State of Hawai`i
Department of Health
Communicable Disease Division
Harm Reduction Services Branch

Request for Proposals

RFP No. HTH- 100-53

Core HIV, STD and Viral Hepatitis Integrated Prevention and Care Services in Kauai County to end the HIV epidemic

July 22, 2016

Note: *It is the applicant's responsibility to check the public procurement notice website, the request for proposals website, or to contact the RFP point-of-contact identified in the RFP for any addenda issued to this RFP. The State shall not be responsible for any incomplete proposal submitted as a result of missing addenda, attachments or other information regarding the RFP.*

July 22, 2016

REQUEST FOR PROPOSALS

CORE HIV, STD, AND VIRAL HEPATITIS INTEGRATED PREVENTION AND CARE SERVICES ON OAHU TO END HIV EPIDEMIC
RFP No. HTH- 100-53

The Department of Health, Communicable Disease Division, Harm Reduction Services Branch, is requesting proposals from qualified applicants to provide HIV, STD and viral hepatitis integrated care and prevention services for HIV-infected individuals and their at-risk partners, men who have sex with men and are at risk for transmitting or contracting HIV, including men who have sex with men and inject drugs in Kauai County. Services shall include pre-HIV diagnosis and post-diagnosis services.

The contract term will be for two-year period from July 1, 2017 through July 30, 2019, with the option to extend up to two additional twenty-four month periods, ending no later than July 30, 2023. The initial period shall commence on the contract start date (July 1, 2017) or the date of State's Notice to Proceed, whichever is later.

Proposals shall be mailed and postmarked by the United State Postal Service on or before September 28, 2016, or hand delivered no later than 4:30 p.m., Hawai`i Standard Time (HST), on September 28, 2016, at the drop-off sites designated on the Proposal Mail-in and Delivery Information Sheet. Proposals postmarked or hand delivered after the submittal deadline shall be considered late and rejected. There are no exceptions to this requirement.

The Harm Reduction Services Branch will conduct an orientation August 10, 2016, at 10:00 am, 728 Sunset Avenue, Conference Room, Honolulu, Hawai`i 96816. All prospective applicants are strongly encouraged to attend the orientation. Applicant can also join by calling toll free number 1-866-505-4121.

The deadline for submission of written questions is 4:30 p.m. HST on August 22, 2016. All written questions will receive a written response from the State on or about August 31, 2016.

Inquiries regarding this RFP should be directed to the RFP contact person, Ms. Nighat Quadri at 728 Sunset Avenue, Conference Room, Honolulu, Hawai`i 96816, telephone: (808) 733-4380, fax: (808) 733-9291, e-mail: nighat.quadri@doh.hawaii.gov.

PROPOSAL MAIL-IN AND DELIVERY INFORMATION SHEET

NUMBER OF COPIES TO BE SUBMITTED: *5*

ALL MAIL-INS SHALL BE POSTMARKED BY THE UNITED STATES POSTAL SERVICE (USPS) NO LATER THAN **September 28, 2016 and received by the state purchasing agency no later than 10 days from the submittal deadline**.

All Mail-ins

Harm Reduction Services Branch
Hawaii State Department of Health
Integrated HIV RFP
3627 Kilauea Avenue, Room 306
Honolulu, HI 96816

HRSB RFP COORDINATOR

Nighat Quadri
Harm Reduction Services Branch
Hawaii State Department of Health
728 Sunset Avenue,
Honolulu, HI 96816

ALL HAND DELIVERIES SHALL BE ACCEPTED AT THE FOLLOWING SITES UNTIL **4:30 P.M., Hawaii Standard Time (HST), September 28, 2016**. Deliveries by private mail services such as FEDEX shall be considered hand deliveries. Hand deliveries shall not be accepted if received after 4:30 p.m., **September 28, 2016**.

Drop-off Sites

Harm Reduction Services Branch
Hawaii State Department of Health
Prevention and care RFP
3627 Kilauea Avenue, Room 306
Honolulu, HI 96816

RFP Table of Contents

Section 1 Administrative Overview

1.1 Procurement Timetable 1-1
1.2 Website Reference 1-2
1.3 Authority 1-2
1.4 RFP Organization 1-3
1.5 Contracting Office 1-3
1.6 RFP Contact Person 1-3
1.7 Orientation 1-4
1.8 Submission of Questions 1-4
1.9 Submission of Proposals 1-4
1.10 Discussions with Applicants 1-8
1.11 Opening of Proposals 1-8
1.12 Additional Materials and Documentation 1-8
1.13 RFP Amendments 1-8
1.14 Final Revised Proposals 1-8
1.15 Cancellation of Request for Proposals 1-9
1.16 Costs for Proposal Preparation 1-9
1.17 Provider Participation in Planning 1-9
1.18 Rejection of Proposals 1-9
1.19 Notice of Award 1-9
1.20 Protests 1-10
1.21 Availability of Funds 1-10
1.22 General and Special Conditions of the Contract 1-11
1.23 Cost Principles 1-11

Section 2 - Service Specifications

2.1.Introduction
- A. Overview, Purpose or Need 2-1
- B. Planning activities conducted in preparation for this RFP 2-3
- C. Description of the Service Goals 2-10
- D. Description of the Target Population to be Served 2-11
- E. Geographic Coverage of Service 2-12
- F. Probable Funding Amounts, Source, and Period of Availability 2-12

2.2.Contract Monitoring and Evaluation 2-13
2.3.General Requirements 2-13
- A. Specific Qualifications or Requirements 2-13
- B. Secondary Purchaser Participation 2-13
- C. Multiple or Alternate Proposals 2-13
- D. Single or Multiple Contracts to be Awarded 2-13
- E. Single or Multi-Term Contracts to be Awarded 2-13

2.4. Scope of Work 2-14
A. Service Activities 2-14
B. Management Requirements 2-31
C. Facilities 2-41
2.5. Compensation and Method of Payment 2-41

Section 3 - Proposal Application Instructions

General Instructions for Completing Applications 3-1
3.1. Program Overview 3-1
3.2. Experience and Capability 3-2
A. Necessary Skills 3-2
B. Experience 3-2
C. Quality Assurance and Evaluation 3-2
D. Coordination of Services 3-2
E. Facilities 3-2
3.3. Project Organization and Staffing 3-3
A. Staffing 3-3
B. Project Organization 3-3
3.4. Service Delivery 3-3
3.5. Financial 3-18
A. Pricing Structure 3-18
B. Other Financial Related Materials 3-19
3.6. Other 3-19
A. Litigation 3-19

Section 4 – Proposal Evaluation

4.1. Introduction 4-1
4.2. Evaluation Process 4-1
4.3. Evaluation Criteria 4-2
A. Phase 1 – Evaluation of Proposal Requirements 4-2
B. Phase 2 – Evaluation of Proposal Application 4-2
C. Phase 3 – Recommendation for Award 4-5

Section 5 – Attachments

Attachment A. Proposal Application Checklist
Attachment B. Sample Proposal Table of Contents
Attachment C. Case Management Practice Standards and Case Manager Standards
Attachment D. Client Acuity Determination
Attachment E. Sample Form SPO-H-205
Attachment F. Sample Narrative Budget Justification

Section 1

Administrative Overview

Section 1
Administrative Overview

Applicants are encouraged to read each section of the RFP thoroughly. While sections such as the administrative overview may appear similar among RFPs, state purchasing agencies may add additional information as applicable. It is the responsibility of the applicant to understand the requirements of *each* RFP.

1.1 Procurement Timetable

Note that the procurement timetable represents the State's best estimated schedule. If an activity on this schedule is delayed, the rest of the schedule will likely be shifted by the same number of days. Contract start dates may be subject to the issuance of a notice to proceed.

Activity	Scheduled Date
Public notice announcing Request for Proposals (RFP)	July 22, 2016
Distribution of RFP	July 22, 2016
RFP orientation session	August 10, 2016
Closing date for submission of written questions for written responses	August 22, 2016
State purchasing agency's response to applicants' written questions	August 31, 2016
Discussions with applicant prior to proposal submittal deadline (optional)	August 31,2016
Proposal submittal deadline	September 28, 2016
Discussions with applicant after proposal submittal deadline (optional)	October 7, 2016
Final revised proposals (optional)	October 14,2016
Proposal evaluation period	October/November
Provider selection	December
Notice of statement of findings and decision	January
Contract start date	July1, 2017

1.2 Website Reference

	Item	Website
1	Procurement of Health and Human Services	http://spo.hawaii.gov/for-vendors/vendor-guide/methods-of-procurement/health-human-services/competitive-purchase-of-services-procurement-method/cost-principles-table-hrs-chapter-103f-2/
2	RFP website	http://hawaii.gov/spo2/health/rfp103f/
3	Hawaii Revised Statutes (HRS) and Hawaii Administrative Rules (HAR) for Purchases of Health and Human Services	http://spo.hawaii.gov Click on the "References" tab.
4	General Conditions, AG-103F13	http://hawaii.gov/forms/internal/department-of-the-attorney-general/ag-103f13-1/view
5	Forms	http://spo.hawaii.gov Click on the "Forms" tab.
6	Cost Principles	http://spo.hawaii.gov Search: Keywords "Cost Principles"
7	Protest Forms/Procedures	http://spo.hawaii.gov/for-vendors/vendor-guide/protests-for-health-and-human-services/
8	Hawaii Compliance Express (HCE)	http://spo.hawaii.gov/hce/
9	Hawaii Revised Statutes	http://capitol.hawaii.gov/hrscurrent
10	Department of Taxation	http://tax.hawaii.gov
11	Department of Labor and Industrial Relations	http://labor.hawaii.gov
12	Department of Commerce and Consumer Affairs, Business Registration	http://cca.hawaii.gov click "Business Registration"
13	Campaign Spending Commission	http://ags.hawaii.gov/campaign/
14	Internal Revenue Service	http://www.irs.gov/
(Please note: website addresses may change from time to time. If a State link is not active, try the State of Hawaii website at http://hawaii.gov)		

1.3 Authority

This RFP is issued under the provisions of the Hawaii Revised Statutes (HRS) Chapter 103F and its administrative rules. All prospective applicants are charged with presumptive knowledge of all requirements of the cited authorities. Submission of a valid executed proposal by any prospective applicant shall constitute admission of such knowledge on the part of such prospective applicant.

1.4 RFP Organization

This RFP is organized into five sections:

Section 1, Administrative Overview: Provides applicants with an overview of the procurement process.

Section 2, Service Specifications: Provides applicants with a general description of the tasks to be performed, delineates provider responsibilities, and defines deliverables (as applicable).

Section 3, Proposal Application Instructions: Describes the required format and content for the proposal application.

Section 4, Proposal Evaluation: Describes how proposals will be evaluated by the state purchasing agency.

***Section 5, Attachments*:** Provides applicants with information and forms necessary to complete the application.

1.5 Contracting Office

The Contracting Office is responsible for overseeing the contract(s) resulting from this RFP, including system operations, fiscal agent operations, and monitoring and assessing provider performance. The Contracting Office is:

Harm Reduction Services Branch
Department of Health
State of Hawai`i
728 Sunset Avenue
Honolulu, HI 96816
Telephone: (808) 733-4380
Fax: (808) 733-9291

1.6 RFP Point-of-Contact

From the release date of this RFP until the selection of the successful provider(s), any inquiries and requests shall be directed to the sole point-of-contact identified below:

Nighat Quadri
Harm Reduction Services Branch
Hawaii State Department of Health
728 Sunset Avenue, Honolulu, HI 96816

1.7 Orientation

An orientation for applicants in reference to the request for proposals will be held as follows:

Date:	**August 10,2016**	**Time:**	**10:00am – 12:30pm**
Location:	**728 Sunset Avenue, Conference Room, Honolulu, Hawai`i 96816**		

Applicants are encouraged to submit written questions prior to the orientation. Impromptu questions will be permitted at the orientation and spontaneous answers provided at the state purchasing agency's discretion. However, answers provided at the orientation are only intended as general direction and may not represent the state purchasing agency's position. Formal official responses will be provided in writing. To ensure a written response, any oral questions should be submitted in writing following the close of the orientation, but no later than the submittal deadline for written questions indicated in the subsection 1.8, Submission of Questions.

1.8 Submission of Questions

Applicants may submit questions to the RFP point-of-contact identified in Section 1.6. Written questions should be received by the date and time specified in Section 1.1 Procurement Timetable. The purchasing agency will respond to written questions by way of an addendum to the RFP.

Deadline for submission of written questions:

Date: **August 22, 2016** **Time:** **4:30pm** HST

State agency responses to applicant written questions will be provided by**:**
Date: **August 31, 2016**

1.9 Submission of Proposals

A. **Forms/Formats -** Forms, with the exception of program specific requirements, may be found on the State Procurement Office website referred to in Section 1.2, Website Reference. Refer to the Section 5, Proposal Application Checklist for the location of program specific forms.

1. **Proposal Application Identification (Form SPOH-200)**. Provides applicant proposal identification.

2. **Proposal Application Checklist**. The checklist provides applicants specific program requirements, reference and location of required RFP proposal forms, and the order in which all proposal components should be collated and submitted to the state purchasing agency.

3. **Table of Contents**. A sample table of contents for proposals is located in Section 5, Attachments. This is a sample and meant as a guide. The table of contents may vary depending on the RFP.

4. **Proposal Application (Form SPOH-200A)**. Applicant shall submit comprehensive narratives that address all proposal requirements specified in Section 3, Proposal Application Instructions, including a cost proposal/budget, if required.

B. **Program Specific Requirements**. Program specific requirements are included in Sections 2 and 3, as applicable. Required Federal and/or State certifications are listed on the Proposal Application Checklist in Section 5.

C. **Multiple or Alternate Proposals**. Multiple or alternate proposals shall not be accepted unless specifically provided for in Section 2. In the event alternate proposals are not accepted and an applicant submits alternate proposals, but clearly indicates a primary proposal, it shall be considered for award as though it were the only proposal submitted by the applicant.

D. **Provider Compliance**. All providers shall comply with all laws governing entities doing business in the State.

- Tax Clearance. Pursuant to HRS §103-53, as a prerequisite to entering into contracts of $25,000 or more, providers are required to have a tax clearance from the Hawaii State Department of Taxation (DOTAX) and the Internal Revenue Service (IRS). Refer to Section 1.2, Website Reference for DOTAX and IRS website address.

- Labor Law Compliance. Pursuant to HRS §103-55, providers shall be in compliance with all applicable laws of the federal and state governments relating to workers' compensation, unemployment compensation, payment of wages, and safety. Refer to Section 1.2, Website Reference for the Department of Labor and Industrial Relations (DLIR) website address.

- Business Registration. Prior to contracting, owners of all forms of business doing business in the state except sole proprietorships, charitable organizations, unincorporated associations and foreign insurance companies shall be registered and in good standing with the Department of Commerce and Consumer Affairs (DCCA), Business Registration Division. Foreign insurance companies must register with DCCA, Insurance Division. More information is on the DCCA website. Refer to Section 1.2, Website Reference for DCCA website address.

Providers may register with Hawaii Compliance Express (HCE) for online compliance verification from the DOTAX, IRS, DLIR, and DCCA. There is a nominal annual registration fee (currently $12) for the service. The HCE's online "Certificate of Vendor Compliance" provides the registered provider's current compliance status as of the issuance date, and is accepted for both contracting and final payment purposes. Refer to Section 1.2, Website Reference, for HCE's website address.

Providers not utilizing the HCE to demonstrate compliance shall provide paper certificates to the purchasing agency. All applications for applicable clearances are the responsibility of the providers. All certificates must be valid on the date it is received by the purchasing agency. The tax clearance certificate shall have an original green certified copy stamp and shall be valid for six months from the most recent approval stamp date on the certificate. The DLIR certificate is valid for six months from the date of issue. The DCCA certificate of good standing is valid for six months from date of issue.

E. **Wages Law Compliance**. If applicable, by submitting a proposal, the applicant certifies that the applicant is in compliance with HRS §103-55, Wages, hours, and working conditions of employees of contractors performing services. Refer to Section 1.2, Website Reference for statutes and DLIR website address.

F. **Campaign Contributions by State and County Contractors**. HRS §11-355 prohibits campaign contributions from certain State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body. Refer to Section 1.2, Website Reference for statutes and Campaign Spending Commission website address.

G. **Confidential Information**. If an applicant believes any portion of a proposal contains information that should be withheld as confidential, the applicant shall request in writing nondisclosure of designated proprietary data to be confidential and provide justification to support confidentiality. Such data shall accompany the proposal, be clearly marked, and shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential sections of the proposal.

***Note that price is not considered confidential and will not be withheld*.**

H. **Insurance Requirements.** The PROVIDER shall obtain from a company authorized by law to issue such insurance in the State of Hawaii (or meet Section 431:8-301, Hawaii Revised Statutes, if utilizing an insurance company not licensed by the State of Hawai`i), general liability insurance in an amount of at least ONE MILLION AND NO/100 DOLLARS ($1,000,000.00) per occurrence and TWO MILLION AND NO/100 DOLLARS ($2,000,000) in the aggregate (the maximum amount paid for claims during a policy term).

In addition to the general liability insurance, the PROVIDER shall obtain from a company authorized to do business in the State of Hawaii (or meet Section 431:8-301, Hawaii Revised Statutes, if utilizing an insurance company not licensed by the State of Hawai`i), automobile liability insurance for automobiles owned or leased by the PROVIDER and used to carry out services specified in this Agreement, that complies with the Hawaii No Fault Insurance Law. The amount shall be at least ONE MILLION AND NO/100 DOLLARS ($1,000,000.00) per accident.

For both the general liability and automobile liability insurance, the insurance coverage shall be primary and shall cover the insured for all work to be performed under the Contract, including changes, and all work performed incidental thereto or directly or indirectly connected therewith. The PROVIDER shall maintain in effect

this liability insurance until the STATE certifies that the PROVIDER's work under the Contract has been completed satisfactorily.

The insurance policies shall also provide that:

1) It is agreed that any insurance maintained by the State of Hawaii will apply in excess of, and not contribute with, insurance provided by this policy.

2) The STATE and its officers and employees are Additional Insureds with respect to operations performed for the State of Hawaii.

Prior to or upon execution of the Agreement, the PROVIDER shall obtain and provide to the STATE a certificate of insurance verifying the existence of the necessary general liability and automobile liability insurance coverage in the amounts stated above. The certificate shall indicate that the STATE and its officers and employees are Additional Insureds.

The PROVIDER shall immediately provide written notice to the contracting department or agency should any of the insurance policies evidenced on its certificate of insurance forms be cancelled, limited in scope, or not renewed upon expiration.

Should the insurance coverages be cancelled, limited in scope, or not renewed upon expiration, before the PROVIDER's work under the Contract is certified by the STATE to have been completed satisfactorily, the PROVIDER shall immediately procure replacement insurance that complies in all respects with the requirements of this section, and provide a current certificate of insurance to the STATE.

If the scheduled expiration date of the liability insurance policy is earlier than the expiration date of the time of performance under the Agreement, the PROVIDER shall timely renew the policy and provide the STATE an updated certificate of insurance.

Nothing in the insurance requirements of this Contract shall be construed as limiting the extent of PROVIDER's responsibility for payment of damages resulting from its operations under this Contract, including the PROVIDER's separate and independent duty to defend, indemnify, and hold the STATE and its officers and employees harmless pursuant to other provisions of this Contract.

I. **Proposal Submittal**. All mail-ins shall be postmarked by the United States Postal System (USPS) and received by the State purchasing agency no later than the submittal deadline indicated on the attached Proposal Mail-in and Delivery Information Sheet, or as amended. All hand deliveries shall be received by the State purchasing agency by the date and time designated on the Proposal Mail-In and Delivery Information Sheet, or as amended. Proposals shall be rejected when:

1. Postmarked after the designated date; or
2. Postmarked by the designated date but not received within 10 days from the submittal deadline; or

3. If hand delivered, received after the designated date and time.

The number of copies required is located on the Proposal Mail-In and Delivery Information Sheet. Deliveries by private mail services such as FEDEX shall be considered hand deliveries and shall be rejected if received after the submittal deadline. Dated USPS shipping labels are not considered postmarks.

1.10 Discussions with Applicants

A. **Prior to Submittal Deadline.** Discussions may be conducted with potential applicants to promote understanding of the purchasing agency's requirements.

B. **After Proposal Submittal Deadline.** Discussions may be conducted with applicants whose proposals are determined to be reasonably susceptible of being selected for award, but proposals may be accepted without discussions, in accordance with HAR §3-143-403.

1.11 Opening of Proposals

Upon the state purchasing agency's receipt of a proposal at a designated location, proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped, and when possible, time-stamped. All documents so received shall be held in a secure place by the state purchasing agency and not examined for evaluation purposes until the submittal deadline.

Procurement files shall be open to public inspection after a contract has been awarded and executed by all parties.

1.12 Additional Materials and Documentation

Upon request from the state purchasing agency, each applicant shall submit additional materials and documentation reasonably required by the state purchasing agency in its evaluation of the proposals.

1.13 RFP Amendments

The State reserves the right to amend this RFP at any time prior to the closing date for final revised proposals.

1.14 Final Revised Proposals

If requested, final revised proposals shall be submitted in the manner and by the date and time specified by the state purchasing agency. If a final revised proposal is not submitted, the previous submittal shall be construed as the applicant's final revised proposal. *The applicant shall submit **only** the section(s) of the proposal that are amended, along with the Proposal Application Identification Form (SPOH-200).* After final revised proposals are received, final evaluations will be conducted for an award.

1.15 Cancellation of Request for Proposal

The RFP may be canceled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interest of the State.

1.16 Costs for Proposal Preparation

Any costs incurred by applicants in preparing or submitting a proposal are the applicants' sole responsibility.

1.17 Provider Participation in Planning

Provider(s), awarded a contract resulting from this RFP,
X are required
☐ are not required
to participate in the purchasing agency's future development of a service delivery plan pursuant to HRS §103F-203.

Provider participation in a state purchasing agency's efforts to plan for or to purchase health and human services prior to the release of a RFP, including the sharing of information on community needs, best practices, and providers' resources, shall not disqualify providers from submitting proposals, if conducted in accordance with HAR §§3-142-202 and 3-142-203.

1.18 Rejection of Proposals

The State reserves the right to consider as acceptable only those proposals submitted in accordance with all requirements set forth in this RFP and which demonstrate an understanding of the problems involved and comply with the service specifications. Any proposal offering any other set of terms and conditions contradictory to those included in this RFP may be rejected without further notice.

A proposal may be automatically rejected for any one or more of the following reasons:

(1) Rejection for failure to cooperate or deal in good faith. (HAR §3-141-201)
(2) Rejection for inadequate accounting system. (HAR §3-141-202)
(3) Late proposals (HAR §3-143-603)
(4) Inadequate response to request for proposals (HAR §3-143-609)
(5) Proposal not responsive (HAR §3-143-610(a)(1))
(6) Applicant not responsible (HAR §3-143-610(a)(2))

1.19 Notice of Award

A statement of findings and decision shall be provided to each responsive and responsible applicant by mail upon completion of the evaluation of competitive purchase of service proposals.

Any agreement arising out of this solicitation is subject to the approval of the Department of the Attorney General as to form, and to all further approvals, including the approval of the Governor, required by statute, regulation, rule, order or other directive.

No work is to be undertaken by the provider(s) awarded a contract prior to the contract commencement date. The State of Hawaii is not liable for any costs incurred prior to the official starting date.

1.20 Protests

Pursuant to HRS §103F-501 and HAR Chapter 148, an applicant aggrieved by an award of a contract may file a protest. The Notice of Protest form, SPOH-801, and related forms are available on the SPO website. Refer to Section 1.2, Website Reference for website address. Only the following matters may be protested:

(1) A state purchasing agency's failure to follow procedures established by Chapter 103F of the Hawaii Revised Statutes;

(2) A state purchasing agency's failure to follow any rule established by Chapter 103F of the Hawaii Revised Statutes; and

(3) A state purchasing agency's failure to follow any procedure, requirement, or evaluation criterion in a request for proposals issued by the state purchasing agency.

The Notice of Protest shall be postmarked by USPS or hand delivered to 1) the head of the state purchasing agency conducting the protested procurement and 2) the procurement officer who is conducting the procurement (as indicated below) within five working days of the postmark of the Notice of Findings and Decision sent to the protestor. Delivery services other than USPS shall be considered hand deliveries and considered submitted on the date of actual receipt by the state purchasing agency.

Head of State Purchasing Agency	**Procurement Officer**
Name: Virginia Pressler	Name: Janis A Morita
Title: Director of Health	Title: Chief, Administrative Services Office
Mailing Address: P.O. Box 3378, Honolulu, HI 96801	Mailing Address: P.O. Box 3378, Honolulu, HI 96801
Business Address: 1250 Punchbowl Street, Honolulu, HI	Business Address: 1250 Punchbowl Street, Honolulu, HI

1.21 Availability of Funds

The award of a contract and any allowed renewal or extension thereof, is subject to allotments made by the Director of Finance, State of Hawaii, pursuant to HRS Chapter 37, and subject to the availability of State and/or Federal funds.

1.22 General and Special Conditions of Contract

The general conditions that will be imposed contractually are on the SPO website. Special conditions may also be imposed contractually by the state purchasing agency, as deemed necessary

1.23 Cost Principles

To promote uniform purchasing practices among state purchasing agencies procuring health and human services under HRS Chapter 103F, state purchasing agencies will utilize standard cost principles as outlined on the SPO website. Refer to Section 1.2 Website Reference for website address. Nothing in this section shall be construed to create an exemption from any cost principle arising under federal law.

Section 2

Service Specifications

Section 2
Service Specifications

2.1 Introduction

A. **Overview, purpose or need**

The vision of Harm Reduction Services Branch (HRSB) of the Hawai‘i State Department of Health (DOH) is “ending new HIV transmission in Hawai‘i and ensuring people in Hawai‘i living with HIV are in HIV care, have access to treatment and are able to maintain a suppressed viral load.”

The mission of the HRSB is to empower people in Hawai‘i to make responsible health decisions for themselves and others by providing statewide leadership and coordination for the prevention, treatment, care and surveillance of infections transmitted primarily through sexual contact or injection drug use; and by assuring the accessibility and delivery of client-centered, non-judgmental, and comprehensive services with the spirit of aloha and respect.

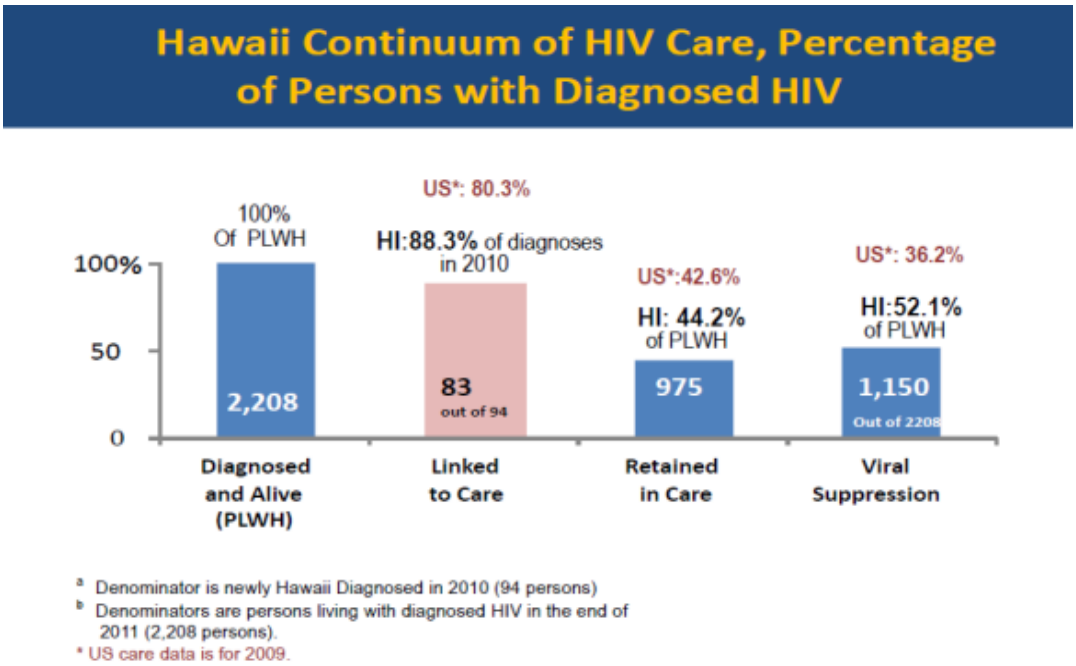
The HRSB provides leadership in program assessment, development and assurance. The HRSB coordinates planning and monitors HIV/STD and viral hepatitis services provided by the Hawai‘i State Department of Health or through purchase of services contracts for community based HIV services for people who are at risk (PWAR) and people living with HIV (PLWH).

The landscape of HIV prevention and care has changed dramatically over the last few years. This change can be attributed to changes in health care system, primarily the implementation of Affordable Care Act (ACA), recent advances in biomedical, structural and behavioral interventions, better epidemiology on who’s getting infected and how, as well as the National HIV/AIDS Strategy (NHAS) and Continuum of Care Initiative. All of these changes have further strengthened the integration of care and prevention.

DOH is the lead state public health agency in Hawaii. In this role, DOH provides statewide leadership and direction for efforts to prevent and control HIV. We invest state and federal funding in programs and services that both prevent new HIV infections and provide care and treatment to those living with HIV. DOH invites community partners to submit applications to develop and implement Community Based HIV Services (CBHS) that integrate case management services for PLWH and targeted prevention services. Through CBHS contracts, DOH will ensure that consistent high quality HIV services are available to Hawaii residents who need and can benefit from these services.

Hawaii HIV Care Continuum:

Care continuum is a model used nationwide to identify issues and prospects to improve the delivery of services to PLWH across the entire continuum of care—from diagnosis of HIV infection and active linkage in care to initiation of antiretroviral (ARV) therapy, retention in care, and eventual undetectable viral load (VL).



Some interventions and strategies, such as outreach, condom distribution, and getting people insured, can be directed to PWAR and PLWH alike. Some critical interventions or strategies, such as HIV testing, are directed to PWAR, and in particular to PWAR who may have undiagnosed HIV infection.

The Continuum of HIV Care model, which Hawai‘i adopted from the NHAS, focuses on: early diagnosis of all persons living with HIV; linkage with HIV medical care as soon as possible but within 1 month of diagnosis; and retention in care, treatment and viral suppression. Improvements along the continuum of care that lead to higher proportions of viral suppression among PLWH support the prevention goal of reducing HIV transmission as well as improving clinical results for PLWH. This monitored approach to HIV prevention and care supports better health outcomes for persons living with HIV as well as decreased HIV incidence rates in the State of Hawai‘i.

The goal of this procurement is to secure CBHS for priority HIV populations. For this procurement priority HIV populations include HIV positive persons and their partners, men who have sex with men (MSM), men who have sex with men and inject drug (MSM/PWID). The goal of releasing an RFP for

integrated services is to reach all PLWH and PWAR living in Hawaii. Integration of services help align resources to provide a more complete range of services along the HIV continuum. It should yield the best health outcomes for the PLWH and PWAR. The purpose of this procurement is to procure these integrated HIV services in Kauai County.

Hawaiʻi Continuum of Care:

http://health.hawaii.gov/harmreduction/files/2013/05/2012-HIV_rep.pdf

B. **Planning activities conducted in preparation for this RFP**

Extensive internal HRSB meetings have been held to discuss the development of this RFP. Topics considered NHAS, High Impact Prevention strategies, ACA, Data to Care, HRSB Prevention Application to Centers for Disease Control and Prevention (CDC), Care application to the Health Resources and Services Administration (HRSA), priorities set by CDC and HRSA, goals and objectives and specific information/data related to HIV/STD and viral hepatitis prevention interventions and HIV related data (Surveillance data, Epi Profile) for this RFP.

A Request for Information was conducted on March 11, 2016, to provide all interested parties an opportunity to pose questions and to collect current service contractor perspectives on the proposed services included in this RFP. The session lasted two hours and was attended by seven potential contractors. Nine joined the RFI meeting by conference call. Four written comment were submitted and oral comments were integrated into this RFP as applicable.

A second RFI was conducted by conference call on July 8, 2016, to provide all interested parties another opportunity to pose questions and to collect input and comments from them. The call lasted two hours and was attended by seven potential contractors. No written comment was submitted and oral comments were integrated into this RFP as applicable.

The following documents and data/reports were used to develop this RFP:

- CDC Funding Opportunity Announcement (FOA)
- HRSA Funding Opportunity Announcement (FOA)
- 2016 HRSA Application
- 2016 CDC Application
- The Spectrum of Engagement in HIV Care and its Relevance to Test-

and-Treat Strategies for Prevention of HIV Infection, Edward M. Gardner. http://cid.oxfordjournals.org/content/52/6/793.full

- National Academies of Sciences, Engineering, and Medicine. 2016. Eliminating the public health problem of hepatitis B and C in the United States: Phase one report. Washington, DC: The National Academies Press. Available online at http://nationalacademies.org/HMD/Reports/2016/Eliminating-the-Public-Health-Problem-of-Hepatitis-B-and-C-in-the-US.aspx.

- United States Department of Health and Human Services. 2014. 2014-2016 Action Plan for the Prevention, Care, and Treatment of Viral Hepatitis. Available online at https://www.aids.gov/pdf/viral-hepatitis-action-plan.pdf.

- United States Centers for Disease Control and Prevention. 2009. White Paper on Program Collaboration and Service Integration. Available online at http://www.cdc.gov/nchhstp/programintegration/About.htm.

- 2013 Annual Hawai‘i DOH HIV/AIDS Surveillance report

- Quarterly Reports from the Contractor providing HIV prevention and case management services for persons at risk in Honolulu County.

All of these documents can be obtained by contacting HRSB at (808) 733-9010.

Resources and information listed in this RFP provide a general overview of the population to be served and the interventions to be implemented, but they are not sufficient for proposal development. The websites provided here and throughout Section 2 should be reviewed, as they provide enhanced information and data related to topics addressed and interventions to be proposed through this RFP:

- National HIV/AIDS Strategy (NHAS)

  http://www.cdc.gov/hiv/strategy/pdf/nhas.pdf

- Centers for Disease Control and Prevention (CDC) main HIV/STD/hepatitis website:

  http://www.cdc.gov/hiv/

  http://www.cdc.gov/std/

  http://www.cdc.gov/hepatitis/

- HRSA

http://www.hrsa.gov/

- High-Impact HIV Prevention; CDC's Approach to Reducing HIV Infections in the United States.

  www.cdc.gov/hiv/strategy/dhap/pdf/nhas_booklet.pdf

- CDC website for the publication of *Morbidity and Mortality Weekly Report* (MMWR):

  http://www.cdc.gov/mmwr/

- HRSB website:

  http://health.hawaii.gov/harmreduction/

Guiding documents and information in the RFP:
Following were used as a guide in the writing of the RFP:

1. **National HIV AIDS Strategy (NHAS)**

In July 2010, the White House released the "National HIV/AIDS Strategy for the United States: Updated to 2020" (NHAS), a comprehensive roadmap for reducing the impact of HIV. The strategy sets clear priorities and targets for HIV prevention and care in the United States, and calls on government agencies and their public and private partners to align efforts toward a common purpose. In July 2015, the White House released the "National HIV/AIDS Strategy for the United States: Updated to 2020." This update reflects the work accomplished and the new scientific developments since 2010 and defines a clear course of action for everyone to move towards the vision of NHAS.

The NHAS Vision:
"The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination."

Primary goals for the NHAS:

- Reducing new HIV infections
- Increasing access to care and improving health outcomes for people living with HIV
- Reducing HIV-related health disparities and health inequities
- Achieving a more coordinated national response to the HIV epidemic

NHAS INDICATORS:
INDICATOR 1

Increase the percentage of people living with HIV who know their serostatus to at least 90 percent.
INDICATOR 2

Reduce the number of new diagnoses by at least 25 percent.
INDICATOR 3

Reduce the percentage of young gay and bisexual men who have engaged in HIV-risk behaviors by at least 10 percent.
INDICATOR 4

Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85 percent.
INDICATOR 5

Increase the percentage of persons with diagnosed HIV infection +who are retained in HIV medical care to at least 90 percent.
INDICATOR 6

Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80 percent.
INDICATOR 7

Reduce the percentage of persons in HIV medical care who are homeless to no more than 5 percent.
INDICATOR 8

Reduce the death rate among persons with diagnosed HIV infection by at least 33 percent.
INDICATOR 9

Reduce disparities in the rate of new diagnoses by at least 15 percent in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females, and persons living in the Southern United States.
INDICATOR 10

Increase the percentage of youth and persons who inject drugs with diagnosed HIV infection who are virally suppressed to at least 80 percent.

NHAS recognizes the connection between prevention, care, and treatment in reducing new infections and improving the health of people living with HIV. The strategy also emphasizes the central importance of reducing disparities in HIV prevention and care and in reducing the stigma and discrimination associated with HIV.

2. **Treatment as Prevention (TasP)**

Treatment-as-prevention (TasP) is an HIV prevention strategy that relies on early and sustained treatment of HIV and achievement of suppressed viral load. Treating HIV infection has been the foundation of individual-level HIV care efforts for many years. Successful treatment of HIV has led to dramatic declines in mortality and to improved quality of life. In 2011, scientists announced that treatment can also provide prevention benefit the HIV-negative partners of PLWH. Results from a randomized clinical trial demonstrated a 96 percent reduction in transmission when an HIV-positive partner is consistently taking ARVs. This finding, that successful treatment of PLWH has significant benefits for population-level HIV prevention and control efforts, supports an integrated approach to prevention and care.

3. **High Impact Prevention strategies**

This approach uses a combination of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas, and promises to significantly increase the impact of HIV prevention efforts. High-Impact Prevention has the objective of achieving a higher level of impact with every dollar spent on HIV services.
This approach guides the broad allocation of resources as well as the development of specific strategies for specific populations at risk, including gay and bisexual men, communities of color, women, injection drug users, transgender women and men, youth and others.

4. **Affordable Care Act**

The ACA expanded access to health insurance for many people across the U.S. Under ACA, people are more likely to be able to access health insurance that will cover HIV and related services, whether HIV care and treatment for PLWH, or HIV screening and Pre-exposure prophylaxis (PrEP)-related medical services, including labs and medication, for PWAR. PrEP and TasP, the newest tools in the HIV prevention "tool box," are interventions that are reliant on engagement with medical providers. It is critical for PLWH and PWAR to be linked with health insurance in order to realize the potential of PrEP and TasP. While insurance coverage can decrease the demand on the public health system for services such as screening and medications, there is an increased need for assistance understanding, accessing, and navigating insurance and the medical system.

5. **Data to Care**

Data to Care is a public health strategy that uses HIV surveillance data to identify PLWH who are not engaged in HIV medical care and offering interventions to help link, engage/re-engage them to care and support the HIV Care Continuum.

Three different methodologies can be used to support Data to Care depending on who does the re-engagement to care.

- Health Department Model
- Healthcare Provider Model
- Combination Model

6. **CDC Services**

As the agency with primary responsibility for HIV prevention, CDC's efforts are central to achieving the NHAS vision. CDC's major HIV prevention activities include supporting state and local HIV prevention programs—including the important work of health departments and community-based organizations—through funding and technical assistance; tracking the epidemic through HIV/AIDS surveillance activities; and supporting strategies that are most likely to yield the greatest benefits, including PrEP and Data to Care among others. CDC also works to overcome complacency about HIV and ensure that all Americans know how to protect themselves, in part through the ongoing media campaigns.

To address these challenges, CDC and its partners are pursuing a High-Impact Prevention approach to reducing new HIV infections. By using combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas, this approach promises to increase the impact of HIV prevention efforts – an essential step in achieving the goals of NHAS. This approach is designed to maximize the impact of prevention efforts for all Americans at risk for HIV infection, including gay and bisexual men, communities of color, women, injection drug users, transgender women and men and youth.

7. **HRSA Services**

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary Federal agency for improving health and achieving health equity through access to quality services, a skilled health workforce and innovative programs. HRSA's programs provide health care to people who are geographically isolated, economically or medically vulnerable. This includes people living with HIV/AIDS, pregnant women, mothers, and their families and those in need of high quality primary health care.

A major source of funding for the provision of HIV car services to individuals living with HIV/AIDS is the Ryan White HIV/AIDS Program Part B grant program. The Ryan White HIV/AIDS Program Part B grant program assists States to increase access to a comprehensive continuum of high quality HIV care and treatment for low-income people living with HIV. This program supports NHAS which is inclusive of the HIV Continuum of Care Initiative. The Ryan White grant program provides core medical services and support services that enable individuals and families living with HIV to access and remain in primary medical care to improve their medical outcomes.

8. **HIV Related Data (Surveillance Data, Epi Profile)**
   For reports and more information:

   http://health.hawaii.gov/harmreduction/hiv-aids/data-and-statistics/

Maximizing Limited Resources:

To maximize reductions in new infections, prevention and care need to use the most efficient strategies tailored for each of the populations affected by the epidemic.

Today, the need to do more with existing resources is greater than ever. HIV resources at the federal financing are more limited and focused on fewer jurisdictions. To address the challenges of the epidemic in the United States, advance the goals of NHAS, and maximize the effectiveness of current HIV services methods, CDC's Division of HIV/AIDS Prevention and HRSA pursues a joint or integrated approach to align resources to better match the geographical burden of HIV in the jurisdiction, foster integration of programs and reduce administrative and reporting burden.

Hawaii Department of Health's (DOH) role:
In keeping with NHAS, CDC and HRSA, Hawaii will follow the national lead in HIV services. The HRSB will focus on reducing new infections in high risk priority populations by assisting individuals to enroll in insurance, targeted testing, increasing appropriate use of PrEP and HIV treatment, increasing access to care, retaining and re-engaging PLWHA, improving health outcomes for PWAR and PLWH, and promoting health equity**. Particular emphasis will be placed on testing and diagnosing new positives among the highest risk individuals, increasing the appropriate use of PrEP to PWAR, linking newly diagnosed and those currently living with HIV to medical and other services, and increased monitoring, evaluation, and quality assurance.** To achieve these outcomes, the HRSB will provide direct services; contract and partner with community based organizations; and collaborate with health care providers throughout the state. The HRSB will implement CBHS that are appropriate, effective, and scalable in the context of Hawaii.

Other website addresses will be provided throughout Section 2, as appropriate. Contractor should refer to these websites for more detailed information regarding interventions they plan to propose.

C. **Description of the service goals**

Services are intended to increase knowledge of HIV status and reduce the frequency of HIV/STD/hepatitis transmission among the indicated populations on Oahu through implementation of community based HIV services. To achieve its mission, HRSB will focus investments on four main public health strategies:

Getting people insured –Having health insurance removes a significant barrier to accessing health care services, including primary medical care, mental health and substances abuse services, HIV/STD/hepatitis testing, hepatitis vaccination, PrEP, and HIV medical care. Contractor shall enroll high risk negative persons in health insurance so they can access health care services to reduce their risk for acquiring HIV or and HIV positive persons to support access to health care and improvement along the continuum of HIV care.

Testing and linkage- targeted testing and linkage allows individuals to know their HIV status. Contractor will perform targeted HIV testing and linking PLWH to appropriate services. After testing, a high risk negative person can be linked to PrEP and a PLWH can be linked to medical care and treatment.

PrEP linkage and follow-up – For PWAR who are not infected with HIV, PrEP can significantly reduce the risk of HIV infection; if taken daily, it can help a high risk person to remain negative. Contractor will assess who may be a candidate for PrEP; will make referral/linkage to medical provider; and for those who initiate PrEP, will follow-up with the client over time to ensure adherence with medications and medical follow up, and access to necessary laboratory services.

Linking, engaging and retaining PLWH to medical care and treatment – Access to medical care and treatment enable PLWH to stay well and virally suppressed. Contractor will perform case management services to link, engage/re-engage and retain PLWH in medical care and achieve viral suppression. If a PLWH is not in care or falls out of care the contractor will seek to re-engage and retain them in care. The Contractor will seek to engage those PLWH who reside within the county who are not currently enrolled in case management services, and are not successfully retained in medical and virally suppressed so they can access the most appropriate services

The purpose of this procurement is to provide integrated community based HIV services that assist PWAR and PLWH by identifying and reducing barriers to entry and retention in HIV medical care, access and adherence to treatment, and viral suppression. Overall the goal is to support eligible persons to obtain the maximum benefit of HIV prevention, care and treatment.

For the purposes of this procurement, an individual with HIV/AIDS is considered to be "in HIV medical care" if the individual has:

- seen a health care provider at least once within the previous six (6) months; and
- had an HIV viral load test at least once within the previous six (6) months.

D. **Description of the target population to be served**

Services shall be provided to:

1. Persons living with HIV and their partners.

People living with HIV are the highest priority population for CBHS. The goal is to identify new positive persons through HIV testing, contact their partners and reduce their risk of transmitting HIV to others.

Comprehensive CBHS for PLWH shall also ensure access to STD and viral hepatitis services and linking all positive persons with medical care and treatment as appropriate. Partner services are an integral part of CBHS.

Services shall be provided to PLWHA in Kauai County who require assistance to access and remain in and benefit fully from HIV medical care and treatment. These include:

1. PLWH who are not in medical care, including those who are newly diagnosed HIV positive;
2. PLWH who have fallen out of medical care or discontinued HIV treatment;
3. PLWH who require assistance to access medical care and treatment; and
4. PLWH who require assistance to remain in HIV medical care and treatment.

Within the target population, special emphasis must be placed on ensuring access to HIV medical care and treatment care for:

- Women;

- Infants (less than two (2) years of age);
- Children (two to twelve (2-12) years of age);
- Youth (thirteen to twenty-four (13-24) years of age);
- Individuals with substance abuse issues;
- Individuals with mental illness;
- Individuals who are homeless; and
- Specific demographic or risk populations that, based on ongoing data analysis by HRSB, may be underserved with respect to CBHS.

2. Men who have sex with men (MSM) and their partners

- MSM represent the majority of persons living with HIV in Hawaii. This priority population includes both adult and young MSM, and men who identify themselves as gay or bisexual, as well as MSM who do not identify as gay or bisexual. Particular services needed for MSM with syphilis or gonorrhea. CBHS must be designed to reach MSM.

3. Men who have sex with men and inject drugs (MSM/PWID) and their partners

While the population of MSM/PWID may be small, their HIV risk is extremely high. Comprehensive CBHS for MSM must be inclusive of MSM/PWID. Comprehensive CBHS to MSM/PWID must address injection-related risk, and every effort must be made to ensure that these persons are linked with syringe exchange services.

E. **Geographic coverage of service**

Kauai County

F. **Probable funding amounts, source, and period of availability**

Probable funding: Total funding of $600,000 each fiscal year (is possible in future, pending availability of funds). Contractor should submit a budget of $224,342 with their proposal in response to this RFP.

The agency that is awarded the contract to provide services described in this RFP may, with the prior written consent of HRSB, sub-contact portion(s) of the service delivery to other agencies. Full responsibility for meeting the terms of the contract will remain with the original Contractor. The specific details of any proposed sub-contract shall be laid out in the application responding to the RFP.

Source of funds: Federal and State Funding
Availability: 7/1/17-6/30/19 with the option to extend up to three additional twenty-four month periods, ending no later than 6/30/2025.

2.2 Contract Monitoring and Evaluation

The criteria by which the performance of the contract will be monitored and evaluated are:

(1) Performance/Outcome Measures
(2) Output Measures
(3) Quality of Care/Quality of Services
(4) Financial Management
(5) Administrative Requirements

The HRSB will use the criteria of 'Performance/Outcome Measures' for contract monitoring.

2.3 General Requirements

A. **Specific qualifications or requirements, including but not limited to licensure or accreditation**
None

B. **Secondary purchaser participation**
(Refer to HAR §3-143-608)

After-the-fact secondary purchases will be allowed.

Planned secondary purchases: None

C. **Multiple or alternate proposals**
(Refer to HAR §3-143-605)

☐ Allowed ☒ Unallowed

D. **Single or multiple contracts to be awarded**
(Refer to HAR §3-143-206)

☒ Single ☐ Multiple ☐ Single & Multiple

Criteria for multiple awards: Not Applicable to this RFP

E. **Single or multi-term contracts to be awarded**
(Refer to HAR §3-149-302)

☐ Single term (2 years or less) ☒ Multi-term (> 2 yrs.)

Contract terms:

Initial term of contract:	7/1/17- 6/30/19
Length of each extension:	twenty-four months
Number of possible extensions:	3
Maximum length of contract:	ninety-six months

The initial period shall commence on the contract start date or Notice to Proceed, whichever is later.

Conditions for extension: extension must be in writing and must be executed prior to expiration of the initial contract term.

2.4 Scope of Work

The scope of work encompasses the following tasks and responsibilities:

A. **Service Activities**

(Mandatory tasks and responsibilities)

Services sought under this RFP include the following services to be provided to the target population. The requested services represent interventions critical to identify new positive persons and preventing the greatest number of new HIV infections, linking PLWH to care and keeping them virally suppressed.

1. **Internet Outreach**

Contractor will conduct internet outreach via smart phone application, Internet chat rooms, social networks and other online communities. Internet outreach shall target persons who are HIV positive or are at highest risk for HIV such as MSM to link them to CBHS. This outreach must make every attempt to focus narrowly on PWAR or PLWH who are not in care or fallen out of care in the geographic area of service. This outreach involves providing information on HIV testing, insurance coverage options, availability of ARV for PrEP and HIV treatment, re-engagement to care and case management for PLWH who are not engaged, information on and encouragement to access HIV testing and linkage to services (TL), STD and hepatitis risk, providing STD and hepatitis B and C testing and treatment, and hepatitis A and B vaccinations as appropriate. Referrals and linkage to in-person services such as syringe exchange and CBHS should be made as appropriate and when possible. Contractor shall develop policies and procedures for implementing internet outreach in consultation with HRSB before starting the services.

Note: outreach services must be bundled with multiple direct services like testing, insurance enrollment/navigation, condom distribution, engagement/re-engagement in care etc. Outreach will not be funded as a stand-alone service.

2. **Outreach with assessment for, recruitment, enrollment, linkage and re-engagement in services outlined in the RFP**

Outreach Services (PLWH, PWAR)

- Identification of people who do not know their HIV status and linkage

into HIV Community Services, Outpatient/Ambulatory Health Services
- Provision of additional information and education on health care coverage option
- Recruitment into CBHS
- Re-engagement of people who know their status into HIV Community Services, Outpatient/Ambulatory Health Services

Outreach Services for PWAR may include the provision of the activities above but must be bundled with one or more direct services including, but not limited to, HIV testing, condom distribution, healthcare support and access, linking to PrEP and insurance enrollment/navigation. **In case of a STD outbreak, contractor will work closely with HRSB to reach contracted target populations to support provision of information and support access to testing, care and treatment.** Outreach services will not be funded as stand-alone activities.

Outreach and recruitment services for PLWH shall include activities to reach and engage individuals within the target population who may require services and are not receiving them. Activities may be provided to these individuals directly, through other community agencies, health care providers, HIV testing and linkage providers, other PLWH and other means to ensure that HIV medical case management and CBHS are available to those who need it. Outreach and recruitment activities shall reach individuals with HIV, both newly and previously diagnosed, who are not in case management and:

- are not fully benefiting from care and treatment (due to issues of access, adherence, or other barriers); or
- are at risk for dropping out of HIV medical care and/or discontinuing HIV treatment; or
- are not in HIV medical care.

The integration of HIV prevention and care services includes outreach for a range of different purposes: recruitment to testing and insurance enrollment assistance; providing information on HIV, STDs, viral hepatitis, PrEP, SEP, and services for PLWH; recruitment to HIV case management and linkage engagement/re-engagement in medical care for PLWH; and condom distribution. Importantly, outreach to MSM also includes outreach to HIV positive persons who are not in medical care and treatment and provision of support to help them re-engage in CBHS, and support at access PrEP for the highest risk negative persons. Outreach will be focused on providing information about health insurance coverage options and linking the client to health insurance. Outreach may also include distributing condoms, safer sex kits, and other risk reduction materials, information on HIV, viral hepatitis

and STD risks, and on-site HIV testing, STD and hepatitis B and C screening and treatment, hepatitis A and B vaccinations, and comprehensive CBHS. Contractor should have a condom distribution plan that align with National HIV/AIDS Strategy (NHAS) and emphasize the distribution of condoms to HIV positive people, their partners and people who are at highest risk of contracting HIV. The contractor's proposed condom distribution strategy for PLWH and PWAR must be bundled with a direct service including, but not limited to, HIV testing, CBHS activities, healthcare navigation/coordination, and insurance enrollment/navigation. **Condom distribution will not be funded as a stand-alone activity.**

3. **Getting people insured:**
   Healthcare access & coordination (PLWH, PWAR)
   - Education on health care coverage options (e.g. qualified health plans through the work place, Marketplace, Medicaid coverage, Medicare coverage)
   - Access and linkage to care and treatment services, including, but not limited to, case management, HIV clinical services, public health services, and other support services
   - Referral services to improve care and treatment services at key points of entry
   - Health literacy

Provider will ensure insurance services for PWAR and PLWH include the provision of the activities above and must be bundled with other CBHS. Getting people insured is a critical and vital intervention for both PWAR and PLWH. Contractor will need to actively engage the clients in getting them insured to best meet their needs.

In addition to the above services, agencies may include other support services such as, but not limited to, community-based testing for HIV and sexually transmitted infections, condom distribution, and sexual health education. These complimentary services must actively promote linkage to insurance and will not be funded as stand-alone services.

Helping uninsured PWAR to enroll in health insurance can increase their access to important primary medical care. Under the ACA, certain prevention services are covered by individual insurance plans, usually without cost to the insured individual (no copay). Among these are services that may be particularly relevant to this RFP, such as:

- HIV screening;
- Hepatitis C screening;
- Hepatitis B screening;
- Immunizations including hepatitis A and B;
- Sexually transmitted infection prevention counseling;

- Syphilis screening;
- Chlamydia infection screening; and
- Gonorrhea screening.

Recommended populations vary. For more information https://www.healthcare.gov/coverage/preventive-care-benefits/

4. PrEP and HIV treatment

Funded HIV Community Service programs will focus on a common goal of increasing the use of ARV therapy to support successful PrEP and HIV treatment. PrEP, is an HIV prevention method in which PWAR take daily ARV medication to reduce their risk of infection. When used in combination with other prevention tools, such as condoms and sterile injection equipment, PrEP among at-risk individuals can lead to a significant reduction in new HIV infections in the population. Programs will accomplish this by providing a spectrum of interrelated services. Contractor shall make sure that their staff is trained and have knowledge of PrEP. Contractor should be able to educate clients about PrEP, provide informational resources regarding PrEP, and link appropriate clients to providers in their community that offer PrEP, Contractor should also be familiar with post-exposure prophylaxis (PEP) and have a plan for responding to clients who inquire about PEP.

ARV recruitment, linkage and support (PLWH, PWAR):

- Educating communities about PrEP and HIV treatment
- Recruiting individuals into services that support PrEP and HIV treatment
- Ensuring individuals know their HIV status
- Providing support to individuals so they can successfully enroll in health insurance
- Providing support to individuals so they can successfully initiate and sustain healthcare
- Providing support to individuals so they can successfully initiate and sustain ARV for PrEP and HIV treatment

In addition to the above services, agencies may include other support services such as, but not limited to, community-based testing for HIV and sexually transmitted infections, condom distribution, and sexual health education. These complimentary services must actively promote PrEP and HIV treatment and will not be funded as stand-alone services.

While ARV use is the priority outcome for CBHS, PrEP is not appropriate for all PWAR, and some PLWH may choose not to be on ARVs. These individuals can still benefit and should be offered support services other

than ARVs.

5. Linkage with HIV care

Linkage to care – Referral and engagement in HIV medical services; Contractor shall ensure the patient kept their appointment with a medical provider related to their HIV infection within the first 3 months of diagnosis.

Linkage of newly diagnosed positives to case management, medical and other social services: Contractor will focus on HIV-positive persons, particularly those newly diagnosed and those with higher acuity and the development of ongoing contacts to monitor their needs and access to care and treatment. The Contractor must explain in detail their system for rapidly linking newly diagnosed HIV positive persons with HIV medical case management, medical care, treatment and other appropriate services and the procedures that will be used for follow up.

HIV Medical Case Management Services are defined as range of client-centered services that link clients with health care, psychosocial and other services. Coordination and follow up of medical treatment is a component of medial case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of client's needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness and adherence to complex HIV/AIDS treatments. Medical case management services may include assisting clients to access support services but only when the support services are clearly needed in order to reduce barriers to a client accessing and remaining in medical care and treatment. Medical case management services shall be provided in a manner consistent with the HRSB Case Management Practice Standards (Attachment C).

Intake/initial assessment: Entry into HIV case management services shall include documenting and assessing a full range of medical and psychosocial information related to eligibility, access, and barriers to engaging, remaining in, and fully benefiting from HIV medical care and treatment. Intake/initial assessment information shall be recorded in the client's electronic data record. Each client shall be assigned an initial acuity level on the HRSB-specified one-to-four scale acuity scale (See Client Acuity Determination, Attachment D).

a. **Medical and related information** shall include:

- source of referral;
- date of HIV diagnosis;
- date of AIDS diagnosis, if applicable;
- current health status;

- current HIV and other medical care providers;
- history of and most recent HIV laboratory testing and results;
- complete information on current HIV treatment regimen;
- treatment adherence and barriers to adherence;
- health insurance status and coverage including limitations, premiums, co-pays, deductibles, etcetera;
- need/eligibility for HSPAMM, HDAP and HCOBRA;
- immunization for hepatitis A or B, or both;
- hepatitis C test results;
- recent STD testing history, including results and any treatment;
- recent TB results; and
- PAP for women, as appropriate.

b. **Psychosocial information and assessments** shall include:

- mental health assessment;
- substance abuse assessment;
- overall health status/care/care assessment;
- assessment of needs related to housing, nutrition, crisis intervention, individual/family counseling, and benefits counseling; and
- HIV prevention sexual and drug use risk assessment, (in connection with Prevention for Positives services).

For every newly confirmed positive HIV test result the agency will ensure the client has an immediate or near term appointment with an HIV medical provider of the person's choice and attends that appointment. This may include agency staff accompanying the client to the provider's office. The agency will continue to follow up with the positive person (with their permission) to ensure they attend their initial medical appointments. Contractor staff shall also inform the client with a reactive HIV rapid test result, about the benefits of prompt care and treatment. They should be informed of the support that is potentially available to them, such as: case management, HIV care and treatment. Every effort shall be made by the agency to link the client to insurance and HIV health care. Strengthening focus on medical outcomes including enrollment and retention in care, adherence and quality of care is a critical initiative of the current CBHS procurement.

6. Retention and Re-engagement in care:

Retention and re-engagement in medical care is a core component of HRSB contracts with agencies. It is required that agencies use client level viral load data to monitor retention in care. Contractor shall support persons to remain in care through a variety of means including linkage with support services, housing and access to Hawaii Seropositivity and Medical Management Program (HSPAMM)

and Hawaii Drug Assistance Program (HDAP). Contractor shall ensure that PLWH are either retained or re-engaged in care. The Contractor will utilize information provided by HRSB regarding "out of care PLWH" and re-engage these persons into care and report back information to HRSB following HRSB guidelines.

Retention and re-engagement to care services apply for all PLWH within funded county.

a) Retention and reengagement for PLWH to medical care:
Contractor must perform medical and supportive case management to ensure that: 1) clients are able to access and remain in HIV medical care and treatment, and 2) possess the information and support necessary, to benefit as fully as possible from HIV medical care and treatment. Case management activities include medical case management activities directly related to medical care, as well as supportive (or "non-medical") case management activities that are non-medical but impact the client's ability to access, remain in, and/or benefit fully from HIV care and treatment. Case notes and documentation related to any contact with the client, activities conducted, services provided, and, if applicable, progress on the client service plan, shall be recorded in the electronic client level data system.

a. **Medical Aspects**:

1) Assist clients to better understand, utilize and benefit from primary medical care.
2) Document fully cases of clients not accessing HIV medical care, reasons why not, efforts made by the agency and if any additional assistance is needed from the agency to overcome barriers to access. A client remains at a high acuity level until they access HIV care.
3) Document fully cases of clients not on ARV treatment, including whether or not treatment is medically appropriate. If ARV treatment is medically appropriate, document reasons client is not on treatment, efforts made by the agency and if any additional assistance is needed from the agency to overcome barriers to access. If treatment is recommended by health care provider the client remains at a high acuity level until they access HIV treatment.
4) Provide appropriate interface on behalf of the client and health care provider.
5) Assist eligible clients to interface with health care organizations and related agencies (particularly community primary care centers) to facilitate the delivery of health care services.
6) Ascertain and support the treatment advocacy needs of individual clients and provide necessary support to meet them.

7) Provide client adherence counseling/support and provide medically related counseling concerning medications, side effects, laboratory results and similar.
8) Support, advocate for and document that clients receive the full range of recommended medical services for PLWH in accordance with Public Health Service guidelines, including HAV/HBV immunizations, HCV screening, and STD screening and follow up services.

b. **Access/Support Aspects**:

1) Ensure that clients apply for and are enrolled in health insurance or programs that provide medical and pharmacy coverage.
2) Determine details of client's medical and pharmacy insurance and coverage.
3) Assist clients to maintain current medical insurance and assist uninsured clients in applying for and accessing Medicaid (Quest) and/or Medicare or other coverage.
4) Assist eligible clients in accessing HSPAMM.
5) Assess eligibility and process application and re-certification for HDAP and HCOBRA following documented process and timeline.
6) Maintain all required hard copy documentation related to eligibility and re-certifications for HDAP and H-COBRA programs in client paper file.
7) Coordinate with other community based organizations to link eligible clients with social support services such as transportation, food and housing that are needed by clients to access HIV medical care and treatment.
8) Develop and maintain an updated resource list of current HIV care service providers and make this list available to clients.
9) Assist client to determine and access from a medical provider who can best meet their accessed range of needs.
10) Based on assessed needs and as appropriate, assist client to access mental health, substance abuse, dental and other related health services.
11) Provide support for clients in hospital, hospice or other care facilities.
12) Maintain the required health, laboratory and medically related information in the electronic client level data system to monitor client need and access to medical services etc.
13) Provide regular sessions on identifying risk, disclosure, partner referral, and risk reduction based on client's risk assessment. Additional sessions should be provided for clients assessed to be of higher risk of HIV transmission. Assessment and follow

up shall be reported in the client level data system. This service may be provided by the most appropriate staff in the agency.

c. **Client Service Plan**:

For clients with acuity levels 1-3, a written client service plan shall be developed and maintained in the client records. The client service plan shall aim to ensure that the client can access and remain in HIV medical care, and can benefit fully from HIV care and treatment. For clients not currently accessing medical care, or not fully benefiting from HIV care and treatment, the client service plan shall address the barriers and aim to support the client in moving in that direction.

2. Ongoing Assessment/Re-assessment:
This component will be similar to the initial intake assessment and will focus on working with the client to update information and the plan to ensure client access to HIV medical care and treatment. The assessment shall particularly include current HIV medical provider, last visit, HIV treatment and issues, laboratory results, STD and viral hepatitis screening, follow up and immunization, insurance coverage, enrollment and any needed recertification for publicly funded programs (Medicaid, Medicare, HDAP, HCOBRA, HSPAMM etc.), co-morbidities including HCV, HBV, homelessness, substance use and mental health. The health, support and prevention needs and acuity level of each client shall be reviewed and updated on a frequency determined by the level of client acuity set out in Attachment D, "Client Acuity Determination." Reassessment of HIV behavioral risk of each client shall take place with any changes in prevention acuity noted. The review process and results shall be recorded in the electronic client level data system with the service plan updated as needed. The initial and revised plans, changes to acuity level, other changes in client's situation shall be recorded in the electronic client level data system

b) Retention and re-engagement on PrEP

Contractor will follow-up with the PWAR regularly once they are linked to PrEP. Contractor will provide ongoing support focused on ensuring that most at risk clients are retained and if needed re-engaged with PrEP. This could be brief face-to-face meetings and/or phone calls or text, whatever the PWAR is most comfortable with.
Staff will ensure that: 1) clients are able to access and remain in PrEP, and 2) possess the information and support necessary, to benefit as fully as possible from PrEP.

Contractor's staff shall actively engage in outreach and recruitment

efforts with the physician offices that prescribe PrEP to provide the education and support to the PWAR.

Other information on components of the interventions is requested in this RFP; consult Section 3 of this RFP for further information.

7. Targeted HIV and hepatitis C Virus (HCV) Testing and Linkage Services (TL) in non-clinical settings and HIV Partner Services (PS):

a) Integrated HIV and HCV Testing in Non-Clinical Settings
Targeted HIV and HCV testing in non-clinical settings of highest risk persons who are unaware of their status. The focus is not on screening large numbers of persons but rather finely targeted testing to find positives. Contractor must work to focus their testing to highest risk persons to achieve 1% positivity measured by # of new HIV positives/# of HIV tests performed. Based on the epidemiology in Hawaii targeted HIV tests will be provided to partners of PLWH, MSM, MSM/PWID and PWID**.** It is critical that persons who are HIV or HCV positive learn their status. These persons should access medical care to maintain their health and take steps to reduce their risk of transmitting HIV or HCV to others. Individuals with current high-risk behaviors who test HIV or HCV negative should be encouraged to re-test at appropriate intervals.

- If found to be HIV positive:
- Report status to DOH (per State of Hawaii reporting laws)
- Linkage to HIV medical care and treatment, and case management
- Linkage to Partner Services (provided by HRSB)
- Referral for STD, HBV, HCV testing and HAV, HBV vaccines Health Education / Risk Reduction and - PrEP for partner(s)
- Condom Distribution

- If found to be HIV negative:
- Assess for PrEP. As appropriate, education client about PrEP and linkage to PrEP services
- Referral for STD testing and hepatitis testing, vaccines, if appropriate
- Health Education / Risk Reduction
- Condom Distribution

- If found to be HCV positive
- Report status to DOH (per state of Hawaii reporting laws)
- Linkage to confirmatory RNA testing
- Linkage to HCV care

- Targeted on-site STD testing or referral to clinical settings of people who at risk for STDs
- If found positive for STDs:
  - Report status to DOH (per State of Hawaii reporting laws)
  - Linkage to clinical provider for treatment
  - Linkage to Partner Services (provided by HRSB)
  - Referral for HIV testing and hepatitis testing, vaccines, if appropriate
  - Condom Distribution

*In case of a STD outbreak, contractor's staff will work closely with DOH staff and reach out to target population through outreach and testing

HIV TL is a core component of CBHS for persons at risk for HIV and/or HCV. TL is an adjunct service offered to persons at risk for HCV. HIV TL should be based on CDC's publication on *Implementing HIV Testing in Nonclinical Settings A Guide for HIV Testing Providers* (March 2, 2016). HCV TL should be based on CDC's publication on *A Guide to Comprehensive Hepatitis C Counseling and Testing*. These documents can be found at the following websites:

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers:

http://www.cdc.gov/hiv/pdf/testing/cdc_hiv_implementing_hiv_testing_in_nonclinical_settings.pdf

A Guide to Comprehensive Hepatitis C Counseling and Testing:

http://www.cdc.gov/hepatitis/resources/professionals/pdfs/counselingandtesting.pdf

Partner Services (PS) is a priority CBHS because partners of HIV-positive persons are more likely to be at high-risk for having, /transmitting or acquiring HIV.

Contractors shall link all newly diagnosed persons with HRSB PS staff. Contractor will work to ensure that 100% of all newly diagnosed persons are successfully linked to partner services provided by HRSB. PS helps ensure the newly diagnosed individual is linked with care and support services, and to notify partners of possible exposure to HIV infection and offer HIV testing. Linkage to PS must be included in the informed consent for HIV testing.

Another integral part of TL pertains to ensuring that all HIV-positive persons are aware of and linked to HIV medical care and treatment, and case management and support services as appropriate.

a. **HIV and HCV (TL) Requirements and Responsibilities:**

TL services are a fundamental component of this RFP. The expectation is that HIV TL services will be provided to as many persons from target populations as possible so they can learn their HIV status and receive, as appropriate, other services such as STD/HCV screening and hepatitis A and B vaccinations. The expectation is that HCV TL services will be provided to persons from the HCV target population which includes: HIV-positive persons, people who inject drugs and persons answering "yes" to additional hepatitis risk questions on testing data collection form. Current approved testing data collection form can be found in the HRSB Outreach, Testing and Linkage (OTL) policies and procedures.

TL must be conducted in accordance with HRSB OTL policies and procedures. Current HRSB policies and procedures can be obtained from HRSB staff. TL may be conducted only by persons who have current HRSB HIV/HCV testing certification. (See section B. 1. a. "Staffing").

CONTRACTOR SHALL USE HRSB APPROVED HIV TEST TECHNOLOGY FOR TL BASED ON CURRENT TL POLICIES AND PROCEDURES.

The Contractor is required to purchase rapid test kits, controls, and supplies and should budget for it in the proposal. HIV test kits may be made available by HRSB to Contractor as funding allows. Contractor may use other sources of non-contract funds to do HIV testing to populations not targeted through this RFP. HRSB will pay for processing of confirmatory tests for preliminary positive cases.

HRSB shall purchase and provide HCV TL supplies to the agency, as funding allows. Adherence to quality assurance measures as outlined in the OTL policies and procedures is required at all times in order to continue receiving HCV TL supplies. HRSB will pay for processing of confirmatory tests for preliminary positive cases, as funding allows.

The HRSB staff shall serve as resource persons to support agencies in implementing effective, appropriate rapid TL services.

CDC TL website:

http://www.cdc.gov/hiv/testing/nonclinical/

b. **TL requirements after individual test HIV positive:**

For all preliminary positive HIV rapid test results, contractor MUST provide and document confirmatory HIV test (including result). For confirmed HIV positive individuals additional TL services shall include linkage to PS, HIV care case management as appropriate, medical care (including hepatitis C testing, hepatitis A/B immunization, and STD testing), and other appropriate services for persons living with HIV.

Opt-out confidential HIV testing is required and all identifying information about the person being tested will go into a medical record and be attached to a test result. Prior to each testing event, the agency's testers will advise clients during the informed consent process that in the event they test positive an HRSB PS staff person will meet with them to help ensure they are linked with HIV care services and to ensure that their sex and needle sharing partner(s) are confidentially informed by the DOH that they may be at risk.

The contractor will enter all required TL client data into the HRSB approved data collection system.

c. **TL requirements after individual test HCV positive**:

For all positive HCV antibody test results, contractor MUST refer the client, and document that it has done so, for confirmatory HCV RNA test (including result, if possible). For newly diagnosed HCV positive individuals, additional TL services shall include referral and/or linkage to case management/care coordination and medical care.

Confidential HCV testing is required and all identifying information about the person being tested will go into a medical record and be attached to a test result. Reactive HCV antibody tests must be reported using the HRSB "Hepatitis C Infection: Point of Care ("Rapid") Test Reporting Form".

When HCV referrals or linkages to case management or medical care are made, Contractor must document the following details: who made the referral, type of referral (e.g., client given flyer, client directly introduced to case manager, client called referral

while still on-site, etc.), who client was referred to. These details must be reported to the HRSB Viral Hepatitis Prevention Coordinator on a regular basis, as outlined in the HCV TL policies and procedures.

b) Partner Services (PS):

PS is recognized as a critical component and is a high priority HIV service activity of the HRSB program. PS is critical for the partners of persons who test positive for HIV because they are at the highest risk of acquiring or transmitting HIV. They need to be provided with the opportunity to learn their sero-status and access appropriate services. PS includes partner elicitation and partner notification. Through PS, partners are confidentially informed of their possible exposure to HIV. Partners previously diagnosed with HIV are offered assistance with retention and re-engagement in care, as necessary. Notified partners are encouraged and counseled to be tested and to receive a full range of HIV, STD and viral hepatitis testing services. Partners testing negative should be informed of PrEP and, as appropriate, referred if interested. In addition, partners testing positive for HIV, STD or viral hepatitis should be linked with medical care, treatment and appropriate support services.

Contractor shall be responsible for linking newly diagnosed HIV positive clients to designated HRSB staff for the provision of PS. All PS related activities shall be provided in full accordance with HRSB PS policies and procedures, which are available through HRSB.

Contractor staff shall inform clients during the process that obtains informed consent that if the rapid test result is reactive then HRSB staff will meet with the client and begin to provide partner services support, each agency will have a lead PS staff person who will liaise with the HRSB PS staff. Partner notification is the responsibility of HRSB.

Ongoing Partner Services:

Contractor shall develop and implement a methodology for ongoing PS to reduce risk behavior. PLWH enrolled in HIV case management will be offered ongoing PS, in particular clients who are out of medical care or have a high viral load.

PS referral by the agency can result in the HRSB PS program identifying new cases of HIV as well as reaching out of care PLWH, these are critical outcomes of an agency's referral. The HRSB PS program will document any new HIV diagnoses and out of care PLWH who are identified as a result of referral.

HRSB shall provide technical assistance and support to the agency for PS and facilitate trainings for the Contractor staff.

c) **Integration of HIV/STD and viral hepatitis Services:**

In 2010, the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP) began the Program Collaboration and Service Integration (PCSI) initiative and emphasized it as one of the three priorities for the Center. PCSI, as defined by CDC, is "a mechanism of organizing and blending inter-related health issues, separate activities, and services in order to maximize public health impact through new and established linkages between programs to facilitate the delivery of services". PCSI promotes improved integrated HIV, viral hepatitis, STD, and TB prevention and treatment services at the client level through enhanced collaboration at the health department jurisdictional level, as well as organizational program level, thereby offering opportunities to: (1) increase efficiency, reduce redundancy, and eliminate missed opportunities; (2) increase flexibility and better adapt to overlapping epidemics and risk behaviors; and (3) improve operations through the use of shared data, enabling service providers to adapt to, and keep pace with, changes in disease epidemiology and new technologies. HIV, STD and viral hepatitis service integration at the client level is supported by HRSB and is reflected in this RFP.

Details of this strategy and approach are outlined in the NCHHSTP PCSI White Paper:

http://www.cdc.gov/nchhstp/programintegration/docs/207181-_C_NCHHSTP_PCSI%20WhitePaper-508c.pdf

Linkage:

A linkage occurs when the contractor ensures that the client has been referred to **and received care from** an appropriate service provider or agency. Contractor will develop a linkage tracking system.

CDC Referral website:

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm

If the Contractor does not provide the service, it must be referred out. It must have agreement with outside contractors and these must be evidenced by MOUs.

If a Contractor is proposing to provide linkages to outside sources for clients to obtain STD, hepatitis or any other services, the contractor shall explain

their linkage system including but not limited to a linkage form, tracking system, follow-up plan and a list of DOH programs for linkage such as: family planning for chlamydia testing, HRSB community partners and other community agencies which will provide the STD and hepatitis services. Linkage should be first made to client's health care provider at no cost to Health Department. If the client does not have appropriate health insurance coverage, then they should be linked to Health Department partner agencies in the community that provide STD and hepatitis testing and hepatitis A and B immunizations.

Contractor **must** attach a Memorandum of Understanding, Letter of Intent or a Letter of Support **from** each of these agencies that will clearly delineate responsibilities, services and procedures.

a. STD Services

Many persons at-risk for sexually transmitting or contracting HIV may also be at-risk for transmitting or contracting other sexually transmitted diseases. Testing for and treatment of syphilis, gonorrhea and chlamydia not only improves the health of those infected and prevents further spread of these diseases, but also plays a significant role in reducing the spread of HIV. CDC recommends that testing for persons at-risk should be based on assessment of risk. Appropriate clients should be informed about STD risks and the importance of STD testing, and should be encouraged to access STD testing by their healthcare provider. Clients without providers or health care insurance may be referred to alternative STD testing sites such as partner agencies and community health centers. Referral can also be made to DOH Diamond Head STD clinic. Contractor shall perform on-site testing services for syphilis, chlamydia and gonorrhea services, or develop strong collaboration with other community health care partners who provide the clinical services. Contractor shall incorporate linkages to STD testing and treatment into HIV prevention efforts for appropriate clients who are unable to access STD testing through their healthcare provider. HRSB may facilitate training on STDs and will be available to assist and support agencies in integrating STD prevention into HIV prevention programs.

Provision of STD services on-site or referral of clients to STD services is a required activity.

CDC recommended STD screening from the 2015 Treatment Guidelines for all populations:

http://www.cdc.gov/std/tg2015/screening-recommendations.htm

MSM screening:

http://www.cdc.gov/std/tg2015/specialpops.htm#msm

STD screening guideline website:

http://hawaii.gov/health/healthy-lifestyles/std-aids/info-medical-providers/Screening%202011.pdf

b. Viral Hepatitis Services

Many persons at risk for transmitting or contracting HIV may also be at risk for transmitting or contracting viral hepatitis. The U.S. Public Health Service highly recommends that people living with HIV be screened for hepatitis B and C and receive hepatitis A and B vaccinations. The CDC highly recommends that PWID be screened for hepatitis B and C; MSM should be screened for hepatitis B; MSM/PWID should receive hepatitis A and B vaccinations; and persons from other populations should be screened for hepatitis C and receive hepatitis A and B vaccinations as indicated by risk assessment. Other at-risk clients should be offered hepatitis C testing on-site and if possible, hepatitis B testing and hepatitis A and B immunizations as well. If hepatitis B testing and hepatitis A and/or B immunizations are not offered on site, referrals must be made for clients at-risk. Hepatitis B testing and vaccinations for hepatitis A and B are available through the HRSB staff in each county. The HRSB Viral Hepatitis Prevention Coordinator will be available to assist and support agencies in integrating viral hepatitis prevention activities into HIV prevention programs. **Hepatitis C testing on-site, referrals for hepatitis B testing, and referrals for viral hepatitis A and B vaccination are required activities. Please see appendix F for a list of recommendations on target populations for hepatitis B and C testing and hepatitis A and B immunizations.**

8) Treatment adherence for PrEP and ARV for PLWR and PLWH:

Promotion of adherence to antiretroviral medications: HIV testers shall work to link new and out-of-care positive persons with care and HIV treatment. Provider's staff shall work to monitor and support client's access to and retention in care and ongoing adherence with ARV therapy as measured by viral load tests within the past six months. Agencies shall ensure that clients understand proven prevention benefits of adherence to

HIV treatment regimens both for the individual and to reduce possible transmission of HIV infection to others

Contractor shall participate in DOH's program which releases HIV-related laboratory test results to the Contractor. This information will be utilized by the Contractor to allow its case managers to identify and assist its clients who may not be successfully linked to HIV care, not retained in care, or not adequately achieving viral suppression.

B. **Management Requirements (Minimum and/or mandatory requirements)**

1. **Personnel**

a. Staffing

Services requested in this RFP shall be provided by appropriate number of FTE to achieve viral suppression in clients including a designated 1 FTE for a designated staff lead for PrEP. All staff providing case management services under this agreement shall meet qualifications specified in the HIV Case Management Standards (Attachment C)

b. Staff Training and Development

All staff providing services under this procurement shall have demonstrated skills and expertise in the service areas in which they will be working. Contractor shall ensure that:

(1) **HIV/HCV Tester Certification**. All outreach staff obtain and maintain current HIV/HCV certifications. Certification and tester ID numbers will be provided by HRSB.

(2) **Program Monitoring and Evaluation Requirements:** Relevant staff shall complete all HRSB mandated training and technical assistance requirements pertaining to program monitoring and evaluation. Such training and technical assistance will be provided by HRSB staff or HRSB contractor and will include training sessions, as well as technical assistance and quality assurance site visits. The Contractor shall also assist with scheduling and logistics of organizing these activities at their agency.

(3) Contractor shall attend meetings/sessions as required by HRSB.

(4) New Staff Training Requirements: New staff members receive initial training within sixty (60) days of employment. This training shall ensure that they:

(a) have correct factual knowledge of HIV, STDs and hepatitis, including:
   i. history and epidemiology of the HIV epidemic
   ii. biology of HIV
   iii. modes of HIV transmission
   iv. information on STDs
   v. information on hepatitis A, B & C
   vi. populations at risk for HIV
   vii. utilizing theories of behavioral interventions
   viii. treatment of HIV infection
   ix. community resources statewide
   x. HIV antibody testing sites statewide

(b) understand clearly the high risk populations to be served under this contract

(c) understand the purposes of activities they will be implementing

(d) are oriented to behavioral interventions

(e) understand basic methods and uses of evaluation

(f) are familiar with the specific requirements of the contract.

(g) understand the procedures laid out in the Manual of Operations, and receive a copy of the same and have signed off;

(h) understand clearly the populations to be served under this contract;

(i) understand the purpose, process, methods and outcomes related to the State HIV contract.

Arrangements for, and any expenses related to, this training shall be the responsibility of the Contractor. Completion by each new staff member of all elements of this training, and how this training was provided, shall be reported to the HRSB in the quarterly program reports.

2. **Administrative**

During the contract period, CONTRACTOR shall:

a. develops user friendly written description of medical case management and client support services and resources that are available from the agency and in the geographic area. These documents shall be accessible to all clients;

b. provides all clients with a mechanism in writing of registering complaints and dissatisfaction which ensures that valid concerns are addressed. Clients shall be involved in the grievance process;

c. ensure staff providing services under this scope of services are provided with a copy of the scope of work in the final contract prior to the start of the contract and provided with quarterly data related to the level of the employee's and the agency's attainment of medical case management objectives;

d. conducts the uniform client satisfaction survey, approved for statewide use by HRSB, at least once per twelve (12) month fiscal year period, on the quality of services provided by CONTRACTOR, and provide a summary of the survey to the HRSB;

e. maintains and respect the confidentiality of client medical records and information including electronic storage, sharing and transfer of data, regarding HIV status and any test results, pursuant to all relevant sections of the Hawaii Revised Statutes and HIPAA;

f. Annually agreed to and signs a Memorandum of Understanding on Security and Confidentiality of HIV data.

g. develops and maintain a mechanism to ensure consumer input or involvement with the agency's board of directors. This mechanism shall be written up and submitted to HRSB at the start of the contract period and made available to all clients.

Contractor shall conduct its business affairs in a professional manner that meets or exceeds the standard industry practices for similarly situated contractors as to the following areas, as applicable:

i. fiscal or accounting policies and procedures, or both;
ii. written personnel policies and procedures;
iii. written program policies and procedures;
iv. written policies required by applicable federal, state, or county laws; and
v. client and employee grievance policies and procedures.
vi. Employee HIPPA data security and confidentiality provisions policies and procedure.

3. **Quality assurance and evaluation specifications**

Activities to monitor, evaluate, and improve the results of medical case management services based on the Case Management Practice Standards (Attachment C) and contract process objectives must be an integral part of program design.

The CONTRACTOR shall be responsible for gathering and inputting data into the electronic data system. These data are necessary to measure compliance with standards, process objective and performance measures. The CONTRACTOR shall establish and implement internal quality assurance plans so that required

data is collected, recorded electronically, analyzed and used with staff to assure case management standards and client level performance measures are met.

The CONTRACTOR shall collect and document for one hundred percent (100%) of its clients, up-to-date information on the client's status with respect to the following compliance/process measures. For each measure, the client's status may be: 1) Yes; 2) No; 3) Not Applicable. Client status with respect to these measures provides a foundation for measuring and on-going improvement of CONTRACTOR compliance with case management standards, contract process objectives and the highest priority performance measures. The goal for the CONTRACTOR is to have no client records with "Status Unknown" or "No Data Entered" on these items:

Administrative Data

1. Client provided written consent to participate in the program.
2. Client supplied verification of HIV status.
3. Client is Ryan White eligible.
4. Client was informed of the agency's grievance procedure.
5. Client signed release(s) of information.
6. Client was contacted by agency at least once within last six (6) months.
7. Case management information regarding client's personal resources was updated within last six (6) months.
8. Client contact information verified/updated within last six (6) months.

Medical Case Management Data

9. Client has an HIV medical provider (physician).
10. Clients has seen HIV medical provider (physician) within last 6 (6) months.
11. Clients had HIV viral load tests performed within last six (6) months.
12. Client is on ARV treatment.
13. Specific reasons for and follow-up of clients not served in items 9-12 above.
14. Client has health insurance.
15. Client has pharmacy coverage.
16. Client is enrolled in HSPAMM.
17. Client is enrolled in HDAP.
18. Client is enrolled in HCOBRA.
19. For client in HDAP/HCOBRA, client recertification is up-to-date as of June 30 and December 31.

The CONTRACTOR shall regularly prepare for agency quality assurance and internal evaluation use and submit quarterly to HRSB a report based on the measures in the following section.

The Contractor will be required to use data collection systems specified by HRSB for testing.

4. **Performance/Outcome Measurements**

Client level health outcomes are among the critical measures of the performance of the HIV system of care as supported by Ryan White and State funds. The overall goal is that one hundred percent (100%) of clients shall meet the performance objectives in both Priority One and Priority Two below. Medical case management service providers are a key (but not the only) component in achieving these outcomes. Medical case management contractors shall measure and report progress with respect to the following performance measures in their required progress reports.

Performance Measures

Priority One and Priority Two performance measures reflect the primary goal and intent of these medical case management services. The CONTRACTOR shall ensure that one hundred percent (100%) of clients have met these measures and that it has collected and recorded up-to-date information on all clients in the designated data collection system.

A. Priority One Performance Measures

Performance Measure 1.1: Client saw an HIV health care provider in past six (6) months.

Performance Measure 1.2: Client had viral load test done in past six (6) months.

Performance Measure 1.3: Pregnant women with HIV infection received appropriate antiretroviral therapy during the ante-partum period.

Performance Measure 1.4: Client is on an ARV treatment if recommended by health care provider.

B. Priority Two Performance Measures

Performance Measure 2.1: Clients with a CD4+ count below 200 cells/mm3 prescribed PCP prophylaxis, unless contraindicated.

Performance Measure 2.2: Clients screened for hepatitis C virus infection.

Performance Measure 2.3: Clients completed the vaccination series for hepatitis A and B.

Performance Measure 2.4: Women with HIV infection had a PAP screening test annually.

Performance Measure 2.5: Clients on ARVs received adherence counseling at least every six (6) months.

Performance Measure 2.6: Clients on ARVs underwent lipid screening/profile annually.

Performance Measure 2.7: Clients without previous treatment for TB or a previous positive PPD screen were screened for TB.

Performance Measure 2.8: Clients were screened for syphilis, gonorrhea and Chlamydia annually.

Performance Measure 2.9: Clients received an oral health examination annually.

Performance Measure 2.10: Clients received prevention and risk reduction counseling annually.

Outcome and performance of the Contractor shall be measured by the data variables shown below.

This table below is required to be included in agencies' quarterly report along with other outcome measures submitted to the HRSB.

Data from HRSB approved testing database						
Number of Test Events	Newly-diagnosed Positives					Previously-diagnosed Positives
	Number of New Positives	Results Received	Linked to Medical Care and Attend 1st Appointment	Referred and Linked to Partner Services	Received or Referred for Prevention Services	
		Entered within 72 hours (3days)				

Number of test entered into HRSB approved testing database		Entered within 7 days of test	
		Entered after 7 days of test	

The Contractor must provide an estimate of the number of individuals in each contract year who shall receive medical case management services to access and remain in HIV medical care and treatment.

5. **Experience**

The CONTRACTOR shall have a history of providing the services sought in this procurement, or similar services, to either the target population or other populations requiring ongoing access to medical care.

6. **Coordination of services**

Coordination of services is a critical component in addressing the risk of persons who are HIV positive for co-infection with other STDs. The contractor shall coordinate services with HRSB, other HRSB contractors serving the target population(s), the HRSB Partner Services program, HRSB Prevention program, and the HRSB Hepatitis C program to address these critical needs. Contractor shall also coordinate services with agencies that will be utilized in providing services to clients.

The target population may access a range of different medical providers for primary medical and HIV specialty care (e.g., physicians in private practice, community clinics, Health Maintenance Organizations). Case management services cannot limit the clients' choice of provider, and case management services must be provided regardless of who the medical provider may be. The extent of coordination and information sharing that is possible may vary depending on the medical provider.

The CONTRACTOR must devote staff resources and/or develop formalized linkages with other providers (e.g., through MOU) to support client access to medical services for clients to benefit fully from HIV medical care and treatment. Services include but are not limited to, primary care, nutritional assessment and counseling, dental care, mental health care, substance abuse treatment and home health services.

MOU are required to be submitted with the Application.

7. **Reporting requirements for program and fiscal data**

a. The CONTRACTOR shall be required to use a standardized electronic client level data management and reporting system as identified by HRSB. This data system shall contain required common intake and assessment information across all contractor agencies as well as specified and required information related to service plan and services to enable clients to assess HIV medical care and treatment, service utilization and other data elements.

b. The CONTRACTOR shall provide HRSB with written program and budget reports within thirty (30) days after the end of each quarter. The program report shall provide information from the electronic client level data system on the results of the last quarter in meeting the client data collection/entry objectives and the process and performance outcome objectives laid out in paragraph 4 above and any others determined by HRSB. The quarterly and annual reports shall include a narrative with analysis based on client level data, identification of barriers to achieving performance objectives and steps taken and planned to improve quality and outcome performance.

Reporting shall include all data necessary to report on quality assurance and evaluation measures as specified in B-3 and Performance/Outcome Measures specified in B-4.

c. The budget report shall include a listing of all services provided and expenses incurred under this procurement.

d. The CONTRACTOR shall provide the HRSB with a final written report within thirty (30) calendar days after the end of each contract period which reflects results of the CONTRACTOR's program, including data on meeting client data collection/entry as well as process and performance objectives, information on populations served, other information specified by HRSB.

e. The CONTRACTOR shall provide the HRSB with the names, title and full time equivalent (FTE) of all staff positions funded under this procurement. The name, qualifications and experience of the individual providing clinical supervision shall be included. The CONTRACTOR shall report any vacancy and the length of time the position has remained vacant for all positions funded under that procurement as part of each quarterly report.

f. The Contractor shall collect, enter and manage data for all interventions as designated by HRSB in HRSB approved testing database. These data shall include client-level HIV and HCV testing

data and IDI interventions, and aggregate data for Outreach and Condom Distribution interventions.

g. The Contractor shall perform data entry following the timelines required by the HRSB. In general, all client-level testing data are required to be entered into the approved HRSB testing database within 72 hours of the event, with exceptions approved by the HRSB. Positive/reactive testing events must be entered within 24 hours of the event. Exceptions are granted due to specific circumstances within an agency that won't allow the required timeline. All aggregate level data are required to be recorded in Evaluation Web system within 14 days of the service provided.

h. Each Contractor shall appoint a database administrator who will oversee the ongoing daily data entry within the agency and routinely perform quality assurance of the data entered in the system. The quality assurance should ensure the completeness and consistency of data. The database administrator shall work closely with the HRSB when questionable data need to be followed up.

i. The Contractor is encouraged to utilize data for their own program monitoring and evaluation on an ongoing basis.

j. Ongoing data entry and management technical assistance is provided by the HRSB and its private software development contractor. Site visits, webinars and everyday support through phone and email are available to the contracted agencies to ensure smooth process of the data related operation.

k. Provide the State with written program and budget reports within thirty (30) days after the end of each quarter. These reports shall consist of:

(1) a **budget report** indicating expenses incurred;
(2) a **table** indicating the contractor's quarterly and year-to-date progress on contract objectives based on Evaluation Web data;
(3) A **table** indicating the funded positions and staff members working under the contract and the FTE information.
(4) **a narrative report** that must include an analysis of progress in meeting quantitative contract objectives, description of progress on meeting contract objectives and other service requirements, analysis of program implementation, how information gained from process evaluation has been used for program improvement, insights learned from experiences during the past quarter.

The narrative should also specifically address barriers to meeting quantitative service objectives implementing services as planned and meeting objectives, modifications to service delivery, and any other points that might provide an understanding of the program. Any additional information requested by HRSB to satisfy program monitoring requirements.

(5) As appropriate, HRSB will provide written or oral feedback. The subsequent quarterly report must address the issues raised by HRSB.

l. Provide the State with an annual or final written report within thirty (30) days after the end of the fiscal year or contract period. This report shall reflect the results of the program, including accomplishment of service requirements and program objectives, populations served, development of program methodology, lessons learned, and adherence to projected budget costs, including a list of all equipment purchased during the year or contract period. **An annual report is required at the end of each fiscal year of an ongoing contract and must cover the entire year. A final report is to be submitted in place of an annual report at the end of the contract and must cover the entire contract period.** Final and annual reports are required in addition to quarterly reports; at the end of each year, a final or annual report for a program must be submitted in addition to a quarterly report.

m. Contractor will host site visit(s) by HRSB program staff. The Contractor's staff shall be available for these on-site visits for evaluation and monitoring of contracts and program implementation by HRSB staff. Executive Director and Contractor outreach staff shall be available for the site visit, as requested by HRSB. Agency staff will also be available for other site visits and/or conference calls as deemed necessary by HRSB. Any materials or curricula obtained, developed, or distributed by the Contractor shall be submitted to the DOH for approval prior to use.

n. The Contractor shall ensure adherence to the requirements of the PRP, a Hawai`i -based group of persons facilitated by HRSB staff and mandated by CDC to ensure that media developed and/or utilized by the Contractor contains appropriate messages designed to communicate with various community-based groups.

Program Review Panel website:
http://www.cdc.gov/od/pgo/forms/hiv.htm

Program Performance Indicators will be integrated into the contract and reporting requirements. Their purpose is to monitor and evaluate the

level of achievement of program objectives for contracted services and for reporting to funders. The contract based on this RFP will operationalize the Performance Indicators as objectives for each intervention. The contractor shall use the objectives provided in Section 3 of Proposal Application. The contractor is required to propose objectives by filling in appropriate numbers for each objective, reflecting realistic goals. The Contractor will be monitored and evaluated based on its performance on objectives on an ongoing basis during the contract period. Note that the STATE reserves the right to negotiate with the selected contractor the modification of proposed objectives prior to the execution of a contract.

In the event the selected agency undertakes additional evaluation activities not required by HRSB, these activities shall be discussed with and approved by HRSB before implementation.

C. **Facilities**

Contractor's facilities must meet all applicable Federal and State requirements for accessibility and safety.

2.5 COMPENSATION AND METHOD OF PAYMENT

Pricing Structure Based on Cost Reimbursement

The cost reimbursement pricing structure reflects a purchase arrangement in which the State pays the contractor for budgeted costs that are actually incurred in delivering the services specified in the contract, up to a stated maximum obligation.

Payments for services shall occur on a quarterly basis upon submission of an invoice from the contractor. There shall be four (4) quarterly payments each year of the term of this contract. In the first year, an advance equal to one-eighth (1/8) of the total amount of the contract may be requested by the contractor in the form of an invoice submitted to the contracting agency in the first month of the contract period.

D. **Facilities**

Not Applicable

2.6 COMPENSATION AND METHOD OF PAYMENT

Pricing Structure Based on Cost Reimbursement

The cost reimbursement pricing structure reflects a purchase arrangement in which the State pays the contractor for budgeted costs that are actually incurred in delivering the services specified in the contract, up to a stated maximum obligation.

Section 3

Proposal Application Instructions

Section 3
Proposal Application Instructions

General instructions for completing applications:

- *Proposal Applications shall be submitted to the state purchasing agency using the prescribed format outlined in this section.*
- *The numerical outline for the application, the titles/subtitles, and the applicant organization and RFP identification information on the top right hand corner of each page should be retained. The instructions for each section however may be omitted.*
- *Page numbering of the Proposal Application should be consecutive, beginning with page one and continuing through for each section. See sample table of contents in Section 5.*
- *Proposals may be submitted in a three ring binder (Optional).*
- *Tabbing of sections (Recommended).*
- *Applicants must also include a Table of Contents with the Proposal Application. A sample format is reflected in Section 5, Attachment B of this RFP.*
- *A written response is required for **each** item unless indicated otherwise. Failure to answer any of the items will impact upon an applicant's score.*
- *Applicants are **strongly** encouraged to review evaluation criteria in Section 4, Proposal Evaluation when completing the proposal.*
- *This form (SPOH-200A) is available on the SPO website (Refer to Section 1.2 Website Reference). However, the form will not include items specific to each RFP. If using the website form, the applicant must include all items listed in this section.*

The Proposal Application is comprised of the following sections:

- *Proposal Application Identification Form*
- *Table of Contents*
- *Program Overview*
- *Experience and Capability*
- *Project Organization and Staffing*
- *Service Delivery*
- *Financial*
- *Other*

3.1 Program Overview

Applicant shall give a brief overview to orient evaluators as to the program/services being offered.

3.2 Experience and Capability

A. Necessary Skills

The applicant shall demonstrate that it has the necessary skills, abilities, and knowledge relating to the delivery of the proposed services.

B. Experience

The applicant shall provide a description of projects/contracts pertinent to the proposed services.

C. Quality Assurance and Evaluation

Activities to monitor, evaluate, and improve the results of medical case management services based on the Case Management Practice Standards in Attachment E must be an integral part of program design. APPLICANT shall provide a quality assurance plan including process, timing and person(s) responsible so that:

i. required data is collected and recorded completely, accurately and in a timely manner;
ii. electronic data is reviewed and analyzed by supervisors and management;
iii. data is used with staff to ensure the terms of the medical case management contract are met and client level performance measures are met and/or improving.

CONTRACTOR shall regularly prepare for agency's own quality assurance and evaluation purposes and submit quarterly (30 days after the end of the quarter) to HRSB a report based on the performance measures provided in of SECTION 2 and plans to improve client outcomes particularly Priority One Performance Measures (1.1 to 1.4) and all the objectives in SECTION 3.

D. Coordination of Services

The CONTRACTOR shall describe its capability to coordinate services with other agencies and resources in the community. CONTRACTOR shall also describe the HIV services available in its community and the CONTRACTOR's ability to provide HIV services to clients accessing these services.

E. Facilities

The Contractor shall provide a description of its facilities and demonstrate its adequacy in relation to the proposed services. If facilities are not presently

available, describe plans to secure facilities. Also describe how the facilities meet ADA requirements, as applicable, and the special equipment that may be required for the services.

3.3 Project Organization and Staffing

A. Staffing

1. Proposed Staffing

CONTRACTOR shall provide the names, title, and full time equivalent (FTE) of all staff positions proposed under this procurement. The name, qualifications and experience of the individual or proposed individual providing clinical supervision shall also be included. The CONTRACTOR shall also describe the proposed staffing pattern, client/staff ratio and proposed caseload capacity appropriate for the viability of the services.

2. Staff Qualifications

The CONTRACTOR shall provide the minimum qualifications (including experience) for all staff proposed to provide services under this procurement.

B. Project Organization

1. Supervision and Training

The Contractor shall describe its ability to supervise, train and provide administrative direction relative to the delivery of the proposed services.

2. Organization Chart

The Contractor shall reflect the position of each staff and line of responsibility/supervision. (Include position title, name and full time equivalency). Both the "Organization-wide" and "Program" organization charts shall be attached to the Proposal Application.

3.4 Service Delivery

In this section CONTRACTOR shall include a detailed discussion of the CONTRACTOR's approach to applicable service activities and management requirements from Section 2, Item 2.4. - Scope of Work, including all service activities and tasks to be completed, related work assignments/responsibilities and timelines/schedules. As stated in the Scope of Work the purpose of this procurement is to provide CBHS services which support clients' access to and assists clients to remain in HIV medical care and treatment. CONTRACTOR shall describe in detail

how each CBHS outlined in the Scope of Service shall be implemented and by which Contractor staff positions.

1) Internet Outreach

1. Descriptive Information

Provide a detailed description of how this program will increase the use of internet outreach among high-risk persons and will be used to link or re-engage people who are out of care, ***utilizing information in Section 2 as a guide.*** *In the proposal, include responses to each of the following questions, numbering each response to correspond to the numbering below (e.g., a, b ...)*

a. Provide an **overview (description)** of the internet outreach intervention including its activities.
b. How would you **identify** people who do not know their HIV status, are high risk and/or are PLWH but are not retained in care and link them to HIV Community Services?
c. How you would **provide additional information** and education on health care coverage options?
d. Indicate **internet sites** at which internet outreach and recruitment will be delivered.
e. What are the **essential features** of the intervention and how will you address them (this includes core elements, key characteristics, and other features of the intervention)?
f. How would you **re-engage** people who know their status into HIV Community Services, Outpatient/Ambulatory Health Services?

2. Objectives

In the proposal, Contractors must respond to all of the objectives below, filling in "number" to reflect the Contractor's goals for outreach among high-risk persons. Progress on objectives will be determined using information collected by the Contractor.

a. The number of PWAR who were linked to CBHS as a result of outreach contact (*e.g., by the end of each fiscal year, a minimum of (number) of PWAR will be linked to PrEP).* Provide separate objectives for each of the target populations.
b. The number of PLWH who were linked to CBHS as a result of outreach contact (*e.g., by the end of each fiscal year, a minimum of (number) of PLWH will be linked to medical care).*

2) Outreach with assessment for, recruitment, enrollment, linkage and re-engagement in services outlined in the RFP

Outreach Services (PLWH, PWAR)

1. Descriptive Information

Note that this section refers to outreach other than internet-based. (Internet outreach is covered in section above.) Provide a detail description of how this program will use of outreach among HIV positive individuals, their partners and high-risk persons, ***utilizing information in Section 2 as a guide.*** *In the proposal, include responses to each of the following questions, numbering each response to correspond to the numbering below (e.g., a, b …*

a. Provide an **overview (description)** of the outreach intervention including its activities.
b. How would you **identify**: (1) PWAR who do not know their HIV status; and (2) PLWH who are not retained in care? How would you link these individuals to HIV Community Services?
c. How you would provide additional information and education on health care coverage options?
d. Indicate **sites/physical settings** or other means by which outreach and recruitment will be delivered.
e. How would you re-engage people who know their status into HIV Community Services, Outpatient/Ambulatory Health Services?
f. In case of a STD outbreak how would you reach the target populations and what activities will you conduct with them?

2. Objectives

In the proposal, Contractors must respond to all of the objectives below, filling in "number" to reflect the Contractor's goals for outreach among high-risk persons. Progress on objectives will be determined using information collected by the Contractor.

a. The number of PWAR who were linked to CBHS as a result of outreach contact (*e.g., by the end of each fiscal year, a minimum of (number) of PWAR will be linked to PrEP).* Provide separate objectives for each of the target populations.
b. The number of PLWH who were linked to CBHS as a result of outreach contact (*e.g., by the end of each fiscal year, a minimum of (number) of PLWH will be linked to medical care).*
c. The number of condoms to be distributed to PWAR/PLWH (*e.g., by the end of each contract year, a minimum of (number) condoms will be distributed to MSM*) Provide separate objectives for each of the target populations (includes loose condoms *and* condoms in safer sex kits; include only condoms distributed directly to outreach contacts by outreach workers.)

3) Getting people insured:

Insurance Navigation & Coordination (PLWH, PWAR)

1. Descriptive Information

Provide a detailed description of how this program will increase the number of people in the target population who are insured, ***utilizing information in Section 2 as a guide.*** *In the proposal, include responses to each of the following questions, numbering each response to correspond to the numbering below (e.g., a, b ...)*

a. How you would identify and **provide information** and education on health care coverage options to meet the varying needs of different negative and positive persons?
b. How would you provide health and **insurance navigation** to these people?
c. How would you **ensure** that clients are enrolled in health insurance.?
d. How would you **provide access** and linkage to care and treatment services, including, but not limited to, case management, HIV clinical services, public health services, and other support and referral services?
e. What data will be collected on individuals who are signed up for insurance that can be used to help monitor if they can access appropriate medical services?

2. Objectives

In the proposal, Contractors must respond to all of the objectives below, filling in "number" to reflect the agency's goals for insurance among high-risk persons. Progress on objectives will be determined using information collected by the Contractor.

a. The number of people who were educated about insurance within each target population (*e.g., by the end of each contract year, at least* (*number*) *MSM will be insured*). Provide separate objectives for each of the target populations.
b. The number of people who were insured/link with insurance within each target population (*e.g., by the end of each contract year, at least* (*number*) *MSM will be insured*). Provide separate objectives for each of the target populations.
c. Information why individuals who are still uninsured and remain so after the Contractor's intervention.

4) PrEP/ARV

ARV recruitment, linkage and support (PLWH, PWAR):

1. Descriptive Information

Provide a detailed description of how this program will increase the number of people in the target population of PLWH are on ARV, and PWAR who are on PrEP or know about it, ***utilizing information in Section 2 as a guide.*** *In*

the proposal, include responses to each of the following questions, numbering each response to correspond to the numbering below (e.g., a, b …)

a. How you would **provide information** and education on ARV and PrEP?
b. How would you **recruit** individuals into PrEP and HIV treatment?
c. How would you **provide access** and linkage to care and treatment services, including, but not limited to, case management, HIV clinical services, public health services, and other support and referral services?
d. How would you **support** individuals so they can successfully enroll in health insurance?
e. How would you **support** individuals so they can successfully initiate and sustain PrEP or ARV for HIV treatment?
f. How would you reach out and work with physicians in your county to encourage and support their provision of PrEP?
g. How would you follow-up referral of persons for PrEP to specific physicians. How will ongoing support be provided to assist with adherence?
h. How would you help ensure STD testing is integrated into PrEP and HIV treatment?
i. Provider will have to submit a PrEP Implementation Plan to HRSB. The plan can include; how you propose to support individuals in receiving medical evaluation for PrEP, in accessing medications and assistance with cost as necessary, and in accessing the required medical follow up; how you will measure PWAR progress on PrEP and how you propose to increase medical provider's participation in PrEP etc.

2. Objectives

In the proposal, Contractors must respond to all of the objectives below, filling in "number" to reflect the Contractor's goals for ARV use among PWAR and PLWH. Progress on objectives will be determined using information collected by the Contractor.

a. The number of people who were educated and referred for PrEP within each target population (*e.g., by the end of each contract year, at least* (*number*) *MSM will be educated about PrEP*). Provide separate objectives for each of the target populations.
b. The number of people who were educated and referred to HIV treatment
c. The number of people who were retained on HIV treatment.
d. The number of PLWH who, having fallen out of care, were re-engaged into care within each target population. Provide separate objectives for each of the target populations.
e. The number of people who were enrolled into PrEP within each target population (*e.g., by the end of each contract year, at least* (*number*) *MSM will be on PrEP*). Provide separate objectives for each of the target populations.

f. The number of people who were maintained on PrEP within each target population (*e.g., by the end of each contract year, at least* (*number*) *MSM will retained on PrEP*). Provide separate objectives for each of the target populations.

5) Linkage with HIV care

CONTRACTOR shall provide information on how Contractor will reach and deliver medical case management services for clients who: are not in care, who may fall out of care, and those who are late entering care and/or have difficulty with adherence. These clients are often at higher levels of acuity and include multiply diagnosed individuals (HIV and substance misuser, and/or mental illness and/or homeless); women, youth, children and infants and specific demographic or risk populations that ongoing data analysis by HRSB suggests are over represented with HIV infection and/or underserved with HIV services.
Linkage to care – Referral and engagement in HIV medical services; the patient had an appointment with a medical provider related to their HIV infection within the first 3 months of diagnosis.

Contractor will focus on positive persons, particularly those newly diagnosed and those with higher acuity and the development of ongoing contacts to monitor their needs and access to care and treatment. The Contractor must explain in detail their system for linking newly diagnosed HIV positive persons with HIV medical case management, medical care, treatment and other appropriate services and the procedures that will be used for follow up.

1. Descriptive Information

Provide a detailed description of how this program will increase the number of people in the target population who are linked to care, ***utilizing information in Section 2 as a guide.*** *In the proposal, include responses to each of the following questions, numbering each response to correspond to the numbering below (e.g., a, b …)*

a. Provide an overview (description) of how the Contractor will provide linkage to newly diagnosed HIV positive persons with HIV medical care. Also to medical case management and other social services as appropriate?
b. Provide an overview (description) and protocol/procedures of the sessions and activities that will be provided in implementing this intervention, including descriptions of the activities during the initial and subsequent sessions?
c. Describe how persons with HIV who are out of care but not currently case managed will be identified, enrolled and re-engaged in care, PS and STD services?
d. Describe how would you link to care the persons who test positive but do not want to be case managed?

e. Indicate site(s)/physical setting(s) at which the intervention will be implemented?

2. Objectives

In the proposal, Contractors must respond to all of the objectives below, filling in "number" to reflect the Contractor's goals for the proposed intervention. Progress on objectives will be determined using information collected by the Contractor. (Contractor can use the following objectives as guide for writing the objectives for the intervention they propose for PLWH)

a. By the end of each fiscal year, at least (*number*) out of care HIV-positive persons will be enrolled in medical care.
b. In each fiscal year, Provider shall enroll (*number*) appropriate clients into its case management program. This would include PLWH who are out of care or need assistance to remain in care.
c. By the end of each fiscal year (*number*) of the new HIV-positive persons enrolled in case management who were not in care or case management. [*Note: This objective is intended to ensure that services are also provided to and accessed by persons out of care who are not already clients of the Contractor]*

6) Retention and re-engagement in care:

Retention and re-engagement in medical care is a core component of HRSB contracts with agencies. It is required that agencies use client level viral load laboratory data to monitor retention in care. Case managers and medical case managers in the contracted agencies have the specific task of supporting persons to remain in care through a variety of means including linkage with support services, housing and access to Hawaii Seropositivity and Medical Management Program (HSPAMM) and Hawaii Drug Assistance Program (HDAP). The situation is more complex for positive persons who are not in case management and may be out of care. The Contractor's staff who conduct outreach, may be the only staff who meets a positive person not in care. Every effort shall be made by the Contractor to promote retention and re-engagement of these individual in medical care Staff of the contracted Contractor will ensure that all the PLWH are either retained or re-engaged in care.

a. Retention and re-engagement for PLWH to medical care:

1. Descriptive Information

Contractor has to perform a range of activities to ensure that clients have the access, information, and support needed to be able to benefit as fully as possible from HIV medical care and treatment. Medical case management activities include activities directly related to medical care, as

well as activities that are non-medical but impact the client's ability to access, remain in, and/or benefit fully from HIV care and treatment. Case notes and documentation related to any contact with the client, activities conducted, services provided, and, if applicable, progress on the client service plan, shall be recorded in the electronic client level data system.

d. **Medical Aspects**:

1) Assist clients to better understand, utilize and benefit from primary medical care.
2) Document fully cases of clients not accessing primary medical care, reasons why not, efforts made by the Contractor and if any additional assistance is needed from the Contractor to overcome barriers to access. A client remains at a high acuity level until they access HIV care.
3) Document fully cases of clients not on antiretroviral (ARV) treatment, including whether or not treatment is medically appropriate. If ARV treatment is medically appropriate, document reasons client is not on treatment, efforts made by the Contractor and if any additional assistance is needed from the Contractor to overcome barriers to access. If treatment is recommended by health care provider the client remains at a high acuity level until they access HIV treatment.
4) Provide appropriate interface on behalf of the client and health care provider.
5) Assist eligible clients to interface with health care organizations and related agencies (particularly community primary care centers) to facilitate the delivery of health care services.
6) Ascertain and support the treatment advocacy needs of individual clients and provide necessary support to meet them.
7) Provide client adherence counseling/support and provide medically related counseling concerning medications, side effects, laboratory results and similar.
8) Support, advocate for and document that clients receive the full range of recommended medical services for PLWHA in accordance with U.S. Public Health Service guidelines, including HAV/HBV immunizations, HCV screening, and STD screening and follow up services.

e. **Access/Support Aspects**:

1) Ensure that clients apply for and are enrolled in health insurance or programs that provide medical and pharmacy coverage.
2) Determine details of client's medical and pharmacy insurance and coverage.

3) Assist clients to maintain current medical insurance and assist uninsured clients in applying for and accessing Medicaid (Quest) and/or Medicare or other coverage.
4) Assist eligible clients in applying for HSPAMM.
5) Assess eligibility and process application and re-certification for HDAP and HCOBRA following documented process and timeline.
6) Maintain all required hard copy documentation related to eligibility and re-certifications for the HSPAMM, HDAP and H-COBRA programs in client paper file.
7) Coordinate with other community based organizations to link eligible clients with social support services such as transportation, food and housing that are needed by clients to access HIV medical care and treatment.
8) Develop and maintain an updated resource list of current HIV care service providers and make this list available to clients.
9) Based on assessed needs and as appropriate, assist client to access mental health, substance abuse, dental and other related health services.
10) Provide support for clients in hospital, hospice or other care facilities.
11) Maintain the required health, laboratory and medically related information in the electronic client level data system to monitor client need and access to medical services etc.
12) Provide regular sessions on identifying risk, disclosure, partner referral, and risk reduction based on client's risk assessment. Additional sessions should be provided for clients assessed to be of higher risk of HIV transmission. Assessment and follow up shall be reported in the client level data system. This service may be provided by the most appropriate staff in the Contractor.

Contractor must provide assurances in its application that all case management requirements outlined in Section 2, of this RFP shall be met.

Contractor must provide assurances in its application that it agrees to participate in the DOH's program which releases HIV- related laboratory test results to the Contractor, which will allow the Contractor's case managers to identify and assist its clients who may not be successfully linked to HIV care, not retained in care, or not adequately achieving viral suppression. Contractor must also provide assurances that it will adhere to all requirements for data security and confidentiality necessary to participate in this program.

In addition to the above, provide a detailed description of how this program will increase the number of people in the target population who are retained or re-engaged into care, ***utilizing information in Section 2 as a guide.*** *In the proposal, include responses to each of the following questions, numbering*

each response to correspond to the numbering below (e.g., a, b …)

a. How will the Contractor ensure that HIV-**positive persons are retained or re-engaged** if they **fall out of HIV medical care or treatment**?
b. How will the Contractor enhance retention and re-engagement services for clients with substance use and/or mental health challenges and/or are homeless?
c. How will the Contractor ensure services delivery to women, infants, children and youth as needed?
d. Provide an **overview (description)** and protocol/procedures of the activities that will be provided in implementing this intervention.
e. Indicate **site(s)/physical setting(s)** at which the intervention will be implemented.

2. Objectives

In the proposal, Contractors must respond to all of the objectives below, filling in "number" to reflect the agency's goals for retention and re-engagement among positives, their partners and among high-risk persons. Progress on objectives will be determined using information collected by the Contractor.

a. By the end of each fiscal year, at least (*number*) HIV-positive persons at risk for transmitting HIV who were enrolled in medical care are retained in care.
b. By the end of each fiscal year, at least (*number*) PLWH who were out of care are re-engaged into care.
c. Describe how many PLWH, annually, who are out of care will be identified and referred to HRSB for PS and STD services.

b) Retention and re-engagement for PWAR

1. Descriptive Information

Provide a detailed description of how this program will increase the number of people in the target population who are retained or re-engaged into care, ***utilizing information in Section 2 as a guide.*** *In the proposal, include responses to each of the following questions, numbering each response to correspond to the numbering below (e.g., a, b …)*

a. How will the Contractor ensure that PWAR who discontinue PrEP are retained or re-engaged in services as appropriately?
b. Describe how many PWAR will be annually identified, enrolled and reengaged and referred to HRSB for STD services?
c. Provide an **overview (description)** and protocol/procedures of the activities that will be provided in implementing this intervention?
d. Indicate **site(s)/physical setting(s)** at which the intervention will be

implemented?

2. Objectives

In the proposal, Contractors must respond to all of the objectives below, filling in "number" to reflect the agency's goals for retention and re-engagement among positives, their partners and among high-risk persons. Progress on objectives will be determined using information collected by the Contractor.

a. By the end of each fiscal year, at least (*number*) PWAR who were enrolled in PrEP will be retained in it.
b. By the end of each fiscal year, at least (*number*) PWAR who were enrolled in PrEP and have stopped PrEP will be re-engaged and followed-up.

7) Targeted HIV and hepatitis C Virus (HCV) Testing and Linkage Services (TL) in non-clinical settings and/or HIV and Partner Services (PS):

1. Descriptive Information

Provide a detailed description of how this program will increase HIV and HCV testing and linkage (TL) among the highest risk priority HIV populations which include HIV-positive persons and their partners, men who have sex with men, men who have sex with men and inject drugs, and people who injects drugs

utilizing information in Section 2 as a guide. *In the proposal, include responses to each of the following questions, numbering each response to correspond to the numbering below (e.g., a, b…).*

a. How will the HIV testing program attain 1% positivity?

b. How will the program promote/provide TL to ensure that TL services are accessed by the target populations for HIV (HIV positive persons and their partners, MSM, MSM/PWID and PWID) and/or HCV?

c. How will the program ensure that clients who test preliminary positive for HIV return for their confirmatory results?

d. How will the program collaborate with TL services offered by the HRSB staff for confirmatory HIV and/or HCV testing?

e. How will the program successfully link newly diagnosed HIV clients with HRSB PS staff?

f. How will the program successfully link newly identified HIV positive clients to comprehensive prevention with positives services (see Section 2)

g. How will the program rapidly link HIV positive TL clients to HIV medical care and case management services?

h. How will the program link HCV positive TL clients to care services?

2. Objectives

In the proposal, Contractors must respond to all of the objectives below, filling in "number" to reflect the agency's goals for TL. Progress on objectives will be determined using information collected by the Contractor.

a. By the end of each fiscal year, the contractor will provide HIV antibody TL to at least (*number*) persons.

b. Of the total number of persons tested for HIV, at least 100% will be from targeted highest risk populations (partners of HIV positive persons, MSM, MSM/PWID, PWID. *(number)* (*This objective is non-negotiable*)

c. By the end of each fiscal year, the contractor will provide HIV TL to at least (*number*) partners of HIV positive persons.

d. By the end of each fiscal year, the contractor will provide HIV TL to at least (*number*) MSM.

e. By the end of each fiscal year, the contractor will provide HIV antibody TL to at least (*number*) MSM/PWID.

f. By the end of each fiscal year, the contractor will provide HIV antibody TL to at least (*number*) PWID.

g. By the end of each fiscal year, 100% of clients will receive their reactive and non-reactive rapid HIV test results. (*This objective is non-negotiable.*)

h. By the end of each fiscal year, at least 90% of newly diagnosed clients will receive their confirmed HIV-positive test results. (*This objective is non-negotiable*.)

i. By the end of each fiscal year, 90% of newly identified, confirmed HIV positive persons who received their confirmatory results will be linked to HRSB partner services. (*This objective is non-negotiable*.)

j. By the end of each fiscal year, 90% of newly identified, confirmed HIV-positive clients who receive their confirmatory test results will be linked to medical care within 30 days of the confirmatory results. (*This objective is non-negotiable*.)

k. By the end of each fiscal year, 90% percent of newly identified, confirmed HIV-positive persons who receive their confirmatory test results will be linked to medical and case management services.

l. By the end of each fiscal year, 100% of client data will be entered into the HRSB approved testing data collection system.

m. By end of each fiscal year, the contractor will provide HCV TL to at least (*number*) persons at risk.

n. By the end of each fiscal year, at least 90% of newly identified HCV antibody positive clients will receive their test results. (*This objective is non-negotiable.*)

o. By the end of each fiscal year, at least (*number*) percent of HCV antibody positive clients who received their test results will be referred to confirmatory HCV RNA testing.

p. By the end of each fiscal year, at least (*number*) percent of HCV antibody positive clients who received their test results will be referred to medical care and/or care coordination.

a) **Partner Services (PS):**

1. **Descriptive Information**

Provide a detailed description of the intervention activities that will be implemented as part of PS services, ***utilizing information in Section 2 as a guide****. In the proposal, include responses to each of the following questions, numbering each response to correspond to the numbering below (e.g., a, b…).*

a. How will the Contractor provide **Ongoing Partner Services** to positive clients enrolled in case management, including those that are out of medical care and/or have a high viral load?
b. How will the Contractor link newly-diagnosed HIV clients with HRSB for provision of PS?

2. **Objectives**

In the proposal, Contractors must respond to all of the objectives below, filling in "number" to reflect the agency's goals for the proposed intervention. Progress on objectives will be determined using information collected by the Contractor. (Contractor can use the following objectives as guide for writing the objectives for the intervention they propose for PS)

a. The number of positive persons who were linked to HRSB to receive ongoing PS.

b) Integration of HIV/STD and Viral Hepatitis Services:

1. **Descriptive Information**

Provide a description of integration activities that will be implemented, ***utilizing information in Section 2 as a guide.*** *In the proposal, include responses to each of*

the following questions, numbering each response to correspond to the numbering below (e.g., a, b…).

a. Provide a **description of** HIV, STD and viral hepatitis integration activities and how they will be implemented;
b. Describe how you will **provide program linkages** to STD and viral hepatitis prevention services involving the priority populations;
c. Describe how you will **ensure the referral** made for STDs is followed through.
d. Provide plans to **collaborate with HRSB partner agencies** and the HRSB counselor/tester(s) and on your island to ensure linkages to hepatitis B testing and treatment, hepatitis A and B vaccinations for appropriate clients, and STD services;

2. Objectives:

In the proposal, Contractors must respond to all of the objectives below, filling in "number" to reflect the agency's goals for integrating STD and viral hepatitis services. Progress on objectives will be determined using information collected by the Contractor.

If the Contractor is proposing to provide <u>on-site</u> STDs and /or hepatitis B testing/hepatitis A and B immunizations from the beginning of the contract, then please fill out following objectives:

a. By the end of each fiscal year, the contractor will provide syphilis testing on-site to at least (*number*) persons at risk for HIV.
b. By the end of each fiscal year, the contractor will provide gonorrhea testing on-site to at least (*number*) persons at risk for HIV.
c. By the end of each fiscal year, the contractor will provide hepatitis A and B immunization on-site to at least (*number*) persons at risk for HIV.
d. By the end of each fiscal year, the contractor will provide hepatitis B testing on-site to at least (*number*) persons at risk for HIV.
e. By the end of each fiscal year, the Contractor will provide on-site services to at least (*number*) PLWH clients for STD and/or hepatitis services.
f. By the end of each fiscal year, the Contractor will provide on-site services to at least (*number*) sexual and drug using partners of PLWH for STD and/or hepatitis
g. By the end of each fiscal year, the Contractor will provide on-site services to at least (*number*) persons at risk for STD and/or hepatitis services

If Contractor proposes to provide <u>referrals</u> for STD services and /or hepatitis B testing/hepatitis A and B immunizations, please fill out the following

objectives:

h. By the end of the fiscal year, the contractor will provide referral for syphilis testing to at least (*number*) persons at risk for HIV.
i. By the end of the fiscal year, the contractor will provide referral for gonorrhea testing to at least (*number*) persons at risk for HIV.
j. By the end of each fiscal year, the contractor will provide hepatitis A and B immunization referral to at least (*number*) persons at risk for HIV.
k. By the end of each fiscal year, the contractor will provide hepatitis B testing referral to at least (*number*) persons at risk for HIV.
l. By the end of the fiscal year, the Contractor will provide referral to at least (*number*) to PLWH clients for STD and/or hepatitis services.
m. By the end of the fiscal year, the Contractor will provide referral to at least (*number*) to the sexual and drug using partners of PLWH for STD and/or hepatitis services
n. By end of fiscal year, the Contractor will follow-up at least (*percent*) of clients who were referred.
o. By end of the fiscal year, the Contractor will have at least (*number*) completed the referrals

8) Medication Adherence for HIV Treatment and PrEP

Promotion of adherence to antiretroviral medications: Contractor shall work to link new and out-of-care positive persons with care and HIV treatment. Contractor shall monitor and support client's access to and retention in care and ongoing adherence with ART as measured by viral load tests within the past six months. Agencies shall ensure that clients understand proven benefits of adherence to HIV treatment regimens both for the individual and to reduce possible transmission of HIV infection to others.

1. Descriptive Information

Provide a description of integration activities that will be implemented, ***utilizing information in Section 2 as a guide.*** *In the proposal, include responses to each of the following questions, numbering each response to correspond to the numbering below (e.g., a, b…).*

a. Provide a description of how adherence to antiretroviral medications shall be supported and prompted for positive clients?
b. Provide a description of how the adherence to PrEP shall be supported and prompted?

2. Objectives:

In the proposal, Contractors must respond to all of the objectives below, filling in "number" to reflect the agency's goals for adherence. Progress on objectives will be determined using information collected by the Contractor:

a. By the end of each fiscal year, at least (*number*) of PLWH who were not virally suppressed will be virally suppressed.

3.5 Financial

A. Pricing Structure

CONTRACTOR shall submit a cost proposal utilizing the pricing structure designated by the state purchasing agency. The cost proposal shall be attached to the Proposal Application.

All budget forms, instructions and samples are located on the SPO website. Refer to Section 1.2, Websites References for website address. The following budget form(s) shall be submitted with the Proposal Application:

SPO-H-205
SPO-H-206A
SPO-H-206B
SPO-H-206C
SPO-H-206D
SPO-H-206E
SPO-H-206F
SPO-H-206G
SPO-H-206H
SPO-H-206I
SPO-H-206J

On Budget Form SPO-H-205, CONTRACTOR shall indicate all expenditures proposed under this RFP. A minimum of three (3) columns must be included on SPO-H-205 (see Section 5, Attachment Sample Form SPO-H-205):

– one column showing all proposed program(s) specific direct service costs funded under this RFP;

– one column showing all proposed administrative and program support costs funded under this RFP;

– one column showing the total budget request which combines the above two (2) and any other columns which show expenditures proposed under this RFP.

For purposes of this RFP, "administrative and program support costs" include lease/rental of space, lease/rental of equipment, repair and maintenance, and general administration and general expenses, such as the salaries and expenses of executive officers, personnel administration and accounting. "Direct service costs" include wages and benefits of employees who directly provide the services, and the cost of materials, equipment, and supplies used to provide these services, and any staff training required under the agreement.

The CONTRACTOR must include a detailed line by line narrative justification for all budget items proposed under this RFP (see Section 5, Attachment F: Sample Narrative Budget Justification).

B. **Other Financial Related Materials**

Accounting System

In order to determine the adequacy of the CONTRACTOR's accounting system as described under the administrative rules, the following documents must be attached as part of the Proposal Application:

– A copy of the CONTRACTOR's most recent financial audit.

3.6 Other

A. **Litigation**

The Contractor shall disclose and explain any pending litigation to which they are a party, including the disclosure of any outstanding judgment.

Section 4

Proposal Evaluation

Section 4
Proposal Evaluation

4.1 Introduction

The evaluation of proposals received in response to the RFP will be conducted comprehensively, fairly and impartially. Structural, quantitative scoring techniques will be utilized to maximize the objectivity of the evaluation.

4.2 Evaluation Process

The procurement officer or an evaluation committee of designated reviewers selected by the head of the state purchasing agency or procurement officer shall review and evaluate proposals. When an evaluation committee is utilized, the committee will be comprised of individuals with experience in, knowledge of, and program responsibility for program service and financing.

The evaluation will be conducted in three phases as follows:

- Phase 1 - Evaluation of Proposal Requirements
- Phase 2 - Evaluation of Proposal Application
- Phase 3 - Recommendation for Award

Evaluation Categories and Thresholds

Evaluation Categories		**Possible Points**
Administrative Requirements		
Proposal Application		**100 Points**
Program Overview	0 points	
Experience and Capability	20 points	
Project Organization and Staffing	15 points	
Service Delivery	55 points	
Financial	10 Points	
TOTAL POSSIBLE POINTS		**100 Points**

4.3 Evaluation Criteria

A. Phase 1 - Evaluation of Proposal Requirements

1. Administrative Requirements

2. Proposal Application Requirements

- Proposal Application Identification Form (Form SPOH-200)
- Table of Contents
- Program Overview
- Experience and Capability
- Project Organization and Staffing
- Service Delivery
- Financial (All required forms and documents)
- Program Specific Requirements (as applicable)

B. Phase 2 - Evaluation of Proposal Application (100 Points)

Program Overview: No points are assigned to Program Overview. The intent is to give the Contractor an opportunity orient evaluators as to the service(s) being offered.

1. *Experience and Capability (20 Points)*

The State will evaluate the Contractor's experience and capability relevant to the proposal contract, which shall include:

A. Necessary Skills **4**

- Demonstrated skills, abilities, and knowledge relating to the delivery of the proposed services.

B. Experience **4**

- Experience delivering similar services
- Quality of performance on previous contracts with the state purchasing agency (if any).

C. Quality Assurance and Evaluation **4**

- Sufficiency of quality assurance and evaluation plans for the proposed services, including methodology.

D. Coordination of Services ***4***

- Demonstrated capability to coordinate services with other agencies and resources in the community.

E. Facilities 4

- Adequacy of facilities relative to the proposed services.
-

2. *Project Organization and Staffing (15 Points)*

The State will evaluate the Contractor's overall staffing approach to the service that shall include:

A. *Staffing* 10

- Proposed Staffing: That the proposed staffing pattern, client/staff ratio, and proposed caseload capacity is reasonable to insure viability of the services.
- Staff Qualifications: Minimum qualifications (including experience) for staff assigned to the program.

B. *Project Organization* 5

- Supervision and Training: Demonstrated ability to supervise, train and provide administrative direction to staff relative to the delivery of the proposed services.
- Organization Chart**:** Approach and rationale for the structure, functions, and staffing of the proposed organization for the overall service activity and tasks.

3. *Service Delivery (55 Points)*

Evaluation criteria for this section will assess the Contractor's approach to the service activities and management requirements outlined in the Proposal Application.

The State will evaluate the Contractor's approach to the service activities and management requirements outlined in the Proposal Application, including:

- Clarity in work assignment and responsibilities _____
- Clarity and detail of "Descriptive information" and planned activities provided by Contractor for each of the sections _____
- Extent to which proposed objectives are reasonable and based on past performance of the Contractor or other providers. _____
- Extent to which the proposed objectives represent a realistically maximal level of service provision to achieve the goals of the RFP, given the capacity, time and resources available. _____
- Clarity and detail of planned activities. _____
- Clarity in work assignments and responsibilities. _____
- Realism of the timelines and schedules, as applicable. Logic of the work plan for the major service activities and tasks to be completed _____

4. *Financial (10 Points)*

Pricing Structure Based on Cost Reimbursement

The cost reimbursement pricing structure reflects a purchase arrangement in which the State pays the contractor for budgeted costs that are actually incurred in delivering the services specified in the contract, up to a stated maximum obligation.

- Personnel costs are reasonable and comparable to positions in the community.
- Non-personnel costs are reasonable and adequately justified.
- The budget fully supports the scope of service and requirements of the RFP.
- The Narrative Budget Justification adequately explains the basis for all costs and adequately justifies all costs.
- Administrative costs represent a reasonable and modest proportion of total costs.

- Adequacy of accounting system.

5. Phase 3 - Recommendation for Award

Each notice of award shall contain a statement of findings and decision for the award or non-award of the contract to each Contractor.

Section 5

Attachments

Attachment A. **Competitive Proposal Application Checklist**

Attachment B. **Sample Proposal Table of Contents**

Attachment C. **Case Management Practice Standards and Case Manager Standards**

Attachment D. **Client Acuity Determination**

Attachment E. **Sample Form SPO-H-205**

Attachment F. **Sample Narrative Budget Justification**

Proposal Application Checklist

Applicant: _____ RFP No.: _____

The applicant's proposal must contain the following components in the order shown below. Return this checklist to the purchasing agency as part of the Proposal Application. SPOH forms are on the SPO website.

Item	Reference in RFP	Format/Instructions Provided	Required by Purchasing Agency	Applicant to place "X" for items included in Proposal
General:				
Proposal Application Identification Form (SPOH-200)	Section 1, RFP	SPO Website*	**X**	
Proposal Application Checklist	Section 1, RFP	Attachment A	**X**	
Table of Contents	Section 5, RFP	Section 5, RFP	**X**	
Proposal Application (SPOH-200A)	Section 3, RFP	SPO Website*	**X**	
Provider Compliance	Section 1, RFP	SPO Website*		
Cost Proposal (Budget)				
SPO-H-205	Section 3, RFP	SPO Website*		
SPO-H-205A	Section 3, RFP	SPO Website* Special Instructions are in Section 5		
SPO-H-205B	Section 3, RFP,	SPO Website* Special Instructions are in Section 5		
SPO-H-206A	Section 3, RFP	SPO Website*		
SPO-H-206B	Section 3, RFP	SPO Website*		
SPO-H-206C	Section 3, RFP	SPO Website*		
SPO-H-206D	Section 3, RFP	SPO Website*		
SPO-H-206E	Section 3, RFP	SPO Website*		
SPO-H-206F	Section 3, RFP	SPO Website*		
SPO-H-206G	Section 3, RFP	SPO Website*		
SPO-H-206H	Section 3, RFP	SPO Website*		
SPO-H-206I	Section 3, RFP	SPO Website*		
SPO-H-206J	Section 3, RFP	SPO Website*		
Certifications:				
Federal Certifications		Section 5, RFP		
Debarment & Suspension		Section 5, RFP		
Drug Free Workplace		Section 5, RFP		
Lobbying		Section 5, RFP		
Program Fraud Civil Remedies Act		Section 5, RFP		
Environmental Tobacco Smoke		Section 5, RFP		
Program Specific Requirements:				

*Refer to Section 1.2, Website Reference for website address.

Proposal Application
Table of Contents

1.0 Program Overview 1

2.0 Experience and Capability 1
- A. Necessary Skills 2
- B. Experience 4
- C. Quality Assurance and Evaluation 5
- D. Coordination of Services 6
- E. Facilities 6

3.0 Project Organization and Staffing 7
- A. Staffing 7
  - 1. Proposed Staffing 7
  - 2. Staff Qualifications 9
- B. Project Organization 10
  - 1. Supervision and Training 10
  - 2. Organization Chart (Program & Organization-wide)
    (See Attachments for Organization Charts

4.0 Service Delivery 12

5.0 Financial 20
See Attachments for Cost Proposal

6.0 Litigation 20

7.0 Attachments
- A. Cost Proposal
  - SPO-H-205 Proposal Budget
  - SPO-H-206A Budget Justification - Personnel: Salaries & Wages
  - SPO-H-206B Budget Justification - Personnel: Payroll Taxes and Assessments, and Fringe Benefits
  - SPO-H-206C Budget Justification - Travel: Interisland
  - SPO-H-206E Budget Justification - Contractual Services – Administrative
- B. Other Financial Related Materials
  - Financial Audit for fiscal year ended June 30, 1996
- C. Organization Chart
  - Program
  - Organization-wide
- D. Performance and Output Measurement Tables
  - Table A
  - Table B
  - Table C
- E. Program Specific Requirements

PROPOSED

CASE MANAGEMENT PRACTICE STANDARDS

Hawaii Cares
Quality Assurance Committee

Ruth Antone, Chair, Gregory House Programs
Nitsa McCarthy, Life Foundation
Olaf Tollefsen, AIDS Education Project
Earle Core, Big Island Community Participant
Kate Nawahine, Big Island AIDS Project
Dan Uhrich, Maui AIDS Foundation
Paul Spears, Malama Pono
Jerry Ford, Gregory House Programs
Gene Smith, Big Island Community Participant
Jay Geffert, Kaua'I Community Participant
David Stagno, Maui Community Participant
Steffi Glass, Volunteer/Save the FoodBasket
Chuck Linton, Oahu Community Participant
James Weihe, Oahu Community Participant

Community Planning Group
Quality Assurance Committee

Ruth Antone
Ray Higa, DOH
Madi Silverman, DHS
Tim McCormick, DOH
David Braaten, Community
David Roos, Life Foundation

CASE MANAGEMENT PRACTICE STANDARDS (PROPOSED)
Table of Contents

Table of Contents 2

Practice Standards
Customer Service 3

Access 4

Screening & Intake 5

Initial Assessment 6

Acuity Level 7

Development and Implementation of Individual Written Care Plan 8

Monitoring 9

Reassessment 10

Crisis Intervention 11

Case Closure 12

Discharge 13

Documentation 15

Grievance 16

Quality Improvement and Quality Assurance 17

Linking Prevention and Care 18

CASE MANAGEMENT PRACTICE STANDARDS

I. CUSTOMER SERVICE STANDARD

Case management will be client-centered, acuity based, and culturally aware and sensitive. Client-centered case management involves a mutually respectful collaboration between the case manager and the client. The client is the primary decision maker regarding his/her care, and is urged to take the leadership role in identifying and prioritizing needs. Acuity based case management matches the intensity of case management to a client's needs and ensures that clients do not miss out on services and are not 'over case managed'. Culturally aware case management is sensitive to the history, experiences, values and languages that are a part of clients' cultural identities. Case management will ultimately be focused on outcomes that determine that the services or program has the desired effect or impact on a client or a family.

In addition, the AIDS service organizations will provide their clients/consumers with competent and respectful care in the client's preferred language.

II. ACCESS STANDARD

Standard:

Case management services must be available to all persons with HIV who meet eligibility requirements, to include the unserved/ underserved/emerging populations. This will be accomplished through identification and elimination of access barriers with a focus on cultural awareness and sensitivity.

Elements:

Provide case management services to all clients. AIDS service organizations will provide services to meet the varying needs of each population served, including but not limited to:

1. Those belonging to any racial, gender, sexual preference, ethnic, cultural or age group;
2. Those with co-morbidities, including individuals with physical and mental disabilities, and substance abuse;
3. Individuals experiencing socio-economic barriers to accessing services, such as:
    a. Issues with finances;
    b. Issues regarding geographies;
    c. Issues surrounding logistics such as lack of childcare, physical space issues for disabled clients, and hours of operation;
    d. Lack of knowledge regarding available services;
    e. Issues about confidentiality;
    f. Issues of cultural sensitivity;
    g. Issues with food, clothing, shelter, transportation.

III. SCREENING AND INTAKE

Standard: Screening and intake are collaborative, client-centered processes between the case manager (and other service providers) and the client where client information is collected and the need for services is determined in a timely manner.

Elements:

Screening identifies potential clients. Intake collects demographic information needed by program. Each client or guardian must participate in an initial intake and screening procedure. The purpose of the screening and intake portion of the case management process is for client identification and eligibility determination. This stage will assist in obtaining client baseline data to be used in determining potential needs. This component is crucial in setting the foundation for providing a coordinated set of services.

1. Intake will be initiated within 72 hours after the first contact with the agency.
2. The intake procedures are performed using the process approved by the agency.
3. The intake process indicates appropriate eligibility for the program. Process includes, but is not limited to:
    - Date of intake;
    - Verification of HIV diagnosis;
    - Verification of Hawai'i residency;
    - Appropriate financial information;
    - Referral needs:
        Housing
        Food, Nutrition
        Transportation
        Support Services
        Other
    - Current health status, medical care;
    - Information on any co-morbidities such as psychiatric diagnosis, substance abuse;
    - Insurance information;
    - Client goals (work, education, personal, etc.);
    - Client or guardian signature of authorization.
4. Reason for ineligibility for program must be indicated (if applicable).
5. Intake instruments must comply with necessary State and Federal laws regarding the privacy and confidentiality and must comply with the Hawaii State law on HIV Confidentiality.
6. The client or guardian authorizes intake process.
7. If a client is determined eligible, a client file is created and client information will be maintained in the file.
8. Client will be assigned an initial acuity level upon intake and assessment.
9. Client will be given a written copy of the following information at intake:
    - Overview of agency services;
    - Rights and responsibilities of client and of ASO;
    - Grievance procedure;
    - Community resources;
    - Discharge policy.

IV. INITIAL ASSESSMENT

Standard:

Initial assessment is a collaborative, client-centered process between the case manager and client. The outcome of the assessment will determine acuity level, client needs, resources available and gaps in services. In this process a plan of care is developed and progress is reviewed jointly and the plan of care is amended based on interactions between the client and case manager. Assessment and evaluation will be characterized by the following:

1. Collaboration, acuity, and outcomes;
2. Focus on client concerns, short and long-term goals and solutions;
3. Recognition that the plan of care is a "living, evolving" written document based on on-going evaluation;
4. Identification of resources and gaps.

Elements:

After each client is determined eligible for the program, needs must be assessed in a systematic and culturally sensitive manner in order to provide appropriate information for the written plan of care. A written assessment from this meeting must be kept in the client's paper or electronic file. The purpose of this stage is to develop an understanding of what support and services the client may need. This stage builds on the information gathered in the initial intake; however, more detailed information is sought. A written service plan is generated from this assessment.

1. While the assessment of each client may require the selection from a variety of Assessment tools, the assessment(s) should gather information from the many areas in which the client functions. These areas include:
   - Psychosocial status;
   - Medical history/physical health/dental health;
   - Nutritional status;
   - Mental health/psychiatric status;
   - Current or past substance abuse;
   - Financial resources/benefits;
   - Food/nutrition needs;
   - Housing needs;
   - Transportation needs;
   - Legal assistance needs;
   - Spiritual needs;
   - Ohana/support system;
   - Educational/job training needs;
   - Work history;
   - HIV transmission, risk reduction, and prevention needs;
   - Other support services;
   - Other.

V. ACUITY LEVEL

Standard:

Services will be based on acuity. Acuity level determinations shall be made by the individual provider agency based on a four-point scale. Acuity level will be determined at intake and reviewed as indicated in the Acuity Guidelines to meet changing client needs or whenever substantial changes occur.

Acuity level changes when there is a significant change in the client's status. Both positive and negative changes in acuity level will be made when there is any change in client status. Significant changes indicating increased level of need for services include death, illness or hospitalization of client or caregiver, change in condition or circumstance that prohibits client from caring for self, change in the client's functioning, loss of housing.

Elements:

1. Frequency and type of contact with the case manager will be based upon client acuity level.
2. Based on acuity the provider agency will contact clients in order to assess changing client needs and development of a written care/service plan.
3. Clients may receive services as needed on a drop-in basis.
4. All interactions will be charted daily in the client chart.

State of Hawaii
Acuity Guidelines

Level One – Highest Need

HIV positive clients with severe and acute medical, financial, housing, substance abuse or psychosocial crisis, who may have difficulty in successfully managing a personal care/services plan. Based on situation client will receive initial response immediately or within 24 hours (or 72 hours if it is over a weekend). On-going contacts should be attempted daily or weekly to allow intensive support and service coordination with other agencies/providers. Appropriate referrals for crisis assistance will be made.

Level Two – High

HIV-positive clients with complex and acute medical, financial, or psychosocial needs whose needs require emotional and/or environmental support in order to manage their own care/service plan. Contact attempts should be at least twice monthly.

Level Three – Moderate

HIV-positive symptomatic individuals with aggravating, but not acute medical, financial or psychosocial needs who request assistance from the provider agency with case management and/or medical strategy decisions and who may benefit from moderate care assistance. Client contacts are recommended once a month, but, in no circumstances, less than once a quarter.

Level Four – Low

HIV-positive individuals without acute or complex medical, financial or psychosocial needs. Clients are able to function independently without case management. They are able to initiate contact for assistance and/or information from a provider agency. At this level there are no currently un-addressed medical problems. Client will need minimal contact. There will be contact every six months by the agency to assess change in acuity.

VI. DEVELOPMENT AND IMPLEMENTATION OF AN INDIVIDUAL WRITTEN CARE PLAN

Standard:

A written plan of care will be developed through a collaborative process between the case manager and each individual client, and may include their families/significant others, and should include these parameters:

1. Client driven;
2. Responsible person(s) delineated;
3. Outcome based;
4. Action oriented;
5. Time Specific.

Elements:

A written plan of care is developed with the participation and agreement of the client and/ or guardian and addresses all the issues identified in the Screening and Intake. The purpose of the written plan is to facilitate client access to resources and to enhance coordination of care. The case manager identifies client needs based on a comprehensive client assessment that turns into a workable plan of action through the care plan process. Development of the client plan of care is an interactive process between the case manager and the client. It is a process which supports client self-determination whenever possible and empowers a client to participate actively in planning and delivery of services. The client must agree that the plan is realistic and obtainable. The client has a right to refuse any service, but may still receive other services.

1. The written plan clearly defines specific priority areas, time frames, referrals to be made by case manager, tasks to be done by client. The plan will be based on client's acuity, and will change as client's needs and acuity change.
2. Information included in the plan of care will include:
   - List of client service needs;
   - Prioritization of client needs to be met;
   - Establishment of measurable short and long term goals that will meet client needs;
   - Establishment of measurable objectives and action steps to meet plan of care and desired outcomes**;**
   - Identification of formal and informal resources to accomplish desired outcomes**;**
   - Identification of alternatives to meet client goals.
   - Identification of what case manager will do, and what client will do to accomplish needs.
3. The plan is facilitated, implemented, and monitored by a case manager in collaboration with client or guardian.
4. The reason client compliance was not, or could not be obtained must be included in the written plan when applicable.
5. Effort will be made to have a client sign the care plan. If client does not want to sign, case manager will document reason. Client can still receive services without signing care plan.
6. No written care plan is required for acuity level four, and this will be documented in client chart.

VII. MONITORING

Standard:

The needs and status of each client receiving case management services will be monitored regularly based on client need and acuity level. The purpose of this stage is to allow the client and case manager to observe the progress of the plan of care. Information will be kept in client's paper or electronic chart. Reassessment and need to up date care plan will be based on monitoring of client, his/her needs and progress.

A. Elements

1. Methods used to obtain information include:
   - Communication with client;
   - Direct observation of the client;
   - Contact with the client's family and/or guardian, significant other, primary care physician, service providers, and other professionals. Client's signed consent to share information is required.

2. The types of information to be gathered will include:
   - Present status of client;
   - Client progress;
   - Quality and appropriateness of services provided;
   - Client satisfaction;
   - Barriers to client outcomes.

3. The client is instructed to notify case manager of any change in status or any problems with the services provided**.** Case manager will contact client as directed by client's acuity level.
4. Non-scheduled care plan meetings may occur as the need arises.
5. Monitored information is documented in client's paper or electronic chart in order to aid in the client reassessment.

VIII. REASSESSMENT

Standard:

Addresses the issues identified in the monitoring phase. Each client receiving case management services shall be reassessed through a comprehensive bio-psychosocial reassessment at least every six months, or more often based on client's presenting need and/or change in acuity.

Elements:

The purpose of reassessment is to re-address and evaluate the issues noted and the outcomes achieved during the monitoring phase. Reassessment will include, but is not limited to, the original assessment areas. The client and case manager will work together to reevaluate the course of the plan of care.

If there are no changes needed in care plan, note this in client's paper or electronic chart. If there are changes in care plan, it will be updated and changes noted in client's paper or electronic chart.

Reassessment also allows for client readmission to programs, determination of need, and the termination of services.

1. Communication with client regarding needs and services.
2. Topics to be addressed in the reassessment will include initial assessment areas and the following:
   - Newly identified needs;
   - Changes in medical status;
   - Resources and barriers;
   - Special needs;
   - Outcomes from previous assessment will be documented;
   - Client satisfaction by self-report.
3. Client acknowledgment of changes resulting from the reassessment.
4. Once reassessment is complete, care plan will be updated as appropriate.

IX. CRISIS INTERVENTION

Standard:

Crisis puts client at the highest acuity level. Crisis intervention provides assessment and referral for acute medical, social, physical or emotional distress (crisis includes medical situations, psychiatric situations, financial situations where a person has no money for food, etc.). When a client presents in crisis the case manager will assist the client within the time set by acuity level one, and will obtain an appropriate response to the situation.

A. Elements

An assessment of the emergency situation will be made and there will be a determination of needs and an appropriate response. If the person is a client, the case manager will proceed to secure the needed emergency services. If the person is not a client, the case manager will refer the person to a program that can secure emergency services. If person is a client, case management plan will be revised.

1. Immediate assessment of person.
2. Determination of eligibility as client.
3. Either secure services or refer out for crisis intervention.
4. Documentation of the crisis intervention in client's chart.

X. CASE CLOSURE

Standard:

Cases will be closed when client is no longer eligible for services, no longer desires services, is lost to follow-up, or when client behavior violates the rights and responsibilities of other clients and case management or other program staff.

Elements

1. Documentation of decision to close case: client's request**,** client to move out of area, client no longer eligible for services, client dies.
2. As applies, appropriate referrals are made prior to termination.
3. Case summary will be prepared stating reasons for closure, services that have been provided to client/family.
4. Case summary will be forwarded to new provider with client consent.
5. Document client outcomes from stated goals and objectives.
6. Document discharge plan.

XI. DISCHARGE

Standard:

A systematic process shall be in place to guide discharge from case management services and allow for client appeal of discharge decisions.

Discharge from case management does not mean the client is barred from receiving other services and should not necessitate discharge from the agency. With the changes in the epidemic, agencies may now offer other, less intensive services not under the auspices of case management and which clients can access directly. If the agency does not offer these services, the agency has an obligation to explore alternatives with their clients, and refer as appropriate and in accordance with their clients' wishes, to agencies that do have this capacity.

A. Conditions Under Which Discharge Shall Occur:

1. The client no longer meets eligibility requirements as established by AIDS service organization.
2. The client and/or client's legal guardian has requested the case be closed.
3. Death of the client.

Process:
Discharge occurring under any of the above circumstances, with the exception of client death, should be conducted in a manner consistent with the following process:

a. Reason for discharge and/or request for case closure is discussed with the client and options for other service provision is explored and documented. In instances where a face to face meeting cannot be arranged and the client cannot be reached, a letter indicating intent to discharge should be mailed to the client's last known mailing address unless otherwise specified.
b. A discharge summary is prepared, which minimally includes reason for discharge and a service transition plan, as appropriate.

B. Conditions Under Which Discharge May Occur:

1. Client relocates outside the service area.
2. The client is noncompliant with case management rules and regulations.
3. Inability to contact the client for a period of not less than 90 days.
4. Verbal or physical violence toward agency staff or property as defined by agency policies and as provided in writing to the client upon initiation of services.
5. Inappropriate use of services as defined by agency policy as provided in writing to the client upon initiation of services.

Process:
Discharge occurring under any of the above circumstances should be conducted in a manner consistent with the following process:

a. Case manager conducts case review with his/her supervisor and/or peer, as appropriate, to make final determination for discharge.
b. The client is informed in writing of intent to discharge and is provided with information regarding appeal of that decision. Where possible, client will be informed of discharge first in person and then in writing.
c. A discharge summary is prepared, which minimally includes reason for discharge and or a transition plan.
d. The client is provided a letter stating the reasons for the discharge. The letter shall be mailed to the client when direct delivery is not possible.

C. Condition Under Which Discharge May Occur Upon Mutual Agreement and/or At The Direction of the Client:

The client has, by his/her own report and in consultation with the client's health care provider(s), obtained optimal health for a period of not less than 6 months and is receiving all necessary ancillary services as planned.

Process:
Discharge occurring under mutual agreement should be conducted in a manner consistent with the following process:

a. Case Manager conducts case review with his/her supervisor and/or peer, as appropriate, to determine appropriateness for discharge.
b. A discharge summary is prepared, which minimally includes reason for discharge and a transition plan with plan for follow-up.
c. The client is provided a letter stating the reasons for the discharge. The discharge letter shall be mailed to the client when direct delivery is not possible.

D. Criteria for Discharge Under All Conditions:

1. Cases shall be closed and all services concluded within 6 months of discharge.
2. Date of discharge is established by either:
   a. Date of death
   b. Date agency and client or guardian agree on termination of services
   c. Date agency determines and documents client ineligibility for case management services
3. In the event of client's death, follow-up case management services may be offered to the family/significant other(s) for six (6) months.
4. Within 3 working days of the final decision to terminate services, a discharge summary is prepared and signed by the case manager, reviewed and countersigned by the case management supervisor.
5. The original discharge summary is placed in the client record.
6. The client is sent a letter stating the reasons for the discharge.
7. Client records are stored and are retrievable by the agency for a period following discharge as required by applicable law and/or agency policy.

E. Additional Criteria For Discharge Under All Conditions, Except Client Death:

1. A letter is provided to the client and/or his/her legal representative.
2. Clients are offered in writing, a copy of the service record at the date of discharge.

F. Documentation:

1. Evidence of discussion with client and/or notification of client regarding intent to discharge from services.
2. When discharge is agency initiated, evidence that client has been informed of appeal process and understands his/her right to appeal decision to discharge.
3 A discharge summary which includes reason for discharge and a transition plan. A transition plan should minimally include other services/activities that the client and case manager have identified as appropriate to the client's needs, all information necessary for the client to arrange those services and/or referrals to be made by the case management agency. The transition plan should also include time lines as appropriate, an agreement to maintain communication between client

and case manager should problems arise and/or for the purpose of follow-up assessment as supported under certain conditions of discharge.

4. Time limited releases should be in place as needed to allow follow-up as indicated and as agreed to by the client.
5. Evidence that the client was sent a letter informing of the discharge and has been informed of the option to obtain a copy of his/her service records.

Discharge occurring upon the death of a client does not require documentation as indicated above, but should be charted including date of death and follow-up plan for provision of services to family members, as appropriate.

XII. DOCUMENTATION

Standard:

All interactions with or on behalf of the client must be documented daily, be readable, objective, and be preserved in a confidential and complete file.

A. Elements

At minimum written documentation of case management services shall include: 1) The first contact from the client and the request for services; 2) The initial assessment of client's needs and any reassessments; 3) The initial care plan (and any subsequent care plans) specifying the services to which the client is being referred and the manner in which the referral will take place; 4) Any subsequent care plans; 5) Ongoing chart/progress notes documenting client's progress and needs.

Documentation will also include client's eligibility for services, documentation of HIV, releases of information; and

1. Dates of encounters with client;
2. Dates of referrals;
3. Dates of service delivery;
4. Initial assessment, reassessments, initial care plan, follow-up care plans;
5. The names of the persons or agencies providing the referred service;
6. Information indicating whether the service requested was received;
7. Ongoing notes detailing client's progress and needs;
8. Outcomes achieved.

XIII. GRIEVANCE

Standard:

Clients have a right to file a grievance when they believe their rights have been violated. Each case management agency will implement written client grievance policies and procedures. Clients will be informed of the grievance procedure upon intake, and be given a written description of the procedure. Clients shall acknowledge in writing receipt of the information. Each case management agency and system will notify the client in writing of resolution or action taken in a grievance.

Elements:

Clients have a right to grieve when:

1. Conflict with their case manager, other case management staff, or with the case management agency itself has reached the point where it cannot be resolved to their mutual satisfaction.
2. There is an irreconcilable deterioration in the relationship with a client's case manager, other case management staff, or with the case management agency as a whole.
3. Any other situation where the client feels he/she has no other alternative.

Each AIDS service organization case management agency will have in place the following minimum policies and procedures for client grievance procedures:

1. Provide an impartial, fair, and expedited review process for client grievances;
2. Include the client grievance procedure in the client orientation packet;
3. Provide client with mandatory alternatives to use before initiating a grievance (client empowerment; conflict resolution tips; referral to case management supervisor; use of ombudsman, etc.).
4. Provide a clear chain of command for addressing client grievances;
5. Provide proof of an impartial, fair, and expedited review process for client grievances;
6. Delineate the mechanism and criteria whereby a client who has been suspended or terminated from case management may re-access services;
7. Grievances will be handled in the time frame set out in the policy.

XIV. QUALITY IMPROVEMENT AND QUALITY ASSURANCE

Standard:

HIV case management must be involved in a continuous process to improve every part of the program, with the intent of meeting or exceeding client expectations and outcomes. HIV case management must continually engage in activities that provide evidence that basic standards are met in the HIV case management program.

Elements:

1. Case management services will design and implement activities to monitor, evaluate and improve the results of case management services based on the Case Management Standards.
2. Evaluation will be based on information from clients and case managers, client satisfaction surveys, access to care, decreased hospital admissions, shorter lengths of stay and fewer readmissions.
3. Evaluation will be done at three different levels: 1) Client; 2) Organizational; 3) Systems.
   Client Level evaluation may include: Time from assessment to implementation of care plan; Successful linkages; Behavior changes; Empowerment of clients; Quality of life issues; Improvement in knowledge; Resource utilization vs. crisis.
   Organizational evaluation may include: Case manager ability to deal with loss; Staff turnover; Staff satisfaction.
   System level evaluation may include: Changes in interaction between organizations; Cooperative agreements with other agencies; sharing data, etc.; Changes in available resources.
4. Outcome and performance measurements will be an integral part of the program design.

XV.LINKING PREVENTION AND CARE

Standard:

Case management is part of a dynamic continuum of care that includes education, prevention, early detection, treatment, and optimization of the quality and quantity of life for persons with HIV and their communities. It is the role of case management to provide on-going evaluation of clients while promoting and maintaining this continuum of care.

Elements:

1. Conduct ongoing assessment and documentation at intake and annually of risk factors
2. Offer assistance with partner notification.
    a. Client to partner(s) – offer encouragement, information and support to the client to disclose to partner(s).
    b. Client to partner(s) with direct case management assistance – offer encouragement, information and support to the client to assist client in disclosure to partner(s).
    c. Referral to Department of Health – Give support to client through referral to Department of Health for partner(s) notification if client requests.
3. Document linkages created between case managers and prevention workers about referred clients.
4. On-going assessment and documentation of evaluation of risk factors (safe sex behavior, and drug use).
5. Collaborate with client to create risk behavior modification plan with goals or refer to prevention workers or Department of Health.
6. Maintain sensitivity and understanding of sexual and cultural norms for diverse populations.
7. Follow all Federal and State laws concerning spousal notification.
8. Training that address needs of case managers and prevention workers.

NOTE:

Standards were not written for services that may be needed such as the following:

- Medical/dental care
- Psychiatric
- Housing
- Food/Nutrition
- Transportation
- Substance abuse
- Other

Each ASO will develop policies and procedures to address these and other support services that may be needed by clients in ways that meet each ASO's particular needs and resources/constraints.

HIV CASE MANAGEMENT STANDARDS

State of Hawaii, Department of Health

November 1, 2000

1. Definition:

Case management is a system of service provision based on a relationship between the consumer and case manager. This relationship facilitates and increases consumer participation and enables the process to be consumer driven. The case manager collaborates, assesses, facilitates, educates, plans and advocates for the range of services needed by consumer and 'family'. The case manager coordinates with other service providers to create a multidisciplinary team for the consumer. The goal of this system is to increase access to services, improve coordination of services, and promote quality and cost-efficient outcomes to support people living with HIV/AIDS.

Case Manager Functions	Case Manager Tasks
Assessor	Outreach (Outreach defined by DOH as nontradional service delivery to assist multiply diagnosed and/or homeless consumers to access services and to prevent consumers from falling through gaps and not receiving care.)
	Screening Intake/Assessment/Re-assessment Problem Identification Crisis Intervention Termination/Inactive
Planner	Written Service Plan with Goals and Objectives Periodic Monitoring/Updating Cases
Facilitator/Coordinator	Referrals Brokering/Linking Coordinating with Agencies/Workers Supportive Counseling (Includes Prevention Counseling) With Families, Significant Others, etc. Teach/Encourage Self-Advocacy

Other Functions	Charting, Documentation Paperwork/Productivity Reports Evaluation/Monitoring/Research Teaching/Education

II. Standards (Based on Case Management Society of America)

A. Advocacy Standard

The case manager's central focus is on the consumer and his/her family. The case manager should advocate for the consumer/family at the service–delivery level.

Measurement Criteria: The case manager will:

1. Establish an effective working relationship with the consumer/family, provider and payor.
2. Foster the consumer's/family's decision-making, independence, and growth and development.
3. Educate the consumer/family about appropriate services and support them in moving toward self-care.
4. Advocate for consumers with long-term care needs at local and state government levels through membership in relevant professional organizations and by becoming knowledgeable about new laws and policies that affect consumer care and case management practice.

B. Collaboration Standard

The case manager's role requires collaborative, proactive and consumer-focused relationship to focus, facilitate and maximize consumer outcomes.

Measurement Criteria: The case manager will:

1. Be knowledgeable and educated with regard to the roles and capabilities of various professions and resources.
2. Provide effective leadership and cooperative with community interdisciplinary team members prior to implementing a plan of action.
3. Demonstrate creativity, care, balance and commitment to the individual served.
4. Place the consumer/family outcomes as primary.

C. Ethical Standard

The care manager's practice will be guided by ethical principles.

Measurement Criteria: The case manager will:

1. Provider services based on autonomy, dignity, privacy and personal rights of the individual.
2. Provider information to the individual to facilitate informed health decisions.
3. Seek appropriate resources and consultation to help formulate and to resolve ethical dilemmas.

D. Evaluation Standard

The case manager will use on-going feedback from supervisor, peers, and consumers to measure the effectiveness/necessity/efficacy of the service plan and the quality of the services.

Measurement Criteria: The case manager will:

1. Routinely make a comprehensive and independent assessment of the consumer's status and progress toward reaching the goals set in the service plan.
2. The case manager will monitor cases and make periodic appropriate adjustments in the service plan; providers and services to promote better outcome.

E. Legal Standard

The case manager practices in accordance with applicable laws.

Measurement Criteria. The case manger will:

1. Act in accordance with applicable laws related to:

    a. Consumer confidentiality and the release of information.
    b. The Americans with Disabilities Act.
    c. Worker's Compensation.
    d. Other consumer protection laws.
    e. Abuse reporting.
    f. Healthcare proxies (power of attorney for healthcare), and advanced medical directives.
    g. Benefits and benefits administration.

2. Be knowledgeable about the legal scope of practice of various healthcare providers.
3. Seek appropriate resources for resolution of legal questions.

NOTE: Professionals are required by law to report child abuse.

F. Quality of Care Standard

Case management is an appropriate, timely and beneficial service which promotes quality of life and cost effective consumer–related outcomes.

Measurement Criteria: The case manager will:

1. Work within established standards/ethics for case management practice and those of the case manager's professional discipline.
2. Use evaluation and outcome data to improve ongoing case management services.
3. Promote health care outcomes in concert with currently accepted clinical practice guidelines.

G. Research Standard

Case management practice will be based on valid research findings: specifically plans and interventions that result in high quality, cost-effective outcomes.

Measurement Criteria: The case management supervisor will provide case managers with guidance to:

Use intervention substantiated by research that are appropriate to the ongoing care needs of the consumer.

Case management administration will provide case managers with opportunities to:

Participate in research activities that are appropriate to the practice environment. Such activities could include:

1. Design and/or utilize data gathering tools.
2. Identifying suitable clinical/social problems that would advance or support the consumer's quality of life.
3. Participating in data collection, specifically outcome data.
4. Conducting research independently or in collaboration with others.
5. Critiquing research literature for application to case management practice.
6. Using appropriate research findings in the development of policies, procedures and guidelines for cost-effective, high quality consumer care.

H. Resource Utilization Standard

The case manager will integrate factors related to quality, safety, efficiency and cost-effectiveness in planning, delivering, monitoring and evaluating consumer care.

Measurement Criteria: The case manager will:

1. Evaluate safety, effectiveness, cost and potential outcomes when developing a plan for the ongoing care needs of the consumer.
2. Refer, broker and/or deliver care based on the ongoing healthcare needs of the consumer and the ability, knowledge and skill of the health and human services providers.
3. In conjunction with the consumer/family, link the consumer/family with the most appropriate institutional or community resources, and advocate for development of new resources if gaps exist in the service continuum.
4. Monitor and evaluate those services through progress reporting, which would include eligibility, reimbursement and collaboration with other professional service providers.
5. Promote the most effective and efficient use of human and financial resources.

I. Education/Preparation/Certification Qualification Standard

Case Management requires professional skills, education and experience.

Measurement Criteria: The case manager will:

1. Complete a baccalaureate or higher level educational program for health and human services (social work, sociology, psychology, RN) and a minimum of 12 months of experience working with people with HIV/AIDS or in case management to other populations.
2. Individuals with MSW are considered qualified to work as a case manager.
3. A person without a Bachelor's degree will have 12 months experience providing services to the HIV population or working as a case manager and will work to fill in gaps in their education by taking appropriate courses at accredited colleges. Courses to be in the area of study listed in #1 above.
4. Clinical supervision for case managers will be provided by a professional with a Master's degree in a field related to clinical health or social services and experience with HIV/AIDS. These case supervision services will be provided by either a staff member or contracted to a qualified individual.
5. Criteria 1-4 above, will apply to State- or federally-funded case managers and case management supervisors hired after November 1, 2000.

However, employees hired prior to this date should be encouraged and supported to meet the criteria.

6. Complete agency orientation and training including HIV and case management training.
7. Maintain current professional licensure or national certification in a health and human services profession as available and applicable.
8. Demonstrate knowledge of health, social services, and funding sources.
9. Maintain continuing education appropriate to case management and professional licensure.

Quality Assurance

Quality assurance, although not a case management standard, must accompany the process of developing standards. Quality assurance data should be set up by agencies in ways that allow each access to data about compliance with standards, e.g. evaluation, up-dating service plans, types of services provided, etc. The data should ideally be computerized in a standard way across agencies.

The following reflect the Case Management Advisory Committee's concerns that there be a plan within each agency, as well as State Department of Health, for quality assurance.

For Agency Level Monitoring/Evaluation:

Policies and procedures must reflect standards
Set case load size and composition (by acuity level) to guide case management practice
Quality Assurance plan in place
Consumer involvement in evaluation
Internal supervision and chart review
Computer data system to track number of visits, referrals, consumers, etc.

For Department of Health Level Monitoring/Evaluation:

Yearly site visit to evaluate each agency
Access to computer data, chart review, interviews with personnel
Program review

Exhibit “2”

Client Acuity Determination

Subject: Client Acuity Determination

PURPOSE:
To formulate a set of guidelines to be used by HIV/AIDS case management providers in Hawaii regarding the relationship between the client and the provider group. Acuity level is one analytical method by which the relationship between client and provider group may be reviewed.

POLICY:
Acuity level determinations shall be made by the individual provider agency. Acuity guidelines may be used at the discretion of the local provider agency in determining services. Acuity level will be determined at intake and reviewed as needed to meet changing client needs or whenever substantial changes occur. It is not the intention of the acuity level determination process to limit clients from access to services, but as a tool to focus attention upon services that the client deems beneficial or an integral part of the client's functioning support plan.

PROCEDURE:
Case managers will endeavor to make periodic contact with clients in order to assess changing client's needs and appropriateness of a written care/service plan. Frequency and type of contact will be based upon client acuity level and expressed client need. Case managers will act as liaisons between clients and service providers to facilitate meeting client needs. Case managers will also provide supportive counseling for clients for whom services have yet to be found or implemented. The following broad acuity level criteria have been formulated to assist case managers and service providers in the process of determining a client's service needs. Specific acuity level determinations will be made at the local agency level based upon the individual client's needs and requests. It is recognized that acuity evaluations will fluctuate based upon client need, request, and services received.

Level One – Highest
HIV-positive clients with severe and acute medical, financial or psychosocial crisis who may have difficulty in successfully managing a personal care/service plan. Client will receive initial response within 24 hours when possible. When feasible, ongoing contacts should be attempted with such frequency as daily to weekly to allow intensive service coordination with other agencies/providers.

Level Two – High
HIV-positive clients with complex and acute medical, financial or psychosocial needs whose needs require emotional and/or environmental support in order to manage their own care/service plan. Contact attempts should be at least twice monthly within a significant amount of collateral contacts.

Level Three – Moderate
HIV-positive symptomatic individuals with aggravating, but not acute medical, financial or, psychosocial needs who request assistance from the provider agency with case management and/or medical strategy decisions and who may benefit from moderate care assistance. Contact attempts should be less than once a month but more than once a quarter.

Level Four – Low
HIV-positive individuals without acute or complex medical, financial or psychosocial needs. Clients perform independent case management with assistance and/or information from a provider agency upon client's request. No currently unaddressed medical problems. Client will need minimum contact. Quarterly contact by the agency, not necessarily from a case manager.

Types of contact with or on behalf of clients:
Face-to-face, telephone, written notes and letters, electronic mail, ohana communications

BUDGET

(Period _____ to _____)

Applicant/Provider: _____

RFP No.: _____

Contract No. (As Applicable): _____

BUDGET CATEGORIES	Budget Request (a)	(b)	(c)	(d)
A. PERSONNEL COST				
1. Salaries				
2. Payroll Taxes & Assessments				
3. Fringe Benefits				
TOTAL PERSONNEL COST				
B. OTHER CURRENT EXPENSES				
1. Airfare, Inter-Island				
2. Airfare, Out-of-State				
3. Audit Services				
4. Contractual Services - Administrative				
5. Contractual Services - Subcontracts				
6. Insurance				
7. Lease/Rental of Equipment				
8. Lease/Rental of Motor Vehicle				
9. Lease/Rental of Space				
10. Mileage				
11. Postage, Freight & Delivery				
12. Publication & Printing				
13. Repair & Maintenance				
14. Staff Training				
15. Substance/Per Diem				
16. Supplies				
17. Telecommunication				
18. Transportation				
19. Utilities				
20				
21.				
22.				
23.				
TOTAL OTHER CURRENT EXPENSES				
C. EQUIPMENT PURCHASES				
D. MOTOR VEHICLE PURCHASES				
TOTAL (A+B+C+D)				
SOURCES OF FUNDING		Budget Prepared By:		
(a) Budget Request		Name (Please type or print)		Phone
(b)				
(c)		Signature of Authorized Official		Date
(d)		Name and Title (Please type or print)		
TOTAL REVENUE		For State Agency Use Only		
		Signature of Reviewer		Date

Form SPO-H-205 (Effective10/01/98)

SAMPLE: NARRATIVE BUDGET JUSTIFICATION

1999 HIV Prevention Budget and Justification

Summary

Hawai'i's FY 1999 HIV/AIDS Prevention Cooperative Agreement is requesting $1,735,732 in federal financial assistance. This is the same amount received in FY 1998. In accordance with the revised *1999 HIV Prevention Plan Update for the State of Hawai i*, adjustments have been made to the contracts for HIV prevention activities to increasingly focus on those priority groups as identified by the plan. At a time of level funding and increasing demand for services, the STD/AIDS Prevention Branch of the Department of Health (DOH) has made every effort to reduce costs without negatively impacting upon the delivery of services as well as conforming to the recommendations of the Hawai i HIV Prevention Community Planning Group.

I. PERSONNEL $502,500

Request includes 16 previously funded positions.

A. Disease Intervention Specialists (DIS) 265,200

8.5 Positions: (Employee 1), (Employee 2), (Employee 3), (Employee 4), (Employee 5), (Employee 6), (Employee 7), (Employee 8), and (Employee 9).

These positions are under the STD/AIDS Prevention Branch of the Department of Health (DOH). Although they are housed in different health centers, they all have the same functions -- HIV antibody counseling and testing. The staff in these positions will be performing full-time HIV antibody counseling and testing (C&T) activities including: Phlebotomy; pretest counseling; post-test counseling; encouraging partner notification and referral of seropositive patients, including guidance of appropriate methods of referrals, and notifying sex and needle-sharing partners of seropositive patients, including counseling and testing as appropriate. These positions will also be involved in outreach counseling and testing with OraSure by accompanying CHOW outreach workers on all islands. They also will collaborate with other agencies to provide counseling and testing to at-risk populations. These positions will allow the program to accomplish the objectives in Counseling, Testing, Referral, and Partner Notification (CTRPN).

Five positions will be working in the HIV Antibody Clinic at the Diamond Head Health center on O'ahu during various days. They also provide HIV antibody counseling, testing, referral and partner notification services in support of the STD Clinic. The HIV Antibody Clinic at the Diamond Head

SAMPLE

Health Center currently performs 600 HIV antibody tests per month. These five positions will also provide outreach counseling and testing services in other sites which include drug treatment facilities, TB Clinic, family planning clinics, colleges, prisons, medical clinics, and the CHOW mobile van. These counseling and testing sites are scheduled during various days and hours.

Four positions are assigned to the neighbor islands -- one for Maui County; two for the island of Hawai‘i, which is the largest island geographically and has one position assigned to each of the two main population centers on the opposite sides of the island -- Hilo and Kona; and one half-time position for the island of Kaua’i.

B. Clerk Stenographer 22,100

(Employee 10)

This position is under the DOH and will be housed on O’ahu. This position will be responsible for all the clerical, stenographic and statistical functions of the HIV Antibody Counseling and Testing Program, including: preparing HIV antibody clinic records and forms, posting of laboratory results onto medical records; filing of HIV antibody medical records, tabulating all epidemiologic data through an electronic data system; providing stenographic support to the DIS; and preparing all purchase orders for office and laboratory supplies of the HIV Antibody Counseling and Testing Program.

C. Public Health Educator IV 138,700

4 Positions: (Employee 11), (Employee 12), (Employee 13), and vacant to be hired.

These four public health educators are located on O’ahu. Each of these educators will undertake a diversity of statewide, community-based activities to implement the impact objectives stated in the grant. These educators will coordinate and collaborate with government and community leaders throughout the state to establish networks which facilitate HIV/STD education among populations at risk for HIV. These educators will continue to provide some direct service HIV/STD education to populations at high risk for HIV, including men who have sex with men, injection drug users, women, transgender, youth at risk for HIV, cultural and ethnic minority populations, incarcerated populations, and other underserved populations at risk for HIV. However, the priority for these health educators will be community coordination and providing technical assistance to HIV/STD-related agencies statewide.

SAMPLE

II. FRINGE BENEFITS
27.17% x $502,500 $136,529

TOTAL PERSONNEL COSTS $639,029

III. TRAVEL $ 44,880

A. In-state Travel 33,150

1. Interisland Travel 23,650

a. Counseling and Testing 2,530

This amount is necessary for the four neighbor island disease intervention specialists to travel to O'ahu for the annual staff meeting and training. The costs of the meetings include $300 ($74 per person x 4 people) air fare; per diem costs of $160 ($40 per day x 4 people); car rental costs of $40; and airport parking fees of $40 ($10 per day x 4 people).

Interisland travel is also necessary for the CTRPN trainer to travel to each island to provide HIV Prevention Counseling training to staff at community agencies and at AIDS service organizations. Costs for this activity include $150 ($74 per person X 2 trips) airfare; per diem costs of $720 ($80 per day X 9 days); car rental costs of $360 ($40 per day X 9 days); and airport parking fees of $100 ($10 per day X 10 days).

b. Community Planning 13,170

This amount is necessary for the neighbor island community planning group representatives to travel to O'ahu to attend Community Planning Group (PCPG) and PCPG committee meetings. The costs of the meetings include $6,660 ($74 per person X 9 people X 10 meetings) air fare. Funding is also necessary for the seven committees to meet on O'ahu for a total of 45 meetings.

c. Health Education/Risk Reduction and Public Information 2,600

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Travel costs are also necessary for the 4 public health educators on O'ahu for use of their personal car for travel to various AIDS prevention activities. The estimated cost is $2,400 ($50 per month X 4 people X 12 months). The clerk stenographer also is assigned duties which involves the use of her personal car for such travel to various AIDS meetings to take minutes and travel to the various vendors to pick up educational supplies. The estimated cost is $200 ($17 per month X 12 months).

IV. SUPPLIES **$101,893**

A. ELISA Kits (serum) 50,400
$3.00 per test X 16,800

This amount is necessary to purchase the HIV antibody testing kits for the Laboratories Branch of the Department of Health. An estimated 14,000 tests will be performed by the laboratory for HIV antibody testing during this budget period. Assuming an average of 20% of the tests will be performed for repeat testing of positives/indeterminates and for quality control testing as required by the manufacturer as well as for CLIA, a total of 16,800 tests will be performed. This total includes all tests performed through the counseling, testing and partner notification program. Thus, the estimated cost for this budget period is $50,400. (16,800 tests X $3.00/test)

B. Reagents and Laboratory Supplies 5,500
($25 per test X 220 tests)

This amount is necessary to purchase laboratory supplies to perform the Western Blot test. During the budget period, we plan to perform a total of 14,000 tests. Assuming a 1.6% positivity rate/indeterminate rate, we may anticipate performing 220 Western Blot tests.

C. Laboratory Supplies 1,000

This amount is necessary to purchase the miscellaneous laboratory supplies to perform the ELISA and Western Blot tests. Costs include dilution tubes, storage vials, gloves, certified mailing packages and disinfectants.

D. Other Counseling and Testing Supplies 17,600

SAMPLE

1. Laboratory Forms 8,300

11,000 forms X $.75 per form

2. Paper Supplies and Printing Costs 1,000

This amount is needed for AIDS Informed Consent Forms and educational supplies.

3. Phlebotomy Supplies 8,300

This amount is necessary to purchase vacutainers, needles, needle holders, bandaids, cotton, alcohol, gloves and sharps collectors necessary for performing phlebotomy on 11,000 patients at $0.75 per patient.

E. HIV Antibody Counseling and Testing Supplies (oral) 13,400

The HIV antibody counseling and testing program is planning to continue the outreach program to provide HIV counseling and testing services through oral collection devices to hard to reach men who have sex with men as well as IDUs. Assuming an average of 20% of the tests will be performed for repeat testing of positives/indeterminates and for quality control testing as required by the manufacturer as well as for CLIA, a total of 1,620 tests will be performed. The laboratory costs include:

HIV antibody test kits
1,620 tests X $4.00 per test = $6,480

OraSure oral specimen collection device
1,350 X $3.60 = $4,860

Reagents and other
laboratory supplies $2,060

F. Educational Supplies $7,200

Educational supplies such as pamphlets are an integral part of the AIDS health education program. Pamphlets and booklets from Channing L. Bete Company and other vendors. The pamphlets are distributed to Hawai‘i residents on all islands.

20,000 pamphlets @ $0.36 $7,200

SAMPLE