants must specify the number of clients they propose to serve during a typical full year of program operation at normal capacity after start-up. Proposal budgets must be realistic and cover all resources needed to implement the program as proposed. Applicants should propose an annual budget representing a full year of full program operation at normal capacity after start-up. The budget must include:

   i. Salaries for key staff per the service category, corresponding to the experience and qualifications needed to carry out assigned roles. Salaries or wages should comply with The Fair Wages for New Yorkers Act, as applicable.

   ii. All other than personnel services expenses needed to complete the proposed activities.

   iii. Any indirect costs requested by the applicant, in accordance with the *City of New York Health and Human Services Cost Policies and Procedures Manual* (*https://www1.nyc.gov/assets/nonprofits/downloads/pdf/NYC%20HHS%20Cost%20Policies%20and%20Procedures%20Manual_8.25.20.pdf*; hereafter referred to as "Cost Manual"). Per the Cost Manual, if requesting indirect costs, options include:

      1. At or below 10% de minimus Indirect Cost Rate (ICR) applied to a modified total direct cost base.
      2. If available, an organization's federally negotiated Indirect Cost Rate, specified within a Negotiated Indirect Cost Rate Agreement (NICRA), applied to a modified total direct cost base. If selecting this option, applicant must enclose a copy of its NICRA with application.
      3. If available, an organization's New York City-approved Indirect Cost Rate, specified within an Independent Accountant's Report signed by an independent Certified Public Accountant, applied to a modified total direct cost base. If selecting this option, applicant must enclose a copy of its Accepted ICR and Verification Documentation, which the City would have previously uploaded to the applicant's organizational profile in PASSPort.

**2. <u>Proposal Instructions</u>**

Complete the Budget Management section of the Structured Proposal Form (Attachment A), the Budget form (Attachment B), and the Service Projections (Attachment C1-2 or Attachment C3).

**3. <u>Evaluation</u>**

This section is worth a maximum of 10 points in the Proposal Evaluation will be evaluated based on the extent to which the applicant a) presents a budget plan that accurately reflects the program proposed and delivers value according to the number of clients served as well as the types and number of services provided, and b) comprehensively responds to questions on the Structured Proposal Form.

- Higher scores will be awarded to applicants whose **cost per client** (the annual budget representing a full year of full program operation at normal capacity after start-up DIVIDED BY the number of clients served during a typical full year of program operation at normal capacity after start-up) does not exceed the following thresholds:
  - Service Category 1: $1,147 per client
  - Service Category 2: $960 per client
  - Service Category 3:
    - $6,000 per client (for programs that propose to provide contingency management services **and** opt to cover both a patient navigator and substance use counselor on the budget)
    - $4,000 per client for all other proposed programs

## Section 3 – List of Attachments

**A. The following attachments for this RFP can be downloaded from the PHS Procurement Portal:**

**https://healthsolutions.bonfirehub.com/portal/?tab=openOpportunities**

1. Attachment A: Structured Proposal Form *(must be submitted in MS Word)*
2. Attachment B: RFP Budget Template Form *(must be submitted in MS Excel)*
3. Attachment C1-2: ETE Service Projection Template-SC1 & SC2 UND *(must be submitted in MS Excel)*
4. Attachment C3: ETE Service Projection Template-SC3 MTH *(must be submitted in MS Excel)*
5. Attachment D: Organization and Program Information *(must be submitted in MS Excel)*
6. Attachment H: Board of Directors' Statement Template (template provided)
7. Attachment I: PHS Procurement Portal – Asking a Question Instructions
8. Attachment J: Sharing Documents to Public Health Solutions in the Document Vault

**B. The following Required Documents must be submitted via Public Health Solutions Bonfire Procurement Portal:**

1. Attachment A: Structured Proposal Form *(must be submitted in MS Word)*
2. Attachment B: RFP Budget Template Form *(must be submitted in MS Excel)*
3. Attachment C1-2: ETE Service Projection Template-SC1 & SC2 UND *(must be submitted in MS Excel)*

   ***OR***

   Attachment C3: ETE Service Projection Template-SC3 MTH *(must be submitted in MS Excel)*
4. Attachment D: Organization and Program Information *(must be submitted in MS Excel)*
5. Attachment E: Program Organizational Chart *(no template provided)*
6. Attachment F: Curricula Vitae or Resumes of Key Staff *(no template provided)*
7. Attachment G: Linkage Agreement (LA) / Memorandum of Understanding (MOU) / Memorandum of Agreement (MOA) with collaborative partner organization(s), *if any (no template provided)*
8. Attachment H: Board of Directors' Statement Template *(template provided)*
9. Internal Revenue Service 501(c)(3) Determination Letter
10. New York State Certificate of Incorporation
11. Current Board of Directors List
12. Article 28 License, *if applying for Service Category 1 or Service Category 2,* to document that the applicant is licensed to provide HIV medical care (i.e., prescribe ART and monitor viral load) ***OR*** a written agreement (e.g., memorandum of understanding) with a licensed provider of HIV primary care.
13. Most recent audited Annual Financial Statement; if total expenditures associated with federal funding exceed $750,000 a year, a Single Audit Report is required.

## Section 4 – Basis for Subawards and Procedures

**Proposal Evaluation**

All proposals received by PHS will be reviewed to determine whether they are responsive or non-responsive to the requirements of this RFP. Proposals that are determined by PHS and DOHMH to be non-responsive will be rejected. The DOHMH evaluation committee will review and rate each responsive proposal. The proposals will be ranked in order of highest to lowest technical score. PHS and DOHMH reserve the right to conduct site visits and/or interviews and/or to request that proposers make presentations and/or demonstrations, as PHS and DOHMH deem applicable and appropriate. Although discussions may be conducted with proposers submitting responsive and fundable proposals, PHS and DOHMH may make award decisions based on initial proposals received, without discussions; therefore, the proposer's initial proposal should contain its best programmatic and cost terms.

**Subawards**

Subawards will be given to the responsible applicants whose proposal(s) is determined to be the most qualified to PHS, in collaboration with the Health Department, taking into consideration the factors which are set forth in this RFP. Subawards will be made to the highest rated applicants whose proposals are technically viable. However, PHS, in collaboration with the Health Department, may:

- Make subaward funding decisions out of rank order to ensure appropriate distribution of services across geographic areas.
- Not make subawards in one or more geographic areas depending on availability of funding or need.
- Make more than one subaward per geographic area or increase the number of units served by a subrecipient if additional funding becomes available.
- Prior to subaward execution, determine the length of the initial subaward term and each option to renew, if any.
- Prior to subaward execution and during the term of the subaward (by written agreement), change the reimbursement structure/model, program service size, and program type depending on the needs of the system.

Subawards shall be subject to timely completion of negotiations between PHS and the subrecipients.

Final subaward decisions will be made by PHS in collaboration with the Health Department. At the discretion of the Health Department, final subawards may be less than requested to distribute funds among subrecipients to ensure adequate distribution of services throughout NYC.

Final subaward decisions may also consider past subaward performance (if applicant has current subaward(s) or had subawards within the last two years with PHS) or reference/background checks for applicants without any prior or recent contracting relationship with PHS.

Final subaward execution is contingent upon successful completion of negotiations; vendor background check; and demonstration of all required insurance coverage and all other requirements of and approvals by PHS, the Health Department, the City of New York, the State of New York, and the U.S. government, as applicable.

## Section 5 – Insurance Requirements

The following insurance requirements will be incorporated into the final agreements with Public Health Solutions:

Insurance Requirements

a. The Subrecipient shall maintain workers' compensation insurance, employers' liability insurance, and disability benefits insurance, in accordance with law on behalf of, or regarding, all employees providing services under the Agreement.

b. The Subrecipient represents and warrants that it has, and covenants to maintain continuously during the term of the Agreement, the following types of insurance, as applicable:

    i. Commercial general liability insurance, covering operations under the Agreement, in amounts as follows: one million dollars ($1,000,000) per occurrence; one million dollars ($1,000,000) personal and advertising injury (unless waived in writing by the Department); two million dollars ($2,000,000) in the aggregate. Coverage must be at least as broad as the coverage provided by the most recently issued ISO Form CG 00 01, primary and non-contributory, and "occurrence" based rather than "claims-made". Such coverage shall list Public Health Solutions and the City of New York, including its officials and employees, as an additional insured with coverage at least as broad as the most recently issued ISO Form CG 20 10 or CG 20 26.

    ii. If vehicles are used in the provision of services under the Agreement, commercial automobile liability insurance for liability arising out of ownership, maintenance, or use of any owned, non-owned, or hired vehicles to be used in connection with the Agreement, in the amount of one million dollars ($1,000,000) per accident combined single limit. Coverage shall be at least as broad as the most recently issued ISO Form CA 00 01.

    iii. If Subrecipient is performing professional services under the Agreement, professional liability insurance or errors & omissions insurance of at least one million dollars ($1,000,000) per claim. Claims-made policies may be accepted for professional liability insurance. All such policies shall have an extended reporting period option or automatic coverage of not less than two years. If available as an option, the Subrecipient shall purchase extended reporting period coverage effective on cancellation or termination of such insurance unless a new policy is secured with a retroactive date, including at least the last policy year.

c. All insurance required above must be provided by companies that may lawfully issue such policies; have an A.M. Best rating of at least A- / VII, a Standard & Poor's rating of at least A, a Moody's Investors Service rating of at least A3, a Fitch Ratings rating of at least A-, or a similar rating by any other nationally recognized statistical rating organization acceptable to Public Health Solutions unless prior written approval is obtained from Public Health Solutions; and be primary (and non-contributing) to any insurance or self-insurance maintained by Public Health Solutions or the City.