CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH
Population Health Division – Community Health Equity & Promotion (CHEP)
101 Grove Room 402
San Francisco, CA 94102

REQUEST FOR PROPOSALS
RFP No. 4-2019

An Equity-Focused, Community-Centered, Whole Person Care Approach to Integrated HIV, HCV, and STD Prevention Programs for Affected Communities

SCHEDULE OF EVENTS AND SUBMISSION DEADLINES

ACTIVITY	TIMES	DATES
Solicitation Issued:	**NA**	**September 12, 2019**
E-Questions	**NA**	**September 16, 2019 thru September 19, 2019**
Bidders' Conference	**9:00 a.m. to 12:00 noon**	**September 26, 2019**
Letter of Intent (LOI) Due *(Mandatory. Please use template provided in Appendix A-1.)*	**By 12:00 Noon**	**October 9, 2019**
Qualifications Statements and Proposals Due	**By 12:00 Noon**	**November 25, 2019**
		ESTIMATED DATES
Technical Review	**NA**	December 2019
Oral Presentation & Review	**NA**	December 2019
Start Date of Service	**NA**	July 1, 2020

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RFP APPENDICIES: A-1, A-2, AND A-3

A-1 REQUIRED FORMS, New Contracting Information

1) Letter of Intent Form
   - Service Category 1.1 thru 1.7
2) Qualifications Statement Form
   - Service Category 2.1 thru 2.7
   - 2A Sub-Contract MOU form
3) CMD Form 3 – Non-Discrimination Affidavit Form
4) DPH General Budget Forms
5) MCO HCAO Declaration Forms
6) Non Profit MCO Hourly Rate Information
7) Insurance Requirements 7.01.2019 (information)
8) Website addresses for hyperlinks in RFP

A-2 STANDARD SUPPLIER/VENDOR FORMS:

- **This Application Process is only accepting proposals from Approved City Suppliers/Vendors.**
- **If you are a current City Supplier/Vendor you are not required to complete these forms.**
- **If you are a potential NEW SUPPLIER/VENDOR with the City and County, the following is required to be completed via the OCA Web Site:**
- **Please paste to your browser:** https://sfgov.org/oca/qualify-do-business to learn how to "Qualify to Do Business" with the City and County of San Francisco.

1) Vendor Profile Application/Package

2) CMD Attachment 2: CMD/HRC Requirements for Architecture, Engineering, and Professional Services Contracts

A-3 FOR INFORMATION ONLY

1) Standard Legal Agreement Boilerplate Draft Copy (P-600)
2) Insurance Requirements 7.01.2019
3) LBE Certification Instructions
4) LBE Applications
   - LBE Application – Small/Micro/Local Business
   - LBE Application – Non-Profit Entity
5) SFDPH Procedures regarding Subcontracting

Standard BAA documents Below:

6a) Business Associate Agreement
6b) BAA All Attachments

Travel Ban Information:

7) Contract Travel Ban Memo/Ban on City Contracts and Travel Involving States with Anti-LGBT Laws **(Amended 9.19.2019)**

MCO Non Profit Minimum Wage Poster:

8) July 1, 2019 Non Profit Minimum Wage Rate

I. Introduction

The San Francisco Department of Public Health (SFDPH), Community Health Equity and Promotion Branch (CHEP), is soliciting proposals for **An Equity-Focused, Community-Centered, Whole Person Care Approach to Integrated HIV, HCV, and STD Prevention Programs for Affected Communities.** Each proposal must meet the necessary qualifications and service requirements set forth in this solicitation. Whether a proposal meets these qualifications and service requirements will be determined through the Review and Selection Process described in Section IV. No Proposer shall have any legal or equitable right or obligation to enter into a contract or to perform the work as a result of qualifying for selection.

A. Solicitation Overview

The SFDPH Community Health Equity and Promotion Branch (CHEP) is soliciting proposals to provide **Integrated HIV, HCV, and STD Prevention Programs for Affected Communities in seven (7) separate service categories**, further detailed in Section II "Program Services Specifications".

Please note:

- The Department intends to support seven (7) agreements as result of this solicitation process.
- Successful applicants are limited to negotiating and developing one (1) contract agreement as a result of participating in this RFP process.
- Applicants may submit a proposal to more than one service category.
- Applicants must submit a separate proposals package for each specific service category if applying for more than one service category.
- Applicants who submit multiple proposals will only be eligible to negotiate and secure one contract agreement, limited to one (1) service category.

To participate in this solicitation process, Proposers are required to submit:

- A Letter of Intent (LOI):
  - You must submit a LOI for each separate Service Category that you intend to submit a proposal.
- A Qualifications Statement and Sub-Contractor MOU Form:
  - You must attach a signed Qualification Statement form to each proposal package per Service Category
  - You must attach a signed Sub-Contractor MOU form for each identified sub-contractor
- A complete Proposal Package with all requested documentation by the stated deadlines and according to Submission Requirements in Section III of this solicitation.
- Verification of being a current approved City Supplier/Vendor
- Verification of compliance with the HIPAA Business Associate Addendum
- CMD Form 3
- MCO and HCAO Declaration (copy)

In the event that only one Letter of Intent (LOI) or if one Proposal is submitted for this solicitation or for a specific category within this solicitation, the Department will determine the viability of entering into negotiations with that vendor/supplier. If more than one LOI or if more than one Proposal is received, the process will progress through the submittal steps outlined in this solicitation. Vendors/Suppliors who submit an LOI and then decide to not submit a proposal afterward, should contact the Contracts Unit and communicate their intent to not participate in the RFP.

Prior to submitting your Letter of Intent, please review the Service Category Minimum Qualifications outlined in Section II to determine if your agency is qualified.

Incomplete or non-compliant Proposals will be rejected during Initial Screening. A Technical Review Panel, as described in Section V, Review and Selection Process, will evaluate proposals progressing to the Review and Selection Process.

Opportunities for bidders to ask pre-bid questions will be afforded through a Bidders' Conference or E-questions as specified in Section VI.

Section VI covers Standard Terms and Conditions for Receipt of Proposals, as established by the City and County of San Francisco.
Appeals Procedures for breach of solicitation procedures are covered in Section VIII.

Required forms, standard forms, and informational documents are provided in Appendices A-1, A-2, and A-3.
Potential Contractors must have a **registered/valid City and County of San Francisco Supplier ID number** (previously known as the Vendor ID#), and provide your current **Supplier ID number.**

If you **are not registered** as an approved City Supplier, you must begin the process at the time of proposal submission.

- Please go to: **https://sfcitypartner.sfgov.org/** to learn how to "Qualify to Do Business" with the City and County of San Francisco.
- Potential contractors who have questions regarding navigating the "Supplier" portal may send emails to **sfcitypartnersupport@sfgov.org** for help or questions regarding the PeopleSoft system.

The complete solicitation package is available for download at:
http://www.sfdph.org/dph/comupg/aboutdph/insideDept/Contracts

Click on **RFP# 4-2019** and follow the instructions.

For questions about solicitation procedures or documents, please contact:

Irene Carmona
SFDPH – Contracts Unit
(415) 554-2778
irene.carmona@sfdph.org

B. Contract Term

The City reserves the option to award initial contract(s) for **original term(s) from one (1) to five (5) years**, and the right to exercise options to extend the original term of the contract(s) for any period(s) not to exceed a **total maximum of ten (10) years** of services from the original contract agreement.

Contract terms allowable are mandated under the "Administrative Code Section 21.9 Multiple Year Contracts; Options to Extend or Renew."

The City reserves the right to procure services similar or identical to the services specified in this RFP by any other means. No respondent is guaranteed a contract.

The Department reserves the right to issue multiple contracts to multiple vendors that are qualified and that submitted a proposal. Throughout the course of the contract, the Department will monitor the performance of the contractor(s) in accordance with Departmental monitoring procedures and reserves the right to alternate primary providers for non-performance.

The Department reserves the right to solicit services under a new RFP in the event that submitted proposals are not responsive to the service categories outlined in this RFP.

A contract or contract funding notice is not a guarantee of funding for a program or the continuation of services. Annual funding for contracts may vary or change according to the availability of funds. The Department reserves the right to re-open the solicitation to request additional proposals or to resolicit services.

C. Funding

1. Funding Amounts

The **estimated** annual amount of funds available through this RFP is up to **$8,000,000**, distributed across the service categories as follows:

Summary of Service Categories and Funding Amounts		
#	**Service Category**	**Estimated Amount Available**
1	Health Access Point (HAP) for Latinx	$1,600,000 to $2,000,000
2	Health Access Point (HAP) for Trans women	$650,000 to $800,000
3	Health Access Point (HAP) for People who use drugs, including injecting drugs (PWUD/ID)	$760,000 to $930,000
4	Health Access Point (HAP) for Males who have sex with males (MSM), with a focus on Gay males (Gay/MSM)	$1,000,000 to $1,200,000
5	Health Access Point (HAP) for Asians and Pacific Islanders (API)	$540,000 to $660,000
6	Health Access Point (HAP) for Young Adults (18-24)	$350,000 to $500,000
7	Training and Capacity Building for a Health Access Point (HAP) for Black/African Americans	$1,900,000 to $2,400,000

The estimated annual amount of funding available to support the services described in this RFP is subject to increase or decrease depending on changes in available Federal, State and local, funding resources; changes in HIV, HCV, and STD prevention priorities as recommended by the HIV Community Planning Council (HCPC), or as determined by CHEP; or other circumstances.

All General Fund funding is based on the City & County of San Francisco "Annual General Fund Budget Approval Process."

All GRANT funding including "Special Revenue" is determined by the grantor. Annual funding may increase or decrease depending on availability of funds. Grant funding is based on the conditions of the grant award. ("Special Revenue" may be a result of funding from the Federal Government or the State of California)
There are no guarantees of annual funding.

Should additional funds become available after the release of this RFP or after awards from this RFP have been made, SFDPH reserves the right to allocate these additional funds as it deems appropriate according to program planning and service needs, including but not limited to: adjusting the number and/or size of awards; supplementing awards from this RFP with additional funds during service periods; supporting SFDPH-delivered services; or issuing a new solicitation.

San Francisco Minimum Wage Rates:

- **Beginning July 1, 2019, the Minimum Wage Rate is: $16.50 per hour for Nonprofit and Public Entities, and $17.66 for For-Profit suppliers.**
- **All contracts supporting hourly staff must comply with this hourly rate.**
- **See MCO requirements in Appendix A-1**

- **System for Award Management (SAM) Registration – Federal Funding Requirement:**

- Agencies/Vendors who receive funding from the Federal Government must register with the System for Award Management (SAM) and renew their membership annually.
- This requirement includes sub-recipients and subcontractors.
- Please complete the registration/renewal process and forward a printout indicating your membership is active.
- No grant funds will be encumbered until SAM membership is active.
- SAM registration can be done here: https://www.sam.gov/portal/SAM/##11

2. Funding Sources, Terms, and Restrictions

- Funds for this solicitation will come from one or more of the following: a) the federal Centers for Disease Control and Prevention (CDC) (fiscal year January 1 through December 31); b) the State of California Department of Public Health (fiscal year July 1 through June 30); c) the San Francisco General Fund (fiscal year July 1 through June 30); and d) the federal Substance Abuse and Mental Health Services Administration (SAMHSA) (fiscal year July 1 through June 30). SFDPH reserves the right to determine funding source and to package funds appropriately for specific services and contractors.
- Funds for this solicitation may be renewable annually (dependent on availability of funds, successful performance of contract obligations, compliance with data and reporting requirements and public health priorities, and changes in the epidemic affecting need for services) for a period of up to ten (10) years.
- SFDPH reserves the right to terminate or not to renew a contract funded through this request for proposals (RFP) at any time.
- If the submitted applications to this RFP are deemed not qualified, CHEP reserves the right not to issue awards in any given service category. CHEP may implement a separate process to obtain the services identified in this RFP.
- Funds must be used for programs and services located in San Francisco.
- Funds may not be used for the following:
    - HIV medications
    - Primary care
    - Sexually transmitted disease (STD) treatment (to be discussed during negotiations)
    - Hepatitis C treatment
    - Other medical testing (except HIV, HCV, and STD testing) or treatment
    - Research
    - Cash incentives

- Subcontractors - Allowable Direct Cost.
    - Subcontracted services are allowable as direct costs when necessary to support the final cost objective. As such, these direct costs may be used in the calculation of the prime contractor's indirect cost rate with some limitations. The prime contractor can charge indirect costs on the first $25,000 of each subcontract at the approved/allowed indirect cost rate. Additional subcontract expenses beyond $25,000 must be excluded from the indirect rate calculation.
    - Reference: OMB Uniform Guidance Part 200 Subpart A Section 200.68 Modified Total Direct Cost (MTDC)

D. Ban on City Contracts Involving States with Anti LGBT Laws

Per Administrative Code Section 12X prohibits City contracting with companies from states that have enacted laws after June 26, 2015, reversing anti-discrimination protections for LGBT individuals or that permit discrimination against LGBT individuals. Administrative Code Section 12X.5 (a) cites that the City shall not enter into any Contract with a Contractor that has its United States headquarters in a state on the Covered State List or where any or all of the work on the Contract will be performed in a state on the Covered State List.
In accordance with the Administrative Code Section 12X.5 (b), the Contracting Department may waive the requirements of Section 12X.5 in full or in part, if the department determines that strict application of the requirement would not be feasible, would create an undue hardship or practical difficulty, or that similar circumstances otherwise warrant granting of the waiver.

MEMO issued by the "City Administrator" regarding "Ban on City Contracts Involving States with Anti LGBT Laws" is located in attached **Appendix 3** of this solicitation.

E. Guidelines for Reading and Responding to this Specific RFP

Section II.C. "Services Solicited, Proposal Narrative Instructions" describes in detail the seven (7) service categories for which CHEP is seeking services. Since each description has been developed to contain all the information needed to apply to that category, it is not necessary to read the service categories the applicant does not intend to apply to.

The following resources are available to assist applicants:

- **2017 – 2021 San Francisco Integrated HIV Prevention and Care Plan**. This document provides a wide-ranging blueprint, including specific goals, objectives, and strategies, designed to help guide the future of HIV activities in our region. The plan can be found online here: HIV Community Planning Council Integrated Plan

- **HIV/HCV/STD Roadmap: Stakeholder Engagement Report**. This report summarizes the themes that emerged from an extensive planning process, comprised of SFDPH staff and community stakeholders, for the future of HIV, hepatitis C (HCV), and sexually transmitted disease (STD) programs and services. Stakeholder Engagement Report**.**

- **2017 HIV Epidemiology Annual Report.** This report presents annual San Francisco HIV surveillance data that is widely used to measure progress toward reducing HIV incidence and improving health outcomes for people living with HIV (PLWH), as well as identify successes and vulnerable populations who are experiencing barriers to HIV prevention, treatment, and care. The report can be found online here: 2017 HIV Epi Report.

- **2016 San Francisco Sexually Transmitted Disease Annual Summary**. This report presents annual San Francisco STD surveillance data for syphilis, gonorrhea, and chlamydia, as well as identifies successes and vulnerable populations that are disproportionately affected by these diseases. This RFP uses 2016 STD data. The 2017 San Francisco Sexually Transmitted Disease Annual Summary is now available. The reports can be found online here: 2016 STD Summary and 2017 STD Summary

- **End Hep C SF Strategic Plan, 2017-2019**. This plan details strategic priorities identified by the End Hep C SF Collective Impact Initiative that maximize progress toward HCV elimination in San Francisco. The plan can be found online here: End Hep C Plan.

- **Getting to Zero (GTZ) Strategic Plan**, 2015. This plan describes a comprehensive approach that continues funding for successful efforts and calls for three signature initiatives to begin—1) PrEP expansion; 2) RAPID ART (antiretroviral therapy); and 3) ART Retention—that focus on eliminating new HIV infections, preventing HIV-related disease complications, and reducing the health disparities for HIV infected and affected populations in San Francisco. The plan can be found online here: GTZ Plan.

- **Acronyms/Glossary of Terms:**. A glossary of terms and abbreviations used in this RFP appears in **Exhibit 1: 6.4.**

- To minimize the use of abbreviations and make this RFP easier to read, when the term "men who have sex with men (MSM)" is used, it is intended to be inclusive of men who have sex with women (MSM/F), trans men who have sex with men (TMSM), and MSM-injection drug users (MSM-IDU), unless otherwise indicated.

- To access the highlighted links place your curser over the highlighted type and follow the instructions to access links.

- If you **can not** access the highlighted links please refer to the Reference document in Appendix A-1

F. Additional Program Guidelines for Responding to this Specific RFP

1. Program Administrative and Reporting Requirements

The following are CHEP's administrative and reporting requirements. Additional city and SFDPH requirements will apply to all contractors. These will include but are not limited to requirements related to contracting procedures, contract monitoring, cultural competency, client satisfaction surveys, data security, and the Health Insurance Portability and Accountability Act (HIPAA).

Program Administrative and Reporting Requirements	
Requirement	**Description**
Participation in Special Projects and Studies	Programs will be invited to participate in special projects or studies. Whether participation is mandatory will depend on the project/study.
Training and Technical Assistance	Program staff and volunteers will be required to attend CHEP's trainings as relevant to their job functions. Programs will also be required to work with CHEP's technical assistance team (program liaisons) as needed.
Evaluation and Data Collection Activities	Programs must submit all data as required (see service category descriptions). In addition, periodically, programs will be required to work with CHEP to assess whether program goals and objectives are being met. CHEP may require agencies to periodically write up or present a short summary of data and evaluation findings, including program successes, challenges, and improvements made based on the findings.
Client Satisfaction Survey	CHEP may require programs to conduct a client satisfaction survey/activity in addition to the city requirement.
Program and Continuous Quality Improvement (CQI) Policies and Procedures	All programs must have policies and procedures in place for programs, including a CQI plan, that meet the minimum CHEP requirements.
Program Policies and Procedures	All programs must have policies and procedures in place describing their program protocols, curricula, and other important program-related information.
Client Date Security and Management	All programs must maintain a policy regarding client date security, which includes policy for storage, access, retention and destruction of data.

II. Program Service Specifications

A. Goals and Program Overview

1. Community Health Equity and Promotion Branch (CHEP) Goals

The Community Health Equity and Promotion Branch (CHEP) of the San Francisco Department of Public Health (SFDPH) is focused on ensuring health equity among all communities. This RFP focuses on reaching equity by focusing on the disparities that result in disproportionate levels of HIV, HCV, and STD for some populations. The CHEP mission is that **all people have fair and equal access to the highest quality of prevention, care, and treatment service opportunities in order to attain optimal health in regards to HIV, STD, and HCV status.**

To move toward health equity, CHEP has focused this RFP on populations where the greatest disparities lie, has included disparities as decision-making criteria for funding, and made some significant changes to its expectations of service providers. For example, STD and HCV testing must be available anywhere HIV testing is offered, all providers must demonstrate increased harm reduction services capacity including syringe access and disposal and overdose prevention, and agencies are expected to increase outreach to people experiencing homelessness and people who use drugs. CHEP is committed to the new training, expanded services, and stronger relationships that this new service model requires.

CHEP, Disease Prevention and Control (DPC), and Applied Research, Community Health Epidemiology & Surveillance (ARCHES), and the Population Health Division in SFDPH, in partnership with the HIV Community Planning Council (HCPC), are in alignment with and in support of the following goals:

- Zero new HIV infections, zero HIV-related deaths, and zero stigma and discrimination
- Eliminate hepatitis C (HCV)
- Reverse increasing STD rates
- Eliminate racial disparities in access to services and health outcomes

2. Services Solicited

CHEP is soliciting prevention services for people at risk for and/or living with HIV, HCV, and/or STD(s). CHEP seeks programs in the categories listed below that:

- Have the expertise and capacity to implement evidence-based, innovative, and culturally appropriate HIV/HCV/STD prevention programs to persons at greatest risk for HIV, STD, and HCV infection or transmission in San Francisco,
- Are willing to aggressively contribute to zero new HIV infections, zero HIV-related deaths, and zero stigma and discrimination; elimination of HCV; reduction of STD rates; and elimination of racial disparities in access to services and health outcomes; and
- Are committed to working in a spirit of partnership and collaboration with the SFDPH, the HCPC, End Hep C SF, Getting to Zero (GTZ), and other initiatives or programs with the shared purpose of meeting the needs of San Francisco's HIV, HCV, and STD-affected populations.

B. Minimum Qualifications

See **Section C: Services Solicited, Proposal Narrative Instructions, and Review Criteria** for the minimum qualifications required for each specific service category.

- Applicants must submit the Qualifications Statement, **located in Appendix A-1,** certifying that all minimum qualifications are met.
- Proposal packages must meet the specified service category minimum qualifications in order to be approved for RFP review process.
- Proposal packages that do not meet the specified minimum qualifications will be eliminated from the RFP review process.
- Should an applicant be issued an invitation to negotiate (ITN), documentation verifying compliance may be required during the negotiation process.

C. Services Solicited, Proposal Narrative Instructions

Background and Rationale

With scaled up testing starting in 2012, early and widespread treatment, a strong linkage to care program, syringe and condom access, and more recently PrEP, San Francisco (SF) cut new HIV diagnoses by more than half, from 459 in 2010 to 221 in 2017. Data from the National HIV Behavioral Surveillance Survey (NHBS) indicates that the proportion of undiagnosed HIV has plummeted to an estimated 7% among all people living with HIV (PLWH).[1]

The data clearly indicates that our current high impact prevention (HIP) strategies have been effective, and that we have been most successful in addressing HIV among men who have sex with men (MSM), the population most affected by HIV for the last 30 years. In terms of new diagnoses, white MSM have benefited the most from current HIP efforts. Even though most new infections continue to occur among white MSM, people of color make up a disproportionate and increasing higher percentage of new diagnoses. Now with only a few hundred new diagnoses each year, getting to zero new HIV infections for all populations, even those with low incidence, will require new and culturally specific strategies to reach them.

In addition to HIV, San Francisco is profoundly impacted by hepatitis C (HCV) and sexually transmitted diseases (STD). There are an estimated 12,000 people with viremic, untreated HCV in SF despite relatively widespread access to curative therapy. San Francisco has one of the highest rates of liver cancer in the U.S., driven by both hepatitis B and C.[2] There are almost 1,300 San Franciscans who are known to be co-infected with HIV and HCV (most of these are MSM, which is consistent with the epidemiology of HIV in San Francisco). Like many

[1] Raymond HF, Scheer S, Santos G-M, McFarland W. (2016) Examining progress toward the UNAIDS 90-90-90 framework among men who have sex with men, San Francisco, 2014. AIDS Care, DOI: 10.1.1080/09540121.2016.l 153593

[2] National Cancer Institute. State Cancer Profiles: Incidence Rate Report of Liver & Bile Duct Cancer, 2009-2013, for United States by County.

communicable diseases, HCV disproportionately impacts marginalized populations, specifically people who inject drugs, people who are homeless or marginally housed, people of color (most notably Black/African Americans), and people living with HIV.[3]

STDs continue to increase as new HIV diagnoses decline. San Francisco has experienced increases in chlamydia, gonorrhea, and syphilis since 2007. The highest rates of chlamydia, gonorrhea, and syphilis are among gay and other men who have sex with men (Gay/MSM), adolescents and young adults (primarily Black/African Americans), and transgender people. [4]

According to the Centers for Disease Control and Prevention (CDC), health disparities in HIV are inextricably linked to a complex blend of social determinants that influence populations most severely affected by HIV. Health equity is a desirable goal that entails special efforts to improve the health of those who experience social or economic disadvantages. Social determinants of health affect disparities in HIV, viral hepatitis, STD, and tuberculosis (TB). Environmental factors such as housing conditions, social networks, and social support are also key drivers for acquisition and transmission of HIV, viral hepatitis, STDs, and TB. CDC supports efforts to improve the health of populations disproportionately affected by HIV by maximizing the health impact of public health services, reducing disease prevalence, and promoting health equity.

In order to stay in alignment with CDC and achieve San Francisco's citywide goals of getting to zero new HIV diagnoses, eliminating HCV, and reversing the rising trend of STDs, San Francisco will increase focus on prevention needs in communities of color and the related HIV, HCV, and STD disparities they experience, as well as maintain focus on high prevalence populations (MSM, PWID, and trans women).

SF Roadmap: Stakeholder Perspectives

In Fall 2017, SFDPH launched a planning process for the future of HIV, HCV, and STD programs and services. This "HIV/HCV/STD Roadmap" effort was inspired by a number of driving forces, including continued disparities, changing needs among affected populations, level or decreasing funding, and the continued existence of disease "silos." To inform the Roadmap, SFDPH sought input from SFDPH staff and community stakeholders.

Stakeholders acknowledged that the landscape of HIV, HCV, and STDs has changed over the last 5-8 years. Epidemiologic profiles have shifted. The impacts of social determinants of health, such as lack of housing, are more pervasive and significant. Some disparities have declined, but others persist. Policy, systems, and environmental factors are different—the Affordable Care Act (ACA) exists (despite its uncertain future), resident tolerance for visible homelessness and drug use is unusually low given SF's history as a progressive and compassionate city. All of these factors strongly suggest the need for an increased focus on person-centered integrated services and increased innovation to keep up with changing times. In essence, participants in this process expressed that SF has a rich network of services and efforts that form a strong foundation that must be maintained. At the same time, shifts are needed to realize the goals of getting to zero, ending HCV, and turning the curve on STDs.

[3] Facente SN, Grebe E, Burk K. Estimated Hepatitis C Prevalence and Key Population Sizes in San Francisco: A Foundation for Elimination. *PLOS ONE*. April 11, 2018 https://doi.org/10.1371/journal.pone.0195575

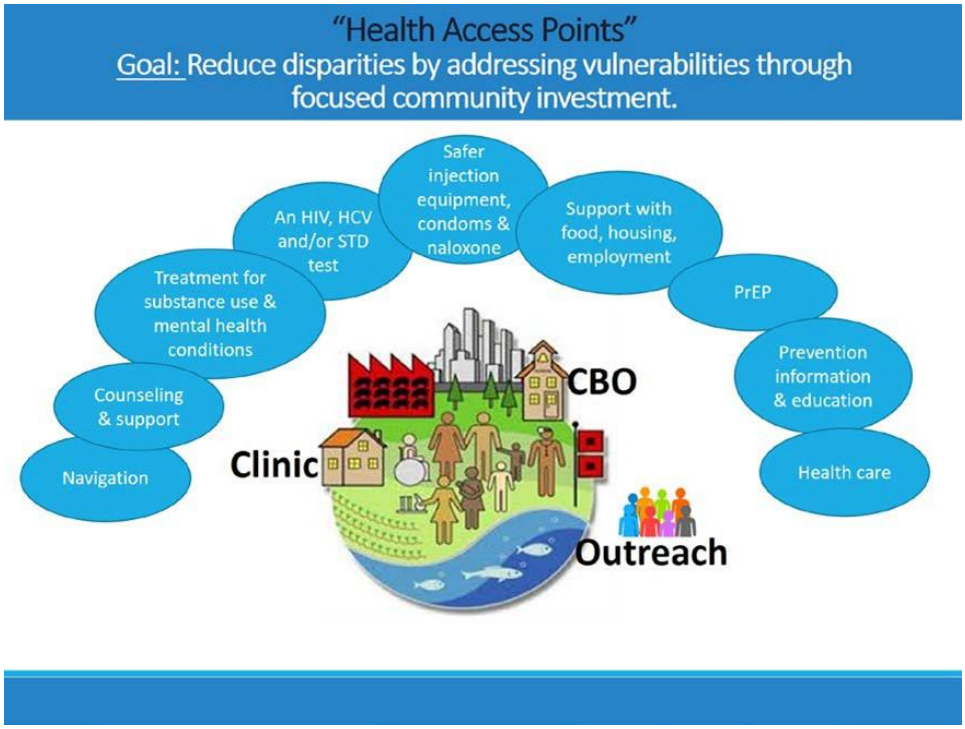
[4] San Francisco Sexually Transmitted Disease Annual Summary 2016. Available at https://www.sfdph.org/dph/files/reports/StudiesData/STD/SFSTDAnnlSum2016.pdf

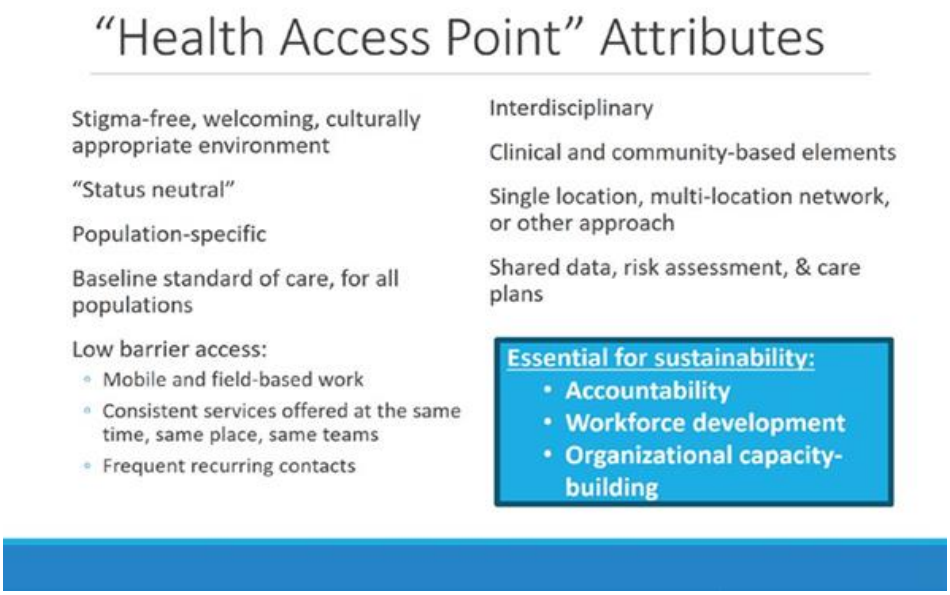
As a result of the many meetings and dialogues with stakeholders, four high-level core principles for integrated HIV/HCV/STD prevention, care, and treatment emerged:

Core Principle 1: Community- and Person-Centered Approach
Core Principle 2: Integrated Services
Core Principle 3: Partnerships for Impact and Accountability
Core Principle 4: Sustainability Strategies

Please see the HIV/HCV/STD Roadmap: Findings from Stakeholder Engagement report for details regarding the implementation strategies for each of the core principles noted above.

The data from the report was used to guide SFDPH's approach to addressing HIV, HCV, and STDs in the coming years and develop a program framework called a "Health Access Point" (HAP) in response to stakeholder recommendations. A HAP is defined as a population specific, one-stop shop or network of agencies/programs with a lead agency that provides an equity-focused, stigma-free, and low barrier access to person-centered, standard of care services regardless of HIV, HCV, or STD status. Although HAPs are population-specific due to the expertise that it entails to engage and deliver services to a specific population, they can provide services to people of all races, ethnicities, and sexualities. Health Access Points (HAP) also allow people who identify with multiple populations to receive services where they feel most comfortable.




"Health Access Point" Attributes
Stigma-free, welcoming, culturally appropriate environment
"Status neutral"
Population-specific
Baseline standard of care, for all populations
Low barrier access:
Mobile and field-based work
Consistent services offered at the same time, same place, same teams
Frequent recurring contacts
Interdisciplinary
Clinical and community-based elements
Single location, multi-location network, or other approach
Shared data, risk assessment, & care plans
Essential for sustainability:
Accountability
Workforce development
Organizational capacity-building

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Category 1: Health Access Point for Latinx

Estimated Amount Available: From $1,600,000 to $2,000,000
Number of Awards: 1

1. Background

Latinx communities make up 15% of the SF population, 19% of people living with HIV in SF as of December 2017, and 25% of new HIV diagnoses. Of the HCV cases newly reported to SFDPH in 2016 with race/ethnicity information, Latinx accounted for 13.3% of the cases. Chlamydia and gonorrhea rates have been increasing since 2013 among all racial/ethnic groups, including Latinx; syphilis rates increased among Latinx from 2012 to 2015 and declined in 2016, although they remain higher than rates for white residents. Across all diseases, the Latinx subpopulation most affected in terms of absolute number of cases is Latinx MSM. However, more than one fifth (22%) of females living with HIV are Latina. Chlamydia rates in particular are disproportionately high among young Latinas.

Strong clinical and community-based efforts have helped to decrease HIV rates among Latinx MSM. This RFP seeks to build on these successes by taking a community-centered, whole person approach to HIV, HCV, and STD prevention, implemented by and for Latinx populations.

2. Minimum Qualifications

- By Jan 1, 2020 applicant must be a nonprofit agency that is tax-exempt under Section 501(c)(3) of the Internal Revenue Code and be licensed to do business with the City and County of San Francisco. City and County of San Francisco government departments/sections may NOT apply.
- Applicant must have at least three (3) years of experience providing HIV, HCV, and/or STD testing, or similar services to Latinx populations. (If a collaboration, only the agency providing the HIV, HCV, and STD testing must meet this qualification.)

3. Service Description

CHEP seeks to fund a Health Access Point (HAP) to meet the needs of Latinx communities. A HAP is defined as a population specific, one-stop shop or network of agencies/programs with a lead agency that provides an equity-focused, stigma-free, and low barrier access to person-centered, standard of care services regardless of HIV, HCV, or STD status. The HAP should deliver services that contribute to the following citywide goals:

- Get to zero new HIV infections, zero HIV-related deaths, and zero stigma and discrimination
- Eliminate HCV
- Reverse increasing STD rates
- Eliminate racial disparities in access to services and health outcomes

Services provided within this HAP must be harm reduction-based, sex-positive, and trauma-informed. Staff at all levels must demonstrate cultural humility in working with Latinx populations. Peer-delivered services must be an integral part of the network. Services must honor the cultural diversity within the Latinx community, and respect and work within Latinx cultural contexts, social systems, institutions, and norms. Services must be provided in (but not limited to) the Mission District. Services, printed materials, and other media/communications must be offered in Spanish and English. Latinx must be included in the design, implementation, and evaluation of services. It is especially important that services address the realities regarding fears about accessing services due to federal immigration policies and practices. Health education is also especially important for immigrant Latinx, who may not have had access to health information in their home countries.

The HAP should ensure that services reach the Latinx population, using both **targeted** efforts (focused on identified primary subpopulations) as well as **broad-based community-wide engagement and mobilization, regardless of HIV, HCV, and STD risk**, to increase awareness, reduce stigma, and reduce barriers to accessing services at the community-level.

4. Population

Programs must be designed to meet the needs of and focus on serving Latinx; however, the program must welcome and serve all who are eligible.

5. Restrictions

- Proposed services must be designed and focus on serving only Latinx and identified primary subpopulations. Services for other populations cannot be part of the proposal, although others may access services.
- Funds for HIV/HCV/STD testing must be used for community-based HIV/HCV/STD testing, not testing in clinical or medical settings.

6. Program Requirements

Required Services

The Latinx HAP shall provide the following "standard of care" services. The services marked with an asterisk (*) must be provided by the lead applicant or one of its subcontractors, with funding from either this RFP or other in-kind resources. The other services can be provided either by the lead applicant or one of its subcontractors, or by other Latinx HAP partners (e.g., via linkage to a HAP collaborating agency, via the collaborating agency providing services on site at the applicant's service location, or other approach). For services provided by other Latinx HAP partners who are not subcontractors, MOUs and warm hand-off protocols must be in place as appropriate. Each of the following services are described in detail in **Exhibit 1: 6.1**, including required and preferred elements and performance measures for each service.

- Integrated HIV, HCV, and STD testing*
- Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, case management/intensive case management (ICM) and other services*

- Harm reduction services for substance use (including for opioids, stimulants, alcohol, tobacco, cannabis)*
- Syringe access and disposal*
- Overdose prevention (including naloxone distribution)*
- Condom distribution*
- Community engagement and mobilization (physical and online, social media)*
- HIV, HCV, STD health education and prevention counseling, delivered in the context of overall sexual and drug user health (integrated into all of the above services, not stand alone)*
- Services to meet basic needs services (examples: food, housing, and employment)*
- Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage
- Mental health services
- Primary care
- Substance use treatment

Required Strategies

- **Maintain a workforce that mirrors the populations served.** Applicants and subcontractors should have Latinx staff represented at all levels of the organization. Client-facing positions (e.g., front desk staff, outreach workers, service delivery staff) should demographically reflect the population served.
- **Ensure that some services are delivered by peers.** "Peers" are defined as people with lived experience similar to that of the populations served, and may or may not share demographic characteristics such as race or gender. For example, an agency could create a community advisory board (CAB) and/or hire and train staff to conduct services, such as outreach, client satisfaction surveys, and assemble hygiene kits.
- **Involve the Latinx community in program development.** Include community voices and qualitative lived experience in all aspects of planning, program design and implementation, and service delivery using a systematic and continuous process. Build on community strengths and ensure that cultural and historical barriers (e.g., mistrust of service providers, language barriers) are removed.
- **Take a sex-positive sexual health approach.** Integrate HIV and STD messaging using a sexual health framework. Develop integrated HIV and STD prevention messages that address condoms, PrEP, and why STDs are an important concern. Incorporate integrated sexual health messaging throughout all HIV and STD prevention efforts—for example, PrEP navigation programs, HIV community forums, and social marketing.
- **Provide services using a harm reduction-based, trauma-informed, and cultural humility approach.** See required staff training in **Exhibit 1: 6.3**.
- **All services must be as low barrier as possible.** "Low barrier" means that as few expectations as possible are placed upon clients and potential clients when they are trying to access services. Examples of low barrier services include mobile services; co-located services (e.g., HCV treatment co-located with methadone services); drop-in services; express services (e.g., testing without talking to a counselor); and services provided at times convenient for the populations such as evenings, weekends, or late at night.
- **Address stigma for clients.** Provide a non-stigmatizing environment.
- **Address community-level stigma.** Increase the social media presence that promotes integrated sexual health messages and provided information on how to access services. Disseminate DPH-approved messaging, including PrEP and U=U messaging. Increase education and innovation around how to

address HIV-related stigma. De-stigmatize substance use through harm reduction education and messaging.

- **Leverage the private healthcare system whenever possible.** People with private insurance should be encouraged and counseled to use their insurance and develop meaningful relationships with primary care providers, when possible.
- **Ensure services are culturally specific**. Develop testing models that incorporate nuances to address different cultural barriers and specific population needs.
- **Build partnerships and collaborations with other organizations. This RFP requires collaboration to ensure populations have access to required services.**

Optional Strategies

- **Offer incentives.** Programs may propose to use non-cash incentives when they are critical for engaging the population of focus, to recruit people for testing, PrEP, treatment, or other service when warranted (e.g., food vouchers, gift cards, cell phones, cell phone credits, etc.).

Compliance

- Comply with CHEP Policies and Operations Manual for HIV/HCV Testing Services in Community-Based Settings, which are subject to modification at any time. The current policies and procedures can be found HERE
- Comply with SFDPH's Harm Reduction Policy found HERE
- Comply with SFDPH's Syringe Access and Disposal Program Policies and Guidelines found (being updated)
- Comply with the CHEP's Materials Review Process Guidelines found HERE

7. Healthy Staff, Agencies, and Collaborations

Healthy Staff

- **Staff training.** SFDPH and its partners are committed to building and maintaining a highly skilled workforce, prepared to deal with the complexity of client and community needs. To that end, agency staff funded through this RFP will be required to participate in the following trainings: racial humility, trauma informed systems (TIS), and harm reduction training of all staff. The staff that must participate in these trainings will be addressed during contract negotiations.
- **Staff pay.** According to Housing and Urban Development (HUD), in SF in 2018, a single adult is considered to be low income if they make less than $82,200 per year; for a 4-person family the cut-off is $117,300. (Source: https://www.huduser.gov/portal/datasets/il/il2018/2018summary.odn) SFDPH encourages agencies to provide livable wages to staff.

Healthy Agencies

- **Staff retention.** Agencies must have a plan in place to support client-facing staff to prevent burnout and address the vicarious trauma that can occur while working with traumatized populations. Examples of an effective plan include (but are not limited to): staff support group facilitated by a clinician such as an LMFT or LSCW who is also available for individual support as needed. Agencies must allow staff to participate in the San Francisco HIV Frontline Organizing Group (SF HIV FOG), Navigators meetings, and other professional development activities.

Healthy Collaborations

Collaboration with other community-based organizations (CBOs), clinics, and other organizations is required in order to ensure populations have access to required services. Even though two (2) or more agencies are involved, these collaborations should result in one (1) cohesive program for the clients they serve.

8. Additional Considerations

- CHEP will provide:
  - HIV/HCV/STD Skills Certification Training
  - Harm Reduction Training
  - Overdose Prevention Training (via its contract with Harm Reduction Coalition's DOPE Project)
  - Training on STD specimen collection
  - Test kits
  - Condoms, lube, and female condoms
  - Training on Clear Impact Results Scorecard
  - Racial Humility resources
  - Trauma Informed Systems (TIS) training
  - Training on syringe access and disposal

- HAP lead applicant should budget for:
  - Clear Impact Results Scorecard logins (2 per agency at $1200/annually total)
  - Phlebotomy Training and Certification
  - Condoms and safer sex supplies (if not going through the condom distribution program)
  - Syringe access and disposal supplies (including syringes)

9. Program Evaluation and Accountability

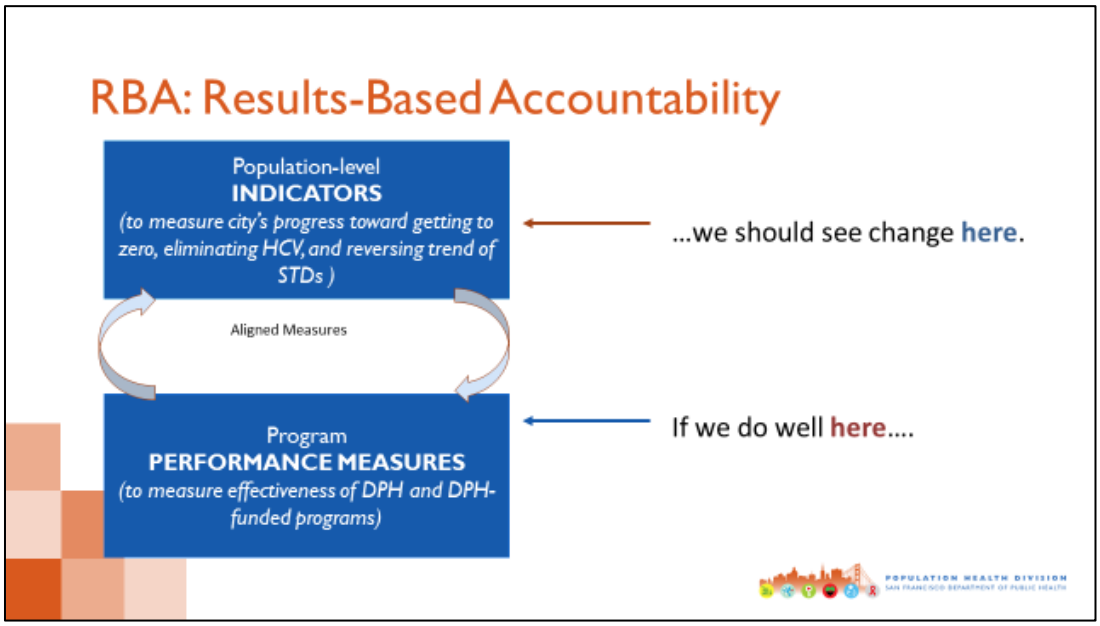
SFDPH seeks to implement program evaluation that allows for flexibility, supports accountability, and encourages innovation. Evaluation findings will be used to improve services, and to hold providers accountable for improving community health. Program innovations are encouraged when accompanied by evaluation plans that can rapidly determine whether the innovations should be adopted, adapted, or abandoned.

Funded programs will be required to use the Results-Based Accountability (RBA) Framework and the Clear Impact Results Scorecard (https://clearimpact.com/scorecard/). RBA is a framework used to improve and track the effectiveness of programs. It is data driven and has two distinct parts: population accountability and performance accountability.

A. Performance Measures

A "program performance measure" is a measure used to track the results of the applicant's specific program. Performance measures and other data collection requirements for each "standard of care" service are provided in **Exhibit 1: 6.1**.

A "population indicator" is a measure used to track the health outcomes of a particular population group. No single program can be held accountable for changing HIV, HCV, or STD rates among Latinx. However, by collaborating with HAP partner agencies and other relevant entities, SFDPH expects to see reductions in HIV, HCV, and STD rates among Latinx over the next 3-5 years. SFDPH will convene regular HAP partner meetings to review relevant population indicators and facilitate discussion and action planning for achieving the desired outcomes.



B. Data Collection and Reporting

Funded programs must comply with all CHEP requirements regarding data collection and submission, which will include working with CHEP to measure and report on program-specific objectives and collecting/reporting basic demographic, behavioral risk, and other essential information. Systems/processes used to collect and submit data will include:

- Evaluation Web
- Clear Impact Results Scorecard
- Annual narrative report
- Other systems/processes as requested

10. Narrative Instructions

Below are the instructions for the narrative portion of the proposal package. Instructions for development and submission of the complete proposal package can be found in **Section III: Submission Requirements**.

- Complete all sections of the narrative as outlined below. Applicants must complete the sections and questions **in the order listed**. (Applicants do not have to address the bullet points within each question in the order listed, just the questions.) Label the beginning of each section as indicated and include each question number, but do not repeat the question text.

- The narrative may not exceed **38 pages** (1.5 spacing between lines). Page numbers for individual sections and questions are guidelines only.
- Describe all the components of the proposed program here, even if some components are funded by another source, and be clear about which portion you are asking CHEP to support. For example, mental health is a component of the proposed program and could be funded by another source.
- In narrative Sections 1-4, describe your program as it will be when it is fully operational. Start-up needs can be discussed in narrative Section 5.
- Be specific.

Section 1: Population of Focus (3 pages)

➢ **Describe:**
- The population of focus your program will serve including subpopulations, age, geography, language, socioeconomic status, and other characteristics.
- The HIV, HCV, and STD risk behaviors and social determinants of health affecting your population,
- Why you have chosen this specific population (including any identified primary subpopulations), and why your program meets their needs. Use epidemiologic, community assessment, and other data to support your argument.

Section 2: Program Design and Effectiveness (29 pages)

Note: In this section of the narrative, collaborative proposals should clearly describe the specific roles and responsibilities of the partners and who will implement which portions of the program.

➢ **Describe your program components.**

A. Program overview (2 pages).
Provide an overview of your program and explain how it represents an equity-focused, stigma-free, low barrier, and whole person health approach to HIV, HCV, and STD prevention for the identified population of focus.

B. Integrated HIV, HCV, and STD testing (6 pages).
Describe your agency's testing model, including:
- Your agency's experience providing HIV, HCV, and STD testing. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.
- The number of testing experiences (by primary subpopulations, if applicable) your program will provide (i.e. 2,000 testing experiences for trans women and 10,000 for Gay/MSM). Provide the rationale for those numbers. **CHEP's goal is to conduct 50,000 testing experiences annually citywide**. An experience is defined as getting at least one (1) of five (5) tests (HIV, HCV, gonorrhea, chlamydia, and/or syphilis) in a single visit (See Integrated HIV, HCV, and STD testing in **Exhibit 1: 6.1**. For example, a client can receive one (1) test, all five (5), or anything in between and it is considered an "experience".

- Recruitment, Retention:
  The strategies and interventions you will use to recruit people for HIV, HCV, and STD testing and encourage them to return for testing at least every 6 months, and the evidence or experience supporting the effectiveness of these activities.
  The HIV, HCV, and STD testing barriers for this population, including identified primary subpopulations. Describe how your program will address these barriers.
  Where and when your agency will provide HIV, HCV, and STD testing and why these sites and venues are appropriate.

- Testing Flow:
  The flow of services at the testing location(s). Describe how this will help your agency to provide the proposed number of experiences, provide the required and optional services you are proposing, and meet client needs.
  Describe any relevant technologies being used, e.g. if conducting rapid testing, how you will ensure that confirmatory blood draws are obtained, if using drop 'n' go/express model, please describe the process that will be utilized and how patient time will be minimized.
  Describe your plan for getting people to return for their results.
  How will your agency will ensure that clients who do not receive counseling as a part of a testing experience still receive HIV, HCV, and STD health information, risk reduction, support, and appropriate prevention messages?

- Data and Quality Assurance:
  Demonstrate how your agency will track these experiences, how your agency will integrate client-level data collection into the flow of services, without creating unnecessary burden for clients. Describe how you will conduct training and quality assurance to meet the requirements of the CHEP Policies and Operations Manual for HIV and HCV Testing Services in Community-Based Settings (found HERE).

C. Linkage and Navigation (3 pages).
Describe your criteria and processes for linkage within and outside of your program, including a description of any collaborations or referral agreements with other agencies (attach MOUs to your proposal). Specifically, describe how linkage and/or navigation will occur related to:

- HIV-negative, HCV- and STD-unknown status clients to HIV/HCV/STD testing within the program.
- HIV-negative clients to PrEP within the program or to a PrEP navigator.
- Newly diagnosed HIV-positive clients to care within program or to LINCS.
- Clients that have a STD to treatment within the program or other provider.
- HCV-positive clients to HCV treatment within program or to a HCV navigator.
- Sexual and/or needle-sharing partners of HIV, HCV, and/or STD-positive clients, to HIV, HCV, and/or STD testing within the program (or elsewhere).
- Clients to other services/HAPs, if client needs cannot be met within the program.
- Out-of-care HIV-positive clients to LINCS.
- How your program will track linkages to ensure they are successful.

- Your agency's experience providing linkage and/or navigation services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

D. Prevention And Treatment Medication: PrEP and ART for HIV; HCV Treatment; STD Treatment, Including Medical Storage (2 pages)
Describe your criteria and processes for ensuring access to prevention and treatment medication within and outside of your program, including a description of any collaborations or referral agreements with other agencies (attach MOUs to your proposal). Specifically, describe how prevention and treatment medication will occur related to:

- HIV-negative clients receiving PrEP within the program or other provider.
- Newly diagnosed HIV-positive clients initiating ART within program or other provider.
- HCV-positive clients receiving treatment within program or other provider.
- Clients that have a STD receiving treatment within program or other provider.
- How your program will track prevention and treatment medication initiation and/or completion to ensure it was successful.
- Your agency's experience providing prevention and treatment medication. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

E. Community Engagement (2 pages).
Describe in detail:

- Your agency's experience conducting community engagement activities for population of focus. How long have you been conducting these activities? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

Describe in detail how your program will:

- Build trust within the community and have a consistent presence.
- Partner with other local CBOs, agencies and/or community leaders who have a strong relationship with the community.
- Include community voices and qualitative lived experience in all aspects of planning, program design/implementation, and service delivery. Build on community strengths and ensure that cultural and historical barriers (e.g. mistrust of service providers, language barriers) are removed.
- Build a highly skilled cross-trained workforce that reflects the populations served, has low turnover rates, and is valued and supported.
- Expand or implement peer-delivered services. Involve peers in program development, and use peers to conduct outreach and provide services.
- Increase mobile service delivery (if program is or will be providing mobile service). Provide multidisciplinary mobile services to meet a variety of needs among populations who do not access health care in traditional settings.
- Provide culturally appropriate outreach to community.

F. Syringe Access and Disposal (1 page).
Describe in detail:

- Your agency's experience conducting syringe access and disposal services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- Describe how you will conduct quality assurance to meet the requirements of the CHEP Syringe Access and Disposal Program Policy and Guidelines located HERE.
- Your program's plans for integrating the provision of safer injection supplies during the course of other services for clients in need, in a seamless, discrete, and non-stigmatizing way.
- Any preferred elements from the Syringe Access and Disposal table in **Exhibit 1: 6.1** that will be provided within the program. Explain how these elements will be integrated into existing programming.
- How you will reach and meet the specific cultural needs of PWID, including any PWID subpopulations (e.g. MSM, youth, women, and trans women and men, people experiencing homelessness) within your agency's population of focus and create a safe and welcoming environment for them.
- How your data will be tracked for number of syringes distributed and number of syringes collected.
- Your program's syringe disposal plan.

G. Harm reduction services for substance use (including opioids, stimulants, alcohol, tobacco, and cannabis (2 pages).
Describe in detail:

- Your agency's experience providing substance use harm reduction services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program
- How your program will ensure ALL staff participate in ongoing harm reduction training. How staff training will be tracked.
- Your program's mechanism for assessing client needs on an ongoing, systematic basis for substance use including opioids, stimulants, alcohol, tobacco, and cannabis.
- How your program will integrate harm reduction principles and the SFDPH Harm Reduction Policy into program design and delivery and put them into practice in a meaningful and impactful way.

H. Overdose Prevention (2 pages).
Describe in detail:

- Your agency's experience with overdose prevention and response. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.

- How you will meet the required elements of overdose prevention. How your program will integrate overdose prevention and response into your existing program.
- Any preferred elements from the overdose prevention table in **Exhibit 1: 6.1** that will be provided within the program. Explain how these elements will be integrated into existing programming.
- What overdose prevention materials your agency will make available to clients.
- How your program will ensure ALL client facing staff participate in annual overdose prevention and response training. Describe how the program will track training.
- How your program will host at least one overdose prevention training for clients annually. How will this be tracked?

I. Mental Health (1 page).
Describe in detail:

- Your agency's experience providing mental health services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- How your program will integrate culturally appropriate, stigma-free, mental health support into your existing program (e.g. onsite or through linkages to other program).
- How your program will confirm and track linkages to mental health services.

J. Condom Distribution (1 page).
Describe in detail:

- How your program will ensure condoms and other safe sex supplies are easily accessible on site, during outreach, and in mobile facilities.
- The sex-positive and meaningful messaging and education your agency will provide to emphasize that condoms are relevant, particularly for STD prevention.

K. Basic Needs (1 page).
Describe in detail:

- Your program's experience providing basic needs to your population of focus and/or any subpopulations.
- How your program will integrate the provision of basic needs into existing program for the population of focus and/or any subpopulations of focus.

➢ **Describe your program as a whole.**

A. Program Cohesiveness (2 pages).
Describe how the various program components (see below) work together to form one logical, cohesive program. Include a discussion of service times and locations that shows how the program components are linked together. Collaborative proposals: Discuss how the collaborators will work together to provide one cohesive and seamless program. Note: Please see **Exhibit 1: 6.1** for details on the program components listed below.

- Integrated HIV, HCV, and STD testing
- Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, and other services
- Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis)
- Syringe access and disposal
- Overdose prevention (including naloxone distribution)
- Condom distribution
- Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis)
- Community engagement and mobilization (physical and online, social media)
- Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage
- Services to meet basic needs services (examples: food, housing, employment)
- Primary care
- Substance use treatment
- Mental health services

B. Cross-program Elements (2 pages).
Describe:

- How your program will address the specific cultural needs of your population of focus and/or subgroups within your population of focus.
- Any incentives you plan to use. Provide a strong justification for why they are needed as well as evidence or experience supporting their effectiveness. If you are proposing cash incentives, justify why cash is preferred to a non-cash incentive and describe how you will manage cash on the premises.
- How your program will ensure health education and prevention counseling is delivered in the context of overall sexual health and harm reduction and integrated into all of the standard of care services (not stand alone).

- Staffing Plan (2 pages).
Describe your staffing plan (including volunteers) for service delivery. (Describe staffing for data and evaluation in Section 4.) Describe who will provide which services. What percent of their time is allocated to service delivery? What are the staff members' responsibilities and percent full-time equivalent (FTE)? You may include a one-page organization chart or visual that represents the collaboration as an attachment.

Section 3: Data Collection, Evaluation, and Quality Assurance (2 pages)

- **(1 page) Describe your plans for collecting and managing the data for the standard of care services (Exhibit 1: 6.1), including:**

  - Your staffing plan for supporting data collection and management.
  - Your methods and processes for collecting, entering, and reporting client-level data.
  - If you are currently a CHEP contractor, whether your data submissions were on time and complete for the year 2019.
  - If you are not currently a CHEP contractor, whether data submissions for other funders were on time and complete for the year 2019.

- **(1 page) Describe your staffing plan and general process for program evaluation, including:**
  - Staff assigned to program evaluation. Indicate which staff position will be responsible for leading the program evaluation efforts, and how much time will be devoted to it.
  - How you will review and assess the extent to which your program is meeting its objectives.
  - What you will do if you learn the program is not meeting its objectives.
  - How you will use data/evaluation findings to improve the program.

Section 4: Organizational and Fiscal Capacity (3 pages)

- **(1 page) Describe** the agency's experience conducting recruitment and retention with Latinx population and/or specific subpopulations. What types of activities have you done in the past, and how successful have they been at engaging the population(s)? If relevant, include a summary of any data demonstrating your capacity to reach this population and/or specific subpopulations, such as program attendance records, a list of venues where you routinely conduct outreach, or other data.
- **(1 page) Describe** your ability to recruit and retain qualified staff, staff reflective of the population being served, peers, and volunteers. Discuss all of the above, not just staff in general. What staff development/training opportunities will you offer or require? What is the approximate average length of stay for both front-line staff and staff in leadership positions?

- **Budget Detail Booklet:**

  - Complete the Budget Detail and Justification Booklet for a 12 Month Period
  - If you are requesting start up funds please, submit a separate Detail and Justification.

- **Applicants who are LBE Certified will receive additional points.**
  - **This will be added to the "Technical Review Score".**
  - **See LBE Participation terms outlined in the VI. Standard Terms and Conditions for Receipt of Proposals.**

	Bidder Rating Discount:	**0-10**
	10% discount to LBE; or joint venture between or among LBEs	
	5% discount to joint venture with LBE participation that equals or exceeds 35% but is under 40%.	
	7.5% discount to a joint venture with LBE participation that equals or exceeds 40%.	
	10% discount to a certified non-profit entity.	
	Total Available Points:	**10**

11. Scoring Criteria and Rating System

The proposal review process is described in **Section IV: Review and Selection Process**. This table provides the scoring criteria and rating system for **Category 1 proposals.**

Category 1: Health Access Point (HAP) for Latinx			
Question Number	**Scoring Criteria**	**Max. Pts. per Criterion**	**Max. Pts. per Question**
Section 1: Population of Focus (10 points)			
1	Extent to which the applicant demonstrates an understanding of the needs of the population of focus	4	10
	Extent to which the program focuses on the population of focus	2	
	Understanding of risk behaviors and social determinants of health affecting the population of focus.	4	
Section 2: Program Design and Effectiveness (67 points)			
2A	Extent to which program takes an equity-focused, stigma-free, low barrier, and whole person health approach	5	5
2B	Ability of the recruitment/retention plan to result in the proposed number of testing experiences among the population of focus	2	8
	Extent to which the integrated HIV, HCV, and STD testing model and flow of services (including any state-certified test counseling and data collection) is seamless and minimizes barriers to testing	2	
	Extent to which the needs of clients testing HIV-negative or HIV-positive will be met (through state certified counseling and/or other means)	2	
	Ability to which quality assurance plan for HIV, HCV, and STD integrated testing will result in high quality service.	2	
2C	Ability of proposed program to link and navigate clients (within or outside of the program) to LINCS, PrEP, HCV treatment, STD treatment; and sexual/needle-sharing partners to testing	7	7
2D	Ability of proposed program to ensure clients have access (within or outside program) to PrEP and ART for HIV, HCV treatment, and STD treatment.	7	7
2E	Ability to build trust and rapport and have a consistent presence in the community of the population of focus, as well as include community voices in planning, program design, and implementation	3	6
	Extent to which proposed program provides services outside of the agency and in the community, and at various venues in order to engage population of focus	2	
	Extent to which proposed program provides culturally appropriate outreach to population of focus	1	
2F	Ability of proposed program to integrate the provision of safer injection supplies (including data collection) in a seamless, discrete, and non-stigmatizing way	2	4
	Ability of proposed program to reach PWID within population of focus	2	
2G	Extent to which proposed program integrates harm reduction principles into program design and delivery, and put them into practice in a meaningful and impactful way	5	5

2H	Extent to which proposed program integrates overdose prevention and response into existing program services in a seamless way	4	4
2I	Extent to which proposed program integrates mental health support services into existing program in a seamless way	3	3
2J	Extent to which proposed program provides sex-positive and meaningful messaging and education about the relevancy of condom use (particularly for STD prevention)	2	3
	Extent to which proposed program ensures condoms and other safe sex supplies are accessible	1	
2K	Extent to which proposed program ensures the provision of basic needs are available and integrated into existing program services for population of focus	3	3
3A	Extent to which the program design is logical and results in one cohesive effort	1	2
	Appropriateness of times and locations of services for the population of focus	1	
3B	Strength of plan to incorporate the following cross-program elements: a) promote a new testing norm. b) integrate hepatitis C and STD prevention, and c) incentives (if proposed)	2	5
	Extent to which program meets the specific cultural needs of the focus population	3	
3C	Extent to which staffing levels are sufficient given scope of work	2	5
	Extent to which responsibilities are assigned to appropriate staff	1	
	Extent to which it is clear which staff will perform which duties/activities	2	
Section 3: Data Collection, Evaluation, and Quality Assurance (8 points)			
4	Extent to which staffing levels are sufficient given scope of work	1	3
	Efficiency of methods and processes for data collection and entry of client-level data	1	
	Data for 2019 100% on time and complete	1	
5	Extent to which responsibilities are assigned to appropriate staff	2	5
	Extent to which evaluation process will result in continuous program improvement	3	
Section 4: Organizational and Fiscal Capacity (15 points)			
6	Applicant capacity to reach the population of focus and capacity to provide proposed services	5	5
7	Extent to which policies, procedures, practices will lead to recruitment, hiring, and retention of qualified staff	1	2
	Extent to which staff tenure will promote program continuity	1	
8	Budget Detail Expenses are appropriate and support the proposed services.	8	8
		TOTAL POINTS	**100**
LBE Participation % Points			
	LBE Participation	0-10	0-10

Category 2: Health Access Point (HAP) for Trans Women

Estimated Amount Available: From $650,000 to $800,000
Number of Awards: 1

1. Background

Although HIV prevalence has remained stable among trans women throughout the current decade, infection is still highest among this group compared to any other group in San Francisco, a pattern consistent with global trends. Gender-based stigma, discrimination, condomless sex, drug use, homelessness, and lack of job opportunities all contribute to this disparity. From 2006 through 2017, there were 155 trans women newly diagnosed with HIV in San Francisco.[5] Trans women comprised 3% of all persons diagnosed with HIV in this time period, yet, on average, nearly one-third of the population of trans women in SF had HIV during this same period. Compared to all persons diagnosed with HIV, trans women were more likely to be non-white, PWID, and younger; 43% of newly diagnosed trans women were 18-29 years old. As of December 31, 2017, African Americans and Latinas were the largest racial/ethnic groups represented among all trans women living with HIV in San Francisco. HIV-positive trans women, each accounting for 33% and 34% respectively, and 44% PWID. Limited available data also suggest that transgender residents (majority trans women) have higher rates of STDs than San Francisco residents as a whole. Trans women are also disproportionately affected by HCV in SF. HCV antibody seroprevalence was 23.6% among a cohort of 315 trans women tested in San Francisco in 2016 and 2017.[6]

Programs in San Francisco to prevent HIV among trans women are helping to lower the rate of new infections. This RFP seeks to build on these successes by taking a community-centered, whole person approach to HIV, HCV, and STD prevention, implemented by and for trans women.

2. Minimum Qualifications

- By Jan 1, 2020 applicant must be a nonprofit agency that is tax-exempt under Section 501(c)(3) of the Internal Revenue Code and be licensed to do business with the City and County of San Francisco. City and County of San Francisco government departments/sections may NOT apply.
- Applicant must have at least 3 years of experience providing HIV, HCV, and/or STD testing, or similar services to trans women populations. (If a collaboration, only the agency providing the HIV, HCV, and STD testing must meet this qualification.)

[5] San Francisco Department of Public Health. HIV Epidemiology Annual Report 2017. Available at https://www.sfdph.org/dph/comupg/oprograms/HIVepiSec/HIVepiSecReports.asp

[6] Hepatitis C seroprevalence and engagement in related care and treatment among trans women. Erin C. Wilson, Caitlin Turner, Jess Lin, Willi McFarland, Katie Burk, Henry Fisher Raymond. *Journal of Viral Hepatitis*: 27 February 2019. https://doi.org/10.1111/jvh.13089

3. Service Description

CHEP seeks to fund a Health Access Point (HAP) to meet the needs of trans women. A HAP is defined as a population specific, one-stop shop or network of agencies/programs with a lead agency that provides an equity-focused, stigma-free, and low barrier access to person-centered, standard of care services regardless of HIV, HCV, or STD status. The HAP should deliver services that contribute to the following citywide goals:

- Get to zero new HIV infections, zero HIV-related deaths, and zero stigma and discrimination
- Eliminate HCV
- Reverse increasing STD rates
- Eliminate racial disparities in access to services and health outcomes

Services provided within this HAP must be also be harm reduction-based, sex-positive, and trauma-informed. Staff at all levels must demonstrate cultural humility in working with trans women. Peer-delivered services must be an integral part of the network. Trans women must be included in the design, implementation, and evaluation of services.

The HAP should ensure that services reach trans women and/or identified using both **targeted** efforts (focused on these primary subpopulations) as well as **broad-based community-wide engagement and mobilization, regardless of HIV/HCV/STD risk,** to increase awareness, reduce stigma, and reduce barriers to accessing services at the community- level.

4. Population

Programs must be designed to meet the needs of and focus on serving trans women; however, the program must welcome and serve all who are eligible.

5. Restrictions

- Proposed services must be only for trans women and identified primary subpopulations. Proposed services must be only for trans women and identified primary subpopulations. Services for other populations cannot be part of the proposal, although others may access services.
- Funds for HIV/HCV/STD testing must be used for community-based HIV/HCV/STD testing, not testing in clinical or medical settings.

6. Program Requirements

Required Services

The trans women HAP shall provide the following "standard of care" services. The services marked with an asterisk (*) must be provided by the lead applicant or one of its subcontractors, with funding from either this RFP or other in-kind resources. The other services can be provided either by the lead applicant or one of its subcontractors, or by other trans women HAP partners (e.g., via linkage to a HAP collaborating agency, via the collaborating agency providing services on site at the applicant's service location, or other approach). For services provided by other trans women HAP partners who are not subcontractors, MOUs and warm hand-off protocols must be in place as appropriate. Each of the following services is described in detail in **Exhibit 1: 6.1**, including required and preferred elements and performance measures for each service.

- Integrated HIV, HCV, and STD testing*
- Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, case management/intensive case management (ICM) and other services*
- Harm reduction services for substance use (including for opioids, stimulants, alcohol, tobacco, cannabis)*
- Syringe access & disposal*
- Overdose prevention (including naloxone distribution)*
- Condom distribution*
- Community engagement and mobilization (physical and online, social media)*
- HIV, HCV, STD health education and prevention counseling, delivered in the context of overall sexual and drug user health (integrated into all of the above services, not stand alone)*
- Services to meet basic needs services (examples: food, housing, employment)*
- Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage
- Mental health services
- Primary care
- Substance use treatment

Required Strategies

- **Maintain a workforce that mirrors the populations served.** Applicants and subcontractors should have trans staff represented at all levels of the organization. Client-facing positions (e.g., front desk staff, outreach workers, service delivery staff) should demographically reflect the population served.
- **Ensure that some services are delivered by peers.** "Peers" are defined as people with lived experience similar to that of the populations served, and may or may not share demographic characteristics such as race or gender. For example, an agency could create a community advisory board (CAB) and/or hire and train staff to conduct services, such as outreach, client satisfaction surveys, and assemble hygiene kits.
- **Involve the trans women community in program development.** Include community voices and qualitative lived experience in all aspects of planning, program design and implementation, and service delivery using a systematic and continuous process. Build on community strengths and ensure that cultural and historical barriers (e.g., mistrust of service providers, language barriers) are removed.
- **Take a sex-positive sexual health approach.** Integrate HIV and STD messaging using a sexual health framework. Develop integrated HIV and STD prevention messages that address condoms, PrEP, and why STDs are an important concern. Incorporate integrated sexual health messaging throughout all HIV and STD prevention efforts—for example, PrEP navigation programs, HIV community forums, and social marketing
- **Provide services using a harm reduction-based, trauma-informed, and cultural humility approach.** See required staff training in **Exhibit 1: 6.3**.
- **All services must be as low barrier as possible.** "Low barrier" means that as few expectations as possible are placed upon clients and potential clients when they are trying to access services. Examples of low barrier services include: mobile services; co-located services (e.g., HCV treatment co-located with methadone services); drop-in services; express services (e.g., testing without talking to a counselor); and services provided at times convenient for the populations such as evenings, weekends, or late at night.
- **Address stigma for clients.** Provide a non-stigmatizing environment.
- **Address community-level stigma.** Increase the social media presence that promotes integrated sexual health messages and provided information on how to access services. Disseminate DPH-approved

messaging, including PrEP and U=U messaging. Increase education and innovation around how to address HIV-related stigma. De-stigmatize substance use through harm reduction education and messaging.

- **Leverage the private healthcare system whenever possible.** People with private insurance should be encouraged and counseled to use their insurance and develop meaningful relationships with primary care providers, when possible.
- **Ensure services are culturally specific**. Develop testing models that incorporate nuances to address different cultural barriers and specific population needs.
- **Build partnerships and collaborations with other organizations. This RFP requires collaboration to ensure populations have access to required services.**

Optional Strategies

- **Offer incentives.** Programs may propose to use non-cash incentives when they are critical for engaging the population of focus, to recruit people for testing, PrEP, treatment, or other service when warranted (e.g., food vouchers, gift cards, cell phones, cell phone credits, etc.).

Compliance

- Comply with CHEP Policies and Operations Manual for HIV/HCV Testing Services in Community-Based Settings, which are subject to modification at any time. The current policies and procedures can be found HERE
- Comply with SFDPH's Harm Reduction Policy found HERE
- Comply with SFDPH's Syringe Access and Disposal Program Policies and Guidelines found (being updated)
- Comply with the CHEP's Materials Review Process Guidelines found HERE

7. Healthy Staff, Agencies, and Collaborations

Healthy Staff

- **Staff training.** SFDPH and its partners are committed to building and maintaining a highly skilled workforce, prepared to deal with the complexity of client and community needs. To that end, agency staff funded through this RFP will be required to participate in the following trainings: racial humility, trauma informed systems (TIS), and harm reduction training of all staff. The staff that must participate in these trainings will be addressed during contract negotiations.
- **Staff pay.** According to Housing and Urban Development (HUD), in SF in 2018, a single adult is considered to be low income if they make less than $82,200 per year; for a 4-person family the cut-off is $117,300. (Source: https://www.huduser.gov/portal/datasets/il/il2018/2018summary.odn) SFDPH encourages agencies to provide livable wages to staff.

Healthy Agencies

- **Staff retention.** Agencies must have a plan in place to support client-facing staff to prevent burnout and address the vicarious trauma that can occur while working with traumatized populations. Examples of an effective plan include (but are not limited to): staff support group facilitated by a clinician such as an LMFT or LSCW who is also available for individual support as needed. Agencies must allow staff to

participate in the San Francisco HIV Frontline Organizing Group (SF HIV FOG), Navigator's meeting, and other professional development activities.

Healthy Collaborations

Collaboration with other community-based organizations (CBOs), clinics, and other organizations is required in order to ensure populations have access to required services. Even though two or more agencies are involved, these collaborations should result in one cohesive program for the clients they serve.

8. Additional Considerations

- CHEP will provide:
  - HIV/HCV/STD Skills Certification Training
  - Harm Reduction Training
  - Overdose Prevention Training (via its contract with Harm Reduction Coalition's DOPE Project)
  - Training on STD specimen collection
  - Test kits
  - Condoms, lube, and female condoms
  - Training on Clear Impact Results Scorecard
  - Racial Humility resources
  - Trauma informed systems (TIS) training
  - Training on Syringe Access and Disposal

- Health Access Point lead applicant should budget for:
  - Clear Impact Results Scorecard logins (2 per agency at $1200/annually total)
  - Phlebotomy Training and Certification
  - Condoms and safer sex supplies (if not going through the condom distribution program)
  - Syringe access and disposal supplies (including syringes)

9. Program Evaluation and Accountability

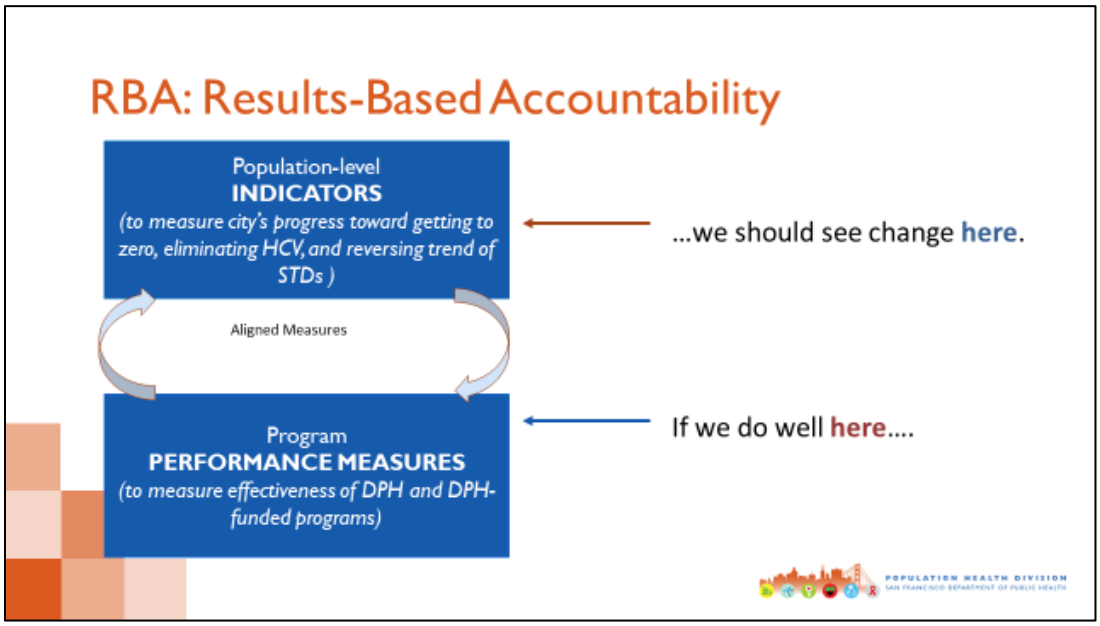
SFDPH seeks to implement program evaluation that allows for flexibility, supports accountability, and encourages innovation. Evaluation findings will be used to improve services, and to hold providers accountable for improving community health. Program innovations are encouraged when accompanied by evaluation plans that can rapidly determine whether the innovations should be adopted, adapted, or abandoned.

Funded programs will be required to use the Results-Based Accountability (RBA) Framework and the Clear Impact Results Scorecard (https://clearimpact.com/scorecard/). RBA is a framework used to improve and track the effectiveness of programs. It is data driven and has two distinct parts: population accountability and performance accountability.

A. Performance Measures

A "program performance measure" is a measure used to track the results of the applicant's specific program. Performance measures and other data collection requirements for each "standard of care" service are provided in **Exhibit 1: 6.1**.

A "population indicator" is a measure used to track the health outcomes of a particular population group. No single program can be held accountable for changing HIV, HCV, or STD rates among trans women. However, by collaborating with HAP partner agencies and other relevant entities, SFDPH expects to see reductions in HIV, HCV, and STD rates among trans women over the next 3-5 years. SFDPH will convene regular HAP partner meetings to review relevant population indicators and facilitate discussion and action planning for achieving the desired outcomes.



B. Data Collection and Reporting

Funded programs must comply with all CHEP requirements regarding data collection and submission, which will include working with CHEP to measure and report on program-specific objectives and collecting/reporting basic demographic, behavioral risk, and other essential information. Systems/processes used to collect and submit data will include:

- Evaluation Web
- Clear Impact Results Scorecard
- Annual narrative report
- Other systems/processes as requested

10. Narrative Instructions

Below are the instructions for the narrative portion of the proposal package. Instructions for development and submission of the complete proposal package can be found in **Section III: Submission Requirements**.

- Complete all sections of the narrative as outlined below. Applicants must complete the sections and questions **in the order listed**. (Applicants do not have to address the bullet points within each question in the order listed, just the questions.) Label the beginning of each section as indicated and include each question number, but do not repeat the question text.

- The narrative may not exceed **38 pages** (1.5 spacing between lines). Page numbers for individual sections and questions are guidelines only.
- Describe all the components of the proposed program here, even if some components are funded by another source, and be clear about which portion you are asking CHEP to support. For example, mental health is a component of the proposed program and could be funded by another source.
- In narrative Sections 1-4, describe your program as it will be when it is fully operational. Start-up needs can be discussed in narrative Section 5.
- Be specific.

Section 1: Population of Focus (3 pages)

➢ **Describe:**

- The population of focus your program will serve including subpopulations, age, geography, language, socioeconomic status, and other characteristics.
- The HIV, HCV, and STD risk behaviors and social determinants of health affecting your population,
- Why you have chosen this specific population (including any identified primary subpopulations) and why your program meets their needs. Use epidemiologic, community assessment, and other data to support your argument.

Section 2: Program Design and Effectiveness (29 pages)

Note: In this section of the narrative, collaborative proposals should clearly describe the specific roles and responsibilities of the partners and who will implement which portions of the program.

➢ **Describe your program components.**

A. Program overview (2 pages).

Provide an overview of your program and explain how it represents an equity-focused, stigma-free, low barrier, and whole person health approach to HIV, HCV, and STD prevention for the identified population of focus.

B. Integrated HIV, HCV, and STD testing (6 pages).

Describe your agency's testing model, including:

- Your agency's experience providing HIV, HCV, and STD testing. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.
- The number of testing experiences (by primary subpopulations, if applicable) your program will provide (i.e. 2,000 testing experiences for trans women and 10,000 for Gay/MSM). Provide the rationale for those numbers. **CHEP's goal is to conduct 50,000 testing experiences annually citywide**. An experience is defined as getting at least one (1) of five (5) tests (HIV, HCV, gonorrhea, chlamydia, and/or syphilis) in a single visit (See Integrated HIV, HCV, and STD testing in **Exhibit 1: 6.1**. For example, a client can receive one (1) test, all five (5), or anything in between and it is considered an "experience".

- Recruitment, Retention:
  The strategies and interventions you will use to recruit people for HIV, HCV, and STD testing and

encourage them to return for testing at least every 6 months, and the evidence or experience supporting the effectiveness of these activities.
The HIV, HCV, and STD testing barriers for this population, including identified primary subpopulations. Describe how your program will address these barriers.
Where and when your agency will provide HIV, HCV, and STD testing and why these sites and venues are appropriate.

- Testing Flow:
  The flow of services at the different testing location(s). Describe how this will help your agency to provide the proposed number of experiences, provide the required and optional services you are proposing, and meet client needs.
  Describe any relevant technologies being used, e.g. if conducting rapid testing, how you will ensure that confirmatory blood draws are obtained, if using drop 'n' go/express model, please describe the process that will be utilized and how patient time will be minimized.
  Describe your plan for getting people to return for their results.
  How your agency will ensure that clients who do not receive counseling as a part of a testing experience still receive HIV, HCV, and STD health information, risk reduction, support, and appropriate prevention messages.

- Data and Quality Assurance:
  Demonstrate how your agency will track these experiences, how your agency will integrate client-level data collection into the flow of services, without creating unnecessary burden for clients. Describe how you will conduct training and quality assurance to meet the requirements of the CHEP Policies and Operations Manual for HIV and HCV Testing Services in Community-Based Settings (found HERE).

C. Linkage and Navigation (3 pages).
Describe your criteria and processes for linkage within and outside of your program, including a description of any collaborations or referral agreements with other agencies (attach MOUs to your proposal). Specifically, describe how linkage and/or navigation will occur related to:

- HIV-negative, HCV- and STD-unknown status clients to HIV/HCV/STD testing within the program.
- HIV-negative clients to PrEP within the program or to a PrEP navigator.
- Newly diagnosed HIV-positive clients to care within program or to LINCS
- Clients that have a STD to treatment within the program or other provider.
- HCV-positive clients to HCV treatment within program or to a HCV navigator.
- Sexual and/or needle-sharing partners of HIV, HCV, and/or STD-positive clients, to HIV, HCV, and/or STD testing within the program (or elsewhere).
- Clients to other services/HAPs, if client needs cannot be met within the program.
- Out-of-care HIV-positive clients to LINCS.
- How your program will track linkages to ensure they are successful.
- Your agency's experience providing linkage and/or navigation services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

D. Prevention And Treatment Medication: Prep and ART for HIV; HCV Treatment; STD Treatment, Including Medical Storage (2 pages)
Describe your criteria and processes for ensuring access to prevention and treatment medication within and outside of your program, including a description of any collaborations or referral agreements with other agencies (attach MOUs to your proposal). Specifically, describe how prevention and treatment medication will occur related to:

- HIV-negative clients receiving PrEP within the program or other provider.
- Newly diagnosed HIV-positive clients initiating ART within program or other provider.
- HCV-positive clients receiving treatment within program or other provider.
- Clients that have a STD receiving treatment within program or other provider.
- How your program will track prevention and treatment medication initiation and/or completion to ensure it was successful.
- Your agency's experience providing prevention and treatment medication. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

E. Community Engagement (2 pages).
Describe in detail:

- Your agency's experience conducting community engagement activities for population of focus. How long have you been conducting these activities? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

Describe in detail how your program will:

- Build trust within the community and have a consistent presence.
- Partner with other local CBOs, agencies and/or community leaders who have a strong relationship with the community.
- Include community voices and qualitative lived experience in all aspects of planning, program design/implementation, and service delivery. Build on community strengths and ensure that cultural and historical barriers (e.g. mistrust of service providers, language barriers) are removed.
- Build a highly skilled cross-trained workforce that reflects the populations served, has low turnover rates, and is valued and supported.
- Expand or implement peer-delivered services. Involve peers in program development, and use peers to conduct outreach and provide services.
- Increase mobile service delivery (if program is or will be providing mobile service). Provide multidisciplinary mobile services to meet a variety of needs among populations who do not access health care in traditional settings.
- Provide culturally appropriate outreach to community.

F. Syringe Access and Disposal (1 pages).
Describe in detail:

- Your agency's experience conducting syringe access and disposal services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- Describe how you will conduct quality assurance to meet the requirements of the CHEP Syringe Access and Disposal Program Policy and Guidelines located HERE.
- Your program's plans for integrating the provision of safer injection supplies during the course of other services for clients in need, in a seamless, discrete, and non-stigmatizing way.
- Any preferred elements from the Syringe Access and Disposal table in **Exhibit 1: 6.1** that will be provided within the program. Explain how these elements will be integrated into existing programming.
- How you will reach and meet the specific cultural needs of PWID, including any PWID subpopulations (e.g. MSM, youth, women, and trans women and men, homeless) within your agency's population of focus and create a safe and welcoming environment for them.
- How your data will be tracked for number of syringes distributed and number of syringes collected.
- Your program's syringe disposal plan.

G. Harm reduction services for substance use (including opioids, stimulants, alcohol, tobacco, and cannabis (2 pages).
Describe in detail:

- Your agency's experience providing substance use harm reduction services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program
- How your program will ensure ALL staff participate in ongoing harm reduction training. How staff training will be tracked.
- Your program's mechanism for assessing client needs on an ongoing, systematic basis for substance use including opioids, stimulants, alcohol, tobacco, and cannabis.
- How your program will integrate harm reduction principles and the SFDPH Harm Reduction Policy into program design and delivery and put them into practice in a meaningful and impactful way.

H. Overdose Prevention (2 pages).
Describe in detail:

- Your agency's experience with overdose prevention and response. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.

- How you will meet the required elements of overdose prevention. How your program will integrate overdose prevention and response into your existing program.
- Any preferred elements from the overdose prevention table in **Exhibit 1: 6.1** that will be provided within the program. Explain how these elements will be integrated into existing programming.
- What overdose prevention materials your agency will make available to clients.
- How your program will ensure ALL client facing staff participate in annual overdose prevention and response training. Describe how the program will track training.
- How your program will host at least one overdose prevention training for clients annually. How will this be tracked?

I. Mental Health (1 pages).
Describe in detail:

- Your agency's experience providing mental health services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- How your program will integrate culturally appropriate, stigma-free, mental health support into your existing program (e.g. onsite or through linkages to other program).
- How your program will confirm and track linkages to mental health services.

J. Condom Distribution (1 pages).
Describe in detail:

- How your program will ensure condoms and other safe sex supplies are easily accessible on site, during outreach, and in mobile facilities.
- The sex-positive and meaningful messaging and education your agency will provide to emphasize that condoms are relevant, particularly for STD prevention.

K. Basic Needs (1 pages).
Describe in detail:

- Your program's experience providing basic needs to your population of focus and/or any subpopulations.
- How your program will integrate the provision of basic needs into existing program for the population of focus and/or any subpopulations of focus.

➢ **Describe your program as a whole.**

A. Program Cohesiveness (2 pages).
Describe how the various program components (see below) work together to form one logical, cohesive program. Include a discussion of service times and locations that shows how the program components are linked together. Collaborative proposals: Discuss how the collaborators will work together to provide one cohesive and seamless program. Note: Please see **Exhibit 1: 6.1** for details on the program components listed below.

- Integrated HIV, HCV, and STD testing
- Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, and other services
- Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis)
- Syringe access and disposal
- Overdose prevention (including naloxone distribution)
- Condom distribution
- Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis)
- Community engagement and mobilization (physical and online, social media)
- Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage
- Services to meet basic needs services (examples: food, housing, employment)
- Primary care
- Substance use treatment
- Mental health services

B. Cross-program Elements (2 pages).
Describe:

- How your program will address the specific cultural needs of your population of focus and/or subgroups within your population of focus.
- Any incentives you plan to use. Provide a strong justification for why they are needed as well as evidence or experience supporting their effectiveness. If you are proposing cash incentives, justify why cash is preferred to a non-cash incentive and describe how you will manage cash on the premises.
- How your program will ensure health education and prevention counseling is delivered in the context of overall sexual health and harm reduction and integrated into all of the standard of care services (not stand alone).

C. Staffing Plan (2 pages).
Describe your staffing plan (including volunteers) for service delivery. (Describe staffing for data and evaluation in Section 4.) Describe who will provide which services. What percent of their time is allocated to service delivery? What are the staff members' responsibilities and percent full-time equivalent (FTE)? You may include a one-page organization chart or visual that represents the collaboration as an attachment.

Section 3: Data Collection, Evaluation, and Quality Assurance (2 pages)

- **(1 page) Describe your plans for collecting and managing the data for the standard of care services (Exhibit 1: 6.1), including:**

  - Your staffing plan for supporting data collection and management.
  - Your methods and processes for collecting, entering, and reporting client-level data.

- If you are currently a CHEP contractor, whether your data submissions were on time and complete for the year 2019.
- If you are not currently a CHEP contractor, whether data submissions for other funders were on time and complete for the year 2019.

➢ **(1 page) Describe your staffing plan and general process for program evaluation, including:**
- Staff assigned to program evaluation. Indicate which staff position will be responsible for leading the program evaluation efforts, and how much time will be devoted to it.
- How you will review and assess the extent to which your program is meeting its objectives.
- What you will do if you learn the program is not meeting its objectives.
- How you will use data/evaluation findings to improve the program.

Section 4: Organizational and Fiscal Capacity (3 pages)

➢ **(1 page) Describe the agency's experience conducting recruitment and retention with trans women population and/or specific subpopulations.** What types of activities have you done in the past, and how successful have they been at engaging the population(s)? If relevant, include a summary of any data demonstrating your capacity to reach this population and/or specific subpopulations, such as program attendance records, a list of venues where you routinely conduct outreach, or other data.

➢ (**1 page) Describe your ability to recruit and retain qualified staff, staff reflective of the population being served, peers, and volunteers.** Discuss all of the above, not just staff in general. What staff development/training opportunities will you offer or require? What is the approximate average length of stay for both front-line staff and staff in leadership positions?

➢ **Budget Detail Booklet:**

- Complete the Budget Detail and Justification Booklet for a 12 Month Period
- If you are requesting start up funds please, submit a separate Detail and Justification.

➢ **Applicants who are LBE Certified will receive additional points.**
- **This will be added to the "Technical Review Score".**
- **See LBE Participation terms outlined in the VI. Standard Terms and Conditions for Receipt of Proposals.**

	Bidder Rating Discount:	**0-10**
	10% discount to LBE; or joint venture between or among LBEs	
	5% discount to joint venture with LBE participation that equals or exceeds 35% but is under 40%.	
	7.5% discount to a joint venture with LBE participation that equals or exceeds 40%.	
	10% discount to a certified non-profit entity.	
	Total Available Points:	**10**

11. Scoring Criteria and Rating System

The proposal review process is described in **Section IV: Review and Selection Process**. This table provides the scoring criteria and rating system for **Category 2 proposals.**

Category 2: Health Access Point (HAP) for Trans women			
Question Number	**Scoring Criteria**	**Max. Pts. per Criterion**	**Max. Pts. per Question**
Section 1: Population of Focus (10 points)			
1	Extent to which the applicant demonstrates an understanding of the needs of the population of focus	4	10
	Extent to which the program focuses on the population of focus	2	
	Understanding of risk behaviors and social determinants of health affecting the population of focus.	4	
Section 2: Program Design and Effectiveness (67 points)			
2A	Extent to which program takes an equity-focused, stigma-free, low barrier, and whole person health approach	5	5
2B	Ability of the recruitment/retention plan to result in the proposed number of testing experiences among the population of focus	2	8
	Extent to which the integrated HIV, HCV, and STD testing model and flow of services (including any state-certified test counseling and data collection) is seamless and minimizes barriers to testing	2	
	Extent to which the needs of clients testing HIV-negative or HIV-positive will be met (through state certified counseling and/or other means)	2	
	Ability to which quality assurance plan for HIV, HCV, and STD integrated testing will result in high quality service.	2	
2C	Ability of proposed program to link and navigate clients (within or outside of the program) to LINCS, PrEP, HCV treatment, STD treatment; and sexual/needle-sharing partners to testing	7	7
2D	Ability of proposed program to ensure clients have access (within or outside program) to PrEP and ART for HIV, HCV treatment, and STD treatment.	7	7
2E	Ability to build trust and rapport and have a consistent presence in the community of the population of focus, as well as include community voices in planning, program design, and implementation	3	6
	Extent to which proposed program provides services outside of the agency and in the community, and at various venues in order to engage population of focus	2	
	Extent to which proposed program provides culturally appropriate outreach to population of focus	1	
2F	Ability of proposed program to integrate the provision of safer injection supplies (including data collection) in a seamless, discrete, and non-stigmatizing way	2	4
	Ability of proposed program to reach PWID within population of focus	2	
2G	Extent to which proposed program integrates harm reduction principles into program design and delivery, and put them into practice in a meaningful and impactful way	5	5
2H	Extent to which proposed program integrates overdose prevention and response into existing program services in a seamless way	4	4

2I	Extent to which proposed program integrates mental health support services into existing program in a seamless way	3	3
2J	Extent to which proposed program provides sex-positive and meaningful messaging and education about the relevancy of condom use (particularly for STD prevention)	2	3
	Extent to which proposed program ensures condoms and other safe sex supplies are accessible	1	
2K	Extent to which proposed program ensures the provision of basic needs are available and integrated into existing program services for population of focus	3	3
3A	Extent to which the program design is logical and results in one cohesive effort	1	2
	Appropriateness of times and locations of services for the population of focus	1	
3B	Strength of plan to incorporate the following cross-program elements: a) promote a new testing norm. b) integrate hepatitis C and STD prevention, and c) incentives (if proposed)	2	5
	Extent to which program meets the specific cultural needs of the focus population	3	
3C	Extent to which staffing levels are sufficient given scope of work	2	5
	Extent to which responsibilities are assigned to appropriate staff	1	
	Extent to which it is clear which staff will perform which duties/activities	2	
Section 3: Data Collection, Evaluation, and Quality Assurance (8 points)			
4	Extent to which staffing levels are sufficient given scope of work	1	3
	Efficiency of methods and processes for data collection and entry of client-level data	1	
	Data for 2019 100% on time and complete	1	
5	Extent to which responsibilities are assigned to appropriate staff	2	5
	Extent to which evaluation process will result in continuous program improvement	3	
Section 4: Organizational and Fiscal Capacity (15 points)			
6	Applicant capacity to reach the population of focus and capacity to provide proposed services	5	5
7	Extent to which policies, procedures, practices will lead to recruitment, hiring, and retention of qualified staff	1	2
	Extent to which staff tenure will promote program continuity	1	
8	Budget Detail Expenses are appropriate and support the proposed services.	8	8
		Total Points	**100**
LBE Participation % Points			
	LBE Participation	0-10	0-10

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Category 3: Health Access Point (HAP) for People who use drugs, including people who inject drugs (PWUD/ID)

Estimated Amount Available: From $760,000 to $930,000
Number of Awards: 1

1. Background

People who use drugs, including injecting drugs (PWUD/ID), often experience stigma, trauma, violence, and barriers to care that increase their risks and negatively affect their health outcomes. In San Francisco, substance use is a driver of HIV, hepatitis C (HCV), and sexually transmitted diseases (STDs).

There are approximately 24,500 people who inject drugs (PWID) in San Francisco. End Hep C SF estimates that around 12,000 people (a little less than 2% of the city's population) are actively infected with hepatitis C. Approximately 68% of active HCV infections in San Francisco are among people who inject drugs, despite PWID making up less than 3% of the city's population. [7]

Substance use is associated with HIV acquisition. Heavy alcohol use among MSM has been shown to be independently associated with twice the risk of acquiring HIV. Other substances including cocaine and/or crack, methamphetamine, and poppers are known drivers of HIV transmission among MSM in San Francisco due to their association with impaired risk perception and decision-making regarding injection drug use or unprotected sex.

The number of new diagnoses among MSM-PWID and non-MSM PWID increased in 2017 to 25% from 18%.[8] Injection drug use was the predominant transmission category for white, Black/African American, and multi-racial females. PWID (including MSM-PWID) are less likely to be linked to care, retained in care, are less likely to achieve viral suppression and have lower probability of survival after being diagnosed with AIDS compared to other groups. Between 2014 and 2017, drug overdose was the 4th leading cause of death among people living with HIV.

STDs rates are high among people who use drugs. In San Francisco, during 2013-2018, the proportion of primary and secondary syphilis cases who reported methamphetamine use in the past year increased among females (15% to 39%) and heterosexual men (17% to 67%). The proportion who reported sex with a PWID in the past 12 months more than doubled among heterosexual men (9% to 23%) and remained high among females (26%).[9] Similar rising rates of syphilis among females and heterosexual men in the U.S has been reported by the Centers for Disease Control and Prevention (CDC). Between 2013 and 2017, the proportion of females and heterosexual

[7] https://journals.plos.org/plosone/article/comments?id=10.1371/journal.pone.0195575

[8] San Francisco Department of Public Health. HIV Epidemiology Annual Report 2017. Available at https://www.sfdph.org/dph/comupg/oprograms/HIVepiSec/HIVepiSecReports.asp

[9] SF Monthly STD Report. (2019, April 10).

men with primary and secondary syphilis who reported sex with PWID and use of methamphetamine, injection drugs, and heroin more than doubled.[10]

In order to optimize the health of PWUD/ID and reduce HIV/HCV/STD transmission, the complex and interwoven needs they have must be addressed in an effective, culturally competent manner. Services must be easily accessible and integrated into other services.

This RFP seeks to take a community-centered, whole person, integrated approach to HIV, HCV, and STD prevention, implemented by and for PWUD/ID.

2. Minimum Qualifications

- By Jan 1, 2020 applicant must be a nonprofit agency that is tax-exempt under Section 501(c)(3) of the Internal Revenue Code and be licensed to do business with the City and County of San Francisco. City and County of San Francisco government departments/sections may NOT apply.
- Applicant must have at least 3 years of experience providing HIV, HCV, and/or STD testing, or similar services to PWUD/ID. (If a collaboration, only the agency providing the HIV, HCV, and STD testing must meet this qualification.)

3. Service Description

CHEP seeks to fund a Health Access Point (HAP) to meet the needs of PWUD/ID. A HAP is defined as a population specific; one –stop shop or network of agencies/programs with a lead agency that provides an equity-focused stigma-free, and low barrier access to person-centered, standard of care services regardless of HIV, HCV, or STD status. The HAP should deliver services that contribute to the following citywide goals:

- Get to zero new HIV infections, zero HIV-related deaths, and zero stigma and discrimination
- Eliminate HCV
- Reverse increasing STD rates
- Eliminate racial disparities in access to services and health outcomes

Services provided within this HAP must be also be culturally specific, harm reduction-based, sex-positive, and trauma-informed. Staff at all levels must demonstrate cultural humility in working with PWUD/ID. Peer-delivered services must be an integral part of the network. PWUD/ID must be included in the design, implementation, and evaluation of services.

The HAP should ensure that services reach PWUD/ID, using both **targeted** efforts (focused on identified primary subpopulations) as well as **broad-based community-wide engagement and mobilization, regardless of HIV/HCV/STD risk,** to increase awareness, reduce stigma, and reduce barriers to accessing services at the community- level.

[10] Centers for Disease Control. Morbidity and Mortality Weekly Report. (2019, February).

4. Population

Programs must be designed to meet the needs of and focus on serving PWUD/ID; however, the program must welcome and serve all who are eligible.

5. Restrictions

- Proposed services must be only for PWUD/ID and identified primary subpopulations. Proposed services must be only for PWUD/ID and identified primary subpopulations. Services for other populations cannot be part of the proposal, although others may access services.
- Funds for HIV/HCV/STD testing must be used for community-based HIV/HCV/STD testing, not testing in clinical or medical settings.

6. Program Requirements

Required Services

The PWUD/ID HAP shall provide the following "standard of care" services. The services marked with an asterisk (*) must be provided by the lead applicant or one of its subcontractors, with funding from either this RFP or other in-kind resources. The other services can be provided either by the lead applicant or one of its subcontractors, or by other trans women HAP partners (e.g., via linkage to a HAP collaborating agency, via the collaborating agency providing services on site at the applicant's service location, or other approach). For services provided by other PWUD/ID HAP partners who are not subcontractors, MOUs and warm hand-off protocols must be in place as appropriate. Each of the following services is described in detail in **Exhibit 1: 6.1** , including required and preferred elements and performance measures for each service.

- Integrated HIV, HCV, and STD testing*
- Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, case management/intensive case management (ICM) and other services*
- Harm reduction services for substance use (including for opioids, stimulants, alcohol, tobacco, cannabis)*
- Syringe access and disposal*
- Overdose prevention (including naloxone distribution)*
- Condom distribution*
- Community engagement and mobilization (physical and online, social media)*
- HIV, HCV, STD health education and prevention counseling, delivered in the context of overall sexual and drug user health (integrated into all of the above services, not stand alone)*
- Services to meet basic needs services (examples: food, housing, employment)*
- Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage
- Mental health services
- Primary care
- Substance use treatment

Required Strategies

- **Maintain a workforce that mirrors the populations served.** Applicants and subcontractors should have staff with a lived experience related to substance use represented at all levels of the organization. Client-facing positions (e.g., front desk staff, outreach workers, service delivery staff) should demographically reflect the population served.
- **Ensure that some services are delivered by peers.** "Peers" are defined as people with lived experience similar to that of the populations served, and may or may not share demographic characteristics such as race or gender. For example, an agency could create a community advisory board (CAB) and/or hire and train staff to conduct services, such as outreach, client satisfaction surveys, and assemble hygiene kits.
- **Involve the PWUD/ID community in program development.** Include community voices and qualitative lived experience in all aspects of planning, program design and implementation, and service delivery using a systematic and continuous process. Build on community strengths and ensure that cultural and historical barriers (e.g., mistrust of service providers, language barriers) are removed.
- **Take a sex-positive sexual health approach.** Integrate HIV and STD messaging using a sexual health framework. Develop integrated HIV and STD prevention messages that address condoms, PrEP, and why STDs are an important concern. Incorporate integrated sexual health messaging throughout all HIV and STD prevention efforts—for example, PrEP navigation programs, HIV community forums, and social marketing
- **Provide services using a harm reduction-based, trauma-informed, and cultural humility approach.** See required staff training in **Exhibit 1: 6.3**.
- **All services must be as low barrier as possible.** "Low barrier" means that as few expectations as possible are placed upon clients and potential clients when they are trying to access services. Examples of low barrier services include: mobile services; co-located services (e.g., HCV treatment co-located with methadone services); drop-in services; express services (e.g., testing without talking to a counselor); and services provided at times convenient for the populations such as evenings, weekends, or late at night.
- **Address stigma for clients.** Provide a non-stigmatizing environment.
- **Address community-level stigma.** Increase the social media presence that promotes integrated sexual health messages and provided information on how to access services. Disseminate DPH-approved messaging, including PrEP and U=U messaging. Increase education and innovation around how to address HIV-related stigma. De- stigmatize substance use through harm reduction education and messaging.
- **Leverage the private healthcare system whenever possible.** People with private insurance should be encouraged and counseled to use their insurance and develop meaningful relationships with primary care providers, when possible.
- **Ensure services are culturally specific**. Develop testing models that incorporate nuances to address different cultural barriers and specific population needs.
- **Build partnerships and collaborations with other organizations. This RFP requires collaboration to ensure populations have access to required services.**

Optional Strategies

- **Offer incentives.** Programs may propose to use non-cash incentives when they are critical for engaging the population of focus, to recruit people for testing, PrEP, treatment, or other service when warranted (e.g., food vouchers, gift cards, cell phones, cell phone credits, etc.).

Compliance

- Comply with CHEP Policies and Operations Manual for HIV/HCV Testing Services in Community-Based Settings, which are subject to modification at any time. The current policies and procedures can be found HERE
- Comply with SFDPH's Harm Reduction Policy found HERE
- Comply with SFDPH's Syringe Access and Disposal Program Policies and Guidelines found (being updated)
- Comply with the CHEP's Materials Review Process Guidelines found HERE

7. Healthy Staff, Agencies, and Collaborations

Healthy Staff

- **Staff training.** SFDPH and its partners are committed to building and maintaining a highly skilled workforce, prepared to deal with the complexity of client and community needs. To that end, agency staff funded through this RFP will be required to participate in the following trainings: racial humility, trauma informed systems (TIS), and harm reduction training of all staff. The staff that must participate in these trainings will be addressed during contract negotiations.
- **Staff pay.** According to Housing and Urban Development (HUD), in SF in 2018, a single adult is considered to be low income if they make less than $82,200 per year; for a 4-person family the cut-off is $117,300. (Source: https://www.huduser.gov/portal/datasets/il/il2018/2018summary.odn) SFDPH encourages agencies to provide livable wages to staff.

Healthy Agencies

- **Staff retention.** Agencies must have a plan in place to support client-facing staff to prevent burnout and address the vicarious trauma that can occur while working with traumatized populations. Examples of an effective plan include (but are not limited to): staff support group facilitated by a clinician such as an LMFT or LSCW who is also available for individual support as needed. Agencies must allow staff to participate in the San Francisco HIV Frontline Organizing Group (SF HIV FOG), Navigator's meeting, and other professional development activities.

Healthy Collaborations

Collaboration with other community-based organizations (CBOs), clinics, and other organizations is required in order to ensure populations have access to required services. Even though two or more agencies are involved, these collaborations should result in one cohesive program for the clients they serve.

8. Additional Considerations

- CHEP will provide:
    - HIV/HCV/STD Skills Certification Training
    - Harm Reduction Training
    - Overdose Prevention Training (via its contract with Harm Reduction Coalition's DOPE Project)
    - Training on STD specimen collection
    - Test kits

- Condoms, lube, and female condoms
- Training on Clear Impact Results Scorecard
- Racial Humility resources
- Trauma informed systems (TIS) training
- Training on Syringe Access and Disposal

- Health Access Point lead applicant should budget for:
  - Clear Impact Results Scorecard logins (2 per agency at $1200/annually total)
  - Phlebotomy Training and Certification
  - Condoms and safer sex supplies (if not going through the condom distribution program)
  - Syringe access and disposal supplies (including syringes)

9. Program Evaluation and Accountability

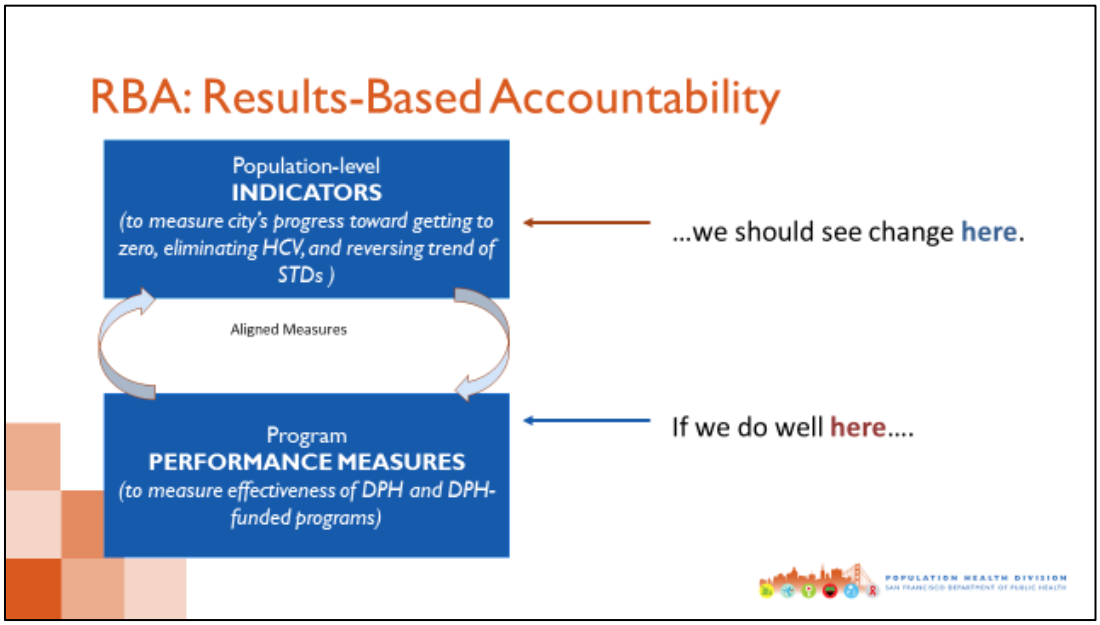
SFDPH seeks to implement program evaluation that allows for flexibility, supports accountability, and encourages innovation. Evaluation findings will be used to improve services, and to hold providers accountable for improving community health. Program innovations are encouraged when accompanied by evaluation plans that can rapidly determine whether the innovations should be adopted, adapted, or abandoned.

Funded programs will be required to use the Results-Based Accountability (RBA) Framework and the Clear Impact Results Scorecard (https://clearimpact.com/scorecard/). RBA is a framework used to improve and track the effectiveness of programs. It is data driven and has two distinct parts: population accountability and performance accountability.

A. Performance Measures

A "program performance measure" is a measure used to track the results of the applicant's specific program. Performance measures and other data collection requirements for each "standard of care" service are provided in **Exhibit 1: 6.1**.

A "population indicator" is a measure used to track the health outcomes of a particular population group. No single program can be held accountable for changing HIV, HCV, or STD rates among PWUD/ID. However, by collaborating with HAP partner agencies and other relevant entities, SFDPH expects to see reductions in HIV, HCV, and STD rates among PWUD/ID over the next 3-5 years. SFDPH will convene regular HAP partner meetings to review relevant population indicators and facilitate discussion and action planning for achieving the desired outcomes.



B. Data Collection and Reporting

Funded programs must comply with all CHEP requirements regarding data collection and submission, which will include working with CHEP to measure and report on program-specific objectives and collecting/reporting basic demographic, behavioral risk, and other essential information. Systems/processes used to collect and submit data will include:

- Evaluation Web
- Clear Impact Results Scorecard
- Annual narrative report
- Other systems/processes as requested

10. Narrative Instructions

Below are the instructions for the narrative portion of the proposal package. Instructions for development and submission of the complete proposal package can be found in **Section III: Submission Requirements**.

- Complete all sections of the narrative as outlined below. Applicants must complete the sections and questions **in the order listed**. (Applicants do not have to address the bullet points within each question in the order listed, just the questions.) Label the beginning of each section as indicated and include each question number, but do not repeat the question text.
- The narrative may not exceed **38 pages** (1.5 spacing between lines). Page numbers for individual sections and questions are guidelines only.
- Describe all the components of the proposed program here, even if some components are funded by another source, and be clear about which portion you are asking CHEP to support. For example, mental health is a component of the proposed program and could be funded by another source.
- In narrative Sections 1-4, describe your program as it will be when it is fully operational. Start-up needs can be discussed in narrative Section 5.
- Be specific.

Section 1: Population of Focus (3 pages)

- **Describe:**
  - The population of focus your program will serve including subpopulations, age, geography, language, socioeconomic status, and other characteristics.
  - The HIV, HCV, and STD risk behaviors and social determinants of health affecting your population,
  - Why you have chosen this specific population (including any identified primary subpopulations) and why your program meets their needs. Use epidemiologic, community assessment, and other data to support your argument.

Section 2: Program Design and Effectiveness (29 pages)

Note: In this section of the narrative, collaborative proposals should clearly describe the specific roles and responsibilities of the partners and who will implement which portions of the program.

- **Describe your program components.**

A. Program overview (2 pages).

Provide an overview of your program and explain how it represents an equity-focused, stigma-free, low barrier, and whole person health approach to HIV, HCV, and STD prevention for the identified population of focus.

B. Integrated HIV, HCV, and STD testing (6 pages).

Describe your agency's testing model, including:

- Your agency's experience providing HIV, HCV, and STD testing. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.
- The number of testing experiences (by primary subpopulations, if applicable) your program will provide (i.e. 2,000 testing experiences for trans women and 10,000 for Gay/MSM). Provide the rationale for those numbers. **CHEP's goal is to conduct 50,000 testing experiences annually citywide**. An experience is defined as getting at least one (1) of five (5) tests (HIV, HCV, gonorrhea, chlamydia, and/or syphilis) in a single visit (See Integrated HIV, HCV, and STD testing in **Exhibit 1: 6.1**. For example, a client can receive one (1) test, all five (5), or anything in between and it is considered an "experience".

- Recruitment, Retention:

  The strategies and interventions you will use to recruit people for HIV, HCV, and STD testing and encourage them to return for testing at least every 6 months, and the evidence or experience supporting the effectiveness of these activities.

  The HIV, HCV, and STD testing barriers for this population, including identified primary subpopulations. Describe how your program will address these barriers.

  Where and when your agency will provide HIV, HCV, and STD testing and why these sites and venues are appropriate.

- Testing Flow:
  The flow of services at the different testing location(s). Describe how this will help your agency to provide the proposed number of experiences, provide the required and optional services you are proposing, and meet client needs.
  Describe any relevant technologies being used, e.g. if conducting rapid testing, how you will ensure that confirmatory blood draws are obtained, if using drop 'n' go/express model, please describe the process that will be utilized and how patient time will be minimized.
  Describe your plan for getting people to return for their results.
  How your agency will ensure that clients who do not receive counseling as a part of a testing experience still receive HIV, HCV, and STD health information, risk reduction, support, and appropriate prevention messages.

- Data and Quality Assurance:
  Demonstrate how your agency will track these experiences, how your agency will integrate client-level data collection into the flow of services, without creating unnecessary burden for clients. Describe how you will conduct training and quality assurance to meet the requirements of the CHEP Policies and Operations Manual for HIV and HCV Testing Services in Community-Based Settings (found HERE).

C. Linkage and Navigation (3 pages).
Describe your criteria and processes for linkage within and outside of your program, including a description of any collaborations or referral agreements with other agencies (attach MOUs to your proposal). Specifically, describe how linkage and/or navigation will occur related to:

- HIV-negative, HCV- and STD-unknown status clients to HIV/HCV/STD testing within the program.
- HIV-negative clients to PrEP within the program or to a PrEP navigator.
- Newly diagnosed HIV-positive clients to care within program or to LINCS
- Clients that have a STD to treatment within the program or other provider.
- HCV-positive clients to HCV treatment within program or to a HCV navigator.
- Sexual and/or needle-sharing partners of HIV, HCV, and/or STD-positive clients, to HIV, HCV, and/or STD testing within the program (or elsewhere).
- Clients to other services/HAPs, if client needs cannot be met within the program.
- Out-of-care HIV-positive clients to LINCS.
- How your program will track linkages to ensure they are successful.
- Your agency's experience providing linkage and/or navigation services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

D. Prevention And Treatment Medication: Prep and ART for HIV; HCV Treatment; STD Treatment, Including Medical Storage (2 pages)
Describe your criteria and processes for ensuring access to prevention and treatment medication within and outside of your program, including a description of any collaborations or referral agreements with other agencies (attach MOUs to your proposal). Specifically, describe how prevention and treatment medication will occur related to:

- HIV-negative clients receiving PrEP within the program or other provider.
- Newly diagnosed HIV-positive clients initiating ART within program or other provider.
- HCV-positive clients receiving treatment within program or other provider.
- Clients that have a STD receiving treatment within program or other provider.
- How your program will track prevention and treatment medication initiation and/or completion to ensure it was successful.
- Your agency's experience providing prevention and treatment medication. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

E. Community Engagement (2 pages).
Describe in detail:

- Your agency's experience conducting community engagement activities for population of focus. How long have you been conducting these activities? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

Describe in detail how your program will:

- Build trust within the community and have a consistent presence.
- Partner with other local CBOs, agencies and/or community leaders who have a strong relationship with the community.
- Include community voices and qualitative lived experience in all aspects of planning, program design/implementation, and service delivery. Build on community strengths and ensure that cultural and historical barriers (e.g. mistrust of service providers, language barriers) are removed.
- Build a highly skilled cross-trained workforce that reflects the populations served, has low turnover rates, and is valued and supported.
- Expand or implement peer-delivered services. Involve peers in program development, and use peers to conduct outreach and provide services.
- Increase mobile service delivery (if program is or will be providing mobile service). Provide multidisciplinary mobile services to meet a variety of needs among populations who do not access health care in traditional settings.
- Provide culturally appropriate outreach to community.

F. Syringe Access and Disposal (1 pages).
Describe in detail:

- Your agency's experience conducting syringe access and disposal services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- Describe how you will conduct quality assurance to meet the requirements of the CHEP Syringe Access and Disposal Program Policy and Guidelines located HERE.

- Your program's plans for integrating the provision of safer injection supplies during the course of other services for clients in need, in a seamless, discrete, and non-stigmatizing way.
- Any preferred elements from the Syringe Access and Disposal table in **Exhibit 1: 6.1** that will be provided within the program. Explain how these elements will be integrated into existing programming.
- How you will reach and meet the specific cultural needs of PWID, including any PWID subpopulations (e.g. MSM, youth, women, and trans women and men, homeless) within your agency's population of focus and create a safe and welcoming environment for them.
- How your data will be tracked for number of syringes distributed and number of syringes collected.
- Your program's syringe disposal plan.

G. Harm reduction services for substance use (including opioids, stimulants, alcohol, tobacco, and cannabis (2 pages).
Describe in detail:

- Your agency's experience providing substance use harm reduction services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program
- How your program will ensure ALL staff participate in ongoing harm reduction training. How staff training will be tracked.
- Your program's mechanism for assessing client needs on an ongoing, systematic basis for substance use including opioids, stimulants, alcohol, tobacco, and cannabis.
- How your program will integrate harm reduction principles and the SFDPH Harm Reduction Policy into program design and delivery and put them into practice in a meaningful and impactful way.

H. Overdose Prevention (2 pages).
Describe in detail:

- Your agency's experience with overdose prevention and response. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- How you will meet the required elements of overdose prevention. How your program will integrate overdose prevention and response into your existing program.
- Any preferred elements from the overdose prevention table in **Exhibit 1: 6.1** that will be provided within the program. Explain how these elements will be integrated into existing programming.
- What overdose prevention materials your agency will make available to clients.
- How your program will ensure ALL client facing staff participate in annual overdose prevention and response training. Describe how the program will track training.
- How your program will host at least one overdose prevention training for clients annually. How will this be tracked?

I. Mental Health (1 pages).
Describe in detail:

- Your agency's experience providing mental health services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- How your program will integrate culturally appropriate, stigma-free, mental health support into your existing program (e.g. onsite or through linkages to other program).
- How your program will confirm and track linkages to mental health services.

J. Condom Distribution (1 pages).
Describe in detail:

- How your program will ensure condoms and other safe sex supplies are easily accessible on site, during outreach, and in mobile facilities.
- The sex-positive and meaningful messaging and education your agency will provide to emphasize that condoms are relevant, particularly for STD prevention.

K. Basic Needs (1 pages).
Describe in detail:

- Your program's experience providing basic needs to your population of focus and/or any subpopulations.
- How your program will integrate the provision of basic needs into existing program for the population of focus and/or any subpopulations of focus.

➢ **Describe your program as a whole.**

A. Program Cohesiveness (2 pages).
Describe how the various program components (see below) work together to form one logical, cohesive program. Include a discussion of service times and locations that shows how the program components are linked together. Collaborative proposals: Discuss how the collaborators will work together to provide one cohesive and seamless program. Note: Please see **Exhibit 1: 6.1** for details on the program components listed below.

- Integrated HIV, HCV, and STD testing
- Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, and other services
- Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis)
- Syringe access and disposal
- Overdose prevention (including naloxone distribution)
- Condom distribution
- Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis)

- Community engagement and mobilization (physical and online, social media)
- Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage
- Services to meet basic needs services (examples: food, housing, employment)
- Primary care
- Substance use treatment
- Mental health services

B. Cross-program Elements (2 pages).
Describe:

- How your program will address the specific cultural needs of your population of focus and/or subgroups within your population of focus.
- Any incentives you plan to use. Provide a strong justification for why they are needed as well as evidence or experience supporting their effectiveness. If you are proposing cash incentives, justify why cash is preferred to a non-cash incentive and describe how you will manage cash on the premises.
- How your program will ensure health education and prevention counseling is delivered in the context of overall sexual health and harm reduction and integrated into all of the standard of care services (not stand alone).

C. Staffing Plan (2 pages).
Describe your staffing plan (including volunteers) for service delivery. (Describe staffing for data and evaluation in Section 4.) Describe who will provide which services. What percent of their time is allocated to service delivery? What are the staff members' responsibilities and percent full-time equivalent (FTE)? You may include a one-page organization chart or visual that represents the collaboration as an attachment.

Section 3: Data Collection, Evaluation, and Quality Assurance (2 pages)

- **(1 page) Describe your plans for collecting and managing the data for the standard of care services (Exhibit 1: 6.1), including:**

  - Your staffing plan for supporting data collection and management.
  - Your methods and processes for collecting, entering, and reporting client-level data.
  - If you are currently a CHEP contractor, whether your data submissions were on time and complete for the year 2019.
  - If you are not currently a CHEP contractor, whether data submissions for other funders were on time and complete for the year 2019.

- **(1 page) Describe your staffing plan and general process for program evaluation, including:**
  - Staff assigned to program evaluation. Indicate which staff position will be responsible for leading the program evaluation efforts, and how much time will be devoted to it.
  - How you will review and assess the extent to which your program is meeting its objectives.

- What you will do if you learn the program is not meeting its objectives.
- How you will use data/evaluation findings to improve the program.

Section 4: Organizational and Fiscal Capacity (3 pages)

- (1 page) Describe the agency's experience conducting recruitment and retention with the PWUD/ID population and/or specific subpopulations. What types of activities have you done in the past, and how successful have they been at engaging the population(s)? If relevant, include a summary of any data demonstrating your capacity to reach this population and/or specific subpopulations, such as program attendance records, a list of venues where you routinely conduct outreach, or other data.

- (1 page) Describe your ability to recruit and retain qualified staff, staff reflective of the population being served, peers, and volunteers. Discuss all of the above, not just staff in general. What staff development/training opportunities will you offer or require? What is the approximate average length of stay for both front-line staff and staff in leadership positions?

- **Budget Detail Booklet:**

  - Complete the Budget Detail and Justification Booklet for a 12 Month Period
  - If you are requesting start up funds please, submit a separate Detail and Justification.

- **Applicants who are LBE Certified will receive additional points.**
  - **This will be added to the "Technical Review Score".**
  - **See LBE Participation terms outlined in the VI. Standard Terms and Conditions for Receipt of Proposals.**

	Bidder Rating Discount:	**0-10**
	10% discount to LBE; or joint venture between or among LBEs	
	5% discount to joint venture with LBE participation that equals or exceeds 35% but is under 40%.	
	7.5% discount to a joint venture with LBE participation that equals or exceeds 40%.	
	10% discount to a certified non-profit entity.	
	Total Available Points:	**10**

11. Scoring Criteria and Rating System

The proposal review process is described in **Section IV: Review and Selection Process**. This table provides the scoring criteria and rating system for **Category 3 proposals.**

Category 3: Health Access Point (HAP) for PWUD/ID			
Question Number	**Scoring Criteria**	**Max. Pts. per Criterion**	**Max. Pts. per Question**
Section 1: Population of Focus (10 points)			
1	Extent to which the applicant demonstrates an understanding of the needs of the population of focus	4	10
	Extent to which the program focuses on the population of focus	2	
	Understanding of risk behaviors and social determinants of health affecting the population of focus.	4	
Section 2: Program Design and Effectiveness (67 points)			
2A	Extent to which program takes an equity-focused, stigma-free, low barrier, and whole person health approach	5	5
2B	Ability of the recruitment/retention plan to result in the proposed number of testing experiences among the population of focus	2	8
	Extent to which the integrated HIV, HCV, and STD testing model and flow of services (including any state-certified test counseling and data collection) is seamless and minimizes barriers to testing	2	
	Extent to which the needs of clients testing HIV-negative or HIV-positive will be met (through state certified counseling and/or other means)	2	
	Ability to which quality assurance plan for HIV, HCV, and STD integrated testing will result in high quality service.	2	
2C	Ability of proposed program to link and navigate clients (within or outside of the program) to LINCS, PrEP, HCV treatment, STD treatment; and sexual/needle-sharing partners to testing	7	7
2D	Ability of proposed program to ensure clients have access (within or outside program) to PrEP and ART for HIV, HCV treatment, and STD treatment.	7	7
2E	Ability to build trust and rapport and have a consistent presence in the community of the population of focus, as well as include community voices in planning, program design, and implementation	3	6
	Extent to which proposed program provides services outside of the agency and in the community, and at various venues in order to engage population of focus	2	
	Extent to which proposed program provides culturally appropriate outreach to population of focus	1	
2F	Ability of proposed program to integrate the provision of safer injection supplies (including data collection) in a seamless, discrete, and non-stigmatizing way	2	4
	Ability of proposed program to reach PWID within population of focus	2	
2G	Extent to which proposed program integrates harm reduction principles into program design and delivery, and put them into practice in a meaningful and impactful way	5	5
2H	Extent to which proposed program integrates overdose prevention and response into existing program services in a seamless way	4	4

2I	Extent to which proposed program integrates mental health support services into existing program in a seamless way	3	3
2J	Extent to which proposed program provides sex-positive and meaningful messaging and education about the relevancy of condom use (particularly for STD prevention)	2	3
	Extent to which proposed program ensures condoms and other safe sex supplies are accessible	1	
2K	Extent to which proposed program ensures the provision of basic needs are available and integrated into existing program services for population of focus	3	3
3A	Extent to which the program design is logical and results in one cohesive effort	1	2
	Appropriateness of times and locations of services for the population of focus	1	
3B	Strength of plan to incorporate the following cross-program elements: a) promote a new testing norm. b) integrate hepatitis C and STD prevention, and c) incentives (if proposed)	2	5
	Extent to which program meets the specific cultural needs of the focus population	3	
3C	Extent to which staffing levels are sufficient given scope of work	2	5
	Extent to which responsibilities are assigned to appropriate staff	1	
	Extent to which it is clear which staff will perform which duties/activities	2	
Section 3: Data Collection, Evaluation, and Quality Assurance (8 points)			
4	Extent to which staffing levels are sufficient given scope of work	1	3
	Efficiency of methods and processes for data collection and entry of client-level data	1	
	Data for 2019 100% on time and complete	1	
5	Extent to which responsibilities are assigned to appropriate staff	2	5
	Extent to which evaluation process will result in continuous program improvement	3	
Section 4: Organizational and Fiscal Capacity (15 points)			
6	Applicant capacity to reach the population of focus and capacity to provide proposed services	5	5
7	Extent to which policies, procedures, practices will lead to recruitment, hiring, and retention of qualified staff	1	2
	Extent to which staff tenure will promote program continuity	1	
8	Budget Detail Expenses are appropriate and support the proposed services.	8	8
		TOTAL POINTS	**100**
LBE Participation % Points			
	LBE Participation	0-10	0-10

Category 4: Health Access Point (HAP) for Gay men and other men who have sex with men (Gay/MSM)

Estimated Amount Available: $1,000,000 to $1,200,000
Number of Awards: 1

1. Background

Gay men and other men who have sex with men (Gay/MSM) are disproportionately affected by HIV, HCV, and STDs in San Francisco. Gay/MSM (including MSM-PWID) represent 74% of new HIV cases in 2017.[11] White MSM account for the highest percentage (41%) of new diagnoses in 2017. HIV infection rates reveal disparities among communities of color. Black/African Americans had the highest rate of new infections (116 per 100,000 people) followed by Latinx (68 per 100,000 people), compared with 39 per 100,000 for white men. In SF, MSM account for nearly 13% of those infected with HCV, and almost three-quarters of Gay/MSM infected with HCV are co-infected with HIV.[12] Gay/MSM have the highest prevalence rates of gonorrhea, chlamydia, and early syphilis.[13] Gay/MSM also overwhelmingly account for the majority of HIV and STD co-infected cases (>95%).

Strong clinical and community-based efforts have helped to significantly decrease HIV incidence among Gay/MSM, especially white MSM. This RFP seeks to build on these successes by taking a community-centered, whole person approach to HIV, HCV, and STD prevention, in order to see continued decreases among Gay/MSM overall, and to decrease disparities among Gay/MSM of color.

2. Minimum Qualifications

- By Jan 1, 2020 applicant must be a nonprofit agency that is tax-exempt under Section 501(c)(3) of the Internal Revenue Code and be licensed to do business with the City and County of San Francisco. City and County of San Francisco government departments/sections may NOT apply.
- Applicant must have at least 3 years of experience providing HIV, HCV, and/or STD testing, or similar services to Gay/MSM. (If a collaboration, only the agency providing the HIV, HCV, and STD testing must meet this qualification.)

[11] San Francisco Department of Public Health. HIV Epidemiology Annual Report 2017. Available at https://www.sfdph.org/dph/comupg/oprograms/HIVepiSec/HIVepiSecReports.asp

[12] https://journals.plos.org/plosone/article/comments?id=10.1371/journal.pone.0195575

[13] San Francisco Sexually Transmitted Disease Annual Summary 2016. Available at https://www.sfdph.org/dph/files/reports/StudiesData/STD/SFSTDAnnlSum2016.pdf

3. Service Description

CHEP seeks to fund a Health Access Point (HAP) to meet the needs of Gay/MSM. A HAP is defined as a population specific, one-stop shop or network of agencies/programs with a lead agency that provides an equity-focused, stigma-free, and low barrier access to person-centered, standard of care services regardless of HIV, HCV, or STD status. The HAP should deliver services that contribute to the following citywide goals:

- Get to zero new HIV infections, zero HIV-related deaths, and zero stigma and discrimination
- Eliminate HCV
- Reverse increasing STD rates
- Eliminate racial disparities in access to services and health outcomes

Services provided within this HAP must be also be culturally specific, harm reduction-based, sex-positive, and trauma-informed. Staff at all levels must demonstrate cultural humility in working with Gay/MSM. Peer-delivered services must be an integral part of the network. Gay/MSM must be included in the design, implementation, and evaluation of services.

The HAP should ensure that services reach all Gay/MSM, using both **targeted** efforts (focused on identified primary subpopulations) as well as **broad-based community-wide engagement and mobilization, regardless of HIV/HCV/STD risk,** to increase awareness, reduce stigma, and reduce barriers to accessing services at the community- level.

4. Population

Programs must be designed to meet the needs of Gay/MSM (including MSM-IDU), regardless of race/ethnicity, age, socioeconomic status, neighborhood, or other factors; however, the program must welcome and serve all who are eligible.

5. Restrictions

- Proposed services must be only for Gay/MSM and identified primary subpopulations. Proposed services must be only for Gay/MSM and identified primary subpopulations. Services for other populations cannot be part of the proposal, although others may access services.
- Funds for HIV/HCV/STD testing must be used for community-based HIV/HCV/STD testing, not testing in clinical or medical settings.

6. Program Requirements

Required Services

The Gay/MSM HAP shall provide the following “standard of care” services. The services marked with an asterisk (*) must be provided by the lead applicant or one of its subcontractors, with funding from either this RFP or other in-kind resources. The other services can be provided either by the lead applicant or one of its subcontractors, or by other Gay/MSM HAP partners (e.g., via linkage to a HAP collaborating agency, via the collaborating agency providing services on site at the applicant’s service location, or other approach). For

services provided by other Gay/MSM HAP partners who are not subcontractors, MOUs and warm hand-off protocols must be in place as appropriate. Each of the following services is described in detail in **Exhibit 1: 6.1**, including required and preferred elements and performance measures for each service.

- Integrated HIV, HCV, and STD testing*
- Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, case management/intensive case management (ICM) and other services*
- Harm reduction services for substance use (including for opioids, stimulants, alcohol, tobacco, cannabis)*
- Syringe access and disposal*
- Overdose prevention (including naloxone distribution)*
- Condom distribution*
- Community engagement and mobilization (physical and online, social media)*
- HIV, HCV, STD health education and prevention counseling, delivered in the context of overall sexual and drug user health (integrated into all of the above services, not stand alone)*
- Services to meet basic needs services (examples: food, housing, employment)*
- Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage
- Mental health services
- Primary care
- Substance use treatment

Required Strategies

- **Maintain a workforce that mirrors the populations served.** Applicants and subcontractors should have Gay/MSM staff represented at all levels of the organization. Client-facing positions (e.g., front desk staff, outreach workers, service delivery staff) should demographically reflect the population served.
- **Ensure that some services are delivered by peers.** "Peers" are defined as people with lived experience similar to that of the populations served, and may or may not share demographic characteristics such as race or gender. For example, an agency could create a community advisory board (CAB) and/or hire and train staff to conduct services, such as outreach, client satisfaction surveys, and assemble hygiene kits.
- **Involve the Gay/MSM community in program development.** Include community voices and qualitative lived experience in all aspects of planning, program design and implementation, and service delivery using a systematic and continuous process. Build on community strengths and ensure that cultural and historical barriers (e.g., mistrust of service providers, language barriers) are removed.
- **Take a sex-positive sexual health approach.** Integrate HIV and STD messaging using a sexual health framework. Develop integrated HIV and STD prevention messages that address condoms, PrEP, and why STDs are an important concern. Incorporate integrated sexual health messaging throughout all HIV and STD prevention efforts – for example, PrEP navigation programs, HIV community forums, and social marketing
- **Provide services using a harm reduction-based, trauma-informed, and cultural humility approach.** See required staff training in **Exhibit 1: 6.3**.
- **All services must be as low barrier as possible.** "Low barrier" means that as few expectations as possible are placed upon clients and potential clients when they are trying to access services. Examples of low barrier services include: mobile services; co-located services (e.g., HCV treatment co-located with

methadone services); drop-in services; express services (e.g., testing without talking to a counselor); and services provided at times convenient for the populations such as evenings, weekends, or late at night.

- **Address stigma for clients.** Provide a non-stigmatizing environment.
- **Address community-level stigma.** Increase the social media presence that promotes integrated sexual health messages and provided information on how to access services. Disseminate DPH-approved messaging, including PrEP and U=U messaging. Increase education and innovation around how to address HIV-related stigma. De- stigmatize substance use through harm reduction education and messaging.
- **Leverage the private healthcare system whenever possible.** People with private insurance should be encouraged and counseled to use their insurance and develop meaningful relationships with primary care providers, when possible.
- **Ensure services are culturally specific**. Develop testing models that incorporate nuances to address different cultural barriers and specific population needs.
- **Build partnerships and collaborations with other organizations. This RFP requires collaboration to ensure populations have access to required services.**

Optional Strategies

- **Offer incentives.** Programs may propose to use non-cash incentives when they are critical for engaging the population of focus, to recruit people for testing, PrEP, treatment, or other service when warranted (e.g., food vouchers, gift cards, cell phones, cell phone credits, etc.).

Compliance

- Comply with CHEP Policies and Operations Manual for HIV/HCV Testing Services in Community-Based Settings, which are subject to modification at any time. The current policies and procedures can be found HERE
- Comply with SFDPH's Harm Reduction Policy found HERE
- Comply with SFDPH's Syringe Access and Disposal Program Policies and Guidelines found (being updated)
- Comply with the CHEP's Materials Review Process Guidelines found HERE

7. Healthy Staff, Agencies, and Collaborations

Healthy Staff

- **Staff training.** SFDPH and its partners are committed to building and maintaining a highly skilled workforce, prepared to deal with the complexity of client and community needs. To that end, agency staff funded through this RFP will be required to participate in the following trainings: racial humility, trauma informed systems (TIS), and harm reduction training of all staff. The staff that must participate in these trainings will be addressed during contract negotiations.
- **Staff pay.** According to Housing and Urban Development (HUD), in SF in 2018, a single adult is considered to be low income if they make less than $82,200 per year; for a 4-person family the cut-off is $117,300. (Source: https://www.huduser.gov/portal/datasets/il/il2018/2018summary.odn) SFDPH encourages agencies to provide livable wages to staff.

Healthy Agencies

- **Staff retention.** Agencies must have a plan in place to support client-facing staff to prevent burnout and address the vicarious trauma that can occur while working with traumatized populations. Examples of an effective plan include (but are not limited to): staff support group facilitated by a clinician such as an LMFT or LSCW who is also available for individual support as needed. Agencies must allow staff to participate in the San Francisco HIV Frontline Organizing Group (SF HIV FOG), Navigator's meeting, and other professional development activities.

Healthy Collaborations

Collaboration with other community-based organizations (CBOs), clinics, and other organizations is required in order to ensure populations have access to required services. Even though two (2) or more agencies are involved, these collaborations should result in one (1) cohesive program for the clients they serve.

8. Additional Considerations

- CHEP will provide:
  - HIV/HCV/STD Skills Certification Training
  - Harm Reduction Training
  - Overdose Prevention Training (via its contract with Harm Reduction Coalition's DOPE Project)
  - Training on STD specimen collection
  - Test kits
  - Condoms, lube, and female condoms
  - Training on Clear Impact Results Scorecard
  - Racial Humility resources
  - Trauma informed systems (TIS) training
  - Training on Syringe Access and Disposal

- Health Access Point lead applicant should budget for:
  - Clear Impact Results Scorecard logins (2 per agency at $1200/annually total)
  - Phlebotomy Training and Certification
  - Condoms and safer sex supplies (if not going through the condom distribution program)
  - Syringe access and disposal supplies (including syringes)

9. Program Evaluation and Accountability

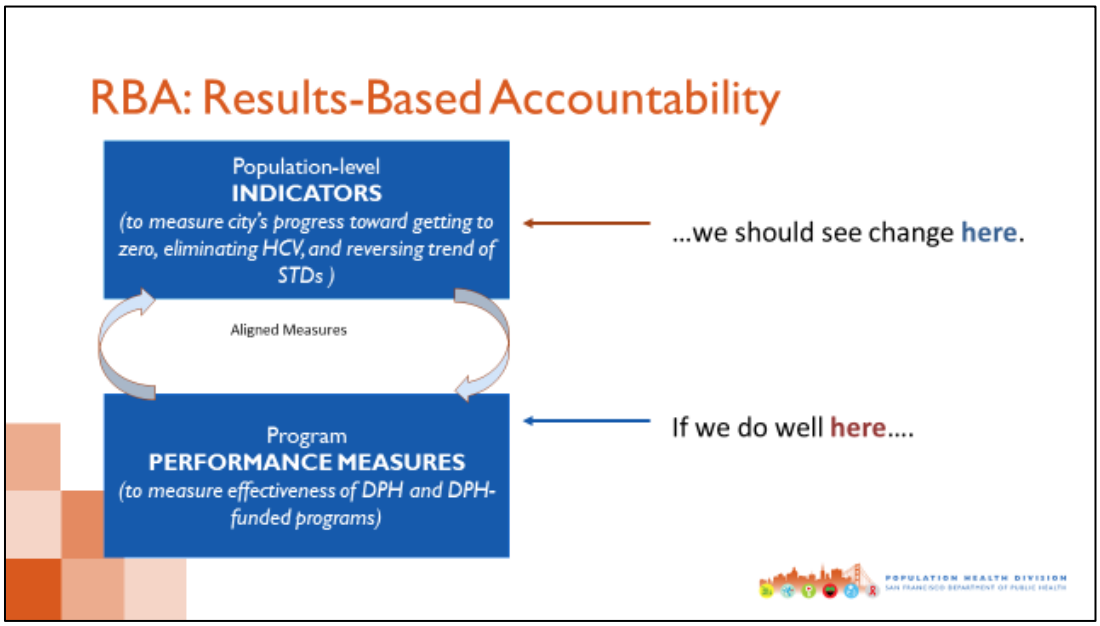
SFDPH seeks to implement program evaluation that allows for flexibility, supports accountability, and encourages innovation. Evaluation findings will be used to improve services, and to hold providers accountable for improving community health. Program innovations are encouraged when accompanied by evaluation plans that can rapidly determine whether the innovations should be adopted, adapted, or abandoned.

Funded programs will be required to use the Results-Based Accountability (RBA) Framework and the Clear Impact Results Scorecard (https://clearimpact.com/scorecard/). RBA is a framework used to improve and track the effectiveness of programs. It is data driven and has two distinct parts: population accountability and performance accountability.

A. Performance Measures

A "program performance measure" is a measure used to track the results of the applicant's specific program. Performance measures and other data collection requirements for each "standard of care" service are provided in **Exhibit 1: 6.1**.

A "population indicator" is a measure used to track the health outcomes of a particular population group. No single program can be held accountable for changing HIV, HCV, or STD rates among Gay/MSM. However, by collaborating with HAP partner agencies and other relevant entities, SFDPH expects to see reductions in HIV, HCV, and STD rates among MSM over the next 3-5 years. SFDPH will convene regular HAP partner meetings to review relevant population indicators and facilitate discussion and action planning for achieving the desired outcomes.



B. Data Collection and Reporting

Funded programs must comply with all CHEP requirements regarding data collection and submission, which will include working with CHEP to measure and report on program-specific objectives and collecting/reporting basic demographic, behavioral risk, and other essential information. Systems/processes used to collect and submit data will include:

- Evaluation Web
- Clear Impact Results Scorecard
- Annual narrative report
- Other systems/processes as requested

10. Narrative Instructions

Below are the instructions for the narrative portion of the proposal package. Instructions for development and submission of the complete proposal package can be found in **Section III: Submission Requirements**.

- Complete all sections of the narrative as outlined below. Applicants must complete the sections and questions **in the order listed**. (Applicants do not have to address the bullet points within each question in the order listed, just the questions.) Label the beginning of each section as indicated and include each question number, but do not repeat the question text.
- The narrative may not exceed **38 pages** (1.5 spacing between lines). Page numbers for individual sections and questions are guidelines only.
- Describe all the components of the proposed program here, even if some components are funded by another source, and be clear about which portion you are asking CHEP to support. For example, mental health is a component of the proposed program and could be funded by another source.
- In narrative Sections 1-4, describe your program as it will be when it is fully operational. Start-up needs can be discussed in narrative Section 5.
- Be specific.

Section 1: Population of Focus (3 pages)

➢ **Describe:**

- The population of focus your program will serve including subpopulations, age, geography, language, socioeconomic status, and other characteristics.
- The HIV, HCV, and STD risk behaviors and social determinants of health affecting your population,
- Why you have chosen this specific population (including any identified primary subpopulations) and why your program meets their needs. Use epidemiologic, community assessment, and other data to support your argument.

Section 2: Program Design and Effectiveness (29 pages)

Note: In this section of the narrative, collaborative proposals should clearly describe the specific roles and responsibilities of the partners and who will implement which portions of the program.

➢ **Describe your program components.**

A. Program overview (2 pages).

Provide an overview of your program and explain how it represents an equity-focused, stigma-free, low barrier, and whole person health approach to HIV, HCV, and STD prevention for the identified population of focus.

B. Integrated HIV, HCV, and STD testing (6 pages).

Describe your agency's testing model, including:

- Your agency's experience providing HIV, HCV, and STD testing. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.
- The number of testing experiences (by primary subpopulations, if applicable) your program will

provide (i.e. 2,000 testing experiences for trans women and 10,000 for Gay/MSM). Provide the rationale for those numbers. **CHEP's goal is to conduct 50,000 testing experiences annually citywide**. An experience is defined as getting at least one (1) of five (5) tests (HIV, HCV, gonorrhea, chlamydia, and/or syphilis) in a single visit (See Integrated HIV, HCV, and STD testing in **Appendix A-1, 6.1**). For example, a client can receive one (1) test, all five (5), or anything in between and it is considered an "experience".

- Recruitment, Retention
  The strategies and interventions you will use to recruit people for HIV, HCV, and STD testing and encourage them to return for testing at least every 6 months, and the evidence or experience supporting the effectiveness of these activities.
  The HIV, HCV, and STD testing barriers for this population, including identified primary subpopulations. Describe how your program will address these barriers.
  Where and when your agency will provide HIV, HCV, and STD testing and why these sites and venues are appropriate.

- Testing Flow
  The flow of services at the different testing location(s). Describe how this will help your agency to provide the proposed number of experiences, provide the required and optional services you are proposing, and meet client needs.
  Describe any relevant technologies being used, e.g. if conducting rapid testing, how you will ensure that confirmatory blood draws are obtained, if using drop 'n' go/express model, please describe the process that will be utilized and how patient time will be minimized.
  Describe your plan for getting people to return for their results.
  How your agency will ensure that clients who do not receive counseling as a part of a testing experience still receive HIV, HCV, and STD health information, risk reduction, support, and appropriate prevention messages.

- Data and Quality Assurance:
  Demonstrate how your agency will track these experiences, how your agency will integrate client-level data collection into the flow of services, without creating unnecessary burden for clients. Describe how you will conduct training and quality assurance to meet the requirements of the CHEP Policies and Operations Manual for HIV and HCV Testing Services in Community-Based Settings (found HERE).

C. Linkage and Navigation (3 pages).
Describe your criteria and processes for linkage within and outside of your program, including a description of any collaborations or referral agreements with other agencies (attach MOUs to your proposal). Specifically, describe how linkage and/or navigation will occur related to:

- HIV-negative, HCV- and STD-unknown status clients to HIV/HCV/STD testing within the program.
- HIV-negative clients to PrEP within the program or to a PrEP navigator.
- Newly diagnosed HIV-positive clients to care within program or to LINCS
- Clients that have a STD to treatment within the program or other provider.
- HCV-positive clients to HCV treatment within program or to a HCV navigator.

- Sexual and/or needle-sharing partners of HIV, HCV, and/or STD-positive clients, to HIV, HCV, and/or STD testing within the program (or elsewhere).
- Clients to other services/HAPs, if client needs cannot be met within the program.
- Out-of-care HIV-positive clients to LINCS.
- How your program will track linkages to ensure they are successful.
- Your agency's experience providing linkage and/or navigation services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

D. Prevention And Treatment Medication: Prep and ART for HIV; HCV Treatment; STD Treatment, Including Medical Storage (2 pages)
Describe your criteria and processes for ensuring access to prevention and treatment medication within and outside of your program, including a description of any collaborations or referral agreements with other agencies (attach MOUs to your proposal). Specifically, describe how prevention and treatment medication will occur related to:

- HIV-negative clients receiving PrEP within the program or other provider.
- Newly diagnosed HIV-positive clients initiating ART within program or other provider.
- HCV-positive clients receiving treatment within program or other provider.
- Clients that have a STD receiving treatment within program or other provider.
- How your program will track prevention and treatment medication initiation and/or completion to ensure it was successful.
- Your agency's experience providing prevention and treatment medication. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

E. <u>Community Engagement (2 pages).</u>
Describe in detail:

- Your agency's experience conducting community engagement activities for population of focus. How long have you been conducting these activities? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

Describe in detail how your program will:
- Build trust within the community and have a consistent presence.
- Partner with other local CBOs, agencies and/or community leaders who have a strong relationship with the community.
- Include community voices and qualitative lived experience in all aspects of planning, program design/implementation, and service delivery. Build on community strengths and ensure that cultural and historical barriers (e.g. mistrust of service providers, language barriers) are removed.
- Build a highly skilled cross-trained workforce that reflects the populations served, has low turnover rates, and is valued and supported.

- Expand or implement peer-delivered services. Involve peers in program development, and use peers to conduct outreach and provide services.
- Increase mobile service delivery (if program is or will be providing mobile service). Provide multidisciplinary mobile services to meet a variety of needs among populations who do not access health care in traditional settings.
- Provide culturally appropriate outreach to community.

F. Syringe Access and Disposal (1 pages).
Describe in detail:

- Your agency's experience conducting syringe access and disposal services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- Describe how you will conduct quality assurance to meet the requirements of the CHEP Syringe Access and Disposal Program Policy and Guidelines located HERE.
- Your program's plans for integrating the provision of safer injection supplies during the course of other services for clients in need, in a seamless, discrete, and non-stigmatizing way.
- Any preferred elements from the Syringe Access and Disposal table in **Exhibit 1: 6.1** that will be provided within the program. Explain how these elements will be integrated into existing programming.
- How you will reach and meet the specific cultural needs of PWID, including any PWID subpopulations (e.g. MSM, youth, women, and trans women and men, homeless) within your agency's population of focus and create a safe and welcoming environment for them.
- How your data will be tracked for number of syringes distributed and number of syringes collected.
- Your program's syringe disposal plan.

G. Harm reduction services for substance use (including opioids, stimulants, alcohol, tobacco, and cannabis (2 pages).
Describe in detail:

- Your agency's experience providing substance use harm reduction services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program
- How your program will ensure ALL staff participate in ongoing harm reduction training. How staff training will be tracked.
- Your program's mechanism for assessing client needs on an ongoing, systematic basis for substance use including opioids, stimulants, alcohol, tobacco, and cannabis.
- How your program will integrate harm reduction principles and the SFDPH Harm Reduction Policy into program design and delivery and put them into practice in a meaningful and impactful way.

H. Overdose Prevention (2 pages).
Describe in detail:

- Your agency's experience with overdose prevention and response. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- How you will meet the required elements of overdose prevention. How your program will integrate overdose prevention and response into your existing program.
- Any preferred elements from the overdose prevention table in **Exhibit 1: 6.1** that will be provided within the program. Explain how these elements will be integrated into existing programming.
- What overdose prevention materials your agency will make available to clients.
- How your program will ensure ALL client facing staff participate in annual overdose prevention and response training. Describe how the program will track training.
- How your program will host at least one overdose prevention training for clients annually. How will this be tracked?

I. Mental Health (1 page).
Describe in detail:

- Your agency's experience providing mental health services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- How your program will integrate culturally appropriate, stigma-free, mental health support into your existing program (e.g. onsite or through linkages to other program).
- How your program will confirm and track linkages to mental health services.

J. Condom Distribution (1 page).
Describe in detail:

- How your program will ensure condoms and other safe sex supplies are easily accessible on site, during outreach, and in mobile facilities.
- The sex-positive and meaningful messaging and education your agency will provide to emphasize that condoms are relevant, particularly for STD prevention.

K. Basic Needs (1 page).
Describe in detail:

- Your program's experience providing basic needs to your population of focus and/or any subpopulations.
- How your program will integrate the provision of basic needs into existing program for the population of focus and/or any subpopulations of focus.

- **Describe your program as a whole.**

A. Program Cohesiveness (2 pages).

Describe how the various program components (see below) work together to form one logical, cohesive program. Include a discussion of service times and locations that shows how the program components are linked together. Collaborative proposals: Discuss how the collaborators will work together to provide one cohesive and seamless program. Note: Please see **Exhibit 1: 6.1** for details on the program components listed below.

- Integrated HIV, HCV, and STD testing
- Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, and other services
- Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis)
- Syringe access and disposal
- Overdose prevention (including naloxone distribution)
- Condom distribution
- Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis)
- Community engagement and mobilization (physical and online, social media)
- Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage
- Services to meet basic needs services (examples: food, housing, employment)
- Primary care
- Substance use treatment
- Mental health services

B. Cross-program Elements (2 pages).

Describe:

- How your program will address the specific cultural needs of your population of focus and/or subgroups within your population of focus.
- Any incentives you plan to use. Provide a strong justification for why they are needed as well as evidence or experience supporting their effectiveness. If you are proposing cash incentives, justify why cash is preferred to a non-cash incentive and describe how you will manage cash on the premises.
- How your program will ensure health education and prevention counseling is delivered in the context of overall sexual health and harm reduction and integrated into all of the standard of care services (not stand alone).

C. Staffing Plan (2 pages).
Describe your staffing plan (including volunteers) for service delivery. (Describe staffing for data and evaluation in Section 4.) Describe who will provide which services. What percent of their time is allocated to service delivery? What are the staff members' responsibilities and percent full-time equivalent (FTE)? You may include a one-page organization chart or visual that represents the collaboration as an attachment.

Section 3: Data Collection, Evaluation, and Quality Assurance (2 pages)

- (1 page) **Describe your plans for collecting and managing the data for the standard of care services (Exhibit 1: 6.1), including:**

  - Your staffing plan for supporting data collection and management.
  - Your methods and processes for collecting, entering, and reporting client-level data.
  - If you are currently a CHEP contractor, whether your data submissions were on time and complete for the year 2019.
  - If you are not currently a CHEP contractor, whether data submissions for other funders were on time and complete for the year 2019.

- (1 page**) Describe your staffing plan and general process for program evaluation, including:**
  - Staff assigned to program evaluation. Indicate which staff position will be responsible for leading the program evaluation efforts, and how much time will be devoted to it.
  - How you will review and assess the extent to which your program is meeting its objectives.
  - What you will do if you learn the program is not meeting its objectives.
  - How you will use data/evaluation findings to improve the program.

Section 4: Organizational and Fiscal Capacity (3 pages)

- (1 page) **Describe the agency's experience conducting recruitment and retention with the Gay/MSM population and/or specific subpopulations.** What types of activities have you done in the past, and how successful have they been at engaging the population(s)? If relevant, include a summary of any data demonstrating your capacity to reach this population and/or specific subpopulations, such as program attendance records, a list of venues where you routinely conduct outreach, or other data.

- (1 page) **Describe your ability to recruit and retain qualified staff, staff reflective of the population being served, peers, and volunteers.** Discuss all of the above, not just staff in general. What staff development/training opportunities will you offer or require? What is the approximate average length of stay for both front-line staff and staff in leadership positions?

- **Budget Detail Booklet:**

  - Complete the Budget Detail and Justification Booklet for a 12 Month Period
  - If you are requesting start up funds please, submit a separate Detail and Justification.

- **Applicants who are LBE Certified will receive additional points.**
  - **This will be added to the "Technical Review Score".**
  - **See LBE Participation terms outlined in the VI. Standard Terms and Conditions for Receipt of Proposals.**

	Bidder Rating Discount:	**0-10**
	10% discount to LBE; or joint venture between or among LBEs	
	5% discount to joint venture with LBE participation that equals or exceeds 35% but is under 40%.	
	7.5% discount to a joint venture with LBE participation that equals or exceeds 40%.	
	10% discount to a certified non-profit entity.	
	Total Available Points:	**10**

11. Scoring Criteria and Rating System

The proposal review process is described in **Section IV: Review and Selection Process**. This table provides the scoring criteria and rating system for **Category 4 proposals.**

Category 4: Health Access Point (HAP) for Gay/MSM			
Question Number	**Scoring Criteria**	**Max. Pts. per Criterion**	**Max. Pts. per Question**
Section 1: Population of Focus (10 points)			
1	Extent to which the applicant demonstrates an understanding of the needs of the population of focus	4	10
	Extent to which the program focuses on the population of focus	2	
	Understanding of risk behaviors and social determinants of health affecting the population of focus	4	
Section 2: Program Design and Effectiveness (67 points)			
2A	Extent to which program takes an equity-focused, stigma-free, low barrier, and whole person health approach	5	5
2B	Ability of the recruitment/retention plan to result in the proposed number of testing experiences among the population of focus	2	8
	Extent to which the integrated HIV, HCV, and STD testing model and flow of services (including any state-certified test counseling and data collection) is seamless and minimizes barriers to testing	2	
	Extent to which the needs of clients testing HIV-negative or HIV-positive will be met (through state certified counseling and/or other means)	2	
	Ability to which quality assurance plan for HIV, HCV, and STD integrated testing will result in high quality service	2	
2C	Ability of proposed program to link and navigate clients (within or outside of the program) to LINCS, PrEP, HCV treatment, STD treatment; and sexual/needle-sharing partners to testing	7	7
2D	Ability of proposed program to ensure clients have access (within or outside program) to PrEP and ART for HIV, HCV treatment, and STD treatment.	7	7
2E	Ability to build trust and rapport and have a consistent presence in the community of the population of focus, as well as include community voices in planning, program design, and implementation	3	6
	Extent to which proposed program provides services outside of the agency and in the community, and at various venues in order to engage population of focus	2	
	Extent to which proposed program provides culturally appropriate outreach to population of focus	1	
2F	Ability of proposed program to integrate the provision of safer injection supplies (including data collection) in a seamless, discrete, and non-stigmatizing way	2	4
	Ability of proposed program to reach PWID within population of focus	2	
2G	Extent to which proposed program integrates harm reduction principles into program design and delivery, and put them into practice in a meaningful and impactful way	5	5
2H	Extent to which proposed program integrates overdose prevention and response into existing program services in a seamless way	4	4

2I	Extent to which proposed program integrates mental health support services into existing program in a seamless way	3	3
2J	Extent to which proposed program provides sex-positive and meaningful messaging and education about the relevancy of condom use (particularly for STD prevention)	2	3
	Extent to which proposed program ensures condoms and other safe sex supplies are accessible	1	
2K	Extent to which proposed program ensures the provision of basic needs are available and integrated into existing program services for population of focus	3	3
3A	Extent to which the program design is logical and results in one cohesive effort	1	2
	Appropriateness of times and locations of services for the population of focus	1	
3B	Strength of plan to incorporate the following cross-program elements: a) promote a new testing norm. b) integrate hepatitis C and STD prevention, and c) incentives (if proposed)	2	5
	Extent to which program meets the specific cultural needs of the focus population	3	
3C	Extent to which staffing levels are sufficient given scope of work	2	5
	Extent to which responsibilities are assigned to appropriate staff	1	
	Extent to which it is clear which staff will perform which duties/activities	2	
Section 3: Data Collection, Evaluation, and Quality Assurance (8 points)			
4	Extent to which staffing levels are sufficient given scope of work	1	3
	Efficiency of methods and processes for data collection and entry of client-level data	1	
	Data for 2019 100% on time and complete	1	
5	Extent to which responsibilities are assigned to appropriate staff	2	5
	Extent to which evaluation process will result in continuous program improvement	3	
Section 4: Organizational and Fiscal Capacity (15 points)			
6	Applicant capacity to reach the population of focus and capacity to provide proposed services	5	5
7	Extent to which policies, procedures, practices will lead to recruitment, hiring, and retention of qualified staff	1	2
	Extent to which staff tenure will promote program continuity	1	
8	Budget Detail Expenses are appropriate and support the proposed services.	8	8
		TOTAL POINTS	**100**
LBE Participation % Points			
	LBE Participation	0-10	0-10

Category 5: Health Access Point (HAP) for Asians and Pacific Islanders

Estimated Amount Available: From $540,000 to $660,000
Number of Awards: 1

1. Background

In the United States from 2011 to 2015, HIV diagnoses increased by 28% among Asians and Pacific Islanders (API), and by 35% among Asian gay and bisexual men. Although HIV rates in these communities are still relatively low, high levels of stigma leave many living with HIV undiagnosed and untreated.[14]

In San Francisco, trends in race/ethnicity show small increases in the proportion of API newly diagnosed with HIV since 2012. Early syphilis rates declined moderately from 2015 to 2016 across all race/ethnicity groups except API, among whom there was a 22.4% increase.[15] Although hepatitis B (HBV) disproportionately impacts the API community, levels of HCV have been and remain low. API individuals accounted for 8.1% of the HCV cases newly reported to SFDPH in 2016 that contained race/ethnicity information.

Strong clinical and community-based efforts have helped to significantly decrease (50%) new HIV diagnoses since 2012. This RFP seeks to build on this success by taking a community-centered, whole person approach to HIV, HCV, and STD prevention.

2. Minimum Qualifications

- By Jan 1, 2020 applicant must be a nonprofit agency that is tax-exempt under Section 501(c)(3) of the Internal Revenue Code and be licensed to do business with the City and County of San Francisco. City and County of San Francisco government departments/sections may NOT apply.
- Applicant must have at least 3 years of experience providing HIV, HCV, and/or STD testing, or similar services to API. (If a collaboration, only the agency providing the HIV, HCV, and STD testing must meet this qualification.)

3. Service Description

CHEP seeks to fund a Health Access Point (HAP) to meet the needs of API. A HAP is defined as a population specific, one-stop shop or network of agencies/programs with a lead agency that provides an equity-focused, stigma-free, and low barrier access to person-centered, standard of care services regardless of HIV, HCV, or STD status. The HAP should deliver services that contribute to the following citywide goals:

- Get to zero new HIV infections, zero HIV-related deaths, and zero stigma and discrimination

[14] AmfAR. HIV Among Asian-Americans and Pacific Islanders—A Problem Too Often in the Shadows Published Friday. (2019, May 17).

[15] San Francisco Sexually Transmitted Disease Annual Summary 2016. Available at https://www.sfdph.org/dph/files/reports/StudiesData/STD/SFSTDAnnlSum2016.pdf

- Eliminate HCV
- Reverse increasing STD rates
- Eliminate racial disparities in access to services and health outcomes

Services provided within this HAP must be also be culturally specific, harm reduction-based, sex-positive, and trauma-informed. Staff at all levels must demonstrate cultural humility in working with API. Peer-delivered services must be an integral part of the network. API must be included in the design, implementation, and evaluation of services.

The HAP should ensure that services reach all API, using both **targeted** efforts (focused on identified primary subpopulations) as well as **broad-based community-wide engagement and mobilization, regardless of HIV/HCV/STD risk,** to increase awareness, reduce stigma, and reduce barriers to accessing services at the community- level.

4. Population

Programs must be designed to meet the needs of API, regardless of age, socioeconomic status, neighborhood, or other factors; however, the program must welcome and serve all who are eligible.

5. Restrictions

- Proposed services must be only for API and identified primary subpopulations. Proposed services must be only for API and identified primary subpopulations. Services for other populations cannot be part of the proposal, although others may access services.
- Funds for HIV/HCV/STD testing must be used for community-based HIV/HCV/STD testing, not testing in clinical or medical settings.

6. Program Requirements

Required Services

The API HAP shall provide the following "standard of care" services. The services marked with an asterisk (*) must be provided by the lead applicant or one of its subcontractors, with funding from either this RFP or other in-kind resources. The other services can be provided either by the lead applicant or one of its subcontractors, or by other API HAP partners (e.g., via linkage to a HAP collaborating agency, via the collaborating agency providing services on site at the applicant's service location, or other approach). For services provided by other API HAP partners who are not subcontractors, MOUs and warm hand-off protocols must be in place as appropriate. Each of the following services is described in detail in **Exhibit 1: 6.1**, including required and preferred elements and performance measures for each service.

- Integrated HIV, HCV, and STD testing*
- Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, case management/intensive case management (ICM) and other services*
- Harm reduction services for substance use (including for opioids, stimulants, alcohol, tobacco, cannabis)*
- Syringe access and disposal*
- Overdose prevention (including naloxone distribution)*
- Condom distribution*

- Community engagement and mobilization (physical and online, social media)*
- HIV, HCV, STD health education and prevention counseling, delivered in the context of overall sexual and drug user health (integrated into all of the above services, not stand alone)*
- Services to meet basic needs services (examples: food, housing, employment)*
- Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage
- Mental health services
- Primary care
- Substance use treatment

Required Strategies

- **Maintain a workforce that mirrors the populations served.** Applicants and subcontractors should have API staff represented at all levels of the organization. Client-facing positions (e.g., front desk staff, outreach workers, service delivery staff) should demographically reflect the population served.
- **Ensure that some services are delivered by peers.** "Peers" are defined as people with lived experience similar to that of the populations served, and may or may not share demographic characteristics such as race or gender. For example, an agency could create a community advisory board (CAB) and/or hire and train staff to conduct services, such as outreach, client satisfaction surveys, and assemble hygiene kits.
- **Involve the API community in program development.** Include community voices and qualitative lived experience in all aspects of planning, program design and implementation, and service delivery using a systematic and continuous process. Build on community strengths and ensure that cultural and historical barriers (e.g., mistrust of service providers, language barriers) are removed.
- **Take a sex-positive sexual health approach.** Integrate HIV and STD messaging using a sexual health framework. Develop integrated HIV and STD prevention messages that address condoms, PrEP, and why STDs are an important concern. Incorporate integrated sexual health messaging throughout all HIV and STD prevention efforts—for example, PrEP navigation programs, HIV community forums, and social marketing
- **Provide services using a harm reduction-based, trauma-informed, and cultural humility approach.** See required staff training in **Exhibit 1: 6.3**.
- **All services must be as low barrier as possible.** "Low barrier" means that as few expectations as possible are placed upon clients and potential clients when they are trying to access services. Examples of low barrier services include mobile services; co-located services (e.g., HCV treatment co-located with methadone services); drop-in services; express services (e.g., testing without talking to a counselor); and services provided at times convenient for the populations such as evenings, weekends, or late at night.
- **Address stigma for clients.** Provide a non-stigmatizing environment.
- **Address community-level stigma.** Increase the social media presence that promotes integrated sexual health messages and provided information on how to access services. Disseminate DPH-approved messaging, including PrEP and U=U messaging. Increase education and innovation around how to address HIV-related stigma. De- stigmatize substance use through harm reduction education and messaging.
- **Leverage the private healthcare system whenever possible.** People with private insurance should be encouraged and counseled to use their insurance and develop meaningful relationships with primary care providers, when possible.
- **Ensure services are culturally specific**. Develop testing models that incorporate nuances to address different cultural barriers and specific population needs.

- **Build partnerships and collaborations with other organizations. This RFP requires collaboration to ensure populations have access to required services.**

Optional Strategies

- **Offer incentives.** Programs may propose to use non-cash incentives when they are critical for engaging the population of focus, to recruit people for testing, PrEP, treatment, or other service when warranted (e.g., food vouchers, gift cards, cell phones, cell phone credits, etc.).

Compliance

- Comply with CHEP Policies and Operations Manual for HIV/HCV Testing Services in Community-Based Settings, which are subject to modification at any time. The current policies and procedures can be found HERE
- Comply with SFDPH's Harm Reduction Policy found HERE
- Comply with SFDPH's Syringe Access and Disposal Program Policies and Guidelines found (being updated)
- Comply with the CHEP's Materials Review Process Guidelines found HERE

7. Healthy Staff, Agencies, and Collaborations

Healthy Staff

- **Staff training.** SFDPH and its partners are committed to building and maintaining a highly skilled workforce, prepared to deal with the complexity of client and community needs. To that end, agency staff funded through this RFP will be required to participate in the following trainings: racial humility, trauma informed systems (TIS), and harm reduction training of all staff. The staff that must participate in these trainings will be addressed during contract negotiations.
- **Staff pay.** According to Housing and Urban Development (HUD), in SF in 2018, a single adult is considered to be low income if they make less than $82,200 per year; for a 4-person family the cut-off is $117,300. (Source: https://www.huduser.gov/portal/datasets/il/il2018/2018summary.odn) SFDPH encourages agencies to provide livable wages to staff.

Healthy Agencies

- **Staff retention.** Agencies must have a plan in place to support client-facing staff to prevent burnout and address the vicarious trauma that can occur while working with traumatized populations. Examples of an effective plan include (but are not limited to): staff support group facilitated by a clinician such as an LMFT or LSCW who is also available for individual support as needed. Agencies must allow staff to participate in the San Francisco HIV Frontline Organizing Group (SF HIV FOG), Navigator's meeting, and other professional development activities.

Healthy Collaborations

Collaboration with other community-based organizations (CBOs), clinics, and other organizations is required in order to ensure populations have access to required services. Even though two or more agencies are involved, these collaborations should result in one cohesive program for the clients they serve.

8. Additional Considerations

- CHEP will provide:
  - HIV/HCV/STD Skills Certification Training
  - Harm Reduction Training
  - Overdose Prevention Training (via its contract with Harm Reduction Coalition's DOPE Project)
  - Training on STD specimen collection
  - Test kits
  - Condoms, lube, and female condoms
  - Training on Clear Impact Results Scorecard
  - Racial Humility resources
  - Trauma informed systems (TIS) training
  - Training on Syringe Access and Disposal

- Health Access Point lead applicant should budget for:
  - Clear Impact Results Scorecard logins (2 per agency at $1200/annually total)
  - Phlebotomy Training and Certification
  - Condoms and safer sex supplies (if not going through the condom distribution program)
  - Syringe access and disposal supplies (including syringes)

9. Program Evaluation and Accountability

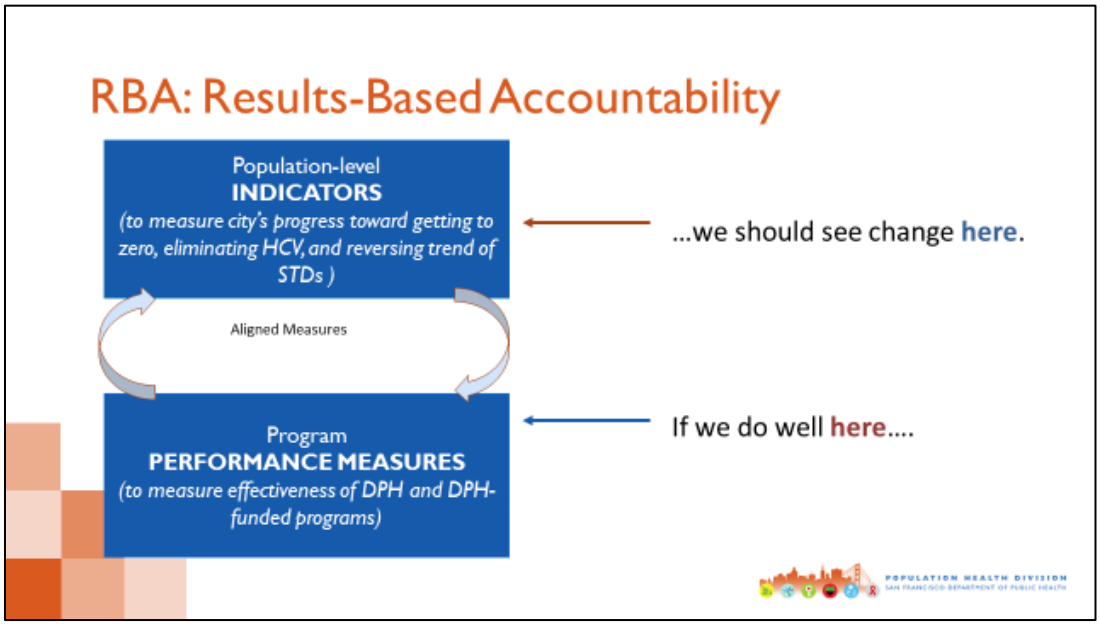
SFDPH seeks to implement program evaluation that allows for flexibility, supports accountability, and encourages innovation. Evaluation findings will be used to improve services, and to hold providers accountable for improving community health. Program innovations are encouraged when accompanied by evaluation plans that can rapidly determine whether the innovations should be adopted, adapted, or abandoned.

Funded programs will be required to use the Results-Based Accountability (RBA) Framework and the Clear Impact Results Scorecard (https://clearimpact.com/scorecard/). RBA is a framework used to improve and track the effectiveness of programs. It is data driven and has two distinct parts: population accountability and performance accountability.

A. Performance Measures

A "program performance measure" is a measure used to track the results of the applicant's specific program. Performance measures and other data collection requirements for each "standard of care" service are provided in **Exhibit 1: 6.1**.

A "population indicator" is a measure used to track the health outcomes of a particular population group. No single program can be held accountable for changing HIV, HCV, or STD rates among API. However, by collaborating with HAP partner agencies and other relevant entities, SFDPH expects to see reductions in HIV, HCV, and STD rates among API over the next 3-5 years. SFDPH will convene regular HAP partner meetings to review relevant population indicators and facilitate discussion and action planning for achieving the desired outcomes.



B. Data Collection and Reporting

Funded programs must comply with all CHEP requirements regarding data collection and submission, which will include working with CHEP to measure and report on program-specific objectives and collecting/reporting basic demographic, behavioral risk, and other essential information. Systems/processes used to collect and submit data will include:

- Evaluation Web
- Clear Impact Results Scorecard
- Annual narrative report
- Other systems/processes as requested

10. Narrative Instructions

Below are the instructions for the narrative portion of the proposal package. Instructions for development and submission of the complete proposal package can be found in **Section III: Submission Requirements**.

- Complete all sections of the narrative as outlined below. Applicants must complete the sections and questions **in the order listed**. (Applicants do not have to address the bullet points within each question in the order listed, just the questions.) Label the beginning of each section as indicated and include each question number, but do not repeat the question text.
- The narrative may not exceed **38 pages** (1.5 spacing between lines). Page numbers for individual sections and questions are guidelines only.
- Describe all the components of the proposed program here, even if some components are funded by another source, and be clear about which portion you are asking CHEP to support. For example, mental health is a component of the proposed program and could be funded by another source.
- In narrative Sections 1-4, describe your program as it will be when it is fully operational. Start-up needs can be discussed in narrative Section 5.
- Be specific.

Section 1: Population of Focus (3 pages)

- **Describe:**
  - The population of focus your program will serve including subpopulations, age, geography, language, socioeconomic status, and other characteristics.
  - The HIV, HCV, and STD risk behaviors and social determinants of health affecting your population,
  - Why you have chosen this specific population (including any identified primary subpopulations) and why your program meets their needs. Use epidemiologic, community assessment, and other data to support your argument.

Section 2: Program Design and Effectiveness (29 pages)

Note: In this section of the narrative, collaborative proposals should clearly describe the specific roles and responsibilities of the partners and who will implement which portions of the program.

- **Describe your program components.**

A. Program overview (2 pages).
Provide an overview of your program and explain how it represents an equity-focused, stigma-free, low barrier, and whole person health approach to HIV, HCV, and STD prevention for the identified population of focus.

B. Integrated HIV, HCV, and STD testing (6 pages).
Describe your agency's testing model, including:

- Your agency's experience providing HIV, HCV, and STD testing. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.
- The number of testing experiences (by primary subpopulations, if applicable) your program will provide (i.e. 2,000 testing experiences for trans women and 10,000 for Gay/MSM). Provide the rationale for those numbers. **CHEP's goal is to conduct 50,000 testing experiences annually citywide**. An experience is defined as getting at least one (1) of five (5) tests (HIV, HCV, gonorrhea, chlamydia, and/or syphilis) in a single visit (See Integrated HIV, HCV, and STD testing in **Exhibit-1: 6.1**. For example, a client can receive one (1) test, all five (5), or anything in between and it is considered an "experience".

- Recruitment, Retention:
  The strategies and interventions you will use to recruit people for HIV, HCV, and STD testing and encourage them to return for testing at least every 6 months, and the evidence or experience supporting the effectiveness of these activities.
  The HIV, HCV, and STD testing barriers for this population, including identified primary subpopulations. Describe how your program will address these barriers.
  Where and when your agency will provide HIV, HCV, and STD testing and why these sites and venues are appropriate

- Testing Flow:
  The flow of services at the different testing location(s). **Describe how this will help your agency to provide the proposed number of experiences, provide the required and optional services**

you are proposing, and meet client needs.
Describe any relevant technologies being used, e.g. if conducting rapid testing, how you will ensure that confirmatory blood draws are obtained, if using drop 'n' go/express model, please describe the process that will be utilized and how patient time will be minimized.
Describe your plan for getting people to return for their results.
How your agency will ensure that clients who do not receive counseling as a part of a testing experience still receive HIV, HCV, and STD health information, risk reduction, support, and appropriate prevention messages.

- Data and Quality Assurance:
  Demonstrate how your agency will track these experiences, how your agency will integrate client-level data collection into the flow of services, without creating unnecessary burden for clients. Describe how you will conduct training and quality assurance to meet the requirements of the CHEP Policies and Operations Manual for HIV and HCV Testing Services in Community-Based Settings (found HERE).

C. Linkage and Navigation (3 pages).
Describe your criteria and processes for linkage within and outside of your program, including a description of any collaborations or referral agreements with other agencies (attach MOUs to your proposal). Specifically, describe how linkage and/or navigation will occur related to:

- HIV-negative, HCV- and STD-unknown status clients to HIV/HCV/STD testing within the program.
- HIV-negative clients to PrEP within the program or to a PrEP navigator.
- Newly diagnosed HIV-positive clients to care within program or to LINCS
- Clients that have a STD to treatment within the program or other provider.
- HCV-positive clients to HCV treatment within program or to a HCV navigator.
- Sexual and/or needle-sharing partners of HIV, HCV, and/or STD-positive clients, to HIV, HCV, and/or STD testing within the program (or elsewhere).
- Clients to other services/HAPs, if client needs cannot be met within the program.
- Out-of-care HIV-positive clients to LINCS.
- How your program will track linkages to ensure they are successful.
- Your agency's experience providing linkage and/or navigation services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

D. Prevention And Treatment Medication: Prep and ART for HIV; HCV Treatment; STD Treatment, Including Medical Storage (2 pages)
Describe your criteria and processes for ensuring access to prevention and treatment medication within and outside of your program, including a description of any collaborations or referral agreements with other agencies (attach MOUs to your proposal). Specifically, describe how prevention and treatment medication will occur related to:

- HIV-negative clients receiving PrEP within the program or other provider.
- Newly diagnosed HIV-positive clients initiating ART within program or other provider.
- HCV-positive clients receiving treatment within program or other provider.

- Clients that have a STD receiving treatment within program or other provider.
- How your program will track prevention and treatment medication initiation and/or completion to ensure it was successful.
- Your agency's experience providing prevention and treatment medication. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

E. Community Engagement (2 pages).
Describe in detail:

- Your agency's experience conducting community engagement activities for population of focus. How long have you been conducting these activities? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

Describe in detail how your program will:

- Build trust within the community and have a consistent presence.
- Partner with other local CBOs, agencies and/or community leaders who have a strong relationship with the community.
- Include community voices and qualitative lived experience in all aspects of planning, program design/implementation, and service delivery. Build on community strengths and ensure that cultural and historical barriers (e.g. mistrust of service providers, language barriers) are removed.
- Build a highly skilled cross-trained workforce that reflects the populations served, has low turnover rates, and is valued and supported.
- Expand or implement peer-delivered services. Involve peers in program development, and use peers to conduct outreach and provide services.
- Increase mobile service delivery (if program is or will be providing mobile service). Provide multidisciplinary mobile services to meet a variety of needs among populations who do not access health care in traditional settings.
- Provide culturally appropriate outreach to community.

F. Syringe Access and Disposal (1 page).
Describe in detail:

- Your agency's experience conducting syringe access and disposal services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- Describe how you will conduct quality assurance to meet the requirements of the CHEP Syringe Access and Disposal Program Policy and Guidelines located HERE.
- Your program's plans for integrating the provision of safer injection supplies during the course of other services for clients in need, in a seamless, discrete, and non-stigmatizing way.

- Any preferred elements from the Syringe Access and Disposal table in **Exhibit 1: 6.1** that will be provided within the program. Explain how these elements will be integrated into existing programming.
- How you will reach and meet the specific cultural needs of PWID, including any PWID subpopulations (e.g. MSM, youth, women, and trans women and men, homeless) within your agency's population of focus and create a safe and welcoming environment for them.
- How your data will be tracked for number of syringes distributed and number of syringes collected.
- Your program's syringe disposal plan.

G. Harm reduction services for substance use (including opioids, stimulants, alcohol, tobacco, and cannabis (2 pages).
Describe in detail:

- Your agency's experience providing substance use harm reduction services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program
- How your program will ensure ALL staff participate in ongoing harm reduction training. How staff training will be tracked.
- Your program's mechanism for assessing client needs on an ongoing, systematic basis for substance use including opioids, stimulants, alcohol, tobacco, and cannabis.
- How your program will integrate harm reduction principles and the SFDPH Harm Reduction Policy into program design and delivery and put them into practice in a meaningful and impactful way.

H. Overdose Prevention (2 pages).
Describe in detail:

- Your agency's experience with overdose prevention and response. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- How you will meet the required elements of overdose prevention. How your program will integrate overdose prevention and response into your existing program.
- Any preferred elements from the overdose prevention table in **Exhibit 1: 6.1** that will be provided within the program. Explain how these elements will be integrated into existing programming.
- What overdose prevention materials your agency will make available to clients.
- How your program will ensure ALL client facing staff participate in annual overdose prevention and response training. Describe how the program will track training.
- How your program will host at least one overdose prevention training for clients annually. How will this be tracked?

I. Mental Health (1 page).
Describe in detail:

- Your agency's experience providing mental health services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- How your program will integrate culturally appropriate, stigma-free, mental health support into your existing program (e.g. onsite or through linkages to other program).
- How your program will confirm and track linkages to mental health services.

J. Condom Distribution (1 page).
Describe in detail:

- How your program will ensure condoms and other safe sex supplies are easily accessible on site, during outreach, and in mobile facilities.
- The sex-positive and meaningful messaging and education your agency will provide to emphasize that condoms are relevant, particularly for STD prevention.

K. Basic Needs (1 page).
Describe in detail:

- Your program's experience providing basic needs to your population of focus and/or any subpopulations.
- How your program will integrate the provision of basic needs into existing program for the population of focus and/or any subpopulations of focus.

➢ **Describe your program as a whole.**

A. Program Cohesiveness (2 pages).
Describe how the various program components (see below) work together to form one logical, cohesive program. Include a discussion of service times and locations that shows how the program components are linked together. Collaborative proposals: Discuss how the collaborators will work together to provide one cohesive and seamless program. Note: Please see **Exhibit 1: 6.1** for details on the program components listed below.

- Integrated HIV, HCV, and STD testing
- Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, and other services
- Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis)
- Syringe access and disposal
- Overdose prevention (including naloxone distribution)
- Condom distribution
- Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis)
- Community engagement and mobilization (physical and online, social media)

- Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage
- Services to meet basic needs services (examples: food, housing, employment)
- Primary care
- Substance use treatment
- Mental health services

B. Cross-program Elements (2 pages).
Describe:

- How your program will address the specific cultural needs of your population of focus and/or subgroups within your population of focus.
- Any incentives you plan to use. Provide a strong justification for why they are needed as well as evidence or experience supporting their effectiveness. If you are proposing cash incentives, justify why cash is preferred to a non-cash incentive and describe how you will manage cash on the premises.
- How your program will ensure health education and prevention counseling is delivered in the context of overall sexual health and harm reduction and integrated into all of the standard of care services (not stand alone).

C. Staffing Plan (2 pages).
Describe your staffing plan (including volunteers) for service delivery. (Describe staffing for data and evaluation in Section 4.) Describe who will provide which services. What percent of their time is allocated to service delivery? What are the staff members' responsibilities and percent full-time equivalent (FTE)? You may include a one-page organization chart or visual that represents the collaboration as an attachment.

Section 3: Data Collection, Evaluation, and Quality Assurance (2 pages)

- (1 page) **Describe your plans for collecting and managing the data for the standard of care services (Exhibit 1: 6.1), including:**

  - Your staffing plan for supporting data collection and management.
  - Your methods and processes for collecting, entering, and reporting client-level data.
  - If you are currently a CHEP contractor, whether your data submissions were on time and complete for the year 2019.
  - If you are not currently a CHEP contractor, whether data submissions for other funders were on time and complete for the year 2019.

- (1 page**) Describe your staffing plan and general process for program evaluation, including:**
  - Staff assigned to program evaluation. Indicate which staff position will be responsible for leading the program evaluation efforts, and how much time will be devoted to it.
  - How you will review and assess the extent to which your program is meeting its objectives.
  - What you will do if you learn the program is not meeting its objectives.
  - How you will use data/evaluation findings to improve the program.

Section 4: Organizational and Fiscal Capacity (3 pages)

- (1 page) **Describe the agency's experience conducting recruitment and retention with API population and/or specific subpopulations**. What types of activities have you done in the past, and how successful have they been at engaging the population(s)? If relevant, include a summary of any data demonstrating your capacity to reach this population and/or specific subpopulations, such as program attendance records, a list of venues where you routinely conduct outreach, or other data.

- (1 page) **Describe your ability to recruit and retain qualified staff, staff reflective of the population being served, peers, and volunteers.** Discuss all of the above, not just staff in general. What staff development/training opportunities will you offer or require? What is the approximate average length of stay for both front-line staff and staff in leadership positions?

- **Budget Detail Booklet:**

  - Complete the Budget Detail and Justification Booklet for a 12 Month Period
  - If you are requesting start up funds please, submit a separate Detail and Justification.

- **Applicants who are LBE Certified will receive additional points.**
  - **This will be added to the "Technical Review Score".**
  - **See LBE Participation terms outlined in the VI. Standard Terms and Conditions for Receipt of Proposals.**

	Bidder Rating Discount:	**0-10**
	10% discount to LBE; or joint venture between or among LBEs	
	5% discount to joint venture with LBE participation that equals or exceeds 35% but is under 40%.	
	7.5% discount to a joint venture with LBE participation that equals or exceeds 40%.	
	10% discount to a certified non-profit entity.	
	Total Available Points:	**10**

11. Scoring Criteria and Rating System

The proposal review process is described in **Section IV: Review and Selection Process**. This table provides the scoring criteria and rating system for **Category 5 proposals.**

Category 5: Health Access Point (HAP) for API			
Question Number	**Scoring Criteria**	**Max. Pts. per Criterion**	**Max. Pts. per Question**
Section 1: Population of Focus (10 points)			
1	Extent to which the applicant demonstrates an understanding of the needs of the population of focus	4	10
	Extent to which the program focuses on the population of focus	2	
	Understanding of risk behaviors and social determinants of health affecting the population of focus	4	
Section 2: Program Design and Effectiveness (67 points)			
2A	Extent to which program takes an equity-focused, stigma-free, low barrier, and whole person health approach	5	5
2B	Ability of the recruitment/retention plan to result in the proposed number of testing experiences among the population of focus	2	8
	Extent to which the integrated HIV, HCV, and STD testing model and flow of services (including any state-certified test counseling and data collection) is seamless and minimizes barriers to testing	2	
	Extent to which the needs of clients testing HIV-negative or HIV-positive will be met (through state certified counseling and/or other means)	2	
	Ability to which quality assurance plan for HIV, HCV, and STD integrated testing will result in high quality service.	2	
2C	Ability of proposed program to link and navigate clients (within or outside of the program) to LINCS, PrEP, HCV treatment, STD treatment; and sexual/needle-sharing partners to testing	7	7
2D	Ability of proposed program to ensure clients have access (within or outside program) to PrEP and ART for HIV, HCV treatment, and STD treatment.	7	7
2E	Ability to build trust and rapport and have a consistent presence in the community of the population of focus, as well as include community voices in planning, program design, and implementation	3	6
	Extent to which proposed program provides services outside of the agency and in the community, and at various venues in order to engage population of focus	2	
	Extent to which proposed program provides culturally appropriate outreach to population of focus	1	
2F	Ability of proposed program to integrate the provision of safer injection supplies (including data collection) in a seamless, discrete, and non-stigmatizing way	2	4
	Ability of proposed program to reach PWID within population of focus	2	
2G	Extent to which proposed program integrates harm reduction principles into program design and delivery, and put them into practice in a meaningful and impactful way	5	5
2H	Extent to which proposed program integrates overdose prevention and response into existing program services in a seamless way	4	4

2I	Extent to which proposed program integrates mental health support services into existing program in a seamless way	3	3
2J	Extent to which proposed program provides sex-positive and meaningful messaging and education about the relevancy of condom use (particularly for STD prevention)	2	3
	Extent to which proposed program ensures condoms and other safe sex supplies are accessible	1	
2K	Extent to which proposed program ensures the provision of basic needs are available and integrated into existing program services for population of focus	3	3
3A	Extent to which the program design is logical and results in one cohesive effort	1	2
	Appropriateness of times and locations of services for the population of focus	1	
3B	Strength of plan to incorporate the following cross-program elements: a) promote a new testing norm. b) integrate hepatitis C and STD prevention, and c) incentives (if proposed)	2	5
	Extent to which program meets the specific cultural needs of the focus population	3	
3C	Extent to which staffing levels are sufficient given scope of work	2	5
	Extent to which responsibilities are assigned to appropriate staff	1	
	Extent to which it is clear which staff will perform which duties/activities	2	
Section 3: Data Collection, Evaluation, and Quality Assurance (8 points)			
4	Extent to which staffing levels are sufficient given scope of work	1	3
	Efficiency of methods and processes for data collection and entry of client-level data	1	
	Data for 2019 100% on time and complete	1	
5	Extent to which responsibilities are assigned to appropriate staff	2	5
	Extent to which evaluation process will result in continuous program improvement	3	
Section 4: Organizational and Fiscal Capacity (15 points)			
6	Applicant capacity to reach the population of focus and capacity to provide proposed services	5	5
7	Extent to which policies, procedures, practices will lead to recruitment, hiring, and retention of qualified staff	1	2
	Extent to which staff tenure will promote program continuity	1	
8	Budget Detail Expenses are appropriate and support the proposed services.	8	8
		TOTAL POINTS	**100**
LBE Participation % Points			
	LBE Participation	0-10	0-10

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Category 6: Health Access Point (HAP) for Youth (18-24)

Estimated Amount Available: From $350,000 to $500,000
Number of Awards: 1

1. Background

Adolescents and young adults (AYA) are disproportionately impacted by HIV in the U.S. A combination of individual, social, and structural barriers such as stigma and lack of confidential insurance coverage in accessing HIV testing, effective prevention methods such as PrEP, and HIV care drive this disparity.[16] In San Francisco, adolescents (current age 13-17 years) and young adults (current age 18-24 years) represent 12% of new HIV diagnosis, and less than 1% of persons living with HIV in the city. Although adolescents and young adults make up small numbers, three-quarters were MSM (either with or without a history of injecting drugs), and PrEP uptake is lowest of any age group.

In 2016, case rates for chlamydia, gonorrhea, and syphilis increased for adolescents and young adults in SF. Racial/ethnic disparities for chlamydia and gonorrhea remain large, particularly for Black/African American adolescents/young adults.[17]

HCV infection rates, driven by the country's opioid epidemic, are rising fastest among young people, contributing to more than 19,000 annual hepatitis C-related deaths in the U.S. in recent years. In SF, there is a high incidence of HCV among young PWIDs.

Strong clinical and community-based efforts have helped to significantly decrease new HIV infections by 50% since 2012. This RFP seeks to build on this success by taking a community-centered, whole person approach to HIV, HCV, and STD prevention, implemented by and for youth.

2. Minimum Qualifications

- By Jan 1, 2020 applicant must be a nonprofit agency that is tax-exempt under Section 501(c)(3) of the Internal Revenue Code and be licensed to do business with the City and County of San Francisco. City and County of San Francisco government departments/sections may NOT apply.
- Applicant must have at least 3 years of experience providing HIV, HCV, and/or STD testing, or similar services to youth adults. (If a collaboration, only the agency providing the HIV, HCV, and STD testing must meet this qualification.)

[16] https://www.gettingtozerosf.org/our_work/adolescent-young-adult/

[17] San Francisco Sexually Transmitted Disease Annual Summary 2016. Available at https://www.sfdph.org/dph/files/reports/StudiesData/STD/SFSTDAnnlSum2016.pdf

3. Service Description

CHEP seeks to fund a Health Access Point (HAP) to meet the needs of young adults. A HAP is defined as a population specific, one-stop shop or network of agencies/programs with a lead agency that provides an equity-focused, stigma-free, and low barrier access to person-centered, standard of care services regardless of HIV, HCV, or STD status. The HAP should deliver services that contribute to the following citywide goals:

- Get to zero new HIV infections, zero HIV-related deaths, and zero stigma and discrimination
- Eliminate HCV
- Reverse increasing STD rates
- Eliminate racial disparities in access to services and health outcomes

Services provided within this HAP must also be culturally specific, harm reduction-based, sex-positive, and trauma-informed. Staff at all levels must demonstrate cultural humility in working with young adults. Peer-delivered services must be an integral part of the network. Young adults must be included in the design, implementation, and evaluation of services.

The HAP should ensure that services reach all young adults, using both **targeted** efforts (focused on identified primary subpopulations) as well as **broad-based community-wide engagement and mobilization, regardless of HIV/HCV/STD risk,** to increase awareness, reduce stigma, and reduce barriers to accessing services at the community- level.

4. Population

Programs must be designed to meet the needs of young adults (aged 18-24), regardless of race, socioeconomic status, neighborhood, or other factors; however, the program must welcome and serve all who are eligible.

5. Restrictions

- Proposed services must be only for youth and identified primary subpopulations. Proposed services must be only for youth and identified primary subpopulations. Services for other populations cannot be part of the proposal, although others may access services.
- Funds for HIV/HCV/STD testing must be used for community-based HIV/HCV/STD testing, not testing in clinical or medical settings.

6. Program Requirements

<u>Required Services</u>

The HAP for young adults shall provide the following “standard of care” services. The services marked with an asterisk (*) must be provided by the lead applicant or one of its subcontractors, with funding from either this RFP or other in-kind resources. The other services can be provided either by the lead applicant or one of its subcontractors, or by other youth HAP partners (e.g., via linkage to a HAP collaborating agency, via the collaborating agency providing services on site at the applicant’s service location, or other approach). For services provided by other young adult HAP partners who are not subcontractors, MOUs and warm hand-off

protocols must be in place as appropriate. Each of the following services is described in detail in **Exhibit 1: 6.1**, including required and preferred elements and performance measures for each service.

- Integrated HIV, HCV, and STD testing*
- Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, case management/intensive case management (ICM) and other services*
- Harm reduction services for substance use (including for opioids, stimulants, alcohol, tobacco, cannabis)*
- Syringe access and disposal*
- Overdose prevention (including naloxone distribution)*
- Condom distribution*
- Community engagement and mobilization (physical and online, social media)*
- HIV, HCV, STD health education and prevention counseling, delivered in the context of overall sexual and drug user health (integrated into all of the above services, not stand alone)*
- Services to meet basic needs services (examples: food, housing, employment)*
- Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage
- Mental health services
- Primary care
- Substance use treatment

Required Strategies

- **Maintain a workforce that mirrors the populations served.** Applicants and subcontractors should have young adult staff represented at all levels of the organization. Client-facing positions (e.g., front desk staff, outreach workers, service delivery staff) should demographically reflect the population served.
- **Ensure that some services are delivered by peers.** "Peers" are defined as people with lived experience similar to that of the populations served, and may or may not share demographic characteristics such as race or gender. For example, an agency could create a community advisory board (CAB) and/or hire and train staff to conduct services, such as outreach, client satisfaction surveys, and assemble hygiene kits.
- **Involve the young adult community in program development.** Include community voices and qualitative lived experience in all aspects of planning, program design and implementation, and service delivery using a systematic and continuous process. Build on community strengths and ensure that cultural and historical barriers (e.g., mistrust of service providers, language barriers) are removed.
- **Take a sex-positive sexual health approach.** Integrate HIV and STD messaging using a sexual health framework. Develop integrated HIV and STD prevention messages that address condoms, PrEP, and why STDs are an important concern. Incorporate integrated sexual health messaging throughout all HIV and STD prevention efforts—for example, PrEP navigation programs, HIV community forums, and social marketing
- **Provide services using a harm reduction-based, trauma-informed, and cultural humility approach.** See required staff training in **Exhibit 1: 6.3**.
- **All services must be as low barrier as possible.** "Low barrier" means that as few expectations as possible are placed upon clients and potential clients when they are trying to access services. Examples of low barrier services include mobile services; co-located services (e.g., HCV treatment co-located with

methadone services); drop-in services; express services (e.g., testing without talking to a counselor); and services provided at times convenient for the populations such as evenings, weekends, or late at night.

- **Address stigma for clients.** Provide a non-stigmatizing environment.
- **Address community-level stigma.** Increase the social media presence that promotes integrated sexual health messages and provided information on how to access services. Disseminate DPH-approved messaging, including PrEP and U=U messaging. Increase education and innovation around how to address HIV-related stigma. De-stigmatize substance use through harm reduction education and messaging.
- **Leverage the private healthcare system whenever possible.** People with private insurance should be encouraged and counseled to use their insurance and develop meaningful relationships with primary care providers, when possible.
- **Ensure services are culturally specific**. Develop testing models that incorporate nuances to address different cultural barriers and specific population needs.
- **Build partnerships and collaborations with other organizations. This RFP requires collaboration to ensure populations have access to required services.**

Optional Strategies

- **Offer incentives.** Programs may propose to use non-cash incentives when they are critical for engaging the population of focus, to recruit people for testing, PrEP, treatment, or other service when warranted (e.g., food vouchers, gift cards, cell phones, cell phone credits, etc.).

Compliance

- Comply with CHEP Policies and Operations Manual for HIV/HCV Testing Services in Community-Based Settings, which are subject to modification at any time. The current policies and procedures can be found HERE
- Comply with SFDPH's Harm Reduction Policy found HERE
- Comply with SFDPH's Syringe Access and Disposal Program Policies and Guidelines found (being updated)
- Comply with the CHEP's Materials Review Process Guidelines found HERE

7. Healthy Staff, Agencies, and Collaborations

Healthy Staff

- **Staff training.** SFDPH and its partners are committed to building and maintaining a highly skilled workforce, prepared to deal with the complexity of client and community needs. To that end, agency staff funded through this RFP will be required to participate in the following trainings: racial humility, trauma informed systems (TIS), and harm reduction training of all staff. The staff that must participate in these trainings will be addressed during contract negotiations.
- **Staff pay.** According to Housing and Urban Development (HUD), in SF in 2018, a single adult is considered to be low income if they make less than $82,200 per year; for a 4-person family the cut-off is $117,300. (Source: https://www.huduser.gov/portal/datasets/il/il2018/2018summary.odn) SFDPH encourages agencies to provide livable wages to staff.

Healthy Agencies

- **Staff retention.** Agencies must have a plan in place to support client-facing staff to prevent burnout and address the vicarious trauma that can occur while working with traumatized populations. Examples of an effective plan include (but are not limited to): staff support group facilitated by a clinician such as an LMFT or LSCW who is also available for individual support as needed. Agencies must allow staff to participate in the San Francisco HIV Frontline Organizing Group (SF HIV FOG), Navigator's meeting, and other professional development activities.

Healthy Collaborations

Collaboration with other community-based organizations (CBOs), clinics, and other organizations is required in order to ensure populations have access to required services. Even though two or more agencies are involved, these collaborations should result in one cohesive program for the clients they serve.

8. Additional Considerations

- CHEP will provide:
  - HIV/HCV/STD Skills Certification Training
  - Harm Reduction Training
  - Overdose Prevention Training (via its contract with Harm Reduction Coalition's DOPE Project)
  - Training on STD specimen collection
  - Test kits
  - Condoms, lube, and female condoms
  - Training on Clear Impact Results Scorecard
  - Racial Humility resources
  - Trauma informed systems (TIS) training
  - Training on Syringe Access and Disposal

- Health Access Point lead applicant should budget for:
  - Clear Impact Results Scorecard logins (2 per agency at $1200/annually total)
  - Phlebotomy Training and Certification
  - Condoms and safer sex supplies (if not going through the condom distribution program)
  - Syringe access and disposal supplies (including syringes)

9. Program Evaluation and Accountability

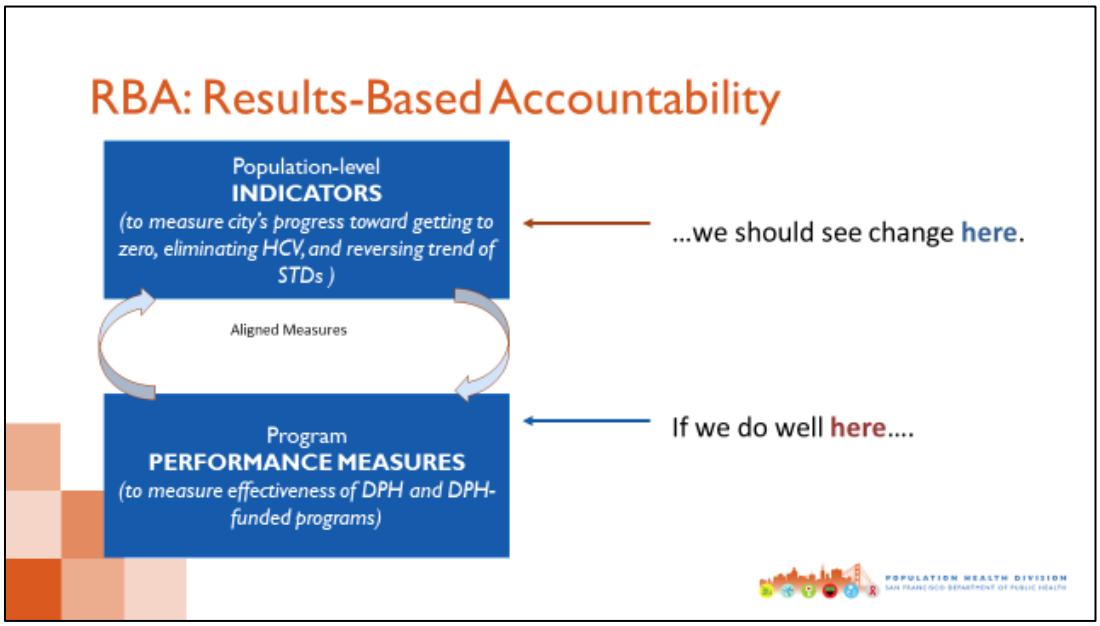
SFDPH seeks to implement program evaluation that allows for flexibility, supports accountability, and encourages innovation. Evaluation findings will be used to improve services, and to hold providers accountable for improving community health. Program innovations are encouraged when accompanied by evaluation plans that can rapidly determine whether the innovations should be adopted, adapted, or abandoned.

Funded programs will be required to use the Results-Based Accountability (RBA) Framework and the Clear Impact Results Scorecard (https://clearimpact.com/scorecard/). RBA is a framework used to improve and track the effectiveness of programs. It is data driven and has two distinct parts: population accountability and performance accountability.

A. Performance Measures

A "program performance measure" is a measure used to track the results of the applicant's specific program. Performance measures and other data collection requirements for each "standard of care" service are provided in **Exhibit 1: 6.1**.

A "population indicator" is a measure used to track the health outcomes of a particular population group. No single program can be held accountable for changing HIV, HCV, or STD rates among youth. However, by collaborating with HAP partner agencies and other relevant entities, SFDPH expects to see reductions in HIV, HCV, and STD rates among youth over the next 3-5 years. SFDPH will convene regular HAP partner meetings to review relevant population indicators and facilitate discussion and action planning for achieving the desired outcomes.



B. Data Collection and Reporting

Funded programs must comply with all CHEP requirements regarding data collection and submission, which will include working with CHEP to measure and report on program-specific objectives and collecting/reporting basic demographic, behavioral risk, and other essential information. Systems/processes used to collect and submit data will include:

- Evaluation Web
- Clear Impact Results Scorecard
- Annual narrative report
- Other systems/processes as requested

10. Narrative Instructions

Below are the instructions for the narrative portion of the proposal package. Instructions for development and submission of the complete proposal package can be found in **Section III: Submission Requirements**.

- Complete all sections of the narrative as outlined below. Applicants must complete the sections and questions **in the order listed**. (Applicants do not have to address the bullet points within each question in the order listed, just the questions.) Label the beginning of each section as indicated and include each question number, but do not repeat the question text.
- The narrative may not exceed **38 pages** (1.5 spacing between lines). Page numbers for individual sections and questions are guidelines only.
- Describe all the components of the proposed program here, even if some components are funded by another source, and be clear about which portion you are asking CHEP to support. For example, mental health is a component of the proposed program and could be funded by another source.
- In narrative Sections 1-4, describe your program as it will be when it is fully operational. Start-up needs can be discussed in narrative Section 5.
- Be specific.

Section 1: Population of Focus (3 pages)

➢ **Describe:**

- The population of focus your program will serve including subpopulations, age, geography, language, socioeconomic status, and other characteristics.
- The HIV, HCV, and STD risk behaviors and social determinants of health affecting your population,
- Why you have chosen this specific population (including any identified primary subpopulations) and why your program meets their needs. Use epidemiologic, community assessment, and other data to support your argument.

Section 2: Program Design and Effectiveness (29 pages)

Note: In this section of the narrative, collaborative proposals should clearly describe the specific roles and responsibilities of the partners and who will implement which portions of the program.

➢ **Describe your program components.**

A. Program overview (2 pages).
Provide an overview of your program and explain how it represents an equity-focused, stigma-free, low barrier, and whole person health approach to HIV, HCV, and STD prevention for the identified population of focus.

B. Integrated HIV, HCV, and STD testing (6 pages).
Describe your agency's testing model, including:

- Your agency's experience providing HIV, HCV, and STD testing. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.
- The number of testing experiences (by primary subpopulations, if applicable) your program will provide (i.e. 2,000 testing experiences for trans women and 10,000 for Gay/MSM). Provide the

rationale for those numbers. **CHEP's goal is to conduct 50,000 testing experiences annually citywide**. An experience is defined as getting at least one (1) of five (5) tests (HIV, HCV, gonorrhea, chlamydia, and/or syphilis) in a single visit (See Integrated HIV, HCV, and STD testing in **Exhibit 1: 6.1**. For example, a client can receive one (1) test, all five (5), or anything in between and it is considered an "experience".

- Recruitment, Retention:
  The strategies and interventions you will use to recruit people for HIV, HCV, and STD testing and encourage them to return for testing at least every 6 months, and the evidence or experience supporting the effectiveness of these activities.
  The HIV, HCV, and STD testing barriers for this population, including identified primary subpopulations. Describe how your program will address these barriers.
  Where and when your agency will provide HIV, HCV, and STD testing and why these sites and venues are appropriate.

- Testing Flow:
  The flow of services at the different testing location(s). Describe how this will help your agency to provide the proposed number of experiences, provide the required and optional services you are proposing, and meet client needs.
  Describe any relevant technologies being used, e.g. if conducting rapid testing, how you will ensure that confirmatory blood draws are obtained, if using drop 'n' go/express model, please describe the process that will be utilized and how patient time will be minimized.
  Describe your plan for getting people to return for their results.
  How your agency will ensure that clients who do not receive counseling as a part of a testing experience still receive HIV, HCV, and STD health information, risk reduction, support, and appropriate prevention messages.

- Data and Quality Assurance:
  Demonstrate how your agency will track these experiences, how your agency will integrate client-level data collection into the flow of services, without creating unnecessary burden for clients. Describe how you will conduct training and quality assurance to meet the requirements of the CHEP Policies and Operations Manual for HIV and HCV Testing Services in Community-Based Settings (found HERE).

C. Linkage and Navigation (3 pages).
Describe your criteria and processes for linkage within and outside of your program, including a description of any collaborations or referral agreements with other agencies (attach MOUs to your proposal). Specifically, describe how linkage and/or navigation will occur related to:

- HIV-negative, HCV- and STD-unknown status clients to HIV/HCV/STD testing within the program.
- HIV-negative clients to PrEP within the program or to a PrEP navigator.
- Newly diagnosed HIV-positive clients to care within program or to LINCS
- Clients that have a STD to treatment within the program or other provider.
- HCV-positive clients to HCV treatment within program or to a HCV navigator.

- Sexual and/or needle-sharing partners of HIV, HCV, and/or STD-positive clients, to HIV, HCV, and/or STD testing within the program (or elsewhere).
- Clients to other services/HAPs, if client needs cannot be met within the program.
- Out-of-care HIV-positive clients to LINCS.
- How your program will track linkages to ensure they are successful.
- Your agency's experience providing linkage and/or navigation services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

D. Prevention And Treatment Medication: Prep and ART for HIV; HCV Treatment; STD Treatment, Including Medical Storage (2 pages)

Describe your criteria and processes for ensuring access to prevention and treatment medication within and outside of your program, including a description of any collaborations or referral agreements with other agencies (attach MOUs to your proposal). Specifically, describe how prevention and treatment medication will occur related to:

- HIV-negative clients receiving PrEP within the program or other provider.
- Newly diagnosed HIV-positive clients initiating ART within program or other provider.
- HCV-positive clients receiving treatment within program or other provider.
- Clients that have a STD receiving treatment within program or other provider.
- How your program will track prevention and treatment medication initiation and/or completion to ensure it was successful.
- Your agency's experience providing prevention and treatment medication. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

E. <u>Community Engagement (2 pages).</u>

Describe in detail:

- Your agency's experience conducting community engagement activities for population of focus. How long have you been conducting these activities? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program.

Describe in detail how your program will:

- Build trust within the community and have a consistent presence.
- Partner with other local CBOs, agencies and/or community leaders who have a strong relationship with the community.
- Include community voices and qualitative lived experience in all aspects of planning, program design/implementation, and service delivery. Build on community strengths and ensure that cultural and historical barriers (e.g. mistrust of service providers, language barriers) are removed.
- Build a highly skilled cross-trained workforce that reflects the populations served, has low turnover rates, and is valued and supported.

- Expand or implement peer-delivered services. Involve peers in program development, and use peers to conduct outreach and provide services.
- Increase mobile service delivery (if program is or will be providing mobile service). Provide multidisciplinary mobile services to meet a variety of needs among populations who do not access health care in traditional settings.
- Provide culturally appropriate outreach to community.

F. Syringe Access and Disposal (1 page).
Describe in detail:

- Your agency's experience conducting syringe access and disposal services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- Describe how you will conduct quality assurance to meet the requirements of the CHEP Syringe Access and Disposal Program Policy and Guidelines located HERE.
- Your program's plans for integrating the provision of safer injection supplies during the course of other services for clients in need, in a seamless, discrete, and non-stigmatizing way.
- Any preferred elements from the Syringe Access and Disposal table in **Exhibit 1: 6.1** that will be provided within the program. Explain how these elements will be integrated into existing programming.
- How you will reach and meet the specific cultural needs of PWID, including any PWID subpopulations (e.g. MSM, youth, women, and trans women and men, homeless) within your agency's population of focus and create a safe and welcoming environment for them.
- How your data will be tracked for number of syringes distributed and number of syringes collected.
- Your program's syringe disposal plan.

G. Harm reduction services for substance use (including opioids, stimulants, alcohol, tobacco, and cannabis (2 pages).
Describe in detail:

- Your agency's experience providing substance use harm reduction services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program
- How your program will ensure ALL staff participate in ongoing harm reduction training. How staff training will be tracked.
- Your program's mechanism for assessing client needs on an ongoing, systematic basis for substance use including opioids, stimulants, alcohol, tobacco, and cannabis.
- How your program will integrate harm reduction principles and the SFDPH Harm Reduction Policy into program design and delivery and put them into practice in a meaningful and impactful way.

H. Overdose Prevention (2 pages).
Describe in detail:

- Your agency's experience with overdose prevention and response. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- How you will meet the required elements of overdose prevention. How your program will integrate overdose prevention and response into your existing program.
- Any preferred elements from the overdose prevention table in **Exhibit 1: 6.1** that will be provided within the program. Explain how these elements will be integrated into existing programming.
- What overdose prevention materials your agency will make available to clients.
- How your program will ensure ALL client facing staff participate in annual overdose prevention and response training. Describe how the program will track training.
- How your program will host at least one overdose prevention training for clients annually. How will this be tracked?

I. Mental Health (1 page).
Describe in detail:

- Your agency's experience providing mental health services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. If these services are new for you, please describe your implementation plan.
- How your program will integrate culturally appropriate, stigma-free, mental health support into your existing program (e.g. onsite or through linkages to other program).
- How your program will confirm and track linkages to mental health services.

J. Condom Distribution (1 page).
Describe in detail:

- How your program will ensure condoms and other safe sex supplies are easily accessible on site, during outreach, and in mobile facilities.
- The sex-positive and meaningful messaging and education your agency will provide to emphasize that condoms are relevant, particularly for STD prevention.

K. Basic Needs (1 page).
Describe in detail:

- Your program's experience providing basic needs to your population of focus and/or any subpopulations.
- How your program will integrate the provision of basic needs into existing program for the population of focus and/or any subpopulations of focus.

- **Describe your program as a whole.**

A. Program Cohesiveness (2 pages).

Describe how the various program components (see below) work together to form one logical, cohesive program. Include a discussion of service times and locations that shows how the program components are linked together. Collaborative proposals: Discuss how the collaborators will work together to provide one cohesive and seamless program. Note: Please see **Exhibit 1: 6.1** for details on the program components listed below.

- Integrated HIV, HCV, and STD testing
- Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, and other services
- Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis)
- Syringe access and disposal
- Overdose prevention (including naloxone distribution)
- Condom distribution
- Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis)
- Community engagement and mobilization (physical and online, social media)
- Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage
- Services to meet basic needs services (examples: food, housing, employment)
- Primary care
- Substance use treatment
- Mental health services

B. Cross-program Elements (2 pages).

Describe:

- How your program will address the specific cultural needs of your population of focus and/or subgroups within your population of focus.
- Any incentives you plan to use. Provide a strong justification for why they are needed as well as evidence or experience supporting their effectiveness. If you are proposing cash incentives, justify why cash is preferred to a non-cash incentive and describe how you will manage cash on the premises.
- How your program will ensure health education and prevention counseling is delivered in the context of overall sexual health and harm reduction and integrated into all of the standard of care services (not stand alone).

C. Staffing Plan (2 pages).

Describe your staffing plan (including volunteers) for service delivery. (Describe staffing for data and evaluation in Section 4.) Describe who will provide which services. What percent of their time is allocated to service delivery? What are the staff members' responsibilities and percent full-time equivalent (FTE)? You may include a one-page organization chart or visual that represents the collaboration as an attachment.

Section 3: Data Collection, Evaluation, and Quality Assurance (2 pages)

- **(1 page) Describe your plans for collecting and managing the data for the standard of care services (Exhibit 1: 6.1), including:**

  - Your staffing plan for supporting data collection and management.
  - Your methods and processes for collecting, entering, and reporting client-level data.
  - If you are currently a CHEP contractor, whether your data submissions were on time and complete for the year 2019.
  - If you are not currently a CHEP contractor, whether data submissions for other funders were on time and complete for the year 2019.

- **(1 page) Describe your staffing plan and general process for program evaluation, including:**
  - Staff assigned to program evaluation. Indicate which staff position will be responsible for leading the program evaluation efforts, and how much time will be devoted to it.
  - How you will review and assess the extent to which your program is meeting its objectives.
  - What you will do if you learn the program is not meeting its objectives.
  - How you will use data/evaluation findings to improve the program.

Section 4: Organizational and Fiscal Capacity (3 pages)

- **(1 page) Describe the agency's experience conducting recruitment and retention with the Youth (18-24) population and/or specific subpopulations**. What types of activities have you done in the past, and how successful have they been at engaging the population(s)? If relevant, include a summary of any data demonstrating your capacity to reach this population and/or specific subpopulations, such as program attendance records, a list of venues where you routinely conduct outreach, or other data.
- **(1 page) Describe your ability to recruit and retain qualified staff, staff reflective of the population being served, peers, and volunteers.** Discuss all of the above, not just staff in general. What staff development/training opportunities will you offer or require? What is the approximate average length of stay for both front-line staff and staff in leadership positions?

- **Budget Detail Booklet:**

  - Complete the Budget Detail and Justification Booklet for a 12 Month Period
  - If you are requesting start up funds please, submit a separate Detail and Justification.

- **Applicants who are LBE Certified will receive additional points.**
  - **This will be added to the "Technical Review Score".**
  - **See LBE Participation terms outlined in the VI. Standard Terms and Conditions for Receipt of Proposals.**

	Bidder Rating Discount:	**0-10**
	10% discount to LBE; or joint venture between or among LBEs	
	5% discount to joint venture with LBE participation that equals or exceeds 35% but is under 40%.	
	7.5% discount to a joint venture with LBE participation that equals or exceeds 40%.	
	10% discount to a certified non-profit entity.	
	Total Available Points:	**10**

11. Scoring Criteria and Rating System

The proposal review process is described in **Section IV: Review and Selection Process**. This table provides the scoring criteria and rating system for **Category 6 proposals.**

Category 6: Health Access Point (HAP) for Youth (18-24)			
Question Number	**Scoring Criteria**	**Max. Pts. per Criterion**	**Max. Pts. per Question**
Section 1: Population of Focus (10 points)			
1	Extent to which the applicant demonstrates an understanding of the needs of the population of focus	4	10
	Extent to which the program focuses on the population of focus	2	
	Understanding of risk behaviors and social determinants of health affecting the population of focus	4	
Section 2: Program Design and Effectiveness (67 points)			
2A	Extent to which program takes an equity-focused, stigma-free, low barrier, and whole person health approach	5	5
2B	Ability of the recruitment/retention plan to result in the proposed number of testing experiences among the population of focus	2	8
	Extent to which the integrated HIV, HCV, and STD testing model and flow of services (including any state-certified test counseling and data collection) is seamless and minimizes barriers to testing	2	
	Extent to which the needs of clients testing HIV-negative or HIV-positive will be met (through state certified counseling and/or other means)	2	
	Ability to which quality assurance plan for HIV, HCV, and STD integrated testing will result in high quality service.	2	
2C	Ability of proposed program to link and navigate clients (within or outside of the program) to LINCS, PrEP, HCV treatment, STD treatment; and sexual/needle-sharing partners to testing	7	7
2D	Ability of proposed program to ensure clients have access (within or outside program) to PrEP and ART for HIV, HCV treatment, and STD treatment.	7	7
2E	Ability to build trust and rapport and have a consistent presence in the community of the population of focus, as well as include community voices in planning, program design, and implementation	3	6
	Extent to which proposed program provides services outside of the agency and in the community, and at various venues in order to engage population of focus	2	
	Extent to which proposed program provides culturally appropriate outreach to population of focus	1	
2F	Ability of proposed program to integrate the provision of safer injection supplies (including data collection) in a seamless, discrete, and non-stigmatizing way	2	4
	Ability of proposed program to reach PWID within population of focus	2	
2G	Extent to which proposed program integrates harm reduction principles into program design and delivery, and put them into practice in a meaningful and impactful way	5	5
2H	Extent to which proposed program integrates overdose prevention and response into existing program services in a seamless way	4	4

2I	Extent to which proposed program integrates mental health support services into existing program in a seamless way	3	3
2J	Extent to which proposed program provides sex-positive and meaningful messaging and education about the relevancy of condom use (particularly for STD prevention)	2	3
	Extent to which proposed program ensures condoms and other safe sex supplies are accessible	1	
2K	Extent to which proposed program ensures the provision of basic needs are available and integrated into existing program services for population of focus	3	3
3A	Extent to which the program design is logical and results in one cohesive effort	1	2
	Appropriateness of times and locations of services for the population of focus	1	
3B	Strength of plan to incorporate the following cross-program elements: a) promote a new testing norm. b) integrate hepatitis C and STD prevention, and c) incentives (if proposed)	2	5
	Extent to which program meets the specific cultural needs of the focus population	3	
3C	Extent to which staffing levels are sufficient given scope of work	2	5
	Extent to which responsibilities are assigned to appropriate staff	1	
	Extent to which it is clear which staff will perform which duties/activities	2	
Section 3: Data Collection, Evaluation, and Quality Assurance (8 points)			
4	Extent to which staffing levels are sufficient given scope of work	1	3
	Efficiency of methods and processes for data collection and entry of client-level data	1	
	Data for 2019 100% on time and complete	1	
5	Extent to which responsibilities are assigned to appropriate staff	2	5
	Extent to which evaluation process will result in continuous program improvement	3	
Section 4: Organizational and Fiscal Capacity (15 points)			
6	Applicant capacity to reach the population of focus and capacity to provide proposed services	5	5
7	Extent to which policies, procedures, practices will lead to recruitment, hiring, and retention of qualified staff	1	2
	Extent to which staff tenure will promote program continuity	1	
8	Budget Detail Expenses are appropriate and support the proposed services.	8	8
		TOTAL POINTS	**100**
LBE Participation % Points			
	LBE Participation	0-10	0-10

Category 7: Training and Capacity Building for a Health Access Point (HAP) for Black/African Americans

Estimated Amount Available: From $1,900,000 to $2,400,000
Number of Awards: 1

1. Background

According to the 2018 San Francisco Department of Public Health (SFDPH) Black/African-American Health Report, Black/African-Americans (B/AA) in San Francisco continue to experience disproportionate social, economic, and environmental burdens that impact their living conditions and constrain their life choices. These constraints can ultimately lead to negative health outcomes across the prevention/care continuum.

Although newly diagnosed HIV cases in San Francisco have drastically declined from 532 cases in 2006 to 221 cases in 2017, B/AA continue to be disproportionately affected by HIV. B/AA represent 6% of the total population in San Francisco, yet comprised 12% of people living with HIV in San Francisco, as of December 31, 2017. B/AA women accounted for 37% of women living with HIV in SF.[18] B/AA represent one of the largest racial/ethnic groups among trans women living with HIV (33%) in SF. Also, annual rates of men newly diagnosed with HIV are highest among B/AA (116 per 100,000 vs. 39 per 100,000 for whites in 2017).[19] In terms of HCV, similar disparities persist among the B/AA population; of the 2016 HCV cases newly reported to SFDPH, 24.2% were among B/AA San Franciscans, despite the fact that B/AAs make up 6% of the general population in SF.[20]

In addition to HIV and HCV, chlamydia and gonorrhea occur at higher rates in B/AA residents in SF and nationally. In 2016, B/AA residents were 2.1 times more likely to have chlamydia, and 1.7 times more likely to have gonorrhea than white residents in SF.[21] Among adolescents and young adults the racial/ethnic disparities for chlamydia and gonorrhea are large. The rates of chlamydia and gonorrhea among B/AA youth were 4.5 and 3.4 times that of white adolescents and young adults, respectfully.[22]

In an effort to address these disparities among the Black/African American community, this RFP seeks to fund capacity building activities with the goal of implementing a Health Access Point (HAP) to improve health outcomes for the B/AA residents by using an equity-focused, community-centered, whole person, integrated approach.

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[18] San Francisco Department of Public Health. HIV Epidemiology Annual Report 2017. Available at https://www.sfdph.org/dph/comupg/oprograms/HIVepiSec/HIVepiSecReports.asp

[19] San Francisco Department of Public Health. HIV Epidemiology Annual Report 2017. Available at https://www.sfdph.org/dph/comupg/oprograms/HIVepiSec/HIVepiSecReports.asp

[20] Personal communication with Amy Nishimura for the HCV data and the 2010 census for the population data

[21] San Francisco Sexually Transmitted Disease Annual Summary 2016. Available at https://www.sfdph.org/dph/files/reports/StudiesData/STD/SFSTDAnnlSum2016.pdf

[22] San Francisco Sexually Transmitted Disease Annual Summary 2016. Available at https://www.sfdph.org/dph/files/reports/StudiesData/STD/SFSTDAnnlSum2016.pdf

2. Minimum Qualifications

- By January 1, 2020, applicant must be a nonprofit agency that is tax-exempt under Section 501(c)(3) of the Internal Revenue Code and be licensed to do business with the City and County of San Francisco. City and County of San Francisco government departments/sections may NOT apply.
- Applicant must have at least 3 years of experience providing services and resources to Black/African American populations.
- Applicant organization must be located in the community where Black/African Americans reside.
- Applicant must be currently providing services and resources to Black/African Americans.

3. Service Description

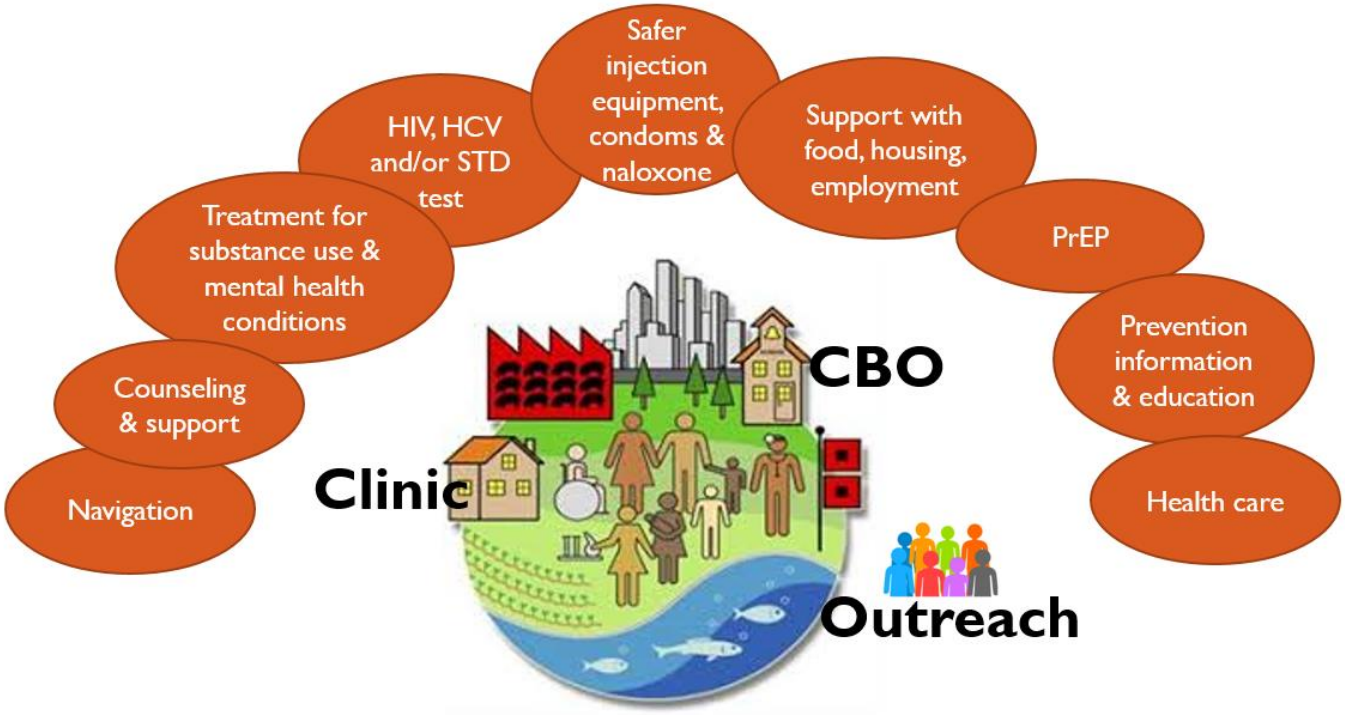
CHEP seeks to fund capacity building activities with the goal of implementing a Health Access Point (HAP) to meet the needs of the Black/African American community. A HAP is defined as a population specific, one-stop shop or network of agencies/programs with a lead agency that provides an equity-focused, stigma-free, and low barrier access to person-centered, standard of care services, regardless of HIV, HCV, or STD status. The HAP should deliver services that contribute to the following citywide goals:

- Get to zero new HIV infections, zero HIV-related deaths, and zero stigma and discrimination
- Eliminate HCV
- Reverse increasing STD rates
- Eliminate racial disparities in access to services and health outcomes

Services provided within this HAP must also be harm reduction-based, sex-positive, and trauma-informed. Staff at all levels must demonstrate cultural humility in working with Black/African American populations. Peer-delivered services must be an integral part of the network. Services must honor the cultural diversity within the Black/African American community, and respect and work within Black/African American cultural contexts, social systems, institutions, and norms. Services must be provided in (but not limited to) the Bayview Hunter's point and other predominantly Black/African American neighborhoods in San Francisco. Services, printed materials, and other media/communications must resonate with the Black/African American community and community members must be included in the design, implementation, and evaluation of services. It is especially important that services address the realities regarding fears about accessing services due to mistrust of the medical system and racial discrimination in the system. Health education is also especially important for Black/African American residents, who may not have had access to accurate health information within their communities.

The primary subpopulations within the Black/African American community living with or at risk for HIV, HCV, and/or STDs are women, men who have sex with men (MSM), people who inject drugs (PWID) or injected drugs in the past, trans women and men, people experiencing homelessness, previously incarcerated, and youth. The HAP should ensure that services reach these populations using both **targeted** efforts (focused on these primary subpopulations) as well as **broad-based community-wide engagement and mobilization, regardless of HIV/HCV/STD risk,** to increase awareness, reduce stigma, and reduce barriers to accessing services at the community- level.

Example of HAP Model/Network of Services:



Capacity Building Activities:

The funded agency must have a positive relationship and consistent meaningful engagement with the Black/African American community, provide services and resources to Black/African American residents in San Francisco, but may be less experienced in providing HIV, HCV, and STD prevention/testing services and may need additional technical assistance and capacity building efforts to successfully implement a HAP within its current organizational structure. This capacity building RFP for the Black/African American community is designed to help agencies implement a HAP model/network and build strong collaborations/partnerships with other agencies with the primary goal of reducing disparities among the Black/African American community by addressing vulnerabilities through focused community investment.

Capacity building activities/support include the following, but are not limited to (based on individual agency needs):

- A Shared Data Management System. Development of data collection tools and system to share data with SFDPH and collaborating partners.
- Facility Acquisition. Designated space in organization to provide additional services (e.g. testing room).
- Development of Strong Collaborations & Partnerships. Development of Memorandum of Understandings (MOUs), subcontract agreements to ensure, and comprehensive neighborhood

resource list to ensure clients have access to required services and culturally appropriate educational materials, trainings, and workshops.
- Social Marketing Strategies. Development of materials, campaigns, billboards, social media platform, and/or other strategies to promote new agency services (e.g. Health Access Point)
- Assigned Community Health Equity and Promotion (CHEP) Program Liaison. Facilitate new program model implementation and staff/organizational training and technical assistance.
- Staff Recruitment and Retention. Build agency staff capacity and diversity. Development of support for client-facing staff to prevent burnout

SFDPH will partner closely with the funded agency to ensure the agency receives all of the support (e.g. training, technical assistance, capacity building efforts) it needs in order to implement a HAP. SFDPH will partner with agency during the first funding year to:

- Conduct an assessment of training and capacity needs.
- Develop a plan to build capacity.
- Receive training/s and capacity building efforts.

Some of the funds awarded through this RFP will be allocated towards capacity building activities.
Depending on the needs of the agency, program implementation may not begin immediately in the first funding year, and will begin by the second funding year.

4. Population

Programs must be designed to meet the needs of and focus on serving the Black/African Americans; however, the program must welcome and serve all who are eligible for program services and resources.

5. Restrictions

- Proposed services must be only for Black/African Americans and identified primary subpopulations. Services for other populations cannot be part of the proposal, although others may access services.
- Funds for HIV/HCV/STD testing must be used for community-based HIV/HCV/STD testing, not testing in clinical or medical settings.

6. Program Requirements

Required Services

The Black/African American HAP shall provide the following “standard of care” services. The services marked with an asterisk (*) must be provided by the lead applicant or one of its subcontractors, with funding from either this RFP or other in-kind resources. The other services can be provided either by the lead applicant or one of its subcontractors, or by other Black/African American HAP partners (e.g., via linkage to a HAP partner agency, via the partner agency providing services on site at the applicant’s service location, or other approach). For services provided by other Black/African American HAP partners who are not subcontractors, MOUs and warm hand-off protocols must be in place as appropriate. Each of the following services is described in detail in **Exhibit 1: 6.1**, including required and preferred elements and performance measures for each service. CHEP assigned Program

Liaison will provide ongoing capacity building assistance to the lead agency to ensure that all program requirements are met.

- Integrated HIV, HCV, and STD testing*
- Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, case management/intensive case management (ICM) and other services*
- Harm reduction services for substance use (including for opioids, stimulants, alcohol, tobacco, cannabis)*
- Syringe access and disposal*
- Overdose prevention (including naloxone distribution)*
- Condom distribution*
- Community engagement and mobilization (physical and online, social media)*
- HIV, HCV, STD health education and prevention counseling, delivered in the context of overall sexual and drug user health (integrated into all of the above services, not stand alone)*
- Services to meet basic needs services (examples: food, housing, employment)*
- Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage
- Mental health services
- Primary care
- Substance use treatment

Required Strategies

- **Maintain a workforce that mirrors the populations served.** Applicants and subcontractors should have Black/African American staff represented at all levels of the organization. Client-facing positions (e.g., front desk staff, outreach workers, service delivery staff) should demographically reflect the population served.
- **Ensure that some services are delivered by peers.** "Peers" are defined as people with lived experience similar to that of the populations served, and may or may not share demographic characteristics such as race or gender. For example, an agency could create a community advisory board (CAB) and/or hire and train staff to conduct services, such as outreach, client satisfaction surveys, and assemble hygiene kits.
- **Involve the Black/African American community in program development.** Include community voices and qualitative lived experience in all aspects of planning, program design and implementation, and service delivery using a systematic and continuous process. Build on community strengths and ensure that cultural and historical barriers (e.g., mistrust of service providers, language barriers) are removed.
- **Take a sex-positive sexual health approach.** Integrate HIV and STD messaging using a sexual health framework. Develop integrated HIV and STD prevention messages that address condoms, PrEP, and why STDs are an important concern. Incorporate integrated sexual health messaging throughout all HIV and STD prevention efforts – for example, PrEP navigation programs, HIV community forums, and social marketing
- **Provide services using a harm reduction-based, trauma-informed, and cultural humility approach.** See required staff training in **Exhibit 1: 6.3**.
- **All services must be as low barrier as possible.** Low barrier means that as few expectations as possible are placed upon clients and potential clients when they are trying to access services. Examples of low barrier services include mobile services; co-located services (e.g., HCV treatment co-located with

methadone services); drop-in services; express services (e.g., testing without talking to a counselor); and services provided at times convenient for the populations such as evenings, weekends, or late at night.

- **Address stigma for clients.** Provide a non-stigmatizing environment.
- **Address community-level stigma.** Increase the social media presence that promotes integrated sexual health messages and provided information on how to access services. Disseminate DPH-approved messaging, including PrEP and U=U messaging. Increase education and innovation around how to address HIV-related stigma. De- stigmatize substance use through harm reduction education and messaging.
- **Leverage the private healthcare system whenever possible.** People with private insurance should be encouraged and counseled to use their insurance and develop meaningful relationships with primary care providers, when possible.
- **Ensure services are culturally specific**. Develop testing models that incorporate nuances to address different cultural barriers and specific population needs. For example, immigrant Latinx populations may benefit from messaging about testing as an important part of taking care of your health.
- **Build partnerships and collaborations with other organizations. This RFP requires collaboration to ensure populations have access to required services.**

Optional Strategies

- **Offer incentives.** Programs may propose to use non-cash incentives when they are critical for engaging the population of focus, to recruit people for testing, PrEP, treatment, or other service when warranted (e.g., food vouchers, gift cards, cell phones, cell phone credits, etc.).

Compliance

- Comply with CHEP Policies and Operations Manual for HIV/HCV Testing Services in Community-Based Settings, which are subject to modification at any time. The current policies and procedures can be found HERE
- Comply with SFDPH's Harm Reduction Policy found HERE
- Comply with SFDPH's Syringe Access and Disposal Program Policies and Guidelines found (being updated)
- Comply with the CHEP's Materials Review Process Guidelines found HERE

7. Healthy Staff, Agencies, and Collaborations

Healthy Staff

- **Staff training.** SFDPH and its partners are committed to building and maintaining a highly skilled workforce, prepared to deal with the complexity of client and community needs. To that end, agency staff funded through this RFP will be required to participate in the following trainings: racial humility, trauma informed systems (TIS), and harm reduction training of all staff. The staff that must participate in these trainings will be addressed during contract negotiations.
- **Staff pay.** According to Housing and Urban Development (HUD), in SF in 2018, a single adult is considered to be low income if they make less than $82,200 per year; for a 4-person family the cut-off is $117,300. (Source: https://www.huduser.gov/portal/datasets/il/il2018/2018summary.odn) SFDPH encourages agencies to provide livable wages to staff.

Healthy Agencies

- **Staff retention.** Agencies must have a plan in place to support client-facing staff to prevent burnout and address the vicarious trauma that can occur while working with traumatized populations. Examples of an effective plan include (but are not limited to): staff support group facilitated by a clinician such as an LMFT or LSCW who is also available for individual support as needed. Agencies must allow staff to participate in the San Francisco HIV Frontline Organizing Group (SF HIV FOG), Navigator's meeting, and other professional development activities.

Healthy Collaborations

Collaboration with other community-based organizations (CBOs), clinics, and other organizations is required in order to ensure populations have access to required services. Even though two or more agencies are involved, these collaborations should result in one cohesive program for the clients they serve.

8. Additional Considerations

- CHEP will provide:
  - HIV/HCV/STD Skills Certification Training
  - Harm Reduction Training
  - Overdose Prevention Training (via its contract with Harm Reduction Coalition's DOPE Project)
  - Training on STD specimen collection
  - Test kits
  - Condoms, lube, and female condoms
  - Training on Clear Impact Results Scorecard
  - Racial Humility resources
  - Trauma informed systems (TIS) training
  - Training on Syringe Access and Disposal

- Health Access Point lead applicant should budget for:
  - Clear Impact Results Scorecard logins (2 per agency at $1200/annually total)
  - Phlebotomy Training and Certification
  - Condoms and safer sex supplies (if not going through the condom distribution program)
  - Syringe access and disposal supplies (including syringes)

9. Program Evaluation and Accountability

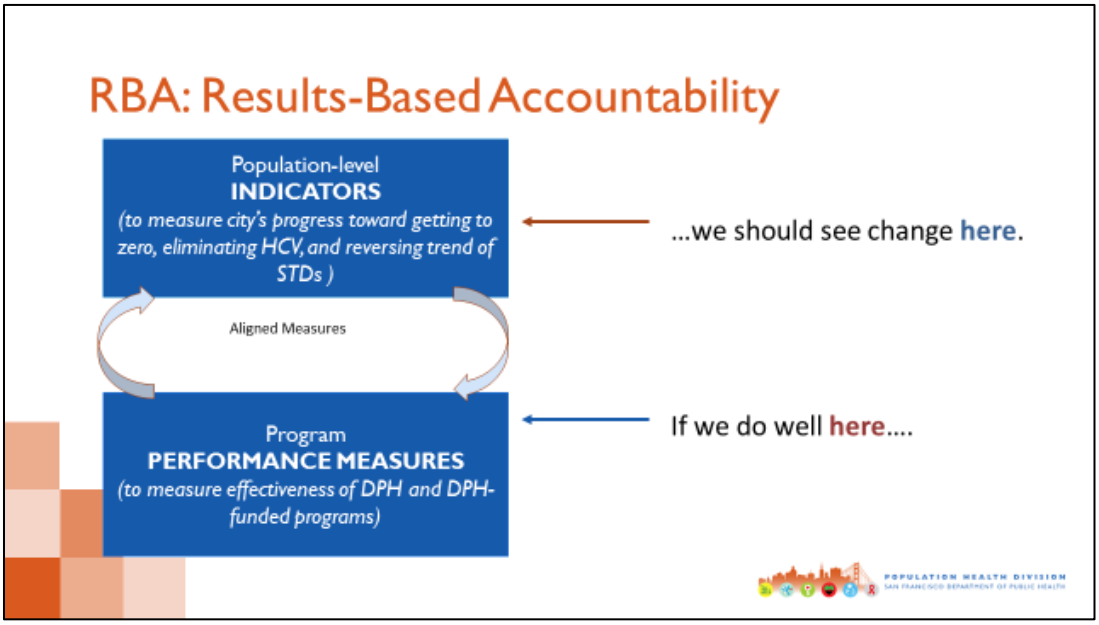
SFDPH seeks to implement program evaluation that allows for flexibility, supports accountability, and encourages innovation. Evaluation findings will be used to improve services, and to hold providers accountable for improving community health. Program innovations are encouraged when accompanied by evaluation plans that can rapidly determine whether the innovations should be adopted, adapted, or abandoned.

Funded programs will be required to use the Results-Based Accountability (RBA) Framework and the Clear Impact Results Scorecard (https://clearimpact.com/scorecard/). RBA is a framework used to improve and track the effectiveness of programs. It is data driven and has two distinct parts: population accountability and performance accountability.

A. Performance Measures

A "program performance measure" is a measure used to track the results of the applicant's specific program. Performance measures and other data collection requirements for each "standard of care" service are provided in **Exhibit 1: 6.1**.

A "population indicator" is a measure used to track the health outcomes of a particular population group. No single program can be held accountable for changing HIV, HCV, or STD rates among Black/African Americans. However, by collaborating with HAP partner agencies and other relevant entities, SFDPH expects to see reductions in HIV, HCV, and STD rates among Black/African American population over the next 3-5 years. SFDPH will convene regular HAP partner meetings to review relevant population indicators and facilitate discussion and action planning for achieving the desired outcomes.



B. Data Collection and Reporting

Funded programs must comply with all CHEP requirements regarding data collection and submission, which will include working with CHEP to measure and report on program-specific objectives and collecting/reporting basic demographic, behavioral risk, and other essential information. Systems/processes used to collect and submit data will include:

- Evaluation Web
- Clear Impact Results Scorecard
- Annual narrative report
- Other systems/processes as requested

10. Narrative Instructions

Below are the instructions for the narrative portion of the proposal package. Instructions for development and submission of the complete proposal package can be found in **Section III: Submission Requirements**.

- Complete all sections of the narrative as outlined below. Applicants must complete the sections and questions **in the order listed**. (Applicants do not have to address the bullet points within each question in the order listed, just the questions.) Label the beginning of each section as indicated and include each question number, but do not repeat the question text.
- The narrative may not exceed **14 pages** (1.5 spacing between lines). Page numbers for individual sections and questions are guidelines only.
- Be specific.

Section 1: Population of focus (4 pages)

1. Describe your agency's experience providing services to Black/African American residents in SF. What kind of services? How many years of providing services?
2. What is your organization's understanding of the underlying causes of health disparities, and in particular HIV, HCV, and STD health disparities for San Francisco Black/African American residents?

Section 2: Health Access Point (HAP) Model (4 pages)

1. Please describe your organization's experience and capacity to support the Health Access Point (HAP) model, perform the required strategies of the model, and build and sustain collaborative partnerships with community service sites.

   Please provide a list of existing organizational partnerships that could support the HAP model (e.g., primary care, substance use, mental health, case management, housing, food, and other services), including a brief description of the nature of the partnership(s) (e.g., partnership members, purpose, partner roles and responsibilities, major accomplishments, number of years in partnership). Applicants should include the list with brief descriptions of the nature of the partnerships under the Appendix of the application. The list will not be counted against the maximum page limit for this section and will not be evaluated under the application scoring process.

Section 3: Organizational and Fiscal Capacity (6 pages)

1. Describe your agency's experience and successes conducting recruitment and retention activities with Black/African American residents in SF. What types of activities have you done in the past, and how successful have they been at engaging the population(s)? If relevant, include a summary of any data demonstrating your capacity to reach this population and/or specific subpopulations, such as program attendance records, a list of venues where you routinely conduct outreach, data on changes in client knowledge; attitudes, behavior, and other data.

2. Describe your agency's experience providing any of the required standard of care services listed below, or other related services. How long have you been providing these services? Describe any policies and procedures, curricula, materials, or program protocols that you currently have in place that will be used or adapted for the proposed program. Please see **Exhibit 1: 6.1** for details regarding all of the standard of care services.

    - Integrated HIV, HCV, and STD testing
    - Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, and other services
    - Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis)
    - Syringe access and disposal
    - Overdose prevention (including naloxone distribution)
    - Condom distribution
    - Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis)
    - Community engagement and mobilization (physical and online, social media)
    - Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage
    - Services to meet basic needs services (examples: food, housing, employment)
    - Primary care
    - Substance use treatment
    - Mental health services

3. Describe your ability to recruit and retain qualified and diverse staff and volunteers. What staff development/training opportunities will you offer or require? What is the approximate average length of stay for both front-line staff and staff in leadership positions?

➢ **Budget Detail Booklet:**

- Complete the Budget Detail and Justification Booklet for a 12 Month Period
- If you are requesting start up funds please, submit a separate Detail and Justification.

➢ **Applicants who are LBE Certified will receive additional points.**

- **This will be added to the "Technical Review Score".**
- **See LBE Participation terms outlined in the VI. Standard Terms and Conditions for Receipt of Proposals.**

	Bidder Rating Discount:	**0-10**
	10% discount to LBE; or joint venture between or among LBEs	
	5% discount to joint venture with LBE participation that equals or exceeds 35% but is under 40%.	
	7.5% discount to a joint venture with LBE participation that equals or exceeds 40%.	
	10% discount to a certified non-profit entity.	
	Total Available Points:	**10**

11. Scoring Criteria and Rating System

The proposal review process is described in **Section IV: Review and Selection Process**. This table provides the scoring criteria and rating system for **Category 7 proposals**.

Category 7: Training and Capacity Building for a Health Access Point (HAP) for Black/African Americans			
Question Number	**Scoring Criteria**	**Max. Pts. per Criterion**	**Max. Pts. per Question**
Section 1: Population of Focus (35 points)			
1	Extent to which the applicant demonstrates an understanding of the needs of the population of focus	15	35
2	Extent to which the program has the experience to provide services to the population of focus	20	
Section 2: Health Access Point (HAP) Model (30 points)			
3	Ability, through the organization's experience and capacity, to perform the required strategies of the HAP	15	30
	Ability of the organization to build and sustain collaborative partnerships with community services	15	
Section 3: Organizational and Fiscal Capacity (35 points)			
4	Applicant capacity to reach and retain the population of focus	15	15
5	Applicant experience providing the required standard of care services	5	5
6	Extent to which policies, procedures, practices will lead to recruitment, hiring, and retention of qualified staff	1	2
	Extent to which staff tenure will promote program continuity	1	
7	Sufficiency of unrestricted cash reserves	2	3
	Extent to which line of credit is used appropriately	1	
8	Budget Detail Expenses are appropriate and support the proposed services.	10	10
		TOTAL POINTS	**100**
LBE Participation % Points			
	LBE Participation	0-10	0-10

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EXHIBIT 1: RFP CHEP Resources and Information

6.1: "Standard of Care" Service Descriptions

INTEGRATED HIV, HCV, and STD TESTING

Background

In 2012, San Francisco's community based testing programs as well as primary and other clinical settings helped to normalize HIV testing as part of regular health maintenance. These strategies have been proven effective, as seen in the reduced number of HIV diagnoses over the years.

In 2017, 221 people received a new HIV diagnoses in San Francisco. As HIV cases decrease, there has been an increase in sexually transmitted disease (STD) rates and hepatitis C (HCV) rates. Anyone who is at risk for HIV is also at risk for becoming infected with HCV and STDs. Studies have shown that people who know they are HIV-positive reduce their sexual risk behavior and the risk of passing it onto others. On a national level, integration of HIV and viral hepatitis has been suggested, and in San Francisco, many of our agencies conduct both tests. Due to the overlapping risk factors for STDs, integrating STD testing would create a person-centered holistic approach to sexual health which will help in achieving the city's goals of getting to zero new HIV diagnosis, eliminating HCV, and reducing the number of STDs.

Moving forward, SFDPH is taking the initiative to create integrated programs tailored to meet the needs of the community in collaboration with our funded partners. Funded programs are expected to implement innovative integrated HIV, HCV, and STD testing programs with the goal of greatly reducing barriers to accessing testing for anyone in San Francisco.

Required and Preferred Service Elements

Required Elements	Preferred Elements
• Provide culturally humble, non-judgmental, stigma-free, sex-positive services, which entails building rapport and trust. • Ensure that all client-facing staff* develops client centered counseling skills by attending the CHEP's HIV, HCV, and STD Skills Training. • Perform outreach to recruit people for testing – street based, flyers, venue based, and mobile. • Incorporate health education and counseling in integrated testing activities. (See Health Education and Counseling) • Provide confidential testing for all clients. • Obtain written consent from clients for all tests performed. • Provide clients with rapid HIV & HCV testing. • Allow for self-collected oral, rectal, vaginal swabs for gonorrhea & chlamydia testing.	• Implementation of a "Drop 'n' go" or express testing model. • Provide testing at shelters, housing sites, etc. • Testing during late night and weekend hours (8pm-5am = Late, 6am-9am = Early Morning). • Implement a Testing reminder system. • Provide clients with vaccinations for Hep A & Hep B and testing for TB, pregnancy tests, or hormone levels check. • Allow for online results.

Required Elements	Preferred Elements
• Provide clients with blood draw for syphilis testing. • Provide linkage and/or navigation to LINCS, or direct linkage and/or navigation to care for clients to access: ○ Primary care, including HIV care, HCV treatment, and/or PrEP. ○ Provider for STD treatment ○ Other low barrier treatment access points (i.e. SAS, mental health, substance use, etc.) • Agencies providing STD testing ensure follow up on all clients testing positive to ensure they are adequately treated or referred for treatment. • Provide face-to-face disclosure of HIV, HCV, and Std-positive test results. • Inform clients testing positive for STDs to notify their sex partners to be tested/treated in an effort to avoid re-infection. • Provide DPH with name based reporting for all tests. • Implement case reporting as required. • Use of DPH laboratory for all testing. • Use of courier service for delivery of specimens to DPH lab. • Ability to provide health education and counseling upon request or clients' needs. (see health education and counseling section) • Provide mobile testing. • Maintain a rate of 10% unduplicated testing clients. • Allow for geographical diversity with at least 10% of tests conducted done 3 miles from headquarters. • Offer mental health referrals. • Follow DPH Harm Reduction Policy. • Follow DPH HIV, HCV, STD testing Policies and Operations Manual requirements.	

Note: All programs must be able report on all required elements and any chosen preferred elements, to DPH upon request.

Additional Information

- Collectively, programs funded in this building block will be expected to provide 50,000 testing experiences for the entire city. An experience is defined as getting at least one of five tests (HIV, HCV, gonorrhea, chlamydia, and/or syphilis) in a single visit (See Integrated HIV, HCV, and STD testing). For example, a client can receive one test, all five, or anything in between and it's considered an experience.

Data Requirements

1. **Program Performance Measures.** The following measures will be tracked and reported in Clear Impact Results Scorecard. Applicants should include Year 1 targets for these measures in their application. (note: these can be turned into outcome objectives for contracts)
    - **HIV Testing**
        - # of HIV tests to date
        - # of reactive HIV tests to date
    - **HCV Testing**
        - # of HCV tests to date
        - # of reactive HCV antibodies tests
        - # of reactive HCV RNA tests
    - **STD Tests/Screenings**
        - # of syphilis tests
        - # of reactive syphilis tests
        - # of gonorrhea tests
        - # of reactive gonorrhea tests
        - # of chlamydia tests
        - # of reactive chlamydia tests
2. **Data Tracking.** Applicants must track the following measures and supply data to DPH upon request.
    - None

Opt Out Criteria

Applicants **must** provide integrated HIV/HCV/STD testing as part of their proposed program, even if the testing is funded all or in part by another source, with the following exceptions:

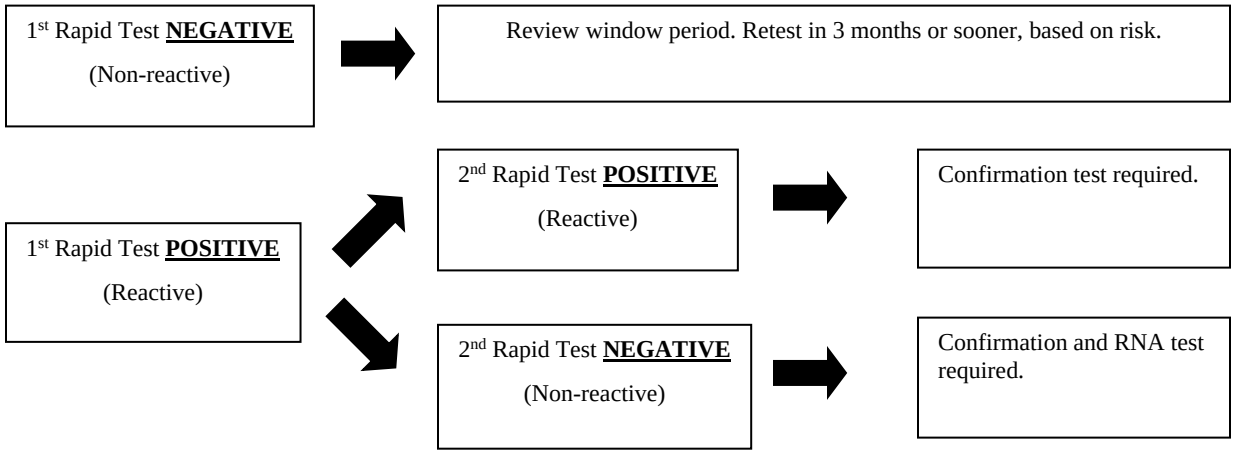
- There is no opportunity to opt out of the required elements of this building block.

***Client-facing staff refers to all those people in an agency or program that may have the opportunity of interacting with a client and can include security guards, front desk staff, volunteers, custodians, and staff providing direct services, coordinators, and directors.**

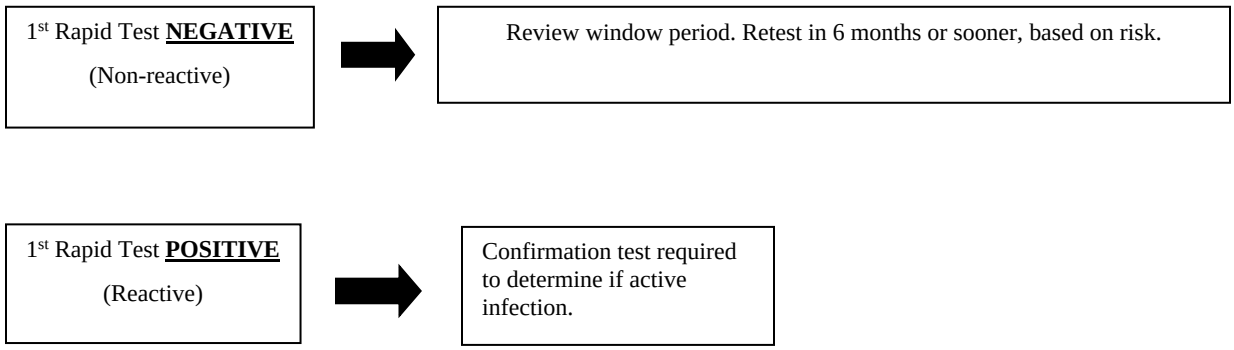
PROTOCOLS

HIV Testing Protocol

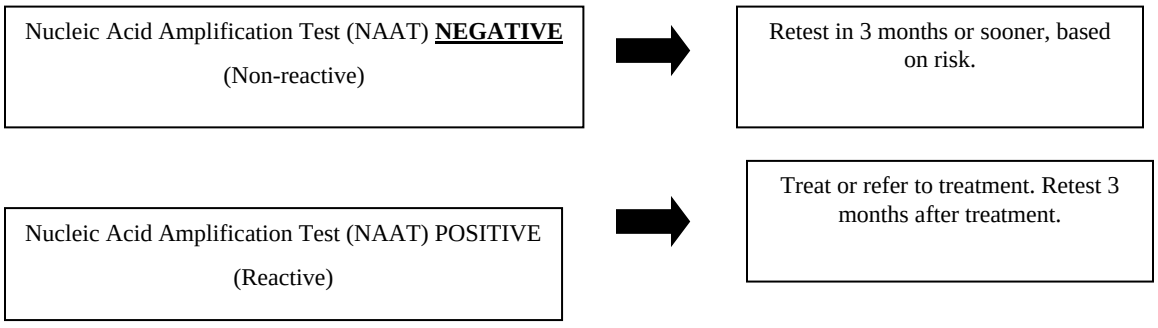
- (Rapid testing programs) Use the following rapid test algorithm:



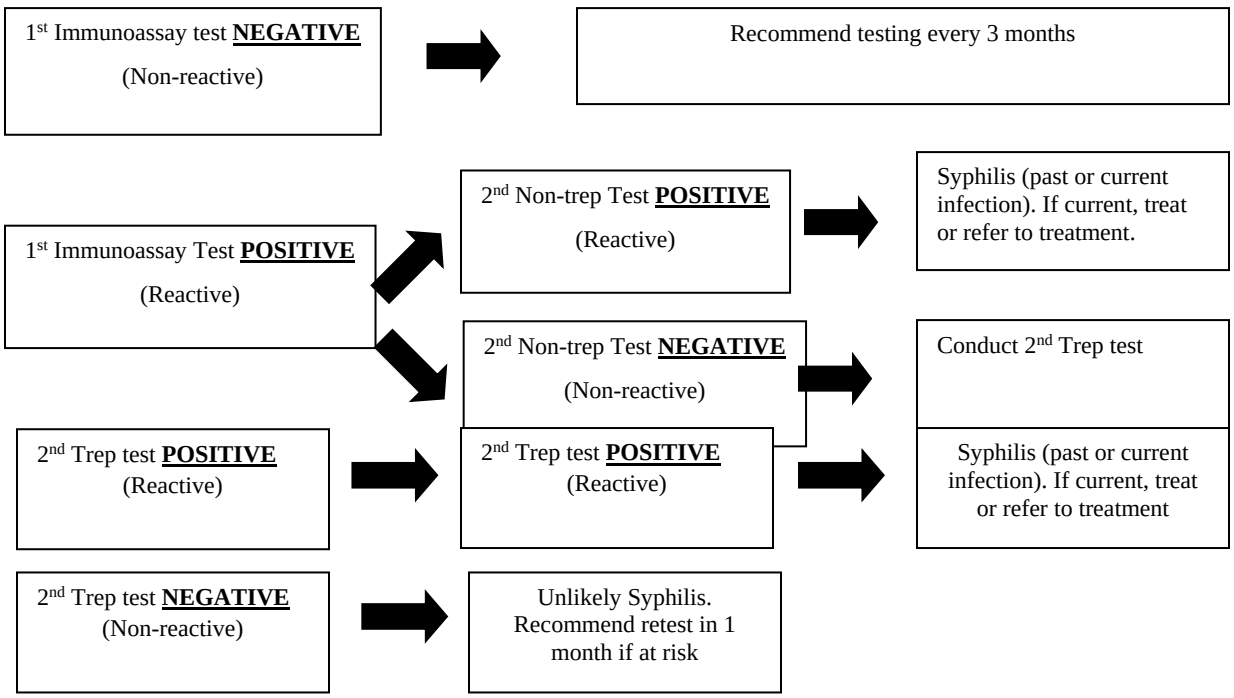
HCV Testing Protocol



Gonorrhea/Chlamydia Testing Protocol – (self) collected oral, rectal, vaginal swab



Syphilis Testing Protocol – blood draw



Drop 'n' go/Express Protocol

This model is for people without symptoms of a sexually transmitted disease who walk into a site for HIV/HCV/STD testing without seeing a clinician.

Example of how this process may look:

1. Client checks in with front desk to fill out consent and other forms. They will request what test they want to receive.
2. Client sees phlebotomist for blood draw for Syphilis and HIV testing.
3. Client uses restroom for self-collected oral, rectal, and/or vaginal swabs.
4. Client is told when test results are ready and how results are given. If client tests negative, they will not hear back from clinic. If client tests reactive, they will get a call from clinic about results and treatment.

LINKAGE AND NAVIGATION

Background

People living with HIV (PLWH), hepatitis C (HCV), and/or a sexually transmitted disease (STD) often face barriers in accessing care. The role of linkage and navigation services is to address and mitigate these barriers. In San Francisco, youth, gay and bi-sexual men of color, transgender women, the marginally housed or experiencing homelessness, and people who inject drugs are at the highest risk of falling out of care. Based on individual needs, navigators help to identify and reduce barriers to care, including access to insurance, benefits, and other support services. Client linkage and navigation services are shown to be positively associated with HIV care and retention, hepatitis C treatment, pre-exposure prophylaxis (PrEP) adherence, and sexually transmitted disease treatment.[24, 25, 26, 27]

Funded programs must complement existing HIV, HCV, STD and PrEP services. The Linkage, Integration, Navigation, and Comprehensive Services Team (LINCS), identifies, locates, and connects those who test positive for HIV to HIV care services and ensures those who have fallen out of care are re-engaged[28]. Funded programs must work with LINCS staff to ensure that clients are engaged in HIV care. Additionally, clients living with hepatitis C can access existing hepatitis C linkage programs. These programs ensure that clients have access to hepatitis C testing and treatment, as well as assisting clients through the treatment process. Finally, clients living with an STD, who do not have access to medical care, should be linked to a provider to ensure treatment.

Definitions of Services

Linkage: Linkage services are defined as a warm hand-off to a service, typically a one-time occurrence with minimal complexity. A warm hand-off is defined as a face-to-face interaction, where the service providers have an open line of communication. Linkage services differ from a referral in that the service is followed-up on to ensure successful linkage to services. The purpose of linkage services is to ensure that a client is successfully linked to care.

Navigation: Navigation services guide clients through and around barriers in complex health care systems and ensure timely and appropriate care or treatment. Navigation services should help a client address barriers in their own lives that are preventing them from accessing care. Additionally, navigation services are tailored to each individual client to ensure client needs are being met, including mobile services and after hour services. Navigation services usually span a few months in time (1-3 months).

Case Management: Case management services are similar to navigation services, except they span a longer period of time (4-12 months).

Required and Preferred Elements

Required Elements	Preferred Elements
• Provide culturally humble, non-judgmental, stigma-free, sex-positive services, which entails building rapport and trust. • Incorporate health education and counseling in linkage and navigation activities. (See Health Education and Counseling)	• Provide case management (including intensive case management) for people with complex needs, regardless of HIV or HCV status. • Provide evening and weekend linkage and navigation services.

Required Elements	Preferred Elements
• Provide linkage and/or navigation to LINCS, or direct linkage and/or navigation to care for clients to access: ○ Primary care, including HIV care, HCV treatment, and/or PrEP. ○ Provider for STD treatment ○ Other low barrier treatment access points (i.e. SAS, mental health, substance use, etc.) • Ensure all navigators attend monthly navigator meetings at SFDPH. • Ensure all navigators attend training.	

Note: All programs must be able report on all required elements and any chosen preferred elements, to DPH upon request.

Additional Information

Linkage

- Linkage to services must be offered for HIV, HCV, and STD treatment and care. These services should be offered in any instance where a client tests positive for HIV, HCV, or an STD (see Testing Block and Treatment Block). Treatment initiations should be rapid and based on the unique needs of each client. Additionally, HIV-negative clients interested in PrEP should be immediately linked to PrEP navigation or a prescribing provider.

Navigation

- Navigation services should be offered for HIV, HCV and PrEP care. Care navigation should ensure streamlined access to care, and coordination with other providers. Navigation service modalities include:
    - Integrated navigation: Cross-trained navigators that can provide navigation services for HIV, HCV, and PrEP. Or,
    - Designated navigation: Each navigator on staff is designated to a specific need (i.e. HIV, HCV, and PrEP).
- All funded programs must report to LINCS all new HIV-positive clients no more than 24 hours after disclosure. Known HIV-positive clients out of care for more than six months must also be reported to LINCS for re-engagement in care.
- As linkage and navigation services are to be measured for success, agencies must have each client sign a release of information form to ensure program staff can follow-up to ensure successful linkage. Further, agencies should create a memorandum of understanding (MOU) with referral agencies to ensure sharing of patient information and coordination of care.
- As linkage and navigation services are to be measured for success, agencies must have each client sign a release of information form to ensure program staff can follow-up to ensure successful linkage. Further, agencies should create a memorandum of understanding (MOU) with referral agencies to ensure sharing of patient information and coordination of care.

Data Requirements

1. **Program Performance Measures.** The following measures will be tracked and reported in the Performance Scorecard. Applicants should include Year 1 targets for these measures in their application. The following measures will be tracked and reported in Clear Impact Results Scorecard (note: these can be turned into outcome objectives for contracts).
    - # of clients linked to HIV care
    - # of clients linked to HCV care
    - # of clients linked to STD care
    - # of clients provided navigation to PrEP services
    - # of clients provided navigation to HIV services
    - # of clients provided navigation to HCV services
2. **Data Tracking. Applicants must track the following measures and supply data to DPH upon request.**
    - None

Opt Out Criteria

Applicants **must** provide linkage, navigation, and case management services as part of their proposed program, even if the services are funded all or in part by another source, with the following exceptions:

- There is no opportunity to opt out of the required elements of this building block.

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24. Mizuno, Y., Higa, D.H., Leighton, C.A., Roland, K.B., Deluca, J.B., & Koenig, L.J. (2018). IS HIV patient navigation associated with HIV care continuum outcomes? A systematic review. *AIDS.* DOI: 10.1097/QAD.0000000000001987
25. HIV ReConnect: Increasing Retention and Re-Engagement. (2017). Getting to Zero and San Francisco Department of Public Health. http://www.gettingtozerosf.org/wp-content/uploads/2017/06/HIV-ReConnect-Universal.pdf
26. Bajis, S., Dore, G.J., Hajarizadeh, B., Cunningham, E.V., Maher, L., & Grebely, J. (August 2017). Interventions to enhance testing, linkage to care and treatment uptake for hepatitis C virus infection among people who inject drugs: A systematic review. *International Journal of Drug Policy, 47*, 34-46.
27. Spinelli, M.A., Scott, H.M., Vittinghoff, E., Liu, A.Y., Morehead-Gee, A., Gonzalez, R., Gandhi, M. & Buchbinder, S.P. (2018). Brief report: A panel management and patient navigation intervention is associated with earlier PrEP initiation in a safety-net primary care health system. *JAIDS Journal of Acquired Immune Deficiency Syndromes, 79*(3), 347–351. doi: 10.1097/QAI.0000000000001828.
28. Focus Area: Health for People at Risk or Living with HIV. San Francisco Department of Public Health. https://www.sfdph.org/dph/files/sfchip2/FocusArea-HealthforPeopleatRiskorLivingwithHIV.pdf

PREVENTION AND TREATMENT MEDICATION: PREP AND ART FOR HIV; HCV TREATMENT; STD TREATMENT, INCLUDING MEDICAL STORAGE

Background

Through The Roadmap Stakeholder Engagement process community stakeholders gave direct input on our prevention efforts to "fully integrate HIV, HCV, STD services…" and to "prioritize HCV and STD services within HIV and other services and systems. "Larger organizations can provide a full system of care, while others focus on specific populations, however access to medications for HIV, HCV and STD treatment is not equal among populations. Therefore, in this new integrated approach, early detection and treatment of curable STDs and HCV, immediate initiation of antiretroviral therapy for the management of HIV, and the provision of PrEP as an HIV prevention tool must become major explicit components of our system of care.

Funded programs in this category must ensure that testing is accompanied by rapid treatment, that medications are equally accessible to all, that PrEP is acceptable and available, that linkages are easy, and that a strong relationship between community and clinical providers exists. All settings should be low-threshold with access to community-based and clinic-based services; this may mean moving clinical services out into the community, or bringing agencies into the clinic.

Building Block Required and Preferred Elements

Required Elements	Preferred Elements

• Provide culturally humble, non-judgmental, stigma-free, sex-positive services, which entails building rapport and trust.
• Incorporate health education and counseling in treatment provision activities. (See Health Education and Counseling)
• Ability to refer to and work with a prescribing clinician directly, or through sub contractual agreement or MOU.
• Provide linkage and/or navigation to LINCS, or direct linkage and/or navigation to care for clients to access:
  ○ Primary care, including HIV treatment, HCV treatment, and/or PrEP.
  ○ Provider for STD treatment
• Other low barrier treatment access points (i.e. SAS, mental health, substance use, etc.). (See Linkage and Navigation)
	• Provide a clinician on staff who can prescribe appropriate treatment immediately, on site, and in all low-threshold environments.
	• Treatment for HIV will be prescribed on site on the same day as diagnosis.
	• Ensure regular client case conferences
	• Treatment for HCV will be prescribed on site including low-threshold sites within a week of confirmatory RNA result.
	• Treatment for STD will be prescribed and delivered on site on the same day as lab results are provided.
	• PrEP will be prescribed on site on the same day as requested.
	
	Medication Storage
	• HAPs will provide a range of options for medication provision and storage. For example:
	  a) self-serve lockers,
	  b) staff storing it for clients (if allowed by license),
	  c) Directly observed therapy.
	• Provide incentives for adherence to medications in populations where they are effective.

Note: All programs must be able report on all required elements and any chosen preferred elements, to DPH upon request

Performance Measures. The following measures will be tracked and reported in Clear Impact Results Scorecard. Applicants should include Year 1 targets for these measures in their application. (Note: these can be turned into outcome objectives for contracts)

- % of clients linked to HIV care who initiated ART
- % of clients linked to HCV care who completed treatment
- % of clients linked to STD care who receive treatment
- % of clients provided navigation to PrEP services who initiated treatment

Opt-out criteria

There is no opportunity to opt out of the required elements of this building block

COMMUNITY ENGAGEMENT AND MOBILIZATION

Background

Mobilizing communities is critical to the success of all health prevention strategies, especially HIV, HCV, STDs and overdose prevention. Building a long-lasting relationship with the community ensures that its members are proactive in their individual health, actively engaged in care, and confidently accessing resources and services without the fear of judgment or mistreatment.

To successfully address longstanding health disparities, especially within communities of color and other vulnerable populations, funded programs must implement new approaches to outreach and community engagement that go beyond the agencies "four walls", traditional efforts such as street health fairs, palm cards and "risk-based" testing only models. Services must be built on a deep foundation and understanding of the strong association between socioeconomic status, health inequities and race due to institutionalized racism. This shift will not always require additional resources, but rather a change in thinking about how we design outreach and community engagement models that also focuses on community basic needs, structural, systemic, personally mediated and internalized racism as key determinants of poor health outcomes and health inequities. This requires transforming the way that services reach and connect with communities in the places they live, work, play, pray as well as building strong partnerships with other community agencies and leaders.

Required and Preferred Service Elements

Required Elements	Preferred Elements
• Provide culturally humble, non-judgmental, stigma-free, sex-positive services, which entails building rapport and trust. • Utilize outreach as a tool to engage community members by disseminating pertinent prevention information and supplies to raise awareness, create visibility for the program, recruit participants, and make appropriate referrals to other services. • Utilize outreach as a means to build rapport and trust with the community. • Develop strong partnerships with other community based organizations and leaders within community. • Implement culturally appropriate efforts to raise awareness about HIV, HCV, STD prevention and treatment options. • Implement culturally appropriate efforts to raise awareness about overdose prevention (i.e. How to access Narcan). • Implement efforts to engage individuals in services that might not otherwise have been reached. • Field-based service delivery for marginalized or under-served populations.	• Schedule engagement events and/or activities during evenings and weekends. • Increase mobile service delivery. • Develop and implement a field-based safety protocol.

Required Elements	Preferred Elements
• Staff must reflect the population being served. • Peer-led efforts. • Expand beyond the "HIV prevention risk group" model. • Incorporate health education in community engagement activities. (See Health Education and Counseling) • Provide low-threshold basic needs services and/or resources. (See Basic Needs)	

Note: All programs must be able report on all required elements and any chosen preferred elements, to DPH upon request.

Data Requirements

1. **Program Performance Measures.** The following measures will be tracked and reported on in the Results Based Accountability (RBA) Scorecard. Applicants should include Year 1 targets for these measures in their application. (note: these can be turned into outcome objectives for contracts)
   - #/% of staff that reflect the community served.
   - # of community engagement activities (including outreach).

2. **Data Tracking.** Applicants must track the following measures and supply data to DPH upon request.
   - Date of community engagement activity/event
   - Was this a peer led effort?
   - How the event was promoted.
   - Brief description of activity/event (including location, number of participants, demographics to the extent known, etc.)
   - Describe services provided (including basic need services or resources, was health education and counseling provided).
   - Describe challenges/barriers; clients are facing to access services (including psychosocial and structural factors, stigma, etc.)
   - Describe any lessons learned or best practices.
   - Describe how the program is addressing challenges/barriers or implementing lessons learned.
   - Describe community partnerships/collaborations (if applicable).

Opt Out Criteria

Applicants **must** provide community engagement as part of their proposed program, even if the services are funded all or in part by another source, with the following exceptions:

- There is no opportunity to opt out of the required elements of this building block.

SYRINGE ACCESS AND DISPOSAL

Background

The San Francisco Department of Public Health (SFDPH) funds the San Francisco AIDS Foundation, Glide, Homeless Youth Alliance, St. James Infirmary, and San Francisco Drug Users Union to provide education, resources, referrals, and support groups for people who inject drugs (PWID). These programs provide sterile injecting equipment to PWID to reduce the likelihood of transmission of HIV and Hepatitis C (HCV) and bacterial infections, which often lead to preventable and costly treatment. They also provide a place where people can safely dispose of used syringes. These programs serve as places where people who use drugs can connect with providers to obtain other services and education to keep them healthy and alive. This includes overdose prevention education, naloxone, HIV, Hepatitis C, and STD testing, supportive counseling, drug use management, and referrals to health and drug treatment services. 2015 estimates indicated there were approximately 22,500 people who inject drugs (PWID) in San Francisco. Recent estimates have put the number of PWIDs closer to 24,500 in 2018.

Funded programs will expand the availability of harm reduction supplies, injection equipment, and syringe disposal to be available in the course of receiving other services. Providing expanded access locations, hours, types of sites – will reduce syringe litter *and* promote access to sterile injecting equipment and other ancillary services (e.g. referrals to health care, drug treatment, naloxone training) that address a variety of needs of PWID and promote connection and engagement.

SFDPH will provide training and certification to CHEP programs to become part of the Syringe Programs (SP) Network, with the goal of improving access to new sterile syringes for PWID. SP Network members will provide syringe access and disposal services to PWID as appropriate during the course of their receiving other services. These services will supplement the large-scale citywide syringe access and disposal program.

Required and Preferred Service Elements

Required Elements	Preferred Elements
• Provide culturally humble, non-judgmental, stigma-free, sex-positive services, which entails building rapport and trust. • Provision of the following safer injection supplies during the course of providing other services: syringes, water, needles, tourniquets, cookers, spoons, filters, water, swabs, vitamin C. • Mandatory syringe sizes: “Small” (31 G,1 CC), “Medium” (28 G, 0.5 CC), “Large” (27 G, 1 CC) and Musclers. • Provision of FitPacks or small biohazard containers • On site disposal (mounted biohazard containers, etc.). • Provision of current syringe site schedule (posted and in handout form). • Provision of current syringe disposal list including locations of 24 hr. boxes and kiosks.	• All client-facing staff* trained to provide supplies • Supplies provided during outreach ONLY upon client request and with prior approval by DPH • Late night and weekend availability and/or hours not covered by the Syringe Access and disposal programs. • Current SAS programs provide mentorship and training opportunities to (SP) Network providers. • SP Network agencies join Syringe Access Collaborative on a quarterly or bimonthly basis to learn best practices and ensure quality of services.)

Required Elements	Preferred Elements
• All client-facing staff* trained on harm reduction, including working with drug users, and syringe access and disposal response. • Drug Overdose Prevention Education (D.O.P.E.) training to train staff and volunteers to distribute naloxone as well as implement overdose response protocol(s) within and/or around (SP) Network spaces. • Training for all client-facing staff trained in administering Naloxone and recognizing signs of possible overdose. Must have a written overdose response plan. • Syringe clean-up/sweeps around the exterior of the site location on a daily basis during business hours. • Monthly data submission on syringes distributed and returned. • Must have a written disposal plan that includes Stericycle collecting waste on a weekly basis. • All staff must proactively offer linkage to HIV/HCV/STD testing services, overdose prevention, basic needs, and condoms (Refer to "Required Elements" section of building blocks for testing, overdose prevention, basic needs, and condoms). • Follow DPH syringe access protocol. • Provide linkage to recovery and mental health services. • Provide disposal education. • Incorporate health education and counseling in syringe access and disposal activities. (See Health Education and Counseling)	

Note: All programs must be able report on all required elements and any chosen preferred elements, to DPH upon request.

Additional Information

- Applicants need to include a line item in their budget for supplies (including syringes).
- DPH will provide syringe access and disposal training.

Data Requirements

1. **Program Performance Measures.** The following measures will be tracked and reported in the Syringe Access and disposal Dashboard (note: these can be turned into outcome objectives for contracts).
    - # of syringes distributed
    - # of syringes collected by DPH-funded efforts
2. **Data Tracking. Applicants must track** the following measures and supply data to DPH upon request.
    - None

All syringe programs must submit data to CHEP on a monthly basis. **Please review the program policies and guidelines (found HERE).**

Opt Out Criteria

Applicants **must** provide overdose prevention services as part of their proposed program, even if the services are funded all or in part by another source, with the following exceptions:

- There is no opportunity to opt out of the required elements of this building block.

***Client-facing staff refers to all those people in an agency or program that may have the opportunity of interacting with a client and can include security guards, front desk staff, volunteers, custodians, and staff providing direct services, coordinators, and directors.**

SUBSTANCE USE HARM REDUCTION SERVICES FOR OPIOIDS, STIMULANTS, ALCOHOL, TOBACCO, AND CANNABIS

Background

People who use drugs (PWUD) experience stigma, trauma, violence, and barriers to care that negatively affect health outcomes. In San Francisco, substance use is a driver of HIV, Hepatitis C (HCV) and sexually transmitted diseases (STDs). LGBT communities, PWUD, and those living with mental health challenges experience the highest tobacco use rates and greatest difficulty quitting, putting them at increased risk for tobacco-related harms. Long-term homelessness and displacement are urgent public health concern for people who use drugs. In order to optimize people's health and reduce HIV/HCV/STI transmission, these complexities must be addressed in an effective, culturally competent manner that aligns with SFDPH's commitment to harm reduction.

There is a need for substance use services beyond traditional, abstinence-based treatment models that are available on demand to meet the full range of our clients' needs. Integrated, harm reduction-based, trauma informed, non-stigmatizing, low threshold, peer-delivered substance use services in community settings can improve health outcomes for PWUD and also have the potential to reduce HIV/HCV/STD transmission and related morbidity and mortality.
SFDPH funded programs should align with harm reduction principles and the SFDPH Harm Reduction Policy (found here), which states that "Harm reduction is a public health philosophy, which promotes methods of reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors on individuals and their community. Harm reduction methods and treatment goals are free of judgment or blame and directly involve the client in setting their own goals." Funded programs need to demonstrate how they integrate these principles and policies into program design and delivery and put them into practice in a meaningful and impactful way.

Required and Preferred Service Elements

Required Elements	Preferred Elements
• Provide culturally humble, non-judgmental, stigma-free, sex-positive services, which entails building rapport and trust. • Ensure that ALL staff participate in ongoing harm reduction training. • Assess clients' needs on an ongoing, systematic basis for substance use including opioids, stimulants, alcohol, tobacco, and cannabis. • Use client-centered harm reduction counseling to discuss substance use. • Provide harm reduction information and education for all substances in addition to information regarding treatment models, including medication-assisted treatment (MAT) such as opioid-replacement therapy (ORT), naltrexone, nicotine-replacement therapy (NRT). • Provide Tobacco "Quit Kits" to clients, as needed and requested, as well as information about tobacco reduction/quitting classes. (SFDPH Tobacco Free Project will deliver the	• Provide harm reduction-based substance use support and education groups • Provide onsite outpatient substance use treatment, including MAT (note: cannot use these funds to pay for medication; this can happen in partnership with other agencies, clinics, etc.) • Provide mobile MAT starts (note: cannot use these funds to pay for medication, can occur in partnership with another agency or program). • Provide gender-specific treatment services. • Provide substance-specific treatment services. • Provide tobacco reduction/quitting class onsite (technical assistance available from SFDPH Tobacco Free Project). • Provide mobile/field-based brief counseling and referral. • Provide participant-delivered services • Provide weekend and evening services. • Provide medication lockers for participants.

Required Elements	Preferred Elements
kits to funded agencies and will provide information on resources.) • Educate clients about their rights and responsibilities under the SFDPH harm reduction policy, including providing written materials and/or signage in agencies. • Link clients (as needed) to substance use treatment services, including MATs for all substances (opioids, stimulants, alcohol, tobacco). • Develop innovative outreach strategies for PWUD. • Incorporate health education and counseling in harm reduction activities. (See Health Education and Counseling) • Develop an "agency-specific harm reduction policy" (putting SFDPH harm reduction policy into practice). This policy should describe how agency will systematically include PWUD in service design and delivery and create a structure in which clients can provide feedback on their experience to assess an agency's adherence to harm reduction principles. (Technical Assistance will be available from Harm Reduction Coalition).	• Provide information about drug testing services. • Provide fentanyl testing strips

Note: All programs must be able report on all required elements and any chosen preferred elements, to DPH upon request

Additional Information

- The SFDPH Harm Reduction Training Institute (HRTI), which is a collaboration between Harm Reduction Coalition and SFDPH, is available to provide harm reduction training and technical assistance to funded agencies. Monthly trainings will be provided at 25 Van Ness Avenue, room #610. Trainings can also be provided on-site to funded agencies.
- The SFDPH HRTI is available to provide harm reduction technical assistance to funded agencies. The technical assistance can be used to develop the agency-specific harm reduction policy (see the first bulleted performance measure below)
- The SFDPH Tobacco Free Project will provide "Quit Kits" and informational sessions on tobacco-related resources to all funded agencies.
- The SFDPH Tobacco Free Project will be available to provide technical assistance to agencies interested in implementing on-site tobacco reduction/quit classes to their clients.

Data Requirements

1. **Performance Measures.** The following measures will be tracked and reported in Clear Impact Results Scorecard. Applicants should include Year 1 targets for these measures in their application. (note: these can be turned into outcome objectives for contracts)
    - % of agency staff participating in two harm reduction trainings, provided by SFDPH HRTI (annually).

2. **Data Tracking.** Applicants must track the following measures and supply data to DPH upon request.
    - Technical assistance from SFDPH Harm Reduction Training Institute (HRTI)
    - Outreach activities to PWUD
    - Referrals to substance use services
    - Number of tobacco Quit Kits provided to clients
    - Harm reduction groups (if applicable)
    - Substance use counseling hours (if applicable)
    - Documentation of agency-specific harm reduction policy, developed with technical assistance from SFDPH HRTI, by the end of the first year.

Opt Out Criteria

Applicants **must** provide substance use harm reduction services as part of their proposed program, even if the services are funded all or in part by another source, with the following exceptions:

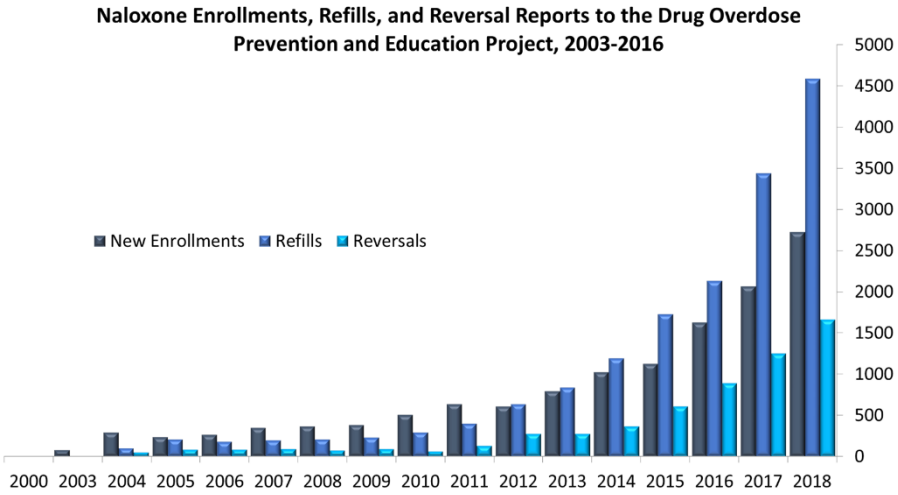
- There is no opportunity to opt out of the required elements of this building block.

OVERDOSE PREVENTION

Background

In San Francisco, people who inject drugs (PWIDs) are an increasing percentage of the population living with HIV, and opioid overdose is the leading cause of accidental death in the United States. San Francisco has experienced some moderate increases in the number of fatal opioid overdoses in recent years in part because of the introduction of synthetic opioids in the drug supply. The city has largely managed to avoid dramatic increases in overdose-related deaths seen in other jurisdictions in part because of its commitment to supporting evidence-based overdose prevention and response programming. Instead, the overall overdose death rate in San Francisco has remained mainly stable, with some steep drop offs in heroin-related overdose deaths and increasing prescription opioid-related overdose deaths.

SFDPH has partnered with the DOPE Project, a program of the Harm Reduction Coalition, since 2002. This program trains those who are most likely to witness an overdose to recognize and respond to an overdose. The DOPE Project also disseminates naloxone, the opioid overdose antidote, to community members most likely to witness an overdose. The figure on the right (credit: Phillip Coffin) depicts the program's growth, demonstrating that the more naloxone that is disseminated in the community, the higher the number of opioid overdose reversals reported.



Funded programs for this building block are required to collaborate with the DOPE Project to develop an onsite overdose response policy, and to ensure program participants have unfettered access to Nalaxone and overdose prevention and response trainings.

Required and Preferred Service Elements

Required Elements	Preferred Elements
• Provide culturally humble, non-judgmental, stigma-free, sex-positive services, which entails building rapport and trust. • Post and distribute DOPE Project schedule. • Post and distribute information about how to get naloxone from 1380 Howard Community Pharmacy • Maintain onsite overdose response policy and train staff annually on policy • Review onsite overdose policy semi-annually, and update as needed.	• Train all staff in overdose response. • Incorporate questions about prior overdose experience and overdose knowledge in intakes. • Become a naloxone distribution site. • Identify an overdose prevention liaison on staff who will lead all overdose prevention efforts at the agency (managing policy issues, training staff, educating staff at staff meetings, planning memorials, etc.).

Required Elements	Preferred Elements
• As part of policy, maintain a supply of naloxone on site to use for overdoses occurring on site. • All client-facing staff* trained in overdose response annually (these trainings can happen internally by experience staff, or with the support of the DOPE Project). • Incorporate health education and counseling in overdose prevention activities. (See Health Education and Counseling) • Host overdose prevention trainings for clients at your agency. • Host overdose prevention education groups for clients	• Develop active referral systems and information packets for methadone or buprenorphine-based treatment initiation • Make overdose prevention information visible and accessible in agency spaces that clients frequent. • Agency staff has facility working with people who use drugs. • Provide evening and weekend services.

Note: All programs must be able report on all required elements and any chosen preferred elements, to DPH upon request

Additional Information

- The Harm Reduction Coalition's DOPE Project, funded by DPH, is available to provide technical assistance in the development of agency's overdose prevention and response policies. The DOPE Project is also available to provide annual trainings to staff.
- Agencies that have internal capacity to train on overdose prevention and response are encouraged to leverage that capacity to train new and existing staff so as not to overburden the DOPE Project.
- Agencies are encouraged to make overdose prevention information visible and available to clients in the lobby of the building and to incorporate questions about prior overdose experience and overdose knowledge in intakes.

Data Requirements

1. **Performance Measures.** The following measures will be tracked and reported in Clear impact Results Scorecard. Applicants should include Year 1 targets for these measures in their application. (note: these can be turned into outcome objectives for contracts)
    - # of client-facing staff* participating in annual overdose prevention and response trainings.
    - # of overdose prevention training for clients
2. **Data Tracking.** Applicants must track the following measures and supply data to DPH upon request.
    - Overdose prevention education groups for clients
    - Documentation of onsite overdose response policy by the end of the first funded year.

Opt Out Criteria

Applicants **must** provide overdose prevention services as part of their proposed program, even if the services are funded all or in part by another source, with the following exceptions:

- There is no opportunity to opt out of the required elements of this building block.

***Client-facing staff refers to all those people in an agency or program that may have the opportunity of interacting with a client and can include security guards, front desk staff, volunteers, custodians, and staff providing direct services, coordinators, and directors.**

MENTAL HEALTH SERVICES

Background

Mental Health refers to a person's overall emotional, psychological, and social well-being. It affects how a person thinks, feels, and acts. In 2014, 1 in 5 American adults experienced a mental health issue. The impact of mental health increases among groups or populations that are oppressed and marginalized. One of the main mental health issues is depression. Some of the factors that can contribute to depression and other mental health issues include: major life changes such as a death of a loved one, loss of a job, change of HIV status, abuse, trauma, racism, and family history of mental health. Many studies have found that depression symptoms are associated with greater sexual risk behaviors among people who are HIV positive and those that are at risk for becoming HIV positive. Hepatitis C (HCV) also disproportionately impacts the mental health of some of the most vulnerable populations including people who use substances, people who experience homelessness, trauma, and violence. Anecdotally, people have shared that they did not realize how much HCV affected their mental health until after they had been cured.

Funded programs must integrate mental health services grounded in harm reduction theory, motivational interviewing, or short-term solution focused therapy into their HIV, HCV, and STD programs. These services should address the complex and interwoven needs of people living with and at risk for overdose, HIV, HCV, and STDs who are also experiencing stigma, trauma, homophobia, transphobia, violence, racism, and barriers to receiving appropriate services. Understanding the impact of mental health and providing services that are trauma-informed, non-stigmatizing, devoid of racial bias, peer-delivered, low threshold, harm reduction-based, and co-located/integrated with other services can contribute to reducing the number of overdose cases, HIV, HCV, and STD transmission while improving health outcomes.

Required and Preferred Elements

Required Elements	Preferred Elements
• Provide culturally humble, non-judgmental, stigma-free, sex-positive services, while building rapport and trust. • Address mental health stigma. • Provide appropriate counseling (i.e. motivational interviewing, Cognitive Behavior Therapy, client centered counseling). • Incorporate health education and counseling in mental health activities. (See Health Education and Counseling) • Provide linkages to culturally appropriate therapists. • Establish clear and effective linkage to mental health services • Ensure regular client case conferences • Provide ongoing training for staff around mental health • Collaborate with other city programs, community-based organizations, and/or community mental health clinics	• Provide support groups (focused on depression, anxiety, trauma, anger management) • Provide evening and weekend services • Assess all clients for mental health disorders (i.e. depression, anxiety, trauma) • Provide individual, couple, and family therapy • Incorporate a trauma informed system approach • Establish a policy where the social worker, therapist, or counselor has the flexibility to meet clients where there are at (i.e. home visit) • Embed psychiatrist, therapist, social worker, licensed volunteer, or counselor at site

Note: All programs must be able report on all required elements and any chosen preferred elements, to DPH upon request

Additional Information

None

Data Requirements

1. **Performance Measures.** The following measures will be tracked and reported on in the Results Scorecard. Applicants should include Year 1 targets for these measures in their application (note: these can be turned into outcome objectives for contracts).
    - # of counseling sessions in a year,
    - # of staff trained on mental health issues

2. **Data Tracking.** Applicants must track the following measures and supply data to DPH upon request.
    - # of Mental health service linkages made

Opt Out Criteria

Applicants **must** provide mental health services as part of their proposed program, even if the services are funded all or in part by another source, with the following exceptions:

- There is no opportunity to opt out of the required elements of this building block.

CONDOM DISTRIBUTION

Background

In San Francisco, access to free condoms is high. SFDPH and its community partners distributed more than 1.6 million free condoms in 2016, and NHBS data show that 70% of MSM reported receiving free condoms, over 60% reported using them, and free condoms from HIV organizations increased from 9% to 40% from 2004 to 2011[7]. To maintain access, SFDPH will continue to support targeted distribution at clubs, bars, clothing stores, leather goods stores, gyms, and other locations frequented by MSM.

San Francisco's biggest challenge with condoms is not access, but use. The changing role of condoms in HIV prevention is perhaps best exemplified by the change in language—we no longer talk about "unprotected sex" but rather "condomless sex"—because data shows that sex while on PrEP or ART is essentially protected sex when it comes to HIV transmission. With PrEP uptake and the proliferation of the "undetectable=un-transmittable" message among MSM, there have been concurrent declines in condom use and increases in STDs. A recent publication using SF Medical Monitoring Project and surveillance data found that HIV-positive MSM reported a higher prevalence of condom-less anal sex with negative partners on PrEP vs. not on PrEP.[23] Among heterosexual men, the number of early syphilis cases has generally increased over time reaching a peak in 2015 and for heterosexual women, the rates have stable, although higher numbers were observed in 2015-2017. Data continues to show how the rates of chlamydia, gonorrhea and early syphilis disproportionately affect the African American and Latinx communities—especially people under 20 years of age.

Consistent and correct use of condoms reduce the risk of STDs and HIV transmission. Condoms are also 98% effective at preventing pregnancy when used correctly. Funded programs are required to make condoms and lubricant accessible and free to clients on site, during outreach, in mobile services and during special events, as well as find ways to promote meaningful messages that emphasize condoms are still relevant for STD prevention.

Required and Preferred Service Elements

Required Elements	Preferred Elements
• Provide culturally humble, non-judgmental, stigma-free, sex-positive services, which entails building rapport and trust. • Make lube and male and female condoms easily accessible and free on site, during outreach, in mobile services and during special events. • Incorporate health education and counseling in condom distribution activities. (See Health Education and Counseling)	• Provide sex-positive training on condom usage, types, varieties, styles, etc. • Implement mechanisms to make condoms available during evenings, late nights, and weekends.

[23] Hughes A, Chen YH, Scheer S. (2017) Condomless anal sex among HIV-positive men who have sex with men: biomedical context matters. AIDS and Behavior. DOI: 10.1007/s10461- 017-1852-0

Required Elements	Preferred Elements
• When appropriate, client-facing staff* must provide education about condoms for protection against HIV and STDs.	

Note: All programs must be able report on all required elements and any chosen preferred elements, to DPH upon request.

Additional Information

- **Agencies can decide whether to include a line item in their budget or go through the CHEP Condom Distribution Program.**

Data Requirements

1. Performance Measures. The following measures will be tracked and reported on in the Results Scorecard. Applicants should include Year 1 targets for these measures in their application. (note: these can be turned into outcome objectives for contracts)

- **# of condoms distributed annually**

2. Data Tracking. Applicants must track the following measures and supply data to DPH upon request.

- **None**

Opt Out Criteria

Applicants must provide condom distribution services as part of their proposed program, even if the services are funded all or in part by another source, with the following exceptions:

- **There is no opportunity to opt out of the required elements of this building block.**

***Client-facing staff refers to all those people in an agency or program that may have the opportunity of interacting with a client and can include security guards, front desk staff, volunteers, custodians, and staff providing direct services, coordinators, and directors.**

BASIC NEEDS

Background

"Basic Needs" are essential items or referrals to local social service agencies that are necessary for clients to maintain their sexual health and overall well-being. Some of the "needs" may include but are not limited to items such as water, food, condoms, lubricant; and transportation access to get to/from services; health education, prevention information and more. Funded programs should tailor basic need services to meet the needs of the population they serve and provide them at no cost to the client.

Required and Preferred Service Elements

Required Elements	Preferred Elements
• Provide culturally humble, non-judgmental, stigma-free, sex-positive services, which entails building rapport and trust. • Programs must make visible to clients the hours of operation by posting them on site and/or website. • Provide clients in need of transportation with muni tokens, taxi vouchers, or car ride services such Uber or Lyft; or linkage to services that provide the above • Provide clients with access to drinking water. • Provide clients with food insecurities, light snack options and linkages to food resources • Provide clients with hygiene kits containing items such as deodorant, wet wipes, Chap Stick, toothbrush and toothpaste, soap, etc., as needed	• Provide resource information on health, social, employment, disability or other pertinent services that will help address the specific needs of a client. These services may include, but are not limited to the following: housing or shelter, smoking cessation, free clothing items for adults and children, shower locations, childcare, ID card access, free laundry facilities, free animal care and supplies, free cell phone access, etc. • Provide warm weather supplies such as hand warmers, socks, Mylar blankets, other washable blankets, beanies, gloves, etc. • Provide basic need services during evenings, late nights, and weekends.

Note: All programs must be able report on all required elements and any chosen preferred elements, to DPH upon request

HEALTH EDUCATION AND COUNSELING

Background

The role of health education and counseling is to provide information and behavioral interventions that support clients in adopting HIV, HCV, STD, overdose prevention and harm reduction strategies and link them to testing and other services. Traditionally, health education and counseling has been thought of as testing or one-on-one structured setting interventions only. Moving forward, the expectation is to see every client-facing staff* interaction used as an opportunity for engagement in health education and counseling interventions. These interactions can range from casually engaging a client while in line while accessing syringe access to a more in depth session while a client is going through a PrEP navigation intake.

Health education and counseling can be provided using different interventions (i.e. one-on-ones, groups, social marketing, outreach, or community engagement). In addition, these interventions can be implemented using different modalities (i.e. client centered counseling, harm reduction, motivational interviewing, trauma informed care, or a whole person approach), all using a similar approach with active listening skills and client autonomy as commonalities. The goal is to create a space in which clients can experience the best possible health outcomes and reduce opportunities for overdosing and acquisition or transmission of HIV, HCV, and STDs.

Funded programs should develop an integrated approach that considers health education and counseling an essential component of all client services.

Required and Preferred Service Elements

Required Elements	Preferred Elements
• Ensure that all client-facing staff* develops client centered counseling skills by attending the CHEP's HIV, HCV, and STD Skills Certification Training. • All client-facing staff* must be able to provide HIV, HCV, STD and overdose prevention information and education regarding transmission, prevention, and treatment/cure in a manner that is sex-positive, culturally appropriate, and includes harm reduction strategies appropriate for the population(s) served. • Provide information regarding overdose prevention including how to access Narcan. • De-stigmatize substance use through harm reduction education and messaging. • Provide information regarding PrEP, PEP, condom use, navigation services, and U=U. • Provide information regarding HIV, HCV, STD treatment adherence and treatment as prevention • Refer to clients using their pronoun preference. • Increase education and innovative efforts to address HIV, HCV, and STD stigma.	• Ensure that all client-facing staff* is trained in motivational interviewing. • Increase social media presence of integrated sexual and overdose prevention messages. • Provide health education and counseling services during evenings, late nights, and weekends.

Note: All programs must be able report on all required elements and any chosen preferred elements, to DPH upon request.

***Client-facing staff refers to all those people in an agency or program that may have the opportunity of interacting with a client and can include security guards, front desk staff, volunteers, custodians, staff providing direct services, coordinators, and directors.**

6.2: Standard of Care Services Performance Measures

Standard of Care Service	Performance Measures	Additional Data Tracking
COMMUNITY ENGAGEMENT AND MOBILIZATION	• #/% of staff that reflect the community served. • # of community engagement activities (including outreach).	• Date of community engagement activity/event • Was this a peer led effort? • How the event was promoted. • Brief description of activity/event (including location, number of participants, demographics to the extent known, etc.) • Describe services provided (including basic need services or resources, was health education and counseling provided). • Describe challenges/barriers; clients are facing to access services (including psychosocial and structural factors, stigma, etc.) • Describe any lessons learned or best practices. • Describe how the program is addressing challenges/barriers or implementing lessons learned. • Describe community partnerships/collaborations (if applicable).
CONDOM DISTRIBUTION	• # of condoms distributed annually	• None

INTEGRATED HIV/HCV/STD TESTING	• **HIV Testing**
	  • # of HIV tests to date
	  • # of reactive HIV tests to date
	• **HCV Testing**
	  • # of HCV tests to date
	  • # of reactive HCV antibodies tests
	  • # of reactive HCV RNA tests
	• **STD Tests/Screenings**
	  • # of syphilis tests
	  • # of reactive syphilis tests
	  • # of gonorrhea tests
	  • # of reactive gonorrhea tests
	  • # of chlamydia tests
	  • # of reactive chlamydia tests
		• None

LINKAGE AND NAVIGATION	• # of clients linked to HIV care • # of clients linked to HCV care • # of clients linked to STD care • # of clients provided navigation to PrEP services	

	• # of clients provided navigation to HIV services • # of clients provided navigation to HCV services	
PREVENTION AND TREATMENT MEDICATION	• % of clients linked to HIV care who initiated ART • % of clients linked to HCV care who completed treatment • % of clients linked to STD care who receive treatment • % of clients provided navigation to PrEP services who initiated treatment •	
MENTAL HEALTH SERVICES	• # of counseling sessions in a yea, • # of staff trained on mental health issues	• Mental health service linkages made
OVERDOSE PREVENTION	• # of client-facing staff* participating in annual overdose prevention and response trainings. • # of overdose prevention training for clients	• Overdose prevention education groups for clients • Documentation of onsite overdose response policy by the end of the first funded year.
SUBSTANCE USE HARM REDUCTION SERVICES FOR OPIOIDS, STIMULANTS, ALCOHOL, TOBACCO, AND CANNABIS	• % of agency staff participating in two harm reduction trainings, provided by SFDPH HRTI (annually).	• Technical assistance from SFDPH Harm Reduction Training Institute (HRTI) • Outreach activities to PWUD • Referrals to substance use services • Number of tobacco Quit Kits provided to clients • Harm reduction groups (if applicable) • Substance use counseling hours (if applicable) • Documentation of agency-specific harm reduction policy, developed with technical assistance from SFDPH HRTI, by the end of the first year.
SYRINGE ACCESS AND DISPOSAL	• # of syringes distributed • # of syringes collected by DPH-funded efforts	• None

6.3: Required Trainings

- **HIV, HCV, and STD Skills Certification**
  This five-day course is a state certified training that introduces aspiring counselors from our funded programs to the client-centered counseling model. Topics covered include basic local epidemiology, sexual health (STDs and birth control), HCV, harm reduction and overdose prevention, counseling tools, disclosure of test results. The training also covers HCV (OraQuick) and HIV (Determine) testing procedures and proper fingerstick technique for sample collection.

- **Harm Reduction**
  CHEP partners with the Harm Reduction Training Institute to provide staff in our branch and funded agencies with ongoing trainings that that promote non-judgmental evidence-based approaches to enhancing individual, organizational and community effectiveness.

- **Overdose Response/Naloxone Administration** (DOPE Project or internal)
  The DOPE Project offers a basic and comprehensive training on overdose for staff of San Francisco service providers working with people who use drugs who may be at risk of overdose. This training includes how to recognize an overdose, what puts people at risk for an overdose, how to respond to an overdose with naloxone, how to develop a protocol for overdose response and policy implementation, and what the context and current trends are around overdose in San Francisco.

- **Syringe Access and Disposal (TBD)**

- **Trauma Informed Systems**
  This training explores the application of our six principles of trauma-informed systems (Safety and Stability, Cultural Humility and Responsiveness, Compassion and Dependability, Resilience and Recovery, and Empowerment and Collaboration). The work of system change begins with sharing foundational knowledge of the impact of trauma on the people we serve, ourselves, our colleagues, our system and our community. Creating a shared language within our system is critical to responding to this impact.

- **Clear Impact Scorecard**
  Clear Impact Scorecard is built using Results-Based Accountability (RBA) methodology. RBA is a decision-making framework used by organizations, agencies, and communities to measure the performance of their programs and services and measure their impact on community well-being. RBA is a popular framework for social change in the public sector because it emphasizes the use of data and context to make effective decisions, gets organizations from talk to action quickly, is easy to understand and follow relative to other frameworks, and is actually leading to measurable results in community wellbeing.

- **Technical Assistance**
  CHEP commits to assess the needs of our funded programs and provide technical assistance in an effort to address any issue that may impede reaching contractual obligations with the Health Department.

6.4: Acronyms/Glossary of Terms

Acronyms

AYA	Adolescents and Young Adults
A/PI	Asian and Pacific Islander
ACA	Affordable Care Act
ART	Anti-retroviral therapy
B/AA	Black/African-American
CDC	Centers for Disease Control and Prevention
CHEP	Community Health Equity and Promotion
EHCSF	End Hepatitis C San Francisco
GTZ	Getting to Zero
HAP	Health Access Point
HCPC	HIV Community Planning Council
HCV	Hepatitis C Virus
HIP	High Impact Prevention
HIPPA	Health Insurance Portability Accountability Act
HIV	Human Immunodeficiency Virus
ITN	Invitation to Negotiate
Latinx	Gender-neutral term used in lieu of Latinx or Latina. The plural is Latinxs.
LINCS	Linkage Integration Navigation Comprehensive Services
LOI	Letter of Intent
MOU	Memorandum of Understanding
MSM	Men who have sex with men
MSM-PWID	Men who have sex with men and inject drugs
NHBS	National HIV behavioral Survey
PrEP	Pre-Exposure Prophylaxis
PWID	People who inject drugs
PWUD	People who use drugs
PWUD/ID	People who use drugs, including injecting drugs
RFP	Request for proposals
SAM	System for award management
SAMHSA	Substance abuse and mental health services administration
SFDPH	San Francisco Department of Public Health
STD	Sexually transmitted disease
TFSM	Trans female who has sex with men
TMSM	Trans men who has sex with men
U=U	Undetectable equals untransmittable
UCSF	University of California San Francisco

Glossary of Terms

RBA : a framework used to improve and track the effectiveness of programs. It is data driven and has two distinct parts: population accountability and performance accountability.

Client-facing staff: refers to all those people in an agency or program that may have the opportunity of interacting with a client and can include security guards, front desk staff, volunteers, custodians, staff providing direct services, coordinators, and directors.

HAP : a population specific, one-stop shop or network of agencies/programs with a lead agency that provides an equity-focused, stigma-free, and low barrier access to person-centered, standard of care services regardless of HIV, HCV, or STD status.

Linkage: Linkage services are defined as a warm hand-off to a service, typically a one-time occurrence with minimal complexity. A warm hand-off is defined as a face-to-face interaction, where the service providers have an open line of communication. Linkage services differ from a referral in that the service is followed-up on to ensure successful linkage to services. The purpose of linkage services is to ensure that a client is successfully linked to care.

Navigation: Navigation services guide clients through and around barriers in complex health care systems and ensure timely and appropriate care or treatment. Navigation services should help a client address barriers in their own lives that are preventing them from accessing care. Additionally, navigation services are tailored to each individual client to ensure client needs are being met, including mobile services and after hour services. Navigation services usually span a few months in time (1-3 months).

Case Management: Case management services are similar to navigation services, except they span a longer period of time (4-12 months).

References

1. Raymond HF, Scheer S, Santos G-M, McFarland W. (2016) Examining progress toward the UNAIDS 90-90-90 framework among men who have sex with men, San Francisco, 2014. AIDS Care, DOI: 10.1.1080/09540121.2016.l 153593

2. National Cancer Institute. State Cancer Profiles: Incidence Rate Report of Liver & Bile Duct Cancer, 2009-2013, for United States by County.

3. Facente SN, Grebe E, Burk K. Estimated Hepatitis C Prevalence and Key Population Sizes in San Francisco: A Foundation for Elimination. *PLOS ONE*. April 11, 2018 https://doi.org/10.1371/journal.pone.0195575

4. San Francisco Sexually Transmitted Disease Annual Summary 2016. Available at https://www.sfdph.org/dph/files/reports/StudiesData/STD/SFSTDAnnlSum2016.pdf

5. San Francisco Department of Public Health. HIV Epidemiology Annual Report 2017. Available at https://www.sfdph.org/dph/comupg/oprograms/HIVepiSec/HIVepiSecReports.asp

6. Hepatitis C seroprevalence and engagement in related care and treatment among trans women. Erin C. Wilson, Caitlin Turner, Jess Lin, Willi McFarland, Katie Burk, Henry Fisher Raymond. *Journal of Viral Hepatitis*: 27 February 2019. https://doi.org/10.1111/jvh.13089

7. https://journals.plos.org/plosone/article/comments?id=10.1371/journal.pone.0195575

8. San Francisco Department of Public Health. HIV Epidemiology Annual Report 2017. Available at https://www.sfdph.org/dph/comupg/oprograms/HIVepiSec/HIVepiSecReports.asp

9. SF Monthly STD Report. (2019, April 10).

10. Centers for Disease Control. Morbidity and Mortality Weekly Report. (2019, February).

11. San Francisco Department of Public Health. HIV Epidemiology Annual Report 2017. Available at https://www.sfdph.org/dph/comupg/oprograms/HIVepiSec/HIVepiSecReports.asp

12. https://journals.plos.org/plosone/article/comments?id=10.1371/journal.pone.0195575

13. San Framcisco Sexually Transmitted Disease Annual Summary 2016. Available at https://www.sfdph.org/dph/files/reports/StudiesData/STD/SFSTDAnnlSum2016.pdf
14. AmfAR. HIV Among Asian-Americans and Pacific Islanders—A Problem Too Often in the Shadows. (2019, May 17).

15. San Francisco Sexually Transmitted Disease Annual Summary 2016. Available at https://www.sfdph.org/dph/files/reports/StudiesData/STD/SFSTDAnnlSum2016.pdf
16. https://www.gettingtozerosf.org/our_work/adolescent-young-adult/

17. San Francisco Sexually Transmitted Disease Annual Summary 2016. Available at https://www.sfdph.org/dph/files/reports/StudiesData/STD/SFSTDAnnlSum2016.pdf
18. San Francisco Department of Public Health. HIV Epidemiology Annual Report 2017. Available at https://www.sfdph.org/dph/comupg/oprograms/HIVepiSec/HIVepiSecReports.asp

19. San Francisco Department of Public Health. HIV Epidemiology Annual Report 2017. Available at https://www.sfdph.org/dph/comupg/oprograms/HIVepiSec/HIVepiSecReports.asp

20. Personal communication with Amy Nishimura for the HCV data and the 2010 census for the population data

21. San Francisco Sexually Transmitted Disease Annual Summary 2016. Available at https://www.sfdph.org/dph/files/reports/StudiesData/STD/SFSTDAnnlSum2016.pdf

22. San Francisco Sexually Transmitted Disease Annual Summary 2016. Available at https://www.sfdph.org/dph/files/reports/StudiesData/STD/SFSTDAnnlSum2016.pdf
23. Hughes A, Chen YH, Scheer S. (2017) Condomless anal sex among HIV-positive men who have sex with men: biomedical context matters. AIDS and Behavior. DOI: 10.1007/s10461- 017-1852-0

24. Mizuno, Y., Higa, D.H., Leighton, C.A., Roland, K.B., Deluca, J.B., & Koenig, L.J. (2018). IS HIV patient navigation associated with HIV care continuum outcomes? A systematic review. *AIDS.* DOI: 10.1097/QAD.0000000000001987

25. HIV ReConnect: Increasing Retention and Re-Engagement. (2017). Getting to Zero and San Francisco Department of Public Health. http://www.gettingtozerosf.org/wp-content/uploads/2017/06/HIV-ReConnect-Universal.pdf

26. Bajis, S., Dore, G.J., Hajarizadeh, B., Cunningham, E.V., Maher, L., & Grebely, J. (August 2017). Interventions to enhance testing, linkage to care and treatment uptake for hepatitis C virus infection among people who inject drugs: A systematic review. *International Journal of Drug Policy, 47*, 34-46.

27. Spinelli, M.A., Scott, H.M., Vittinghoff, E., Liu, A.Y., Morehead-Gee, A., Gonzalez, R., Gandhi, M. & Buchbinder, S.P. (2018). Brief report: A panel management and patient navigation intervention is associated with earlier PrEP initiation in a safety-net primary care health system. *JAIDS Journal of Acquired Immune Deficiency Syndromes, 79*(3), 347–351. doi: 10.1097/QAI.0000000000001828.

28. Focus Area: Health for People at Risk or Living with HIV. San Francisco Department of Public Health.
https://www.sfdph.org/dph/files/sfchip2/FocusArea-HealthforPeopleatRiskorLivingwithHIV.pdf

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III. Submission Requirements

All forms are available for download at the Department's RFP/Q center at:

http://www.sfdph.org/dph/comupg/aboutdph/insideDept/Contracts .

A. Deadlines/Delivery Location

1. Letter of Intent Deadline

A **Letter of Intent (LOI)** to submit a proposal is mandatory. The letter must use the template in Appendix A-1 and must be signed by the appropriate authorities.

Please Note: There are seven (7) Service Categories. Please complete one LOI form per service category.

Please Note: Suppliers/vendors who submit an LOI and then decide to not submit a Proposal afterward, should contact the Contracts Unit and communicate their **intent to not** participate in the RFP.

The Letter of Intent must be submitted as follows:

By: 12:00 Noon **On:** October 9, 2019

To: Irene Carmona
SFDPH Contracts Unit
101 Grove St. Room 402
San Francisco, CA 94102
email: Irene.carmona@sfdph.org

Please complete the Letter of Intent form and email to irene.carmona @sfdph.org

Please include the following in the Subject area of the email:

LOI response to RFP 4-2019 SFDPH-CHEP Servicers

If your agency does not have access to email you may hand deliver or mail the Letter of Intent. You must submit by the listed deadline. No post stamped dates will be accepted.

2. Qualifications Statement and Proposal Package Deadline

Qualifications Statements, Sub-Contract MOU, and Proposal Packages must be received at the following deadline and address:

Potential contractors interested in multiple Service Categories must submit one Qualification Statement and Proposal Package per service category. Service Category Qualification Statements are located in Appendix A-1.

By: 12:00 Noon **On:** November 25, 2019

Place: Attn: Irene Carmona
SFDPH Contracts Unit
101 Grove St. Room 402
San Francisco, CA 94102

RFP # 4-2019

Proposals may be delivered in person or mailed; however, postmarks will not be considered in judging the timeliness of submissions. Proposals received after the deadline but within 24 hours may be accepted for extenuating circumstances at the sole discretion of the Director of the Department of Public Health. Applicants that submit proposals within this grace period must provide a letter to the Director explaining the extenuating circumstances by **12 noon** on **11/26/2019**. Decisions of the Director to accept or reject the proposal during the grace period will not be appealable. If the proposal is accepted, the letter of explanation will be provided to the Technical Review Panel. Following the 24-hour grace period no late proposals will be accepted for any reason and there will be no appeal. Email letter to Irene.carmona@sfdph.org, include **"Late Submission Request"** in the subject area.

In addition, the required CMD Form 3 and MCO HCAO Declaration forms must be submitted separately in a sealed envelope clearly marked with the above address and solicitation number.

Proposals may NOT be submitted by fax or email and will not be accepted if so received.

B. Solicitation Package Documentation

1. Qualifications Statement and Sub-Contract MOU documents:

To respond to this solicitation, a Proposer must follow the submittal steps outlined in this Submissions Requirements Section, to include a Qualifications Statement, Sub-Contract MOU document, and a complete and assembled proposal package by the deadline outlined in this RFP.

The **Qualifications Statement and Sub-Contract MOU documents can be found in Appendix A-1** and is also available for download at http://www.sfdph.org/dph/comupg/aboutdph/insideDept/Contracts.
These are the only forms that can be used for the Qualifications Statement and Sub-Contract MOU. Applications that do not use these forms will be rejected.

A person authorized to bind the Lead Applicant/Proposer to the representations, commitments and statements contained in the Qualifications Statement must sign the Qualifications Statement document. The Qualifications Statement must contain the following information and any applicable supporting documents:

- Description of Proposer: A description of the Proposer's organizational structure (e.g., corporation, partnership, limited liability company, etc.), the jurisdiction in which the Proposer is organized and date of such organization.
- Authorized Representative: The name, address, telephone number, facsimile number and e-mail address of the person authorized to represent the Proposer with respect to all notices, negotiations, discussions and other communications relating to this solicitation and to any negotiations relating to a contract.
- Representations Regarding Good Standing, Licenses, etc.: A representation that the Proposer is in good standing in the State of California and has all necessary licenses, permits, approvals and authorizations necessary in order to perform the Work and conduct the Proposer's business.
- Representations Regarding CITY Contracting Requirements: A representation that the Proposer is able and willing to comply with all of the contracting requirements described in "Section VII. Standard Contract Requirements."

A person authorized to bind the Lead Applicant/Proposer and the identified Sub-Contractors to the representations, commitments and statements contained in the RFP application must sign the Sub-Contract MOU document.

2. Proposal Package (see Section II, Program Service Specifications, for detailed content)

The process requires submission of a proposal package consisting of the following documentation.

(a) Introductory Documents
  (i) Qualifications Statement (use as cover page)
  (ii) Sub-Contract MOU document
  (iii) Table of Contents

(b) Standard Documents
  (i) Program Narrative
  (ii) Budget Document

(c) Mandatory attachments
  (i) CMD FORM 3 (for the Lead Agency, if a collaboration). Per the San Francisco Contract Monitoring Division (CMD), this form must be submitted with your proposal. The CMD Form 3 is provided in Appendix A-1, with additional forms and instructions in CMD Attachment 2 in Appendix A-2. **Submit only the original (no additional copies are required) in a *separate envelope labeled "CMD Form 3" and the solicitation number*.**
  (ii) HCAO and MCO Declaration forms. The HCAO MCO Declaration Forms are provided in Appendix A-1,

Additional pages beyond any limits specified will be eliminated before the proposal is reviewed.

Applicants may not submit other items not listed above. For example, do not submit curricula or policies and procedures manuals. Anything submitted that is not on the list above will be discarded.

3. Proposal Format

- Proposers must submit **One Original** and **five (5) Copies** of the Qualifications Statement and the same number of complete and assembled Proposal Packages.
- The original must be clearly marked "ORIGINAL."
- Each proposal should be unbound (document clips, binder clips, and/or rubber bands as necessary, please **NO STAPLES**, collated, and include a table of contents.
- Each section must be clearly labeled with the appropriate heading, and pages should be clearly numbered.
- The Proposer's name and program name should be shown in the page footers.

IV. Review and Selection Process

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A. Initial Screening

Any proposal submitted without the required Qualifications Statement and a complete proposal package will be rejected without further review.

1. Minimum Qualifications

During the initial screening process, any proposal that does not demonstrate that the Proposer meets the Minimum Qualifications specified in the Program Service Category Specifications, Section II, of this solicitation will be considered non-responsive and will not be eligible for further review or consideration.

B. Technical Review, Oral Presentation Review, and Scoring of Proposals

1. Technical Review:

- The proposal will be reviewed and rated by (a) Technical Review Panel(s) with expertise in the services required.
- The Technical Review Panel(s) will be recruited with strict attention to ensuring that no conflict of interest exists related to any member of the panel and the proposals anticipated according to required Letters of Intent received.
- The Technical Review Panel(s) will review and score each proposal according to the criteria outlined in the **"Program Service Specifications, Section II Scoring Criteria Per Service Category"** of this solicitation.
- **Proposals must have a total score of 75 or more to be eligible to advance.**
- The applicants' proposal with the **highest score in each Service Category** will be recommended and invited to an **"Oral Presentation Review"** with the Department.

2. Oral Presentation Review:

- In the Oral Presentation Review, the applicant will have an opportunity to present their proposed scope of services and negotiate terms of service.
- Applicants who may have submitted multiple proposals, and who have scored the highest in multiple service categories, will only have the opportunity to be selected to provide services in one service category.
- The Department reserves the right to select the applicant who has demonstrated the ability to perform the services requested, and who will reach the desired target populations, and service needs.

- If that Proposer cannot demonstrate that their agency can meet the terms of service or refuses the offer, the Department will continue to contact Proposers from the qualified list until the offer to provide the solicited services is accepted.
- In the event that the review process does not result in the identification of a qualified proposer, the Department reserves the right to solicit services to increase the pool of qualified vendors.
- During program review, any aspect of the proposal will be considered negotiable, including the budget, the services to be provided, and the target population to be reached. Receiving an invitation to the Oral Presentation Review and entering into negotiations does not obligate either the Department or the applicant to enter into a contract; either party may decide to end the review and negotiations at any time for any reason. If the review and negotiations fail to result in a contract award in a reasonable period of time, the Department reserves the right to invite another Proposer to the Oral Presentation and Review process or to issue a new solicitation for the services.

3. Bidder Rating Discount:

Applicants who are LBE Certified will receive additional points. This will be added to the "Technical Review Score". See LBE Participation terms outlined in the VI. Standard Terms and Conditions for Receipt of Proposals.

	Bidder Rating Discount:	**0-10**
	10% discount to LBE; or joint venture between or among LBEs	
	5% discount to joint venture with LBE participation that equals or exceeds 35% but is under 40%.	
	7.5% discount to a joint venture with LBE participation that equals or exceeds 40%.	
	10% discount to a certified non-profit entity.	
	Total Available Points:	**10**

C. Contract Notification Process

If the Technical Review and Oral Presentation Review process is completed to the satisfaction of both the SFDPH and the applicant, the applicant will receive a notification letter indicating the negotiated services and funding amount.

The anticipated start date for contracts resulting from this solicitation is **July 1, 2020.** Failure to negotiate the contract in a timely manner, or to furnish any and all certificates, bonds, or other materials required in the contract, shall be deemed an abandonment of the contract offer.

The SFDPH reserves the right to award a single contract or multiple contracts to multiple Proposers that submitted proposal(s).

D. Stipulations

The issuance of this solicitation does not constitute an agreement by the City that any contract actually will be entered into by the City. The City reserves the right at any time to:

1. Waive or correct any defect or informality in any response, proposal, or proposal procedure;
2. Reject any or all proposals;
3. Reissue this solicitation;
4. Procure any materials, equipment, or services specified in this solicitation by any other means;
5. Ensure that all target populations are served and service requirements are met; and
6. Determine that no project will be funded.

In addition to the ability to provide the specified services, the applicant must comply with general SFDPH and City and County of San Francisco contractual requirements and ordinances, San Francisco Health Network, Primary Care reporting requirements, and the Standard Agreement for Services (P-600).

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V. E-Questions Process and Bidders Conference

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A. E-Questions (Amended 9.19.2019)

~~Only Proposers that have submitted a Letter of Intent (LOI) with an email address by the due date may e-mail questions concerning the specifics of the services solicited.~~

Dates/Period when e-mail questions will be accepted:

Pre-Bidders Conference E-Questions Period:

Begin: **September 16, 2019** End: **September 19, 2019**

Post-Bidders Conference E-Questions Period:

Begin: **September 26, 2019** End: **October 2, 2019**

All questions are to be directed to the following e-mail address:

irene.carmona@sfdph.org

You must insert the following language in the Subject area of your email message: E-Questions RFP 4-2019 CHEP Prevention Services

The questions will be compiled and coordinated with program staff for appropriate answers. The compilation of Pre-Bidders Conference questions and answers will be provided at the Bidders Conference and returned by email to the questioners who have provided their contact information. The Post-Bidders Conference questions and answers will emailed to all potential bidders who have downloaded a copy of the RFP, and who have provided contact information at the Bidders Conference. In addition, a copy of the compiled E-Questions, and other submitted questions and answers will be posted to the RFP Web Site for reference.

B. Bidders Conference

The Department will present an overview of RFP 4-2019 at a Bidders Conference on the following date and location:

- **September 26, 2019**
- **From 9 AM to 12 Noon**
- **Location:**
  - **Department of Public Health**
    101 Grove, Room 300, San Francisco, CA 94102

C. RFP Questions and Answers

The outlined "E-Questions" period(s) and the Bidders Conference event are the only opportunities suppliers/vendors may ask direct programmatic questions of the Departmental staff.

Please Note:

On 09.19.2019 Section V. E-Questions Process and Bidders Conference has been amended to remove the LOI reference and to include an additional time line for potential bidders to submit E-Questions post Bidders Conference.

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VI. Standard Terms and Conditions for Receipt of Proposals

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A. Errors and Omissions in Solicitation

Proposers are responsible for reviewing all portions of this solicitation. Proposers are to promptly notify the Department, in writing, if the Proposer discovers any ambiguity, discrepancy, omission, or other error in the solicitation. Any such notification should be directed to the Department promptly after discovery, but in no event later than five working days prior to the date for receipt of proposals. Modifications and clarifications will be made by addenda as provided below.

B. Inquiries Regarding Solicitation

Technical or procedural inquiries regarding this solicitation, other than programmatic questions addressed at either a Bidder's Conference or through the E-Questions procedure described in Section V, above, must be directed to:

Irene Carmona
SFDPH – Contracts Unit
Phone: **(415) 554-2652**
Email: **Irene.carmona@sfdph.org**

C. Objections to Solicitation Terms

Should a Proposer object on any ground to any provision or legal requirement set forth in this solicitation, the Proposer must, not more than ten calendar days after the solicitation is issued, provide written notice to the Department setting forth with specificity the grounds for the objection. The failure of a Proposer to object in the manner set forth in this paragraph shall constitute a complete and irrevocable waiver of any such objection.

D. Change Notices

The Department may modify the solicitation, prior to the proposal due date, by issuing Change Notices, which will be posted on the website. The Proposer shall be responsible for ensuring that its proposal reflects any and all Change Notices issued by the Department prior to the proposal due date regardless of when the proposal is submitted. Therefore, the City recommends that the Proposer consult the website frequently, including shortly before the proposal due date, to determine if the Proposer has downloaded all Change Notices.

In the event that modifications are posted to the website, the SFDPH will send a courtesy notice by email to Proposers that have submitted a Letter of Intent. This notice will advise the Proposer that changes have been posted. Notwithstanding this provision, the Proposer shall be responsible for ensuring that its proposal reflects any and all modifications or addenda issued by the SFDPH prior to the proposal due date.

E. Term of Proposal

Submission of a proposal signifies that the proposed services and prices are valid for 120 calendar days from the proposal due date and that the quoted prices are genuine and not the result of collusion or any other anti-competitive activity.

F. Revision of Proposal

A Proposer may revise a proposal on the Proposer's own initiative at any time before the deadline for submission of proposals. The Proposer must submit the revised proposal in the same manner as the original. A revised proposal must be received on or before the proposal due date.

In no case will a statement of intent to submit a revised proposal, or commencement of a revision process, extend the proposal due date for any Proposer.

At any time during the proposal evaluation process, the Department may require a Proposer to provide oral or written clarification of its proposal. The Department reserves the right to make an award without further clarifications of proposals received.

G. Errors and Omissions in Proposal

Failure by the Department to object to an error, omission, or deviation in the proposal will in no way modify the solicitation or excuse the vendor from full compliance with the specifications of the solicitation or any contract awarded pursuant to the solicitation.

H. Financial Responsibility

The City accepts no financial responsibility for any costs incurred by a firm in responding to this solicitation. Submissions of the solicitation will become the property of the City and may be used by the City in any way deemed appropriate.

Proposer's Obligations under the Campaign Reform Ordinance

Proposers must comply with Section 1.126 of the S.F. Campaign and Governmental Conduct Code, which states:

No person who contracts with the City and County of San Francisco for the rendition of personal services, for the furnishing of any material, supplies or equipment to the City, or for selling any land or building to the City, whenever such transaction would require

approval by a City elective officer, or the board on which that City elective officer serves, shall make any contribution to such an officer, or candidates for such an office, or committee controlled by such officer or candidate at any time between commencement of negotiations and the later of either (1) the termination of negotiations for such contract, or (2) three months have elapsed from the date the contract is approved by the City elective officer or the board on which that City elective officer serves.

If a Proposer is negotiating for a contract that must be approved by an elected local officer or the board on which that officer serves, during the negotiation period the Proposer is prohibited from making contributions to:

- the officer's re-election campaign
- a candidate for that officer's office
- a committee controlled by the officer or candidate.

The negotiation period begins with the first point of contact, either by telephone, in person, or in writing, when a contractor approaches any city officer or employee about a particular contract, or a city officer or employee initiates communication with a potential contractor about a contract. The negotiation period ends when a contract is awarded or not awarded to the contractor. Examples of initial contacts include: (1) a vendor contacts a city officer or employee to promote himself or herself as a candidate for a contract; and (2) a city officer or employee contacts a contractor to propose that the contractor apply for a contract. Inquiries for information about a particular contract, requests for documents relating to a Request for Proposal, and requests to be placed on a mailing list do not constitute negotiations.

Violation of Section 1.126 may result in the following criminal, civil, or administrative penalties:

1. Criminal. Any person who knowingly or willfully violates section 1.126 is subject to a fine of up to $5,000 and a jail term of not more than six months, or both.

2. Civil. Any person who intentionally or negligently violates section 1.126 may be held liable in a civil action brought by the civil prosecutor for an amount up to $5,000.

3. Administrative. Any person who intentionally or negligently violates section 1.126 may be held liable in an administrative proceeding before the Ethics Commission held pursuant to the Charter for an amount up to $5,000 for each violation.

For further information, Proposers should contact the San Francisco Ethics Commission at (415) 581-2300.

I. Sunshine Ordinance

In accordance with S.F. Administrative Code Section 67.24(e), contractors' bids, responses to solicitations and all other records of communications between the City and persons or firms seeking contracts shall be open to inspection immediately after a contract has been awarded. Nothing in this provision requires the disclosure of a private person's or organization's net worth or other proprietary financial data submitted for qualification for a contract or other benefits until and unless that person or organization is awarded the contract or benefit. Information provided which is covered by this paragraph will be made available to the public upon request.

J. Public Access to Meetings and Records

If a Proposer is a non-profit entity that receives a cumulative total per year of at least $750,000 in City funds or City-administered funds and is a non-profit organization as defined in Chapter 12L of the S.F. Administrative Code, the Proposer must comply with Chapter 12L. The Proposer must include in its proposal (1) a statement describing its efforts to comply with the Chapter 12L provisions regarding public access to Proposer's meetings and records, and (2) a summary of all complaints concerning the Proposer's compliance with Chapter 12L that were filed with the City in the last two years and deemed by the City to be substantiated. The summary shall also describe the disposition of each complaint. If no such complaints were filed, the Proposer shall include a statement to that effect. Failure to comply with the reporting requirements of Chapter 12L or material misrepresentation in Proposer's Chapter 12L submissions shall be grounds for rejection of the proposal and/or termination of any subsequent Agreement reached on the basis of the proposal.

K. Reservations of Rights by the City

The issuance of this solicitation does not constitute an agreement by the City that any contract will actually be entered into by the City. The City expressly reserves the right at any time to:

1. Waive or correct any defect or informality in any response, proposal, or proposal procedure;
2. Reject any or all proposals;
3. Reissue a Request for Proposals;
4. Prior to submission deadline for proposals, modify all or any portion of the selection procedures, including deadlines for accepting responses, the specifications or requirements for any materials, equipment or services to be provided under this solicitation, or the requirements for contents or format of the proposals;

5. Procure any materials, equipment or services specified in this solicitation by any other means; or
6. Determine that no project will be pursued.

L. Waiver

No waiver by the City of any provision of this solicitation shall be implied from any failure by the City to recognize or take action on account of any failure by a Proposer to observe any provision of this solicitation.

M. Local Business Enterprise Goals and Outreach

The requirements of the Local Business Enterprise and Non-Discrimination in Contracting Ordinance set forth in Chapter 14B of the San Francisco Administrative Code as it now exists or as it may be amended in the future (collectively the "LBE Ordinance") shall apply to this solicitation.

1. LBE Subconsultant Participation Goals

The LBE subconsulting goal for this project is **0**% of the total value of the goods and/or services to be procured. **(Grant Funded)**

Each firm responding to this solicitation shall demonstrate in its response that it has used good-faith outreach to select LBE subcontractors as set forth in S.F. Administrative Code §§14B.8 and 14B.9, and shall identify the particular LBE subcontractors solicited and selected to be used in performing the contract. For each LBE identified as a subcontractor, the response must specify the value of the participation as a percentage of the total value of the goods and/or services to be procured, the type of work to be performed, and such information as may reasonably be required to determine the responsiveness of the proposal. LBEs identified as subcontractors must be certified with the San Francisco Contract Monitoring Division (CMD) at the time the proposal is submitted, and must be contacted by the Proposer (prime contractor) prior to listing them as subcontractors in the proposal. Any proposal that does not meet the requirements of this paragraph will be non-responsive.

In addition to demonstrating that it will achieve the level of subconsulting participation required by the contract, a Proposer shall also undertake and document in its submittal the good faith efforts required by Chapter 14B.8(C) & (D) and CMD Attachment 2, Requirements for Architecture, Engineering and Professional Services Contracts.

Proposals which fail to comply with the material requirements of S.F. Administrative Code §§14B.8 and 14B.9, CMD Attachment 2 and this solicitation will be deemed

non-responsive and will be rejected. During the term of the contract, any failure to comply with the level of LBE subcontractor participation specified in the contract shall be deemed a material breach of contract. Subconsulting goals can only be met with CMD-certified LBEs located in San Francisco.

2. LBE Participation

The City strongly encourages proposals from qualified LBEs. Pursuant to Chapter 14B, the following rating discount will be in effect for the award of this project for any Proposers who are certified by CMD as a LBE, or joint ventures where the joint venture partners are in the same discipline and have the specific levels of participation as identified below. Certification applications may be obtained by calling **CMD at (415) 581-2310**. The rating discount applies at each phase of the selection process. The application of the rating discount is as follows:

a. A 10% discount to an LBE; or a joint venture between or among LBEs; or
b. A 5% discount to a joint venture with LBE participation that equals or exceeds 35%, but is under 40%; or
c. A 7.5% discount to a joint venture with LBE participation that equals or exceeds 40%; or
d. A 10% discount to a certified non-profit entity.

If applying for a rating discount as a joint venture: The LBE must be an active partner in the joint venture and perform work, manage the job and take financial risks in proportion to the required level of participation stated in the proposal, and must be responsible for a clearly defined portion of the work to be performed and share in the ownership, control, management responsibilities, risks, and profits of the joint venture. The portion of the LBE joint venture's work shall be set forth in detail separately from the work to be performed by the non-LBE joint venture partner. The LBE joint venture's portion of the contract must be assigned a commercially useful function.

3. CMD Forms to be Submitted with Proposal

a. All proposals submitted must include the following Contract Monitoring Division (CMD) Form 3 Non Discrimination Affidavit.

- If these forms are not returned with the proposal, the proposal may be determined to be non-responsive and may be rejected.

b. Please submit only one copy of the CMD Form 3 with your proposal. The form should be placed in a separate, sealed envelope labeled CMD Form 3.

If you have any questions concerning the CMD Forms, you may call the Contract Monitoring Division at (415) 581-2310.

N. Ban on City Contracts and Travel Involving States with Anti LGBT Laws

Per Administrative Code Section 12X prohibits City contracting with companies from states that have enacted laws after June 26, 2015, reversing anti-discrimination protections for LGBT individuals or that permit discrimination against LGBT individuals. Administrative Code Section 12X.5 (a) cites that the City shall not enter into any Contract with a Contractor that has its United States headquarters in a state on the Covered State List or where any or all of the work on the Contract will be performed in a state on the Covered State List.

In accordance with the Administrative Code Section 12X.5 (b), the Contracting Department may waive the requirements of Section 12X.5 in full or in part if the department determines that strict application of the requirement would not be feasible, would create an undue hardship or practical difficulty, or that similar circumstances otherwise warrant granting of the waiver.

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VII. Standard Contract Requirements

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A. Standard Contract Provisions (Legal Agreement)

Upon award of a contract, the Contractor will be required to enter into and sign a legal agreement ("Agreement") containing standard terms and conditions. A sample Agreement can be found in Appendix A-3, available for download at http://www.sfdph.org/dph/comupg/aboutdph/insideDept/Contracts/. Failure to timely execute the contract, or to furnish any and all insurance certificates and policy endorsement, surety bonds or other materials required in the contract, shall be deemed an abandonment of a contract offer. The City, in its sole discretion, may select another firm and may proceed against the original selectee for damages.

Proposers are urged to pay special attention to the requirements of Administrative Code Chapters 12B and 12C, Nondiscrimination in Contracts and Benefits, the Minimum Compensation Ordinance; the Health Care Accountability Ordinance; the First Source Hiring Program; and applicable conflict of interest laws, as set forth in paragraphs B, C, D, E and F below.

B. Nondiscrimination in Contracts and Benefits

The successful Proposer will be required to agree to comply fully with and be bound by the provisions of Chapters 12B and 12C of the San Francisco Administrative Code. Generally, Chapter 12B prohibits the City and County of San Francisco from entering into contracts or leases with any entity that discriminates in the provision of benefits between employees with domestic partners and employees with spouses, and/or between the domestic partners and spouses of employees. The Chapter 12C requires nondiscrimination in contracts in public accommodation. Additional information on Chapters 12B and 12C is available on the HRC's website at www.sfgov.org/sfhumanrights.

C. Minimum Compensation Ordinance (MCO)

The successful Proposer will be required to agree to comply fully with and be bound by the provisions of the Minimum Compensation Ordinance (MCO), as set forth in S.F. Administrative Code Chapter 12P. Generally, this Ordinance requires contractors to provide employees covered by the Ordinance who do work funded under the contract with hourly gross compensation and paid and unpaid time off that meet certain minimum requirements.

For the amount of hourly gross compensation currently required under the MCO, see www.sfgov.org/olse/mco. Note that this hourly rate may increase on January 1 of each year and that contractors will be required to pay any such increases to covered employees during the term of the contract.

Additional information regarding the MCO is available on the web at www.sfgov.org/olse/mco.

D. Health Care Accountability Ordinance (HCAO)

The successful Proposer will be required to agree to comply fully with and be bound by the provisions of the Health Care Accountability Ordinance (HCAO), as set forth in S.F. Administrative Code Chapter 12Q. Contractors should consult the San Francisco Administrative Code to determine their compliance obligations under this chapter. Additional information regarding the HCAO is available on the web at www.sfgov.org/olse/hcao.

E. First Source Hiring Program (FSHP)

If the contract is for more than $50,000, then the First Source Hiring Program (Administrative Code Chapter 83) may apply. Generally, this ordinance requires contractors to notify the First Source Hiring Program of available entry-level jobs and provide the Workforce Development System with the first opportunity to refer qualified individuals for employment.

Contractors should consult the San Francisco Administrative Code to determine their compliance obligations under this chapter. Additional information regarding the FSHP is available on the web at www.onestopsf.org, under the "Employers" menu, and from the First Source Hiring Administrator, (415) 401-4960.

F. Conflicts of Interest

The successful Proposer will be required to agree to comply fully with and be bound by the applicable provisions of state and local laws related to conflicts of interest, including Section 15.103 of the City's Charter, Article III, Chapter 2 of City's Campaign and Governmental Conduct Code, and Section 87100 et seq. and Section 1090 et seq. of the Government Code of the State of California. The successful Proposer will be required to acknowledge that it is familiar with these laws; certify that it does not know of any facts that constitute a violation of said provisions; and agree to immediately notify the City if it becomes aware of any such fact during the term of the Agreement.

Individuals who will perform work for the City on behalf of the successful Proposer might be deemed consultants under state and local conflict of interest laws. If so, such individuals will be required to submit a Statement of Economic Interests, California Fair Political Practices Commission Form 700, to the City within ten calendar days of the City notifying the successful Proposer that the City has selected the Proposer.

G. Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA)

The parties acknowledge that City is a Covered Entity as defined in the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") and is therefore required to abide by the Privacy Rule contained therein. The parties further agree that Contractor may be defined as one of the following definitions under the HIPAA regulations:

- A Business Associate[24] subject to the terms set forth in P-600 - Standard Legal Agreement Boilerplate.
- See Appendix A-3 for further information.

H. Insurance Requirements

Upon award of contract, Contractor shall furnish to the SFDPH a Certificate or Certificates of Insurance, with applicable Additional Insured Endorsements, stating that there is insurance presently in effect for Contractor with limits of not less than those established by the City.

Requirements are listed in Appendix A-3 and are available for download at the Department's RFP/Q center:

http://www.sfdph.org/dph/comupg/aboutdph/insideDept/Contracts/.

[24] "*Business Associate" shall mean an entity that has an agreement with CITY and may have access to private information, and does not receive reimbursement for direct health services from insurance companies or authorities and thus is not a Covered Entity as defined by HIPAA.*

VIII. Appeals Procedures

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An appeal of an award to provide services decision may be filed if the Proposer has reason to believe that there was a substantial failure by the Department of Public Health in following standard solicitation procedures. The appeal must be filed within five (5) working days of receipt of the notification letter. All appeals will be presented to the Director, Office of Contracts Management and Compliance. Appeals will be ruled on, and the appealing entity notified in writing, within five (5) working days after its receipt. All decisions are final. If you wish to appeal, prepare a brief statement describing the procedural breach that is the reason for your appeal to the SFDPH Office Contracts Management and Compliance, San Francisco Department of Public Health, 101 Grove St. Room 402, San Francisco, CA 94102, irene.carmona@sfdph.org .

Reference Chart of Sources for Standard, City-required forms:

This chart describes the most essential forms, where to find them on the Internet, and where to file them. If a contractor cannot get the documents off the Internet, the contractor should call (415) 554-6248 or e-mail Purchasing (purchasing@sfgov.org) and Purchasing will fax, mail or e-mail them to the contractor. If a contractor has already filled out items 1-3 on the chart**, the contractor should not do so again unless the contractor's answers have changed**. To find out whether these forms have been submitted, the contractor should call Vendor File Support in the Controller's Office at (415) 554-6702.

If a contractor would like to apply to be certified as a local business enterprise, it must submit item 4. To find out about item 4 and certification, the contractor should call Human Rights Commission at (415) 252-2500.

Item	Form name and Internet location	Form	Description	Return the form to; For more info
1.	Request for Taxpayer Identification Number and Certification www.sfgov.org/oca/purchasing/forms.htm www.irs.gov/pub/irs-fill/fw9.pdf	W-9	The City needs the contractor's taxpayer ID number on this form. If a contractor has already done business with the City, this form is not necessary because the City already has the number.	Controller's Office Vendor File Support City Hall, Room 484 San Francisco, CA 94102 (415) 554-6702
2.	Business Tax Declaration www.sfgov.org/oca/purchasing/forms.htm	P-25	All contractors must sign this form to determine if they must register with the Tax Collector, even if not located in San Francisco. All businesses that qualify as "conducting business in San Francisco" must register with the Tax Collector.	Controller's Office Vendor File Support City Hall, Room 484 San Francisco, CA 94102 (415) 554-6702

3.	S.F. Administrative Code Chapters 12B & 12C Declaration: Nondiscrimination in Contracts and Benefits www.sfgov.org/oca/purchasing/forms.htm – **in "Vendor Profile Application"** Also at www.sfgov.org/site/sfhumanrights **under "Equal Benefits"**	HRC-12B-101	Contractors tell the City if their personnel policies meet the City's requirements for nondiscrimination against protected classes of people, and in the provision of benefits between employees with spouses and employees with domestic partners. Form submission is not complete if it does not include the additional documentation asked for on the form. Other forms may be required, depending on the answers on this form. **Contract-by-Contract Compliance status vendors must fill out an additional form for each contract.**	Human Rights Comm. 25 Van Ness, #800 San Francisco, CA 94102-6059 (415) 252-2500

4.	HRC LBE Certification Application www.sfgov.org/oca/purchasing/forms.htm – **in "Vendor Profile Application"** Also at www.sfgov.org/site/sfhumanrights **under "LBE"**		Local businesses complete this form to be certified by HRC as LBEs. Certified LBEs receive a bid discount pursuant to Chapter 14B when bidding on City contracts. To receive the bid discount, you must be certified by HRC by the proposal due date.	Human Rights Comm. 25 Van Ness, #800 San Francisco, CA 94102-6059 (415) 252-2500

How to navigate to the forms on the Internet sites:

Office of Contract Administration (Purchasing)

Homepage: www.sfgov.org/oca/

Purchasing forms: Click on "Required Vendor Forms" under the "Information for Vendors and Contractors" banner.

Human Rights Commission

Homepage: www.sfgov.org/sfhumanrights

Equal Benefits forms: Click on "Forms" under the "Equal Benefits" banner near the bottom.

LBE certification form: Click on "…Forms" un