REQUEST FOR PROPOSALS

Issued by
Public Health Solutions

On behalf of
New York City Department of Health and Mental Hygiene
Bureau of HIV/AIDS Prevention and Control

Ryan White Part A Services in the Tri-County Region

[Solicitation #: 2018.05.HIV.03.~~01~~02 (REVISED 6/28/2018)]

Issue Date: May 25, 2018

Proposals Due Date: August 7, 2018, 2:00pm EDT

RFP Contact: Mayna Gipson, Public Health Solutions

RFP Email: RWTriCountyRFP@healthsolutions.org

For a copy of this Request for Proposals, please go to:

https://www.healthsolutions.org/get-funding/request-for-proposals/

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RFP Timetable

The following are important dates and deadlines pertaining to the issuance of this Request for Proposals (RFP).

RFP Issue Date **May 25, 2018**

Pre-Proposal Conference **June 8, 2018, 10:00am - 1:00pm EDT**

There will be a Pre-Proposal Conference held for this RFP. Attendance at the Pre-Proposal Conference is not mandatory; however, those organizations interested in submitting a proposal are ***strongly*** urged to attend.

Please RSVP if you plan to attend via the RFP email address, ***RWTriCountyRFP@healthsolutions.org*** . RSVP is not required, but it is encouraged.

The Pre-Proposal Conference location is:
Westchester County Department of Social Services
10 County Center Road, Floor 2, DSS Training Room
White Plains, NY 10607
Parking is available and the Metro-North Railroad is nearby.

Deadline for Written Inquiries **June 14, 2018, 5:00pm EDT**

Questions about eligibility, proposal requirements or other requests for clarification about information in the RFP must be submitted via email to ***RWTriCountyRFP@healthsolutions.org*** no later than ***5:00pm on June 14, 2018***.

Responses to questions from the Pre-Proposal Conference, as well as questions submitted via email, may be addressed in a supplement to the RFP. The Supplement will also include the presentation slides from the Pre-Proposal Conference, and both will be posted on Public Health Solutions' website, **https://www.healthsolutions.org/get-funding/request-for-proposals/**

An email notification will be sent to all individuals that have registered on Public Health Solutions' RFP website and download the RFP, submitted questions via the RFP email and/or attended the Pre-Proposal Conference. Please note that *not all* written inquiries will receive written responses. *NYC DOHMH and Public Health Solutions reserve the right not to respond to questions received after **June 14, 2018**.*

Notice of Intent to Respond **July 31, 2018, 5:00pm EDT**

The Notice of Intent to Respond form is not mandatory; however, proposers interested in responding to this RFP are strongly urged to submit the form by the due date so that Public Health Solutions may be better able to plan for the proposal evaluation process. Any information related to this RFP will be emailed to the individual(s) designated as the Proposal Contact Person. The form should be submitted by email no later than ***July 31, 2018*** to ***RWTriCountyRFP@healthsolutions.org***

Proposals Due Date	**August 7, 2018, 2:00pm EDT**

NOTE: Please see Proposal Submission Instructions on page 93 of this RFP. To ensure that you have a working portal login, and to familiarize yourself with the CAMS Contracting Portal's Proposal Upload area, you should create and test the portal login at least one week before the proposal submission deadline.

Proposals received after ***2:00pm*** *on* ***August 7, 2018*** are late and shall not be accepted, except as provided under the New York City's Procurement Policy Board Rules.

Projected Award Notification Date	**October 2018**
Contract Start Date	**March 1, 2019**

RFP Contact

The RFP Contact is Mayna Gipson and the RFP email is ***RWTriCountyRFP@healthsolutions.org***

All inquiries concerning this RFP, from the date of issuance until contract awards are made, must be directed via email to the RFP Contact. *Organizations are advised that no contact related to this RFP is permitted with any other staff of Public Health Solutions or NYC DOHMH*.

General Information

Introduction

Since 1991, the federal government has provided emergency relief to cities and counties hardest hit by HIV and AIDS through the Ryan White HIV/AIDS Program, formerly known as the Ryan White CARE Act. Ryan White Part A funding is directed to eligible metropolitan areas (EMAs) and transitional grant areas (TGAs), including the New York EMA.

The Ryan White HIV/AIDS Program funding is administered by the federal Health Resources and Services Administration (HRSA), a division of the U.S. Department of Health and Human Services (HHS). The New York EMA includes the five boroughs of New York City (NYC) and the counties of Westchester, Rockland, and Putnam (Tri-County). In the New York EMA, the grantee for Part A funds is the New York City Department of Health and Mental Hygiene (NYC DOHMH). The HIV Health and Human Services Planning Council of New York (Planning Council), whose members are appointed by the Mayor, prioritizes service categories and allocates funds. The Planning Council also designs service directives that drive the development of programs. Public Health Solutions (PHS), under contract with NYC DOHMH, procures and administers contracts in the New York EMA.

Available Funds

The Planning Council has allocated funding for RWPA services in the Tri-County Region. Funding ranges are as follow (amounts reflect approximate annual contract amounts and are subject to change).

Service Category	Available Funding Amount	Anticipated Number of Awards	Annual Funding Range (min – max)
1. Food and Nutrition Services	$968,807	1-3	$322,936 - $968,807
2. Housing/Short Term Assistance Services	$585,008	1-2	$292,504 - $585,008
3. Medical Case Management Services	$1,388,093	3-7	$198,299 - $462,698
4. Mental Health Services	$99,697	1	$99,697
5. Oral Health Care Services	$186,986	1	$186,986
6. Psychosocial Support Services	$129,155	1-2	$64,578 - $129,155
7. Medical Transportation Services	$345,246	1	$345,246
8. Emergency Financial Services	$250,000	1	$250,000
Total	$3,952,992	10-18	

Proposed amounts must fall within the minimum and maximum range. However, final awards may be less than requested in order to meet the needs of target populations and to ensure adequate geographic distribution of services. The first funded year might start during the fiscal year and will be prorated accordingly.

The amount awarded to each successful applicant will be based on the merits of the proposal. Proposals will be evaluated according to the evaluation criteria outlined in this RFP (see Proposal Evaluation Criteria on page 85). The proposals will be ranked according to the score received. Those proposals ranked at or

above a score of 70% will be funded in order of their rank. Proposals may be funded outside of rank order to ensure:

1. Adequate geographic distribution of services, and
2. Adequate access to services by populations that are disproportionately affected by the HIV epidemic.

Note that this funding is not limited to currently funded organizations. Any organization that meets the general eligibility requirements and the program-specific eligibility requirements, as detailed in this RFP, may apply for these funds.

NYC DOHMH reserves the right to restrict the amount of funding should there be a reduction in funding or change in service category allocation by the Planning Council.

Notice to Currently Funded Programs

Organizations that are currently funded by NYC DOHMH through contracts with PHS to provide RWPA-funded services under any of these service categories in Tri-County ***must*** submit a proposal in response to this RFP to be considered for continuation of funding.

Contract Term

Contracts will be awarded for a term of up to three years with two 2-year renewal options. Initial and continued funding for all contracts is contingent upon the following:

- the yearly notification of grant award to the New York EMA from HRSA;
- availability of funds;
- spending priorities determined by the Planning Council;
- approval by NYC DOHMH;
- satisfactory contractor performance; and
- Continued compliance with all other terms and conditions of the award and contract agreement.

Organizations whose proposal are deemed fundable but not initially awarded a contract, due to funding limitations, may receive an award later if additional funds become available. Organizations will be advised in the funding notification letter if this potential for future funding applies to their proposal.

General Eligibility Requirements

All organizations applying to provide RWPA services must meet the organizational eligibility requirements described below.

General Organizational Eligibility Requirements

This RFP is intended to solicit proposals from non-profit organizations with experience serving people living with HIV/AIDS (PLWH), as well as experience providing relevant services. General organizational eligibility criteria are as follow:

1. Legal incorporation by the State of New York as a not-for-profit corporation;
2. Federal tax-exempt status under Section 501(c)(3) of the Internal Revenue Code; and
3. Currently operating with a brick-and-mortar site in Westchester, Rockland or Putnam counties.

Facilities must comply with the Americans with Disability Act (ADA) and be accessible by public transportation. Although any individual applicant agency does not have to serve clients from all eight counties in the New York EMA (the five boroughs in NYC and three counties in Tri-County), funded agencies should have the capacity to serve clients from throughout the New York EMA.

Applicants must have demonstrated experience providing related services to PLWH. Applicants should meet the following experience requirements to be eligible for funding under RFP. Organizations must:

- Have demonstrated experience providing the designated service to people living with HIV equivalent to:
    - At least 2 years of experience serving PLWH
    - At least 1 year of experience providing the designated service
- Be co-located with service programs to refer patients for needed medical and/or social support services **OR**;
- Have established Linkage Agreement (LA) or Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA) with service programs to refer patients for needed medical and/or social support services.
- Be able to address, either directly or through referral, the needs of clients with physical, behavioral, psychosocial, or sensory impairments.
- Be able to bill Medicaid for services that are billable to Medicaid.

Agencies must ensure that staff members have HIV knowledge, training, and cultural sensitivity appropriate to the populations that they serve. Agencies must have the capacity to provide services in the languages spoken by the populations served.

For-profit organizations are not eligible for funding through this RFP. HRSA guidance prohibits not-for-profit organizations from serving as conduits that pass awards to for-profit entities.

All applicants must meet the General Organizational Eligibility Requirements outlined in this section AND any Program Specific Eligibility Requirements outlined in the specific service category in this RFP.

General Client Eligibility Requirements

The general client eligibility requirements for all RWPA services include HIV status, residency, and income.

Eligibility documentation requirements will be provided during the contracting process/post-award.

1. **HIV Status Requirements**
   The principal intent of the RWPA Program is the provision of services that improve the health of low-income, uninsured and under-insured PLWH. Organizations will be required to obtain and maintain written documentation of HIV-positive status once an individual is enrolled in RWPA services.
2. **Residency Eligibility Requirements**
   All new and continuing clients enrolled in RWPA programs must provide documentation of residency in the NY EMA (i.e., one of the five boroughs of New York City or Putnam, Rockland or Westchester counties).
3. **Income Eligibility Requirements**
   All new and continuing clients enrolled in RWPA programs must meet income eligibility requirements to receive services. The Planning Council has currently set the maximum household income at 435% of the Federal Poverty Level (FPL). Income eligibility guidelines for 2017 are:

Family Size	2017 Poverty Guidelines	RWPA Maximum Household Income (435% FPL)
1	$11,880	$51,678.00
2	$16,020	$69,687.00
3	$20,160	$87,696.00
4	$24,300	$105,705.00
5	$28,440	$123,714.00
6	$32,580	$141,723.00
7	$36,730	$159,775.50
8	$40,890	$177,871.50

Services may only be provided to clients who meet general eligibility criteria for RWPA services listed above. *Note that active substance use or incarceration history does not preclude client eligibility for services.*

Aside from the General Eligibility Criteria for receipt RWPA services (listed above), service categories included in this RFP outline priority populations that should be focused on for recruitment and enrollment. These program-specific client priority populations are outlined within each service category below.

Tri-County Background

General Background

The New York Eligible Metropolitan Area (NY EMA), which includes the five boroughs of NYC and the adjacent Tri-County region of Westchester, Rockland, and Putnam counties, is home to more than 9.9 million people. The NY EMA continues to have the largest HIV epidemic in the U.S., with approximately 12% of the nation's PLWH in 2014 and 7% of all HIV diagnoses in 2015. As of December 31, 2016, there were 131,933 reported PLWH in the NY EMA. Of those, 4,023 cases were reported in the Tri-County Region. Of the 57 counties outside of New York City, Westchester County has the highest number of HIV diagnoses and reported PLWH, with Rockland and Putnam Counties following closely behind. [1] Despite annual declines in new HIV diagnoses and significant advances in medical care for PLWH, disparities in health outcomes and access to health care persist. Factors associated with high service need and low service utilization in the Tri-County region include being unstably housed and having low mental health functioning.

As of December 31, 2016, 4,023 HIV cases have been reported in the Tri-County region.[2] Of the total number of PLWH in the Tri-County region 80.9% reside in Westchester, 15.4% in Rockland, and 3.7% in Putnam County. It is estimated that an additional 9% of PLWH in the Tri-County region (i.e. another 324 individuals) are unaware of their positive sero-status. As is the case throughout the United States, the Tri-County epidemic continues to disproportionately affect communities of color. While non-Hispanic blacks comprise only 12.9% of the region's population,[3] 36.4% of reported HIV cases are black. Hispanics, who comprise 19.5% of the area's residents, represent 28.8% of those reported living with HIV.

[1] Yomogida, M., Messeri, P., Irvine, M. Service Needs and Utilization Tri-County 2012-2013. CHAIN 2013-5b Report, December 30, 2014.

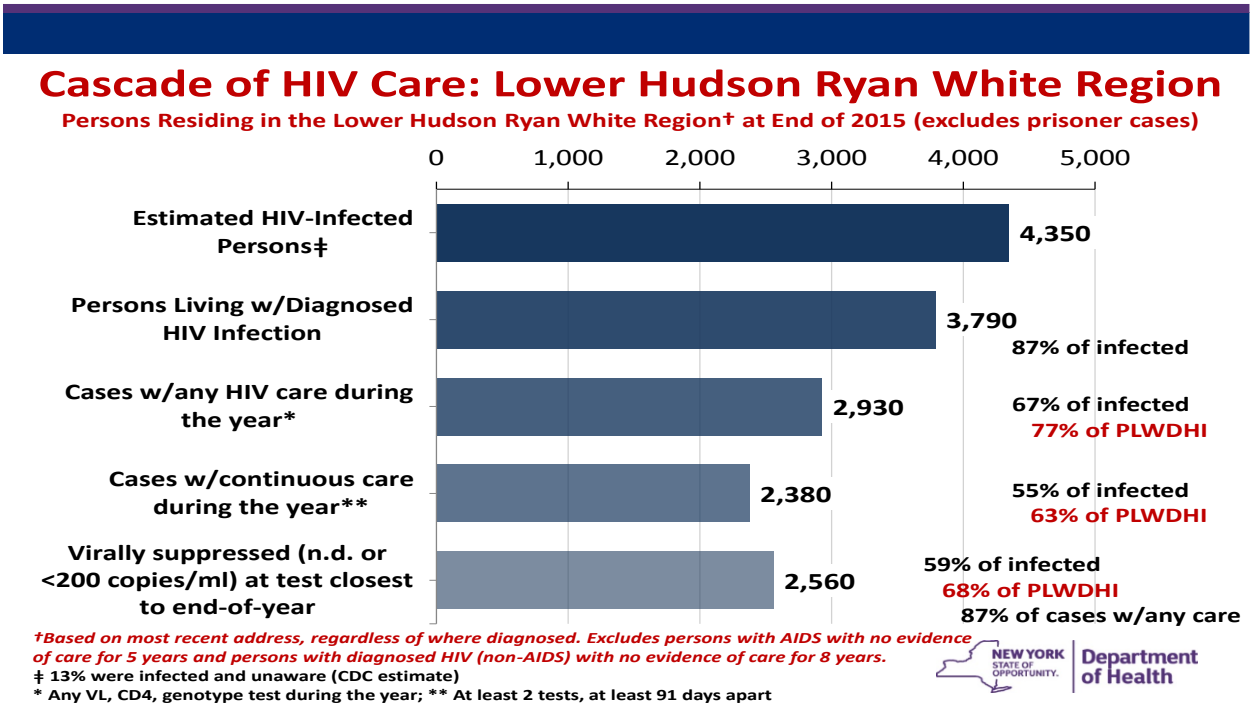
[2] Source NYS Department of Health (NYS DOH), Bureau of HIV/AIDS Epidemiology, data as of September 3, 2017.

[3] The 2010 U.S. Census is the source for all population data cited.

HIV Care Continuum

The HIV Continuum of Care (also known as the Cascade of HIV Care) displays the various stages of engagement in HIV care after infection. It can be used to highlight the unmet need of PLWH with the length of the bars representing progress towards complete (100%) identification of PLWH, diagnosis of infected persons, retention in HIV care, utilization of ART, and ultimately viral suppression (Figure 1).

Figure 1- Proportion of PLWH in Lower Hudson Region engaged in selected stages of the HIV care continuum, 2015



According to the New York State (NYS) Cascade of HIV Care in the Tri-County Region, 77% of the 3,790 persons living with a diagnosed HIV infection received HIV care. However, this rate drops to 63% when looking at those who received continuous care during follow up. Of those who received a positive HIV diagnosis, only 68% were virally suppressed, highlighting the approximately 1,200 individuals who are not in care and who are not virally suppressed. Removing barriers and supporting individuals to enter into and maintain consistent HIV medical care requires both a variety of support services and concerted collaborative efforts aimed at retaining patients in HIV care and treatment to achieve viral load suppression. The services sought through this RFP aim to increase the numbers of PLWH who are engaged in primary care and are, ultimately, virally suppressed.

General Service Delivery Framework

Services should be client-centered, non-judgmental, trauma informed,[4] culturally appropriate, sensitive to physical and sensory impairments, and tailored to the population served. A variety of engagement strategies should be employed to ensure that client-specific needs are met. Clients should be included in

[4] "A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings." Harris, M. & Fallot, R. (2001). Using trauma theory to design service systems, cited at http://www.samhsa.gov/traumajustice/traumadefinition/approach.aspx.

the decision making whenever possible. The utilization of peers in all applicable service areas is strongly encouraged. Organizations funded to provide services in the Tri-County Region are encouraged to coordinate services in such a way that referrals between organizations and across services categories ensure smooth and continuous care and treatment for all RWPA clients.

General Service Delivery Model

All RWPA service providers must refer clients, as appropriate, to entitlement and benefits specialists with experience within the health care system. As clients with unmet medical and social service needs are identified, referrals and linkages must be provided.

Concerted outreach efforts should be made to schedule, re-confirm, and follow-up on missed appointments for individuals whose circumstances present added barriers to remaining in care. Providers must discuss viral load, CD4 cell count, antiretroviral therapy adherence, and retention in primary care, as appropriate, with clients.

Ryan White as a Payer of Last Resort

Ryan White dollars must be used as funds of last resort and are expected to be utilized for allowable services only when other funding sources are not available.

Organizations that are awarded contracts through this RFP will be required to document, in client files, how each client was screened for and enrolled in eligible third-party programs to pay for those services that are billable.

Services Availability

Organizations must ensure that the following services are available to clients either through co-location/affiliation* or a formal linkage agreement:

- Food and Nutrition Services
- Harm Reduction Services and Other Appropriate Substance Use Services
- Health Education and Risk Reduction Services, as appropriate
- HIV Testing
- Housing Services
- Legal Services
- Medicaid, Medicare, and NYS Health Insurance Exchange Systems
- Medical Care
- Medical Case Management
- Mental Health Services
- Non-Medical Case Management
- Supportive Counseling, as appropriate

**Affiliation is defined as being geographically close and aligned to provide available patient care.*

Service Category 1: Food and Nutrition Services

Background

While advancements in HIV medical care have been significant, basic needs are still not met for some persons living with HIV (PLWH). For PLWH in the Tri-County region, access to adequate and appropriate food and nutrition is an ongoing need. Food insecurity is common among low-income individuals and racial/ethnic groups disproportionately affected by HIV. This impacts viral load suppression and CD4 cell counts, which are indicators for HIV transmission and the progression of HIV to AIDS, respectively.

A recent Community Health Advisory and Information Network (CHAIN) report on food insecurity indicated that 85% of PLWH in the Tri-County region experience food insecurity and/or rely on food and nutrition programs to address their most basic needs.[5] The CHAIN report also indicated a need for nutritional education and counseling due to a lack of knowledge surrounding the role of nutrition in HIV health. When responding to these findings, it is essential to facilitate a means by which PLWH can improve their nutritional intake and knowledge. Improving access to Food and Nutrition Services (FNS) directly combats food insecurity while simultaneously facilitating access to and engagement with medical care.

Proposals are requested to provide Food and Nutrition Services to PLWH in need of these services. Food and Nutrition Services must also aid in linking PLWH to medical care and in retaining them in care. The program should support access to and knowledge about healthy foods, as well as provide a variety of high quality food products that help to improve health outcomes for PLWH. Programs will be expected to provide nutritious food appropriate to the health needs of PLWH. Food quality must be supported through dietician reviews.

Service Delivery Framework

Food/Meals Services may include:

- Provision of culturally-sensitive and nutritionally-appropriate food or meals through home-delivered meal programs, congregate food settings, food bank/pantry programs whose pantry bag may be home delivered, and/or vouchers to purchase food.
- Congregate meals (CM) have been proven to be a meaningful way to engage clients in medical care and social support services and, where possible, CM programs should be structured in such a way to accomplish the goal of providing a meal in a group setting and engaging clients in care.
- Essential household supplies, such as hygiene items and household cleaning supplies, not covered by other funding sources are also supported.
- Food and nutrition services for PLWH should facilitate access to HIV-related primary care and appropriate support services through improved basic needs and the reduction of nutritional barriers to care.

Service Delivery Model

Nutrition services delivered by a Registered Dietician (RD) or equivalent are provided as deemed necessary by nutritional screening, and may include:

- Brief intake and baseline screening at first encounter.

[5] Aidala, A, Yomogida, M, Vardy, Y, Food Insecurity, Food and Nutrition Services, and HIV Care and Health Outcomes, CHAIN Report, 2012-13, October 27, 2015.

- Clients who are not in primary care must be provided with referral and linkage services for HIV care and treatment.
- Six-month client general reassessment.
- Six-month reassessment as needed and/or requested by client.
- Nutritional care plan developed based on assessment/reassessment.
- Nutritional counseling and education (individual and group), if indicated.
- Diet and nutrition planning.
- Nutritional supplements, as medically necessary.
- Review and approval of program meal plans/menus.

Goals and Objectives

The primary goal of Food and Nutrition Services is to promote access to and maintenance in HIV medical care by ensuring access to nutritious food.

Objectives:

- Promote access to, and maintenance in, HIV medical care.
- Provide nutritious food and/or nutrition services to PLWH who need them.
- Enhance treatment adherence.

Stages of the HIV Care Continuum addressed by this service category (in bold):

Diagnosed Linked to Care **Retained in Care** **Prescribed ART** **VLS**

Reimbursement

Services provided under this service category will be reimbursed using a fee-for-service methodology. A deliverables-based start-up period to reach full service capacity will be provided.

Listed services are indicated as optional or required. ***Required*** *services must be made available by each funded contractor for appropriate clients. This does not mean that all clients must receive every service element.*

Program Specific Client Target Population

Services may be provided to clients who meet eligibility criteria for RWPA services, including, HIV status, residency, and income.

In addition to the general Ryan White eligibility criteria, priority should be given to persons who meet the criteria listed below:

1) Grocery/Pantry Bags - Clients must have limited financial resources to purchase nutritious food.
2) Food Vouchers - Clients must have limited financial resources to purchase nutritious and allowable food(s), but be able to shop for and prepare their own meals.
3) *Home-Delivered Meals - Clients must be unable to shop for themselves due to the physical and/or mental challenges of being essentially home-bound and must lack a network of family or

friends to provide such support. For home-delivered meals, the client's medical provider must document need.

4) *Congregate Meals - Clients must be unable to purchase nutritious food due to limited financial resources and/or inadequate cooking facilities to prepare meals. Additionally, clients may be referred to congregate meal services as part of their care plan.

**These services will not initially be funded but may be added to contracts in subsequent years. You should not set projections for these service types as part of your proposal.*

Program Specific Agency Eligibility Requirements

In addition to the General Organizational Eligibility Requirements, organizations must conform to food industry standards for food preparation, storage, and handling. Organizations offering prepared meals must meet both local and state food safety regulations. See New York State food handling regulations, ***https://www.health.ny.gov/environmental/indoors/food_safety/regs.htm***

Service Type Description

Food and Nutrition Services funded under this RFP are limited to clients living with HIV and minors identified as dependents of the PLWH living in the household. *All listed required services must be made available by funded contractors for eligible clients in the region. However, this does not mean that all clients must receive every service element.*

Table 1: Summary of Services and Rates – Service Category 1

Service Family	PHS Code	Service Type	Unit Type	Rate
Assessment and Planning	115	Intake Assessment	Individual Event	$197.00
	076	Reassessment	Individual Event	$169.00
Linkage Services	P69	Linkage to Care	Individual Event	$97.00
Nutritional Services - Core Services	035	Comprehensive Nutritional Assessment	Individual Event	$242.00
	P09	Nutritional Counseling w/Supplements	Individual Event	$210.00
	P10	Nutritional Counseling w/o Supplements	Individual Event	$178.00
	M49	Nutritional Education Group	Group – PAID PER ATTENDEE - CAP	$83.00
Food Services - Core Services	066	Pantry Bag Meal	Individual Event	$6.00
	P13	Supplemental Food Voucher - $20	Individual Event	$31.00
	P14	~~Emergency~~ Full Food Voucher - $40	Individual Event	$51.00
	046	*Home-Delivered Meal	Individual Event	$15.00
	P46	*Congregate Meal	Group – PAID PER ATTENDEE – NO CAP	$13.00

****These services will not initially be funded but may be added to contracts in subsequent years. You should not set projections for these service types as part of your proposal.***

Table 2: Service Types, Descriptions, and Staff Responsible – Service Category 1

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
Assessment and Planning						
115	**Intake Assessment**	Initial assessment of health, psychosocial status and service needs to facilitate plan development. May include: • Documenting eligibility for services and obtaining information for program enrollment • Gathering demographic data, HIV diagnosis information, insurance coverage information, involvement in criminal justice system • Assessing financial and housing status, substance use and risk behavior, and general health and well-being assessment	Intake assessment must be completed within 45 days of program enrollment.	Program Manager	On-Site	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 plan goals, substance use, mental health and risk behaviors. Re-assessment facilitates service plan updates.	Reassessment must occur at least every six months.	Program Manager	On-Site	Required
Linkage to Care						
P69	**Linkage to Care**	Verification that a client has kept a scheduled medical visit or followed through on a referral to primary care by visiting a primary care provider.	Attendance must be verified. If client attends unaccompanied, program may verify through contact with provider or patient self-report.	Program Manager or Patient Navigator	On-Site or Off-Site	Required
Nutritional Services – Core Services						
035	**Comprehensive Nutritional Assessment**	Initial evaluation of nutritional status to facilitate development of dietary recommendations and counseling interventions. The evaluation may elicit information from clients about nutritional conditions, diet, co-morbidities, medication	No additional standard.	Registered Dietician	On-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
		utilization, and social and behavioral factors influencing their nutritional status.				
P09	**Nutritional Counseling w/Supplements**	Individual counseling to address dietary recommendations and provide support for change (including health education) according to standard professional guidelines. During counseling sessions, clients with a demonstrated medical need are also provided nutritional supplements.	To receive supplements, clients must have a documented nutritional plan developed and maintained by the program's registered dietician. Supplements may only be distributed as determined necessary by nutritional screening.	Registered Dietician	On-Site	Required
P10	**Nutritional Counseling w/o Supplements**	Individual counseling to address dietary recommendations and provide support for change (including health education) according to standard professional guidelines.	No additional standard.	Registered Dietician	On-Site	Required
M49	**Nutritional Education Group**	Group education to improve knowledge and understanding of nutritional issues and of the relationship among nutrition, illness and treatment.	Groups must have at least 3 participants. At least 1 participant must be enrolled in the program.	Registered Dietician	On-Site	Required
Food Services – Core Services						
066	**Pantry Bag Meal**	Distribution of groceries (dry goods and fresh produce) that allow clients to prepare well-balanced meals.	Bags can include either (1) prepackaged contents, or (2) contents selected by clients from a selection of nutritionally suitable items. Pantry bags should include ingredients to prepare a number of meals. Hygiene and household sanitation supplies necessary for food preparation and clean-up may also be distributed as pantry bag items.	Patient Navigator	On-Site	Required
P13	**Supplemental Food Voucher - $20**	~~Vouchers are provided to supplement pantry bags~~ Supplement food vouchers when the program's pantry bags cannot provide ~~the~~ all of the nutritional elements recommended in the Comprehensive Nutritional Assessment.	Vouchers must be in the form of store ~~coupons~~gift cards; vouchers redeemable for cash are not permitted. Clients must present receipts from their purchases to	Program Manager	On-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
			program staff at the following visit to ensure that only allowable purchases were made. Allowable purchases include nutritious food items, kitchen cleaning supplies, food storage supplies, hygiene products, and household products. Vouchers may not be used to purchase alcohol or tobacco.			
P14	**~~Emergency~~ Full Food Voucher - $40**	~~Vouchers provided when a client is unable to access food during a waiting period imposed by a food program or when food services are not readily available from the program (e.g. after hours, weekends, or unforeseen emergency circumstances).~~Vouchers provided to clients who do not receive a pantry bag and are unable to obtain food or food based services.	Vouchers must be in the form of store ~~coupons~~gift cards; vouchers redeemable for cash are not permitted. Clients must present receipts from their purchases to program staff at the following visit to ensure that only allowable purchases were made. Allowable purchases include nutritious food items, kitchen cleaning supplies, food storage supplies, hygiene products, and household products. Vouchers may not be used to purchase alcohol or tobacco.	Program Manager	On-Site	Required
046	***Home Delivered Meal**	Meals delivered to homebound clients who are unable to shop and prepare food for themselves.	Home-delivered meals provide food for 2 meals per day. If not delivered hot, meals should have instructions for warming and/or storing food. Program staff must confirm that client has the ability and facilities available to warm and/or store according to instructions. Meals are prepared according to the highest professional standards under	Registered Dietician or Patient Navigator	Off-Site	Optional

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
			the supervision of Registered Dietitians and the Executive Chef. They are individually tailored to a client's specific medical and nutritional requirements and may be modified as to content and texture.			
P46	***Congregate Meal**	Meals provided in a group setting offering food options that are nutritionally suitable for the population served to promote food stability and social inclusion.	No additional standard.	Registered Dietician or Patient Navigator	On-Site	Optional

These services will <u>not</u> initially be funded but may be added to contracts in subsequent years. You should <u>not</u> set projections for these service types as part of your proposal.

Recommended Staffing Plan

A staffing plan must be submitted with the application materials. The plan is required prior to the award of a contract and contains the anticipated staff assignments. In order to staff the program, outreach, recruitment, and employment activities should reach those whose life experiences, training, education, and expertise promote understanding of the program's target population. When making employment decisions, level of education should not be the only consideration. Please note that the staff titles, functions, and qualifications are recommendations from NYC DOHMH. The staffing plan submitted by each agency will be evaluated based on the proposed program. It is the responsibility of each agency to ensure that proposed programs are adequately and appropriately staffed.

The program is recommended to have staffing capacity as indicated below:

Program Manager

Functions: To provide oversight and management of the program, including monitoring, reporting and quality assurance activities. Program Manager oversees the food pantry inventory and food distribution.

Recommended Minimum Credentials: MPH/MSW/MPA/MBA or other MA degree AND at least 2 years of experience managing services for PLWH.

Registered Dietician

Functions: Responsible for program food quality, menu review, nutrition assessments, nutrition services/treatment plans, and individual nutritional counseling services provision. Registered Dietician will participate in group nutritional education sessions, as necessary. Food and nutrition services MUST be delivered in accordance with NYS Registered Dietician (RD) licensure requirements and rules of practice outlined by the New York State Department of Education

Recommended Minimum Credentials: RD licensed to practice in NYS and at least 12 months of experience working with persons living with HIV/AIDS and their families.

Patient Navigator

Functions: Contributes to the development of the food pantry inventory; packs and distributes pantry bag meals; and distributes, records, and tracks food vouchers.

Recommended Minimum Credentials: High School Diploma (or equivalent) and at least 12 months experience working in food services.

Chef/Kitchen Manager

Functions: Responsible for developing nutritious menus focused on dietary requirements of PLWH. The Chef/Kitchen Manager oversees grocery delivery; manages the food handlers in food preparation and packaging of meals or serving of congregate meals. Ensures food quality and food safety.

Recommended Minimum Credentials: At least 12 months of experience working as a kitchen manager in food services.

Food Handler (Delivery Driver)

Functions: Responsible for assisting with food preparation, packaging and/or food serving. Trained (certificate) in food protection practices to ensure the safety of those receiving Home Delivered Meal and/or Congregate Meal services.

Recommended Minimum Credentials: A certificate in safe food handling practices or be in process of receiving certification and at least 12 months of experience working in food services.

Utilization of Peers with lived experience helps to enhance patient-centered care by delivering services that support engagement in care such as linkage to services, re-connection to care, and adherence counseling, even for clients at the highest risk for being lost to follow-up.[6,7,8,9] *It is encouraged that agencies hire peers whenever possible; peers should either be certified by the NYS AIDS Institute Peer Worker Certification Program or be supported to obtain their certification while working in this capacity.*

The NY EMA encourages hiring people living with HIV, but staff (including Patient Navigators) must not be current clients of the FNS program.

[6] Holtzman CW, Brady KA. Yehia BR. Retention in care and medication adherence: current challenges to antiretroviral therapy success. *Drugs*. 2015; 75(5):445-454

[7] Farrisi D, Dietz N. Patient navigation is a client-centered approach that helps to engage people in HIV care. *HIV Clinician*. 2016; 25(1):1-3

[8] Sarango M, de Groot A, Hirschi M, Umeh CA, Rajabiun S. The role of patient navigators in building a medical home for multiply diagnosed HIV-positive homeless populations. *J Public Health Manag Pract.* 2017; 23(3):276-282

[9] Bradford JB, Coleman S, Cunningham W. HIV system navigation: an emerging model to improve HIV care access. *AIDS Patient Care STDs.* 2007; 21(Suppl 1):S49-S58

Service Category 2: Housing/Short Term Assistance Services

Background

While medical care and treatment options for persons living with HIV (PLWH) have improved, factors associated with poor health outcomes persist, including being homeless or unstably housed. [10] When looking at housing disparities, those who are homeless or unstably housed have a prevalence of HIV that is three to nine times higher than their more stably housed counterparts, necessitating an increased vigilance with regards to linking these individuals to care and treatment.[11]

Health outcomes tend to be worse for homeless PLWH, as research illustrates, they are less likely to have taken antiretrovirals than those with more stable housing. Among those who do report taking antiretrovirals, self-reported adherence is significantly lower for those who are unstably housed. [12] Homeless PLWH tend to have poorer self-reported health status and are more likely to have had viral hepatitis, *Pneumocystis carinii* pneumonia, and a positive tuberculosis skin test. In ending the HIV epidemic, programs are needed to help address homelessness for PLWH.

Addressing housing insecurity can help increase consistent engagement in clinically appropriate HIV primary care.[13] The Community Health Advisory & Information Network (CHAIN) Project[14] findings indicate that receipt of housing was a strong and consistent predictor of increased access to medical care and treatment, retention in care, and improved health outcomes. Moreover, CHAIN Project findings have consistently shown that housing is one of the greatest needs for PLWH in the New York EMA. [15]

Proposals are requested to provide short-term assistance with rent, utilities and telephone service, and moving expenses to secure or maintain stable housing.

Services Delivery Framework

Housing/Short Term Assistance Services for PLWH should facilitate access to HIV-related primary care and appropriate support services. Providers must certify the need for housing assistance for purposes of accessing and maintaining HIV-related medical care and treatment adherence. Organizations providing housing services should establish linkages with and make referrals to legal service organizations that provide housing eviction prevention services and with organizations offering help in paying arrears for clients in need.

[10] Aidala, A., Yomogida, M., Kim, J. Housing Need and Housing Assistance in New York City and Tri-County Region. CHAIN 2016-1 CHAIN Briefing, March, 2016.

[11] Aidala A, Cross J, Stall R, et al. Housing Status and HIV Risk Behaviors: Implications for Prevention and Policy. *AIDS and Behavior*. 2005.9:251-265.

[12] Kidder D, Wolitski R, Campsmith M, Nakamura G. Health Status, Health Care Use, Medication Use, and Medication Adherence Among Homeless and Housed People Living with HIV/AIDS. *American Journal of Public Health.* 2007. 97: 2238-2245.

[13] Aidala A, Lee G, Abramson D, Messeri P, Siegler A. Housing need, housing assistance, and connection to HIV medical care. *AIDS and Behavior.* 2007. 11(S2): S101-S115.

[14] CHAIN is an ongoing prospective study of representative samples of persons living with HIV/AIDS in New York City. It is conducted by researchers from Mailman School of Public Health at Columbia University as part of the evaluation activities of New York City's Health and Human Services Planning Council.

[15] Aidala A, Lee G, Abramson D, Messeri P, Siegler A. Housing need, housing assistance, and connection to HIV medical care. *AIDS and Behavior.* 2007. 11(S2): S101-S115.

Service Delivery Model

Housing/Short Term Assistance Services funded under this RFP are limited to clients living with HIV and are limited to *short term rental/utility assistance*. Short Term Rental/Utility Assistance is defined as, financial assistance, in the form of payments directly to landlords and/or utility providers, which are used to secure or maintain stable housing. Short term assistance includes assistance with rent, utilities and telephone service, and moving expenses to secure or maintain stable housing. Cash payments cannot be made to clients. While there is no formal time limit on how long a client can receive Short Term Rental/Utility Assistance, services should be provided on a temporary basis until the client or family is able to secure long term housing arrangements.

Goals and Objectives

The overarching goal for this service category is to provide housing services directly necessitated by an individual's HIV status in order to engage and retain PLWH in treatment and care, thereby serving to enhance immunological status, improve health outcomes, and reduce disease transmission.

Objectives:

- Help homeless and unstably housed PLWH to obtain/maintain stable housing thereby reducing the risk of HIV transmission associated with homelessness and unstable housing.
- Provide HIV-positive homeless or unstably housed persons with stable housing to increase the number of PLWH who enter into and stay in comprehensive HIV/AIDS medical care, increase ART utilization and treatment adherence, thereby promoting optimal health outcomes.
- Reduce the number of HIV-infected individuals who are homeless or unstably housed.

Reimbursement

Services provided under this service category will be reimbursed using a cost-based methodology.

*All listed services **are required** and must be made available by each funded contractor for appropriate clients. This does not mean that all clients must receive every service element.*

Program Specific Client Target Population

Services may be provided to clients who meet eligibility criteria for RWPA services, including, HIV status, residency, and income. *Note that active substance use or incarceration history does not preclude client eligibility for services.*

In addition to the general Ryan White eligibility criteria, priority should be given to persons with any of the criteria listed below:

1) Individuals who are homeless or unstably housed; and/or
2) Individuals who are in danger of becoming homeless.

*Note: Target populations described above are **not** criteria for program eligibility.*

Program Specific Agency Eligibility Requirements

Non-profit organizations with experience with HIV-positive homeless and unstably housed individuals/families and with experience with providing client housing and financial services are encouraged to apply for funding. *In addition to the General Organizational Eligibility Requirements,* organizations providing services must:

1) Have experience serving HIV-positive individuals and experience reaching out to and engaging individuals who are out of care, sporadically in care, or in need of self-management support;
2) Be co-located or have established linkages with medical and non-medical case management programs to refer participants for other needed medical and/or social support services;
3) Ensure that staff members are appropriately credentialed to provide the services listed and have HIV knowledge, training, and cultural sensitivity appropriate to the populations served; and
4) Have service sites geographically located within Tri-County, accessible to, and able to service clients from throughout the entire NY EMA.

Service Type Description

Housing/Short Term Assistance Services funded under this RFP are limited to clients living with HIV. Housing/Short Term Assistance Service elements may include, but are not limited to, those described in the table below.

Table 1: Summary of Services and Rates – Service Category 2

Service Family	PHS Code	Service Type	Unit Type	Rate
Planning and Assessment	115	Intake Assessment	Individual Event	$0.00
	225	Care/Service Plan Development	Individual Event	$0.00
	076	Reassessment	Individual Event	$0.00
	226	Care/Service Plan Update	Individual Event	$0.00
Navigation	P71	Apartment Inspection	Individual Event	$0.00
	P85	Client Assistance	Individual Event	$0.00
Fiscal Assistance	P73	Rental/Utility Assistance Payment	Individual Event	$0.00

Table 2: Service Types, Descriptions, and Staff Responsible – Service Category 2

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
Planning and Assessment						
115	**Intake Assessment**	Initial assessment of health, psychosocial status and service needs to facilitate plan development. May include: • Documenting eligibility for services and obtaining information for program enrollment • gathering demographic data, HIV diagnosis information, insurance coverage information, involvement in criminal justice system • assessing financial and housing status, substance use and risk behavior, and general health and well-being assessment • Certify the need for housing assistance for purposes of accessing and maintaining HIV-related medical care and treatment adherence • Assess need for case management	Intake assessment must be completed within 45 days of program enrollment.	Housing Case Manager	On-Site	Required
225	**Care/Service Plan Development**	Development of a client-centered 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 to aid in ensuring long-term housing stability.	Initial service plan must be completed within 45 days of program enrollment. All plans must be personalized to reflect each client's individual needs. All plans must include at least one goal relevant to the service category in which the client is enrolled and at least one goal addressing health management for HIV. 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 action step that describes what the program will do to help the client meet the goal.	Housing Case Manager	On-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
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 plan goals, substance use, mental health and risk behaviors. Re-assessment facilitates service plan updates. • Certify the need for housing assistance and case management	Reassessment must occur at least every six months.	Housing Case Manager	On-Site	Required
226	**Care/Service Plan Update**	Review of service plan to evaluate progress toward achieving goals and make revisions in response to the reassessment or emerging needs.	Plans must be updated at least every six months within 30 days of reassessment.	Housing Case Manager	On-Site	Required
		Navigation				
P71	**Apartment Inspection**	An initial apartment/housing inspection using the HUD *Housing Quality Standards* must occur at Intake. The apartment inspection is to assess the habitability of the apartment/housing unit.	Inspections will occur initially, at intake, and at least once annually thereafter for the duration of client's enrollment in program.	Housing Case Manager	Off-Site	Required
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. May include: • Coordination with service providers that assist with housing stabilization and other social services • Referrals to permanent housing (i.e. Section 8, HOPWA, and Senior Housing) where possible • Referrals to legal service organizations that provide housing eviction prevention services	No additional standard.	Housing Case Manager	On-Site or Off-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
Fiscal Assistance						
P73	**Rental/Utility Assistance Payment**	Provide short-term assistance with rent, utilities and telephone, brokers' fees, and moving expenses to secure or maintain stable housing. Fiscal staff will coordinate with Housing Case Manager, referring provider, and/or client to: • Contact payee (landlords, etc.) to discuss payment arrangements and issue letter of guarantee, as needed • Assess each bill submitted for payment to determine if it is an allowable expense under the grant guidelines • Maintain documentation of clients' portion of monthly rent payments to landlord, etc.	Performed on a monthly basis. Provider or patient self-report.	Accountant	On-Site	Required

Recommended Staffing Plan

In addition to the abovementioned requirements for funding, a staffing plan must be submitted with agency application materials. The plan is required prior to the award of a contract and contains the anticipated staff assignments. In order to staff the program, outreach, recruitment, and employment activities should reach those whose life experiences, training, education, and expertise promote understanding of the program's target population. When making employment decisions, level of education should not be the only consideration. Please note that the staff titles, functions, and qualifications are recommendations from NYC DOHMH. The staffing plan submitted by each agency will be evaluated based on the proposed program. It is the responsibility of each agency to ensure that proposed programs are adequately and appropriately staffed.

The program is recommended to have staffing capacity as indicated below:

Program Director

Functions: To provide oversight and management of the program, including monitoring, reporting and quality assurance activities.

Recommended Credentials: MPH/MSW/MPA/MBA or other MA degree or BA/BS degree AND at least 2 years of experience managing services for priority populations.

Accountant

Functions: Responsible for tracking housing payment requests, tracking program income revenue (client rent payments), assessing allowable expenses, submitting check requests to accounting department, obtaining authorizing signatures, issue checks, verify check payment made, and reconcile checking accounts. In addition, accountant is responsible for financial audit of housing program.

Recommended Credentials: BA/BS or CPA degree, at least 24 months of experience working in non-profit organizations AND at least 24 months of experience managing accounting services for this service category.

Housing Case Manager

Functions: Responsible for tasks related to managing client cases for those who are seeking housing. Housing case manager assists clients with; finding appropriate housing, budgeting of finances to best use household resources, and developing ongoing plan to maintain housing stability.

Recommended Credentials: BA/BS or LMSW degree, at least 24 months of case management experience AND at least 24 months of experience managing services for the priority populations in this service category.

Utilization of Peers with lived experience helps to enhance patient-centered care by delivering services that support engagement in care such as linkage to services, re-connection to care, and adherence counseling, even for clients at the highest risk for being lost to follow-up.[16,17,18,19] It is encouraged that agencies hire

[16] Holtzman CW, Brady KA. Yehia BR. Retention in care and medication adherence: current challenges to antiretroviral therapy success. *Drugs*. 2015; 75(5):445-454

[17] Farrisi D, Dietz N. Patient navigation is a client-centered approach that helps to engage people in HIV care. *HIV Clinician*. 2016; 25(1):1-3

[18] Sarango M, de Groot A, Hirschi M, Umeh CA, Rajabiun S. The role of patient navigators in building a medical home for multiply diagnosed HIV-positive homeless populations. *J Public Health Manag Pract.* 2017; 23(3):276-282

[19] Bradford JB, Coleman S, Cunningham W. HIV system navigation: an emerging model to improve HIV care access. *AIDS Patient Care STDs.* 2007; 21(Suppl 1):S49-S58

*peers whenever possible; peers should either be certified by the **NYS AIDS Institute Peer Worker Certification Program** or be supported to obtain their certification while working in this capacity.*

The NY EMA encourages hiring people living with HIV, but staff (including Patient Navigators) must not be current clients of the Housing program.

Service Category 3: Medical Case Management Services

Background

Despite significant advances in medical care for persons living with HIV (PLWH), there continue to be disparities in health outcomes, especially when looking at access to care and treatment. RWPA programs play an essential role in addressing barriers to care and treatment by facilitating access to and maintenance in HIV primary care through integrated medical, social, and support services.

HIV has evolved into a chronic illness, requiring a broad range of services that aid in enhancing self-management skills for PLWH. The complex requirements of antiretroviral treatment (ART) and the life-long nature of HIV care and treatment are challenges best met in the context of strong support systems, including stable housing, access to sufficient food, and adequate social support. Minimizing and removing barriers to medical care via health education and support services (i.e. case management) help in facilitating engagement in HIV care and treatment.[20] Many PLWH benefit from health education, assistance in navigating the healthcare and social service systems, and treatment adherence interventions to become effective managers of their own healthcare. Furthermore, these benefits directly impact whether or not PLWH achieve and maintain viral suppression, improve their health and quality of life, and prevent further transmission of HIV.[21] Early diagnosis, uninterrupted access to ART, continuous engagement in medical care, and consistent adherence to ART are all essential in reducing mortality and morbidity among PLWH.

The Medical Case Management services program seeks to address HIV healthcare disparities by facilitating access to care and other support services. The driving principle of the Medical Case Management services program is to take a client-centered, holistic and comprehensive approach to meeting the needs of PLWH by assisting participants in navigating the complex medical care and social support services systems[22]. Moreover, the program draws from chronic care models to encourage and support PLWH in gaining and maintaining independence in their utilization of healthcare services. The program also works to prevent morbidity and mortality in PLWH so they may enjoy an improved quality of life.

Proposals are requested to provide comprehensive and culturally/linguistically-appropriate medical case management services to link clients with health care, psychosocial, treatment adherence, and other support services aimed at improving and maintaining their HIV-related care and treatment.

Service Delivery Framework

Medical Case Management services funded under this RFP are limited to clients living with HIV. Service elements may include, but are not limited to, those described in the Service Type Description table. These services ensure timely and coordinated access to medically appropriate levels of health/support services and continuity of care through ongoing assessment of the client's needs and personal support systems. Medical Case Management services includes the provision of treatment adherence counseling services to ensure readiness for, and adherence to, complex HIV/AIDS treatments. It includes all types of case management including face-to-face, phone contact, and other forms of communication.

[20] Ibid.

[21] Torian LV, Wiewel EW, Liu KL, Sackoff JE, Frieden TR. Risk factors for delayed initiation of medical care after diagnosis of human immunodeficiency virus. Arch Intern Med 2008; 168:1181-7.

[22] Messeri P. and Ball A., Place of Residence and Location of Services, CHAIN Report, May 14, 2015.

Service Delivery Model

Medical Case Management (MCM) needs can vary from client to client and with the same client over time. The delivery of MCM services can vary depending on the type of facility, resources, and clients served.

The following are proposed approaches in delivering MCM Services:

- An organization can offer all MCM Services.
- An organization can offer select MCM Services depending on organizational capacity. Organizations with limited capacity to providing all services under MCM can form interconnected partnerships with other RWPA funded programs through Linkage Agreements (LA), Memorandum of Understanding (MOA), or Memorandum of Agreement (MOA), to provide selected services not offered on-site.
- Upon the initial intake assessment, Medicaid clients who are eligible to enroll in a Health Home should be referred to Health Home programs. Based on the intake assessment and reassessment, the needs of the client may indicate that RWPA MCM Services specific to HIV treatment adherence and HIV related health promotion may be appropriate. In such cases the client may receive some services from the Health Home program and HIV specific services from a RWPA funded MCM program.

All MCM programs must have access to client lab results either through on-site medical records or through Linkage Agreement (LA), Memorandum of Understanding (MOU), or Memorandum of Agreement (MOA) with medical providers to share client information.

Patient Navigation

Patient Navigators play an integral role in engaging PLWH in services. Patient Navigators (including those who are peers and people with lived experience) enhance patient-centered care by delivering services that support engagement in care such as linkage to services, re-connection to care, and adherence counseling, even for clients at the highest risk for being lost to follow-up.[23,24,25,26] Among PLWH in the United States, patients who had a navigator were more than 6 times more likely to maintain viral suppression than patients who did not have a navigator, after 12 months of follow up.[27] Patient Navigators who are peers have a unique role on the care team, since they share the lived experiences of clients (in this case, those with HIV infection, HCV infection, substance use history, and/or mental health issues). NYC DOHMH promotes a community health worker model that encourages the employment of people from the communities being served; this includes the employment of peers as defined by the NYS AIDS Institute (***https://www.hivtrainingny.org/Home/PeerCertification***).

In the Medical Case Management services program, Patient Navigators are responsible for coordinating all levels of medical and behavioral health. This includes, but is not limited to: logistics coordination, appointment scheduling, preparation and reminders, accompaniment, transportation assistance, return

[23] Holtzman CW, Brady KA. Yehia BR. Retention in care and medication adherence: current challenges to antiretroviral therapy success. *Drugs*. 2015; 75(5):445-454

[24] Farrisi D, Dietz N. Patient navigation is a client-centered approach that helps to engage people in HIV care. *HIV Clinician*. 2016; 25(1):1-3

[25] Sarango M, de Groot A, Hirschi M, Umeh CA, Rajabiun S. The role of patient navigators in building a medical home for multiply diagnosed HIV-positive homeless populations. *J Public Health Manag Pract.* 2017; 23(3):276-282

[26] Bradford JB, Coleman S, Cunningham W. HIV system navigation: an emerging model to improve HIV care access. *AIDS Patient Care STDs.* 2007; 21(Suppl 1):S49-S58

[27] Mcmillian A, Gryzbowski M, White B, Fadul N. The effects of patient navigation on human immunodeficiency virus (HIV) viral load suppression in rural eastern North Carolina. *Open Forum Infect Dis.* 2016;3(Suppl1):487

to care, and outreach activities. Ensure linkage and engagement in other needed medical or specialty care, mental health, and harm reduction and/or substance use services.

Goals and Objectives

The Medical Case Management program aims to provide care coordination and treatment adherence services in order to engage and retain PLWH in care and treatment, thereby improving health outcomes.

The goals of the program are to:

- Increase retention in HIV care and treatment.
- Increase the proportion of clients who have an optimal level of ART adherence.
- Increase the proportion of clients with an undetectable viral load and improve immunological health.
- Reduce mortality.
- To reduce (and then maintain below significance) socio-demographic differences in: prompt linkage to HIV/AIDS care following HIV diagnosis, retention in primary medical care, and undetectable viral load and HIV-related mortality.

Objectives:

- Provide coordinated access to medically appropriate levels of health and support services and continuity of care.
- Provide referrals and linkages to medical or supportive services that improve clients' physical and behavioral health.
- Provide comprehensive treatment adherence services, promoting access to, and the consistent utilization of ART.

Reimbursement

Services provided under this service category will be reimbursed using a fee-for-service methodology. A deliverables-based start-up period to reach full service capacity will be provided.

All listed services must be made available by each funded contractor for appropriate clients. This does not mean that all clients must receive every service element.

Program Specific Client Target Population

Services may be provided to clients who meet eligibility criteria for RWPA services, including, HIV status, residency, and income. Note that active substance use or incarceration history does not preclude client eligibility for services.

In addition to the general Ryan White eligibility criteria, priority should be given to persons with any of the criteria listed below:

1) Newly diagnosed with HIV in the past 12 months.
2) Out of care for at least the past 9 months.
3) Virally unsuppressed at last (most recent) known viral load test within the past 12 months.
4) Currently living with chronic hepatitis C.

5) At high risk for falling out of medical care or becoming virally unsuppressed (e.g. experiencing viral rebound).

Program Specific Agency Eligibility Requirements

In addition to the General Organizational Eligibility Requirements, applicants must meet the following program specific requirements to be eligible for funding under this service category:

1) Have a medical provider on-site or a memorandum of understanding (MOU) with a medical provider that has agreed to coordinate care.
    i. The MOU should detail the process for making referrals to the program and how medical information and MCM program information will be shared among providers.
2) Have demonstrated experience providing medical case management services to PLWH.
3) Have service sites geographically located within Tri-County, accessible to, and able to service clients from throughout the NY EMA.

Service Type Description

Medical Case Management Services funded under this RFP are limited to clients living with HIV. Service elements may include, but are not limited to, those described in the table below.

Table 1: Summary of Services and Rates – Service Category 3

Service Family	PHS Code	Service Type	Unit Type	Rate
Outreach	545	Case Finding	Anon Group – PAID AS EVENT	$96.00
Assessment and Planning	115	Intake Assessment	Individual Event	$217.00
	225	Service Plan Development	Individual Event	$82.00
	076	Reassessment	Individual Event	$135.00
	226	Service Plan Update	Individual Event	$82.00
	N82	Self-Management Assessment	Individual Event	$48.00
Service Coordination - Core Services	P85	Client Assistance	Individual Event	$48.00
	P55	Client Engagement	Individual Event	$48.00
	N83	Case Conference (without Client)	Individual Event	$196.00
	N84	Case Conference (with Client)	Individual Event	$246.00
	P56	Outreach for Client Re-engagement	Individual Event	$48.00
	N43	Linkage to Services	Individual Event	$36.00
	030	Accompaniment	Individual Event	$204.00
Health Education - Core Services	221	Health Education (Individual)	Individual Event	$75.00
	Q20	Health Education (Group)	Group – PAID PER ATTENDEE - CAP	$42.00
Modified Directly Observed Therapy - Core Services	N85	Modified Directly Observed Therapy (mDOT) by Licensed Staff	Individual Event	$94.00

Service Family	PHS Code	Service Type	Unit Type	Rate
	N86	Modified Directly Observed Therapy (mDOT) by Navigator	Individual Event	$49.00
Staff Travel	M50	Staff Travel	Individual Event	$108.00

Table 2: Service Types, Descriptions, and Staff Responsible – Service Category 3

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
			Outreach			
545	**Case Finding**	Activities to locate and engage patients who may meet the eligibility criteria for program enrollment. This includes identifying those who are reported by their medical providers, the program's organizations or organizations with which the program has linkage agreements as virally unsuppressed, lost to care or newly diagnosed.	Case finding should be conducted at least once per month. There are 3 types: • Type 1: an event where program staff work from a list of patients who may meet the program's eligibility criteria and contact, or attempt to contact, them by phone. Program staff must attempt to contact at least 10 patients OR speak with at least 3 patients per event. • Type 2: an event where program staff meet with HIV+ persons (either newly diagnosed or previously diagnosed but never in care or lost to care) identified through testing. Program staff must meet face-to-face with at least one patient per event. • Type 3: an event where program staff go into the field to find clinic patients who, according to their medical providers, are lost to care. Program staff must attempt to find at least one patient per event.	Patient Navigator	On-Site or Off-Site	Required
			Assessment and Planning			
115	**Intake Assessment**	Initial assessment of health, psychosocial status and service needs to facilitate plan development. May include: • Documenting eligibility for services and obtaining information for program enrollment • gathering demographic data, HIV diagnosis information, insurance coverage information, involvement in criminal justice system	Intake assessment must be completed within 45 days of program enrollment.	Case Manager	On-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
		• Assessing financial and housing status, substance use and risk behavior, and general health and well-being assessment.				
225	**Service Plan Development**	Development of a client-centered 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. All plans must include at least one goal relevant to the service category in which the client is enrolled and at least one goal addressing health management for HIV. 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	On-Site	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 plan goals, substance use, mental health and risk behaviors. Re-assessment facilitates service plan updates.	Reassessment must occur at least every six months.	Case Manager or Patient Navigator	On-Site	Required
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.	Plans must be updated at least every six months within 30 days of reassessment.	Case Manager or Patient Navigator	On-Site	Required
N82	**Self-Management Assessment**	Evaluation of client's self-management skills. Assessment may include an evaluation of the client's knowledge about HIV and its treatment; ability to make, keep track of and keep appointments; ability to manage	Initial self-management assessment must be complete within 45 days of enrollment. Follow up should be conducted every 3 months.	Patient Navigator	On-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
		prescriptions; adherence to treatment; ability to independently access healthcare services; and ability to maintain coverage for healthcare services.				
Service Coordination – Core Services						
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.	Case Manager or Patient Navigator	On-Site or Off-Site	Required
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. • Type 2: Client engagement services delivered in the field meet the standard even when clients are unable to be found.	Case Manager or Patient Navigator	On-Site or Off-Site	Required
N83	**Case Conference (without client)**	Discussions with primary care provider or HIV specialist to jointly assess and evaluate client, coordinate services and assess progress toward care/service plan goals. May also patient and other service	Initial case conference with health care provider must be conducted within 30 days of program enrollment. Ongoing case conferences with primary care provider must be conducted at least every 3 months.	Case Manager	On-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
		providers such as patient navigators, pharmacists, behavioral health providers and other members of the care team.	Patient attendance recommended. May be conducted by telephone or videoconference.			
N84	**Case Conference (with client)**	Discussions with primary care provider or HIV specialist to jointly assess and evaluate client, coordinate services and assess progress toward care/service plan goals. May also patient and other service providers such as patient navigators, pharmacists, behavioral health providers and other members of the care team.	Initial case conference with health care provider must be conducted within 30 days of program enrollment. Ongoing case conferences with primary care provider must be conducted at least every 3 months. May be conducted by telephone or videoconference.	Case Manager	On-Site	Required
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.	Outreach for reengagement activities should start immediately after the first missed appointment. This service is reportable only during the 90 days following the most recent missed appointment.	Case Manager or Patient Navigator	On-Site or Off-Site	Required
N43	**Linkage to Services**	Verification that a client has kept a scheduled appointment with a provider of supportive services or followed through on a referral to a provider of supportive services. This includes: harm reduction services; services that address clients' basic needs (e.g. food, shelter, and hygiene products/facilities); employment services; legal services; psycho-education counseling; and substance abuse counseling.	Attendance must be verified. If client attends unaccompanied, program may verify through contact with provider or patient self-report. If client is accompanied to appointment by MCM staff member, reimbursement will occur through 'accompaniment' and not 'linkage to services.'	Patient Navigator	On-Site or Off-Site	Required
030	**Accompaniment**	Escorting and/or accompanying client to health and supportive service appointments. Service may be initiated from the client's home or another	• Type 1: delivering the service requires staff to use transportation. • Type 2: delivering the service does not require staff to use transportation.	Patient Navigator	On-Site or Off-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
		location, including the site of the appointment. Service may include: • navigating transportation systems with clients • accompanying clients to help them locate the site of service, gain entrance and check in and out language interpretation (where permitted), emotional support, coaching, and advocacy during the appointment				
Health Education – Core Services						
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.	For each client enrolled, at least one individual or group session must occur at least every three months. May be conducted by videoconference.	Case Manager or Patient Navigator	On-Site	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.	For each client enrolled, at least one individual or group session must occur at least every three months. Groups must have at least 3 participants. At least 1 participant must be enrolled in the program.	Case Manager or Patient Navigator	On-Site	Optional
Modified Directly Observed Therapy – Core Services						
N85	**Modified Directly Observed Therapy (mDOT) by Licensed Staff**	Observing client administer medication to themselves at their home, in the field or the program site.	mDOT services must appear in care plans and describe type of medications observed, site of service (in person or video), frequency (at least once per week), and duration. mDOT is	Registered Nurse or Equivalent	On-Site	Optional

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
			used to monitor adherence to ARVs and to prescribed treatment for opportunistic infections, Hepatitis C, behavioral health conditions and other conditions as necessary. Programs should develop strategies to provide mDOT beyond normal business hours. At each encounter, ask clients to report any side effects.	(in accordance with clinic's policies and procedures)		
N86	**Modified Directly Observed Therapy (mDOT) by Navigator**	Observing client administer medication to themselves at their home, in the field or the program site.	mDOT services must appear in care plans and describe type of medications observed, site of service (both in person and video are permitted) and frequency. mDOT is used to monitor adherence to ARVs and to prescribed treatment for opportunistic infections, Hepatitis C, behavioral health conditions and other conditions as necessary. Programs should develop strategies to provide mDOT beyond normal business hours. At each encounter, ask clients to report any side effects.	Patient Navigator	On-Site or Off-Site	Required
Staff Travel						
M50	**Staff Travel**	Reimbursement for Patient Navigator travel time when traveling off-site to provide services. Allowable off-site services for Patient Navigator include: • Case Finding • Client Assistance • Client Engagement • Outreach for Client Re-engagement • Linkage to Services • Accompaniment Modified Directly Observed Therapy (mDOT)	No additional standard.	Patient Navigator	Off-Site	Required

Recommended Staffing Plan

In addition to the abovementioned requirements for funding, a staffing plan must submitted with agency application materials. The plan is required prior to the award of a contract and contains the anticipated staff assignments during the contract. In order to staff the program, outreach, recruitment, and employment activities should reach those whose life experiences, training, education, and expertise promote understanding of the program's target population. When making employment decisions, level of education should not be the only consideration. Please note that the staff titles, functions, and qualifications are recommendations from NYC DOHMH. The staffing plan submitted by each agency will be evaluated based on the proposed program. It is the responsibility of each agency to ensure that proposed programs are adequately and appropriately staffed.

The program is recommended to have staffing capacity as indicated below:

Program Director

Functions: Provides oversight and management of the program including monitoring, reporting, and quality assurance activities. Directly supervises case manager(s). Reviews cases during individual supervisory sessions and through chart review. Responsible for staff and program performance reviews. Oversees case finding activities. Serves as a liaison between agency and NYC DOHMH/PHS.

Minimum qualifications: Master's degree in Public Health, Social Work, or Counseling and at least 5 years of experience of work experience in services described in this RFP.

Case Manager

Functions: Responsible for tasks to manage client cases including but not limited to:

- Comprehensive assessment and care/service planning
- Verifies eligibility and ensures that services are not duplicated by another provider
- Supervises and collaborates with the Patient Navigator in ongoing assessment, planning and service delivery
- Link clients to medical care in the community
- Coordinate logistics for with the medical provider
- Facilitate health education individual sessions (groups as needed)
- Provide assistance with benefits and entitlements, including restoration of Medicaid and ADAP resources, treatment education, risk reduction counseling, linkage, referral and follow-up
- Facilitates interdisciplinary case conferences

Minimum qualifications: Bachelors (BA) degree and at least two years case management experience.

Patient Navigator

Functions: Provides all home- and field-based services, including health education, DOT, and accompaniment to routine primary care appointments and other healthcare and social service encounters, as needed. Participates in planning and assessment activities. Provides ongoing navigation and support, making appointment reminders and linkages to needed services. Provides feedback to other members of the healthcare team based on observations from the field.

Minimum qualifications: A high school degree (or its equivalent), and demonstrated experience providing HIV health education and treatment adherence.

Utilization of Peers with lived experience helps to enhance patient-centered care by delivering services that support engagement in care such as linkage to services, re-connection to care, and adherence counseling,

even for clients at the highest risk for being lost to follow-up.[28,29,30,31] *It is encouraged that agencies hire peers whenever possible; peers should either be certified by the* ***NYS AIDS Institute Peer Worker Certification Program*** *or be supported to obtain their certification while working in this capacity.*

We encourage hiring people living with HIV, but staff (including Patient Navigators) must not be current clients of the MCM program.

[28] Holtzman CW, Brady KA. Yehia BR. Retention in care and medication adherence: current challenges to antiretroviral therapy success. *Drugs*. 2015; 75(5):445-454

[29] Farrisi D, Dietz N. Patient navigation is a client-centered approach that helps to engage people in HIV care. *HIV Clinician*. 2016; 25(1):1-3

[30] Sarango M, de Groot A, Hirschi M, Umeh CA, Rajabiun S. The role of patient navigators in building a medical home for multiply diagnosed HIV-positive homeless populations. *J Public Health Manag Pract.* 2017; 23(3):276-282

[31] Bradford JB, Coleman S, Cunningham W. HIV system navigation: an emerging model to improve HIV care access. *AIDS Patient Care STDs.* 2007; 21(Suppl 1):S49-S58

Service Category 4: Mental Health Services

Background

When compared to the general population, persons living with HIV (PLWH) are 4 to 8 times more likely to be impacted by a mental health diagnosis.[32] HIV sero-prevalence studies of people living with severe mental illness provide prevalence estimates that range from 4% to 23%.[33] Moreover, mood (e.g. major depression) and anxiety (e.g. general anxiety disorder, posttraumatic stress disorder) disorders are commonly associated with HIV/AIDS, with an estimated 60% of PLWH succumbing to at least one depressive episode throughout the duration of their illness.[34]

Despite an increase in widespread access to antiretroviral treatment (ART) throughout the United States, HIV outcomes among individuals with mental illness continue to be poor. Providing HIV treatment to this subpopulation poses many unique challenges as the co-existence of a mental health diagnosis negatively impacts engagement in and adherence to care and/or treatment.[35] Additionally, psychiatric illness in PLWH is directly associated with diminished health-related quality of life, independent of the effect of HIV infection alone.[36]

Also playing a larger role in mental illness in PLWH is aging. New research has shed light on HIV-associated neurocognitive disorders, indicating milder cognitive impairment has become more common.

Proposals are requested to provide culturally and linguistically appropriate mental health services that address the barriers to treatment and care among PLWH with mental illness. Funds are available to support mental health programs provided by health centers and community-based organizations that are certified to deliver outpatient mental health services and have the capacity to bill Medicaid.

Services Delivery Framework

In addition to addressing identified mental health issues in counseling and therapy sessions, other service areas, including assessment and planning, navigation and client support, and health education should follow recommended trauma-informed principals. Such a "program, organization, or system … realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings."[37]

The framework for delivering Mental Health Services for PLWH integrates HIV-related mental health services with medical treatment as part of the HIV continuum of care. Key programmatic strategies[38] include the following:

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[32] Bing, E. G., Burnam, M., Longshore, D., & et al. (2001). Psychiatric disorders and drug use among human immunodeficiency virus–infected adults in the United States. Archives of General Psychiatry, 58(8), 721-728. doi: 10.1001/archpsyc.58.8.721

[33] Weiser, S., Wolfe, W., & Bangsberg, D. (2004). The HIV epidemic among individuals with mental illness in the United States. Current HIV/AIDS Reports, 1(4), 186-192. doi: 10.1007/s11904-004-0029-4

[34] Treisman, G. J., Angelino, A. F., & Hutton, H. E. (2001). Psychiatric issues in the management of patients with hiv infection. JAMA, 286(22), 2857-2864. doi: 10.1001/jama.286.22.2857

[35] Pence, B. W. (2009). The impact of mental health and traumatic life experiences on antiretroviral treatment outcomes for people living with HIV/AIDS. Journal of Antimicrobial Chemotherapy, 63(4), 636-640. doi: 10.1093/jac/dkp006

[36] HRSA. Mental Health Matters. HRSA CARE Action. March 2009.

[37] Harris, M. & Fallot, R. (2001). Using trauma theory to design service systems, cited at: http://www.samhsa.gov/traumajustice/traumadefinition/approach.aspx.

Whole Person Orientation to Service Provision: Providers will employ an approach to HIV care that highlights the importance of empowering clients to be informed and active in the self-management of their illness, thereby increasing clients' levels of competence, confidence and autonomy.

Service Delivery Model

Services should be based on best practices, evidence-based protocols, or community-driven initiatives. RWPA-funded Mental Health Services are defined as services that include psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers.

Goals and Objectives

The overarching goal for this service category is to provide Mental Health Services directly necessitated by an individual's HIV status in order to engage and retain PLWH in treatment and care, thereby serving to enhance immunological status and improve health outcomes.

Objectives:

- Provide treatment and counseling services to individuals living with HIV and mental illness, with or without co-occurring substance use disorders, that aim to improve quality of life and mental health functioning.
- Facilitate continued engagement in biomedical, psychological and psychosocial care and treatment including adherence to ART and/or psychotropic medications.
- Overcome barriers to mental health care.

Reimbursement

Services provided under this service category will be reimbursed using a fee-for-service methodology. A deliverables-based start-up period to reach full service capacity will be provided.

Program Specific Client Target Population

Services may be provided to clients who meet eligibility criteria for RWPA services, including, HIV status, residency, and income. Note that active substance use or incarceration history does not preclude client eligibility for services.

In addition to the general Ryan White eligibility criteria, services may ONLY be provided to those with a DSM diagnosis.

In limited cases, affected family members, partners and caregivers (collaterals) may receive family counseling services when such services directly benefit the person living with HIV/AIDS (index client) and the HIV+ client is present.

Program Specific Agency Eligibility Requirements

In addition to the General Organizational Eligibility Requirements, organizations applying to provide mental health services must be NYS licensed Article 28 facilities or Article 31 facilities.

Organizations applying for RWPA funding for Mental Health Services must demonstrate that these funds will be Payer of Last Resort (POLR) and have the capacity to bill Medicaid for those clients with Medicaid. *Eligible clients may be provided services in their home if necessary to engage the client in mental healthcare. RWPA funds cannot be used to replace, or supplant Medicaid supported services.*

Service Type Description

Mental Health Services funded under this RFP are limited to clients living with HIV ***with a DSM-V diagnosis***. All listed required services must be made available by each funded contractor for appropriate clients. *This does not mean that all clients must receive every service element.*

Table 1: Summary of Services and Rates – Service Category 4

Service Family	PHS Code	Service Type	Unit Type	Rate
Assessment and Planning	115	Intake Assessment	Individual Event	$237.00
	225	Service Plan Development	Individual Event	$90.00
	076	Reassessment	Individual Event	$203.00
	226	Service Plan Update	Individual Event	$90.00
Mental Health Services - Core Services	050	Mental Health Counseling – Individual	Individual Event	$157.00
	P88	Mental Health Counseling – Group	Group – PAID PER ATTENDEE - CAP	$63.00
	032	Mental Health Counseling – Family	Family/Group – PAID AS EVENT	$160.00
	073	Psychiatric Evaluation	Individual Event	$390.00
	074	Psychiatric Visit	Individual Event	$209.00
Other Counseling Services - Core Services	049	AOD Counseling – Individual	Individual Event	$157.00
	P87	AOD Counseling – Group	Group – PAID PER ATTENDEE - CAP	$63.00
	031	AOD Counseling – Family	Family/Group – PAID AS EVENT	$160.00
	239	Treatment Adherence Counseling – Individual	Individual Event	$157.00
	P89	Treatment Adherence Counseling – Group	Group – PAID PER ATTENDEE - CAP	$63.00
	237	Treatment Adherence Counseling – Family	Family/Group – PAID AS EVENT	$160.00
	P57	Wellness – Individual	Individual Event	$112.00
	Q15	Wellness – Group	Group – PAID PER ATTENDEE - CAP	$63.00
	P86	Biomedical Counseling – Partners	Individual Event	$112.00

Service Family	PHS Code	Service Type	Unit Type	Rate
Evidence-Based Interventions - Core Services	P61	Seeking Safety – Individual	Individual Event	$157.00
	Q14	Seeking Safety – Group	Group – PAID PER ATTENDEE - CAP	$73.00
Service Coordination	030	Accompaniment	Individual Event	$215.00
	247	Care Coordination – Primary Care Provider	Individual Event	$50.00
	P55	Client Engagement	Individual Event	$50.00
	P56	Outreach for Client Re-engagement	Individual Event	$50.00
	P85	Client Assistance	Individual Event	$50.00
Staff Travel	P81	Staff Travel - High	Individual Event	$189.00
	P83	Staff Travel - Low	Individual Event	$119.00

Table 2: Service Types, Descriptions, and Staff Responsible – Service Category 4

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
Assessment and Planning						
115	**Intake Assessment**	Initial assessment of health, psychosocial status and service needs to facilitate plan development. May include: • Documenting eligibility for services and obtaining information for program enrollment • gathering demographic data, HIV diagnosis information, insurance coverage information, involvement in criminal justice system • assessing financial and housing status, substance use and risk behavior, and general health and well-being assessment	Intake assessment must be completed within 45 days of program enrollment.	Licensed Mental Health Clinician	On-Site	Required
225	**Service Plan Development**	Development of a client-centered 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. All plans must include at least one goal relevant to the service category in which the client is enrolled and at least one goal addressing health management for HIV. 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.	Licensed Mental Health Clinician	On-Site	Required
076	**Reassessment**	Follow up assessment to re-evaluate and record client eligibility, engagement in care and services,	Reassessment must occur at least every six months.	Licensed Mental Health Clinician	On-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
		emerging health and service needs, progress towards achieving 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.	Plans must be updated at least every six months within 30 days of reassessment.	Licensed Mental Health Clinician	On-Site	Required
Mental Health Services – Core 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.	Licensed Mental Health Clinician	On-Site or Off-Site	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 Ryan White program.	Licensed Mental Health Clinician	On-Site	Required
032	**Mental Health Counseling - Family**	Psychotherapeutic counseling that includes client's family members, friends or anyone else who matters to the client to address a diagnosed mental health condition.	Each session is at least 60 minutes. Client must be present during the family counseling session.	Licensed Mental Health Clinician	On-Site	Required
073	**Psychiatric Evaluation**	Interview to evaluate need for psychiatric intervention, determine diagnosis and develop psychiatric treatment plan.	Each session is at least 45 minutes.	Psychiatrist or Psychiatric Mental Health Nurse Practitioner	On-Site	Optional
074	**Psychiatric Visit**	Psychiatric session to follow up on treatment plan and manage psychiatric medication.	Each session is at least 15 minutes.	Psychiatrist or Psychiatric Mental Health Nurse Practitioner	On-Site	Optional
Other Counseling Services – Core 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	No additional standard.	Licensed Mental Health Clinician	On-Site	Optional

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
		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.				
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.	Licensed Mental Health Clinician	On-Site	Optional
031	**AOD Counseling - Family**	Therapeutic counseling that includes client's family members, friends or anyone else who matters to the client 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.	Client must be present during the family counseling session.	Licensed Mental Health Clinician	On-Site	Optional
239	**Treatment Adherence Counseling - Individual**	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 improve adherence, drug interactions and the managing side effects.	No additional standard.	Licensed Mental Health Clinician	On-Site	Required
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,	Groups must have at least 3 participants. At least 1	Licensed Mental Health Clinician	On-Site	Optional

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
		barriers to adherence, strategies to improve adherence, drug interactions and the managing side effects.	participant must be enrolled in the program.			
237	**Treatment Adherence Counseling - Family**	Therapeutic counseling that includes client's family members, friends or anyone else who matters to the client 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.	Client must be present during the family counseling session.	Licensed Mental Health Clinician	On-Site	Optional
P57	**Wellness - Individual**	One-on-one session to provide education and follow-up on issues affecting client's mental health needs. Includes addressing: • Engagement in psychiatric care • Adherence to psychiatric medications • Current stressors and client's perception of stress • Effective coping strategies • Navigating the health care system • Barriers to mental health treatment	No additional standard.	Patient Navigator	On-Site	Optional
Q15	**Wellness - Group**	Group session to provide education and follow-up on issues affecting client's mental health needs. Includes addressing: • Engagement in psychiatric care • Adherence to psychiatric medications • Current stressors and client's perception of stress • Effective coping strategies • Navigating the health care system • Barriers to mental health treatment	Groups must have at least 3 participants. At least 1 participant must be enrolled in the program.	Patient Navigator	On-Site	Optional
P86	**Biomedical Counseling - Partners**	Counseling to address prevention of HIV transmission within serodiscordant couples. Session may cover undetectable=untransmittable, PrEP, PEP and other tools to prevent transmission as well as referrals that are needed to access PrEP and PEP.	No additional standard.	Patient Navigator	On-Site	Optional

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
Evidence-Based Interventions – Core Services						
P61	**Seeking Safety - Individual**	Seeking Safety (SS) is a present-focused intervention to help clients attain safety from trauma/post-traumatic stress disorder (PTSD) and/or substance abuse SS; consists of 25 topics and can be conducted in either individual or group format. **Individual Sessions**: approximately 60 minutes per session.	Each session is at least 60 minutes and may only be delivered by staff trained at DOHMH to conduct the intervention.	Licensed Mental Health Clinician	On-Site	Optional
Q14	**Seeking Safety - Group**	Session for addressing substance use using Seeking Safety (SS), a present-focused intervention to help clients attain safety from trauma, post-traumatic stress disorder (PTSD) and substance use.	Each session is at least 60 minutes and may only be delivered by staff trained at DOHMH to conduct the intervention. Groups must have at least 3 participants. At least 1 participant must be enrolled in the Ryan White program.	Licensed Mental Health Clinician	On-Site	Optional
Service Coordination						
030	**Accompaniment**	Escorting and/or accompanying client to health and supportive service appointments. Service may be initiated from the client's home or another location, including the site of the appointment. Service may include: • navigating transportation systems with clients • accompanying clients to help them locate the site of service, gain entrance and check in and out language interpretation (where permitted), emotional support, coaching, and advocacy during the appointment	Program staff must leave the program site to escort clients or meet clients at a location other than the program site in order to provide accompaniment services.	Patient Navigator	On-Site or Off-Site	Required
247	**Care Coordination - Primary Care Provider**	Direct communication with client's primary care team (i.e. doctor, nurse practitioner, physician assistant, nurse, social worker, case manager, and others involved in the patient's care) to inform	No additional standard.	Licensed Mental Health Clinician or	On-Site or Off-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
		service planning and collaboratively support engagement in care and treatment. Includes addressing retention in care, lab values, ARV use, and adherence to treatment as well as psychosocial factors affecting health and healthcare.		Patient Navigator		
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.	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.	Patient Navigator	On-Site	Required
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 during the 90 days following the most recent missed appointment.	Patient Navigator	On-Site or Off-Site	Required
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	On-Site	Required
		Staff Travel				
P81	**Staff Travel - High**	Reimbursement for Licensed Mental Health Clinician travel time when traveling off-site to provide services. Allowable off-site services for Licensed Mental Health Clinician include: • Mental Health Counseling – Individual	No additional standard.	Licensed Mental Health Clinician	Off-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
		• Care Coordination – Primary Care Provider				
P83	**Staff Travel - Low**	Reimbursement for Patient Navigator travel time when traveling off-site to provide services. Allowable off-site services for Patient Navigator include: • Accompaniment • Care Coordination – Primary Care Provider • Outreach for Patient Re-engagement	No additional standard.	Patient Navigator	Off-Site	Required

Recommended Staffing Plan

In addition to the abovementioned requirements for funding, a staffing plan must be submitted with agency application materials. The plan is required prior to the award of a contract and contains the anticipated staff assignments during the contract. In order to staff the program, outreach, recruitment, and employment activities should reach those whose life experiences, training, education, and expertise promote understanding of the program's target population. When making employment decisions, level of education should not be the only consideration. Please note that the staff titles, functions, and qualifications are recommendations from NYC DOHMH. The staffing plan submitted by each agency will be evaluated based on the proposed program. It is the responsibility of each agency to ensure that proposed programs are adequately and appropriately staffed.

The program is recommended to have staffing capacity as indicated below:

Program Director

Functions: Provides oversight and management of the program including, but not limited to:

- Oversees monitoring, reporting, and quality assurance activities.
- Ensures coordination within agency/program services and linkage with primary care and ancillary services (e.g., housing, food, legal, case management).
- Supervises clinicians and Patient Navigators by chart review and face-to-face case discussions and performance reviews.

Recommended qualifications: Master's Degree in Social Work, Counseling, Public Administration or Public Health and 5 years of work experience in services described in this RFP.

Clinical Director

Functions: Assists the organization in growing direct service competencies and ensures that program is clinically informed. Facilitates clinical supervision with program staff through regular individual and group supervision with a focus on clinical issues and staff attunement to work-related self-care. Provides additional training, support, and evaluation to program staff to ensure a high quality of services to clients within the program.

Preferred Skills/Education: NYS Licensed Mental Health Practitioner OR Licensed Social Worker. Five (5) years working experience with substance use and/or mental illness, and/or chronic medical conditions (particularly HIV/AIDS). Two (2) years of experience supervising clinical and/or case management staff.

Psychiatrist

Functions: Conducts psychiatric evaluations and visits. Appropriately documents provision of MHS services in a timely manner.

Required Credentials: NYS-licensed medical provider (MD, DO, PA, NP)

Licensed Mental Health Clinician

Functions: Develops and updates individualized service plans. Facilitates mental health service family activities. Facilitates individual, group, and family counseling sessions. May also provide treatment adherence services. Conducts care coordination with primary care provider. May conduct care coordination/case conferences with other social service or health care providers. Appropriately documents provision of MHS services in a timely manner.

Required Credentials: NYS Licensed Mental Health Practitioner OR Licensed Social Worker.

Patient Navigators

Functions: Facilitate program activities (accompaniment, engagement, re-engagement, wellness group) that lead to retention in the MHS program. Improve the coordination of care between mental health staff and other service providers. Appropriately documents provision of MHS services in a timely manner.

Preferred Credentials/Skills: Certification through the New York State Department of Health AIDS Institute Certified Peer Worker program, including the Specialized Training Topic "Peer Role in Patient Navigation", course is mandatory, within 6 months implementation. Cultural and linguistic competence highly recommended. Demonstrated basic understanding of mental health illness recommended.

Utilization of Peers with lived experience helps to enhance patient-centered care by delivering services that support engagement in care such as linkage to services, re-connection to care, and adherence counseling, even for clients at the highest risk for being lost to follow-up.[39,40,41,42] *It is encouraged that agencies hire peers whenever possible; peers should either be certified by the* ***NYS AIDS Institute Peer Worker Certification Program*** *or be supported to obtain their certification while working in this capacity.*

The NY EMA encourage hiring people living with HIV, but staff (including Patient Navigators) must not be current clients of the Mental Health Services program.

[39] Holtzman CW, Brady KA. Yehia BR. Retention in care and medication adherence: current challenges to antiretroviral therapy success. *Drugs*. 2015; 75(5):445-454

[40] Farrisi D, Dietz N. Patient navigation is a client-centered approach that helps to engage people in HIV care. *HIV Clinician*. 2016; 25(1):1-3

[41] Sarango M, de Groot A, Hirschi M, Umeh CA, Rajabiun S. The role of patient navigators in building a medical home for multiply diagnosed HIV-positive homeless populations. *J Public Health Manag Pract.* 2017; 23(3):276-282

[42] Bradford JB, Coleman S, Cunningham W. HIV system navigation: an emerging model to improve HIV care access. *AIDS Patient Care STDs.* 2007; 21(Suppl 1):S49-S58

Service Category 5: Oral Health Care Services

Background

Oral health care is recognized as a component of standard HIV primary care, as HIV infection often manifests orally with disease progression. The New York State Department of Health (NYS DOH) AIDS Institute states "all HIV+ patients should receive an annual dental exam."[43] For low-income, under and un-insured persons living with HIV (PLWH), obtaining basic benefits (i.e. oral health care) can be an enormous challenge. Yet, without adequate dental care, PLWH are more likely to experience negative health outcomes.

In addition to providing timely diagnosis and treatment of oral manifestations of HIV/AIDS, oral health care can improve the overall health outcomes for PLWH. While the utilization of oral health care has declined over the years, the need for comprehensive dental treatment remains high among PLWH in the Tri-County region. A 2013 CHAIN study on oral health care utilization reported "… participants… used oral health care services at levels (annualized rate 61%) similar to those reported by the NYC and US general populations" (64%; NYC DOHMH 2007, 69%; CDC 2008, respectively). However, "the annualized rate of oral health care services utilization among Tri-County participants in the most recent round (2010-2012) was significantly lower (51%)," with substance use (including a history of injection drug use and/or current smoking) being the largest predictive factor in the underutilization of oral health care services.[44] The results from the CHAIN study suggest the potential value of promoting oral health care services for all PLWH in the region, with a special focus on substance users and cigarette smokers.

Proposals are requested to provide culturally and linguistically-appropriate, comprehensive oral health care that includes a range of dental services coordinated with medical case management and primary care services.

Service Delivery Framework

Persons living with HIV should receive routine, comprehensive oral health care, including semi-annual examinations and treatment plans. Oral health care services should be fully integrated into, and coordinated with, medical case management and primary care services, with the oral health care provider promptly communicating to the patient's medical provider any clinical findings or planned procedure that may indicate a change in, or impact, the patient's systematic health.

Oral health services should be presented in a user-friendly manner which maximizes access and promotes overall health. Concerted outreach efforts should be made to schedule and re-confirm appointments for those who are homeless, mentally ill, and/or substance-using, whose conditions may present added barriers to maintaining care.

Service Delivery Model

Comprehensive Oral Health Care Services- which must include periodic screenings and preventive, diagnostic, and therapeutic services- may be provided by general dentists, dental specialists, dental

[43] New York State Department of Health AIDS Institute. (2010). HIVQUAL indicator definitions guide for providers of ambulatory care services. http://ehivqual.org/scripts/Adult%20Ambulatory%20Care%20Indicator%20Definitions.pdf

[44] Yomogida, M. Utilization of Oral Health Care, CHAIN Report, 2012-10, April 26, 2013.

hygienists, and/or other professional oral health practitioners operating under standards of the American Dental Association, American Academy of Pediatric Dentistry, and the NYS AIDS Institute.

RWPA may reimburse for comprehensive oral health services for those who are uninsured; the oral health program, either directly or through referral to a case manager/care coordinator, must immediately assist the uninsured patients in obtaining dental care coverage.

For those patients who already have oral care coverage (i.e. Medicaid, ADAP Plus, and commercial insurance), RWPA may pay for a finite list of services which are not reimbursed through these sources. Examples include, but may not be limited to:

- Dental repair/replacement;
- Fixed bridge work;
- Immediate dentures;
- Implants;
- Molar root canals;
- Oral health education;
- Periodontal surgery;
- Sealants; and
- Services to promote access to, or maintenance in, dental care.

Goals and Objectives[45]

The overarching goal for this service category is to provide oral health services directly necessitated by an individual's HIV status, thereby serving to enhance immunological status, improve health outcomes, and reduce disease transmission.

Objectives:

- To promote optimal health and quality of life resulting from the prevention, early detection and treatment of dental decay and periodontal disease, opportunistic infections, and other health-related complications; and the restoration and maintenance of proper oral structure.
- To increase the number of persons with HIV disease who have access to, and receive ongoing, appropriate oral health care services.
- To avoid interruptions in the receipt of HIV primary care or in the adherence to antiretroviral treatment due to oral health issues.
- To improve and maintain proper nutritional intake.
- To assure that oral health care is an integral part of HIV primary care for all PLWH.

[45] HRSA/HAB Division of Metropolitan HIV/AIDS Programs. Program Monitoring Standards – Part A. April 2013: "Oral Health Services…including diagnostic, preventive, and therapeutic dental care that is
in compliance with state dental practice laws, includes evidence-based clinical decisions that are informed by the American Dental Association Dental Practice Parameters, is based on an oral health treatment plan, adheres to specified service caps, and is provided by licensed and certified dental professionals."

Reimbursement

Services provided under this service category will be reimbursed using a cost-based methodology.

Program Specific Client Target Population

Services may be provided to clients who meet eligibility criteria for RWPA services, including, HIV status, residency, and income. *Note that active substance use or incarceration history does not preclude client eligibility for services.*

In addition to the general Ryan White eligibility criteria, Oral Health Care Services are restricted to persons without access to oral health care and those without adequate dental insurance coverage.

Program Specific Agency Eligibility Requirements

In addition to the General Organizational Eligibility Requirements, organizations applying to provide Oral Health Care Services must be a health center authorized to bill NYS Medicaid such as a NYS licensed Article 28 facility. The organization must also have, or obtain, the ability to bill the New York State HIV Uninsured Care Program for dental services.

Service Type Description

Oral Health Care Services funded under this RFP are limited to clients living with HIV. All listed required services must be made available by each funded contractor for appropriate clients. However, this does not mean that all clients must receive every service element.

Table 1: Summary of Services and Rates – Service Category 5

Service Family	PHS Code	Service Type	Unit Type	Rate
Planning and Assessment	115	Intake Assessment	Individual Event	$0.00
	225	Care/Treatment Plan Development	Individual Event	$0.00
	076	Reassessment	Individual Event	$0.00
	226	Care/Treatment Plan Update	Individual Event	$0.00
Navigation	P55	Client Engagement	Individual Event	$0.00
	P69	Referrals	Individual Event	$0.00
Comprehensive Oral Health Care Services	125	Preventive	Individual Event	$0.00
	M57	Palliative	Individual Event	$0.00
	M58	Restorative	Individual Event	$0.00

Table 2: Service Types, Descriptions, and Staff Responsible – Service Category 5

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
Planning and Assessment						
115	**Intake Assessment**	Initial assessment of health, psychosocial status and service needs to facilitate plan development. May include: • Documenting eligibility for services and obtaining information for program enrollment • gathering demographic data, HIV diagnosis information, insurance coverage information, involvement in criminal justice system, dental service needs • assessing financial and housing status, substance use and risk behavior, and general health and well-being assessment	Intake assessment must be completed within 45 days of program enrollment.	Dental Navigator	On-Site	Required
225	**Care/Treatment Plan Development**	Development of a client-centered 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.	Dental Navigator	On-Site	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 plan goals, substance use, mental health and risk behaviors. Re-assessment facilitates service plan updates. May include: Documenting/assessing oral health care service needs	For patients whose services extend beyond six months, reassessment must occur	Dental Navigator	On-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
226	**Care/Treatment Plan Update**	Review of service plan to evaluate progress toward achieving goals and make revisions in response to the reassessment or emerging needs.	Plans must be updated at least every six months within 30 days of reassessment.	Dental Navigator	On-Site	Required
Navigation						
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. Type 2: Client engagement services delivered in the field meet the standard even when clients are unable to be found.	Dental Navigator	On-Site or Off-Site	Required
P69	**Referrals**	Information provided to clients so that they may access needed services including health, legal, mental health, medical and non-medical case management, housing, and substance use services. May include: Referrals to services that promote access to or maintenance in dental care.	Referrals must be completed by a staff member approved by DOHMH.	Dental Navigator	On-Site	Required
Comprehensive Oral Health Services						
125	**Preventive**	New patient or patients with a condition which warrants special instruction should be provided with oral health education. Sessions must be a routine part of the provision of care and may include: • Oral health education • Sealants	No additional standard.	NYS Registered Dentist	On-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
M57	**Palliative**	Services to address dentistry needs (as per service/treatment plan). May include: • Periodontal surgery • Root canal treatment • Dental emergencies	No additional standard.	NYS Registered Dentist	On-Site	Required
M58	**Restorative**	The integrated diagnosis and management of diseases of the teeth and their supporting structures and the rehabilitation of the dentition to functional requirements of the individual. May include: • Molar root canals • Bridge work • Immediate dentures • Overdentures	No additional standard.	NYS Registered Dentist	On-Site	Required

Recommended Staffing Plan

In addition to the abovementioned requirements for funding, a staffing plan must be submitted with agency application materials. The plan is required prior to the award of a contract and contains the anticipated staff assignments during the contract. In order to staff the program, outreach, recruitment, and employment activities should reach those whose life experiences, training, education, and expertise promote understanding of the program's target population. When making employment decisions, level of education should not be the only consideration. Please note that the staff titles, functions, and qualifications are recommendations from NYC DOHMH. The staffing plan submitted by each agency will be evaluated based on the proposed program. It is the responsibility of each agency to ensure that proposed programs are adequately and appropriately staffed.

The program is recommended to have staffing capacity as indicated below:

NYS Registered Dentist

Functions: Conducts oral health examinations, provides diagnosis, and identifies treatment for each client. Provides oversight and management of the program, including monitoring, reporting and quality assurance activities.

Recommended Minimum Credentials: Oral health care must be delivered in accordance with NYS Registered Dentist licensure requirements and rules of practice outlined by the New York State Department of Education. The dentist should have experience working with persons living with HIV.

Dental Navigator

Functions: Assists with oversight of client case management as related to oral health care. Assists with client engagement activities to support clients' attendance at dental appointments, referral to medical case management, referral to HIV primary medical care (for clients identified as out of care), and follow-up that linkage to care has been successful. Assists with input of client dental services into the electronic medical record system and the RWPA client level web-based reporting system (eSHARE). Tracks dental visits and records services to ensure there is no duplication of services with other funding sources.

Recommended Minimum Credentials: Dental Navigator has a high school degree (or its equivalent) and at least 2 years of experience managing services for PLWH community members.

Utilization of Peers with lived experience helps to enhance patient-centered care by delivering services that support engagement in care such as linkage to services, re-connection to care, and adherence counseling, even for clients at the highest risk for being lost to follow-up.[46,47,48,49] *It is encouraged that agencies hire peers whenever possible; peers should either be certified by the* ***NYS AIDS Institute Peer Worker Certification Program*** *or be supported to obtain their certification while working in this capacity.*

The NY EMA encourages hiring people living with HIV, but staff (including Navigators) must not be current clients of the Oral Health Care program.

[46] Holtzman CW, Brady KA. Yehia BR. Retention in care and medication adherence: current challenges to antiretroviral therapy success. *Drugs*. 2015; 75(5):445-454

[47] Farrisi D, Dietz N. Patient navigation is a client-centered approach that helps to engage people in HIV care. *HIV Clinician*. 2016; 25(1):1-3

[48] Sarango M, de Groot A, Hirschi M, Umeh CA, Rajabiun S. The role of patient navigators in building a medical home for multiply diagnosed HIV-positive homeless populations. *J Public Health Manag Pract.* 2017; 23(3):276-282

[49] Bradford JB, Coleman S, Cunningham W. HIV system navigation: an emerging model to improve HIV care access. *AIDS Patient Care STDs.* 2007; 21(Suppl 1):S49-S58

Service Category 6: Psychosocial Support Services

Background

Individuals diagnosed with HIV may require assistance in coping with the implications of their life-long diagnosis. Moreover, grief, fear, stigma, and isolation may make it difficult for a client to engage in and/or adhere to HIV care and treatment. For many individuals living with HIV, medical, social, and emotional challenges are exacerbated by inadequate support systems, economic disadvantage, substance use, and unstable housing; all of which are added barriers to care and treatment. PLWH, especially those impacted by the abovementioned barriers to care, need support in making treatment decisions, adhering to treatment regimens, and establishing stability for their caregivers and children.

Psychosocial support services are associated with improved engagement in HIV care for the purpose of improving health outcomes. PLWH suffering from mental illness and traumatic life events are more difficult to engage in care and less likely to remain treatment adherent.[50] While these individuals would benefit from mental health treatment, they are less likely to seek out psychotherapy. Psychosocial support services can act as a bridge for persons with depressive or anxious symptoms not ready to access mental health services due to fear and stigma. These services offer low threshold support that aid in addressing barriers and needs, accessing and maintaining HIV medical care, and, eventually, seeking mental health counseling. A recent CHAIN report supports this, pointing to an increase in utilization of mental health services following the introduction of psychosocial support services in the Tri-County region.[51]

Proposals are requested to provide culturally- and linguistically-appropriate psychosocial support services that address the barriers to appropriate treatment and care among PLWH. Funds are available to support psychosocial support services programs provided by health centers and community-based organizations that are geographic located in the Tri-County area.

Service Delivery Framework

Psychosocial support services funded under this RFP are limited to clients living with HIV. Exceptions are permitted, in very limited cases, where services are provided for family members, partners, caregivers or others affected by the HIV-infected person and only when such services directly benefit the persons living with HIV/AIDS and when the HIV-infected person is present.[52]

Psychosocial support service provides outreach to individuals who are diagnosed with HIV and may require assistance to cope with their diagnosis as well as with a range of stressors. Individual and group counseling helps individuals engage in, and remain engaged, in care and treatment. Activities aid in dealing with medical, social, and emotional challenges they face. They and their families receive support making treatment decisions, adhering to treatment regimens, and establishing family stability for caregivers and children. The goal of psychosocial support services is to fully engage participants in enhancing self-management skills and, ultimately improve their health outcomes.

Psychosocial support services also act as a bridge to mental health services for those in need of professional counseling services. Providers of psychosocial support services must establish MOUs with

[50] Pence, B. W. (2009). The impact of mental health and traumatic life experiences on antiretroviral treatment outcomes for people living with HIV/AIDS. Journal of Antimicrobial Chemotherapy, 63(4), 636-640. doi: 10.1093/jac/dkp006
[51] McAllister, L., Irvine, M. Irvine, M. CHAIN New York City and Tri-County Trends Over Time from Published Reports, CHAIN Report 2014.1, February 27, 2014.
[52] https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

providers of mental health service to refer clients in need of mental health services and to provide client assistance and accompaniment services to clients from the mental health program. Psychosocial support and mental health programs can be part of a single agency or can share clients and services through a MOU.

Service Delivery Model

Psychosocial Support Services provides outreach, individual, family and group counseling, support groups, crisis intervention, peer and non-peer led interventions, drop-in activities, grief and bereavement counseling, pastoral care, and transitional services to stabilize families after the death of a loved one. The program also provides relationship-building activities, education, training, HIV self-management skills-building activities, treatment readiness and adherence support, linkage and referral to the full range of services available to PLWH in the New York EMA.

Goals and Objectives[53]

The overarching goal for this service category is to provide psychosocial support services directly necessitated by an individual's HIV status in order to engage and retain PLWH in treatment and care, thereby serving to enhance immunological status, improve health outcomes, and reduce disease transmission.

Objectives:

- Provide counseling services to individuals experiencing stress and anxiety who do not necessarily have a DSM-V diagnosis.
- Provide individual and group supportive counseling services that aim to overcome barriers to access and facilitate continued engagement in medical care and treatment adherence in order to increase ART utilization and promote optimal health outcomes.
- Provide family-focused services that reduce stressors in the lives of PLWH in order to remove barriers to engagement in HIV care and adherence to treatment.

Reimbursement

Services provided under this service category will be reimbursed using a fee-for-service methodology. A deliverables-based start-up period to reach full service capacity will be provided

Program Specific Client Target Population

Services may be provided to clients who meet eligibility criteria for RWPA services, including, HIV status, residency, and income. Note that active substance use or incarceration history does not preclude client eligibility for services.

[53] HRSA/HAB Division of Metropolitan HIV/AIDS Programs. Program Monitoring Standards – Part A, April 2013. "Psychosocial support services may include support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care/counseling, caregiver support, bereavement counseling and nutrition counseling provided by a non-registered dietitian. Funds under this service category may not be used to provide nutritional supplements."

Program Specific Agency Eligibility Requirements

In addition to the General Organizational Eligibility Requirements, non-profit organizations must have experience serving PLWH in addition to experience engaging individuals who are out of care or sporadically in care or in need of self-management support. Further, organizations providing services must:

1) Be co-located or have established linkages with medical and social service programs to refer participants;
2) Ensure that staff members are appropriately credentialed to provide the services listed and have HIV knowledge, training, and cultural sensitivity appropriate to the populations served; and
3) Have service sites geographically located within Tri-County, accessible to, and able to service clients from throughout the entire NY EMA.

Service Type Description

Psychosocial Support Services funded under this RFP are limited to clients living with HIV. All listed ***required*** services must be made available by each funded contractor for appropriate clients. *This does not mean that all clients must receive every service element.*

Table 1: Summary of Services and Rates – Service Category 6

Service Family	PHS Code	Service Type	Unit Type	Rate
Outreach	545	Targeted Case Finding	Anon Group – PAID AS EVENT	$290.00
Assessment and Planning	115	Intake Assessment	Individual Event	$197.00
	225	Service Plan Development	Individual Event	$75.00
	076	Reassessment	Individual Event	$169.00
	226	Service Plan Update	Individual Event	$75.00
Psychosocial Support Services - Core Services	319	Counseling – Individual	Individual Event	$131.00
	P91	Counseling – Group	Group – PAID PER ATTENDEE - CAP	$53.00
	329	Counseling – Family	Family/Group – PAID AS EVENT	$150.00
	P80	Pastoral Counseling - Individual	Individual Event	$110.00
	P86	Biomedical Counseling – Partners	Individual Event	$79.00
Service Coordination	P85	Client Assistance	Individual Event	$50.00
	030	Accompaniment	Individual Event	$215.00
	P29	Coordination with Service Providers	Individual Event	$50.00
	P56	Outreach for Client Re-engagement	Individual Event	$50.00
Evidence-Based Interventions - Core Services	P61	Seeking Safety – Individual	Individual Event	$131.00
	Q14	Seeking Safety – Group	Group – PAID PER ATTENDEE - CAP	$61.00
Staff Travel	M50	Staff Travel	Individual Event	$153.00

Table 2: Service Types, Descriptions, and Staff Responsible – Service Category 6

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or 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	Off-Site	Required
Assessment and Planning						
115	**Intake Assessment**	Initial assessment of health, psychosocial status and service needs to facilitate plan development. Program staff conduct a full psychosocial assessment. May include: • Documenting eligibility for services and obtaining information for program enrollment • gathering demographic data, HIV diagnosis information, insurance coverage information, involvement in criminal justice system, dental service needs • assessing financial and housing status, substance use and risk behavior, and general health and well-being assessment	A full psychosocial assessment includes client demographics, HIV status, insurance information, financial and housing assessments, substance use and behavioral risk assessments, general health and wellbeing assessment, and legal history, to ensure that all required information is obtained to enroll the client in the program. Assessment-related services are payable only four times within a 365-day period.	Case Manager / Psychosocial Support Services Coordinator	On-Site	Required
225	**Service Plan Development**	Development of a client-centered 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. All plans must include at least one goal relevant to the service category in which the client is enrolled and at least one goal addressing health management for HIV. Each goal	Case Manager / Psychosocial Support Services Coordinator	On-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
			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.			
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 plan goals, substance use, mental health and risk behaviors. Re-assessment facilitates service plan updates.	Assessment-related services are payable only four times within a 365-day period.	Case Manager / Psychosocial Support Services Coordinator	On-Site	Required
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.	Plans must be updated at least every six months within 30 days of reassessment.	Case Manager / Psychosocial Support Services Coordinator	On-Site	Required
Psychosocial Support Services – Core Services						
319	**Counseling - Individual**	One-to-one supportive counseling to address goals described in the service plan. Counseling will provide support and promote stability. Includes time-limited bereavement counseling for affected family members following the death of the index client.	No additional standard.	Case Manager / Psychosocial Support Services Coordinator	On-Site	Required
P91	**Counseling - Group**	Group supportive counseling to address goals described in the service plan in a mutually supportive setting. Counseling will provide mutual support and promote stability.	Groups must have at least 3 participants. At least 1 participant must be enrolled in the program.	Case Manager / Psychosocial Support Services Coordinator	On-Site	Required
329	**Counseling - Family**	Supportive counseling that includes client's family members, friends or anyone else who matters to the client to	Client must be present during the family counseling session.	Case Manager / Psychosocial Support	On-Site	Optional

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
		address goals described in the service plan.		Services Coordinator		
P80	**Pastoral Counseling - Individual**	One-to-one counseling for clients seeking spiritual guidance in addition to their other counseling needs.	Pastoral counseling must be: • Provided by an institutional pastoral care program (e.g. components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider, such as a home care or hospice provider)	Master of Divinity or a Masters or Doctoral-level degree in theological, spiritual or biblical studies, or a Masters or Doctoral-level degree in pastoral counseling from schools accredited by agencies recognized by the U.S. Department of Education	On-Site	Optional
P86	**Biomedical Counseling - Partners**	Counseling to address prevention of HIV transmission within serodiscordant couples. Session may cover undetectable=untransmittable, PrEP, PEP and other tools to prevent transmission as well as referrals that are needed to access PrEP and PEP.	No additional standard.	Case Manager / Psychosocial Support Services Coordinator	On-Site	Optional
Service Coordination						
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	No additional standard.	Patient Navigator	On-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
		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.				
030	**Accompaniment**	Escorting and/or accompanying client to health and supportive service appointments. Service may be initiated from the client's home or another location, including the site of the appointment. Service may include: • navigating transportation systems with clients • accompanying clients to help them locate the site of service, gain entrance and check in and out • language interpretation (where permitted), emotional support, coaching, and advocacy during the appointment	Type 1: delivering the service requires staff to use transportation. Type 2: delivering the service does not require staff to use transportation.	Patient Navigator	On-Site or Off-Site	Required
P29	**Coordination with Service Providers**	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. Activities	No additional standard.	Patient Navigator	On-Site or Off-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
		may also include direct communication with other service providers to coordinate care.				
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.	Patient Navigator	On-Site or Off-Site	Required
Evidence-Based Interventions – Core Services						
P61	**Seeking Safety - Individual**	Seeking Safety (SS) is a present-focused intervention to help clients attain safety from trauma/post-traumatic stress disorder (PTSD) and/or substance abuse SS; consists of 25 topics and can be conducted in either individual or group format. **Individual Sessions**: approximately 60 minutes per session.	Each session is at least 60 minutes and may only be delivered by staff trained at DOHMH to conduct the intervention.	Case Manager / Psychosocial Support Services Coordinator	On-Site	Optional
Q14	**Seeking Safety - Group**	Session for addressing substance use using Seeking Safety (SS), a present-focused intervention to help clients attain safety from trauma, post-traumatic stress disorder (PTSD) and substance use.	Each session is at least 60 minutes and may only be delivered by staff trained at DOHMH to conduct the intervention. Groups must have at least 3 participants. At least 1 participant must be enrolled in the Ryan White program.	Case Manager / Psychosocial Support Services Coordinator	On-Site	Optional
Staff Travel						
M50	**Staff Travel**	Reimbursement for Patient Navigator travel time when traveling off-site to provide services. Allowable off-site services for Patient Navigator include: • Client Assistance • Targeted Case Finding	No additional standard	Patient Navigator	Off-Site	Required

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
		• Accompaniment • Coordination with Service Providers • Outreach for Client Re-engagement				

Recommended Staffing Plan

In addition to the abovementioned requirements for funding, a staffing plan must be submitted with agency application materials. The plan is required prior to the award of a contract and contains the anticipated staff assignments during the contract. In order to staff the program, outreach, recruitment, and employment activities should reach those whose life experiences, training, education, and expertise promote understanding of the program's target population. When making employment decisions, level of education should not be the only consideration. Please note that the staff titles, functions, and qualifications are recommendations from NYC DOHMH. The staffing plan submitted by each agency will be evaluated based on the proposed program. It is the responsibility of each agency to ensure that proposed programs are adequately and appropriately staffed.

The program is recommended to have staffing capacity as indicated below:

Program Director

Functions: Provide oversight and management of the program, including monitoring, reporting and quality assurance activities.

Minimum Qualifications: MPH/MSW/MPA/MBA or other MA degree or BA/BS degree AND at least 2 years of experience managing a service PLWH and their families.

Case Manager/Psychosocial Support Services Coordinator (CASAC-T, or equivalent)

Functions: Provide individual and group supportive counseling, assess client needs and provide referrals to appropriate services, and follow up on referrals.

Minimum Qualifications: BA/BS degree AND at least 5-years of experience in running support groups and HIV education. Must demonstrate cultural and linguistic competence and basic understanding of social issues related to HIV.

Patient Navigator

Functions: Responsible for carrying out tasks necessary to execute client assistance and support service plans, including the following:

- Accompany and/or transport clients to medical and other appointments.
- Assist with outreach to engage clients and support them in adhering to mental health appointments.

Minimum Qualifications: High school degree (or its equivalent) and demonstrated experience providing client case management support.

Clinical Support/Supervision for Staff

Functions: Provide support to help staff maintain effective client relationships including therapeutic boundaries and personal safety for both staff and clients. Provide supervision to psychosocial support services staff members who are working with clients so that they are equipped to handle a crisis situation and facilitate appropriate referrals to ensure the safety of clients and staff. This function can be addressed by employing a program director with the credentials listed below or through a separate clinical supervisor staff position or through a part-time position.

Minimum Qualifications: LCSW, LMSW, LCAT, LMFT, LMHC, and/or Licensed Psychologist.

Utilization of Peers with lived experience helps to enhance patient-centered care by delivering services that support engagement in care such as linkage to services, re-connection to care, and adherence counseling,

even for clients at the highest risk for being lost to follow-up.[54,55,56,57] *It is encouraged that agencies hire peers whenever possible; peers should either be certified by the NYS AIDS Institute Peer Worker Certification Program or be supported to obtain their certification while working in this capacity.*

We encourage hiring people living with HIV, but staff (including Patient Navigators) must not be current clients of the Psychosocial Support Services program.

[54] Holtzman CW, Brady KA. Yehia BR. Retention in care and medication adherence: current challenges to antiretroviral therapy success. *Drugs*. 2015; 75(5):445-454

[55] Farrisi D, Dietz N. Patient navigation is a client-centered approach that helps to engage people in HIV care. *HIV Clinician*. 2016; 25(1):1-3

[56] Sarango M, de Groot A, Hirschi M, Umeh CA, Rajabiun S. The role of patient navigators in building a medical home for multiply diagnosed HIV-positive homeless populations. *J Public Health Manag Pract.* 2017; 23(3):276-282

[57] Bradford JB, Coleman S, Cunningham W. HIV system navigation: an emerging model to improve HIV care access. *AIDS Patient Care STDs.* 2007; 21(Suppl 1):S49-S58

Service Category 7: Medical Transportation Services

Background

In many cases, medical outcomes for persons living with HIV (PLWH) depend on structural factors as opposed to individual willingness to seek out and maintain HIV primary care appointments. For low-income PLWH, accessing basic services can be an enormous challenge as transportation remains a key structural barrier to adequate medical care and treatment options.

A recent CHAIN study examining the effects of transportation on medical outcomes noted that roughly one third of all respondents (31%) indicated a need for transportation assistance.[58] In the study, clients with transportation needs showed a strong association with poor physical health.[59] A recent CHAIN study noted that approximately half of Tri-County CHAIN participants travel outside their neighborhoods for HIV medical care,[60] potentially posing an added barrier in accessing HIV care and treatment. Many areas in the Tri-County region have little or no public transportation service. Thus, having reliable transport is a necessity in ensuring that PLWH across the Tri-County region receive increased access to and adequate support in their HIV care and treatment.

Proposals are requested to provide a single, unified, Tri-County-wide program that provides for maximum transportation coverage, utilizing public transportation, car (or van for the wheel-chair bound) service, and a system to provide for vouchers used to purchase gas, pay for bridge/tunnel/road tolls, and parking when private vehicles are used by PLWH to enable them to receive HIV-related health and support services.

Service Delivery Framework

Medical Transportation provides transportation services in Westchester, Rockland and Putnam Counties using taxi, van, bus, ambulette vehicles, and gas vouchers from contracted transportation providers. The program also provides access to public transportation in Westchester and Rockland Counties (through the issuance of bus tokens/tickets), and in all three counties to Metro North trains via a voucher system. The chosen means of transportation reflects a combination of clients' needs (e.g., ambulette), availability of vendors and/or public transportation, and cost effectiveness.

A transportation service program is required to have MOUs with all services to ensure that all clients have access to transportation as needed.

RWPA rides to medical visits and supportive services appointments may only be provided for PLWH who have no other means of transportation; Medicaid transport, public transportation services, and all other means of transport options must be ruled out before RWPA rides are accessed.

[58] The Community Health Advisory & Information Network (CHAIN) is an ongoing prospective study of representative samples of persons living with HIV/AIDS in the NY EMA. CHAIN is conducted by researchers from Mailman School of Public Health at Columbia University in collaboration with the New York City Department of Health and Mental Hygiene, Public Health Solutions, Inc. and the Westchester County Department of Health as part of evaluation activities of the New York Health and Human Services Planning Council (Planning Council). Its mission is to supply systematic data from the perspective of persons living with HIV about their needs for health and human services, their encounters with the full continuum of HIV services, and their physical, mental and social wellbeing.

[59] Aidala A, et al. Housing, Transportation, and HIV Medical Care and Outcomes, CHAIN Report, November 1, 2007.

[60] Messeri P. and Ball A., Place of Residence and Location of Services, CHAIN Report, May 14, 2015.

RWPA transportation may only be provided between points within the NY EMA; Metro North Train tickets and/or taxi rides, between the Tri-County region and NYC should be considered on a case-by-case basis taking into account why the ride is necessary and its cost.

Transportation services should be available at off hours, i.e., before or after business hours or on weekends if those are the only times a medical or supportive service appointment is available.

Service Delivery Model

Requests for MetroCards, Metro North Train tickets, bus vouchers, gas vouchers, and taxi services may only be made by a case manager or other care managing provider which has screened and certified the client for eligibility; PLWH cannot book their own rides.

A single unified, Tri-County-wide program should be established that provides for maximum transportation coverage. PLWH able to take public transport must be provided MetroCards, where applicable, bus and other transportation vouchers. The program should develop a system to distribute and track vouchers used to purchase gas, pay for bridge/tunnel tools, or parking when private vehicles are used by PLWH to enable them to receive HIV-related health and support services. Services should also be provided to an accompanying caregiver, home health aide, children, and other collaterals, as necessary.

Goals and Objectives[61]

The overall goal for this service category is to provide transportation services directly necessitated by an individual's HIV status in order to engage and retain PLWH in treatment and care, thereby serving to remove barriers to care.

Objectives:

- To increase accessibility to medical and support services for PLWH across the Tri-County[62] region.
- To ensure that PLWH receive timely services that support maintenance in care and ART adherence to promote positive health outcomes.
- To ensure that PLWH, clinicians, case managers, and other health care professionals are aware of available RWPA transportation services when other transport services are not an option.

Reimbursement

Services provided under this service category will be reimbursed using a cost-based methodology.

*All listed services **<u>are required</u>** and must be made available by each funded contractor for appropriate clients. This does not mean that all clients must receive every service element.*

[61] HRSA/HAB Division of Metropolitan HIV/AIDS Programs. Program Monitoring Standards – Part A. December 2013: "**Transportation Services …** that enable an eligible individual to access HIV- related health and support services, including services needed to maintain the client in HIV medical care, through either direct transportation services or vouchers or tokens."

[62] Tri-County refers to the part of the New York Emergency Metropolitan Area (NY EMA) located north of New York City which includes the three counties of Putnam, Rockland, and Westchester.

Program Specific Client Target Population

Services may be provided to clients who meet eligibility criteria for RWPA services, including, HIV status, residency, and income. Note that active substance use or incarceration history does not preclude client eligibility for services.

In addition to the general Ryan White eligibility criteria, services under this category are restricted to those with no other viable option for attending medical and supportive service appointments.

Program Specific Agency Eligibility Requirements

In addition to the General Organizational Eligibility Requirements, non-profit organizations must have experience serving PLWH. Further, organization providing services must:

1) Have policies and procedures to follow up and resolve client-vendor disputes;
2) Have staff members (both program staff and drivers) that respect and maintain rider confidentiality; and
3) Have service sites geographically located within Tri-County, accessible to, and able to service clients from throughout the NY EMA.

Service Type Description

Medical Transportation Services funded under this RFP are limited to clients living with HIV. Transportation services should also be provided to an accompanying caregiver, home health aide, children (or parents/guardians if the client is a child), and other collaterals, as necessary. Service elements may include, but are not limited to, those described in the table below.

Table 1: Summary of Services and Rates – Service Category 7

Service Family	PHS Code	Service Type	Unit Type	Rate
Assessment and Planning	N71	Intake Assessment (Brief)	Individual Event	$0.00
Transportation Services	N88	Public Transit	Individual Event	$0.00
	M51	Taxi Services	Individual Event	$0.00
	M52	Gas / Mileage Vouchers	Individual Event	$0.00
	M54	Bridge / Tunnel / Road Tolls Vouchers	Individual Event	$0.00
	M55	Parking Vouchers	Individual Event	$0.00

Table 2: Service Types, Descriptions, and Staff Responsible – Service Category 7

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
Assessment and Planning						
N71	**Intake Assessment (Brief)**	Brief interview to collect demographic and HIV-related information and to screen for client eligibility and assess for transportation needs.	Intake assessment must be conducted in-person.	Transportation Specialist	On-Site	Required
Transportation Services						
N88	**Public Transit**	Metro Cards and/or other public transportation vouchers (depending on location of client and service destination) will be provided to PLWH who are physically able to take public transportation.	Transportation may only be within the NY EMA.	Transportation Specialist	On-Site	Required
M51	**Taxi Services**	Taxi services are available for those who are unable to access public transportation and used for the purposes of receiving HIV-related health and support services.	Transportation may only be within the NY EMA.	Transportation Specialist	On-Site	Required
M52	**Gas / Mileage Vouchers**	Requests for reimbursement of gas and mileage for the use of private vehicles for eligible clients going to and from medical visits, pharmacy visits, or supportive services appointments relating to their HIV care and treatment.	Transportation may only be within the NY EMA.	Transportation Specialist	On-Site	Required
M54	**Bridge /Tunnel / Road Tolls Vouchers**	Requests for reimbursement of bridge, tunnel, and/or road tolls for the use of private vehicles for eligible clients going to and from medical visits, pharmacy visits, or supportive services appointments relating to their HIV care and treatment.	Transportation may only be within the NY EMA.	Transportation Specialist	On-Site	Required
M55	**Parking Vouchers**	Requests for reimbursement of parking charges for the use of private vehicles for eligible clients going to and from medical visits, pharmacy visits, or supportive services appointments relating to their HIV care and treatment.	Transportation may only be within the NY EMA.	Transportation Specialist	On-Site	Required

Please note that gas/mileage, bridge/tunnel/road tolls, or parking vouchers may <u>not</u> be used for rides to social/recreational activities or to do banking, grocery shopping, and other errands.

Recommended Staffing Plan

In addition to the abovementioned requirements for funding, a staffing plan must be submitted with agency application materials. The plan is required prior to the award of a contract and contains the anticipated staff assignments during the contract. In order to staff the program, outreach, recruitment, and employment activities should reach those whose life experiences, training, education, and expertise promote understanding of the program's target population. When making employment decisions, level of education should not be the only consideration. Please note that the staff titles, functions, and qualifications are recommendations from NYC DOHMH. The staffing plan submitted by each agency will be evaluated based on the proposed program. It is the responsibility of each agency to ensure that proposed programs are adequately and appropriately staffed.

The program is recommended to have staffing capacity as indicated below:

Program Director

Functions: Oversees tracking of transportation costs. Responsible for programmatic monitoring, reporting to funders, and staff supervision.

Recommended Minimum Credentials: At least 2 years of experience managing a program.

Transportation Specialist

Functions: Carries out tasks necessary to assess transportation needs and execute the appropriate transportation mode, including the following:

- Screen client eligibility
- Assess for transportation need
- Select and execute the appropriate transportation mode per client need
- Coordinate transportation logistics
- Record and track requests for payment of gas/mileage, bridge/tunnel/road tolls, and or parking reimbursement
- Track payment of gas/mileage, bridge/tunnel/road tolls, and parking voucher requests

Recommended Minimum Credentials: High school degree (or equivalent) and experience with HIV positive persons, documentation, and data reporting.

*It is encouraged that agencies hire peers whenever possible; peers should either be certified by the **NYS AIDS Institute Peer Worker Certification Program** or be supported to obtain their certification while working in this capacity.*

We encourage hiring people living with HIV, but staff (including Patient Navigators) must not be current clients of the Medical Transportation Services program.

Service Category 8: Emergency Financial Services

Background

While medical care and treatment options for persons living with HIV (PLWH) have improved, factors associated with poor health outcomes persist. These include being of a racial/ethnic group disproportionately impacted by HIV/AIDS, being of a lower socioeconomic status, and being homeless or unstably housed. [63] [64] The interaction of these factors (in addition to others) increase the likelihood that one will have a delayed initiation and/or lack of HIV care and treatment.

The removal of barriers associated with access to ART, continuous engagement in medical care, and consistent adherence to ART is paramount in helping PLWH achieve and maintain viral load suppression. Emergency Financial Services seek to address these barriers by providing short term financial assistance when evidence of an emergency situation is present, subject to payer of last resort requirements. Proposals are requested to provide short-term emergency financial assistance for essential services including utilities, housing, food (including groceries and food vouchers), or medications, provided to clients with limited frequency and for limited periods of time.

Service Delivery Framework

Emergency Financial Services (EFS) for PLWH should facilitate access to care by providing short term financial assistance for essential services including utilities, housing, food (including groceries and food vouchers), or medications (to prevent an interruption in adherence), provided to clients with limited frequency and for limited periods of time when other resources are not available. Organizations providing housing services should establish linkages with and make referrals to on-going assistance (i.e. other RWPA programs, HOPWA, ADAP, Medicaid, DSS, etc.) for program participants.

Service Delivery Model

Emergency Financial Services provides limited one-time or short-term payments to assist the RWPA client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. Emergency Financial Services funded under this RFP are defined as short term, limited assistance for clients living with HIV. Clients who qualify for Emergency Financial Services can receive up to $2,000 per household over a 12-month period.

Goals and Objectives

The overarching goal of this service category is to provide short term financial assistance for essential services including utilities, housing, food (including groceries and food vouchers), or medications, provided to clients with limited frequency and for limited periods of time to remove barriers to care.

[63] Aidala, A., Yomogida, M., Kim, J. Housing Need and Housing Assistance in New York City and Tri-County Region. CHAIN 2016-1 CHAIN Briefing, March, 2016.

[64] Aidala, A., Yomogida, M., Kim, J. Housing Need and Housing Assistance in New York City and Tri-County Region. CHAIN 2016-1 CHAIN Briefing, March, 2016.

Objectives:

- Enhance efforts that ensure access to adequate, stable housing that is affordable and accessible, transportation, employment, nutrition, substance abuse treatment, mental health services, and child care, as appropriate; and
- Reduce HIV related disparities and health inequities by supporting the coordination of, and access to, additional resources directed at addressing the HIV-related social determinants of health.

Reimbursement

Services provided under this service category will be reimbursed using a cost-based methodology.

*All listed services **are required** and must be made available by contractor for appropriate clients. This does not mean that all clients must receive every service element.*

Program Specific Client Target Population

Services may be provided to clients who meet eligibility criteria for RWPA services, including, HIV status, residency, and income. *Note that active substance use or incarceration history does not preclude client eligibility for services.*

In addition to the general Ryan White eligibility criteria, priority should be given to persons with any of the criteria listed below:

1) Individuals who present an emergency need when evidence of emergency situations is presented, subject to payer of last resort requirements.

Program Specific Agency Eligibility Requirements

Non-profit organizations with experience serving HIV-positive individuals and providing emergency financial assistance services are encouraged to apply for funding. *In addition to the General Organizational Eligibility Requirements,* organizations providing services must:

1) Have experience working with a wide-range of individuals, including those living with HIV and those in need of emergency financial assistance.
2) Be able to address, either directly or through referral, the needs of clients with physical, behavioral, psychosocial, or sensory impairments.
3) Be co-located or have established linkages with programs providing early intervention services, medical care, mental health, alcohol and substance use services, medically appropriate housing programs, food and nutrition services, and other unmet social needs including non-medical case management, supportive counseling and family stabilization services, health education and risk reduction, and navigation, linkage, and reengagement services.
4) Funded agencies providing services to Tri-County residents must have service sites geographically located within Tri-County, accessible to, and able to service clients from throughout the NY EMA.
5) Demonstrate procedures and protections are in place to manage effective accounting of payments made through an EFS program and ensure EFA resources are available to clients throughout the contract year.

Service Type Description

Emergency Financial Services funded under this RFP are limited to clients living with HIV. Clients who qualify for Emergency Financial Services can receive up to $2000 per household over a 12 month period. Service elements may include, but are not limited to, those described in the table below.

Table 1: Summary of Services and Rates – Service Category 8

Service Family	PHS Code	Service Type	Unit Type	Rate
Assessment and Planning	115	Intake Assessment	Individual Event	$0.00
Navigation	P69	Referral	Individual Event	$0.00
Fiscal Assistance	M56	Emergency Assistance Payment	Individual Event	$0.00

Table 2: Service Types, Descriptions, and Staff Responsible – Service Category 8

PHS Code	Service Type	Service Description	Service Standard	Staff Responsible	Service Location	Required or Optional
Assessment and Planning						
115	**Intake Assessment**	Brief interview to collect demographic, HIV-related information, and information documenting necessity for emergency financial services.	Intake assessment must be conducted in-person.	Program Coordinator	On-Site	Required
Navigation						
P69	**Referral**	Information provided to clients so that they may access needed services including health, legal, mental health, medical and non-medical case management, housing, and substance use services.	Referrals must be completed by a staff member approved by DOHMH.	Program Coordinator	On-Site	Required
Fiscal Assistance						
M56	**Emergency Assistance Payment**	Provide short-term, limited assistance with utilities, housing, food (including groceries and food vouchers), or medications. Clients deemed eligible for Emergency Assistance Payments may receive up to $2000 per household over a 12 month period.	Documentation of evidence of need for Emergency Assistance Payment needed	Accountant	On-Site	Required

Recommended Staffing Plan

In addition to the abovementioned requirements for funding, a staffing plan must be submitted with agency application materials. The plan is required prior to the award of a contract and contains the anticipated staff assignments during the contract. In order to staff the program, outreach, recruitment, and employment activities should reach those whose life experiences, training, education, and expertise promote understanding of the program's target population. When making employment decisions, level of education should not be the only consideration. Please note that the staff titles, functions, and qualifications are recommendations from NYC DOHMH. The staffing plan submitted by each agency will be evaluated based on the proposed program. It is the responsibility of each agency to ensure that proposed programs are adequately and appropriately staffed.

The program is recommended to have staffing capacity as indicated below:

Program Coordinator

Functions: To provide oversight and management of the program, including monitoring, reporting and quality assurance activities. The selected candidate will also provider supervision and oversight of (1) accountant for all programmatic fiscal monitoring.

Recommended Minimum Credentials: BA/BS degree AND at least 2 years of experience managing a services for priority populations.

Accountant

Functions: Responsible for tracking housing payment requests, tracking program income revenue (client rent payments), assessing allowable expenses, submitting check requests to accounting department, obtaining authorizing signatures, issue checks, verify check payment made, and reconcile checking accounts. In addition, accountant is responsible for financial audit of Emergency Financial Services program.

Recommended Credentials: BA/BS in accounting (or related) degree AND at least 24 months of experience working in non-profit organizations.

*It is encouraged that agencies hire peers whenever possible; peers should either be certified by the **NYS AIDS Institute Peer Worker Certification Program** or be supported to obtain their certification while working in this capacity.*

The NY EMA encourages hiring people living with HIV, but staff (including Patient Navigators) must not be current clients of the Emergency Financial Services program.

Proposal Evaluation Criteria for All Service Categories

Proposal Narrative

- *An organization may submit only **one proposal per service category as the lead applicant**. However, sites that provide healthcare services to PLWH may also appear as a partner in in other applications.*
- *Your Proposal Narrative is limited to the page requirements outlined below (page limits for each section are indicated below). Any text exceeding the 12-page limit per service category will not be reviewed.*
    - *For organizations applying for funding in only ONE service category, the Proposal Narrative is limited to a maximum of 12 pages.*
    - *For organizations applying for funding in MORE THAN ONE service category, see the Specific Instructions below and in the Proposal Narrative Components for each section.*
- *Your Proposal Narrative must address all of the following questions in the order listed. Label the beginning of each section as indicated (e.g., A. Background and Organizational Capacity, etc.), and include each question number; it is not necessary to repeat the question text.*
- *See Proposal Format Requirements on page 95.*

Specific Instructions for Organization Applying for Funding in One or More Service Categories:

1. *All applicants are required to respond to every section in the Proposal Narrative Components below.*

2. *Sections A, B, C and D are organization-specific and must be submitted with the program-specific section for every service category in which your organization is applying for funding. The page limit for each organization-specific section is as follows:*

    Section A: Background and Organizational Capacity = 1-page limit total

    Section B: Service Delivery Experience = 2-page limit total

    Section C: Program Management = 2-page limit total

    Section D: Confidentiality = 1-page limit total

3. *Sections E, F, and G are program-specific and must be submitted for every service category in which your organization is applying for funding. The page limit for each program-specific section is as follows:*

    Section E: Proposed Approach = 3-page limit per service category

    Section F: Program Design and Implementation = 2-page limit per service category

    Section G: Service Tracking and Reporting = 1-page limit per service category

4. *Although sections A, B, C, and D will remain the same across service categories, sections E, F, and G will change depending on the service category in which you are applying for funding. Thus, **please submit one completed proposal (with sections A-G) for each service category in which you are applying for funding.***

5. *Beneath each proposal narrative section, Evaluation Criteria have been included as an additional resource to aid applicants in crafting their proposal narrative(s). Please use these criteria as additional guides while crafting your responses. They are not meant to serve as additional questions to be answered.*

Proposal Narrative Components

Section A: Background and Organizational Capacity *(10 points) [1-page limit total]*

1. Provide a brief description of your organization's mission and services.
2. Provide a brief description of your organization's experience managing government contracts.
3. Explain how the program(s) being applied for will fit in to your current operations.

Evaluation Criteria for Section A

- *How well do the program(s) being applied for fit into the applicant organization's current operations?*
    - *Has the applicant been providing services to PLWH for at least 2 years?*
    - *Does the applicant have experience managing government contracts?*
        - *If yes, what is their experience?*
        - *If not, do any staff members have experience? Does the agency have a plan in place for implementation and evaluation of RWPA programs in which they are applying for funding?*

Section B: Service Delivery Experience *(15 points) [2-page limit total]*

1. Describe your organization's experience providing services to PLWH eligible for the program(s) being applied for and your capacity to deliver the service(s).
    a. Describe how your organization's experience will contribute to the implementation of the program(s) in which you are applying for funding.

Evaluation Criteria for Section B

- *How experienced is the organization in providing services to PLWH?*
    - *How many years of experience does that agency have providing services to PLWH?*
    - *Does the agency have experience managing RWPA contracts?*
        - *If so, what is the agency's experience?*
        - *If not, what is the agency's experience delivering services to target populations described in RFP?*
- *How well does the applicant's experience contribute to their ability to implement the program(s) potentially being awarded funding?*
    - *If applicant lacks directly applicable service experience, is there a plan described to ensure applicant is able to successfully implement program services in their agency?*

Section C: Program Management *(10 points) [2-page limit total]*

1. Describe the process by which program and fiscal staff will coordinate the completion of monthly reports, contract modifications, and other contract administration prior to submission to PHS.
2. Describe employee orientation process, including:
    - Introduction to your organization's operations
    - Review of policies, procedures and contract requirements
    - Training in confidentiality
3. Describe how your organization ensures that staff are culturally competent and how your organization adheres to the CLAS standards.

Evaluation Criteria for Section C

- *How well do the applicant's program and fiscal staff coordinate their work to administer the contract?*
    - *Does applicant give detailed explanation of the intersection between program and fiscal management in contract/program implementation and management?*
- *How well will the applicant's employee orientation process provide employees with basic introductory information about the organization, the program, and confidentiality?*
    - *Does applicant provide detailed orientation plan for new staff? Does the plan address program requirements, compliance, confidentiality, etc.?*
- *How well does the applicant ensure that the staff are culturally competent and provide services consistent with CLAS standards?*
    - *Does the applicant have a plan to ensure services are delivered in a manner consistent with CLAS standards? Does the applicant describe ways in which cultural competency will be addressed with staff? Does the applicant discuss a plan to ensure training requirements are adhered to?*
- *How well does the applicant provide support to program staff in addressing the program-specific challenges of working with program identified target population (i.e. in psychosocial support services- addressing the behavioral, psychosocial, physical challenges)?*

Section D: Confidentiality *(7 points) [1-page limit total]*

1. Describe the program's process for ensuring client confidentiality, including compliance with New York State Public Health Law (27F) and federal Health Insurance Portability and Accountability Act (HIPAA) regulations. Specify staff responsible for ensuring compliance.

Evaluation Criteria for Section D

- *How well will the applicant protect the privacy of the clients and the confidentiality of information gathered and recorded?*
    - *What processes and procedures are in place to ensure compliance with HIPAA?*
    - *Can processes and procedures described be applied to all programs in which applicant is applying for funding?*
        - *If not, does applicant address program specific processes/procedures?*

Section E: Proposed Approach *(30 points) [3-page limit for each service category in which you are applying for funding]*

Please respond to questions 1-4 (General Programmatic Questions) AND Program Specific Questions below FOR EACH SERVICE CATEGORY IN WHICH YOU ARE APPLYING FOR FUNDING.

General Programmatic Questions:

1. Provide a brief summary of your proposed program(s). Include:
    a. The total staff proposed for the specific program, by role.
    b. Anticipated total number of unduplicated clients (per program) in a single year.
2. Describe your plan for ensuring that all members of the program team, including patients, contribute to:
    a. Assessment and care planning activities.
    b. Case conferences (if applicable).

3. Describe your plan to address, either directly or through referral, the needs of clients with physical, behavioral, psychosocial, or sensory impairments?
4. Describe how your program's proposed approach will contribute to the achievement of goals and objectives for the service category for which funding is being requested (see program specific questions below for further guidance)?

Program Specific Questions:

Service Category 1: Food and Nutrition Services

1. Describe how your program will:
    a. Promote access to, and maintenance in, HIV medical care?
    b. Provide nutritious food and/or nutrition services to PLWH who need them?
        a. Ensure the provision of adequately nutritious and appropriate food to program participants (PLWH)?
    c. Enhance treatment adherence among program participants?

Service Category 2: Housing/Short Term Assistance Services

1. Describe your programmatic capacity to provide housing to homeless and unstably housed PLWH?
2. Describe how your proposed approach will reduce the number of HIV infected individuals who are homeless or living in unstable housing situations?
3. Describe how your program will:
    a. Ensure that housing services for PLWH facilitate access to HIV-related primary care and appropriate support services?
        i. How will this be monitored/tracked?

Service Category 3: Medical Case Management Services

1. How does your plan for case-finding engage those clients eligible for the program?
2. Describe your plan for case finding activities, including: responsible staff, methods/sources used, and proposed frequency of case finding. Specifically, we define case finding as activities to locate and engage patients who may meet the eligibility criteria for program enrollment. This includes identifying those who are referred by their medical providers, other programs within the organization, or organizations with which the program has linkage agreements.
3. Describe how your program will:
    a. Link participants with primary HIV medical services? (e.g., Are your medical services provided in an on-site facility? Do you have an MOU or other agreement with a medical provider?)
    b. Monitor participant engagement in HIV care and treatment? Including accessing viral load, cd4, and ART prescription?
    c. Improve ART adherence amongst program participants?
4. What it your plan to address unsuppressed viral load amongst program participants?
    a. Describe how you plan to address clients not taking or prescribed ART?
    b. Describe how you plan to evaluate patients who might benefit from mDOT services?

Service Category 4: Mental Health Services

1. Describe how your program will:
    a. Locate participants eligible for program services?
    b. Implement various counseling services (i.e. family counseling)?
2. How will your program integrate HIV-related mental health services with medical treatment as part of the HIV continuum of care?
    a. Describe how you plan to share information with the patient's primary care providers and other supportive service providers, i.e., regular case conferencing with medical providers?
    b. Describe how you will address the individual needs of patients, especially those in communities disproportionately affected by HIV?
3. Describe your plan for case finding activities, including: responsible staff, methods/sources used, and proposed frequency of case finding. Specifically, we define case finding as activities to locate and engage patients who may meet the eligibility criteria for program enrollment. This includes identifying those who are referred by their medical providers, other programs within the organization, or organizations with which the program has linkage agreements.

Service Category 5: Oral Health Care Services

1. Describe how your program will:
    a. Increase the number of persons with HIV disease who have access to, and receive ongoing, appropriate oral health care services?
    b. Help clients avoid interruptions in the receipt of HIV primary care or in the adherence to antiretroviral treatment due to oral health issues?
    c. Educate patients in oral health and dental care?
    d. Improve and maintain proper nutritional intake through dental care and education?
    e. Share information with the patient's primary care providers?

Service Category 6: Psychosocial Support Services

1. Describe how your program will:
    a. Locate participants eligible for program services?
    b. Identify and address barriers in HIV medical care?
    c. Link and engage patients in mental health services?
    d. Provide supportive counseling services to reduce barriers to HIV care and treatment adherence?
    e. Facilitate relationship building activities, education, training and skills-building activities focused on treatment readiness and adherence support?
2. Describe your plan for case finding activities, including: responsible staff, methods/sources used, and proposed frequency of case finding. Specifically, we define case finding as activities to locate and engage patients who may meet the eligibility criteria for program enrollment. This includes identifying those who are referred by their medical providers, other programs within the organization, or organizations with which the program has linkage agreements.

Service Category 7: Medical Transportation Services

1. How will your program provide maximum transportation coverage for PLWH in the tri-county region?
    a. Describe how you program will advertise transportation services offered to eligible PLWH?
    b. Describe how your program will assess the eligibility of PLWH seeking transportation services?
2. How will you monitor and track that participants are utilizing medical transportation to receive timely services that promote positive health outcomes?

Service Category 8: Emergency Financial Services

1. How will your program make Emergency Financial Services available to PLWH in the tri-county region?
    a. Describe how your program will advertise Emergency Financial Services offered to eligible PLWH?
    b. Describe how your program will assess the eligibility of PLWH seeking Emergency Financial Services?
2. How will your program dispense and track services provided?
3. Describe how your proposed approach will reduce the number of HIV infected individuals who are homeless or living in unstable housing situations?
4. How will your program link clients to other medical and social services?
5. How will your program balance client demand for EFS with resources available?

Evaluation Criteria for Section E

- *How well does the applicant ensure a team approach to service activities?*
    - *Does the applicant describe work-flow processes and procedures that incorporate every member of the program team in a coordinated manner?*
- *How well does the applicant ensure that the information needed to monitor primary care engagement, ART use, and viral load values is regularly gathered and evaluated?*
    - *How well does the applicant address unsuppressed viral load among those enrolled?*
- *How well does the applicant address each point under BOTH General Programmatic Questions AND Program Specific Questions?*
    - *Are applicant's responses easy to follow? Are responses easy to identify for each point under both general and program specific questions?*

Section F: Program Design and Implementation *(21 points) [2-page limit for each service category in which you are applying for funding]*

Please respond to question 1 (a-g) below FOR EACH SERVICE CATEGORY IN WHICH YOU ARE APPLYING FOR FUNDING

1. Describe the process (including staff responsible) for:
    a. Program start-up or continuation (including staff recruitment and training)?
    b. Enrolling clients into the program?
    c. Assessing clients' needs for services and support?
    d. Developing care plans (if applicable)?
    e. Implementing care plans (if applicable)?

f. Providing services and tracking progress/utilization?

g. Case closure?

Evaluation Criteria for Section F

- *How well does the applicant ensure that the program will either:*
  - *Be able to efficiently begin service delivery for **every service category applied for funding?***
  - *Or continue operating without interruption (for those re-bidding service categories in this RFP)?*
    - *Does applicant address processes identified in question 1 (above)? Is response clear and program specific?*
    - *Does applicant address quality management in this section? What quality management processes are in place to ensure compliant with program standards?*
- *How well does the applicant's proposed service delivery process describe the implementation of all aspects of the program/intervention from enrollment to case closure?*
  - *Who is responsible for ensuring client needs are met? How will clients be tracked? Does applicant discuss patient centered approach in identifying and responding to client needs?*
  - *Does the plan incorporate CLAS standards? How will cultural sensitivity be applied to each program applicant is applying for funding?*
  - *Is there a clear plan that incorporates point's a-g in question 1, above?*

Section G: Service Tracking and Reporting *(7 points) [1-page limit for each service category in which you are applying for funding]*

Please respond to questions 1-2 below FOR EACH SERVICE CATEGORY IN WHICH YOU ARE APPLYING FOR FUNDING

1. Funded programs must maintain records that include legal first and last name, date of birth, gender, sex assigned at birth, race, ethnicity, housing status, ZIP code of residence, and self-identified sexual orientation. In eSHARE, there must be *one and only one* "Common Demographics" profile maintained for each client at the agency (the profile is shared across NYC DOHMH Bureau of HIV/AIDS Prevention and Control (BHIV) contracts serving each person at each agency).
   a. Identify the titles of staff that will be responsible for maintaining such documentation and describe how such records will be maintained to avoid the duplication of profiles for individuals served in multiple programs funded through NYC DOHMH BHIV contracts.
2. For each program in which you are applying for funding, briefly describe your proposed process for ensuring consistency and accuracy of data collection in your program. Describe the steps from service delivery to documentation in the client record through data entry for reporting to NYC DOHMH. Include any intermediate steps and tools used.

Evaluation Criteria for Section G

- *How will the applicant ensure that data is collected consistently and accurately without duplication?*
  - *Does applicant describe plan for coordination of efforts when performing data entry (i.e. flow of documentation from staff delivering services to those entering in eSHARE)?*
  - *How will applicant address (possible) duplicate services being entered in eSHARE?*
- *How will the applicant monitor and track each service delivered to ensure accurate data reporting?*

- *Does applicant describe quality management processes to ensure accuracy of data entry and service delivery? Who is responsible for ensuring accuracy of data collection, documentation, and entry?*

Section H: Budget *(no points) [excluded from Proposal Narrative page-limit]*

Proposed budget must be realistic and address all staffing and resources needed to implement the program as proposed.

Proposals that do not include a completed budget, as detailed below, will be deemed nonresponsive and ineligible for funding consideration.

The total budget request should be the estimated cost of providing the proposed services for a full 12-month budget period. Your budget should assume a full year of operation at normal capacity, *post-start-up (i.e., after all staff are hired and trained and services have begun for the full proposed 12 month caseload)*.

For each category and cost detailed in the line-item budget submitted with the proposal, include cost justification that clearly explains how your line-item cost estimates were derived. This may include estimated number of individuals who will receive services, number of units as applicable, etc. There must be sufficient detail to permit assessment of your estimated costs and proposed use of funds for delivery and management of the proposed services. There must be clear relationship between proposed costs and program activities, including number of projected clients and units of service.

Please review the budget instructions to ensure that your costs are allowable according to federal and Ryan White specific guidelines. A list of unallowable costs for Ryan White funding is included in the Budget Instructions document that can be downloaded with the RFP.

Service Category	Anticipated Reimbursement
1. Food and Nutrition Services	Fee-for-Service
2. Housing/Short Term Assistance Services	Cost-Based
3. Medical Case Management Services	Fee-for Service
4. Mental Health Services	Fee-for-Service
5. Oral Health Care Services	Cost-Based
6. Psychosocial Support Services	Fee-for-Service
7. Medical Transportation Services	Cost-Based
8. Emergency Financial Services	Cost-Based

Proposal Submission Instructions

The deadline for submitting a proposal is ***August 7, 2018, 2:00pm EDT***. A complete proposal consists of all requested documents on the Proposal Checklist.

Uploading Proposal to CAMS Contracting Portal

One electronic copy of the Required Components of the Complete Proposal and one set of all the Required Administrative Documents identified on the Proposal Checklist must be uploaded to the CAMS Contracting Portal on Public Health Solutions' website at ***https://mer.healthsolutions.org*** by the proposal submission deadline. *You do NOT need to submit a hard-copy or submit via email. Use of the Contracting Portal is REQUIRED. Proposals sent by hard copy or email will NOT be considered as submitted.*

The current CAMS Contracting Portal ***https://mer.healthsolutions.org*** has been used by contractors for reporting expenditure (eMER) and/or narrative (ePNR) data. The same Contracting Portal will be used for uploading proposals for this RFP. In order to use the Contracting Portal to upload a proposal, you must have a current login.

- If you have been named on a Contractor Contact Verification Form (CCVF) as an official contact for an existing contract with PHS CAMS, then you already have a login on the CAMS Contracting Portal. If you do not know what your login is, please email ***RFPloginrequest@healthsolutions.org***
- If you have not been named on a CCVF as an official contact for an existing contract, then a new login will need to be created for you. Please email ***RFPloginrequest@healthsolutions.org*** to request a login.
- All login request emails should include the following:
    - First and last name of the proposal submitter
    - Title of proposal submitter
    - Full legal name of the applicant organization
    - EIN of applicant organization
    - RFP title should be on the subject line of the email

Note that only one proposer submitter can be created for an applicant organization.

Please be aware that uploading a proposal will involve multiple files representing different required proposal documents. Please allow sufficient time for checking that you have included all necessary digital file attachments. *Please ensure that you have a working login, and familiarize yourself with the CAMS Contracting Portal's Proposal Upload area, at least one week before the proposal submission deadline*.

Note that proposals received after the deadline may be disqualified from funding consideration.

It is the responsibility of the submitting organization to ensure delivery of the proposal to Public Health Solutions via the CAMS Contracting Portal by the submission deadline. A confirmation of receipt of the required submission (via upload) 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.*

Public Health Solutions is not responsible for any claimed lost or misdirected proposal submissions.

For all other things (submit questions, notice of intent, etc.), please email the RFP Contact at RWTriCountyRFP@healthsolutions.org

Required Components of a Complete Proposal

1. Proposal Checklist – signed and dated by the CEO/Executive Director/President
2. Organization Information Cover Sheet *(must be submitted in MS Word)*
3. Proposal Narrative **and** all attachments referenced in the Proposal Narrative section *(must be submitted in MS Word)*
4. Attachment A – Program Information *(must be submitted in MS Excel)*
    - Program Staff
    - Service Site Locations
5. Budget including Budget Justification *(must be submitted in MS Excel)*
6. Organization Chart for proposed program
7. Curricula Vitae or Resumes of Key Staff (leadership and program level) for proposed program
8. If any, Linkage Agreement (LA) / Memorandum of Understanding (MOU) / Memorandum of Agreement (MOA) with collaborative partner organization(s)
9. Proposal Format Form

***Proposals missing the Proposal Narrative or the Budget will be deemed non-responsive and ineligible for review*.**

Required Administrative Documents

In addition to the Required Components of the Complete Proposal, one set of the following Required Administrative Documents must be submitted with the Complete Proposal:

1. *Internal Revenue Service 501(c)(3) Determination Letter
2. *New York State Certificate of Incorporation (full copy, including any amendments)
3. *Current Board of Directors List
4. *Most recent audited annual Financial Statement; if total expenditures associated with federal funding exceed $750,000 a year, a Single Audit report is required
5. Board of Directors' Statement – written on your letterhead and signed by the Chair/President or Secretary of the Board of Directors (see sample statement provided)
6. Government Contracting Experience/References (see template provided)
7. *New York State Article 28 License; if applicable
8. *New York State Article 31 License, if applicable

Note that you may transmit the Required Administrative 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 the administrative documents. (Download the instructions, "Sharing Documents to PHS in the Document Vault" from Public Health Solutions' RFP website listed on the next page.)

Please indicate on the Proposal Checklist whether you intend to transmit the asterisked (*) Required Administrative Documents via the NYC HHS Accelerator or if you are including them with your submission via the CAMS Contracting Portal. For more information on the NYC HHS Accelerator and to register, go to: ***http://www.nyc.gov/html/hhsaccelerator/html/home/home.shtml***

The following required forms must be download from the Public Health Solutions' RFP website, **https://www.healthsolutions.org/get-funding/request-for-proposals/** :

1. Proposal Checklist
2. Organization Information Cover Sheet
3. Proposal Narrative Form
4. Attachment A – Program Information
5. Budget Form and Budget Instructions
6. Board of Directors' Statement
7. Government Contracting Experience/References
8. Proposal Format Form
9. Notice of Intent to Respond Form
10. Sharing Documents to PHS in the Document Vault

Proposal Format Requirements

Applicants are expected to adhere to the following formatting requirements.

- Each document of the Proposal Package should be titled using the following naming convention: ***Applicant Name_Document Title (as listed in RFP)_TCRFP_Date.***
- Proposal documents should be submitted in the format specified in the RFP *(i.e. Organization Information Cover Sheet in MS Word; Budget in MS Excel; etc.).*
- Proposal Narrative must not exceed the 12-page limit (inclusive of tables). *Note that any text exceeding the 12-page limit will not be reviewed and evaluated.*
- Proposal Narrative should be 1.5-spaced, with the exception of any required tables and any included supportive charts, which may be 1.0-spaced.
- Proposal Narrative should be submitted on 8½" x 11" format.
- Proposal Narrative should have 1" margins all around (headers and footers may appear outside of this margin).
- Minimum font size is Times New Roman 12-point with the exception of any required tables and any included supportive charts, which may use a font no smaller than 10-point.
- Each page of the Proposal Narrative, including attachments, should be consecutively numbered.
- The Proposal Narrative should remain in the same sequence and format as provided; questions should not be renumbered or reordered, however the text of the question can be omitted.
- Each page of the proposal should include as a header or footer the name of the organization submitting the proposal and the name of service category that you are applying for funding.

Proposal Review and Selection Process

Evaluation Criteria

All proposals deemed responsive will be evaluated. Proposals will undergo an administrative review by PHS to determine that applicants meet the eligibility criteria as detailed in this RFP. Proposals that do not meet the general and the program-specific organizational eligibility criteria will not move to the next stage the review process.

Proposals that meet both the general and program-specific organizational eligibility criteria will then undergo a content review by three reviewers. Proposals will be evaluated and scored based on responses in the Proposal Narrative section (as listed below). Proposals will be scored on a scale of **0-100 points**. Only proposals that score, at a minimum, **70 points** will be further considered for funding.

Proposal Narrative	Total Points Assigned	Page Limit
Section A – Background and Organizational Capacity	10	1
Section B – Service Delivery Experience	15	2
Section C – Program Management	10	2
Section D – Confidentiality	7	1
Section E – Proposed Approach	30	3
Section F – Program Design and Implementation	21	2
Section G – Service Tracking and Reporting	7	1
Section H – Budget	N/A	N/A
Total	**100 points**	**12 pages**

Note: Any text in excess of the 12-total page limit will not be evaluated.

Award Selection

NYC DOHMH and PHS reserve the right to award contracts in such a way as to assure:

1. Adequate geographic distribution of services; and/or
2. Adequate access to services by populations that are disproportionately affected by the HIV epidemic.

The NYC DOHMH and Public Health Solutions reserve the right to conduct site visits and/or interviews and/or to request that applicants make presentations and/or demonstrations, as the NYC DOHMH and Public Health Solutions deem applicable and appropriate.

Final award decisions will be made by NYC DOHMH. At the discretion of the NYC DOHMH, final awards may be less than requested in order to distribute funds among awardees and ensure adequate distribution of services throughout the Tri-County Region of the New York EMA.

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

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

General Reporting Requirements

All programs funded through this RFP must comply with the requirements outlined below.

Data Reporting Requirements

Awarded organizations must comply with all NYC DOHMH, PHS, and HRSA data reporting requirements. The NYC DOHMH and PHS will require the submission of client information and service utilization data through the Electronic System for HIV/AIDS Reporting and Evaluation (eSHARE).

Contractors will be required to enter client-level data into eSHARE for all funded services including:

1. Client legal first & last name (nicknames or pseudonyms will not be accepted in place of legal names)
2. Demographic information
3. Client encounters
4. Additional socio-demographic data and primary care status measures

Contractors will also submit an electronic program narrative report (ePNR) each month. Post award, contractors will receive information that details reporting requirements, including format and submission process.

The NYC DOHMH and/or PHS will provide training and technical assistance on the use of the data reporting systems and submission of data.

Contractors will also be required to submit an annual Ryan White Service Report (RSR) to HRSA under the direction of, and with technical support from, NYC DOHMH.

Confidentiality

Funded organizations must follow all applicable confidentiality and privacy laws, including Federal (e.g., HIPAA), State (e.g., Article 27-F) and local laws in order to protect client privacy.

Funded organizations must have a detailed plan to ensure client privacy and confidentiality (including data quality and security) that is compliant with New York State public health law as well as the federal law. The plan must specify data quality and security protections. All organizations providing HIV-related care are subject to New York State public health law (**http://codes.lp.findlaw.com/nycode/PBH/27-F**). All organizations providing clinical care are also subject to Health Insurance Portability and Accountability Act (HIPAA) (**http://www.hhs.gov/ocr/privacy/**).

Funded organizations **must never, under any circumstances, send names** of clients to NYC DOHMH or PHS through regular email or text messages. Contracts resulting from this RFP will require the promulgation of confidentiality practices, which, if not met, may result in contract compliance actions, up to and including contract termination.

General Program Requirements

The following trainings, technical assistance, and quality management-related activities are required as part of the contract management activities.

1. Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare

Agencies must deliver all services in a culturally competent and sensitive manner, taking low health literacy into account, using the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care for guidance. NYC DOHMH will provide further guidance upon award and implementation.

2. Primary Care Status Measures (PCSM)

Ryan White Part A programs are required to promote access to and maintenance in HIV primary care and, if applicable, HIV counseling and testing services for affected family members. For clients enrolled in the program, documentation of their HIV primary care provider and their most recent primary care visit is required at point of intake. Contractors are also required to reassess access to and maintenance in HIV primary care at least every 120 days (quarterly, with a grace period of up to 30 days maximum). Programs which do not engage with a client for more than 90 days do not need to fulfill all of the PCSM requirements.

All required information must be documented in the client record and reported via eSHARE. The following table describes PCSM requirements and actions to be taken.

For Clients Who Report a Primary Care Visit in the Past Four Months	Providers must: • Reassess client status at least every 120 days and report maintenance in primary care; and • Determine if the client is or is not on ART; • Record the most recent HIV-related laboratory test dates and values for monitoring HIV clinical status.
For Clients <u>Who Report No</u> Primary Care Visit in the Past Four Months	Providers must: • Assess whether the client is connected to care; • If not connected to care, make and document a referral to an HIV primary care provider; • Assess and document the status of the appointment within 30 days of the referral date; • Assess the client's status and record the date of the most recent primary care provider visit at least every 120 days; and • Record the most recent HIV-related laboratory test dates and values for monitoring HIV clinical status.
For Clients <u>Who Remain Unconnected</u> to Care More Than 30 Days After Referral Date	Providers must: • Assess and address barriers to care; • Make a new referral, if needed, taking into account any client preference for a different provider or facility for primary care; • Assess and document status of referral at 30-day intervals; • Document the date of the most recent primary care provider visit and reassess at least every 120 days; and

	• Record the most recent HIV-related laboratory test dates and values for monitoring HIV clinical status.
For Clients Not on ART	• Assess and address barriers to treatment; • Work to develop goals with client to include in care plan (drawing on comprehensive assessment and case conferencing); • Review progress with client at case conference and reassessment

3. Condom Availability

Funded organizations are required to make male and female condoms readily available and free to program clients including family members.

Organizations in Tri-County can order from the New York State Condom (NYSCondom) Program, at the following website:
http://www.health.ny.gov/diseases/aids/consumers/condoms/nyscondom.htm

4. Trainings

All the Electronic System for HIV/AIDS Reporting and Evaluation (eSHARE) trainings are available to agency staff and are regularly conducted by NYC DOHMH. Please check the event calendar in the links below for availability:

- eSHARE end user training (***required*** for new data entry staff)
- eSHARE administrator training (***required*** for new agency eSHARE administrators)
- QM 101 and QM 201 (***required,*** unless previously attended)
- eSHARE canned reports training (***optional***)
- QM 301: Using Data for Quality Improvement (***optional***; registration information TBA)

Programs *(excluding Oral Health Care and Medical Transportation Services)* must provide training on site or through a training program on the following:

- Confidentiality
- Cultural competency
- HIV 101
- HIV 201
- PEP/Prep biomedical
- HCV101
- STD 101
- Seeking Safety

5. Quality Management and Technical Assistance

Funded organizations are required to participate in the RWPA Quality Management (QM) Program. The QM Program provides technical assistance to increase capacity for quality assurance (QA) and quality improvement (QI). As part of their participation, funded organizations are required to:

a) Develop a Quality Management Plan

b) Provide annual updated about quality improvement projects

c) Participate in the NYC DOHMH RWPA Client Satisfaction Survey

d) Participate in quality improvement meetings or webinars

In addition, RWPA service providers must participate in technical assistance activities including, but not limited to, provider meetings, webinars, teleconferences, and site visits as requested by NYC DOHMH. Provider meetings are designed to bring together all funded programs to discuss lessons learned, provide program updates, announce training opportunities, and promote peer learning. Quality Management Specialists from NYC DOHMH may conduct Technical Assistance Site Visits at the request of service providers and at NYC DOHMH discretion, to monitor and discuss program performance. Program staff with managerial responsibilities must attend all provider meetings for their service categories and site-visits to their agency.

Routine joint site visits (if applicable) are conducted by both a NYC DOHMH Quality Management Specialist and a PHS-CAMS Contract Manager. The Contract Manager monitors the agency's compliance with terms and conditions of the contact scope of services while the Quality Management Specialist reviews and supports the implementation of plans to improve the agency's programmatic performance.

6. Programmatic and Compliance Monitoring

Program administrative and fiscal compliance monitoring is provided by PHS. Activities related to the compliance monitoring of the RWPA contracts include, but are not limited to:

a) Routine site visits to verify documentation of reported services (i.e. client charts), case closure procedure, and other contract-related documentation to assess whether progress notes reflect the services reported.

b) Reimbursable site visits to verify that services for which a program received reimbursements from PHS were provided and documented as contracted and confirm that RWPA funding is the payer of last resort for services reported under the contract for reimbursement.

c) Fiscal site visits are conducted for contracts which receive cost-based reimbursement for operation of their program.

d) Payer of last resort site visits may be conducted for contracts, as needed. Administrative and fiscal compliance monitoring is conducted by Public Health Solutions. Activities related to the compliance monitoring of the Ryan White Part A contracts include but are not limited to:

   a. Routine site visits to verify services reported against the program's records (i.e. client charts), the quality of progress notes, case closure procedures, and other program-related documentation.

   b. Reimbursable site visits are conducted to verify that the services reported have been rendered and documented in the client's chart.

7. Emergency Preparedness Plan

All contractors will be required to submit an attestation affirming that their organization has a written Emergency Preparedness Plan that is maintained and updated to provide for the safety and security of clients, participants, staff, and the contractor's facility. While the following elements are not required, ideally, each organization's emergency preparedness plan will address:

a) *Emergency Management*: The organization should form an emergency management committee to develop, evaluate and modify the plan.

b) *Training and Exercise*: The organization should educate and train staff on the Emergency Preparedness Plan so that they are familiar with communications, evacuation and relocation plans and procedures.

c) *Command and Control*: The organization's plan should include a description of when/how the plan will be activated, as well as who will have the authority to activate the plan.

d) *Communications*: The organization should have adequate communication capabilities to maintain organization order and enhance safety when responding to service disruptions.

e) *Evacuation Procedures*: The organization should have an evacuation plan with clearly defined procedures if the organization's location is deemed unsafe during an emergency or if instructed to do so by emergency officials.

f) *Logistics Management*: The organization should ensure that they have adequate procurement and delivery of goods and services necessary to support operations during/after an emergency.

g) *Essential Services, Roles and Responsibilities (Continuity of Operations)*: The organization should identify its essential services and the core staff and skills needed to keep it operational during an emergency.

8. Insurance Exchange Enrollment Assistance

All contractors must identify a contact from at least one NYS-funded Navigator program and refer clients who may be eligible for expanded Medicaid or for insurance via the NYS Health Plan Marketplace (Marketplace), as needed, or identify staff to become Certified Application Counselors (CACs).

Navigator programs can be found using the following link:
http://info.nystateofhealth.ny.gov/IPANavigatorMap

General Insurance Requirements

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

a. Acceptability of Insurers

All insurance under this Agreement must be placed with insurers with an A.M. Best rating of no less than A-7 or a Standards and Poor rating of no less than AA, unless Public Health Solutions approves the acceptance of insurance from an insurance company with a lower rating. The Contractor shall maintain on file with Public Health Solutions current Certificates of Insurance for the policies identified in subsection (b) below.

b. Types of Insurance

The Contractor shall obtain the following types of insurance with respect to the services to be performed under this Agreement:

(i) Commercial general liability insurance (including products/completed operations, personal and advertising injury) with limits not less than $1,000,000 combined single limit per accident for bodily injury and property damage. Coverage must be on an occurrence form basis. The policy must name Public Health Solutions and the City of New York, including its officials and employees as additional insured. The designation of the City of New York, including its officials and employees, as additional insured must be demonstrated using ISO Form CG 20 10 (Additional Insured Endorsement Form). Coverage must be primary with respect to Public Health Solutions and must not contribute with or apply in excess of any coverage carried by Public Health Solutions or the City.

(ii) Comprehensive automobile liability with limits not less than $1,000,000 combined single limit coverage against bodily injury, liability, and property damage liability arising out of the use by or on behalf of the Contractor, or any person acting by, through or under the Contractor, of any owned, non-owned or hired motor vehicle. The policy must name Public Health Solutions as additional insured. Coverage must be primary with respect to Public Health Solutions and must not contribute with or apply in excess of any coverage carried by Public Health Solutions.

(iii) (For non-medical services or services that are not provided by medical and health professionals) Professional liability insurance with limits not less than $1,000,000 for any one occurrence, $3,000,000 annual aggregate, covering all professional employees of the Contractor, as well as contracted employees of the Contractor, if these persons provide professional services under this Agreement. Coverage must be on an occurrence form basis. [If coverage is not available or is not written on an occurrence form, Claims-made policies will be accepted. All such policies shall have an extended reporting period option or automatic coverage of not less than two (2) years. If available as an option, the Contractor agrees to purchase the extended reporting period on cancellation or termination unless a new policy is effected with a retroactive date, including at least the last policy year.] The policy must name Public Health Solutions as additional insured. Coverage must be primary with respect to Public Health Solutions and must not contribute with or apply in excess of any coverage carried by Public Health Solutions.

(iv) (For medical services or services provided by medical and health professionals) Professional liability insurance with not less than $2,000,000 for any one occurrence, $4,000,000 annual aggregate, covering all professional employees of the Contractor, including but not limited to physicians, physician's assistants, nurses and other health

professionals, as well as, or, any person or entity acting by, through or under the Contractor, written on an occurrence form. If coverage is not available or is not written on an occurrence form, a claims made form is acceptable provided that, in the event the Contractor's claims made policy is cancelled and not replaced or renewed, tail coverage for the maximum allowable period is purchased in order to ensure continuity of coverage. The policy must name Public Health Solutions as additional insured. Coverage must be primary with respect to Public Health Solutions and must not contribute with or apply in excess of any coverage carried by Public Health Solutions.

(v) Workers' compensation, disability, and employers' liability insurance with limits not less than statutory limits of liability.

(vi) If the Contractor receives an Advance, it shall purchase a fidelity bond in the amount of the Advance. This bond must be issued by an insurer duly licensed by the state and must name Public Health Solutions as a loss payee. A copy of the fidelity bond must be provided to Public Health Solutions.

(vii) Directors and officers liability insurance, whether the directors and officers are compensated or not.

c. Subcontractors

The Contractor shall include all approved subcontractors, if any, as additional insured under its policies or shall furnish separate certificates for each subcontractor. All subcontractors shall provide the same coverages contained in this Agreement, including naming Public Health Solutions and the City of New York, including its officials and employees as additional insureds.

d. Self-Insurance

If the Contractor self-insures, proof of the self-insurance must be provided to Public Health Solutions. Even if the Contractor self-insures, the Contractor will maintain sufficient liability insurance, including malpractice insurance, to protect itself, Public Health Solutions and the City of New York, including its officials and employees from all claims, actions, proceedings, costs, liability, loss or damage from injuries or death arising from the provision of services under this Agreement. If the Contractor generally self-insures for malpractice, it shall provide the proof of malpractice insurance through its self-insurance program including the adequacy of any self-insurance program. Public Health Solutions has the sole right to determine if the evidence of self-insurance is acceptable.

Useful Resources

The following are available information resources that may be helpful in developing your proposal:

HIV/AIDS in New York City

NYC HIV/AIDS Surveillance Statistics
http://www1.nyc.gov/site/doh/data/data-sets/hiv-aids-annual-surveillance-statistics.page

The National HIV/AIDS Strategy
https://www.hiv.gov/federal-response/national-hiv-aids-strategy/overview

The NYC DOHMH BHIV Enhanced Comprehensive HIV Prevention Planning (ECHPP)
http://www.cdc.gov/hiv/research/demonstration/echpp/sites/ny.html

The NYC DOHMH BHIV ECHPP Situational Analysis
https://www.cdc.gov/hiv/pdf/research/demonstration/echpp/sites/prevention_demonstrations_echpp_nyc_plan1.pdf

Comprehensive Jurisdictional Plan for HIV Prevention in New York City, 2012-2016
http://www.uchaps.org/documents/NYCJURISDICTIONALPLANFINAL9-28-12.pdf

NYC HIV/AIDS Surveillance Epidemiology Reports
http://www1.nyc.gov/site/doh/data/data-sets/hiv-aids-surveillance-and-epidemiology-reports.page

PrEP/PEP Resources

NYS Guidance for the Use of Pre-Exposure Prophylaxis (PrEP) to Prevent HIV Transmission
http://www.hivguidelines.org/clinical-guidelines/pre-exposure-prophylaxis/guidance-for-the-use-of-pre-exposure-prophylaxis-prep-to-prevent-hiv-transmission/

NYC DOHMH PrEP/PEP Information
https://www1.nyc.gov/site/doh/health/health-topics/prep-pep-resources.page

PrEP and PEP: Information for Medical Providers
https://www1.nyc.gov/site/doh/providers/health-topics/prep-pep-information-for-medical-providers.page

NYC DOHMH PrEP/PEP Provider Checklist
https://www1.nyc.gov/assets/doh/downloads/pdf/ah/provider-clinical-site-checklist.pdf

CDC Guide to taking a Sexual History
http://www.cdc.gov/std/treatment/sexualhistory.pdf

Glossary of Terms

Common Acronyms in HIV/AIDS Services:

AIDS: Acquired Immunodeficiency Syndrome

ART: Antiretroviral Therapy

ARTAS: Anti-Retroviral Treatment and Access to Services

BHIV: New York City Department of Health and Mental Hygiene's Bureau of HIV/AIDS Prevention and Control

CAMS: Public Health Solutions' Contracting and Management Services (formerly known as HIV Care Services (HIVCS))

CBO: Community-Based Organization (may include community health centers, including FQHCs)

CDC: Centers for Disease Control and Prevention

CHW: Community Health Worker

DOHMH: New York City Department of Health and Mental Hygiene

FBO: Faith-Based Organization

HCV: Hepatitis C Virus

HIPAA: Health Insurance Probability and Accountability Act

HIV: Human Immunodeficiency Virus

HRSA: Health Resources and Services Administration

iART: immediate Antiretroviral Therapy

MAP: Medication Assistance Program

MI: Motivational Interviewing

MOU: Memorandum of Understanding

MSM: Men who have Sex with Men

NYC DOHMH: New York City Department of Health and Mental Hygiene

NYSDOH: New York State Department of Health

PAP: Patient Assistance Program

PEP: Post-Exposure Prophylaxis

PHS: Public Health Solutions (formerly known as Medical and Health Research Association of New York City, Inc. (MHRA); older documents may refer to what is now known as Public Health Solutions as MHRA.)

PLWH or PLWHA: People Living With HIV/AIDS

PrEP: Pre-Exposure Prophylaxis

STD: Sexually-Transmitted Disease

STI: Sexually-Transmitted Infection

TA: Technical Assistant or Technical Assistance

YMSM: Young Men who have Sex with Men