DEPARTMENT OF PUBLIC HEALTH

REQUEST FOR PROPOSALS (RFP)

FOR

PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs

RFP NO.: 2015-003

October 2015

Prepared By
County of Los Angeles
Department of Public Health

These guidelines are intended to provide general information only and are subject to revision. The rights and obligations of any party contracting with the County will be determined in accordance with the terms of the applicable contract and applicable law.

APPENDICES:

A **Sample Contract:** Identifies the terms and conditions in the Contract.

B-1 **Statement of Work for Category 1: HIV and STD Prevention Services for Young African American and Latino Men Who Have Sex with Men:** Explains in detail the required services to be performed by the selected Contractor(s) under Category 1.

B-2 **Statement of Work for Category 2: HIV and STD Prevention Services for Transgender Individuals:** Explains in detail the required services to be performed by the selected Contractor(s) under Category 2.

C **Budget Instructions:** Budget instructions to assist Proposer in completing the budget templates provided in Appendix C.

C-1 **Budget Templates:** The approved Line Item Budget and Budget Summary Justification budget templates Proposer is to use and submit for each proposal for the following costs: 1) Program Concept and Component Related Costs and 2) HIV and STD Screening Program Component Related Costs.

D **Required Forms:** Forms that must be completed and included in the proposal.

E **Request for Proposal (RFP) Transmittal to Request a Solicitation Requirements Review:** Transmittal sent to Department requesting a Solicitation Requirements Review.

F **County of Los Angeles Policy on Doing Business with Small Business:** County Policy.

G **Contractor Employee Jury Service:** County Code.

H **Listing of Contractors Debarred in Los Angeles County:** Contractors who are not allowed to contract with the County for a specific length of time.

I **IRS Notice 1015:** Provides information on Federal Earned Income Credit.

J **Safely Surrendered Baby Law:** County Program.

K **Living Wage Ordinance:** (Intentionally Omitted)

L **Determination of Contractor Non-Responsibility and Contractor Debarment:** County Code.

M **Guidelines for Assessment of Proposer Labor Law/Payroll Violations:** (Intentionally Omitted)

N **Background and Resources: California Charities Regulation:** An information sheet intended to assist Non-profit agencies with compliance with SB 1262 - the Nonprofit Integrity Act of 2004 and identify available resources. (if applicable).

O **Defaulted Property Tax Reduction Program:** County Code.

P **HIV AND STD SYNDEMIC CLUSTER MAP - LOS ANGELES COUNTY:** An illustration of the five cluster areas of Los Angeles County indicating where a disproportionate share of persons were diagnosed with HIV disease, or gonorrhea or syphilis infection in relation to the general population.

P-1 **HIV AND STD SYNDEMIC CLUSTER AREA MAP - CENTRAL CLUSTER AREA:** A visual representation of the Central Cluster Area of Los Angeles County that indicates where a disproportionate share of persons diagnosed with HIV disease and/or gonorrhea or syphilis infection reside within this cluster in relation to the general population.

P-2 **HIV AND STD SYNDEMIC CLUSTER AREA MAP - EAST CLUSTER AREA:** A visual representation of the East Cluster Area of Los Angeles County that indicates where a disproportionate share of persons diagnosed with HIV disease and/or gonorrhea or syphilis infection reside within this cluster in relation to the general population.

P-3 **HIV AND STD SYNDEMIC CLUSTER AREA MAP - NORTH CLUSTER AREA:** A visual representation of the North Cluster Area of Los Angeles County that indicates where a disproportionate share of persons diagnosed with HIV disease and/or gonorrhea or syphilis infection reside within this cluster in relation to the general population.

P-4 **HIV AND STD SYNDEMIC CLUSTER AREA MAP - NORTHWEST CLUSTER AREA:** A visual representation of the Northwest Cluster Area of Los Angeles County that indicates where a disproportionate share of persons diagnosed with HIV disease and/or gonorrhea or syphilis infection reside within this cluster in relation to the general population.

P-5 **HIV AND STD SYNDEMIC CLUSTER AREA MAP - SOUTH CLUSTER AREA:** A visual representation of the South Cluster Area of Los Angeles County that indicates where a disproportionate share of persons diagnosed with HIV disease and/or gonorrhea or syphilis infection reside within this cluster in relation to the general population.

Q **HIV and STD Epidemiological Data and Program Research on Young African American and Latino Men who have Sex with Men:** This guide presents recent HIV and STD epidemiological data and program research based on a thorough review of available data and the current literature describing issues affecting young African American and Latino men who have sex with men (YMSM) including a detailed section on the state of the HIV and STD epidemic in Los Angeles County (LAC) as it affects YMSM and a corresponding statement of need for this population.

R **Issue Report** - ***Addressing the Social Determinants of Health Inequities among Gay Men and Other Men Who Have Sex with Men in the United States*****:** Provides an in-depth report on the social determinants of health inequities affecting gay men and other MSM in the United States as of December 2014.

S **HIV and STD Epidemiological Data and Program Research on Transgender Individuals:** This guide presents recent HIV and STD epidemiological data and program research based on a thorough and exhaustive review of available data and the current literature describing issues affecting transgender individuals including a detailed section on the state of the HIV and STD epidemic in LAC as it affects transgender individuals and a statement of need for this population.

T **White Paper: *Getting to Wellness:*** A local report by the Centers for HIV Identification, Prevention and Treatment Services (CHIPTS) which may serve as a roadmap by providing important background information related to improving the health of transgender individuals in LAC.

1.0 INTRODUCTION

1.1 Purpose

The County of Los Angeles, Department of Public Health (DPH), Division of HIV and STD Programs (DHSP) is issuing this Request for Proposals (RFP) to solicit new and innovative programming to address multiple sociocultural, environmental, and economic challenges faced by young African American and Latino men who have sex with men (YMSM) ages 12 – 29 and transgender individuals. These circumstances known collectively as social determinants of health (SDoH) affect the well-being of YMSM and transgender individuals and are associated with poor health outcomes including an elevated risk of HIV infection and sexually transmitted diseases (STD).

HIV and STD prevention services for YMSM and transgender individuals are intended to be provided as resources for broad holistic prevention services that improve the overall well-being of YMSM and transgender individuals in an effort to increase the likelihood that they will remain HIV negative and STD-free.

The primary goals for HIV and STD prevention programs funded as a result of this RFP are:

1. To decrease new HIV and STD infections among YMSM and transgender individuals; and
2. To increase linkage to care among HIV positive YMSM and transgender individuals not currently in HIV medical care.

1.1.1 Division of HIV and STD Programs

In 2011, in keeping with national efforts to better integrate HIV and STD public health efforts, DPH combined the HIV Epidemiology Program, the Office of AIDS Programs and Policy, and the STD Program to form DHSP. DHSP continues to work closely and collaboratively with community-based organizations, other governmental offices, advocates, and people living with HIV/AIDS as it seeks to control the spread of HIV and STDs, monitor HIV/AIDS and STD morbidity and mortality, increase access to care for those in need, and eliminate HIV-related health inequalities.

Mission

To prevent and control the spread of HIV and STDs through epidemiological surveillance, implementation of evidence-based programs, coordination of prevention, care and treatment services, and the creation of policies that promote health.

Vision

New HIV and STD infections have been eliminated and persons with STD and HIV infections have improved health outcomes through access to high quality prevention, care and treatment services.

1.1.2 Eligible Categories of Services

There are two (2) categories of services available under this RFP. Proposers may choose to apply for one or both categories as follows:

CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR YMSM

- **Subcategory 1A: African American YMSM, 12-29 years of age**
- **Subcategory 1B: Latino YMSM, 12-29 years of age**
- **Subcategory 1C: African American and Latino YMSM, 12-29 years of age**

Program and Technical Requirements for Category 1 HIV and STD Prevention Services for YMSM are located in paragraph 1.2. Proposers may submit multiple proposals under three subcategories on the basis of selected target population(s) to be served. (See RFP sub-paragraphs 1.2.4 Location of Services and 1.2.5. Categories of Services).

CATEGORY 2: HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS

Program and Technical Requirements for Category 2 HIV and STD Prevention Services for Transgender Individuals are located in paragraph 1.3.

1.1.3 **Background Information**

1.1.3.1 **Background Information Category 1 – Issues Affecting YMSM**

For the purposes of this RFP and all associated documents, the acronym YMSM (young men who have sex with men) refers to the behavior of young men ages 12-29 who have sex with men. While this is the behavior of the targeted young men, the self-described sexual identity may include gay, bisexual, straight, same-gender loving, pansexual, polyamorous, queer, down low, questioning, among other sexual identity terms. It is an inclusive, rather than exclusive term.

Two appendices are included as background information along with the RFP package to help Proposer to develop a more thorough and effective response to this RFP. Other HIV and STD epidemiology data and programmatic data sources on YMSM can be used by the Proposer; however these sources should be appropriately credited and cited. The two informational appendices are described below:

HIV and STD Epidemiological Data and Program Research on Young African American and Latino Men who have Sex with Men (Appendix Q)

In order to facilitate timely, appropriate and well-informed responses, DHSP compiled background epidemiological data and program research on YMSM as they navigate the social, cultural, and economic landscape in which HIV and STD prevention are aspects in a larger, more complex whole-life context. This background data and research can be found in Appendix Q, HIV and STD Epidemiological Data and Program Research on Young African American and Latino Men who have Sex with Men (MSM). It includes a detailed section on the state of the HIV and STD epidemic in LAC as it affects YMSM and a statement of need for this population.

Issue Report: *Addressing the Social Determinants of Health Inequities among Gay Men and Other Men Who Have Sex with Men in the United States (Appendix R)*

Appendix R, Issue Report*: Addressing the Social Determinants of Health Inequities among Gay Men and Other Men Who Have Sex with Men in the United States,* provides an in-depth report on the social determinants of health and health inequities affecting gay men and other MSM in the United States [December 2014]. It provides context for Proposer in responding to this RFP and examples of interventions to increase resiliency among all MSM, not just YMSM.

Note: The background information in Appendices Q and R provides useful sources of information to assist Proposers in developing effective responses to this RFP. However, they are not specific recommendations for programs or services and do not bind the County to offer any program/service or type of program/service mentioned in the appendices. Proposers can use these and/or other sources of information, but must credit and cite all sources referenced within their proposal.

1.1.3.2 **Background Information Category 2 – Issues Affecting Transgender Individuals**

Terminology used to refer to transgender people is imperfect. While there is no universally accepted definition of the word "transgender," the National Center for Transgender Equality's definition will be used for this RFP: "an umbrella term for people whose gender identity, expression or behavior is different from those typically associated with their assigned sex at birth[1]."

Two appendices are included as background information

[1] National Center for Transgender Equality. (2014, January 15). *Transgender Terminology.* Retrieved from http://transequality.org/issues/resources/transgender-terminology

along with the RFP package to help Proposer to develop a more thorough and effective response to this RFP. Other HIV and STD epidemiology data and programmatic data sources on transgender individuals can be utilized by the Proposer; however these sources should be appropriately credited and cited. The two informational appendices are described below:

HIV and STD Epidemiological Data and Program Research on Transgender Individuals (Appendix S)

In order to facilitate timely, appropriate and well-informed responses, DHSP compiled background epidemiological data and program research on transgender individuals as they navigate the social, cultural, and economic landscape in which HIV and STD prevention are aspects in a larger, more complex whole-life context. This background data and research can be found in Appendix S, HIV and STD Epidemiological Data and Program Research on Transgender Individuals. It includes a detailed section on the state of the HIV and STD epidemic in LAC as it affects transgender individuals and a statement of need for this population.

Getting to Wellness: A Roadmap for Improving the Health of Transgender Individuals in Los Angeles County (Appendix T)

Appendix T, Getting to Wellness: A Roadmap for Improving the Health of Transgender Individuals in Los Angeles County, provides an overview of the state of transgender health and wellness in LAC, especially with regard to HIV disease and the co-occurring social determinants impacting health. It gives a broad overview of a selection of currently available services accessible to transgender individuals in LAC, with a particular emphasis on those specifically tailored to transgender individuals. The paper discusses gaps in services and opportunities the authors see to strengthen and improve LAC's response to transgender health and wellness needs. This is provided as background only.

Note: The background information in Appendices S and T provides useful sources of information to assist Proposers

in developing effective responses to this RFP. However, they are not specific recommendations for programs or services and do not bind the County to offer any program/service or type of program/service mentioned in the appendices. Proposers can use these and/or other sources of information, but must credit and cite all sources referenced within their proposal.

1.2 Program and Technical Requirements – Category 1: HIV and STD Prevention Services for YMSM

The Proposer shall determine the best method for providing HIV and STD Prevention services for YMSM. Proposer shall develop unique, innovative and creative proposals that address stated target population needs such as those described in Appendices Q and R. Additionally, in order to effectively respond to the RFP, Proposer's program will need to meet all goals and objectives described in Appendix B-1, Statement of Work for Category 1.

In their response, Proposer shall carefully describe relevant work history; demonstrate an in-depth understanding of the proposed target population; clearly describe prior successes and the lessons learned from working with YMSM; and explain how the proposed intervention(s) will work and is/are supported in the current literature or by established theory.

1.2.1 Program Concepts for Category 1

The program concepts are program requirements designed to provide structure to Proposer's response and to ensure that both the County target population's needs and the RFP programmatic goals and objectives are met.

(1) **INNOVATIVE IN DESIGN** – Proposer should reflect on successful evidence-based programs as well as lessons learned from best practice prevention efforts with a range of success to develop their proposed programs. Proposer should apply that knowledge to develop innovative ways to implement new and improved programming that is appropriate and attractive to YMSM in LAC. (***Note:*** Proposer should refer to Appendices B-1, Q, and R for additional criteria).

(2) **HOLISTIC IN CONCEPT** – Programs must be focused on improving whole body health (mental, physical, and spiritual) of the individual, and not simply and solely focused on HIV and STD testing, treatment and linkage to care.

(3) **COLLABORATIVE IN DESIGN AND IMPLEMENTATION** – Each program shall be endorsed in the Community Advisory Board's letter of concurrence verifying the proposed program:

a) Was developed collaboratively in conjunction with the Community Advisory Board;
b) Is designed to be responsive to the needs of the target population;
c) Is designed to be inclusive in its implementation and collaborative with a cross-section of partners and stakeholders;
d) Is innovative in design; and
e) Is holistic in concept.

Note: Proposer should refer to RFP Paragraph 3.1, Category 1-Minimum Mandatory Qualifications, sub-paragraph 3.1.4, Community Advisory Board -and- sub-paragraph 3.1.8, Letter of Concurrence for information regarding the minimum requirements specific to Proposer's Community Advisory Board Letter of Concurrence.

1.2.2 Program Components for Category 1

The program components are program requirements which shall be addressed as part of the Proposer's programmatic response to the RFP. The incorporation of each program component into the proposed program will demonstrate Proposer's ability to comply with the program requirements necessary to attain County programmatic goals and objectives.

(1) **FOCUSED ON YOUTH DEVELOPMENT** – Proposed program(s) shall have a youth development component designed to meet needs which young people, ages 12-29 years, have identified for themselves (listed below):

a. To have life skills;
b. To be cared for and be safe;
c. To be respected, valued and useful; and
d. To be spiritually grounded.

This can be accomplished by building the capabilities of youth; by assisting in the cultivation of individual talents and personal identity; by increasing self-acceptance; by increasing feelings of self-worth; and in providing YMSM youth guidance in the development into adulthood.

(2) **ADDRESSING SOCIAL DETERMINANTS OF HEALTH** – Proposer shall address one or more social determinants of health (SDoH) listed in Table 1, Eligible Social Determinants of Health for Category 1: HIV and STD Prevention Services for YMSM that negatively affect the health of YMSM.

Proposer shall provide a clear justification for their selection and provide a description of how the SDoH is/are addressed within the proposed program design.

Table 1. Eligible Social Determinants of Health for Category 1: HIV and STD Prevention Services for YMSM

SOCIAL DETERMINANTS OF HEALTH (YMSM)
• Harassment in public and private settings
• Violence and abuse (domestic and external)
• Victimization and incarceration
• Lack of access to quality, unbiased, competent and appropriate healthcare
• Homelessness or unstable housing
• Unemployment (financial need)
• Malnutrition or food scarcity
• School dropout/low education level
• Limited or no access to appropriate mental health services
• Limited or no access to appropriate substance abuse and prevention services
• Behavioral and psychosocial factors (self-perception of risk, low self-esteem, low level of self-efficacy, lack of coping skills, unmanaged stress, fatalism, suicidal inclination)

In addition to addressing at least one SDoH from Table 1, Proposers have the option to address additional SDoH not

outlined in Table 1, **provided that a specific set criteria is met**, pursuant to RFP Paragraph 7.8.5.2, Proposer's Approach to Providing Required Services – Category 1 (Section F), subparagraph "C. Program Plan – Category 1 (Section F.3), 1b) Program Design Questions – Category 1, item "2) Addressing social determinants of health."

(3) **PROMOTING RESILIENCY AND PROTECTIVE FACTORS** – Research shows that promoting resiliency and protective factors among individuals (including YMSM) can address SDoH that negatively impact their health. Proposer shall promote at least two resiliency and protective factors that impact each SDoH the Proposer selects to address. These factors can include, but are not limited to those listed in Table 2, Resiliency and Protective Factors for Category 1: HIV and STD Prevention Services for YMSM.

Table 2. Resiliency and Protective Factors for Category 1: HIV and STD Prevention Services for YMSM

- Access to high quality, unbiased, competent, culturally and linguistically appropriate services
- Opportunities for social action and community engagement
- Family acceptance
- Social and peer support
- Access to positive role models
- Spiritual support
- Economic and/or housing support
- Access to harm reduction
- Mentorship
- Safe and unbiased spaces to convene and to access services
- Relationship skills building
- Forming healthy relationships
- Academic and professional development opportunities
- Opportunities that increase acceptance and expression of identity

Proposer choosing factors not listed within Table 2 must provide clear and compelling evidence to justify the choice of such factors. Proposer should cite this evidence to the extent possible and explain when a citation is not available.

(4) **UTILIZING TECHNOLOGY** – Proposed program(s) shall utilize the latest technology and media used by youth to stay socially connected. Such technologies include, but are not limited to: social media, smart phone and/or internet apps, online dating

sites, chat rooms, gaming (behavior change focused) sites, texting, etc.

1.2.3 HIV and STD Screening Program Components for Category 1

Proposer shall provide onsite HIV and STD screening and STD treatment services; with immediate linkage or referral to treatment, if unavailable on-site. Additionally, Proposer should be aware that subcontracting or in-kind services from Proposer's agency or another agency are appropriate methods that can be used to comply with specific HIV and STD screening program component services.

The required HIV and STD screening program components are:

(1) **SCREEN FOR BENEFITS PROGRAMS** – Proposer shall implement a comprehensive approach to assess all sources of public and private benefits available to YMSM for HIV and STD screening, treatment and care services in order to identify available third-party payer sources for eligible clients.

(2) **CONDUCT HIV SCREENING** – Proposer shall ensure:

a. HIV outreach services are provided to promote availability of HIV screening services to YMSM;
b. On-site HIV screening is provided at the primary service delivery site;
c. Additional screening sites may be added upon DHSP approval;
d. Appropriate medical oversight of HIV screening services shall be maintained;
e. HIV screening services are targeted to reach YMSM and their sex and needle-sharing partners; and
f. HIV screening services are provided consistent with federal, State and local guidelines and policies.

(3) **CONDUCT STD SCREENING** – Proposer shall ensure:

a. STD outreach services are provided to promote availability of STD screening services to YMSM;
b. On-site STD screening is provided at the primary service delivery site;

c. Additional screening sites may be added upon DHSP approval;
d. Appropriate medical oversight of STD screening services is maintained at all sites;
e. STD screening services are targeted to reach YMSM and their sex and needle-sharing partners; and
f. STD screening services must be provided consistent with federal, State and local guidelines and policies.

(4) **PROVIDE TREATMENT FOR STD INFECTIONS** – Proposer shall:

a. Provide STD treatment to clients with STD infection, on the same day and in the same location where the diagnosis is made;
b. Ensure all on-site STD treatment services are consistent with federal, State and local guidelines, policies and procedures; and
c. Assure appropriate medical oversight of all on-site STD treatment services is maintained; **OR**
d. Ensure that where on-site STD treatment services are not available, linkage to STD treatment services is made.

(5) **PROVIDE LINKAGE AND RE-ENGAGEMENT INTO HIV MEDICAL CARE** – Proposer shall ensure:

a. Successful linkage of newly diagnosed HIV positive YMSM to HIV medical care and treatment; and
b. Successful re-engagement of HIV positive YMSM, known to be out of care, back into HIV medical care and treatment services.

(6) **ENSURE ACCESS TO EDUCATION ABOUT BIOMEDICAL HIV PREVENTION SERVICES –** Proposer shall ensure one hundred percent (100%) of YMSM are provided access to educational services regarding the availability of Biomedical HIV Prevention Services. Additionally, Proposer shall:
a. Provide direct referrals to YMSM who request pre-exposure prophylaxis (PrEP) services for HIV; and
b. Provide direct, timely referrals to YMSM requesting non-occupational post-exposure prophylaxis (PEP) services

within seventy-two (72) hours of a sexual or needle-sharing exposure.

(7) **PROVIDE LINKAGE TO PARTNER SERVICES -** Proposer shall provide verifiable, recorded linkage for one hundred percent (100%) of newly diagnosed YMSM with HIV, syphilis or gonorrhea to LAC DHSP Partner Counseling and Referral Services. Specific contact information will be provided by DHSP.

1.2.4 Location of Services for Category 1

To facilitate the location of HIV and STD prevention services available to the target population in areas of high morbidity, five (5) HIV and STD syndemic clusters were identified and described by DPH in the Los Angeles County Five-Year Comprehensive HIV Plan 2013-2017. This background information on the significance and impact of the HIV and STD syndemic cluster areas can be found by visiting the DHSP website at http://publichealth.lacounty.gov/dhsp/Reports/HIV/LAC-ComprehensiveHIVPlan2013-2017.pdf.

The Syndemic Cluster Areas description provided in Table 3, Syndemic Cluster Areas for Category 1, gives the tier level corresponding to the cluster areas and the appropriate appendix containing a map for that cluster area.

Table 3. Syndemic Cluster Areas for Category 1: HIV and STD Prevention Services for YMSM

LOS ANGELES COUNTY HIV AND STD SYNDEMIC CLUSTER AREAS		
Name of Cluster Area/Map Appendix Name		Tier Level
Central South	Appendix P-1 Appendix P-5	Tier 1
East North Northwest	Appendix P-2 Appendix P-3 Appendix P-4	Tier 2

A map of Los Angeles County illustrating five (5) HIV and STD syndemic cluster areas is provided as Appendix P, HIV and STD Syndemic Cluster Map. Individual cluster area maps are shown in Appendices P-1 through P-5.

GUIDELINES REGARDING LOCATION OF SERVICE FOR CATEGORY 1

a) HIV and STD prevention services must be located and provided within one of the five (5) HIV and STD syndemic cluster areas.
b) Proposer must state which cluster area they select to provide services.
c) Proposer must specifically identify where within the cluster area their services will be provided by street address, city, and zip code.
d) Proposer service delivery site(s) must be located within the selected cluster; multiple satellite service sites can be located within the designated cluster area but not outside the cluster area. This **does not** mean services cannot be provided to individuals from outside the cluster area.
e) Proposer may submit proposals for more than one cluster area, but each proposal must be a separate proposal.

No consideration will be given to proposals for services outside the cluster areas

1.2.5 Categories of Service – Category 1

There are three (3) subcategories of service described in Table 4, Categories of Service for Category 1: HIV and STD Prevention Services for YMSM which will be funded as a result of this RFP. **Proposer may submit multiple proposals within the three (3) subcategories of service within the five (5) cluster areas, however each subcategory and/or cluster area constitutes a separate proposal.**

Table 4. Categories of Service for Category 1: HIV and STD Prevention Services for YMSM

CATEGORY 1 HIV AND STD PREVENTION SERVICES FOR YOUNG AFRICAN AMERICAN AND LATINO MEN WHO HAVE SEX WHO MEN		
Subcategory	**Target Population**	**Required Service**
1A	African American YMSM, 12 – 29 years of age	HIV and STD Prevention Services
1B	Latino YMSM, 12 – 29 years of age	
1C	African American **and** Latino YMSM, 12 – 29 years of age	

1.2.6 **Availability of Funding for Category 1**

Budget Restrictions for Category 1: HIV and STD Prevention Services for YMSM

Proposer should consider the following budget restrictions when submitting their proposals for Category 1:

Tier Level 1 Restrictions:

Proposal(s) for Tier Level 1 eligible cluster areas (Central and South Cluster Areas) with requested annual budgets in excess of seven hundred fifty thousand dollars ($750,000) will be deemed non-responsive and will be disqualified from further consideration.

Tier Level 2 Restrictions:

Proposal(s) for Tier Level 2 eligible cluster areas (East, North and Northwest Cluster Areas) with requested annual budgets in excess of two hundred fifty thousand dollars ($250,000) will be deemed non-responsive and will be disqualified from further consideration.

Proposer is advised that funding made available as a result of this RFP shall only be used to fund new or enhanced HIV and STD prevention services and shall in no way supplant existing resources. To assure this, Proposer must disclose all currently available or committed revenue and funding resources available in each service category in which Proposer now provides services and, for which, Proposer requests funding through this RFP. Proposer is to refer to RFP Paragraph 1.2.6, Availability of Funding and Paragraph 8.4.11, Recommended Funding Allocations Review, for further information.

Funding Award Recommendations by Tier Level for Category 1

Tier Level 1:

1. DPH expects to recommend to award funding for up to four (4) proposed programs in Tier Level 1 eligible cluster areas (Central and South Cluster Areas), see Table 5 – DHSP Estimated Funding Award Summary for Category 1: HIV and STD

Prevention Services for YMSM.

2. The estimated annual amount of funding per award for Tier Level 1 is up to seven hundred fifty thousand ($750,000).

Tier Level 2:

1. DPH expects to recommend to award for funding for up to three (3) proposed programs in Tier 2 Level eligible cluster areas (East, North and Northwest Cluster Areas), see Table 5.

2. The estimated annual amount of funding per award for Tier Level 2 is up to two hundred fifty thousand dollars ($250,000).

Table 5. DHSP Estimated Funding Award Summary for Category 1: HIV and STD Prevention Services for YMSM

TIER LEVEL	ELIGIBLE CLUSTER AREAS	NUMBER OF ESTIMATED AWARDS	AMOUNT OF PROJECT ANNUAL AWARD (ESTIMATE)	TOTAL ANNUAL AMOUNT OF FUNDING (ESTIMATE)
Tier 1	Central, South	Up to 4	Up to $750,000	Up to $3,000,000
Tier 2	East, North, Northwest	Up to 3	Up to $250,000	Up to $750,000

Proposer must consider the budget restrictions discussed earlier in this section when making the funding request for proposed programs.

For both Tier Level 1 and 2, the available funds identified in Table 5 and the number of awards are estimates and are subject to change. The County reserves the right to adjust the number of awards and the funding allocations based on service category, population served, and cluster area needs.
The amount of funding available to support these services is also subject to the availability of funds from local, State, and federal resources.

1.3 Program and Technical Requirements Category 2: HIV and STD Prevention Services for Transgender Individuals

The Proposer shall determine the best method for providing HIV and STD Prevention services for transgender individuals. Proposer shall develop unique, innovative and creative proposals that address stated target population needs such as those described in Appendices S and T. Additionally, in order to effectively respond to the RFP, Proposer's program will need to meet all goals and objectives described in Appendix B-2, Statement of Work for Category 2.

In their response, Proposer shall carefully describe relevant work history; demonstrate an in-depth understanding of the proposed target population; clearly describe prior successes and the lessons learned from working with transgender individuals; and explain how the proposed intervention(s) will work and is/are supported in the current literature or by established theory.

1.3.1 Program Concepts for Category 2

The program concepts are program requirements designed to provide structure to Proposer's response and to ensure that both the County target population's needs and the RFP programmatic goals and objectives are met.

(1) **INNOVATIVE IN DESIGN** – Proposer should reflect on successful evidence-based programs as well as lessons learned from best practice prevention efforts and apply that knowledge to develop innovative ways to implement new and improved programming that is appropriate and attractive to transgender individuals in LAC. (***Note:*** Proposer should refer to Appendices B-2, S and T for additional criteria).

(2) **HOLISTIC IN CONCEPT** – Programs must be focused on improving whole body health (mental, physical, and spiritual) of the individual, and not simply and solely focused on HIV and STD screening, treatment and linkage to care.

(3) **COLLABORATIVE IN DESIGN AND IMPLEMENTATION** – Each program shall be endorsed in the Community Advisory Board's letter of concurrence verifying the proposed program:

a) Was developed collaboratively in conjunction with the Community Advisory Board;
b) Is designed to be responsive to the needs of the target population;
c) Is designed to be inclusive in its implementation and collaborative with a cross-section of partners and stakeholders;
d) Is innovative in design; and
e) Is holistic in concept.

Note: Proposer should refer to RFP Paragraph 3.2, Category 2-Minimum Mandatory Qualifications, sub-paragraph 3.2.3, Community Advisory Board -and- sub-paragraph 3.2.7, Letter of Concurrence for information regarding the minimum requirements specific to Proposer's Community Advisory Board Letter of Concurrence.

1.3.2 Program Components for Category 2

The program components are program requirements which shall be addressed as part of the Proposer's programmatic response to the RFP. The incorporation of each program component into the proposed program will demonstrate Proposer's ability to comply with the program requirements necessary to attain County programmatic goals and objectives.

(1) **INCORPORATING YOUTH DEVELOPMENT** – Proposed program(s) shall incorporate a youth development component designed to meet needs of young transgender people, ages 12-29 years.

This can be accomplished by building the capabilities of transgender youth; by assisting in the cultivation of individual talents and personal identity; by increasing self-acceptance; by promoting understanding and full acceptance of transgender youth's gender identity; by increasing feelings of self-worth; by easing a transgender youth's gender transition (mentally, socially, and/or legally); and by providing transgender youth with guidance in their development into adulthood.

Proposer should demonstrate awareness of the challenges faced by transgender youth and present a plan that is sensitive

to such challenges and proposes solutions to innovatively and effectively overcome them.

(2) **ADDRESSING SOCIAL DETERMINANTS OF HEALTH** – Proposer shall address one (1) or more social determinants of health (SDoH) listed in Table 6, Eligible Social Determinants of Health for Category 2: HIV and STD Prevention Services for Transgender Individuals that negatively affect the health of transgender people.

Proposer shall provide clear justification for their selection and provide a description of how the SDoH is/are addressed within the proposed program design.

Table 6. Eligible Social Determinants of Health for Category 2: HIV and STD Prevention Services for Transgender Individuals

SOCIAL DETERMINANTS OF HEALTH (Transgender)
• Harassment in public and private settings • Violence and abuse (domestic and external) • Lack of access to high quality, unbiased, competent and appropriate healthcare • Victimization and incarceration • Homelessness or unstable housing • Unemployment • Malnutrition or food scarcity • School dropout/limited access to educational services • Limited or no access to appropriate mental health services • Limited or no access to appropriate substance abuse and prevention services • Behavioral and psychosocial factors (self-perception of risk, low self-esteem, transgender, gender oppression, homophobia, low level of self-efficacy, lack of coping skills, unmanaged stress, fatalism, suicidal inclination)

In addition to addressing at least one SDoH from Table 6, Proposers have the option to address additional SDoH not outlined in Table 6, **provided that a specific set criteria is met,** pursuant to RFP Paragraph 7.8.6.2, Proposer's Approach to Providing Required Services – Category 2 (Section F), subparagraph "C. Program Plan – Category 2 (Section F.3), 1b)

Program Design Questions – Category 2, item "2) Addressing social determinants of health."

(3) **PROMOTING RESILIENCY AND PROTECTIVE FACTORS** – Research shows that promoting resiliency and protective factors among individuals (including transgender people) can address SDoH that negatively affect their health. Proposer shall promote two or more resiliency and protective factors that impact each SDoH the Proposer selects to address. These factors can include, but are not limited to those listed in Table 7, Resiliency and Protective Factors for Category 2: HIV and STD Prevention Services for Transgender Individuals.

Table 7. Resiliency and Protective Factors for Category 2: HIV and STD Prevention Services for Transgender Individuals

- Access to high quality, unbiased, competent, culturally and linguistically appropriate services
- Opportunities for social action and community engagement
- Family acceptance
- Social and peer support
- Access to positive role models
- Spiritual support
- Economic and/or housing support
- Access to harm reduction
- Mentorship
- Safe and unbiased spaces to convene and to access services
- Relationship skills building
- Forming healthy relationships
- Academic and professional development opportunities
- Opportunities to enhance gender expression

Proposer choosing factors not listed within Table 7 must provide clear and compelling evidence to justify the choice of such factors. Proposer should cite this evidence to the extent possible or explain if evidence is not available.

(4) **UTILIZING TECHNOLOGY** – Proposed program(s) shall utilize the latest technology and media used to stay socially connected. Such technologies include, but are not limited to: social media, smart phone and/or internet apps, online dating sites, chat rooms, gaming (behavior change focused) sites, texting, etc.

1.3.3 HIV and STD Screening Program Components for Category 2

Proposer shall provide onsite HIV and STD screening and STD treatment services; with immediate linkage or referral to treatment, if unavailable on-site. Additionally, Proposer should be aware that subcontracting or in-kind services from Proposer's agency or another agency are appropriate methods that can be used to comply with specific HIV and STD screening program component services.

The required HIV and STD screening program components are:

(1) **SCREEN FOR BENEFITS PROGRAMS** – Proposer shall implement a comprehensive approach to assess all sources of public and private benefits available to transgender individuals for HIV and STD screening, treatment and care services in order to identify available third-party payer sources for eligible clients.

(2) **CONDUCT HIV SCREENING** – Proposer shall ensure:

a. HIV outreach services are provided to promote availability of HIV screening services to transgender individuals;
b. On-site HIV screening is provided at the primary service delivery site;
c. Additional screening sites may be added upon DHSP approval;
d. Appropriate medical oversight of HIV screening services shall be maintained;
e. HIV screening services are targeted to reach transgender persons and their sex and needle-sharing partners; and
f. HIV screening services are provided consistent with federal, State and local guidelines and policies.

(3) **CONDUCT STD SCREENING** – Proposer shall ensure:

a. STD outreach services are provided to promote availability of STD screening services to transgender individuals;
b. On-site STD screening is provided at the primary service delivery site;
c. Additional screening sites may be added upon DHSP approval;

d. Appropriate medical oversight of STD screening services is maintained at all sites;
e. STD screening services are targeted to reach transgender individuals and their sex and needle-sharing partners; and
f. STD screening services must be provided consistent with federal, State and local guidelines and policies.

(4) **PROVIDE TREATMENT FOR STD INFECTIONS** – Proposer shall:

a. Provide STD treatment to clients with STD infection, on the same day and in the same location where the diagnosis is made;
b. Ensure all on-site STD treatment services are consistent with federal, State and local guidelines, policies and procedures; and
c. Assure appropriate medical oversight of all on-site STD treatment services is maintained; **OR**
d. Ensure that where on-site STD treatment services are not available, linkage to STD treatment services is made.

(5) **PROVIDE LINKAGE AND RE-ENGAGEMENT INTO HIV MEDICAL CARE** – Proposer shall ensure:

a. Successful linkage of newly diagnosed HIV positive transgender individuals to HIV medical care and treatment; and
b. Successful re-engagement of HIV positive transgender individuals, known to be out of care, back into HIV medical care and treatment services.

(6) **ENSURE ACCESS TO EDUCATION FOR BIOMEDICAL HIV PREVENTION SERVICES –** Proposer shall ensure one hundred percent (100%) of transgender individuals are provided access to educational services regarding the availability of Biomedical HIV Prevention Services. Additionally, Proposer shall:

a. Provide direct referrals to transgender individuals who request pre-exposure prophylaxis (PrEP) services for HIV; and

b. Provide direct, timely referrals to transgender individuals requesting non-occupational post-exposure prophylaxis (PEP) services within seventy-two (72) hours of a sexual or needle-sharing exposure.

(7) **PROVIDE LINKAGE TO PARTNER SERVICES -** Proposer shall provide verifiable, recorded linkage for one hundred percent (100%) of newly diagnosed transgender individuals with HIV, syphilis or gonorrhea to LAC DHSP Partner Counseling and Referral Services. Specific contact information will be provided by DHSP.

1.3.4 Location of Services for Category 2

HIV and STD prevention services are designed to enhance services available to transgender individuals in areas convenient to the community. DHSP has relied on HIV and STD data to develop recommended services targeting transgender individuals. Proposed services for the transgender community must be geographically relevant to transgender individuals; therefore DHSP has identified two (2) target areas for services as outlined below in Table 8, Target Areas for Services for Category 2: HIV and STD Prevention Services for Transgender Individuals.

Table 8. Target Areas for Services for Category 2: HIV and STD Prevention Services for Transgender Individuals

TARGET AREA	SERVICE LOCATION SHOULD BE IN OR NEAR*:
Central	1. Downtown Los Angeles area and/or 2. Hollywood/Santa Monica Boulevard area
South	3. City of Long Beach

*In or near is defined as being proximate to those locations. This definition is intended to be flexible with the goal of providing services in areas frequented and attractive to transgender individuals. As long as Proposer has a strong, well-justified rationale for the site, it will be considered for approval.

GUIDELINES REGARDING LOCATION OF SERVICE FOR CATEGORY 2

a) Proposer **cannot** propose to serve more than one target area in a single proposal.

b) Proposer must specifically identify where within the target area their services will be provided by street address, city and zip code.

c) Proposer may suggest an alternate service location(s) outside the Central and South target areas, however the alternate service location(s) must be within Los Angeles County. To do so, Proposer must provide a strong rationale describing how the site is convenient for transgender persons and how the location will enhance the proposed intervention's likelihood of success.

1.3.5 Categories of Service – Category 2

There is only one (1) category of service as described in Table 9, Category of Service for Category 2: HIV and STD Prevention Services for Transgender Individuals which will be funded as a result of this RFP. Proposer cannot propose to serve more than one target area in a single proposal as outlined in RFP sub-paragraph 1.3.4, Location of Services, Table 8 - Target Areas for Services for Category 2: HIV and STD Prevention Services for Transgender Individuals. **Separate proposals are necessary to serve more than one (1) target area.**

Table 9. Category of Service for Category 2: HIV and STD Prevention Services for Transgender Individuals

CATEGORY 2 HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS		
Category	**Target Population**	**Required Service**
2	Transgender Individuals	HIV and STD Prevention Services

1.3.6 Availability of Funding for Category 2

Budget Restrictions for Category 2: HIV and STD Prevention Services for Transgender Individuals

Proposer should consider the following budget restrictions when submitting their proposals for Category 2:

1. The maximum allowable proposed annual budget is up to one million dollars ($1,000,000). Only proposals with well-documented and exceptional merit, which clearly describe the specific funding criteria listed in Section 7.8.6.2, Proposer's Approach to Providing Required Services – Category 2 (Section F), Subsection C, Program Plan, of this RFP will be eligible for consideration of the maximum allowable award.

2. Proposer should expect that the average award under this RFP will be much lower than the maximum allowable award amount.

3. Proposals with proposed annual budgets submitted in excess of one million dollars ($1,000,000) will be deemed non-responsive and will be disqualified from further consideration (see RFP sub-paragraph 3.2.4, Maximum Annual Budget).

4. Proposer is advised that funding made available as a result of this RFP shall only be used to fund new or enhanced HIV and STD prevention services and shall in no way supplant existing resources. To assure this, Proposer must disclose all currently available or committed revenue and funding resources available in each service category in which Proposer now provides services and, for which, Proposer requests funding through this RFP. Proposer is to refer to RFP Paragraph 7.8.6.4, Program Budget – Category 2 (Section H) for further information.

Number of Funding Recommendations Anticipated for Category 2

DPH expects to recommend to award funding for up to two (2) proposed programs. The available funds and the number of awards are estimates and are subject to change. The County reserves the right to adjust the number of awards and the funding allocations based on service category and target area needs.

The amount of funding available to support these services is also subject to the availability of funds from local, State, and federal resources.

2.0 PURPOSE/AGREEMENT FOR PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs

2.1 Statement of Work

Contractor shall be expected to accomplish all work objectives and deliverables in a timely fashion as outlined in Appendix B-1, Statement of Work for Category 1 and/or Appendix B-2, Statement of Work for Category 2 and **each** of Proposer's submitted Appendix D, Required Forms, Exhibit 27, Sample Scope of Work and Template, of this RFP.

2.2 Sample Agreement: County Terms and Conditions

Contractor shall be expected to implement the Sample Contract as contained in Appendix A, of this RFP for Category 1, HIV and STD Prevention Services for YMSM and/or Category 2, HIV and STD Prevention Services for Transgender Individuals.

2.2.1 Anticipated Contract Term

The Contract term is anticipated to be for a period of three (3) years. The Contract is anticipated to commence on the date of Board approval.

The County shall have the sole option to extend the Contract term for up to two (2) additional one (1) year terms and six (6) month to month optional extensions for a maximum total Contract term of five (5) years and six (6) months. Each such option shall be exercised at the sole discretion of the Department Head or his/her designee as authorized by the Board of Supervisors, subject to Contractor performance and availability of funds.

2.2.2 Contract Rates

The Contractor's rates shall remain firm and fixed for the term of the Contract and any optional extension periods.

2.2.3 Days of Operation

The Contractor shall be required to provide HIV and STD prevention services for YMSM and/or transgender individuals during days and hours pursuant to Section 7.0 of Appendix B-1 and/or B-2, Statement of Work. The County's Contract Program Manager will provide a list of the County holidays to the Contractor at the time the Contract is approved, and annually, at the beginning of the calendar year.

2.2.4 Indemnification and Insurance

Contractor shall be required to comply with the indemnification provisions contained in the - Appendix A, Sample Contract, Paragraph 11. The Contractor shall procure, maintain, and provide to the County proof of insurance coverage for all the programs of

insurance along with associated amounts specified in the Appendix A, Sample Contract, Paragraphs 12 and 13.

2.2.5 SPARTA Program

A County program, known as 'SPARTA' (Service Providers, Artisan and Tradesman Activities) may be able to assist potential Contractors in obtaining affordable liability insurance. The SPARTA Program is administered by the County's insurance broker, Merriwether & Williams. For additional information, Proposers may call Merriwether & Williams toll free at (800) 420-0555 or can access their website directly at www.2sparta.com

2.2.6 Health Insurance Portability and Accountability Act of 1996 (if applicable)

Contractor shall be required to comply with the Administrative Simplification requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) as in effect and as may be amended, as contained in Appendix A, Sample Contract, Exhibit F.

3.0 PROPOSER'S MINIMUM MANDATORY QUALIFICATIONS

The minimum mandatory qualifications for Category 1 (HIV and STD Prevention Services for YMSM) and Category 2 (HIV and STD Prevention Services for Transgender Individuals) are outlined below.

3.1 Category 1 (HIV and STD Prevention Services for YMSM) Minimum Mandatory Qualifications

Interested and qualified Proposers applying for Category 1 must meet **each** of the Minimum Mandatory Qualifications **on the day that proposals are due.** Consultant(s)/subcontractor(s) of Proposer can be used to meet experience, data collection, and service delivery site requirements as outlined in the minimum mandatory qualifications specified in sub-paragraphs 3.1.1, 3.1.2, and 3.1.3. Consultant(s)/subcontractor(s) of Proposer must also meet the specified requirements on the day that proposals are due. All other minimum mandatory qualifications must be met by the Proposer.

3.1.1 **Experience**

Proposer, or consultant/subcontractor, must have a minimum of three (3) years of experience, within the last five (5) years, working with Men who have Sex with Men and providing youth services for African Americans and/or Latinos, ages 12 – 29, in Los Angeles County.

3.1.2 **Data Collection**

Proposer, or consultant/subcontractor, must have a minimum of two (2) years of experience, within the last five (5) years, collecting data for the purpose of evaluation and reporting.

3.1.3 **Service Delivery Site**

Proposer, or consultant/subcontractor, must have a service delivery site located within an eligible cluster area for service as described in RFP sub-paragraph 1.2.4, Location of Service(s) within 90 days from contract execution. *(**Note:** No consideration will be given to proposals for services outside of the eligible cluster service areas or which serve more than one cluster area in the same proposal.)*

3.1.4 **Community Advisory Board (CAB)**

Proposer's CAB must meet the requirements specified under Table 10 - Community Advisory Board (CAB) Minimum Requirements for Category 1. Proposer must submit a completed Exhibit 30A, Community Advisory Board Affidavit for Category 1 of Appendix D, Required Forms with its proposal affirming that its CAB meets the requirements specified in Table 10. *(**Note:** One (1) CAB is sufficient for all Proposer submissions in response to Category 1).*

Table 10. Community Advisory Board (CAB) Minimum Requirements for Category 1: HIV and STD Prevention Services for YMSM

MINIMUM REQUIREMENTS
• Include five (5) to eight (8) members, two assigned as co-chairs;
• Members must reside in Los Angeles County;
• Members must be 16 to 29 years of age;
• CAB must consist of 75 percent youth of color (African American or Latino);
• CAB must consist of 50 percent 16 to 24 years of age; and
• CAB must consist of 60 percent YMSM.

3.1.5 Maximum Annual Budgets

Tier Level 1 (Central and South Cluster Areas): Tier Level 1 proposal submitted must not exceed an annual amount of seven hundred fifty thousand dollars ($750,000). *(Proposals submitted in excess of this amount will be deemed non-responsive and will be disqualified from further consideration consistent with RFP sub-paragraph 1.2.6, Availability of Funding.)*

Tier Level 2 (East, North and Northwest Cluster Areas): Tier Level 2 proposals submitted must not exceed an annual amount of two hundred fifty thousand dollars ($250,000). *(Proposals submitted in excess of this amount will be deemed non-responsive and will be disqualified from further consideration consistent with RFP sub-paragraph 1.2.6, Availability of Funding.)*

3.1.6 Mandatory Intent to Apply

Proposer that intends to respond to this RFP must submit a completed "Mandatory Intent to Apply Form for Category 1" (Exhibit 25A, of Appendix D, Required Forms) form for **each Category 1 proposal** Proposer intends to submit by the date and time specified in Paragraph 7.2, RFP Timetable.

3.1.7 **Mandatory Proposer Conference**

Proposer must attend the Mandatory Proposer Conference (MPC) on the date, time, and location specified pursuant to RFP Paragraph 7.6, Mandatory Proposer Conference.

3.1.8 **Letter of Concurrence**

Proposer must submit a completed Appendix D, Required Forms, Exhibit 31, Letter of Concurrence (LOC) **for each Category 1 proposal submission.** Each of Proposer's LOC must be signed by each CAB member, confirming that the CAB member supports and participated in the development of the proposed program(s) submitted by the Proposer in response to this RFP.

3.2 Category 2 (HIV and STD Prevention Services for Transgender Individuals) Minimum Mandatory Qualifications

Interested and qualified Proposers applying for Category 2 must meet **each** of the Minimum Mandatory Qualifications **on the day that proposals are due.** Consultant(s)/subcontractor(s) of Proposer can be used to meet experience and data collection, requirements as outlined in the minimum mandatory qualifications specified in sub-paragraphs 3.2.1 and 3.2.2. Consultant(s)/subcontractor(s) of Proposer must also meet the specified requirements on the day that proposals are due. All other minimum mandatory qualifications must be met by the Proposer.

3.2.1 **Experience**

Proposer, or consultant/subcontractor, must have a minimum of three (3) years of experience, within the last five (5) years, providing transgender services in Los Angeles County.

3.2.2 **Data Collection**

Proposer, or consultant/subcontractor, must have a minimum of two (2) years of experience, within the last five (5) years, collecting data for the purpose of evaluation and reporting.

3.2.3 **Community Advisory Board (CAB)**

Proposer's CAB must meet the requirements specified under Table 11, Community Advisory Board (CAB) Minimum Requirements –

Category 2. Proposer must submit a completed Exhibit 30B, Community Advisory Board Affidavit for Category 2 of Appendix D, Required Forms with its proposal affirming that the CAB meets the requirements described in Table 11. ***(Note:** One (1) CAB is sufficient for all Proposer submissions in response to Category 2).*

Table 11. Community Advisory Board (CAB) Minimum Requirements – Category 2

MINIMUM REQUIREMENTS
• Include five (5) to eight (8) members, two (2) assigned as co-chairs;
• Members must reside in Los Angeles County; and
• A majority of members must be transgender people who are reflective of the community the proposed program is intended to serve.

3.2.4 Maximum Annual Budgets

Proposals submitted must not exceed an annual amount of one million dollars ($1,000,000). *(Proposals submitted in excess of this amount will be deemed non-responsive and will be disqualified from further consideration consistent with RFP sub-paragraph 1.3.6, Availability of Funding.)*

3.2.5 Mandatory Intent to Apply

Proposer that intends to respond to this RFP must submit a completed "Mandatory Intent to Apply Form for Category 2" (Exhibit 25B, of Appendix D, Required Forms) form for **each Category 2 proposal** Proposer intends to submit by the date and time specified in Paragraph 7.2, RFP Timetable.

3.2.6 Mandatory Proposer Conference

Proposer must attend the Mandatory Proposer Conference (MPC) on the date, time, and location specified pursuant to RFP Paragraph 7.6, Mandatory Proposer Conference.

3.2.7 Letter of Concurrence

Proposer must submit a completed Appendix D, Required Forms, Exhibit 31, Letter of Concurrence (LOC) **for each Category 2 proposal submission.** Each of Proposer's LOC must be signed by each CAB member, confirming that the CAB member supports and

participated in the development of the proposed program(s) submitted by the Proposer in response to this RFP.

4.0 COUNTY'S RIGHTS AND RESPONSIBILITIES

The County is not responsible for representations made by any of its officers or employees prior to the execution of the Contract unless such understanding or representation is included in the Contract.

4.1 Final Contract Award by the Board of Supervisors

Notwithstanding a recommendation of a Department, agency, individual, or other, the Board of Supervisors retains the right to exercise its judgment concerning the selection of a proposal and the terms of any resultant agreement, and to determine which proposal best serves the interests of the County. The Board is the ultimate decision making body and makes the final determinations necessary to arrive at a decision to award, or not award, a contract.

4.2 County Option to Reject Proposals or Cancel Solicitation

Proposers are hereby advised that this RFP is an informal solicitation for proposals only, and is not intended, and is not to be construed as, an offer to enter into a contract or as a promise to engage in any formal competitive bidding or negotiations pursuant to any statute, ordinance, rule, or regulation. The County may, at its sole discretion, reject any or all proposals submitted in response to this RFP or may, in its sole discretion, reject all proposals and cancel the RFP in its entirety. The County shall not be liable for any costs incurred by the Proposer in connection with the preparation and submission of any proposal. The County reserves the right to waive inconsequential disparities in a submitted proposal.

4.3 County's Right to Amend Request for Proposals

The County has the right to amend the RFP by written addendum. The County is responsible only for that which is expressly stated in the solicitation document and any authorized written addenda thereto. Such addendum shall be made available to each person or organization which County records indicate has submitted a Mandatory Intent to Apply Form. Should such addendum require additional information not previously requested, failure to address the requirements of such addendum may

result in the Proposal being found non-responsive and not being considered, as determined in the sole discretion of the County. The County is not responsible for and shall not be bound by any representations otherwise made by any individual acting or purporting to act on its behalf.

4.4 Background and Security Investigations

Background and security investigations of Contractor's staff may be required by the County as a condition of beginning and continuing work under any resulting Contract. The cost of background checks is the responsibility of the Contractor.

4.5 County's Quality Assurance Plan

After contract award, the County or its agent will evaluate the Contractor's performance under the contract on a periodic basis. Such evaluation will include assessing Contractor's compliance with all terms in the Contract and performance standards identified in the Statement of Work. Contractor's deficiencies which the County determines are severe or continuing and that may jeopardize performance of the Contract will be reported to the County's Board of Supervisors. The report will include improvement/corrective action measures taken by the County and Contractor. If improvement does not occur consistent with the corrective action measures, the County may terminate the Contract in whole or in part, or impose other penalties as specified in the Contract.

5.0 PROPOSER'S REQUIREMENTS AND CERTIFICATIONS

5.1 Notice to Proposers Concerning the Public Records Act

5.1.1 Responses to this solicitation shall become the exclusive property of the County. Absent extraordinary circumstances, the recommended proposer's proposal will become a matter of public record when (1) contract negotiations are complete; (2) (Department) receives a letter from the recommended Proposer's authorized officer that the negotiated contract is the firm offer of the recommended Proposer; and (3) (Department) releases a copy of the recommended Proposer's proposal in response to a Notice of Intent to Request a Proposed Contractor Selection Review under Board Policy No. 5.055.

Notwithstanding the above, absent extraordinary circumstances, all proposals will become a matter of public record when the Department's proposer recommendation appears on the Board agenda.

Exceptions to disclosure are those parts or portions of all proposals that are justifiably defined as business or trade secrets, and plainly marked by the Proposer as "Trade Secret," "Confidential," or "Proprietary."

5.1.2 The County shall not, in any way, be liable or responsible for the disclosure of any such record or any parts thereof, if disclosure is required or permitted under the California Public Records Act or otherwise by law. A blanket statement of confidentiality or the marking of each page of the proposal as confidential shall not be deemed sufficient notice of exception. The Proposers must specifically label only those provisions of their respective proposal which are "Trade Secrets," "Confidential," or "Proprietary" in nature.

5.1.3 In the event the County is required to defend an action on a Public Records Act request for any of the aforementioned documents, information, books, records, and/or contents of a proposal marked "confidential," "trade secrets," or "proprietary," Proposer agrees to defend and indemnify County from all costs and expenses, including reasonable attorneys' fees, incurred in connection with any action, proceedings, or liability arising in connection with the Public Records Act request.

5.2 Contact with County Personnel

All contact regarding this RFP or any matter relating thereto must be in writing and may be mailed or e-mailed as follows:

Maritza Recinos, Contract Analyst
County of Los Angeles, Department of Public Health
Contracts and Grants Division
600 South Commonwealth Avenue, 7th Floor, Suite 700
Los Angeles, California 90005
E-mail: mrecinos@ph.lacounty.gov

If it is discovered that Proposer contacted and received information from any County personnel, other than the person specified above, regarding this solicitation, County, in its sole determination, may disqualify their proposal from further consideration.

5.3 Mandatory Requirement to Register on County's WebVen

Prior to a contract award, all potential Contractors must register in the County's WebVen. The WebVen contains the Vendor's business profile and identifies the goods/services the business provides. Registration can be accomplished online via the Internet by accessing the County's home page at http://camisvr.co.la.ca.us/webven/

5.4 Protest Policy Review Process

5.4.1 Under Board Policy No. 5.055 (Services Contract Solicitation Protest), any prospective Proposer may request a review of the requirements under a solicitation for a Board-approved services contract, as described in sub-paragraph 5.4.3 below. Additionally, any actual Proposer may request a review of a disqualification or of a proposed contract award under such a solicitation, as described respectively in the sub-paragraphs below. It is the responsibility of the Proposer challenging the decision of a County Department to demonstrate that the Department committed a sufficiently material error in the solicitation process to justify invalidation of a proposed contract award.

5.4.2 Throughout the review process, the County has no obligation to delay or otherwise postpone an award of contract based on a Proposer protest. In all cases, the County reserves the right to make an award when it is determined to be in the best interest of the County of Los Angeles to do so.

5.4.3 Grounds for Review

Unless state or federal statutes or regulations otherwise provide, the grounds for review of a solicitation for a Board-approved services contract provided for under Board Policy No. 5.055 are limited to the following:

- Review of Solicitation Requirements (Reference Paragraph 7.3 in the Proposal Submission Requirements Section)

- Review of a Disqualified Proposal (Reference Paragraph 8.3 in the Selection Process and Evaluation Criteria Section)

- Review of Proposed Contractor Selection (Reference Paragraph 8.7 in the Selection Process and Evaluation Criteria Section)

5.5 Injury and Illness Prevention Program

Contractor shall be required to comply with the State of California's Cal OSHA's regulations. Section 3203 of Title 8 in the California Code of Regulations requires all California employers to have a written, effective Injury and Illness Prevention Program (IIPP) that addresses hazards pertaining to the particular workplace covered by the program.

5.6 Confidentiality and Independent Contractor Status

As appropriate, Contractor shall be required to comply with the Confidentiality provision contained in Paragraph 9 and the Independent Contractor Status provision contained in Paragraph 47 in Appendix A, Sample Contract.

5.7 Conflict of Interest

No County employee whose position in the County enables him/her to influence the selection of a Contractor for this RFP, or any competing RFP, nor any spouse of economic dependent of such employees, shall be employed in any capacity by a Proposer or have any other direct or indirect financial interest in the selection of a Contractor. Proposer shall certify that he/she is aware of and has read Section 2.180.010 of the Los Angeles County Code as stated in Appendix D - Required Forms Exhibit 5, Certification of No Conflict of Interest.

5.8 Determination of Proposer Responsibility

5.8.1 A responsible Proposer is a Proposer who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity and experience to satisfactorily perform the contract. It is the County's policy to conduct business only with responsible Proposers.

5.8.2 Proposers are hereby notified that, in accordance with Chapter 2.202 of the County Code, the County may determine whether the Proposer is responsible based on a review of the Proposer's performance on any contracts, including but not limited to County contracts. Particular attention will be given to violations of labor laws related to employee compensation and benefits, and evidence of false claims made by the Proposer against public entities. Labor law violations which are the fault of the subcontractors and of which the Proposer had no knowledge shall not be the basis of a determination that the Proposer is not responsible.

5.8.3 The County may declare a Proposer to be non-responsible for purposes of this contract if the Board of Supervisors, in its discretion, finds that the Proposer has done any of the following: (1) violated a term of a contract with the County or a nonprofit corporation created by the County; (2) committed an act or omission which negatively reflects on the Proposer's quality, fitness or capacity to perform a contract with the County, any other public entity, or a nonprofit corporation created by the County, or engaged in a pattern or practice which negatively reflects on same; (3) committed an act or omission which indicates a lack of business integrity or business honesty; or (4) made or submitted a false claim against the County or any other public entity.

5.8.4 If there is evidence that the apparent highest ranked Proposer may not be responsible, the Department shall notify the Proposer in writing of the evidence relating to the Proposer's responsibility, and its intention to recommend to the Board of Supervisors that the Proposer be found not responsible. The Department shall provide the Proposer and/or the Proposer's representative with an opportunity to present evidence as to why the Proposer should be found to be responsible and to rebut evidence which is the basis for the Department's recommendation.

5.8.5 If the Proposer presents evidence in rebuttal to the Department, the Department shall evaluate the merits of such evidence, and based on that evaluation, make a recommendation to the Board of Supervisors. The final decision concerning the responsibility of the Proposer shall reside with the Board of Supervisors.

5.8.6 These terms shall also apply to proposed subcontractors of Proposers on County contracts.

5.9 Proposer Debarment

5.9.1 The Proposer is hereby notified that, in accordance with Chapter 2.202 of the County Code, the County may debar the Proposer from bidding or proposing on, or being awarded, and/or performing work on other County contracts for a specified period of time, which generally will not exceed five (5) years but may exceed five (5) years or be permanent if warranted by the circumstances, and the County may terminate any or all of the Proposer's existing contracts with County, if the Board of Supervisors finds, in its discretion, that the Proposer has done any of the following: (1) violated a term of a contract with the County or a nonprofit corporation created by the County; (2) committed an act or omission which negatively reflects on the Proposer's quality, fitness or capacity to perform a contract with the County, any other public entity, or a nonprofit corporation created by the County, or engaged in a pattern or practice which negatively reflects on same; (3) committed an act or offense which indicates a lack of business integrity or business honesty; or (4) made or submitted a false claim against the County or any other public entity.

5.9.2 If there is evidence that the apparent highest ranked Proposer may be subject to debarment, the Department shall notify the Proposer in writing of the evidence which is the basis for the proposed debarment, and shall advise the Proposer of the scheduled date for a debarment hearing before the Contractor Hearing Board.

5.9.3 The Contractor Hearing Board shall conduct a hearing where evidence on the proposed debarment is presented. The Proposer and/or Proposer's representative shall be given an opportunity to submit evidence at that hearing. After the hearing, the Contractor Hearing Board shall prepare a tentative proposed decision, which shall contain a recommendation regarding whether the Proposer should be debarred, and, if so, the appropriate length of time of the debarment. The Proposer and the Department shall be provided an

opportunity to object to the tentative proposed decision prior to its presentation to the Board of Supervisors.

5.9.4 After consideration of any objections, or if no objections are received, a record of the hearing, the proposed decision and any other recommendation of the Contractor Hearing Board shall be presented to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny or adopt the proposed decision and recommendation of the Contractor Hearing Board.

5.9.5 If a Proposer has been debarred for a period longer than five (5) years, that Proposer may, after the debarment has been in effect for at least five (5) years, submit a written request for review of the debarment determination to reduce the period of debarment or terminate the debarment. The County may, in its discretion, reduce the period of debarment or terminate the debarment if it finds that the Proposer has adequately demonstrated one or more of the following: (1) elimination of the grounds for which the debarment was imposed; (2) a bona fide change in ownership or management; (3) material evidence discovered after debarment was imposed; or (4) any other reason that is in the best interests of the County.

5.9.6 The Contractor Hearing Board will consider requests for review of a debarment determination only where (1) the Proposer has been debarred for a period longer than five (5) years; (2) the debarment has been in effect for at least five (5) years; and (3) the request is in writing, states one or more of the grounds for reduction of the debarment period or termination of the debarment, and includes supporting documentation. Upon receiving an appropriate request, the Contractor Hearing Board will provide notice of the hearing on the request. At the hearing, the Contractor Hearing Board shall conduct a hearing where evidence on the proposed reduction of debarment period or termination of debarment is presented. This hearing shall be conducted and the request for review decided by the Contractor Hearing Board pursuant to the same procedures as for a debarment hearing.

5.9.7 The Contractor Hearing Board's proposed decision shall contain a recommendation on the request to reduce the period of debarment or terminate the debarment. The Contractor Hearing Board shall

present its proposed decision and recommendation to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board.

5.9.8 These terms shall also apply to proposed subcontractors of Proposers on County contracts.

5.9.9 Appendix H, Listing of Contractors Debarred in Los Angeles County provides a link to the County's website where there is a listing of Contractors that are currently on the Debarment List for Los Angeles County.

5.10 Adherence to County's Child Support Compliance Program

Proposers shall: 1) fully comply with all applicable State and Federal reporting requirements relating to employment reporting for its employees; and 2) comply with all lawfully served Wage and Earnings Assignment Orders and Notice of Assignment and continue to maintain compliance during the term of any contract that may be awarded pursuant to this solicitation. Failure to comply may be cause for termination of a contract or initiation of debarment proceedings against the non-compliant Contractor (County Code Chapter 2.202).

5.11 Gratuities

5.11.1 Attempt to Secure Favorable Treatment

It is improper for any County officer, employee or agent to solicit consideration, in any form, from a Proposer with the implication, suggestion or statement that the Proposer's provision of the consideration may secure more favorable treatment for the Proposer in the award of the Contract or that the Proposer's failure to provide such consideration may negatively affect the County's consideration of the Proposer's submission. A Proposer shall not offer or give either directly or through an intermediary, consideration, in any form, to a County officer, employee or agent for the purpose of securing favorable treatment with respect to the award of the Contract.

5.11.2 Proposer Notification to County

A Proposer shall immediately report any attempt by a County officer, employee or agent to solicit such improper consideration. The report shall be made either to the County manager charged with the supervision of the employee or to the County Auditor-Controller's Employee Fraud Hotline at (800) 544-6861. Failure to report such a solicitation may result in the Proposer's submission being eliminated from consideration.

5.11.3 Form of Improper Consideration

Among other items, such improper consideration may take the form of cash, discounts, services, the provision of travel or entertainment, or tangible gifts.

5.12 Notice to Proposers Regarding the County Lobbyist Ordinance

The Board of Supervisors of the County of Los Angeles has enacted an ordinance regulating the activities of persons who lobby County officials. This ordinance, referred to as the "Lobbyist Ordinance", defines a County Lobbyist and imposes certain registration requirements upon individuals meeting the definition. The complete text of the ordinance can be found in County Code Chapter 2.160. In effect, each person, corporation or other entity that seeks a County permit, license, franchise or contract must certify compliance with the ordinance. As part of this solicitation process, it will be the responsibility of each Proposer to review the ordinance independently as the text of said ordinance is not contained within this RFP. Thereafter, each person, corporation or other entity submitting a response to this solicitation, must certify that each County Lobbyist, as defined by Los Angeles County Code Section 2.160.010, retained by the Proposer is in full compliance with Chapter 2.160 of the Los Angeles County Code and each such County Lobbyist is not on the Executive Office's List of Terminated Registered Lobbyists by completing and submitting the Familiarity with the County Lobbyist Ordinance Certification, as set forth in Appendix D - Required Forms, Exhibit 6, as part of their proposal.

5.13 Federal Earned Income Credit

The Contractor shall notify its employees, and shall require each subcontractor to notify its employees, that they may be eligible for the Federal Earned Income Credit under the federal income tax laws. Such notice shall be provided in accordance with the requirements set forth in Internal Revenue Service (IRS) Notice No. 1015. (Reference Appendix I)

5.14 Consideration of GAIN/GROW Participants for Employment

As a threshold requirement for consideration for contract award, Proposers shall demonstrate a proven record of hiring participants in the County's Department of Public Social Services Greater Avenues for Independence (GAIN) or General Relief Opportunity for Work (GROW) Programs or shall attest to a willingness to consider GAIN/GROW participants for any future employment openings if they meet the minimum qualifications for that opening. Proposers shall attest to a willingness to provide employed GAIN/GROW participants access to the Proposers' employee mentoring program, if available, to assist these individuals in obtaining permanent employment and/or promotional opportunities.

Proposers who are unable to meet this requirement shall not be considered for contract award. Proposers shall submit a completed, "Attestation of Willingness to Consider GAIN/GROW Participants", form, as set forth in Appendix D - Required Forms, Exhibit 9, along with their proposal.

5.15 Recycled Bond Paper

Proposer shall be required to comply with the County's policy on recycled bond paper as specified in Appendix A, Sample Contract, Paragraph 62.

5.16 Safely Surrendered Baby Law

The Contractor shall notify and provide to its employees, and shall require each subcontractor to notify and provide to its employees, a fact sheet regarding the Safely Surrendered Baby Law, its implementation in Los Angeles County, and where and how to safely surrender a baby. The fact sheet is set forth in Appendix J of this solicitation document and is also available on the Internet at www.babysafela.org for printing purposes.

5.17 Compliance with the County's Jury Service Program

The prospective contract is subject to the requirements of the County's Contractor Employee Jury Service Ordinance ("Jury Service Program") (Los Angeles County Code, Chapter 2.203). Prospective Contractors should carefully read the Jury Service Ordinance, Appendix G, and the pertinent jury service provisions of the Sample Contract, Appendix A, Paragraph 31, both of which are incorporated by reference into and made a part of this RFP. The Jury Service Program applies to both Contractors and their Subcontractors.

Proposals that fail to comply with the requirements of the Jury Service Program will be considered non-responsive and excluded from further consideration.

5.17.1 The Jury Service Program requires Contractors and their Subcontractors to have and adhere to a written policy that provides that its employees shall receive from the Contractor, on an annual basis, no less than five days of regular pay for actual jury service. The policy may provide that employees deposit any fees received for such jury service with the Contractor or that the Contractor deduct from the employee's regular pay the fees received for jury service. For purposes of the Jury Service Program, "employee" means any California resident who is a full-time employee of a Contractor and "full-time" means 40 hours or more worked per week, or a lesser number of hours if: 1) the lesser number is a recognized industry standard as determined by the County, or 2) the Contractor has a long-standing practice that defines the lesser number of hours as full-time. Therefore, the Jury Service Program applies to all of a Contractor's full-time California employees, even those not working specifically on the County project. Full-time employees providing short-term, temporary services of 90 days or less within a 12-month period are not considered full-time for purposes of the Jury Service Program.

5.17.2 There are two ways in which a Contractor might not be subject to the Jury Service Program. The first is if the Contractor does not fall within the Jury Service Program's definition of "Contractor". The Jury Service Program defines "Contractor" to mean a person, partnership, corporation of other entity which has a contract with

the County or a Subcontract with a County Contractor and has received or will receive an aggregate sum of $50,000 or more in any 12-month period under one or more County contracts or subcontracts. The second is if the Contractor meets one of the two exceptions to the Jury Service Program. The first exception concerns small businesses and applies to Contractors that have 1) ten or fewer employees; and, 2) annual gross revenues in the preceding twelve months which, if added to the annual amount of this Contract is less than $500,000, and, 3) is not an "affiliate or subsidiary of a business dominant in its field of operation". The second exception applies to Contractors that possess a collective bargaining agreement that expressly supersedes the provisions of the Jury Service Program. The Contractor is subject to any provision of the Jury Service Program not expressly superseded by the collective bargaining agreement.

5.17.3 If a Contractor does not fall within the Jury Service Program's definition of "Contractor" or if it meets any of the exceptions to the Jury Service Program, then the Contractor must so indicate in the Certification Form and Application for Exception, Exhibit 10 in Appendix D - Required Forms, and include with its submission all necessary documentation to support the claim such as tax returns or a collective bargaining agreement, if applicable. Upon reviewing the Contractor's application, the County will determine, in its sole discretion, whether the Contractor falls within the definition of Contractor or meets any of the exceptions to the Jury Service Program. The County's decision will be final.

5.18 Living Wage Program (Intentionally Omitted)

5.19 Notification to County of Pending Acquisitions/Mergers by Proposing Company

The Proposer shall notify the County of any pending acquisitions/mergers of their company. This information shall be provided by the Proposer on Required Form - Exhibit 1A and/or 1B - Proposer's Organization Questionnaire/Affidavit. Failure of the Proposer to provide this information may eliminate its proposal from any further consideration. Proposer shall have a continuing obligation to notify County of changes to the information contained in Exhibit 1A and/or 1B (Proposer's Organization

Questionnaire/Affidavit) during the pendency of this RFP by providing a revised Exhibit 1A and/or 1B (Proposer's Organization Questionnaire Exhibit 1A and/or 1B) to the County upon the occurrence of any event giving rise to a change in its previously-reported information.

5.20 Proposer's Charitable Contributions Compliance

5.20.1 California's "Supervision of Trustees and Fundraisers for Charitable Purposes Act" regulates receiving and raising charitable contributions. Among other requirements, those subject to the Charitable Purposes Act must register. The 2004 Nonprofit Integrity Act (SB 1262, Chapter 919) increased Charitable Purposes Act requirements. Prospective Contractors should carefully read the Background and Resources: California Charities Regulations, Appendix N. New rules cover California public benefit corporations, unincorporated associations, and trustee entities and may include similar foreign corporations doing business or holding property in California. Key Nonprofit Integrity Act requirements affect executive compensation, fund-raising practices and documentation. Charities with over $2 million of revenues (excluding funds that must be accounted for to a governmental entity) have new audit requirements.

5.20.2 All prospective contractors must determine if they receive or raise charitable contributions which subject them to the Charitable Purposes Act and complete the Charitable Contributions Certification, Exhibit 20 as set forth in Appendix D - Required Forms. A completed Exhibit 20 is a required part of any agreement with the County.

5.20.3 In Exhibit 20, prospective contractors certify either that:

- they have determined that they do not now receive or raise charitable contributions regulated under the California Charitable Purposes Act, (including the Nonprofit Integrity Act) but will comply if they become subject to coverage of those laws during the term of a County agreement,

- OR -

- they are currently complying with their obligations under the Charitable Purposes Act, attaching a copy of their most recent filing with the Registry of Charitable Trusts.

5.20.4 Prospective County contractors that do not complete Exhibit 20 as part of the solicitation process may, in the County's sole discretion, be disqualified from contract award. A County contractor that fails to comply with its obligations under the Charitable Purposes Act is subject to either contract termination or debarment proceedings or both. (County Code Chapter 2.202)

5.21 Defaulted Property Tax Reduction Program

The prospective contract is subject to the requirements of the County's Defaulted Property Tax Reduction Program ("Defaulted Tax Program") (Los Angeles County Code, Chapter 2.206). Prospective Contractors should carefully read the Defaulted Property Tax Reduction Program, Appendix O, and the pertinent provisions of the Sample Contract, Appendix A, Paragraphs 78 and 79, both of which are incorporated by reference into and made a part of this solicitation. The Defaulted Property Tax Reduction Program applies to both Contractors and their Subcontractors.

Proposers shall be required to certify that they are in full compliance with the provisions of the Defaulted Property Tax Reduction Program and shall maintain compliance during the term of any contract that may be awarded pursuant to this solicitation or shall certify that they are exempt from the Defaulted Property Tax Reduction Program by completing Certification of Compliance with County's Defaulted Property Tax Reduction Program, Exhibit 22 in Appendix D – Required Forms. Failure to maintain compliance, or to timely cure defects, may be cause for termination of a contract or initiation of debarment proceedings against the non-compliance contractor (Los Angeles County Code, Chapter 2.202).

Proposals that fail to comply with the certification requirements of the Defaulted Tax Program will be considered non-responsive and excluded from further consideration.

5.22 Time Off for Voting

The Contractor shall notify its employees, and shall require each subcontractor to notify and provide to its employees, information regarding the time off for voting law (Elections Code Section 14000). Not less than 10 days before every statewide election, every Contractor and subcontractors shall keep posted conspicuously at the place of work, if practicable, or elsewhere where it can be seen as employees come or go to their place of work, a notice setting forth the provisions of Section 14000.

6.0 COUNTY'S PREFERENCE PROGRAMS

6.1 County Policy on Doing Business with Small Business

6.1.1 The County has multiple programs that address small businesses. The Board of Supervisors encourages small business participation in the County's contracting process by constantly streamlining and simplifying our selection process and expanding opportunities for small businesses to compete for our business.

6.1.2 The Local Small Business Enterprise Preference Program requires the Company to complete a certification process. This program and how to obtain certification are further explained in Paragraph 6.2 of this solicitation.

6.1.3 The Jury Service and Living Wage Programs, provide exceptions to the Programs if a company qualifies as a Small Business. It is important to note that each Program has a different definition for Small Business. You may qualify as a Small Business in one Program but not the other. Further explanations of these two Programs are provided in Paragraph 5.17 - Jury Service Program and Paragraph 5.18 - Living Wage Program of this solicitation.

6.1.4 The County also has a County of Los Angeles Policy on Doing Business with Small Business that is stated in Appendix F.

6.2 Local Small Business Enterprise Preference Program (LSBE)

Note: Cost is not a determining factor in this solicitation process; as such no preference will be applied. However, LSBE Proposer is encouraged to apply for certification to take advantage of the LSBE

Prompt Payment Program further identified in RFP Paragraph 6.3 Local Small Business Enterprise Prompt Payment Program.

6.2.1 The County will give Local SBE preference during the solicitation process to businesses that meet the definition of a Local Small Business Enterprise (Local SBE), consistent with Chapter 2.204.030C.2 of the Los Angeles County Code.

6.2.2 A business which is certified as small by the Small Business Administration (SBA) or which is registered as small on the federal Central Contractor Registration data base may qualify to request the Local SBE Preference in a solicitation.

6.2.3 Businesses must complete the Required Form - Request for Local SBE Preference Program Consideration and CBE Firm/Organization Information Form - Exhibit 7 in Appendix D - Required Forms with their proposal. Sanctions and financial penalties may apply to a business that knowingly, and with intent to defraud, seeks to obtain or maintain the Local SBE Preference.

6.3 Local Small Business Enterprise (SBE) Prompt Payment Program

It is the intent of the County that Certified Local SBEs receive prompt payment for services they provide to County Departments. Prompt payment is defined as 15 calendar days after receipt of an undisputed invoice.

6.4 Disabled Veteran Business Enterprise Preference Program (DVBE) (Intentionally Omitted)

6.5 Transitional Job Opportunities Preference Program (Intentionally Omitted)

7.0 PROPOSAL SUBMISSION REQUIREMENTS

This section contains key project dates and activities as well as instructions to Proposer regarding preparation and submission of their proposal.

7.1 Truth and Accuracy of Representations

False, misleading, incomplete, or deceptively unresponsive statements in connection with a proposal shall be sufficient cause for rejection of the

proposal. The evaluation and determination in this area shall be at the Director's sole judgment and his/her judgment shall be final. All proposals shall be firm and final offers and may not be withdrawn for a period of three hundred sixty five (365) days following the final proposal submission date.

7.2 RFP Timetable

The timetable for this RFP is as follows:

Table 12. RFP Timetable

RFP TIMETABLE	
Key Event	**Date of Occurrence**
Release of RFP	10/15/2015
Mandatory Intent to Apply Form due by 3:00 PM on	10/28/2015
Request for a Solicitation Requirements Review due by 3:00 PM on	10/28/2015
Mandatory Proposer Conference at 9:00 AM	11/3/2015
Written Questions due by 3:00 PM on	11/6/2015
Questions and Answers Released	11/23/2015
PROPOSALS DUE BY 3:00 PM	**12/8/2015**

All times as listed above and throughout this RFP are Pacific Time (PT).

7.3 Solicitation Requirements Review

Any person or entity may seek a Solicitation Requirements Review by submitting Appendix E – Request for Proposals (RFP) Transmittal to Request a Solicitation Requirements Review to the Department conducting the solicitation as described in this Section. A request for a Solicitation Requirements Review may be denied, in the Department's sole discretion, if the request does not satisfy all of the following criteria:

1. The request for a Solicitation Requirements Review is made within ten (10) business days of the issuance of the solicitation document;
2. The request for a Solicitation Requirements Review includes documentation, which demonstrates the underlying ability of the person or entity to submit a proposal;
3. The request for a Solicitation Requirements Review itemizes in appropriate detail, each matter contested and factual reasons for the requested review; and

4. The request for a Solicitation Requirements Review asserts either that:
   a. application of the minimum requirements, evaluation criteria and/or business requirements unfairly disadvantages the person or entity; or,
   b. due to unclear instructions, the process may result in the County not receiving the best possible responses from prospective Proposers.

The Solicitation Requirements Review shall be completed and the Department's determination shall be provided to the requesting person or entity, in writing, within a reasonable time prior to the proposal due date. Upon response, the County's decision to the Solicitation Requirements Review shall be final. All requests for a Solicitation Requirements Review should be submitted by email (PDF format only) transmission only, by the date and time indicated pursuant to RFP Paragraph 7.2, RFP Timetable, to:

Maritza Recinos, Contract Analyst
County of Los Angeles, Department of Public Health
Contract and Grants Division
Email: mrecinos@ph.lacounty.gov

7.4 Proposer's Questions

Proposer may submit written questions regarding this RFP via e-mail only (PDF format only) to the individual identified below. All questions must be received by the due date and time pursuant to RFP Paragraph 7.2, RFP Timetable. All questions, without identifying the submitting company, will be compiled with the appropriate answers and issued as an addendum to the RFP.

When submitting questions, the Proposer must specify the RFP section number, paragraph number, page number, and quote the language that prompted the question. This will ensure that the questions can be quickly and accurately found in the RFP. County reserves the right to group similar questions when providing answers.

Questions may address concerns that the application of minimum mandatory qualifications, evaluation criteria and/or business requirements would unfairly disadvantage Proposer or, due to unclear instructions, may

result in the County not receiving the best possible responses from Proposer.

Questions should be addressed to:

Maritza Recinos, Contract Analyst
County of Los Angeles, Department of Public Health
Contracts and Grants Division
E-mail: mrecinos@ph.lacounty.gov

7.5 Submission of Application for Exemption to Living Wage Program (for Living Wage Solicitations) (Intentionally Omitted)

7.6 Mandatory Proposer Conference

A Mandatory Proposer Conference (MPC) will be held to present specific sections and discuss the RFP as it pertains to both Category 1 and Category 2. County staff will respond to questions from potential Proposers. **All potential Proposers must attend this conference or their proposals will be rejected as non-responsive (disqualified) without review and eliminated from further consideration.**

Proposer is advised to register for the MPC. Space is limited, therefore Proposer may only register up to two (2) representatives per agency who must attend the MPC. Substitutions can be made up to the day prior to the MPC. No more than two (2) agency representatives will be admitted to the MPC.

Proposer registering for the MPC should do so via email to the County representative identified in Paragraph 5.2, Contact with County Personnel. Email registrations must include the following:

- Subject Line: MPC Registration
- Proposer (Agency) Name
- Name and title of each agency representative
- Email address of each agency representative
- Contact Number for each agency representative

The MPC for Category 1 and Category 2 is scheduled as follows:

Date:	November 3, 2015
Time:	9:00 AM
Location:	County of Los Angeles, Department of Public Health Division of HIV and STD Programs

600 South Commonwealth Avenue
9th Floor – Room 907 A/B
Los Angeles, California 90005

Proposer is advised to bring a copy of the complete RFP package to the MPC; the County will not distribute copies at the MPC.

Paid parking is available on-site at the Commonwealth location as well as other local parking lots and street parking. The County **will not** validate and or reimburse fees for parking. Parking fees are the responsibility of the Proposer. Proposer should plan to arrive early to secure parking and allow adequate time to pass through building security and metal detectors.

Proposer is not permitted to record and or video tape the MPC.

7.7 Preparation of the Proposal

All RFP forms, Exhibits and or Attachments, required in the submission of the proposal must be printed and signed and dated where applicable. **No other templates shall be accepted.** Where applicable, Proposer must adhere to the required page limits. Proposer is advised that evaluators will disregard and not evaluate any information provided past the page limit. Proposer should respond to each question, as each question that does not have a response (e.g., no response, blank, etc.) will result in zero points for each instance where a response was not provided. Proposer must read the RFP carefully and follow all instructions, giving consideration to all requirements and requested documents as set forth herein when submitting their proposals to ensure that errors or omissions do not cause Proposer to be deemed non-responsive and disqualified.

Proposer is admonished not to alter any Attachments, Exhibits, or any information provided either in hardcopy or electronic format, with the exception of filling in blanks in applicable response forms or complying with directions provided in said forms. If County determines that Proposer has altered or modified any County-provided forms or data in any other manner whatsoever, County may, in its sole discretion, determine the Proposer's submission to be non-responsive, and disqualified. In preparing the written proposal, the Proposer should do so in its own words and not copy the language in the RFP.

Proposer is advised that if the response in one document conflicts with the response given in one or more other documents, County reserves the right, in its sole discretion, to disqualify the proposal or to reduce the score accordingly. In circumstances where the copies of the proposal (including electronic versions) deviate from the original proposal, the proposal labeled "Original" shall be the ruling and presiding document.

Proposal and subsequent copies must be submitted in the prescribed format outlined below. Any proposal that is incomplete, missing required forms, and/or deviates from this format may be rejected without review at the County's sole discretion. The proposal package must adhere to the following:

1. Proposal must be in English.

2. Package must include one (1) original proposal SINGLE-SIDED, including all required attachments and forms with original signatures. The original proposal must be marked as such, e.g., "Original" on the proposal's Title Page.

3. Package must include an additional four (4) DOUBLE-SIDED copies of the original proposal including copies of all required forms and attachments. Each proposal copy, on the proposal's title page, shall be numbered and marked as such (e.g., Copy Number 1, Copy Number 2, etc.).

4. Proposal must be typewritten, single spaced with no less than a 10 point font on 8 ½" by 11" paper, with the 8 ½" ends of the paper as the top and bottom of the page, and 1" margins. Header and footer margins shall be no less than 0.3".

5. Proposal pages must be numbered sequentially, including attachments, from beginning to end, to ensure that there are no duplicate or missing pages.

6. Proposal must be organized and tabbed by applicable parts and/or sections, with proper titles, and alphabetized sub-paragraphs as described herein.

7. Proposal and all copies must be bound, or presented in a folder, or three-ring binder and shall be clearly labeled with the RFP title: "County of Los Angeles, Department of Public Health Request for Proposals for **PROMOTING HEALTH CARE ENGAGEMENT**

AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs, RFP NO.: 2015-003", with the name of the proposer's organization on the front exterior cover. If space is available, binder ends shall also clearly identify the RFP title and name of the proposer's organization.

7.8 Proposal Format

The content and sequence of the proposal must be as follows:

- Proposal Title Page and Cover Letter
- Table of Contents
- Proposal Submission Checklist (Exhibit 33, Appendix D, Required Forms)
- **PART 1: ADMINISTRATIVE SECTION**
  - Proposer's Qualifications (Section A)
    - Proposer's Organization Questionnaire/Affidavit (Section A.1)
    - Proposer's Background and Experience (Section A.2)
    - Proposer's References (Section A.3)
    - Proposer's Pending Litigation and Judgements (Section A.4)
  - Financial Capability (Section B)
  - Terms and Conditions in the Sample Contract and Requirements of the Statement of Work (SOW): Acceptance of / or Exceptions (Section C)
  - Required Forms (Section D)
- **PART 2: PROPOSED PROGRAM AND BUDGET SECTION**
  - Executive Summary (Section E)
  - Proposer's Approach to Providing Required Services (Section F)
    - A. Logic Model Template (Section F.1)
    - B. Statement of Need (Section F.2)
    - C. Program Plan (Section F.3)
      - Program Design (Section F.3.1)
      - Expected Outcomes (Section F.3.2)
    - D. Management Plan (Section F.4)
      - Organizational Capacity and Relationships (Section F.4.1)
      - Staffing and In-Kind Support (Section F.4.2)
      - Community Advisory Support Plan (Section F.4.3)
      - Data Reporting Plan (Section F.4.4)
    - E. Scope of Work (Section F.5)
  - Evaluation and Quality Management Plan (Section G)
  - Program Budget (Section H)

7.8.1 **Proposal Title Page and Cover Letter**

Proposer must create a title page to preface the submitted proposal. Additionally, a Cover Letter must follow the title page which includes all of the information provided in this Paragraph.

A. Proposal Title Page

Proposer must include a Title Page which bears the words **"PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs, RFP NO.: 2015-003."** The Title Page must also include the Proposer's name.

B. Cover Letter

Proposal must include one (1) original Cover Letter signed in blue ink. The Cover Letter must be on agency letterhead and addressed to:

Patricia Gibson, Chief
County of Los Angeles, Department of Public Health
Contracts and Grants Division
600 South Commonwealth Avenue, Suite 700 – 7th Floor
Los Angeles, California 90005

The Cover Letter must include the following:

a. A statement that the proposal submitted is in response to **"PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs, RFP NO.: 2015-003;"**
b. The proposal's annual budget amount requested;
c. The target population to be served (see RFP sub-paragraph 1.2.5 or 1.3.5, Categories of Services) and the cluster area (see RFP sub-paragraph 1.2.4 or 1.3.4, Location of Services) where services are to be provided;
d. A statement indicating whether or not the Proposer intends to perform the contract as a single Proposer. If Proposer will utilize subcontractor(s)/consultant(s) to perform any of

services, Proposer must identify each proposed subcontractor(s)/consultant(s);

e. A statement indicating if the Proposer intends to perform the contract as a single Proposer or intends to use subcontractor(s)/consultant(s) for in-kind services; Proposer must identify each proposed subcontractor(s)/consultant(s) for in-kind provider of services;
f. A statement that the Proposer will bear sole and complete responsibility for all work as defined in Appendix B-1, and/or B-2 (as applicable) Statement of Work, Section 9.0, Specific Work Requirements; Appendix D, Required Forms, Exhibit 27, Sample Scope of Work and Template; and the terms and conditions pursuant to Appendix A, Sample Contract;
g. The name, telephone number, email address, and facsimile number of the Proposer's representative/contact person for the submission; and
h. The signature of the agency's Executive Director, Chief Executive Officer, or other authorized designee.

Do not include any additional information in the Cover Letter. The County may reject any proposal submitted without a Cover Letter or with a Cover Letter that fails to adhere to the requirements specified above.

7.8.2 Table of Contents

List all material included in the Proposal. Include a clear definition of the material, identified by sequential page numbers and by section reference numbers.

7.8.3 Proposal Submission Checklist – Exhibit 33

Proposer must submit Proposal Submission Checklist, Exhibit 33, of Appendix D, Required Forms with their proposal to ensure that all required documents are included in the RFP.

7.8.4 PART 1: ADMINISTRATIVE SECTION

Part 1, Administrative Section outlines the sections and the information Proposer is to provide in its response to the criteria required in Part 1. **Note: Proposer submitting multiple proposals under Category 1 and/or 2 only need to submit a single response to Part 1 sections – unless otherwise indicated.**

The content and sequence of Part 1 is as follows:

7.8.4.1 Proposer's Qualifications (Section A)

A. Proposer's Organization Questionnaire/Affidavit (Section A.1)

Format: Appendix D, Required Forms: Exhibit 1A and/or Exhibit 1B,
Page Limit: Not applicable

The Proposer shall complete, sign and date the Proposer's Organization Questionnaire/Affidavit for Category 1 (Exhibit 1A) and/or Proposer's Organization Questionnaire/Affidavit for Category 2 (Exhibit 1B) as set forth in Appendix D. The person signing the form must be authorized to sign on behalf of the Proposer and be able to legally bind the Proposer in a Contract.

Taking into account the structure of the Proposer's organization, Proposer shall determine which of the below referenced supporting documents the County requires. If the Proposer's organization does not fit into one of these categories, upon receipt of the Proposal or at some later time, the County may, in its discretion, request additional documentation regarding the Proposer's business organization and authority of individuals to sign Contracts.

If the below referenced documents are not available at the time of proposal submission, Proposer must request the appropriate documents from the California Secretary of State and provide a statement on the status of the request.

Required Support Documents

Format: Certificate/Conformed Copy
Page Limit: Not applicable

1. Corporations or Limited Liability Company (LLC):

The Proposer must submit the following documentation with the Proposal:

a. A copy of a "Certificate of Good Standing" with the state of incorporation/organization.
b. A conformed copy of the most recent "Statement of Information" as filed with the California Secretary of State listing corporate officers or members and managers.
c. If applicable, a determination letter granting tax exemption under IRS Section 501(c)(3) status.

2. Limited Partnership:

Format: Certificate/Conformed Copy
Page Limit: Not applicable

The Proposer must submit a conformed copy of the Certificate of Limited Partnership or Application for Registration of Foreign Limited Partnership as filed with the California Secretary of State, and any amendments.

B. Proposer's Background and Experience (Section A.2)

Format: Appendix D, Required Forms: Exhibit 26A and/or Exhibit 26B; 1-Page Narrative
Narrative Page Limit: 1 Page

Proposer's Minimum Mandatory Requirements for Category 1 and/or Category 2

Proposer must submit a completed Appendix D, Required Forms - Exhibit 26A, Proposer's Minimum Mandatory Qualifications Form for Category 1 and/or Exhibit 26B, Proposer's Minimum Mandatory Requirements for Category 2. Each form must clearly demonstrate that the Proposer/Subcontractor meets the applicable minimum mandatory qualifications pursuant to RFP Paragraph 3.0, Proposer's Minimum Mandatory Qualifications. Proposer should ensure that information provided in its Exhibit 26A and/or Exhibit 26B, supports Proposer's responses provided in its Appendix D, Required Forms, Exhibit 1A - Proposer's Organization Questionnaire/Affidavit for Category 1 and/or Exhibit 1B - Proposer's Organization Questionnaire/Affidavit for Category 2.

1-Page Narrative for Category 1 and/or Category 2

Proposer must provide a one (1) page narrative summary of Proposer's relevant background information to demonstrate that the Proposer/Subcontractor has the capability to perform the required services, pursuant to Appendix B-1, Statement of Work for Category 1 and/or Appendix B-2, Statement of Work for Category 2, as a corporation or other entity. **Note:** Proposer must submit a separate 1-Page Narrative for Category 1 and/or Category 2.

C. Proposer's References (Section A.3)

Format: Appendix D, Required Forms, Exhibit 2, Exhibit 3, and Exhibit 4
Page Limit: Not applicable

Reference verification may be conducted on all or a sampling of the references provided as outlined in the

following subsections. It is the Proposer's sole responsibility to ensure that the firm's name, and point of contact's name, title and phone number for each reference is accurate. Please do not list DHSP or DHSP staff as references on Exhibits 2 and 3. The same references may be listed on both forms - Exhibits 2 and 3 (located in Appendix D, Required Forms). **Note:** Proposer applying for either Category 1 and/or Category 2 only need to submit one (1) Exhibit 2, 3, and 4.

County may disqualify a Proposer if:

1) References fail to substantiate Proposer's description of the services provided; or
2) References fail to support that Proposer has a continuing pattern of providing capable, productive and skilled personnel, or
3) The Department is unable to reach the point of contact with reasonable effort. It is the Proposer's responsibility to inform the point of contact of normal working hours.

The Proposer must complete and include the following Required Forms:

a. Prospective Contractor References, Appendix D, Required Forms, Exhibit 2: Proposer must provide five (5) references where the same or similar scope of services was provided. Please do not list DHSP or DHSP staff as references on Exhibit 2.

b. Prospective Contractor List of Contracts, Appendix D, Required Forms, Exhibit 3: The listing must include all non- profit and public entities contracts for the last five (5) years. Use additional sheets if necessary. Please do not list DHSP or DHSP staff as references on Exhibit 3.

c. Prospective Contractor List of Terminated Contracts, Appendix D, Required Forms, Exhibit 4: Listing must include contracts terminated (i.e., due to lack of funding, performance, expiration of term, etc.) within the last five (5) years with a reason for termination. Use additional sheets if necessary.

D. Proposer's Pending Litigation and Judgments (Section A.4)

Format: Appendix D, Required Forms: Exhibit 24
Page Limit: Not applicable

Proposer is to complete and submit Appendix D, Required Forms, Exhibit 24, Proposer's Pending Litigation and/or Judgments, and identify by name, case and court jurisdiction any pending litigation in which Proposer is involved, or judgments against Proposer in the past five (5) years. Provide a statement describing the size and scope of any pending or threatening litigation against the Proposer or principals of the Proposer. If there are no pending litigations and/or judgments, Proposer shall indicate so by checking the box on the form.

7.8.4.2 **Financial Capability (Section B)**

Proposer must provide copies of the company's most current and prior two (2) fiscal years (for example 2012 and 2013) financial statements. Financial statements should reflect the financial strength and capability of the organization in the provision of required services throughout the term(s) of any resultant contract, as well as the organization's capability to absorb all costs related to the provision of services for a minimum of sixty (60) days, during any resultant Contract. The following accounts must be included in the organization's financial statements:

BALANCE SHEET ACCOUNTS

1. Current Assets
   - Cash
   - Short Term Investments*
   - Accounts Receivable*
2. Current Liabilities
3. Total Assets
4. Total Liabilities
5. Owner's/Shareholder's Equity

INCOME STATEMENT ACCOUNTS

1. Total Operating Expenses (before taxes)
   - Bad Debts
   - Depreciation*
   - Amortization*
2. Total Expenses
3. Gross Income
4. Net Income

* may be excluded if they do not apply to your organization's operations

It should be noted that depending on the nature of the entity, i.e., for-profit, non-profit, governmental, the title of financial statements may differ. For example, for a non-profit entity the Balance Sheet is referred to as the Statement of Financial Position. The County may elect to waive any informality in a proposal if the sum and substance of the proposal is present.

If audited statements are available, they should be submitted to meet this requirement.

Do not submit Income Tax Returns to meet this requirement.

Financial statements will be kept confidential if so stamped on each page.

7.8.4.3 **Terms and Conditions in Sample Contract, and Requirements of the Statement of Work (SOW): Acceptance of / or Exceptions to (Section C)**

A) It is the duty of every Proposer to thoroughly review the Sample Contract and Statement of Work to ensure compliance with all terms, conditions and requirements. It is the County's expectation that in submitting a proposal the Proposer will accept, as stated, the County's terms and conditions in the Sample Contract and the County's requirements in the Statement of Work. However, the Proposer is provided the opportunity to take exceptions to the County's terms, conditions, and requirements.

B) Section C of Proposer's response must include:

1. A statement offering the Proposer's acceptance of or exceptions to all terms and conditions listed in Appendix A, Sample Contract.
2. A statement offering the Proposer's acceptance of or exceptions to all requirements listed in Appendix B-1, Statement of Work for Category 1 and/or Appendix B-2, Statement of Work for Category 2; and

For each exception, the Proposer shall provide:

1. An explanation of the reason(s) for the exception;
2. The proposed alternative language; and
3. A description of the impact, if any, to the Proposer's price.

C) Indicate all exceptions to the Sample Contract and/or the Statement of Work by providing a 'red-lined' version of the language in question. The County relies on this procedure and any Proposer who fails to make timely exceptions as required herein, may be barred, at the County's sole discretion, from later making such exceptions.

The County reserves the right to determine if Proposer's exceptions are material enough to deem the proposal non-responsive and not subject to further evaluation.

The County reserves the right to make changes to the Sample Contract and its appendices and exhibits at its sole discretion.

7.8.4.4 **Required Forms (Section D)**

Proposal shall include all completed, signed, and dated exhibits identified in Appendix D - Required Forms in Section D of proposal unless otherwise instructed.

Exhibit 1A	Proposer's Organization Questionnaire / Affidavit for Category 1(Include in Section A of proposal)
Exhibit 1B	Proposer's Organizational Questionnaire / Affidavit for Category 2 (Include in Section A of proposal)
Exhibit 2	Prospective Contractor References (Include Section A.3 of proposal)
Exhibit 3	Prospective Contractor List of Contracts (Include in Section A.3 of proposal)
Exhibit 4	Prospective Contractor List of Terminated Contracts (Include in Section A.3 of proposal)
Exhibit 5	Certification of No Conflict of Interest
Exhibit 6	Familiarity with the County Lobbyist Ordinance Certification
Exhibit 7	Request for Local SBE Preference Program Consideration and CBE Firm/Organization Information Form
Exhibit 8	Proposer's EEO Certification
Exhibit 9	Attestation of Willingness to Consider GAIN/GROW Participants

Exhibit 10	Contractor Employee Jury Service Program – Certification Form and Application for Exception
Exhibits 11-14	Cost Forms (Intentionally Omitted)
Exhibits 15-19	Living Wage Forms (Intentionally Omitted)
Exhibit 20	Charitable Contribution Certification
Exhibit 21	Transitional Job Opportunities Preference Program Application (Intentionally Omitted)
Exhibit 22	Certification of Compliance with County's Default Property Tax Reduction Program
Exhibit 23	Request for DVBE Preference Program Consideration (Intentionally Omitted)
Exhibit 24	Proposer's Pending Litigation and/or Judgments (Include in Section A.4 of proposal)
Exhibit 25A	Mandatory Intent to Apply Form for Category 1 (Summited by date and time specified in Paragraph 7.2, RFP Timetable)
Exhibit 25B	Mandatory Intent to Apply Form for Category 2) (Submitted by date and time specified in Paragraph 7.2, RFP Timetable)
Exhibit 26A	Proposer's Minimum Mandatory Qualifications Form for Category 1 (Include in Section A.2 of proposal)
Exhibit 26B	Proposer's Minimum Mandatory Qualifications Form for Category 2 (Include in Section A.2 of proposal)
Exhibit 27	Sample Scope of Work and Template (Include in Section F.5 of proposal)
Exhibit 28	Logic Model Instructions and Template (Include in Section F.1 of proposal)
Exhibit 29	Proposer's Funding Disclosure Form (Include in Section H of proposal)
Exhibit 30A	Community Advisory Board Affidavit for Category 1 (Include in Section F.3.1 of proposal)

Exhibit 30B	Community Advisory Board Affidavit for Category 2 (Include in Section F.3.1 of proposal)
Exhibit 31	Letter of Concurrence (Include in Section F.3.1 of proposal)
Exhibit 32A	Program Components Checklist for Category 1 (Include in Section F.3.1 of proposal)
Exhibit 32B	Program Components Checklist for Category 2 (Include in Section F.3.1 of proposal)
Exhibit 33	Proposal Submission Checklist (Include after the proposal's Table of Contents)

7.8.5 **PART 2: PROPOSED PROGRAM AND BUDGET SECTION – CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR YMSM**

For Part 2 of the proposal, Proposer must note that if it's applying for more than one (1) service category and/or cluster area Proposer must provide a **separate "Part 2" for each service category and/or cluster area for which Proposer is applying for funding.**

Proposer must divide and tab Part 2 of the proposal into separate sections, i.e., Part 2A: Proposed Program and Budget Section – Category 1: HIV and STD Prevention Services for YMSM (Category 1A, Northwest Cluster Area); Proposal Part 2B: Proposed Program and Budget Section – Category 1: HIV and STD Prevention Services for YMSM (Category 1B, South Cluster Area); and/or Proposal Part 2B: Proposed Program and Budget Section – Category 1: HIV and STD Prevention Services for YMSM (Category 1C, Central Cluster Area). Tabs should be properly labeled and must clearly separate each section of Proposer's Part 2 of the proposal.

Proposer's response must conform to the format and/or page limit specifications as indicated. In addition, Proposer must copy each of the RFP requirements/questions listed in each section (as applicable) and provide a subsequent response. The format and sequence of Part 2 is as follows:

7.8.5.1 **Executive Summary – Category 1 (Section E)**

Format: Narrative
Narrative Page Limit: 1 Page

Proposer must copy each of the RFP requirements/questions listed below, where applicable, and provide a subsequent response in its Section E.

1) Provide a brief summary of the proposed program and how the program coordinates all the HIV and STD prevention services to be provided to YMSM in the selected syndemic cluster area.

2) Briefly describe the goals, objectives, number of clients proposed to serve, and expected outcomes of the program, including strategies for recruitment and retention.

7.8.5.2 **Proposer's Approach to Providing Required Services – Category 1 (Section F)**

A. Logic Model Template – Category 1 (Section F.1)

Format: Appendix D, Required Forms, Exhibit 28
Page Limit: Not applicable

Proposer must submit a completed Exhibit 28, Logic Model Instructions and Template, of Appendix D, Required Forms in its Section F.1. Exhibit 28 provides a template and instructions for Proposer to use in completing Exhibit 28. Proposer should use this template to prepare their own logic model by following the instructions provided.

B. Statement of Need – Category 1 (Section F.2)

Format: Table and Narrative
Narrative Page Limit: 3 Pages

Proposer must copy each of the RFP requirements/questions listed below, where applicable,

and provide a subsequent response in its Section F.2 as follows:

1) Proposer must prepare an HIV and STD Prevention Services Summary table as shown in Table 13, HIV and STD Prevention Services Summary, and insert it into the Proposer's Section F.2, Statement of Need. Proposer must provide only the information requested in Table 13 as shown below. **Do not add or omit information required for any row in the table.**

Table 13. HIV and STD Prevention Services Summary (Category 1)

CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR YOUNG AFRICAN AMERICAN AND/OR LATINO MEN WHO HAVE SEX WITH MEN		
PROGRAM NAME:		
CATEGORY OF SERVICE (MARK ONLY ONE PER RESPONSE):		☐ Subcategory 1A (African American YMSM, 12-29 years of age)
		☐ Subcategory 1B (Latino YMSM, 12-29 years of age)
		☐ Subcategory 1C (African American and Latino YMSM, 12-29 years of age)
ADDRESS(S) OF PROGRAM SERVICE DELIVERY SITES (LIST EACH):		
ANNUAL FUNDING AMOUNT REQUESTED:		
TIER LEVEL FOR CLUSTER AREAS:	**TIER LEVEL 1**	☐ Central Cluster Area
		☐ South Cluster Area
	TIER LEVEL 2	☐ East Cluster Area
		☐ North Cluster Area
		☐ Northwest Cluster Area

2) Proposer must provide a narrative demonstrating an in-depth understanding of the service needs of YMSM in the targeted service area, in particular those service needs related to an increased risk for HIV and STD infections. Include the data used to support the need for the services as described.

C. Program Plan – Category 1 (Section F.3)

Proposer must copy each of the RFP requirements/questions listed below, where applicable, and provide a subsequent response in Proposer's Section F.3.

1) Program Design – Category 1 (Section F.3.1)

Format: Appendix D, Required Forms: Exhibits 32A, 30A, 31 and narrative

Narrative Page Limit: 20 Pages

Proposer's narrative should focus on describing what the proposed intervention is, how and why it has a high likelihood of success and how it will achieve the concepts and components of the program requirements as outlined in Section 1.2 of this RFP. Proposer must also submit a completed Exhibit 32A, Program Components Checklist for Category 1 in its Section F.3.1.

Note: Utilizing background data and research materials in addition to Appendix Q, HIV and STD Epidemiological Data and Program Research on Young African American and Latino Men who have Sex with Men, and Appendix R, Issue Report, will be helpful (but not required) in developing a program plan and formulating a response to the following questions:

Program Design Questions- Category 1

a) Provide a clear and concise description of how the proposed program **design will incorporate** or address each of the program concepts described in RFP sub-paragraph 1.2.1, Program Concepts for Category 1:

1. Innovative in design – Proposer should reflect on prior successful evidence-based programs and explain how that knowledge is used to develop innovative ways to implement new and improved programming that is appropriate and attractive to YMSM in LAC.

2. Holistic in concept – Proposer should explain how the proposed program is designed to improve whole body health (mental, physical and spiritual) of YMSM, as well as integrated with all aspects of HIV and STD screening and treatment services and linkage to care services.

3. Collaborative in design and implementation – Proposer must describe how the proposed program:

    a. Was developed collaboratively with the CAB;
    b. Is responsive to the needs of the target population;
    c. Is inclusive in its implementation and collaborative with a cross-section of partners and stakeholders;
    d. Is innovative in design; and
    e. Is holistic in concept.

    Additionally, Proposer must submit the following:

    i. A completed Exhibit 30A,

Community Advisory Board Affidavit of Appendix D, Required Forms.

ii. A Letter of Concurrence, Exhibit 31, verifying the proposed program as described in Section 1.2.1 (3).

b) Describe how the proposed program incorporates all the elements of the program components as presented below and in RFP sub-paragraph 1.2.2, Program Components for Category 1 by describing Proposer's programmatic approach to each component below:

1. Focused on youth development – Proposer must explain how the proposed program meets the needs which young people, ages 12 – 29 years, have identified for themselves, as described in RFP Sub-section 1.2.2 (1).

2. Addressing social determinant of health – In their narrative Proposer must:

   a. Indicate which SDoH was selected from RFP sub-paragraph 1.2.2, Program Components for Category 1 (Table 1) to be addressed through a program intervention;
   b. Indicate if Proposer has selected its own SDoH to address through a program intervention;
   c. Clearly describe how the intervention(s) will effectively impact the selected SDoH;

d. Provide an evidence-based rationale for the selected intervention(s) and appropriately cite all background resources used to develop the intervention;
e. Provide compelling evidence that indicates a likelihood of success based on Proposer's supporting data which indicates the selected intervention(s) will effectively improve the health of YMSM; and
f. Describe what outcome is expected to result from the proposed intervention.

In addition to addressing at least one SDoH from Table 1, Proposer has the option to address additional SDoH not outlined in Table 1, provided the following criteria are met:

1. Proposer must address a minimum of <u>one</u> SDoH listed in Table 1 (addressing a SDoH not listed in Table 1 does not replace the requirement to address at least one SDoH in Table 1);

2. Proposer must clearly demonstrate the benefit of addressing the SDoH proposed in addition to those in Table 1, and explain how addressing the proposed SDoH would be in the best interest of, and benefit to YMSM in the selected location of service (see RFP sub-paragraph 1.2.4, Location of Services); and

3. Proposer must demonstrate how addressing SDoH not included in Table 1 will help meet the program goals and objectives (Appendix B-1, Statement of Work – Category 1, Section 1.1.1, Primary Goals and Objectives (Table 1) and Section 1.1.2, Program Goals and Objectives (Table 2)).

3. Promoting resiliency and protective factors: Proposer narrative must demonstrate how it promotes at least two resiliency and protective factors that impact each SDoH the Proposer has selected to address.
   a. Proposer's must select two or more resiliency and protective factors from the list provided in Table 2, RFP sub-paragraph 1.2.2, Program Components for Category 1, or propose its own well-justified and evidence-based, alternative resiliency and protective factors, to address the selected SDoH;
   b. Proposer must present supporting evidence justifying the choice of the resiliency and protective factors, specifically citing any published literature that describes how the selected intervention(s) will be used to promote the resiliency and protective factor(s) the program utilizes (see RFP sub-paragraph 1.2.2, Program Components for Category 1); and
   c. Proposer must describe how the proposed intervention(s) will be used to promote the chosen resiliency and protective factor(s) in its implementation.

4. Utilizing technology - Proposer must include a description of how the proposed program intends to incorporate the latest technology and media used by youth to stay socially connected.

c) Proposer must provide a description of how the proposed program incorporates each component described in RFP sub-paragraph 1.2.3, HIV and STD Screening Program Components for Category 1:

1. Screen for Benefits Programs – Proposer must describe how it will implement a comprehensive approach that assesses all sources of public and private client benefits available to YMSM for HIV and STD screening, treatment and care services in order to identify available third-party payer sources for eligible YMSM.

2. Conduct HIV Screening – Proposed programs must include a detailed response to the following:

    a. Describe who and how outreach efforts will be implemented to promote HIV screening availability to YMSM;
    b. Discuss how on-site HIV screening is to be provided at the primary service delivery site;
    c. What procedure will proposed program follow to obtain DHSP approval prior to implementing additional HIV screening sites;
    d. How will the proposed program maintain appropriate medical oversight of HIV screening services;

e. Explain how HIV screening services will be targeted to YMSM and their sexual and needle-sharing partners; and
f. Describe methods to ensure HIV screening services are provided consistent with federal, State and local guidelines and policies.

3. Conduct STD Screening – Proposed programs must include a detailed response to the following:

   a. Describe how outreach efforts will be implemented to promote availability of STD screening services to YMSM;
   b. Discuss how on-site STD screening will be provided at the primary service delivery site;
   c. What procedure will proposed program follow to obtain DHSP approval prior to implementing additional STD screening sites;
   d. How will the proposed program maintain appropriate medical oversight of STD screening services;
   e. Explain how STD screening services will be targeted to YMSM and their sexual and needle sharing partners; and
   f. Describe methods to ensure STD screening services are provided consistent with federal, State and local guidelines and policies.

4. Provide Treatment for STD Infections – Proposer must clearly and concisely answer either the first three questions (a, b, c) or the last question (d), but **not all four (4)**:

a. Explain how Proposer will provide necessary STD treatment to clients on the day of diagnosis and in the same location;
b. Discuss how STD treatment services will be provided consistent with federal, State and local guidelines, policies and procedures;
c. Describe how proposed program will maintain appropriate medical oversight of treatment services; **OR**
d. Describe how the proposed program will ensure that where on-site STD treatment services are not available, linkage to STD treatment services will be made.

5. Provide Linkage and Re-Engagement into HIV Medical Care – Proposer must demonstrate how it will ensure:

    a. Successful linkage of newly diagnosed HIV positive YMSM to HIV medical care and treatment; and
    b. Successful re-engagement of HIV positive YMSM known to be out of care into HIV medical care and treatment services.

6. Ensure Access To Education About Biomedical HIV Prevention Services – Describe how proposed program will ensure one hundred percent (100%) of program participants who request services are provided access to educational services regarding the availability of Biomedical HIV Prevention Services. Proposed programs must clearly and concisely respond to the

following:

a. Describe how proposer will ensure referrals are provided to YMSM who request HIV PrEP services for HIV; and
b. Discuss how referrals will be provided to YMSM requesting PEP services within the recommended 72-hour time period of sexual or needle-sharing exposure.

7. Provide Linkage to Partner Services – Proposer must provide a description of how verifiable, recorded linkage for one hundred percent (100%) of newly diagnosed YMSM with HIV, syphilis or gonorrhea will be made to the LAC DHSP Partner Counseling and Referral Services.

d) Describe how the proposed program will coordinate and link clients with other, non-HIV-specific resources in the community.

e) Explain how the proposed project is developed on a foundation of evidence-based practice. Proposer should cite such evidence in the plan.

2) Expected Outcomes – Category 1 (Section F.3.2)

Format: Narrative
Narrative Page Limit: 2 Pages

Describe the expected outcomes of the proposed program. Proposer must include the following elements in its response:

a) Provide a summary of what the expected

outcomes will be (e.g., number of HIV and STD tests, successful linkage to care rates, percentage increase in health care access and literacy, other behavioral outcomes, etc.).

b) Discuss the quality improvement process the proposer will implement to ensure outcomes will be met.

D. Management Plan – Category 1 (Section F.4)

Format: Job Descriptions/ Qualifications, Resumes, Organization Chart, and Narrative

Narrative Page Limit: 10 Pages

In this section Proposer should describe the management plan for the proposed program. Proposer should include descriptions of staff qualifications as they relate to the service(s) being proposed.

In addition, Proposer must provide brief job descriptions and qualifications for all staff that will provide services under any resultant contract.

Note: The required staff job descriptions and qualifications do not count towards the page limit.

Proposer must copy each of the RFP requirements/questions listed below, where applicable, and provide a subsequent response in its F.4 as follows:

1) Organizational Capacity and Relationships – Category 1 (Section F.4.1)

a) Describe the personnel policies and procedures which exist within the organization to assure that qualified staff are recruited, trained in a culturally and linguistically competent manner,

and supervised in a way that optimizes the impact of the services to be provided.

b) Attach résumés***** of key program staff that will provide services under the proposed program. Résumés should include staff qualifications and certifications as appropriate (refer to Appendix B-1, Statement of Work for Category 1, Paragraph 6.2, Program Manager and Paragraph 6.3, Personnel).

c) Describe how issues such as fund-raising, data management, financial management and capacity, human resources and other operations issues will be addressed for the proposed program.

d) Provide an organizational chart***** that indicates the number of full-time equivalent (FTE) employees dedicated to the proposed program and the lines of reporting authority.

***Note:** The résumés and organizational chart do not count toward the page limit.

2) Staffing and In-kind Support Plan – Category 1 (Section F.4.2)

Describe the staffing plan for the proposed program. The staffing plan should be consistent with the Proposer's Program Budget (Section H of the proposal) and must include key staff from all organizations involved (if more than one):

a) Indicate how many FTE employees will implement the proposed program. Be sure to designate those employees dedicated to the programmatic intervention activities and those to HIV and STD screening and STD treatment services.

b) Provide an explanation of the roles or functions that each staff person performs and staff qualifications for each position.

c) State the proportion of each employee's time to be spent on the proposed program.

d) Describe the standard that will be used to determine staff are culturally competent; and how culturally competent staff will be recruited and trained initially and on an on-going basis.

e) Describe how qualified staff will be retained to ensure consistency and efficiency of the proposed program.

3) Community Advisory Support Plan – Category 1 (Section F.4.3)

Proposer must submit a Community Advisory Board Support Staffing Plan that describes, at a minimum, how it will achieve each of the activities described in Appendix B-1, Statement Work for Category 1, Section 9.3.

4) Data Reporting Plan – Category 1 (Section F.4.4)

Proposer must present a data reporting plan, including the following elements:

a) Describe how client-level data will be collected and reported.

b) Describe the client-level tracking systems, currently in place or proposed, that will be used to track clients under the proposed program.

c) List all the data management systems your organization or network of organizations needs to utilize in order to accurately track and report client-level data.

d) Describe in detail the data reporting roles of the lead agency and subcontractors (if applicable), and how the lead agency will coordinate the reporting efforts, and ensure complete data reporting to DHSP.

E. Scope of Work - Units of Service – Category 1 (Section F.5)

Format: Appendix D, Required Forms: Exhibit 27
Page Limit: 2-Page Narrative Page Limit

Proposer must complete and submit Appendix D, Required Forms - Exhibit 27, Sample Scope of Work and Template in its Section F.5 of the proposal. Proposer is advised that **no other format and/or template will be accepted.** When developing Proposer's Scope of Work, Proposer must follow the instructions and guidelines provided in Exhibit 27 to outline the Proposer's objectives, implementation activities, timeline for completion, and method(s) of evaluating objective(s) and documentation of the proposed program for a 12-month period. Proposer's Scope of Work should indicate exactly how the program design will be implemented in practice. Exhibit 27 should be used by the Proposer as a guideline for completing this section.

Below are details that will assist Proposer in developing their scope of work:

1) Proposer should develop a plan that incorporates activities which will address all of the specific work requirements covered in Appendix B-1, Statement of Work for Category 1, Section 9.0, Specific Work Requirements for a twelve month period.

2) Proposer establishing partnerships and formal agreements with subcontractors or consultants to accomplish specific work requirements should

clearly identify which activities the subcontractor or consultant will accomplish.

Additionally, in narrative format (2-page limit) Proposer should address the following:

3) Proposer must explain how it will determine whether all County goals and objectives, as well as, Proposer's stated goals and objectives for Appendix D, Required Forms, Exhibit 27, Sample Scope of Work Template, are met.

7.8.5.3 Evaluation and Quality Management Plan – Category 1 (Section G)

Proposer must present a comprehensive Evaluation and Quality Management Plan to be utilized by the Proposer as a self-monitoring tool to ensure the required services are provided as specified in Appendix B-1, Statement of Work for Category 1.

Format: Narrative
Page Limit: 10 pages

Proposer must copy each of the RFP requirements/questions listed below, where applicable, and provide a subsequent response in its Section G as follows:

1. Describe the evaluation and quality management activities proposed for this program. The Proposer's description should include program indicators, health outcomes, and the process to collect data.

2. Describe how the Proposer will document all monitoring methods. In Proposer's response, include the frequency of monitoring and documenting method including any corrective action steps.

3. Describe how this program will incorporate staff, client and CAB feedback to improve services.

4. Describe the training and ongoing technical assistance

staff will receive to ensure that evaluation and quality management activities and protocols are being properly implemented.

5. Discuss the level of staff who will evaluate activities and their qualifications to ensure compliance with all Contract requirements.

6. Describe how Proposer plans to ensure services are culturally and linguistically competent.

7. Describe strategies to ensure that the data submitted to DHSP is accurate, complete, and submitted in a timely manner.

7.8.5.4 Program Budget – Category 1 (Section H)

Format:	Appendix C-1A, C-1B, C-1C, C-1D, C-1E, C-1F, C-1G, C-1H, and Exhibit 29
Page Limit:	1 Page (where indicated)

Proposer must follow the instructions provided pursuant to Appendix C, Budget Instructions when preparing the applicable budget forms. **Proposer is advised the below listed budget forms must be submitted for each proposal submitted under Category 1.** Proposer must submit the following budget forms in its Section H as follows:

1. Budget Forms: Program Concept and Component Related Costs

1) Appendix C-1A: 1-Page Budget Narrative for Program Concept and Component Related Costs
2) Appendix C-1B: Line Item Budget for Program Concept and Component Related Costs
3) Appendix C-1C: Budget Summary Justification for Program Concept and Component Related Costs

2. Budget Forms: HIV and STD Screening Program Component Related Costs

1) Appendix C-1D: 1-Page Narrative for HIV and STD Program Component Related Costs
2) Appendix C-1E: Line Item Budget for HIV and

STD Program Component Related Costs
3) Appendix C-1F: Budget Summary Justification for HIV and STD Program Component Related Costs

3. Budget Forms: Disclosure of Additional Resources for HIV and STD Prevention Services

1) Appendix D, Required Forms, Exhibit 29: Proposer's Funding Disclosure Form
2) Appendix C-1G: 1-Page Exhibit 29 Supplemental

4. Budget Forms: Total Program Costs

1) Appendix C-1H: Total Program Costs

Each of Proposer's budget forms should only reflect costs associated with its proposed program(s) and must:

1) Be feasible and cost effective for the proposed quantity and quality of activities pursuant to Appendix B-1, Statement of Work for Category 1 **and** Exhibit 27, Sample Scope of Work and Template;
2) Include staffing patterns that are appropriate for the proposed program services;
3) Provide operating costs that are consistent with the quantity and type of services proposed;
4) Include justification that is detailed and has adequate rationale for each line item expenditure; and
5) Be submitted utilizing the budget format provided and with the correct calculations.

Proposer is advised that budget forms referenced above are the only budget formats acceptable. Any other formats will not be accepted and shall result in Proposer receiving zero/no points for this section of the evaluation.

7.8.6 PART 2: PROPOSED PROGRAM AND BUDGET SECTION – CATEGORY 2: HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS

For Part 2 of the proposal, Proposer must note that if its proposing to serve more than one target area, Proposer must provide a separate **"Part 2" for each target area.**

Proposer must divide and tab his/her Part 2 of the proposal into separate sections, i.e., Part 2A: Proposed Program and Budget Section – Category 2: HIV and STD Prevention Services for Transgender Individuals (Central); Proposal Part 2B: Proposed Program and Budget Section – Category 2: HIV and STD Prevention Services for Transgender Individuals (South). Tabs should be properly labeled and must clearly separate each section of Proposer's Part 2 of the proposal.

Proposer's response must conform to the Format and/or Page Limit specifications as indicated. In addition, Proposer must copy each of the RFP requirements/questions listed in each section (as applicable) and provide a subsequent response. The format and sequence of Part 2 is as follows:

7.8.6.1 **Executive Summary – Category 2 (Section E)**

Format: Narrative
Page Limit: 1 Page

Proposer must copy each of the RFP requirements/questions listed below, where applicable, and provide a subsequent response in its Section E.

1) Provide a brief summary of the proposed program and how the program coordinates all the HIV and STD prevention services to be provided to transgender people in the selected target area.

2) Briefly describe the goals, objectives, number of clients proposed to serve, and expected outcomes of the program, including strategies for recruitment and retention.

7.8.6.2 **Proposer's Approach to Providing Required Services – Category 2 (Section F)**

A. Logic Model Template – Category 2 (Section F.1)

Format: Appendix D, Required Forms, Exhibit 28
Page Limit: Not applicable

Proposer must submit a completed Exhibit 28, Logic Model Instructions and Template, of Appendix D, Required Forms in its Section F.1. Exhibit 28 provides a template and instructions for Proposer to use in completing Exhibit 28. Proposer should use this template to prepare their own logic model by following the instructions provided.

B. Statement of Need – Category 2 (Section F.2)

Format: Table and Narrative
Narrative Page Limit: 3 Pages

Proposer must copy each of the RFP requirements/questions listed below, where applicable, and provide a subsequent response in its Section F.2 as follows:

1) Proposer must prepare an HIV and STD Prevention Services Summary table as shown in Table 14, HIV and STD Prevention Services Summary, and insert it into the Proposer's Section F.2, Statement of Need. Proposer must provide only the information requested in Table 14 as shown below. **Do not add or omit information required for any row in the table.**

Table 14. HIV and STD Prevention Services Summary (Category 2)

CATEGORY 2: HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS		
PROGRAM NAME:		
ADDRESS(S) OF PROGRAM SERVICE SITES(LIST EACH):		
ANNUAL FUNDING AMOUNT REQUESTED:		
TARGET AREA(S) OF SERVICE :	**Central**	☐ Downtown Los Angeles area ☐ Hollywood/Santa Monica Boulevard area
	South	☐ City of Long Beach
		☐ Other _____

2) Proposer must provide a narrative demonstrating an in-depth understanding of the service needs of transgender individuals, in the location where services are being proposed, and particular those service needs related to an increased risk for HIV and STD infections. Include the data used to support the need for these services as described.

3) Proposer selecting an area of service, other than a County targeted area of service, must provide a well-justified explanation with compelling data to show that the location is in an area accessible and attractive to transgender individuals.

C. Program Plan – Category 2 (Section F.3)

Proposer must copy each of the RFP requirements/questions listed below, where applicable, and provide a subsequent response in Proposer's Section F.3.

1) Program Design – Category 2 (F.3.1)

Format: Appendix D, Required Forms: Exhibits 32B, 30B, 31 and narrative

Narrative Page Limit: 20 Pages

Proposer's narrative should focus on describing what the proposed intervention is, how and why it has a high likelihood of success and how it will achieve the concepts and components of the program requirements as outlined in Section 1.3 of this RFP. Proposer must also submit a completed Exhibit 32B, Program Components Checklist for Category 2 in its Section F.3.1.

Note: Utilizing the background data and research materials presented in Appendix S, HIV and STD Epidemiological Data and Program Research on Transgender Individuals, and Appendix T, *Getting to Wellness*, will be helpful (but is not required) in developing a program plan and formulating a response to the following questions:

Program Design Questions – Category 2

a) Provide a clear and concise description of how the proposed program **design will incorporate or** address each of the program concepts described in RFP sub-paragraph 1.3.1, Program Concepts for Category 2:

1) Innovative in design – Proposer should reflect on prior successful evidence-based programs and explain how that knowledge is used to develop innovative ways to implement new and improved programming that is appropriate and attractive to transgender individuals in LAC.

2) Holistic in concept – Proposer should explain how the proposed program is designed to improve whole body health (mental, physical and spiritual health) of transgender individuals, as well as providing all aspects of HIV screening and linkage to care services and STD screening and treatment services.

3) Collaborative in design and implementation – Proposer must describe how the proposed program:
   a. Was developed collaboratively with the CAB;
   b. Is responsive to the needs of the target population;
   c. Is inclusive in its implementation and collaborative with a cross-section of partners and stakeholders;
   d. Is innovative in design; and
   e. Is holistic in concept.

   Additionally, Proposer must submit the following:
      i. A completed Exhibit 30B, Community Advisory Board

Affidavit of Appendix D, Required Forms.

ii. A Letter of Concurrence, Exhibit 31, verifying the proposed program as described in Section 1.3.1 (3).

b) Describe how the proposed program incorporates all the elements of the program components as presented in RFP sub-paragraph 1.3.2, Program Components for Category 2 by describing Proposer's programmatic approach to each component below:

1. Incorporate youth development – Proposer must explain how the proposed program will incorporate a youth development component that meets the needs expressed by young people, ages 12 – 29 years.

2. Addressing social determinant of health –In their narrative Proposer must:

   a. Indicate which SDoH was/were selected from RFP sub-paragraph 1.3.2, Program Component from Category 2 (Table 6) to be addressed through a program intervention;
   b. Indicate if Proposer has selected its own SDoH to address through a program intervention;
   c. Clearly describe how the intervention(s) will effectively impact the selected SDoH;
   d. Provide an evidence-based rationale for the selected intervention(s) and appropriately cite all resources used to develop the intervention;
   e. Provide compelling evidence that indicates a likelihood of success based on Proposer's supporting data which indicates the selected intervention(s) will effectively improve the health of transgender individuals; and
   f. Describe what outcomes are expected to result from the proposed intervention.

In addition to addressing at least one SDoH from Table 6, Proposer has the option to address additional SDoH not outlined in Table 6, provided the following criteria are met:

1. Proposer must address a minimum of <u>one</u> SDoH listed in Table 6 (addressing a SDoH not listed in Table 6 does not replace the requirement to address at least one SDoH in Table 6);

2. Proposer must clearly demonstrate the benefit of addressing the SDoH proposed in addition to those in Table 6, and explain how addressing the proposed SDoH would be in the best interest of, and benefit transgender people in the selected location of service (see RFP sub-paragraph 1.3.4, Location of Services); and

3. Proposer must demonstrate how addressing SDoH not included in Table 6 will help meet the program goals and objectives (Appendix B-2, Statement of Work – Category 2, Section 1.1.1, Primary Goals and Objectives (Table 1) and Section 1.1.2, Program Goals and Objectives (Table 2)).

3. <u>Promoting resiliency and protective factors</u>: The Proposer narrative must demonstrate how the proposed program promotes at least <u>two</u> resiliency and protective factors that impact each SDoH the Proposer has selected to address.

a. Proposer must select two or more resiliency and protective factors from the list provided in Table 7, RFP sub-paragraph 1.3.2, Program Components for Category 2, or propose its own, if its well-justified and evidence-based, alternative resiliency and protective factors, to address the selected SDoH;
b. Proposer must present supporting evidence justifying the choice of the resiliency and protective factors, specifically citing any published literature that describes how the selected intervention(s) will be used to promote the resiliency and protective factor(s) the program utilizes (see RFP sub-paragraph 1.3.2, Program Components for Category 2); and
c. Proposer must describe how the proposed intervention(s) will be used to promote the chosen resiliency and protective factor(s) in implementation.

4. Utilizing technology - Proposer must include a description of how the intervention will incorporate the latest technology and media used by transgender individuals to stay socially connected.

c) Proposer must provide a description of how the proposed program incorporates each component described in RFP sub-paragraph 1.3.3, HIV and STD Screening Program Components for Category 2:

1) Screen for benefits programs – Proposer must describe how it will implement a comprehensive approach that assesses all sources of public and private client benefits available to transgender persons for HIV and STD screening, treatment and care services in order to identify available third-party payer sources for eligible transgender persons.

2) Conduct HIV screening – Proposed programs must include a detailed response to the following:

   a. Describe how outreach efforts will be implemented to promote HIV screening availability to transgender individuals;
   b. Discuss how on-site HIV screening is to be provided at the primary service delivery site;
   c. What procedure will proposed program follow to obtain DHSP approval prior to implementing additional HIV screening sites;
   d. How will the proposed program maintain appropriate medical oversight of HIV screening services;
   e. Explain how HIV screening services will be targeted to transgender individuals and their sexual and needle-sharing partners; and
   f. Describe methods to ensure HIV screening services are provided consistent with federal, State and local guidelines and policies.

3) Conduct STD screening – Proposed programs must include a detailed response to the following:

   a. Describe how outreach efforts will be implemented to promote availability of STD screening services to transgender persons;
   b. Discuss how on-site STD screening will be provided at the primary service delivery site;
   c. What procedure will proposed program follow to obtain DHSP approval prior to implementing additional STD screening sites;

d. How will the proposed program maintain appropriate medical oversight of STD screening services;
e. Explain how STD screening services will be targeted to transgender individuals and their sexual and needle sharing partners; and
f. Describe methods to ensure STD screening services are provided consistent with federal, State and local guidelines and policies.

4) Provide treatment for STD infections - Proposer must clearly and concisely answer either the first three questions (a, b, c) or the last question (d), but **not all four (4)**:

a. Explain how Proposer will provide necessary STD treatment to clients on the day of diagnosis and in the same location;
b. Discuss how STD treatment services will be provided consistent with federal, State and local guidelines, policies and procedures;
c. Describe how proposed program will maintain appropriate medical oversight of treatment services; **OR**
d. Describe how proposed program will ensure that where on-site STD treatment services are not available, linkage to STD treatment services will be made.

5) Provide Linkage and Re-Engagement into HIV Medical Care – Proposer must demonstrate how it will ensure:

a. Successful linkage of newly diagnosed HIV positive transgender individuals to

HIV medical care and treatment; and

b. Successful re-engagement of HIV positive transgender individuals known to be out of care into HIV medical care and treatment services.

6) Ensure Access to Education About Biomedical HIV Prevention Services – Describe how proposed program will ensure one hundred percent (100%) of transgender persons who request services are provided access to educational services regarding the availability of Biomedical HIV prevention services. Proposed programs must clearly and concisely respond to the following:

   a. Explain how proposed program will ensure referrals are provided to transgender individuals who request PrEP services; and
   b. Discuss how referrals will be provided to transgender individuals requesting PEP services within the recommended seventy-two (72) hour period of sexual or needle-sharing exposure.

7) Provide Linkage to Partner Services – Proposer must provide a description of how verifiable, recorded linkage for one hundred percent (100%) of newly diagnosed transgender individuals with HIV, syphilis, or gonorrhea will be made to LAC DHSP Partner Counseling and Referral Services.

d) Describe how the proposed program will coordinate and link clients with other, non-HIV-specific resources in the community.

e) Explain how the proposed program is developed on a foundation of evidence-based practice. Proposer should cite such evidence in the plan.

2) Expected Outcomes – Category 2 (Section F.3.2)

Format: **Narrative**
Page Limit: **2 Pages**

Describe the expected outcomes of the proposed program. Proposer must include the following elements in its response:

a) Provide a summary of what the expected outcomes will be (e.g., number of HIV and STD tests, successful linkage to care rates, percentage increase in health care access and literacy, other behavioral outcomes, etc.).

b) Discuss the quality improvement process the proposer will implement to ensure outcomes will be met.

D. Management Plan – Category 2 (Section F.4)

Format: Job Descriptions/Qualifications, Resumes, Organization Chart and Narrative
Narrative Page Limit: 10 Pages

In this section Proposer should describe the management plan for the proposed program. Proposer should include descriptions of staff qualifications as they relate to the service(s) being proposed.

In addition, Proposer must provide brief job descriptions and qualifications for all staff that will provide services under any resultant contract.

Note: The required staff job descriptions and qualifications do not count towards the page limit.

Proposer must copy each of the RFP requirements/questions listed below, where applicable, and provide a subsequent response in its Section F.4 as follows:

1) Organizational Capacity and Relationships – Category 2 (Section F.4.1)

a) Describe the personnel policies and procedures which exist within the organization to assure that qualified staff are recruited, trained in a culturally and linguistically competent manner, and supervised in a way that optimizes the impact of the services to be provided.

b) Attach résumés* of key program staff that will provide services under the proposed program. Résumés should include staff qualifications and certifications as appropriate (refer to Appendix B-2, Statement of Work for Category 2, Paragraph 6.2, Program Manager and Paragraph 6.3, Personnel).

c) Describe how issues such as fund-raising, data management, financial management and capacity, human resources and other operations issues will be addressed for the proposed program.

d) Provide an organizational chart* indicates the number of full-time equivalent (FTE) employees dedicated to the proposed program and the lines of reporting authority.

***Note:** The résumés and organizational chart do not count toward the page limit.

2) Staffing and In-kind Support Plan– Category 2 (Section F.4.2)

Describe the staffing plan for the proposed program. The staffing plan should be consistent with the Proposer's Program Budget (Section H of the proposal) and must include key staff from all organizations involved (if more than one):

a) Indicate how many FTE employees will implement the proposed program. Be sure to designate those employees dedicated to the programmatic intervention activities and those to

HIV and STD screening and STD treatment services.

b) Provide an explanation of the roles or functions that each staff person performs and staff qualifications for each position.

c) State the proportion of each employee's time to be spent on the proposed program.

d) Describe the standard that will be used to determine staff are culturally competent and how culturally competent staff will be recruited and trained initially and on an on-going basis.

e) Describe how qualified staff will be retained to ensure consistency and efficiency of the proposed program.

3) Community Advisory Support Plan – Category 2 (Section F.4.3)

Proposer must submit a Community Advisory Board Support staffing plan that describes, at a minimum, how it will achieve each of the activities described in Appendix B-2, Statement of Work for Category 2, Section 9.3.

4) Data Reporting Plan- Category 2 (Section F.4.4)

Proposer must present a data reporting plan, including the following elements:

a) Describe how client-level data will be collected and reported.

b) Describe the client-level tracking systems, currently in place or proposed, that will be used to track clients under the proposed program.

c) List all the data management systems the Proposer's organization or network of organizations needs to utilize in order to accurately track and report client-level data.

d) Describe in detail the data reporting roles of the lead agency and subcontractors (if applicable), and how the lead agency will coordinate the reporting efforts, and ensure complete data reporting to DHSP.

E. Scope of Work - Units of Service – Category 2 (Section F.5)

Format: Appendix D, Required Forms: Exhibit 27
Narrative Page Limit: 2 Pages

Proposer must complete and submit Appendix D, Required Forms - Exhibit 27, Sample Scope of Work and Template in its Section F.5 of the proposal. Proposer is advised that **no other format and/or template will be accepted.** When developing Proposer's Scope of Work, Proposer must follow the instructions and guidelines provided in Exhibit 27 to outline the Proposer's objectives, implementation activities, timeline for completion, and method(s) of evaluating objective(s) and documentation of the proposed program for a 12-month period. Proposer's Scope of Work should indicate exactly how the program design will be implemented in practice. Exhibit 27 should be used by the Proposer as a guideline for completing this section.

Below are details that will assist Proposer in developing their scope of work:

1) Proposer should develop a plan that incorporates activities which will address all of the specific work requirements covered in Appendix B-2, Statement of Work for Category 2, Section 9.0, Specific Work Requirements for a twelve month period.

2) Proposer establishing partnerships and formal agreements with subcontractors or consultants to accomplish specific work requirements should clearly identify which activities the subcontractor or consultant will accomplish.

Additionally, in narrative format (2-page limit) Proposer should address the following:

3) Proposer must explain how it will determine whether all County goals and objectives, as well as, Proposer's stated goals and objectives for Appendix D, Required Forms, Exhibit 27, Sample Scope of Work Template, are met.

7.8.6.3 Evaluation and Quality Management Plan – Category 2 (Section G)

Proposer must present a comprehensive Evaluation and Quality Management Plan to be utilized by the Proposer as a self-monitoring tool to ensure the required services are provided as specified in Appendix B-2, Statement of Work for Category 2.

Format: Narrative
Page Limit: 10 Pages

Proposer must copy each of the RFP requirements/questions listed below, where applicable, and provide a subsequent response in its Section G as follows:

1. Describe the evaluation and quality management activities proposed for this program. The Proposer's description should include program indicators, health outcomes, and the process to collect data.

2. Describe how the Proposer will document all monitoring methods. In Proposer's response, include the frequency of monitoring and documenting method including any corrective action steps.

3. Describe how this program will incorporate staff, client and CAB feedback to improve services.

4. Describe the training and ongoing technical assistance staff will receive to ensure that evaluation and quality management activities and protocols are being properly implemented.

5. Discuss the level of staff who will evaluate activities and their qualifications to ensure compliance with all Contract requirements.

6. Describe how the Proposer plans to ensure services are culturally and linguistically competent.

7. Describe strategies to ensure that the data submitted to DHSP is accurate, complete, and submitted in a timely manner.

7.8.6.4 **Program Budget – Category 2 (Section H)**

Format:	Appendix C-1A, C-1B, C-1C, C-1D, C-1E, C-1F, C-1G, C-1H, and Exhibit 29
Page Limit:	1 Page (where indicated)

Proposer must follow the instructions provided pursuant to Appendix C, Budget Instructions when preparing the applicable budget forms. **Proposer is advised the below listed budget forms must be submitted for each proposal submitted under Category 2.** Proposer must submit the following budget forms in its Section H as follows:

1. Budget Forms: Program Concept and Component Related Costs

1) Appendix C-1A: 1-Page Budget Narrative for Program Concept and Component Related Costs
2) Appendix C-1B: Line Item Budget for Program Concept and Component Related Costs
3) Appendix C-1C: Budget Summary Justification for Program Concept and Component Related Costs

2. Budget Forms: HIV and STD Screening Program Component Related Costs

1) Appendix C-1D: 1-Page Narrative for HIV and STD Program Component Related Costs
2) Appendix C-1E: Line Item Budget for HIV and STD Program Component Related Costs
3) Appendix C-1F: Budget Summary Justification for HIV and STD Program Component Related Costs

3. Budget Forms: Disclosure of Additional Resources for HIV and STD Prevention Services

1) Appendix D, Required Forms, Exhibit 29: Proposer's Funding Disclosure Form
2) Appendix C-1G: 1-Page Exhibit 29 Supplemental

4. Budget Forms: Total Program Costs

1) Appendix C-1H: Total Program Costs

Each of Proposer's budget forms should only reflect costs associated with its proposed program(s) and must:

1) Be feasible and cost effective for the proposed quantity and quality of activities pursuant to Appendix B-2, Statement of Work for Category 2 **and** Exhibit 27, Sample Scope of Work and Template;
2) Include staffing patterns that are appropriate for the proposed program services;
3) Provide operating costs that are consistent with the quantity and type of services proposed;
4) Include justification that is detailed and has adequate rationale for each line item expenditure; and
5) Be submitted utilizing the budget format provided and with the correct calculations.

Proposer is advised that budget forms referenced above are the only budget formats acceptable. Any other formats will not be accepted and shall result in Proposer receiving zero/no points for this section of the evaluation.

7.9 Cost Proposal Format (Intentionally Omitted)

7.10 Firm Offer/Withdrawal of Proposal

Until the proposal submission deadline, errors in proposals may be corrected by a request in writing to withdraw the proposal and by submission of another set of proposals with the mistakes corrected. Corrections will not be accepted once the deadline for submission of proposals has passed.

7.11 Proposal Submission

The original Proposal and four (4) copies shall be enclosed in a sealed envelope or box, plainly marked in the upper left-hand corner with the name and address of the Proposer and bear the words:

"PROPOSAL FOR PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs, RFP NO.: #2015-003
SERVICE CATEGORY(IES)____
CLUSTER/TARGET AREA_____"

The proposal and the required number of copies must be hand-delivered or sent by a delivery service only (excluding U.S. Postal Service) and received by the deadline specified in Section 7.2, RFP Timetable, to:

Maritza Recinos, Contracts Analyst
County of Los Angeles,
Department of Public Health
Contracts and Grants Division
600 South Commonwealth Avenue, 7th Floor, Suite 700
Los Angeles, California 90005

It is the sole responsibility of the submitting Proposer to ensure that its Proposal is received before the submission deadline. Submitting Proposer shall bear all risks associated with delays in delivery by any person or entity, including the U.S. Mail. Late proposals received on the due date, but after the scheduled closing time for receipt of Proposals, as listed in Paragraph 7.2, RFP Timetable, will not be evaluated but will be time-stamped and set aside unopened. At the Interim Director's sole discretion, these late proposals may be considered, in the order received, if a determination is made that there is a specific unmet need. Late proposals received after the due date will be time-stamped and returned unopened. Timely hand-delivered Proposals are acceptable. No facsimile (fax) or electronic mail (e-mail) copies will be accepted.

All proposals shall be firm offers and may not be withdrawn for a period of **365 days** following the last day to submit proposals.

8.0 SELECTION PROCESS AND EVALUATION CRITERIA

8.1 Selection Process

The County reserves the sole right to judge the contents of the proposals submitted pursuant to this RFP and to review, evaluate and select the successful proposal(s). The selection process will begin with receipt of the proposal pursuant to RFP Paragraph 7.2, RFP Timeline.

Evaluation of the proposals will be made by an Evaluation Committee selected by the Department. The Committee will evaluate the proposals and will use the evaluation approach described herein to select a prospective Contractor(s). All proposals will be evaluated based on the criteria listed below. Proposals will be evaluated by service category, as well as Tier Level for Category 1, and scored and ranked in numerical sequence from high to low. Upon completion of ranking, funds will be allocated taking into account population and/or target area needs. The County may also, at its option, invite Proposer(s) being evaluated to make a verbal presentation or conduct site visits, if appropriate. The Evaluation Committee may utilize the services of appropriate experts to assist in this evaluation.

After a prospective Contractor(s) has been selected, the County and the prospective Contractor(s) will negotiate a Contract for submission to the Board of Supervisors for its consideration and possible approval. If a satisfactory Contract cannot be negotiated, the County may, at its sole discretion, begin contract negotiations with the next qualified Proposer who submitted a proposal, as determined by the County.

The recommendation to award a Contract will not bind the Board of Supervisors to award a Contract to the prospective Contractor.

The County retains the right to select a proposal other than the proposal(s) receiving the highest number of points if County determines, in its sole discretion, another proposal is qualified, cost-effective, responsive, responsible , and/or meets a service category need based on population and/or area to be served, and/or is in the best interests of the County.

8.2 Stage 1 Review: Adherence to Minimum Mandatory Qualifications (Pass/Fail)

County shall review the information provided in Proposer's Exhibit 1A – Proposer's Organization Questionnaire/Affidavit for Category 1 and/or Proposer's Exhibit 1B - Proposer's Organization Questionnaire/Affidavit for Category 2 submitted in Section A.1 of the proposal and Proposer's information provided in response to Exhibit 26A, Proposer's Minimum Mandatory Qualifications Form for Category 1 and/or Exhibit 26B Proposer's Minimum Mandatory Qualifications Form for Category 2 submitted in Section A.2 of the proposal to determine if the Proposer meets all of the Minimum Mandatory Qualifications as outlined in RFP Paragraph 3.0., Minimum Mandatory Qualifications. This is a "Pass" or "Fail" section. Proposer must "Pass" each of the Minimum Mandatory Qualifications in order to "Pass" the entire Stage 1 Review.

8.3 Disqualification Review

A proposal may be disqualified from consideration because a Department determined it was non-responsive at any time during the review/evaluation process. If a Department determines that a proposal is disqualified due to non-responsiveness, the Department shall notify the Proposer in writing. Upon receipt of the written determination of non-responsiveness, the Proposer may submit a written request for a Disqualification Review within the timeframe specified in the written determination.

A request for a Disqualification Review may, in the Department's sole discretion, be denied if the request does not satisfy all of the following criteria:

1. The person or entity requesting a Disqualification Review is a Proposer;
2. The request for a Disqualification Review is submitted timely (i.e., by the date and time specified in the written determination); and
3. The request for a Disqualification Review asserts that the Department's determination of disqualification due to non-responsiveness was erroneous (e.g. factual errors, etc.) and provides factual support on each ground asserted as well as copies of all documents and other material that support the assertions.

The Disqualification Review shall be completed and the determination shall be provided to the requesting Proposer, in writing, prior to the conclusion of the evaluation process.

Proposer can also be disqualified for non-responsibility – See Section 5.8

8.4 Stage 2 Review: Proposal Evaluation and Criteria (1,000 points)

The Stage 2 Review will consist of the sections listed below:

8.4.1 **Proposer's Qualifications – (95 Total Points)**

A. Proposer's Background and Experience (50 Points)

Proposer will be evaluated based on the information provided in Section A.2 of the proposal as it pertains only to Proposer's 1-Page Narrative for Category 1 and/or Category 2 (as applicable), pursuant to the questions/criteria outlined in RFP Paragraph 7.8.4.1, Proposer's Qualifications (Section A), subparagraph B, Proposer's Background and Experience (Section A.2), 1-Page Narrative for Category 1 and/or Category 2.

B. Proposer's References (45 Points)

Proposer will be evaluated on the verification of references provided on Appendix D, Required Forms, Exhibit 2, Prospective Contractor References, provided in Section A.3 of the proposal. In addition to the references provided, a review will include the County's Contract Database and Contractor Alert Reporting Database, and any other applicable databases (i.e., State or federal), reflecting past performance history on County or other contracts. This review may result in point deductions up to 100% of the total points awarded in this evaluation category.

In addition, a review of terminated contracts will be conducted which may result in point deductions, based on the information provided on Appendix D, Required Forms, Exhibit 4, Prospective Contractor List of Terminated Contracts.

C. Proposer's Pending Litigation (No Points)

A review will be conducted to determine the significance of any litigation or judgments pending against the Proposer based on the information provided in Section A.4 of the proposal. This review may result in point deduction(s).

8.4.2 **Financial Capability (No Points)**

Subject matter experts will evaluate and make a recommendation based on the financial strength and capability of the company in the provision of required services throughout the term of any resultant Contract, as well as evidence of the company's capability to absorb all costs related to the provision of services for a minimum of sixty (60) days, during any resultant Contract.

Proposers that submit financial statements that are determined to be deficient will be required to provide a performance security in the form of a certificate of deposit, letter of credit, or security bond prior to DPH making recommendations to the Board regarding the award of Contracts.

8.4.3 **Terms and Conditions in the Sample Contract and Requirements of the Statement of Work (SOW): Acceptance of / or Exceptions (No Points)**

Based on the information provided in Section C of the proposal, Proposer will be evaluated on their willingness to accept the Terms and Conditions outlined in the Sample Contract, Appendix A, and the Requirements of the Statement of Work outlined in the Statement of Work, Appendices B-1 and B-2. The County may deduct rating points or disqualify the proposal in its entirety if the exceptions are material enough to deem the proposal non-responsive.

Proposer is further notified that the County may, in its sole determination, disqualify any Proposer with whom the County cannot satisfactorily negotiate a Contract.

8.4.4 **Executive Summary (20 Total Points)**

Proposer will be evaluated based on the information provided in its

Section E of the proposal in response to the questions/criteria pursuant to RFP Paragraph 7.8.5.1, Executive Summary – Category 1 (Section E) and/or 7.8.6.1, Executive Summary – Category 2 (Section E) as applicable

8.4.5 **Proposer's Approach to Providing Required Services (705 Total Points)**

A. Logic Model Template – (40 Total Points)

Proposer's Exhibit 28, Logic Model Template (for Category 1 and/or 2) submitted in Section F.1 of the proposal will be evaluated based on the following criteria:

1. The conditions in which the proposed program will function and Proposer's ability to describe how program activities will lead to the outcomes.
2. Proposer's ability to effectively narrate a description of the requirements for each component of the logic model.
3. How the Proposer's narrative description follows a logical progression.
4. Proposer's ability to show the model effectively demonstrates how inputs will be leveraged to produce program activities designed to result in the expected program outcomes in the immediate (up to one year), intermediate (one to three years) and long-term (three years or greater).

B. Statement of Need – (50 Total Points)

Proposer will be evaluated based on the information provided in its Section F.2 of the proposal in response to the questions/criteria pursuant to RFP Paragraph 7.8.5.2, Statement of Need - Category 1 (Section F.2) and/or 7.8.6.2, Statement of Need - Category 2 (Section F.2) as applicable.

C. Program Plan - (400 Total Points)

Proposer will be evaluated based on the information provided in Section F.3 of the proposal, as follows:

1. Program Design - (350 Points)

   Proposer will be evaluated based on the information provided in its Section F.3.1 of the proposal in response to the questions/criteria pursuant to RFP Paragraph 7.8.5.2, Program Plan – Program Design – Category 1 (Section F.3.1) and/or 7.8.6.2, Program Plan – Program Design – Category 2 (Section F.3.1) as applicable.

2. Expected Outcomes - (50 Points)

   Proposer will be evaluated based on the information provided in its Section F.3.2 of the proposal in response to the questions/criteria pursuant to RFP Paragraph 7.8.5.2, Program Plan – Expected Outcomes – Category 1 (Section F.3.2) and/or 7.8.6.2, Program Plan – Expected Outcomes – Category 2 (Section F.3.2) as applicable.

D. Management Plan (165 Total Points)

Proposer will be evaluated based on the information provided in its Section F.4 of the proposal, as follows:

1. Organizational Capacity and Relationships (50 Points)

   Proposer will be evaluated based on the information provided in its Section F.4.1 of the proposal in response to the questions/criteria pursuant to RFP Paragraph 7.8.5.2, Management Plan – Organizational Capacity and Relationships – Category 1 (Section F.4.1) and/or 7.8.6.2, Management Plan – Organizational Capacity and Relationships – Category 2 (Section F.4.1) as applicable.

2. Staffing and In-Kind Support (70 Points)

   Proposer will be evaluated based on the information provided in its Section F.4.2 of the proposal in response to the questions/criteria pursuant to RFP Paragraph 7.8.5.2, Management Plan – Staffing and In-Kind Support - Category 1 (Section F.4.2) and/or 7.8.6.2, Management Plan – Staffing

and In-Kind Support - Category 2 (Section F.4.2) as applicable.

3. Community Advisory Support Plan (20 Points)

Proposer will be evaluated based on the information provided in its Section F.4.3 of the proposal in response to the questions/criteria pursuant to RFP Paragraph 7.8.5.2, Management Plan – Community Advisory Support Plan - Category 1 (Section F.4.3) and/or 7.8.6.2, Management Plan – Community Advisory Support Plan - Category 2 (Section F.4.3) as applicable.

4. Data Reporting Plan (25 Points)

Proposer will be evaluated based on the information provided in its Section F.4.4 of the proposal in response to the questions/criteria pursuant to RFP Paragraph 7.8.5.2, Management Plan – Data Reporting Plan - Category 1 (Section F.4.4) and/or 7.8.6.2, Management Plan – Data Reporting Plan - Category 2 (Section F.4.4) as applicable.

E. Scope of Work (50 Total Points)

Proposer will be evaluated based on the information provided in its Section F.5 of the proposal in response to the questions/criteria pursuant to RFP Paragraph 7.8.5.2, Management Plan – Scope of Work - Category 1 (Section F.5) and/or 7.8.6.2, Scope of Work – Category 2 (Section F.5) as applicable.

8.4.6 **Evaluation and Quality Management Plan (80 Total Points)**

Proposer will be evaluated based on the information provided in its Section G of the proposal in response to the questions/criteria pursuant to RFP Paragraph 7.8.5.3, Evaluation and Quality Management Plan - Category 1 (Section G) and/or 7.8.6.3, Evaluation and Quality Management Plan - Category 2 (Section G) as applicable.

8.4.7 **Program Budget (100 Total Points)**

Proposer will be evaluated based on the information provided in Section H of the proposal, as it pertains to each of the following related costs: 1) Program Concept and Component Related Costs **and** 2) HIV and STD Screening Program Component Related Costs. Each of Proposer's Program Budget(s) will be evaluated based on the following criteria:

1. Proposer submitted each required budget form; each budget form was complete and submitted using the required format/template.
2. Each budget is realistic and cost effective for the proposed quantity and quality of activities consistent with Appendices B-1, Statement of Work for Category 1 and/or Appendix B-2, Statement of Work for Category 2 and Exhibit 27, Sample Scope of Work and Template.
3. Staffing patterns are appropriate for the proposed program services.
4. Operating costs are consistent with the quantity and type of services proposed for both program concept and component services **and** HIV and STD screening services.
5. Each budget summary justification includes detailed and adequate rationale for each line item expenditure.
6. Each budget submitted contains correct calculations.

Also, Proposer's submitted Appendix D, Required Forms - Exhibit 29, Proposer's Funding Disclosure Form and Appendix C-1G, 1-Page Exhibit 29 Supplemental will be reviewed. If Proposer is requesting new or enhanced funding for HIV and STD services under this RFP, Proposer's Appendix C-1G will be evaluated based on its explanation as to how the new/enhanced funding will be used in conjunction with current funding for existing services.

8.4.8 **Living Wage Compliance (Intentionally Omitted)**

8.4.9 **Final Review and Selection**

Category 1 Final Review and Selection

The final review and selection will consist of the following:

Tier Level 1 Proposals

1. Proposals will be ranked from highest to lowest score.
2. Up to four (4) of the highest ranking Proposers shall be considered for recommended funding allocations review.

Tier Level 2 Proposals

1. Proposals will be ranked from highest to lowest score.
2. Up to three (3) of the highest ranking Proposers shall be considered for recommended funding allocations review.

For both Tier Level 1 and 2, the available funds and the number of awards are estimates and are subject to change. The County reserves the right to adjust the number of awards and the funding allocations based on service category, population served, cluster area needs, and the availability of funding.

Note: At the County's sole discretion, any proposal other than the highest ranking proposals may be considered for selection, if it is determined that the proposal is qualified, cost-effective, responsive, responsible, and/or meets a service category need based on population and/or area to be served, and/or is in the best interests of the County.

Category 2 Final Review and Selection

Proposals will be ranked from highest to lowest score. Up to two (2) of the highest ranking Proposers shall be considered for recommended funding allocations review.

Available funds and the number of awards are estimates and are subject to change. The County reserves the right to adjust the number of awards and the funding allocations based on service category, target area needs, and the availability of funding.

Note: At the County's sole discretion, any proposal other than the highest ranking proposals may be considered for selection, if it is determined that the proposal is qualified, cost-effective, responsive, responsible, and/or meets a service category need based on area to be served, and/or is in the best interests of the County.

8.4.10 Pre-Decisional Site Visit Review

The County, at its sole discretion, may conduct a Pre-Decisional Site Visit Review prior to recommending funding allocations as part of its funding allocation process for those proposals being considered for funding. This review shall be conducted by an Internal Site Visit Review Committee comprised of County program staff with appropriate HIV and STD prevention programming expertise. This review will assess and evaluate the Proposer in each of the following standards of appropriateness:

1. Confirmation that each proposed facility is in good repair and is that location is sufficient to facilitate high-quality, appropriate services.
2. Confirmation that each proposed facility and location satisfy each of the following:

    a. Meets American's with Disabilities Act requirements for accessibility;
    b. Is near public transportation;
    c. Is open during client-friendly hours (e.g., evenings, weekends);
    d. Free parking is available;
    e. All equipment needed is in working order;
    f. Easy to enter site (e.g. required to go through security guard, cross multiple gates).
    g. Privacy at the front (sign-in area) or reception desk;
    h. Free of graffiti and trash on grounds and in facility;
    i. Designated room for HIV and STD screening services (Note: Room does not have to be operational; however it must be currently available for use);
    j. Security provided outside and inside the facility

k. Confidential exam, treatment and interview rooms present and available for use;

l. Clear, distinct outside signage; and

m. Facilities are clean, well-lit, clearly marked indicating location of services.

3. Confirmation that the service delivery site location is consistent with the site location provided in the proposal; and that the site is located within the same Cluster Area, target area or selected location as designated within the Proposal.

4. **Category 1 only:** Confirmation that the service delivery site is not outside the cluster areas.

County may disqualify a Proposer from consideration for an award if they fail to meet any of the standards set above, or if the Proposer fails to clearly demonstrate its ability to meet the criteria as delineated above.

8.4.11 Recommended Funding Allocations Review

The selected Proposers, pursuant to RFP sub-paragraph 8.4.9, Final Review and Selection, will be reviewed for recommended funding allocations. The Recommended Funding Allocations Review will be conducted by an Internal Funding Review Committee comprised of selected personnel from DHSP's executive management team.

Inevitably, there will be more funding requested than the amount of funding available. The County's goal is to make funding recommendations most likely to provide services in the most efficient and successful manner, based on the RFP requirements.

Once a funding recommendation has been determined, the County will notify the Proposer's Executive Director, CEO, or designated Board Member of its funding recommendation and any other pertinent information. Those Proposers that did not receive a funding recommendation will also receive notification which shall be addressed to the Proposer's Executive Director, CEO, or designated Board Member.

Those Proposers recommended for funding will advance to negotiate a Contract for submission to the Board of Supervisors.

The final award of funding, pursuant to this RFP, will be made by and at the sole discretion of the County's Board of Supervisors.

8.5 Cost Proposal Evaluation Criteria (Intentionally Omitted)

8.6 Labor Law/Payroll Violations (Intentionally Omitted)

8.7 Department's Proposed Contractor Selection Review

8.7.1 Departmental Debriefing Process

Upon completion of the evaluation, the Department shall notify the remaining Proposers in writing that the Department is entering negotiations with another Proposer. Upon receipt of the letter, any non-selected Proposer may submit a written request for a Debriefing within the timeframe specified in the letter. A request for a Debriefing may, in the Department's sole discretion, be denied if the request is not received within the specified timeframe.
The purpose of the Debriefing is to compare the requesting Proposer's response to the solicitation document with the evaluation document. The requesting Proposer shall be debriefed only on its response. Because contract negotiations are not yet complete, responses from other Proposers shall not be discussed, although the Department may inform the requesting Proposer of its relative ranking.

During or following the Debriefing, the Department will instruct the requesting Proposer of the manner and timeframe in which the requesting Proposer must notify the Department of its intent to request a Proposed Contractor Selection Review (see Section 8.7.2 below), if the requesting Proposer is not satisfied with the results of the Debriefing.

8.7.2 Proposed Contractor Selection Review

Any Proposer that has timely submitted a notice of its intent to request a Proposed Contractor Selection Review as described in

this Section may submit a written request for a Proposed Contractor Selection Review, in the manner and timeframe as shall be specified by the Department.

A request for a Proposed Contractor Selection Review may, in the Department's sole discretion, be denied if the request does not satisfy all of the following criteria:

1. The person or entity requesting a Proposed Contractor Selection Review is a Proposer;
2. The request for a Proposed Contractor Selection Review is submitted timely (i.e., by the date and time specified by the Department);
3. The person or entity requesting a Proposed Contractor Selection Review asserts in appropriate detail with factual reasons one or more of the following grounds for review:
    a. The Department materially failed to follow procedures specified in its solicitation document. This includes:
        i. Failure to correctly apply the standards for reviewing the proposal format requirements.
        ii. Failure to correctly apply the standards, and/or follow the prescribed methods, for evaluating the proposals as specified in the solicitation document.
        iii. Use of evaluation criteria that were different from the evaluation criteria disclosed in the solicitation document.
    b. The Department made identifiable mathematical or other errors in evaluating proposals, resulting in the Proposer receiving an incorrect score and not being selected as the recommended contractor.
    c. A member of the Evaluation Committee demonstrated bias in the conduct of the evaluation.
    d. Another basis for review as provided by state or federal law; and
4. The request for a Proposed Contractor Selection Review sets forth sufficient detail to demonstrate that, but for the Department's alleged failure, the Proposer would have been the lowest cost, responsive and responsible bid or the highest-scored proposal, as the case may be.

Upon completing the Proposed Contractor Selection Review, the Department representative shall issue a written decision to the Proposer within a reasonable time following receipt of the request for a Proposed Contractor Selection Review, and always before the date the contract award recommendation is to be heard by the Board. The written decision shall additionally instruct the Proposer of the manner and timeframe for requesting a County Independent Review. (see Section 8.8 below)

8.8 County Independent Review Process

Any Proposer that is not satisfied with the results of the Proposed Contractor Selection Review may submit a written request for a County Independent Review in the manner and timeframe specified by the Department in the Department's written decision regarding the Proposed Contractor Selection Review.

A request for County Independent Review may, in the County's sole discretion, be denied if the request does not satisfy all of the following criteria:

1. The person or entity requesting a County Independent Review is a Proposer;
2. The request for a County Independent Review is submitted timely (i.e., by the date and time specified by the Department); and
3. The person or entity requesting review by a County Independent Review has limited the request to items raised in the Proposed Contractor Selection Review and new items that (a) arise from the Department's written decision and (b) are one of the appropriate grounds for requesting a Proposed Contractor Selection Review as listed in Section 8.7.2 above.

Upon completion of the County Independent Review, ISD will forward the report to the Department, which will provide a copy to the Proposer.

Contract No. PH-_____

APPENDIX A – SAMPLE CONTRACT

BY AND BETWEEN

COUNTY OF LOS ANGELES

DEPARTMENT OF PUBLIC HEALTH

AND

(CONTRACTOR)

FOR
PROMOTING HEALTH ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs, RFP No.: 2015-003

DEPARTMENT OF PUBLIC HEALTH
APPENDIX A - SAMPLE CONTRACT

Paragraph TABLE OF CONTENTS Page

CONTRACT BODY (CB)

ADDITIONAL PROVISIONS (AP)

STANDARD EXHIBITS

UNIQUE EXHIBITS

Contract No._____

DEPARTMENT OF PUBLIC HEALTH
SERVICES CONTRACT
APPENDIX A – SAMPLE CONTRACT
PROMOTING HEALTH ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs, RFP No.: 2015-003

THIS CONTRACT "Contract" is made and entered into this _____ day of _____, 201_,

by and between COUNTY OF LOS ANGELES (hereafter "County")

and _____ (hereafter "Contractor").

WHEREAS, California Health and Safety Code Section 101025 places upon County's Board of Supervisors ("Board"), the duty to preserve and protect the public's health; and

WHEREAS, California Health and Safety Code Section 101000 requires County's Board to appoint a County Health Officer, who is also the Director of County's Department of Public Health ("DPH" or "Department"), to provide services directed toward the prevention or mitigation of communicable and infectious diseases within the jurisdiction of County; and

WHEREAS, the term "Director" as used herein refers to the County's Director of DPH, or his duly authorized designee; (hereafter jointly referred to as "Director"); and

WHEREAS, County is authorized by Government Code Section 31000 to contract for these services, and

WHEREAS, County is authorize by Government Code Section 53703 to do all acts necessary to participate in any federal program whereby federal funds are granted

to County for purposes of health, education, welfare, public safety, and law enforcement which have not been preempted by State law; and

WHEREAS, Contractor agrees to abide by the requirements of the funding source and all regulations issued pursuant thereto; and

WHEREAS Contractor possesses the competence, financial ability, expertise, facilities, and personnel to provide the services contemplated hereunder; and

WHEREAS, it is the intent of the parties hereto to enter into contract to provide _____ for compensation, as set forth herein; and

WHEREAS, this Contract is therefore authorized under Section 44.7 of the Los Angeles County Charter and Los Angeles County codes Section 2.121.250; and

(Enter program specific contracting authority here); and

WHEREAS, Contractor is willing and able to provide the services described herein, in consideration of the payments under this contract and under the terms and conditions hereafter set forth; and

NOW THEREFORE, in consideration of the mutual covenants contained herein, and for good and valuable consideration, the parties agree to the following:

1. APPLICABLE DOCUMENTS:

Exhibits A, B, C, D, E, F, G, H, I, J and K are attached to and form a part of this Contract. In the event of any conflict or inconsistency in the definition or interpretation of any word, responsibility, budget, or the contents or description of any task, deliverable, goods, service, or other work, or otherwise between the base Contract and the Exhibits, or between Exhibits, such conflict or inconsistency shall be resolved by

giving precedence first to the terms and conditions of the Contract and then to the Exhibits as listed below:

Standard Exhibits

Exhibit A - Statement of Work
Exhibit B - Scope of Work
Exhibit C - Budget(s)
Exhibit D - Contractor's EEO Certification
Exhibit E - Contractor Acknowledgement and Confidentiality Agreement or Contractor Acknowledgement, Confidentiality, and Copyright Assignment Agreement
Exhibit F - Health Insurance Portability and Accountability Act (HIPAA)
Exhibit G - Charitable Contributions Certification

Prop A - Living Wage Ordinance (Intentionally Omitted)

Exhibit H - Living Wage Ordinance (Intentionally Omitted)
Exhibit I - Monthly Certification for Applicable Health Benefit Payments (Intentionally Omitted)
Exhibit J - Payment Statement of Compliance (Intentionally Omitted)
Exhibit K - Contractor's Assignment and Transfer of Copyright (Intentionally Omitted)

2. DEFINITIONS:

A. Contract: This agreement executed between County and Contractor. It sets forth the terms and conditions for the issuance and performance of all tasks, deliverables, services and other work including the Statement of Work, Exhibit A and the Scope of Work, Exhibit B.

B. Contractor: The sole proprietor, partnership, corporation or other person or entity that has entered into this Contract with the County.

3. DESCRIPTION OF SERVICES:

A. Contractor shall provide services in the manner described in Exhibit A (Statement of Work) and/or Exhibit B (Scope of Work), attached hereto and incorporated herein by reference.

B. Contractor acknowledges that the quality of service(s) provided under this Contract shall be at least equivalent to that which Contractor provides to all other clients it serves.

C. If the Contractor provides any tasks, deliverables, goods, services, or other work, other than as specified in this Contract, the same shall be deemed to be a gratuitous effort on the part of the Contractor, and the Contractor shall have no claim whatsoever against the County.

4. TERM OF CONTRACT:

The term of this Contract shall be effective _____ and shall continue in full force and effect through _____, unless sooner terminated or extended, in whole or in part, as provided in this Contract.

The County shall have the sole option to extend this Contract term up to XX additional one-year periods and XX month to month extensions, for a maximum total Contract term of XX years and XX months. Each such extension option be exercised at the sole discretion of the Director through written notification from the Director to the Contractor prior to the end of the Contract term.

The Contractor shall notify (Program Office) when this Contract is within six (6) months from the expiration of the term as provided for hereinabove. Upon occurrence of this event, the Contractor shall send written notification to (Program Office) at the address herein provided in _____.

5. MAXIMUM OBLIGATION OF COUNTY:

A. Effective _____ through _____, the maximum obligation of County for all services provided hereunder shall not exceed _____ ($_____), as set forth in Exhibit C, attached hereto and incorporated herein by reference.

B. Effective _____ through _____, the maximum obligation of County for all services provided hereunder shall not exceed _____ ($_____), as set forth in Exhibit C, attached hereto and incorporated herein by reference.

C. If contract is extended, effective ___ through ___, the maximum obligation of County for all services provided hereunder shall not exceed _____ ($_____), as set forth in Exhibit C, attached hereto and incorporated herein by reference.

D. The Contractor shall not be entitled to payment or reimbursement for any tasks or services performed, nor for any incidental or administrative expenses whatsoever incurred in or incidental to performance hereunder, except as specified herein. Assumption or takeover of any of the Contractor's duties, responsibilities, or obligations, or performance of same by person or entity other than the Contractor, whether through assignment, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever, shall not occur except with the County's express prior written approval.

E. The Contractor shall maintain a system of record keeping that will allow the contractor to determine when it has incurred seventy-five percent (75%)

of the total contract sum under this Contract. Upon occurrence of this event, the Contractor shall send written notification to the Department at the address herein provided under Paragraph 21, NOTICES.

F. No Payment for Services Provided Following Expiration/ Termination of Contract: The Contractor shall have no claim against County for payment of any money or reimbursement, of any kind whatsoever, for any service provided by the Contractor after the expiration or other termination of this Contract. Should the Contractor receive any such payment it shall immediately notify County and shall immediately repay all such funds to County. Payment by County for Services rendered after expiration/termination of this Contract shall not constitute a waiver of County's right to recover such payment from the Contractor. This provision shall survive the expiration or other termination of this Contract.

6. INVOICES AND PAYMENT:

A. The Contractor shall invoice the County only for providing the tasks, deliverables, goods, services, and other work specified in Exhibit A and/or B elsewhere hereunder and in accordance with Exhibit C attached hereto and incorporated herein by reference.

B. The Contractor shall bill County monthly in arrears. All billings shall include a financial invoice and all required reports and/or data. All billings shall clearly reflect all required information as specified on forms provided by County regarding the services for which claims are to be made and any and all payments made to Contractor.

C. Billings shall be submitted to County within thirty (30) calendar days after the close of each calendar month. Within a reasonable period of time following receipt of a complete and correct monthly billing, County shall make payment in accordance to the Budget(s) attached hereto and incorporated herein by reference.

D. While payments shall be made in accordance with the fee-for-service rate(s) set out in the budget (s) attached hereto, Contractor, if requested by County, State, or federal representatives, must be able to produce proof of actual costs incurred in the provision of units of service hereunder. If the actual allowable and documented costs are less than the fee-for-service rate(s) set in the budget (s), Contractor shall be reimbursed for the actual costs. In no event shall County be required to pay Contractor for units of service that are not supported by actual allowable and documented costs. Regardless of the amount of costs incurred by contractor, in no event will the county pay or is obligated to pay contractor more than the fees for the units of service provided.

E. Billings shall be submitted directly to _____.

F. For each term, or portion thereof, that this Contract is in effect, Contractor shall provide an annual cost report within thirty (30) calendar days following the close of the contract period. Such cost report shall be prepared in accordance with generally accepted accounting principles and clearly reflect all required information as specified in instructions and forms provided by the County.

If this Contract is terminated prior to the close of the contract period, the cost report shall be for that Contract period which ends on the termination date. The report shall be submitted within thirty (30) calendar days after such termination date.

The primary objective of the annual cost report shall be to provide the County with actual expenditure data for the contract period that shall serve as the basis for determining final amounts due to/from the Contractor.

If the annual cost report is not delivered by Contractor to County within the specified time, Director may withhold all payments to Contractor under all service agreements between County and Contractor until such report is delivered to County and/or, at the Director's sole discretion, a final determination of amounts due to/from Contractor is determined on the basis of the last monthly billing received.

Failure to provide the annual cost report may constitute a material breach of the Contract, in the sole discretion of the County, upon which the County may suspend or terminate this Contract.

G. Upon expiration or prior termination of this Contract, Contractor shall submit, within thirty (30) calendar days, any outstanding and/or final invoice(s) for processing and payment. Contractor's failure to submit any outstanding and/or final invoice(s) within the specified period shall constitute Contractor's waiver to receive payment for any outstanding and/or final invoice(s).

H. Withholding Payment:

(1) Subject to the reporting and data requirements of this Contract and the exhibit(s) attached hereto, Director may withhold any payment to Contractor if any report or data is not delivered by Contractor to County within the time limits of submission as set forth in this Contract, or if such report or data is incomplete in accordance with requirements set forth in this Contract. This withholding may be invoked for the current month and any succeeding month or months for reports or data not delivered in a complete and correct form.

(2) Subject to the Record Retention and Audits provision of this Contract, Director may withhold any claim for payment by Contractor if Contractor has been given at least thirty (30) calendar days notice of deficiency(ies) in compliance with the terms of this Contract and has failed to correct such deficiency(ies). This withholding may be invoked for any month or months for deficiency(ies) not corrected.

(3) Upon acceptance by County of all report(s) and data previously not accepted under this provision and/or upon correction of the deficiency(ies) noted above, Director shall reimburse all withheld payments on the next regular monthly claim for payment by Contractor.

(4) Subject to the provisions of the exhibit(s) of this Contract, if the services are not completed by Contractor within the specified time, Director may withhold all payments to Contractor under this Contract until proof of such service(s) is/are delivered to County.

(5) In addition to Sub-paragraphs (1) through (4) immediately above, Director may withhold payments due to Contractor for amounts due to County as determined by any cost report settlement, audit report, audit report settlement, or financial evaluation report, resulting from this or any current year's Contract(s) or any prior year's Contract(s) between the County and Contractor. The withheld payments will be used to pay all amounts due to the County. Any remaining withheld payment will be paid to the Contractor accordingly.

(6) Director may withhold any payment to Contractor if Contractor, in the judgment of the County is in material breach of this Contract or has failed to fulfill its obligations under this Contract until Contractor has cured said breaches and/or failures. Director will provide written notice of its intention to withhold payment specifying said breaches and/or failure to Contractor.

I. Fiscal Viability: Contractor must be able to carry the costs of its program without reimbursement under this Contract for at least sixty (60) days at any point during the term of this contract.

7. FUNDING/SERVICES ADJUSTMENTS AND REALLOCATIONS:

A. Upon Director's specific written approval, as authorized by the County's Board of Supervisors, County may: 1) increase or decrease funding up to ten percent (10%) above or below each term's annual base maximum obligation; 2) reallocate funds between budgets within this Contract where such funds can be more effectively used by Contractor up to ten percent (10%) of the

term's annual base maximum obligation; and 3) make modifications to or within budget categories within each budget, as reflected in Exhibit C, up to an adjustment between all budget categories equal to ten percent (10%) of each term's annual base maximum obligation, and make corresponding service adjustments, as necessary. Such adjustments may be made based on the following: (a) if additional monies are available from federal, State, or County funding sources; (b) if a reduction of monies occurs from federal, State, or County funding sources; and/or (c) if County determines from reviewing Contractor's records of service delivery and billings to County that an underutilization of funds provided under this Contract will occur over its term.

All funding adjustments and reallocation as allowed under this Paragraph may be effective upon amendment execution or at the beginning of the applicable contract term, to the extent allowed by the funding source and as authorized by the County's Board of Supervisors. Adjustments and reallocations of funds in excess of the aforementioned amount shall require separate approval by County's Board of Supervisors. Any change to the County maximum obligation or reallocation of funds between budgets in this Contract shall be effectuated by an administrative amendment to this Contract pursuant to the ALTERATION OF TERMS/AMENDMENTS Paragraph of this Contract. Any modification to or within budget categories within each budget, as reflected in Exhibit C, shall be effectuated by a change notice that shall be incorporated into and become part of this Contract pursuant to the ALTERATION OF TERMS/AMENDMENTS Paragraph of this Contract.

B. County and Contractor shall review Contractor's expenditures and commitments to utilize any funds, which are specified in this Contract for the services hereunder and which are subject to time limitations as determined by Director, midway through each County fiscal year during the term of this Contract, midway through the applicable time limitation period for such funds if such period is less than a County fiscal year, and/or at any other time or times during each County fiscal year as determined by Director. At least fifteen (15) calendar days prior to each such review, Contractor shall provide Director with a current update of all of Contractor's expenditures and commitments of such funds during such fiscal year or other applicable time period.

8. ALTERATION OF TERMS/AMENDMENTS:

A. The body of this Contract and any Exhibit(s) attached hereto, fully expresses all understandings of the parties concerning all matters covered and shall constitute the total Contract. No addition to, or alteration of, the terms of this Contract, whether by written or verbal understanding of the parties, their officers, employees or agents, shall be valid and effective unless made in the form of a written amendment to this Contract which is formally approved and executed by the parties in the same manner as this Contract.

B. The County's Board of Supervisors; the Chief Executive Officer or designee; or applicable State and/or federal entities, laws, or regulations may require the addition and/or change of certain terms and conditions in the Contract during the term of this Contract to comply with changes in law or County policy. The County reserves the right to add and/or change such provisions as required

by the County's Board of Supervisors, Chief Executive Officer, or State or federal entity. To implement such changes, an Amendment to the Contract shall be prepared by Director and executed by the Contractor and Director, as authorized by the County's Board of Supervisors.

C. Notwithstanding Paragraph 7.A., in instances where the County's Board of Supervisors has delegated authority to the Director to amend this Contract to permit extensions or adjustments of the contract term; the rollover of unspent Contract funds; and/or an internal reallocation of funds between budgets up to ten percent (10%) of each term's annual base maximum obligation and/or an increase or decrease in funding up to ten percent (10%) above or below each term's annual base maximum obligation, effective upon amendment execution or at the beginning of the applicable Contract term, and make corresponding service adjustments, as necessary, an Administrative Amendment shall be prepared by Director and executed by the Contractor and Director, as authorized by the County's Board of Supervisors, and shall be incorporated into and become part of this Contract.

D. Notwithstanding Paragraph 7.A., in instances where the County's Board of Supervisors has delegated authority to the Director to amend this Contract to permit modifications to or within budget categories within each budget, as reflected in Exhibit C, and corresponding adjustment of the scope of work tasks and/or activities and/or allow for changes to hours of operation, changes to service locations, and/or correction of errors in the Contract's terms and conditions, a written Change Notice shall be signed by the Director and

Contractor, as authorized by the County's Board of Supervisors. The executed Change Notice shall be incorporated into and become part of this Contract.

9. CONFIDENTIALITY:

A. Contractor shall maintain the confidentiality of all records and information in accordance with all applicable Federal, State and local laws, rules, regulations, ordinances, directives, guidelines, policies and procedures relating to confidentiality, including, without limitation, County policies concerning information technology security and the protection of confidential records and information.

B. Contractor shall indemnify, defend, and hold harmless County, its officers, employees, and agents, from and against any and all claims, demands, damages, liabilities, losses, costs and expenses, including, without limitation, defense costs and legal, accounting and other expert, consulting, or professional fees, arising from, connected with, or related to any failure by Contractor, its officers, employees, agents, or subcontractors, to comply with this CONFIDENTIALITY Paragraph, as determined by County in its sole judgment. Any legal defense pursuant to Contractor's indemnification obligations under this CONFIDENTIALITY Paragraph shall be conducted by Contractor and performed by counsel selected by Contractor and approved by County. Notwithstanding the preceding sentence, County shall have the right to participate in any such defense at its sole costs and expense, except that in the event Contractor fails to provide County with a full and adequate defense, as determined by County in its sole judgment, County shall be entitled to retain its own counsel, including,

without limitation, County Counsel, and to reimbursement from Contractor for all such costs and expenses incurred by County in doing so. Contractor shall not have the right to enter into any settlement, agree to any injunction, or make any admission, in each case, on behalf of County without County's prior written approval.

C. Contractor shall inform all of its officers, employees, agents and subcontractors providing services hereunder of the confidentiality provisions of this Contract.

D. Contractor shall sign and adhere to the provisions of the "Contractor Acknowledgement and Confidentiality Agreement", Exhibit E.

10. CONSIDERATION OF HIRING COUNTY EMPLOYEES TARGETED FOR LAYOFF/OR RE-EMPLOYMENT LIST: Should Contractor require additional or replacement personnel after the effective date of this Contract to perform the services set forth herein, Contractor shall give first consideration for such employment openings to qualified, permanent County employees who are targeted for layoff or qualified, former County employees who are on a re-employment list during the life of this Contract.

11. INDEMNIFICATION: The Contractor shall indemnify, defend, and hold harmless the County, its Special Districts, elected and appointed officers, employees, agents and volunteers ("County Indemnitees") from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising from and/or relating to this Contract, except for such loss or damage arising from the sole negligence or willful misconduct of the County Indemnitees.

12. GENERAL PROVISIONS FOR ALL INSURANCE COVERAGES: Without limiting Contractor's indemnification of County and in the performance of this Contract and until all of its obligations pursuant to this Contract have been met, Contractor shall provide and maintain at its own expense insurance coverage satisfying the requirements specified in this paragraph and in the INSURANCE COVERAGE REQUIREMENTS Paragraph of this Contract. These minimum insurance coverage terms, types and limits (the "Required Insurance") also are in addition to and separate from any other contractual obligation imposed upon Contractor pursuant to this Contract. The County in no way warrants that the Required Insurance is sufficient to protect the Contractor for liabilities which may arise from or relate to this Contract.

A. Evidence of Coverage and Notice to County: A certificate(s) of insurance coverage (Certificate) satisfactory to County, and a copy of an Additional Insured endorsement confirming County and its Agents (defined below) has been given Insured status under the Contractor's General Liability policy, shall be delivered to the County at the address shown below and provided prior to commencing services under this Contract.

Renewal Certificates shall be provided to County not less than ten (10) calendar days prior to Contractor's policy expiration dates. The County reserves the right to obtain complete, certified copies of any required Contractor and/or Sub-Contractor insurance policies at any time.

Certificates shall identify all Required Insurance coverage types and limits specified herein, reference this Contract by name or number, and be signed by an authorized representative of the insurer(s). The Insured party named on the

Certificate shall match the name of the Contractor identified as the contracting party in this Contract. Certificates shall provide the full name of each insurer providing coverage, its NAIC (National Association of Insurance Commissioners) identification number, its financial rating, the amounts of any policy deductibles or self-insured retentions exceeding Fifty Thousand Dollars ($50,000), and list any County required endorsement forms.

Neither the County's failure to obtain, nor the County's receipt of, or failure to object to a non-complying insurance certificate or endorsement, or any other insurance documentation or information provided by the Contractor, its insurance broker(s) and/or insurer(s), shall be construed as a waiver of any of the Required Insurance provisions.

Certificates and copies of any required endorsements shall be sent to:

County of Los Angeles – Department of Public Health
Contract Monitoring Division
5555 Ferguson Drive, Suite 210
Commerce, California 90022
Attention: Chief Contract Monitoring Unit

Contractor also shall promptly report to County any injury or property damage accident or incident, including any injury to a Contractor employee occurring on County property, and any loss, disappearance, destruction, misuse, or theft of County property, monies or securities entrusted to Contractor. Contractor also shall promptly notify County of any third party claim or suit filed against Contractor or any of its Sub-Contractors which arises from or relates to this Contract, and could result in the filing of a claim or lawsuit against Contractor and/or County.

B. Additional Insured Status and Scope of Coverage: The County of Los Angeles, its special Districts, Elected Officials, Officers, Agents, Employees and Volunteers (collectively County and its Agents) shall be provided additional insured status under Contractor's General Liability policy with respect to liability arising out of Contractor's ongoing and completed operations performed on behalf of the County. County and its Agents additional insured status shall apply with respect to liability and defense of suits arising out of the Contractor's acts or omissions, whether such liability is attributable to the Contractor or to the County. The full policy limits and scope of protection also shall apply to the County and its Agents as an additional insured, even if they exceed the County's minimum Required Insurance specifications herein. Use of an automatic additional insured endorsement form is acceptable providing it satisfies the Required Provisions herein.

C. Cancellation of or Changes in Insurance: Contractor shall provide County with, or Contractor's insurance policies shall contain a provision that County shall receive, written notice of cancellation or any change in Required Insurance, including insurer, limits of coverage, term of coverage or policy period. The written notice shall be provided to County at least ten (10) days in advance of cancellation for non-payment of premium and thirty (30) days in advance for any other cancellation or policy change. Failure to provide written notice of cancellation or any change in Required Insurance may constitute a material breach of the Contract, in the sole discretion of the County, upon which the County may suspend or terminate this Contract.

D. Failure to Maintain Insurance: Contractor's failure to maintain or to provide acceptable evidence that it maintains the Required Insurance shall constitute a material breach of the Contract, upon which County immediately may withhold payments due to Contractor, and/or suspend or terminate this Contract. County, at its sole discretion, may obtain damages from Contractor resulting from said breach. Alternatively, the County may purchase the Required Insurance, and without further notice to Contractor, deduct the premium cost from sums due to Contractor or pursue Contractor reimbursement.

E. Insurer Financial Ratings: Coverage shall be placed with insurers acceptable to the County with an A.M. Best ratings of not less than A:VII unless otherwise approved by County.

F. Contractor's Insurance Shall Be Primary: Contractor's insurance policies, with respect to any claims related to this Contract, shall be primary with respect to all other sources of coverage available to Contractor. Any County maintained insurance or self-insurance coverage shall be in excess of and not contribute to any Contractor coverage.

G. Waivers of Subrogation: To the fullest extent permitted by law, the Contractor hereby waives its rights and its insurer(s)' right of recovery against County under all the Required Insurance for any loss arising from or relating to this Contract. The Contractor shall require its insurers to execute any waiver of subrogation endorsements which may be necessary to effect such waiver.

H. Compensation for County Costs: In the event that Contractor fails to comply with any of the indemnification or insurance requirements of this

Contract, and such failure to comply results in any costs to County, Contractor shall pay full compensation for all costs incurred by County.

I. Sub-Contractor Insurance Coverage Requirements: Contractor shall include all Sub-Contractors as insureds under Contractor's own policies, or shall provide County with each Sub-Contractor's separate evidence of insurance coverage. Contractor shall be responsible for verifying each Sub-Contractor complies with the Required Insurance provisions herein, and shall require that each Sub-Contractor name the County and Contractor as additional insureds on the Sub-Contractor's General Liability policy. Contractor shall obtain County's prior review and approval of any Sub-Contractor request for modification of the Required Insurance.

J. Deductibles and Self-Insured Retentions (SIRs): Contractor's policies shall not obligate the County to pay any portion of any Contractor deductible or SIR. The County retains the right to require Contractor to reduce or eliminate policy deductibles and SIRs as respects to the County, or to provide a bond guaranteeing Contractor's payment of all deductibles and SIRs, including all related claims investigation, administration and defense expenses. Such bond shall be executed by a corporate surety licensed to transact business in the State of California.

K. Claims Made Coverage: If any part of the Required Insurance is written on a claims made basis, any policy retroactive date shall precede the effective date of this Contract. Contractor understands and agrees it shall

maintain such coverage for a period of not less than three (3) years following Contract expiration, termination or cancellation.

L. Application of Excess Liability Coverage: Contractors may use a combination of primary, and excess insurance policies which provide coverage as broad as ("follow form" over) the underlying primary policies, to satisfy the Required Insurance provisions.

M. Separation of Insureds: All liability policies shall provide cross-liability coverage as would be afforded by the standard ISO (Insurance Services Office, Inc.) separation of insureds provision with no insured versus insured exclusions or limitations.

N. Alternative Risk Financing Programs: The County reserves the right to review, and then approve, Contractor use of self-insurance, risk retention groups, risk purchasing groups, pooling arrangements and captive insurance to satisfy the Required Insurance provisions. The County and its Agents shall be designated as an Additional Covered Party under any approved program.

O. County Review and Approval of Insurance Requirements: The County reserves the right to review and adjust the Required Insurance provisions, conditioned upon County's determination of changes in risk exposures.

13. INSURANCE COVERAGE REQUIREMENTS:

A. Commercial General Liability insurance (providing scope of coverage equivalent to Insurance Services Office ["ISO"] policy form "CG 00 01"),

naming County and its Agents as an additional insured, with limits of not less than:

General Aggregate:	$2 Million
Products/Completed Operations Aggregate:	$1 Million
Personal and Advertising Injury:	$1 Million
Each Occurrence:	$1 Million

B. Automobile Liability insurance (providing scope of coverage equivalent to ISO policy form "CA 00 01") with limits of not less than One Million Dollars ($1,000,000) for bodily injury and property damage, in combined or equivalent split limits, for each single accident. Insurance shall cover liability arising out of Contractor's use of autos pursuant to this Contract, including "owned", "leased", "hired", and/or "non-owned" autos, as each may be applicable.

C. Workers' Compensation and Employers' Liability insurance or qualified self-insurance satisfying statutory requirements, which includes Employers' Liability coverage with limits of not less than One Million Dollars ($1,000,000) per accident. If Contractor will provide leased employees, or, is an employee leasing or temporary staffing firm or a professional employer organization (PEO), coverage also shall include an Alternate Employer Endorsement (providing scope of coverage equivalent to ISO policy form WC 00 03 01 A) naming the County as the Alternate Employer, and the endorsement form shall be modified to provide that County will receive not less than thirty (30) days advance written notice of cancellation of this coverage provision. If

applicable to Contractor's operations, coverage shall be arranged to satisfy the requirements of any federal workers or workmen's compensation law or any federal occupational disease law.

D. Sexual Misconduct Liability: Insurance covering actual or alleged claims for sexual misconduct and/or molestation with limits of not less than Two Million Dollars ($2,000,000) per claim and Two Million Dollars ($2,000,000) aggregate, and claims for negligent employment, investigation, supervision, training or retention of, or failure to report to proper authorities, a person(s) who committed any act of abuse, molestation, harassment, mistreatment or maltreatment of a sexual nature.

E. Professional Liability/Errors and Omissions: Insurance covering Contractor's liability arising from or related to this Contract, with limits of not less than One Million Dollars ($1,000,000) per claim and Two Million Dollars ($2,000,000) aggregate. Further, Contractor understands and agrees it shall maintain such coverage for a period of not less than three (3) years following this Contract's expiration, termination or cancellation.

14. OWNERSHIP OF MATERIALS, SOFTWARE AND COPYRIGHT:

A. Contractor agrees that all public announcements, literature, audiovisuals, and printed material developed or acquired by Contractor or otherwise, in whole or in part, under this Contract, and all works based thereon, incorporated therein, or derived there from, shall be the sole property of County.

B. Contractor hereby assigns and transfers to County in perpetuity for all purposes all Contractors' rights, title, and interest in and to all such items

including, but not limited to, all unrestricted and exclusive copyrights and all renewals and extensions thereof.

C. With respect to any such items which come into existence after the commencement date of the Contract, Contractor shall assign and transfer to County in perpetuity for all purposes, without any additional consideration, all Contractor's rights, title, and interest in and to all items, including, but not limited to, all unrestricted and exclusive copyrights and all renewals and extensions thereof.

D. During the term of this Contract and for five (5) years thereafter, the Contractor shall maintain and provide security for all of the Contractor's working papers prepared under this Contract. County shall have the right to inspect, copy and use at any time during and subsequent to the term of this Contract, any and all such working papers and all information contained therein.

E. Any and all materials, software and tools which are developed or were originally acquired by the Contractor outside the scope of this Contract, which the Contractor desires to use hereunder, and which the Contractor considers to be proprietary or confidential, must be specifically identified by the Contractor to the County's Project Manager as proprietary or confidential, and shall be plainly and prominently marked by the Contractor as "Proprietary" or "Confidential" on each appropriate page of any document containing such material.

F. If directed to do so by County, Contractor will place the County name, its department names and/or its marks and logos on all items developed

under this Contract. If also directed to do so by County, Contractor shall affix the following notice to all items developed under this Contract: "© Copyright 20XX (or such other appropriate date of first publication), County of Los Angeles. All Rights Reserved." Contractor agrees that it shall not use the County name, its department names, its program names, and/or its marks and logos on any materials, documents, advertising, or promotional pieces, whether associated with work performed under this Contract or for unrelated purposes, without first obtaining the express written consent of County.

For the purposes of this Contract, all such items shall include, but not be limited to, written materials (e.g, curricula, text for vignettes, press releases, advertisements, text for public service announcements for any and all media types, pamphlets, brochures, fliers), software, audiovisual materials (e.g., films, videotapes, websites), and pictorials (e.g., posters and similar promotional and educational materials using photographs, slides, drawings, or paintings).

15. PUBLICITY: Contractor agrees that all materials, public announcements, literature, audiovisuals, and printed materials utilized in association with this Contract, shall have prior written approval from the Director or his/her designee prior to its publication, printing, duplication, and implementation with this Contract. All such materials, public announcements, literature, audiovisuals, and printed material shall include an acknowledgement that funding for such public announcements, literature, audiovisuals, and printed materials was made possible by the County of Los Angeles, Department of Public Health and other applicable funding sources.

For the purposes of this Contract, all such items shall include, but not be limited to, written materials (e.g., curricula, text for vignettes, text for public service announcements for any and all media types, pamphlets, brochures, fliers), audiovisual materials (e.g., films, videotapes), and pictorials (e.g., posters and similar promotional and educational materials using photographs, slides, drawings, or paintings).

16. RECORD RETENTION AND AUDITS:

A. Service Records: Contractor shall maintain all service records related to this contract for a minimum period of five (5) years following the expiration or prior termination of this Contract. Contractor shall provide upon request by County, accurate and complete records of its activities and operations as they relate to the provision of services, hereunder. Records shall be accessible as detailed in the subsequent sub-paragraph.

B. Financial Records: Contractor shall prepare and maintain on a current basis, complete financial records in accordance with generally accepted accounting principles and also in accordance with written guidelines, standards, and procedures which may from time to time be promulgated by Director. For additional information, please refer to the Los Angeles County Auditor-Controller's Contract Accounting and Administration Handbook. The handbook is available on the internet at http://publichealth.lacounty.gov/cg/docs/AuditorControllerContractingandAdminHB.pdf

Such records shall clearly reflect the actual cost of the type of service for which payment is claimed and shall include, but not be limited to:

(1) Books of original entry which identifies all designated donations, grants, and other revenues, including County, federal, and State revenues and all costs by type of service.

(2) A General Ledger.

(3) A written cost allocation plan which shall include reports, studies, statistical surveys, and all other information Contractor used to identify and allocate indirect costs among Contractor's various services. Indirect Costs shall mean those costs incurred for a common or joint objective which cannot be identified specifically with a particular project or program.

(4) Personnel records which show the percentage of time worked providing service claimed under this Contract. Such records shall be corroborated by payroll timekeeping records, signed by the employee and approved by the employee's supervisor, which show time distribution by programs and the accounting for total work time on a daily basis. This requirement applies to all program personnel, including the person functioning as the executive director of the program, if such executive director provides services claimed under this Contract.

(5) Personnel records which account for the total work time of personnel identified as indirect costs in the approved contract budget. Such records shall be corroborated by payroll timekeeping records signed by the employee and approved by the employee's supervisor. This requirement applies to all such personnel, including the executive director

of the program, if such executive director provides services claimed under this Contract.

The entries in all of the aforementioned accounting and statistical records must be readily traceable to applicable source documentation (e.g., employee timecards, remittance advice, vendor invoices, appointment logs, client/patient ledgers). The client/patient eligibility determination and fees charged to, and collected from clients/patients must also be reflected therein. All financial records shall be retained by Contractor at a location within Los Angeles County during the term of this Contract and for a minimum period of five (5) years following expiration or earlier termination of this Contract, or until federal, State and/or County audit findings are resolved, whichever is later. During such retention period, all such records shall be made available during normal business hours within ten (10) calendar days, to authorized representatives of federal, State, or County governments for purposes of inspection and audit. In the event records are located outside Los Angeles County and Contractor is unable to move such records to Los Angeles County, the Contractor shall permit such inspection or audit to take place at an agreed to outside location, and Contractor shall pay County for all travel, per diem, and other costs incurred by County for any inspection and audit at such other location. Contractor shall further agree to provide such records, when possible, immediately to County by facsimile/FAX, or through the Internet (i.e. electronic mail [“e-mail”], upon Director’s request.

Director's request shall include appropriate County facsimile/FAX number(s) and/or e-mail address(es) for Contractor to provide such records to County. In any event, Contractor shall agree to make available the original documents of such FAX and e-mail records when requested by Director for review as described hereinabove.

C. Preservation of Records: If following termination of this Contract Contractor's facility is closed or if ownership of Contractor changes, within forty-eight (48) hours thereafter, the Director is to be notified thereof by Contractor in writing and arrangements are to be made by Contractor for preservation of the client/patient and financial records referred to hereinabove.

D. Audit Reports: In the event that an audit of any or all aspects of this Contract is conducted by any federal or State auditor, or by any auditor or accountant employed by Contractor or otherwise, Contractor shall file a copy of each such audit report(s) with the Chief of the County's Department of Public Health ("DPH") Contract Monitoring Division, and with County's Auditor-Controller (Auditor-Controller's Audit Branch) within thirty (30) calendar days of Contractor's receipt thereof, unless otherwise provided for under this Contract, or under applicable federal or State regulations. To the extent permitted by law, County shall maintain the confidentiality of such audit report(s).

E. Independent Audit: Contractor's financial records shall be audited by an independent auditor in compliance with Title 2 of the Code of Federal Regulations (CFR) 200.501. The audit shall be made by an independent auditor in accordance with Governmental Financial Auditing Standards developed by the

Comptroller General of the United States, and any other applicable federal, State, or County statutes, policies, or guidelines. Contractor shall complete and file such audit report(s) with the County's DPH Contract Monitoring Division no later than the earlier of thirty (30) days after receipt of the auditor's report(s) or nine (9) months after the end of the audit period.

If the audit report(s) is not delivered by Contractor to County within the specified time, Director may withhold all payments to Contractor under all service agreements between County and Contractor until such report(s) is delivered to County.

The independent auditor's work papers shall be retained for a minimum of three (3) years from the date of the report, unless the auditor is notified in writing by County to extend the retention period. Audit work paper shall be made available for review by federal, State, or County representative upon request.

F. Federal Access to Records: If, and to the extent that, Section 1861 (v) (1) (I) of the Social Security Act [42 United States Code ("U.S.C.") Section 1395x(v) (1) (I)] is applicable, Contractor agrees that for a period of five (5) years following the furnishing of services under this Contract, Contractor shall maintain and make available, upon written request, to the Secretary of the United States Department of Health and Human Services or the Comptroller General of the United States, or to any of their duly authorized representatives, the contracts, books, documents, and records of Contractor which are necessary to verify the nature and extent of the cost of services provided hereunder. Furthermore, if Contractor carries out any of the services provided hereunder through any

subcontract with a value or cost of Ten Thousand Dollars ($10,000) or more over a twelve (12) month period with a related organization (as that term is defined under federal law), Contractor agrees that each such subcontract shall provide for such access to the subcontract, books, documents, and records of the subcontractor.

G. Program and Audit/Compliance Review: In the event County representatives conduct a program review and/or an audit/compliance review of Contractor, Contractor shall fully cooperate with County's representatives. Contractor shall allow County representatives access to all records of services rendered and all financial records and reports pertaining to this Contract and shall allow photocopies to be made of these documents utilizing Contractor's photocopier, for which County shall reimburse Contractor its customary charge for record copying services, if requested. Director shall provide Contractor with at least ten (10) working days prior written notice of any audit/compliance review, unless otherwise waived by Contractor.

County may conduct a statistical sample audit/compliance review of all claims paid by County during a specified period. The sample shall be determined in accordance with generally accepted auditing standards. An exit conference shall be held following the performance of such audit/compliance review at which time the result shall be discussed with Contractor. Contractor shall be provided with a copy of any written evaluation reports.

Contractor shall have the opportunity to review County's findings on Contractor, and Contractor shall have thirty (30) calendar days after receipt of

County's audit/compliance review results to provide documentation to County representatives to resolve the audit exceptions. If, at the end of the thirty (30) calendar day period, there remains audit exceptions which have not been resolved to the satisfaction of County's representatives, then the exception rate found in the audit, or sample, shall be applied to the total County payment made to Contractor for all claims paid during the audit/compliance review period to determine Contractor's liability to County. County may withhold any claim for payment by Contractor for any month or months for any deficiency(ies) not corrected.

H. Audit Settlements:

(1) If an audit conducted by federal, State, and/or County representatives finds that units of service, actual reimbursable net costs for any services and/or combinations thereof furnished hereunder are lower than units of service and/or reimbursement for stated actual net costs for any services for which payments were made to Contractor by County, then payment for the unsubstantiated units of service and/or unsubstantiated reimbursement of stated actual net costs for any services shall be repaid by Contractor to County. For the purpose of this paragraph an "unsubstantiated unit of service" shall mean a unit of service for which Contractor is unable to adduce proof of performance of that unit of service and "unsubstantiated reimbursement of stated actual net costs" shall mean a stated actual net costs for which Contractor is unable to

adduce proof of performance and/or receipt of the actual net cost for any service.

(2) If an audit conducted by federal, State, and/or County representatives finds that actual allowable and documented costs for a unit of service provided hereunder are less than the County's payment for those units of service, the Contractor shall repay County the difference immediately upon request, or County has the right to withhold and/or offset that repayment obligation against future payments.

(3) If within thirty (30) calendar days of termination of the Contract period, such audit finds that the units of service, allowable costs of services and/or any combination thereof furnished hereunder are higher than the units of service, allowable costs of services and/or payments made by County, then the difference may be paid to Contractor, not to exceed the County maximum Obligation.

(4) In no event shall County be required to pay Contractor for units of services that are not supported by actual allowable and documented costs.

(5) In the event that Contractor's actual allowable and documented cost for a unit of service are less than fee-for-service rate(s) set out in the budget(s), the Contractor shall be reimbursed for its actual allowable and documented costs only.

I. Failure to Comply: Failure of Contractor to comply with the terms of this Paragraph shall constitute a material breach of contract upon which Director may suspend or County may immediately terminate this Contract.

17. TERMINATION FOR NON-ADHERENCE OF COUNTY LOBBYIST ORDINANCE OR RESTRICTIONS ON LOBBYING:

A. The Contractor, and each County Lobbyist or County Lobbying firm as defined in County Code Section 2.160.010 retained by the Contractor, shall fully comply with the County's Lobbyist Ordinance, County Code Chapter 2.160. Failure on the part of the Contractor or any County Lobbyist or County Lobbying firm retained by the Contractor to fully comply with the County's Lobbyist Ordinance shall constitute a material breach of this Contract, upon which the County may in its sole discretion, immediately terminate or suspend this Contract.

B. Federal Certification and Disclosure Requirement: Because federal monies are to be used to pay for Contractor's services under this Contract, Contractor shall comply with all certification and disclosure requirements prescribed by Section 319, Public Law 101-121 (Title 31, U.S.C., Section 1352) and any implementing regulations, and shall ensure that each of its subcontractors receiving funds provided under this Contract also fully comply with all such certification and disclosure requirements.

18A. CONTRACTOR'S CHARITABLE ACTIVITIES COMPLIANCE: The Supervision of Trustees and Fundraisers for Charitable Purposes Act regulates entities receiving or raising charitable contributions. The "Nonprofit Integrity Act of 2004" (SB

1262, Chapter 919) increased Charitable Purposes Act requirements. By requiring Contractors to complete the Charitable Contributions Certification, Exhibit G, the County seeks to ensure that all County contractors which receive or raise charitable contributions comply with California law in order to protect the County and its taxpayers. A Contractor which receives or raises charitable contributions without complying with its obligations under California law commits a material breach subjecting it to either contract termination or debarment proceedings or both. (County Code Chapter 2.202)

18B. CONTRACTOR'S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM:

Contractor hereby warrants that neither it nor any of its staff members is restricted or excluded from providing services under any health care program funded by the federal government, directly or indirectly, in whole or in part, and that Contractor will notify Director within thirty (30) calendar days in writing of: (1) any event that would require Contractor or a staff member's mandatory exclusion from participation in a federally funded health care program; and (2) any exclusionary action taken by any agency of the federal government against Contractor or one or more staff members barring it or the staff members from participation in a federally funded health care program, whether such bar is direct or indirect, or whether such bar is in whole or in part.

Contractor shall indemnify and hold County harmless against any and all loss or damage County may suffer arising from any federal exclusion of Contractor or its staff members from such participation in a federally funded health care program.

Failure by Contractor to meet the requirements of this Paragraph shall constitute a material breach of contract upon which County may immediately terminate or suspend this Contract.

18C. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION - LOWER TIER COVERED TRANSACTIONS (45 C.F.R. PART 76): Contractor hereby acknowledges that the County is prohibited from contracting with and making sub-awards to parties that are suspended, debarred, ineligible or excluded from securing federally funded contracts. By executing this Contract, Contractor certifies that neither it, nor any of its owners, officers, partners, directors or principals is currently suspended, debarred, ineligible, or excluded from securing federally funded contracts. Further, by executing this Contract, Contractor certifies that, to its knowledge, none of its subcontractors, at any tier, or any owner, officer, partner director, or other principal of any subcontractor is currently suspended, debarred, ineligible, or excluded from securing federally funded contracts. Contractor shall immediately notify County in writing, during the term of this Contract, should it or any of its subcontractors or any principals of either being suspended, debarred, ineligible, or excluded from securing federally funded contracts. Failure of Contractor to comply with this provision shall constitute a material breach of this Contract upon which the County may immediately terminate or suspend this Contract.

18D. WHISTLEBLOWER PROTECTIONS:

A. Per statute 41 United States Code (U.S.C.) 4712, all employees working for contractors, grantees, subcontractors, and subgrantees on federal grants and contracts are subject to whistleblower rights, remedies, and

protections and may not be discharged, demoted, or otherwise discriminated against as a reprisal for whistleblowing. In addition, whistleblowing protections cannot be waived by any agreement, policy, form, or condition of employment.

B. Whistleblowing is defined as making a disclosure "that the employee reasonably believes" is evidence of any of the following: gross mismanagement of a federal contract or grant; a gross waste of federal funds; an abuse of authority relating to a federal contract or grant; a substantial and specific danger to public health or safety; or a violation of law, rule, or regulation related to a federal contract or grant (including the competition for, or negotiation of, a contract or grant). To qualify under the statue, the employee's disclosure must be made to: a member of Congress, or a representative of a Congressional committee; an Inspector General; the Government Accountability Office; a federal employee responsible for contract or grant oversight or management at the relevant agency; an official from the Department of Justice, or other law enforcement agency; a court or grand jury; or a management official or other employee of the contractor, subcontractor, grantee, or subgrantee who has the responsibility to investigate, discover, or address misconduct.

C. The National Defense Authorization Act for fiscal year 2013, enacted January 2, 2013, mandates a Pilot Program for Enhancement of Contractor Employee Whistleblower Protections that requires that all grantees, their subgrantees, and subcontractors: to inform their employees working on any federal award that they are subject to the whistleblower rights and remedies of the pilot program; to inform their employees in writing of the employee

whistleblower protections under statute 41 U.S.C. 4712 in the predominant native language of the workforce; and, contractors and grantees shall include such requirements in any agreement made with a subcontractor or subgrantee."

18E. MOST FAVORED PUBLIC ENTITY: If the Contractor's prices decline, or should the Contractor at any time during the term of this Contract provide the same goods or services under similar quantity and delivery conditions to the State of California or any county, municipality, or district of the State at prices below those set forth in this Contract, then such lower prices shall be immediately extended to the County.

18F. LOCAL SMALL BUSINESS ENTERPRISE (SBE) PREFERENCE PROGRAM:

A. This Contract is subject to the provisions of the County's ordinance entitled Local Small Business Enterprise Preference Program, as codified in Chapter 2.204 of the Los Angeles County Code.

B. The Contractor shall not knowingly and with the intent to defraud, fraudulently obtain, retain, attempt to obtain or retain, or aid another in fraudulently obtaining or retaining or attempting to obtain or retain certification as a Local Small Business Enterprise.

C. The Contractor shall not willfully and knowingly make a false statement with the intent to defraud, whether by affidavit, report, or other representation, to a County official or employee for the purpose of influencing the certification or denial of certification of any entity as a Local Small Business Enterprise.

D. If the Contractor has obtained certification as a Local Small Business Enterprise by reason of having furnished incorrect supporting information or by reason of having withheld information, and which knew, or should have known, the information furnished was incorrect or the information withheld was relevant to its request for certification, and which by reason of such certification has been awarded this contract to which it would not otherwise have been entitled, shall:

(1) Pay to the County any difference between the contract amount and what the County's costs would have been if the contract had been properly awarded;

(2) In addition to the amount described in subdivision (1), be assessed a penalty in an amount of not more than 10 percent of the amount of the contract; and

(3) Be subject to the provisions of Chapter 2.202 of the Los Angeles County Code (Determinations of Contractor Non-responsibility and Contractor Debarment).

The above penalties shall also apply to any business that has previously obtained proper certification, however, as a result of a change in their status would no longer be eligible for certification, and fails to notify the State and Internal Services Department of this information prior to responding to a solicitation or accepting a contract award.

18G. TRANSITIONAL JOB OPPORTUNITIES PREFERENCE PROGRAM:

A. This Contract is subject to the provisions of the County's ordinance entitled Transitional Job Opportunities Preference Program, as codified in Chapter 2.205 of the Los Angeles County Code.

B. Contractor shall not knowingly and with the intent to defraud, fraudulently obtain, retain, attempt to obtain or retain, or aid another in fraudulently obtaining or retaining or attempting to obtain or retain certification as a Transitional Job Opportunity vendor.

C. Contractor shall not willfully and knowingly make a false statement with the intent to defraud, whether by affidavit, report, or other representation, to a County official or employee for the purpose of influencing the certification or denial of certification of any entity as a Transitional Job Opportunity vendor.

D. If Contractor has obtained County certification as a Transitional Job Opportunity vendor by reason of having furnished incorrect supporting information or by reason of having withheld information, and which knew, or should have known, the information furnished was incorrect or the information withheld was relevant to its request for certification, and which by reason of such certification has been awarded this Contract to which it would not otherwise have been entitled, shall:

(1) Pay to the County any difference between the Contract amount and what the County's costs would have been if the Contract had been properly awarded;

(2) In addition to the amount described in subdivision (1), be assessed a penalty in an amount of not more than 10 percent (10%) of the amount of the Contract; and

(3) Be subject to the provisions of Chapter 2.202 of the Los Angeles County Code (Determinations of Contractor Non-responsibility and Contractor Debarment).

The above penalties shall also apply to any entity that has previously obtained proper certification, however, as a result of a change in their status would no longer be eligible for certification, and fails to notify the certifying department of this information prior to responding to a solicitation or accepting a contract award.

(PARAGRAPH 18H SHOULD ONLY BE INCLUDED IN CONTRACTS WHERE THE CONTRACTOR REQUESTED AND WAS GRANTED THE DISABLED VETERAN BUSINESS ENTERPRISE PREFERENCE)

18H. DISABLED VETERAN BUSINESS ENTERPRISE PREFERENCE PROGRAM:

A. 74This Contract is subject to the provisions of the County's ordinance entitled Disabled Veteran Business Enterprise Preference Program, as codified in Chapter 2.211 of the Los Angeles County Code.

B. Contractor shall not knowingly and with the intent to defraud, fraudulently obtain, retain, attempt to obtain or retain, or aid another in fraudulently obtaining or retaining or attempting to obtain or retain certification as a Disabled Veteran Business Enterprise.

C. Contractor shall not willfully and knowingly make a false statement with the intent to defraud, whether by affidavit, report, or other representation, to a County official or employee for the purpose of influencing the certification or denial of certification of any entity as a Disabled veteran Business Enterprise.

D. If Contractor has obtained certification as a Disabled Veteran Business Enterprise by reason of having furnished incorrect supporting information or by reason of having withheld information, and which knew, or should have known, the information furnished was incorrect or the information withheld was relevant to its request for certification, and which by reason of such certification has been awarded this contract to which it would not otherwise have been entitled, shall:

(1) Pay to the County any difference between the contract amount and what the County's costs would have been if the contract had been properly awarded;

(2) In addition to the amount described in subdivision (1), be assessed a penalty in an amount of not more than 10 percent of the amount of the contract; and

(3) Be subject to the provisions of Chapter 2.202 of the Los Angeles County Code (Determinations of Contractor Non-responsibility and Contractor Debarment).

The above penalties shall also apply to any business that has previously obtained proper certification, however, as a result of a change in their status

would no longer be eligible for certification, and fails to notify the state and ISD of this information prior to responding to a solicitation or accepting a contract award.

(THE FOLLOWING PARAGRAPH 18I BELOW SHOULD ONLY BE INCLUDED IF THIS IS A PROP A CONTRACT)

18I. COMPLIANCE WITH THE COUNTY'S LIVING WAGE PROGRAM:

A. Living Wage Program: This Contract is subject to the provisions of the County's ordinance entitled Living Wage Program as codified in Sections 2.201.010 through 2.201.100 of the Los Angeles County Code, a copy of which is available at http://publichealth.lacounty.gov/cg/index.htm.

B. Payment of Living Wage Rates:

(1) Unless the Contractor has demonstrated to the County's satisfaction either that the Contractor is not an "Employer" as defined under the Program (Section 2.201.020 of the County Code) or that the Contractor qualifies for an exception to the Living Wage Program (Section 2.201.090 of the County Code), the Contractor shall pay its Employees no less than the applicable hourly living wage rate, as set forth immediately below, for the Employees' services provided to the County, including, without limitation, "Travel Time" as defined below at subsection 5 of this Sub-paragraph B under the Contract:

(a) Not less than $11.84 per hour if, in addition to the per-hour wage, the Contractor contributes less than $2.20 per hour towards the provision of bona fide health care benefits for its Employees and any dependents; or

(b) Not less than $9.64 per hour if, in addition to the per-hour wage, the Contractor contributes at least $2.20 per hour towards the provision of bona fide health care benefits for its Employees and any dependents. The Contractor will be deemed to have contributed $2.20 per hour towards the provision of bona fide health care benefits if the benefits are provided through the County Department of Health Services Community Health Plan. If, at any time during the Contract, the Contractor contributes less than $2.20 per hour towards the provision of bona fide health care benefits, the Contractor shall be required to pay its Employees the higher hourly living wage rate.

(2) For purposes of this sub-paragraph, "Contractor" includes any subcontractor engaged by the Contractor to perform services for the County under the Contract. If the Contractor uses any subcontractor to perform services for the County under the Contract, the subcontractor shall be subject to the provisions of this sub-paragraph. The provisions of this sub-paragraph shall be inserted into any such subcontract and a copy of the Living Wage Program shall be attached to the subcontract. "Employee" means any individual who is an employee of the Contractor under the laws of California and who is providing full-time services to the Contractor, some or all of which are provided to the County under the Contract. "Full-time" means a minimum of 40 hours worked per week, or a lesser number of hours, if the lesser number is a recognized industry

standard and is approved as such by the County; however, fewer than 35 hours worked per week will not, in any event, be considered full-time.

(3) If the Contractor is required to pay a living wage when the Contract commences, the Contractor shall continue to pay a living wage for the entire term of the Contract, including any option period.

(4) If the Contractor is not required to pay a living wage when the Contract commences, the Contractor shall have a continuing obligation to review the applicability of its "exemption status" from the living wage requirement. The Contractor shall immediately notify the County if the Contractor at any time either comes within the Living Wage Program's definition of "Employer" or if the Contractor no longer qualifies for an exception to the Living Wage Program. In either event, the Contractor shall immediately be required to commence paying the living wage and shall be obligated to pay the living wage for the remaining term of the Contract, including any option period. The County may also require, at any time during the Contract and at its sole discretion, that the Contractor demonstrate to the County's satisfaction that the Contractor either continues to remain outside of the Living Wage Program's definition of "Employer" and/or that the Contractor continues to qualify for an exception to the Living Wage Program. Unless the Contractor satisfies this requirement within the time frame permitted by the County, the Contractor shall immediately be required to pay the living wage for the remaining term of the Contract, including any option period.

(5) For purposes of the Contractor's obligation to pay its Employees the applicable hourly living wage rate under this Contract, "Travel Time" shall have the following two meanings, as applicable: 1) With respect to travel by an Employee that is undertaken in connection with this Contract, Travel Time shall mean any period during which an Employee physically travels to or from a County facility if the Contractor pays the Employee any amount for that time or if California law requires the Contractor to pay the Employee any amount for that time; and 2) With respect to travel by an Employee between County facilities that are subject to two different contracts between the Contractor and the County (of which both contracts are subject to the Living Wage Program), Travel Time shall mean any period during which an Employee physically travels to or from, or between such County facilities if the Contractor pays the Employee any amount for that time or if California law requires the Contractor to pay the Employee any amount for that time.

C. Contractor's Submittal of Certified Monitoring Reports: The Contractor shall submit to the County certified monitoring reports at a frequency instructed by the County. The certified monitoring reports shall list all of the Contractor's Employees during the reporting period. The certified monitoring reports shall also verify the number of hours worked, the hourly wage rate paid, and the amount paid by the Contractor for health benefits, if any, for each of its Employees. The certified monitoring reports shall also state the name and identification number of the Contractor's current health care benefits plan, and

the Contractor's portion of the premiums paid as well as the portion paid by each Employee. All certified monitoring reports shall be submitted on forms provided by the County, or other form approved by the County which contains the above information. The County reserves the right to request any additional information it may deem necessary. If the County requests additional information, the Contractor shall promptly provide such information. The Contractor, through one of its officers, shall certify under penalty of perjury that the information contained in each certified monitoring report is true and accurate.

D. Contractor's Ongoing Obligation to Report Labor Law/Payroll Violations and Claims: During the term of the Contract, if the Contractor becomes aware of any labor law/payroll violation or any complaint, investigation or proceeding ("claim") concerning any alleged labor law/payroll violation (including but not limited to any violation or claim pertaining to wages, hours and working conditions such as minimum wage, prevailing wage, living wage, the Fair Labor Standards Act, employment of minors, or unlawful employment discrimination), the Contractor shall immediately inform the County of any pertinent facts known by the Contractor regarding same. This disclosure obligation is not limited to any labor law/payroll violation or claim arising out of the Contractor's contract with the County, but instead applies to any labor law/payroll violation or claim arising out of any of the Contractor's operations in California.

E. County Auditing of Contractor Records: Upon a minimum of twenty-four (24) hours' written notice, the County may audit, at the Contractor's

place of business, any of the Contractor's records pertaining to the Contract, including all documents and information relating to the certified monitoring reports. The Contractor is required to maintain all such records in California until the expiration of four (4) years from the date of final payment under the Contract. Authorized agents of the County shall have access to all such records during normal business hours for the entire period that records are to be maintained.

F. Notifications to Employees: The Contractor shall place County-provided living wage posters at each of the Contractor's places of business and locations where the Contractor's Employees are working. The Contractor shall also distribute County-provided notices to each of its Employees at least once per year. The Contractor shall translate posters and handouts into Spanish and any other language spoken by a significant number of Employees.

G. Enforcement and Remedies: If the Contractor fails to comply with the requirements of this sub-Paragraph, the County shall have the rights and remedies described in this sub-paragraph in addition to any rights and remedies provided by law or equity.

(1) Remedies For Submission of Late or Incomplete Certified Monitoring Reports: If the Contractor submits a certified monitoring report to the County after the date it is due or if the report submitted does not contain all of the required information or is inaccurate or is not properly certified, any such deficiency shall constitute a breach of the Contract. In the event of any such breach, the County may, in its sole discretion, exercise any or all of the following rights/remedies:

(a) Withholding of Payment: If the Contractor fails to submit accurate, complete, timely and properly certified monitoring reports, the County may withhold from payment to the Contractor up to the full amount of any invoice that would otherwise be due, until the Contractor has satisfied the concerns of the County, which may include required submittal of revised certified monitoring reports or additional supporting documentation.

(b) Liquidated Damages: It is mutually understood and agreed that the Contractor's failure to submit an accurate, complete, timely and properly certified monitoring report will result in damages being sustained by the County. It is also understood and agreed that the nature and amount of the damages will be extremely difficult and impractical to fix; that the liquidated damages set forth herein are the nearest and most exact measure of damages for such breach that can be fixed at this time; and that the liquidated damages are not intended as a penalty or forfeiture for the Contractor's breach. Therefore, in the event that a certified monitoring report is deficient, including but not limited to being late, inaccurate, incomplete or uncertified, it is agreed that the County may, in its sole discretion, assess against the Contractor liquidated damages in the amount of $100 per monitoring report for each day until the County has been provided with a properly prepared, complete and certified monitoring report. The County may deduct

any assessed liquidated damages from any payments otherwise due the Contractor.

(c) Termination: The Contractor's continued failure to submit accurate, complete, timely and properly certified monitoring reports may constitute a material breach of the Contract. In the event of such material breach, the County may, in its sole discretion, terminate the Contract.

(2) Remedies for Payment of Less Than the Required Living Wage: If the Contractor fails to pay any Employee at least the applicable hourly living wage rate, such deficiency shall constitute a breach of the Contract. In the event of any such breach, the County may, in its sole discretion, exercise any or all of the following rights/remedies:

(a) Withholding Payment: If the Contractor fails to pay one or more of its Employees at least the applicable hourly living wage rate, the County may withhold from any payment otherwise due the Contractor the aggregate difference between the living wage amounts the Contractor was required to pay its Employees for a given pay period and the amount actually paid to the employees for that pay period. The County may withhold said amount until the Contractor has satisfied the County that any underpayment has been cured, which may include required submittal of revised certified monitoring reports or additional supporting documentation.

(b) Liquidated Damages: It is mutually understood and agreed that the Contractor's failure to pay any of its Employees at least the applicable hourly living wage rate will result in damages being sustained by the County. It is also understood and agreed that the nature and amount of the damages will be extremely difficult and impractical to fix; that the liquidated damages set forth herein are the nearest and most exact measure of damages for such breach that can be fixed at this time; and that the liquidated damages are not intended as a penalty or forfeiture for the Contractor's breach. Therefore, it is agreed that the County may, in its sole discretion, assess against the Contractor liquidated damages of $50 per Employee per day for each and every instance of an underpayment to an Employee. The County may deduct any assessed liquidated damages from any payments otherwise due the Contractor.

(c) Termination: The Contractor's continued failure to pay any of its Employees the applicable hourly living wage rate may constitute a material breach of the Contract. In the event of such material breach, the County may, in its sole discretion, terminate the Contract.

(3) Debarment: In the event the Contractor breaches a requirement of this sub-paragraph, the County may, in its sole discretion, bar the Contractor from the award of future County contracts for a period

of time consistent with the seriousness of the breach, in accordance with Los Angeles County Code, Chapter 2.202, Determinations of Contractor Non-Responsibility and Contractor Debarment.

H. Use of Full-Time Employees: The Contractor shall assign and use full-time Employees of the Contractor to provide services under the Contract unless the Contractor can demonstrate to the satisfaction of the County that it is necessary to use non-full-time Employees based on staffing efficiency or County requirements for the work to be performed under the Contract. It is understood and agreed that the Contractor shall not, under any circumstance, use non-full-time Employees for services provided under the Contract unless and until the County has provided written authorization for the use of same. The Contractor submitted with its proposal a full-time Employee staffing plan. If the Contractor changes its full-time Employee staffing plan, the Contractor shall immediately provide a copy of the new staffing plan to the County.

I. Contractor Retaliation Prohibited: The Contractor and/or its Employees shall not take any adverse action which would result in the loss of any benefit of employment, any contract benefit, or any statutory benefit for any Employee, person or entity who has reported a violation of the Living Wage Program to the County or to any other public or private agency, entity or person. A violation of the provisions of this sub-paragraph may constitute a material breach of the Contract. In the event of such material breach, the County may, in its sole discretion, terminate the Contract.

J. Contractor Standards: During the term of the Contract, the Contractor shall maintain business stability, integrity in employee relations and the financial ability to pay a living wage to its employees. If requested to do so by the County, the Contractor shall demonstrate to the satisfaction of the County that the Contractor is complying with this requirement.

Note: Sub-paragraph K applies only if the contract involves the provision of services that were previously provided by a Contractor under a predecessor Proposition A contract or a predecessor cafeteria services contract, which predecessor contract was terminated by the County prior to its expiration.

K. Employee Retention Rights:

(1) The Contractor shall offer employment to all retention employees who are qualified for such jobs. A "retention employee" is an individual:

(a) Who is not an exempt employee under the minimum wage and maximum hour exemptions defined in the federal Fair Labor Standards Act; and

(b) Who has been employed by a Contractor under a predecessor Proposition A contract or a predecessor cafeteria services contract with the County for at least six months prior to the date of this new Contract, which predecessor contract was terminated by the County prior to its expiration; and

(c) Who is or will be terminated from his or her employment as a result of the County entering into this new contract.

(2) The Contractor is not required to hire a retention employee who:

(a) Has been convicted of a crime related to the job or his or her performance; or

(b) Fails to meet any other County requirement for employees of a Contractor.

(3) The Contractor shall not terminate a retention employee for the first 90 days of employment under the contract, except for cause. Thereafter, the Contractor may retain a retention employee on the same terms and conditions as the Contractor's other employees.

L. Neutrality in Labor Relations: The Contractor shall not use any consideration received under the Contract to hinder, or to further, organization of, or collective bargaining activities by or on behalf of the Contractor's employees, except that this restriction shall not apply to any expenditure made in the course of good faith collective bargaining, or to any expenditure pursuant to obligations incurred under a bona fide collective bargaining Contract, or which would otherwise be permitted under the provisions of the National Labor Relations Act.

(THE FOLLOWING PARAGRAPH 18J IS REQUIRED FOR CHILD CARE, GROUP HOME, FOSTER FAMILY AGENCY, AND OTHER CONTRACTS PROVIDING SERVICES OR PROGRAMS TO CHILDREN)

18J. COMPLIANCE WITH COUNTY'S CHILD WELLNESS POLICY: This Contract is subject to Chapter 3.116 of the County Code entitled Los Angeles County Child Wellness Policy (Child Wellness). As required by the Child Wellness policy Contractor shall make every effort to provide current nutrition and physical activity

information to parents, caregivers, and staff as recommended by the Centers for Disease Control and Prevention, and the American Academy of Pediatrics; ensure that age appropriate nutritional and physical activity guidelines for children both in out-of-home care and in child care settings are promoted and adhered to; and provide opportunities for public education and training.

(THE FOLLOWING PARAGRAPH 18K IS REQUIRED FOR IT CONTRACTS ONLY)

18K. PATENT, COPYRIGHT AND TRADE SECRET INDEMNIFICATION:

A. The Contractor shall indemnify, hold harmless and defend County from and against any and all liability, damages, costs, and expenses, including, but not limited to, defense costs and attorneys' fees, for or by reason of any actual or alleged infringement of any third party's patent or copyright, or any actual or alleged unauthorized trade secret disclosure, arising from or related to the operation and utilization of the Contractor's work under this Contract. County shall inform the Contractor as soon as practicable of any claim or action alleging such infringement or unauthorized disclosure, and shall support the Contractor's defense and settlement thereof.

B. In the event any equipment, part thereof, or software product becomes the subject of any complaint, claim, or proceeding alleging infringement or unauthorized disclosure, such that County's continued use of such item is formally restrained, enjoined, or subjected to a risk of damages, the Contractor, at its sole expense, and providing that County's continued use of the system is not materially impeded, shall either:

(1) Procure for County all rights to continued use of the questioned equipment, part, or software product; or

(2) Replace the questioned equipment, part, or software product with a non-questioned item; or

(3) Modify the questioned equipment, part, or software so that it is free of claims.

C. The Contractor shall have no liability if the alleged infringement or unauthorized disclosure is based upon a use of the questioned product, either alone or in combination with other items not supplied by the Contractor, in a manner for which the questioned product was not designed nor intended.

(THE FOLLOWING PROVISION 18L ONLY APPLIES TO CONTRACTS REQUIRING COMPENSATION FOR DEFAULT [DELETE IF NOT APPLICABLE])

18L. LIQUIDATED DAMAGES:

A. If, in the judgment of the Director, or his/her designee, the Contractor is deemed to be non-compliant with the terms and obligations assumed hereby, the Director, or his/her designee, at his/her option, in addition to, or in lieu of, other remedies provided herein, may withhold the entire monthly payment or deduct pro rata from the Contractor's invoice for work not performed. A description of the work not performed and the amount to be withheld or deducted from payments to the Contractor from the County, will be forwarded to the Contractor by the Director, or his/her designee, in a written notice describing the reasons for said action.

B. If the Director determines that there are deficiencies in the performance of this Contract that the Director deems are correctable by the Contractor over a certain time span, the Director will provide a written notice to the Contractor to correct the deficiency within specified time frames. Should the

Contractor fail to correct deficiencies within said time frame, the Director may: (a) Deduct from the Contractor's payment, pro rata, those applicable portions of the Monthly Contract Sum; and/or (b) Deduct liquidated damages. The parties agree that it will be impracticable or extremely difficult to fix the extent of actual damages resulting from the failure of the Contractor to correct a deficiency within the specified time frame. The parties hereby agree that under the current circumstances a reasonable estimate of such damages is One Hundred Dollars ($100) per day per infraction, and that the Contractor shall be liable to the County for liquidated damages in said amount. Said amount shall be deducted from the County's payment to the Contractor; and/or (c) Upon giving five (5) days' notice to the Contractor for failure to correct the deficiencies, the County may correct any and all deficiencies and the total costs incurred by the County for completion of the work by an alternate source, whether it be County forces or separate private contractor, will be deducted and forfeited from the payment to the Contractor from the County, as determined by the County.

C. The action noted in sub-paragraph B above shall not be construed as a penalty, but as adjustment of payment to the Contractor to recover the County cost due to the failure of the Contractor to complete or comply with the provisions of this Contract.

D. This sub-paragraph shall not, in any manner, restrict or limit the County's right to damages for any breach of this Contract provided by law or as specified in sub-paragraph B above, and shall not, in any manner, restrict or limit the County's right to terminate this Contract as agreed to herein.

18M. DATA DESTRUCTION:

A. Contractor(s) and Vendor(s) that have maintained, processed, or stored the County of Los Angeles' ("County") data and/or information, implied or expressed, have the sole responsibility to certify that the data and information have been appropriately destroyed consistent with the National Institute of Standards and Technology (NIST) Special Publication SP 800-88 titled Guidelines for Media Sanitization.

Available at: http://csrc.nist.gov/publications/PubsDrafts.html#SP-800-88-Rev.%201)

B. The data and/or information may be stored on purchased, leased, or rented electronic storage equipment (e.g., printers, hard drives) and electronic devices (e.g., servers, workstations) that are geographically located within the County, or external to the County's boundaries. The County must receive within 10 business days, a signed document from Contractor(s) and Vendor(s) that certifies and validates the data and information were placed in one or more of the following stored states: unusable, unreadable, and indecipherable.

C. Vendor shall certify that any County data stored on purchased, leased, or rented electronic storage equipment and electronic devices, including, but not limited to printers, hard drives, servers, and/or workstations are destroyed consistent with the current National Institute of Standard and Technology (NIST) Special Publication SP-800-88, *Guidelines for Media Sanitization.* Vendor shall provide County with written certification, within 10 business days of removal of

any electronic storage equipment and devices that validates that any and all County data was destroyed and is unusable, unreadable, and/or undecipherable.

18N. COST OF LIVING ADJUSTMENTS (COLA's): If requested by the Contractor, the contract (hourly, daily, monthly, etc.) amount may at the sole discretion of the County, be increased annually based on the most recent published percentage change in the U.S. Department of Labor, Bureau of Labor Statistics' Consumer Price Index (CPI) for the Los Angeles-Riverside-Orange County Area for the 12-month period preceding the contract anniversary date, which shall be the effective date for any Cost of Living Adjustment (COLA). However, any increase shall not exceed the general salary movement granted to County employees as determined by the Chief Executive Officer as of each July 1 for the prior 12-month period. Furthermore, should fiscal circumstances ultimately prevent the Board from approving any increase in County employee salaries, no COLA will be granted. Where the County decides to grant a COLA pursuant to this paragraph for living wage contracts, it may, in its sole discretion exclude the cost of labor (including the cost of wages and benefits paid to employees providing services under this Contract) from the base upon which a COLA is calculated, unless the Contractor can show that his/her labor cost will actually increase. Further, before any COLA increase shall take effect and become part of this Contract, it shall require a written amendment to this Contract first, that has been formally approved and executed by the parties.

19. CONSTRUCTION: To the extent there are any rights, duties, obligations, or responsibilities enumerated in the recitals or otherwise in this Contract, they shall be

deemed a part of the operative provisions of this Contract and are fully binding upon the parties.

20. CONFLICT OF TERMS: To the extent that there exists any conflict or inconsistency between the language of this Contract and that of any Exhibit(s), Attachment(s), and any documents incorporated herein by reference, the language found within this Contract shall govern and prevail.

21. CONTRACTOR'S OFFICES: Contractor's office is located at _____. Contractor's business telephone number is (____) _____, facsimile (FAX) number is (____) _____, and electronic Mail (e-mail) address is _____. Contractor shall notify County, in writing, of any changes made to their business address, business telephone number, FAX number and/or e-mail address as listed herein, or any other business address, business telephone number, FAX number and/or e-mail address used in the provision of services herein, at least ten (10) calendar days prior to the effective date(s) thereof.

22. NOTICES: Notices hereunder shall be in writing and may either be delivered personally or sent by registered or certified mail, return receipt requested, postage prepaid, attention to the parties at the addresses listed below. Director is authorized to execute all notices or demands which are required or permitted by County under this Contract. Addresses and parties to be notified may be changed by providing at least ten (10) working days prior written notice to the other party.

A. Notices to County shall be addressed as follows:

(1) Department of Public Health
Program Name
Division
Address Line 1

Address Line 2

Attention: Project Director

(2) Department of Public Health
Contracts and Grants Division
1000 S. Fremont Avenue
Building A-9 East, 3rd Floor
Alhambra, California 91803

Attention: Division Chief

B. Notices to Contractor shall be addressed as follows:

(1) _____
_____
_____

Attention: _____

23. ADMINISTRATION OF CONTRACT:

A. County's Director of Public Health or his/her authorized designee(s) (hereafter collectively "Director") shall have the authority to administer this Contract on behalf of County. Contractor agrees to extend to Director the right to review and monitor Contractor's programs, policies, procedures, and financial and/or other records, and to inspect its facilities for contractual compliance at any reasonable time.

B. Approval of Contractor's Staff: County has the absolute right to approve or disapprove all of the Contractor's staff performing work hereunder and any proposed changes in the Contractor's staff, including, but not limited to, the contractor's Project Manager.

C. Contractor's Staff Identification: All of Contractor's employees assigned to County facilities are required to have a County Identification (ID)

badge on their person and visible at all times. Contractor bears all expense related to the badges.

D. Background and Security Investigations: Each of Contractor's staff performing services under this Contract, who is in a designated sensitive position, as determined by County in County's sole discretion, shall undergo and pass a background investigation to the satisfaction of County as a condition of beginning and continuing to perform services under this Contract. Such background investigation must be obtained through fingerprints submitted to the California Department of Justice to include State, local, and federal-level review, which may include, but shall not be limited to, criminal conviction information. The fees associated with the background investigation shall be at the expense of the Contractor, regardless of whether the member of Contractor's staff passes or fails the background investigation. Contractor shall perform the background check using County's mail code, routing results to the County.

If a member of Contractor's staff who is in a designated sensitive position does not obtain work clearance through the criminal history background review, they may not be placed and/or assigned within the Department of Public Health. During the term of the Contract, the Department may receive subsequent criminal information. If this subsequent information constitutes a job nexus, the Contractor shall immediately remove staff from performing services under this Contract and replace such staff within fifteen (15) days of removal or within an agreed upon time with the County. Pursuant to an agreement with the Federal

Department of Justice, the County will not provide to Contractor nor to Contractor's staff any information obtained through the criminal history review.

Disqualification of any member of Contractor's staff pursuant to this section shall not relieve Contractor of its obligation to complete all work in accordance with the terms and conditions of this Contract.

24. ASSIGNMENT AND DELEGATION:

A. Contractor shall not assign its rights or delegate its duties under this Contract, or both, whether in whole or in part, without the prior written consent of County, in its discretion, and any attempted assignment or delegation without such consent shall be null and void. For purposes of this sub-paragraph, County consent shall require a written Amendment to the Contract, which is formally approved and executed by the parties. Any payments by County to any approved delegatee or assignee on any claim under this Contract shall be deductible, at County's sole discretion, against the claims, which Contractor may have against County.

B. Shareholders, partners, members, or other equity holders of Contractor may transfer, sell, exchange, assign, or divest themselves of any interest they may have therein. However, in the event any such transfer, exchange, assignment, or divestment is effected in such a way as to give majority control of Contractor to any person(s), corporation, partnership, or legal entity other than the majority controlling interest therein at the time of execution of the Contract, such disposition is an assignment requiring the prior written consent of County in accordance with applicable provisions of this Contract.

C. Any assumption, assignment, delegation, or takeover of any of the Contractor's duties, responsibilities, obligations, or performance of same by any person or entity other than Contractor, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever without County's express prior written approval, shall be a material breach of the Contract which may result in the termination of this Contract. In the event of such termination, County shall be entitled to pursue the same remedies against Contractor as it could pursue in the event of default by Contractor.

25. AUTHORIZATION WARRANTY: Contractor hereby represents and warrants that the person executing this Contract for Contractor is an authorized agent who has actual authority to bind Contractor to each and every term, condition, and obligation set forth in this Contract and that all requirements of Contractor have been fulfilled to provide such actual authority.

26. BUDGET REDUCTIONS: In the event that the Board adopts, in any fiscal year, a County Budget which provides for reductions in the salaries and benefits paid to the majority of County employees and imposes similar reductions with respect to County Contracts, the County reserves the right to reduce its payment obligation under this Contract correspondingly for that fiscal year and any subsequent fiscal year during the term of this Contract (including any extensions), and the services to be provided by the Contractor under this Contract shall also be reduced correspondingly. County's notice to Contractor regarding said reduction in payment obligation shall be provided within thirty (30) calendar days of the Board's approval of such actions. Except as set

forth in the preceding sentence, Contractor shall continue to provide all of the services set forth in this Contract.

27. CONTRACTOR BUDGET AND EXPENDITURES REDUCTION FLEXIBILITY: In order for County to maintain flexibility with regard to budget and expenditure reductions, Contractor agrees that Director may cancel this Contract, without cause, upon the giving of ten (10) calendar days written notice to Contractor. In the alternative to cancellation, Director may, consistent with federal, State, and/or County budget reductions, renegotiate the scope/description of work, maximum obligation, and budget of this Contract via a written amendment to this Contract.

28. COMPLAINTS: The Contractor shall develop, maintain, and operate procedures for receiving, investigating, and responding to complaints.

A. Within thirty (30) business days after the Contract effective date, the Contractor shall provide the County with the Contractor's policy for receiving, investigating, and responding to user complaints.

B. The policy shall include, but not be limited to, when and how new clients as well as current and recurring clients are to be informed of the procedures to file a complaint.

C. The client and/or his/her authorized representative shall receive a copy of the procedure.

D. The County will review the Contractor's policy and provide the Contractor with approval of said policy or with requested changes.

E. If the County requests changes in the Contractor's policy, the Contractor shall make such changes and resubmit the plan within thirty (30) business days for County approval.

F. If, at any time, the Contractor wishes to change the Contractor's policy, the Contractor shall submit proposed changes to the County for approval before implementation.

G. The Contractor shall preliminarily investigate all complaints and notify the County's Project Manager of the status of the investigation within fifteen (15) business days of receiving the complaint.

H. When complaints cannot be resolved informally, a system of follow-through shall be instituted which adheres to formal plans for specific actions and strict time deadlines.

I. Copies of all written responses shall be sent to the County's Project Manager within three (3) business days of mailing to the complainant.

29. COMPLIANCE WITH APPLICABLE LAW:

A. In the performance of this Contract, Contractor shall comply with all applicable federal, State and local laws, rules, regulations, ordinances, directives, guidelines, policies and procedures, and all provisions required thereby to be included in this Contract are hereby incorporated herein by reference. To the extent that there is any conflict between federal and State or local laws, the former shall prevail.

B. Contractor shall indemnify, defend and hold harmless County, its officers, employees, and agents, from and against any and all claims, demands,

damages, liabilities, losses, costs, and expenses, including, without limitation, defense costs and legal, accounting and other expert, consulting or professional fees, arising from, connected with, or related to any failure by Contractor, its officers, employees, agents, or subcontractors, to comply with any such laws, rules, regulations, ordinances, directives, guidelines, policies, or procedures, as determined by County in its sole judgment. Any legal defense pursuant to Contractor's indemnification obligations under this Paragraph shall be conducted by Contractor and approved by County. Notwithstanding the preceding sentence, County shall have the right to participate in any such defense at its sole costs and expense, except that in the event Contractor fails to provide County with a full and adequate defense, as determined by county in its sole judgment, County shall be entitled to retain its own counsel, including limitation, County Counsel, and to reimbursement from Contractor for all such costs and expenses incurred by County in doing so. Contractor shall not have the right to enter into settlement, agree to any injunction or other equitable relief, or make any admission, in each case, on behalf of County without County's prior written approval.

30. COMPLIANCE WITH CIVIL RIGHTS LAW: The Contractor hereby assures that it will comply with Subchapter VI of the Civil Rights Act of 1964, 42 USC Sections 2000 (e) (1) through 2000 (e) (17), to the end that no person shall, on the grounds of race, creed, color, sex, religion, ancestry, age, condition of physical handicap, marital status, political affiliation, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination

under this Contract or under any project, program, or activity supported by this Contract. The Contractor shall comply with Exhibit D – Contractor's EEO Certification.

31. COMPLIANCE WITH THE COUNTY'S JURY SERVICE PROGRAM:

A. Jury Service Program: This Contract is subject to the provisions of the County's ordinance entitled Contractor Employee Jury Service ("Jury Service Program") as codified in Sections 2.203.010 through 2.203.090 of the Los Angeles County Code, a copy of which is available on the internet at http://publichealth.lacounty.gov/cg/index.htm

B. Written Employee Jury Service Policy:

(1) Unless the Contractor has demonstrated to the County's satisfaction either that the Contractor is not a "Contractor" as defined under the Jury Service Program (Section 2.203.020 of the County Code) or that the Contractor qualifies for an exception to the Jury Service Program (Section 2.203.070 of the County Code), the Contractor shall have and adhere to a written policy that provides that its Employees shall receive from the Contractor, on an annual basis, no less than five days of regular pay for actual jury service. The policy may provide that Employees deposit any fees received for such jury service with the Contractor or that the Contractor deduct from the Employee's regular pay the fees received for jury service.

(2) For purposes of this sub-paragraph, "Contractor" means a person, partnership, corporation or other entity which has a contract with the County or a subcontract with a County Contractor and has received or

will receive an aggregate sum of $50,000 or more in any 12-month period under one or more County contracts or subcontracts. "Employee" means any California resident who is a full-time employee of the Contractor. "Full-time" means 40 hours or more worked per week, or a lesser number of hours if: 1) the lesser number is a recognized industry standard as determined by the County, or 2) Contractor has a long-standing practice that defines the lesser number of hours as full-time. Full-time employees providing short-term, temporary services of 90 days or less within a 12-month period are not considered full-time for purposes of the Jury Service Program. If the Contractor uses any Subcontractor to perform services for the County under the Contract, the Subcontractor shall also be subject to the provisions of this sub-paragraph. The provisions of this sub-paragraph shall be inserted into any such subcontract agreement and a copy of the Jury Service Program shall be attached to the Contract.

(3) If the Contractor is not required to comply with the Jury Service Program when the Contract commences, the Contractor shall have a continuing obligation to review the applicability of its "exception status" from the Jury Service Program, and the Contractor shall immediately notify the County if the Contractor at any time either comes within the Jury Service Program's definition of "Contractor" or if the Contractor no longer qualifies for an exception to the Jury Service Program. In either event, the Contractor shall immediately implement a written policy consistent with the Jury Service Program. The County may

also require, at any time during the Contract and at its sole discretion, that the Contractor demonstrate, to the County's satisfaction that the Contractor either continues to remain outside of the Jury Service Program's definition of "Contractor" and/or that the Contractor continues to qualify for an exception to the Program.

(4) Contractor's violation of this sub-paragraph of the Contract may constitute a material breach of the Contract. In the event of such material breach, County may, at its sole discretion, terminate the Contract and/or bar the Contractor from the award of future County contracts for a period of time consistent with the seriousness of the breach.

32. CONFLICT OF INTEREST:

A. No County employee whose position with the County enables such employee to influence the award of this Contract or any competing Contract, and no spouse or economic dependent of such employee, shall be employed in any capacity by the Contractor or have any other direct or indirect financial interest in this Contract. No officer or employee of the Contractor who may financially benefit from the performance of work hereunder shall in any way participate in the County's approval, or ongoing evaluation, of such work, or in any way attempt to unlawfully influence the County's approval or ongoing evaluation of such work.

B. The Contractor shall comply with all conflict of interest laws, ordinances, and regulations now in effect or hereafter to be enacted during the term of this Contract. The Contractor warrants that it is not now aware of any facts that create a conflict of interest. If the Contractor hereafter becomes aware

of any facts that might reasonably be expected to create a conflict of interest, it shall immediately make full written disclosure of such facts to the County. Full written disclosure shall include, but is not limited to, identification of all persons implicated and a complete description of all relevant circumstances. Failure to comply with the provisions of this sub-paragraph shall be a material breach of this Contract.

33. CONSIDERATION OF HIRING GAIN/GROW PARTICIPANTS:

A. Should the Contractor require additional or replacement personnel after the effective date of this Contract, the Contractor shall give consideration for any such employment openings to participants in the County's Department of Public Social Services Greater Avenues for Independence (GAIN) Program or General Relief Opportunity for Work (GROW) Program who meet the Contractor's minimum qualifications for the open position. For this purpose, consideration shall mean that the Contractor will interview qualified candidates. The County will refer GAIN/GROW participants by job category to the Contractor. Contractors shall report all job openings with job requirements to GainGrow@dpss.lacounty.gov to obtain a list of qualified GAIN/GROW job candidates.

B. In the event that both laid-off County employees and GAIN/GROW participants are available for hiring, County employees shall be given first priority.

34. CONTRACTOR RESPONSIBILITY AND DEBARMENT:

A. Responsible Contractor: A responsible Contractor is a Contractor who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity and experience to satisfactorily perform the contract. It is the County's policy to conduct business only with responsible Contractors.

B. Chapter 2.202 of the County Code: The Contractor is hereby notified that, in accordance with Chapter 2.202 of the County Code, if the County acquires information concerning the performance of the Contractor on this or other contracts which indicates that the Contractor is not responsible, the County may, in addition to other remedies provided in the Contract, debar the Contractor from bidding or proposing on, or being awarded, and/or performing work on County contracts for a specified period of time, which generally will not exceed five years but may exceed five (5) years or be permanent if warranted by the circumstances, and terminate any or all existing Contracts the Contractor may have with the County.

C. Non-Responsible Contractor: The County may debar a Contractor if the Board of Supervisors finds, at its discretion, that the Contractor has done any of the following: (1) violated a term of a contract with the County or a nonprofit corporation created by the County, (2) committed an act or omission which negatively reflects on the Contractor's quality, fitness or capacity to perform a contract with the County, any other public entity, or a nonprofit corporation created by the County, or engaged in a pattern or practice which negatively reflects on same, (3) committed an act or offense which indicates a lack of business integrity or business honesty, or (4) made or submitted a false claim against the County or any other public entity.

D. Contractor Hearing Board: If there is evidence that the Contractor may be subject to debarment, the Department will notify the Contractor in writing of the evidence which is the basis for the proposed debarment and will advise the

Contractor of the scheduled date for a debarment hearing before the Contractor Hearing Board.

E. The Contractor Hearing Board will conduct a hearing where evidence on the proposed debarment is presented. The Contractor and/or the Contractor's representative shall be given an opportunity to submit evidence at that hearing. After the hearing, the Contractor Hearing Board shall prepare a tentative proposed decision, which shall contain a recommendation regarding whether the Contractor should be debarred, and, if so, the appropriate length of time of the debarment. The Contractor and the Department shall be provided an opportunity to object to the tentative proposed decision prior to its presentation to the Board of Supervisors.

F. After consideration of any objections, or if no objections are submitted, a record of the hearing, the proposed decision, and any other recommendation of the Contractor Hearing Board shall be presented to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board.

G. If a Contractor has been debarred for a period longer than five (5) years, that Contractor may after the debarment has been in effect for at least five (5) years, submit a written request for review of the debarment determination to reduce the period of debarment or terminate the debarment. The County may, in its discretion, reduce the period of debarment or terminate the debarment if it finds that the Contractor has adequately demonstrated one or more of the

following: (1) elimination of the grounds for which the debarment was imposed; (2) a bona fide change in ownership or management; (3) material evidence discovered after debarment was imposed; or (4) any other reason that is in the best interest of the County.

H. The Contractor Hearing Board will consider a request for review of a debarment determination only where (1) the Contractor has been debarred for a period longer than five (5) years; (2) the debarment has been in effect for at least five (5) years; and (3) the request is in writing, states one or more of the grounds for reduction of the debarment period or termination of the debarment, and includes supporting documentation. Upon receiving an appropriate request, the Contractor Hearing Board will provide notice of the hearing on the request. At the hearing, the Contractor Hearing Board shall conduct a hearing where evidence on the proposed reduction of debarment period or termination of debarment is presented. This hearing shall be conducted and the request for review decided by the Contractor Hearing Board pursuant to the same procedures as for a debarment hearing.

I. The Contractor Hearing Board's proposed decision shall contain a recommendation on the request to reduce the period of debarment or terminate the debarment. The Contractor Hearing Board shall present its proposed decision and recommendation to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board.

J. Subcontractors of Contractor: These terms shall also apply to Subcontractors of County Contractors.

35. CONTRACTOR'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW: The Contractor acknowledges that the County places a high priority on the implementation of the Safely Surrendered Baby Law. The Contractor understands that it is the County's policy to encourage all County Contractors to voluntarily post the County's "Safely Surrendered Baby Law" poster in a prominent position at the Contractor's place of business. The Contractor will also encourage its Subcontractors, if any, to post this poster in a prominent position in the Subcontractor's place of business. The County's Department of Children and Family Services will supply the Contractor with the poster to be used. Information on how to receive the poster can be found on the Internet at www.babysafela.org

36. CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM:

A. The Contractor acknowledges that the County has established a goal of ensuring that all individuals who benefit financially from the County through Contracts are in compliance with their court-ordered child, family and spousal support obligations in order to mitigate the economic burden otherwise imposed upon the County and its taxpayers.

B. As required by the County's Child Support Compliance Program (County Code Chapter 2.200) and without limiting the Contractor's duty under this Contract to comply with all applicable provisions of law, the Contractor warrants that it is now in compliance and shall during the term of this Contract maintain in

compliance with employment and wage reporting requirements as required by the Federal Social Security Act (42 USC Section 653a) and California Unemployment Insurance Code Section 1088.5, and shall implement all lawfully served Wage and Earnings Withholding Orders or Child Support Services Department Notices of Wage and Earnings Assignment for Child, Family or Spousal Support, pursuant to Code of Civil Procedure Section 706.031 and Family Code Section 5246(b).

37. COUNTY'S QUALITY ASSURANCE PLAN: County or its agent will evaluate Contractor's performance under this Contract on not less than an annual basis. Such evaluation will include assessing Contractor's compliance with all Contract terms and performance standards. Contractor deficiencies which County determines are severe or continuing and that may place performance of this Contract in jeopardy if not corrected will be reported to the Board of Supervisors. The report will include improvement/corrective action measures taken by County and Contractor. If improvement does not occur consistent with the corrective action measures, County may terminate this Contract or impose other penalties as specified in this Contract.

The County maintains databases that track/monitor contractor performance history. Information entered into such databases may be used for a variety of purposes, including determining whether the County will exercise a contract term extension option.

38. SERVICE DELIVERY SITE - MAINTENANCE STANDARDS: Contractor shall assure that the locations where services are provided under provisions of this Contract are operated at all times in accordance with County community standards with regard to property maintenance and repair, graffiti abatement, refuse removal, fire safety, landscaping, and in full compliance with all applicable local laws, ordinances,

and regulations relating to the property. County's periodic monitoring visits to Contractor's facilities shall include a review of compliance with the provisions of this Paragraph.

39. RULES AND REGULATIONS: During the time that Contractor's personnel are at County Facilities such persons shall be subject to the rules and regulations of such County Facility. It is the responsibility of Contractor to acquaint persons who are to provide services hereunder with such rules and regulations. Contractor shall immediately and permanently withdraw any of its personnel from the provision of services hereunder upon receipt of oral or written notice from Director, that (1) such person has violated said rules or regulations, or (2) such person's actions, while on County premises, indicate that such person may do harm to County patients, staff, or other individuals.

40. DAMAGE TO COUNTY FACILITIES, BUILDINGS OR GROUNDS:

A. The Contractor shall repair, or cause to be repaired, at its own cost, any and all damage to County facilities, buildings, or grounds caused by the Contractor or employees or agents of the Contractor. Such repairs shall be made immediately after the Contractor has become aware of such damage, but in no event later than thirty (30) days after the occurrence.

B. If the Contractor fails to make timely repairs, County may make any necessary repairs. All costs incurred by County, as determined by County, for such repairs shall be repaid by the Contractor by cash payment upon demand.

41. EMPLOYMENT ELIGIBILITY VERIFICATION:

A. The Contractor warrants that it fully complies with all federal and State statutes and regulations regarding the employment of aliens and others and that all its employees performing work under this Contract meet the citizenship or alien status requirements set forth in federal and State statutes and regulations. The Contractor shall obtain, from all employees performing work hereunder, all verification and other documentation of employment eligibility status required by federal and State statutes and regulations including, but not limited to, the Immigration Reform and Control Act of 1986, (P.L. 99-603), or as they currently exist and as they may be hereafter amended. The Contractor shall retain all such documentation for all covered employees for the period prescribed by law.

B. The Contractor shall indemnify, defend, and hold harmless, the County, its agents, officers, and employees from employer sanctions and any other liability which may be assessed against the Contractor or the County or both in connection with any alleged violation of any federal or State statutes or regulations pertaining to the eligibility for employment of any persons performing work under this Contract.

42. FACSIMILE REPRESENTATIONS: The County and the Contractor hereby agree to accept facsimile representations of original signatures of authorized officers of each party, when appearing in appropriate places on time-sensitive Amendments prepared pursuant to the ALTERATION OF TERMS/AMENDMENTS Paragraph of this Contract, and received via communications facilities, as legally

sufficient evidence that such original signatures have been affixed to Amendments to this Contract. The facsimile transmission of such documents must be followed by subsequent (non-facsimile) transmission of "original" versions of such documents within five working days.

43. FAIR LABOR STANDARDS: The Contractor shall comply with all applicable provisions of the Federal Fair Labor Standards Act and shall indemnify, defend, and hold harmless the County and its agents, officers, and employees from any and all liability, including, but not limited to, wages, overtime pay, liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law, including, but not limited to, the Federal Fair Labor Standards Act, for work performed by the Contractor's employees for which the County may be found jointly or solely liable.

44. FISCAL DISCLOSURE: Contractor shall prepare and submit to Director, within ten (10) calendar days following execution of this Contract a statement, executed by Contractor's duly constituted officers, containing the following information: (1) A detailed statement listing all sources of funding to Contractor including private contributions. The statement shall include the nature of the funding, services to be provided, total dollar amount, and period of time of such funding; and (2) If during the term of this Contract, the source(s) of Contractor's funding changes, Contractor shall promptly notify Director in writing, detailing such changes.

45. CONTRACTOR PERFORMANCE DURING CIVIL UNREST OR DISASTER: Contractor recognizes that County provides essential services to the residents of the communities they serve, and that these services are of particular importance at the time of a riot, insurrection, civil unrest, natural disaster, or similar

event. Notwithstanding any other provision of this Contract, full performance by Contractor during any riot, strike, insurrection, civil unrest, natural disaster, or similar event is not excused if such performance remains physically possible. Failure to comply with this requirement shall be considered a material breach by Contractor for which Director may suspend or County may immediately terminate this Contract.

46. GOVERNING LAW, JURISDICTION, AND VENUE: This Contract shall be governed by, and construed in accordance with, the laws of the State of California. The Contractor agrees and consents to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this Contract and further agrees and consents that venue of any action brought hereunder shall be exclusively in the County of Los Angeles.

47. INDEPENDENT CONTRACTOR STATUS:

A. This Contract is by and between the County and the Contractor and is not intended, and shall not be construed, to create the relationship of agent, servant, employee, partnership, joint venture, or association, as between the County and the Contractor. The employees and agents of one party shall not be, or be construed to be, the employees or agents of the other party for any purpose whatsoever.

B. The Contractor shall be solely liable and responsible for providing to, or on behalf of, all persons performing work pursuant to this Contract all compensation and benefits. The County shall have no liability or responsibility for the payment of any salaries, wages, unemployment benefits, disability benefits,

Federal, State, or local taxes, or other compensation, benefits, or taxes for any personnel provided by or on behalf of the Contractor.

C. The Contractor understands and agrees that all persons performing work pursuant to this Contract are, for purposes of Workers' Compensation liability, solely employees of the Contractor and not employees of the County. The Contractor shall be solely liable and responsible for furnishing any and all Workers' Compensation benefits to any person as a result of any injuries arising from or connected with any work performed by or on behalf of the Contractor pursuant to this Contract.

D. The Contractor shall adhere to the provisions stated in the CONFIDENTIALITY Paragraph of this Contract.

48. LICENSES, PERMITS, REGISTRATIONS, ACCREDITATIONS, AND CERTIFICATES: Contractor shall obtain and maintain during the term of this Contract, all appropriate licenses, permits, registrations, accreditations, and certificates required by federal, State, and local law for the operation of its business and for the provision of services hereunder. Contractor shall ensure that all of its officers, employees, and agents who perform services hereunder obtain and maintain in effect during the term of this Contract, all licenses, permits, registrations, accreditations, and certificates required by federal, State, and local law which are applicable to their performance hereunder. Contractor shall provide a copy of each license, permit, registration, accreditation, and certificate upon request of County's Department of Public Health (DPH) - at any time during the term of this Contract.

49. NONDISCRIMINATION IN SERVICES:

A. Contractor shall not discriminate in the provision of services hereunder because of race, color, religion, national origin, ethnic group identification, ancestry, sex, age, marital status, political affiliation, or condition of physical or mental disability, in accordance with requirements of federal and State laws, or in any manner on the basis of the client's/patient's sexual orientation. For the purpose of this Paragraph, discrimination in the provision of services may include, but is not limited to, the following: denying any person any service or benefit or the availability of the facility; providing any service or benefit to any person which is not equivalent, or is provided in a non-equivalent manner, or at a non-equivalent time, from that provided to others; subjecting any person to segregation or separate treatment in any manner related to the receipt of any service; restricting any person in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit; and treating any person differently from others in determining admission, enrollment quota, eligibility, membership, or any other requirements or conditions which persons must meet in order to be provided any service or benefit. Contractor shall take affirmative action to ensure that intended beneficiaries of this Contract are provided services without regard to race, color, religion, national origin, ethnic group identification, ancestry, sex, age, marital status, political affiliation, condition of physical or mental disability, or sexual orientation.

B. Facility Access for handicapped must comply with the Rehabilitation Act of 1973, Section 504, where federal funds are involved, and

the Americans with Disabilities Act. Contractor shall further establish and maintain written procedures under which any person, applying for or receiving services hereunder, may seek resolution from Contractor of a complaint with respect to any alleged discrimination in the provision of services by Contractor's personnel. Such procedures shall also include a provision whereby any such person, who is dissatisfied with Contractor's resolution of the matter, shall be referred by Contractor to the Director, for the purpose of presenting his or her complaint of alleged discrimination. Such procedures shall also indicate that if such person is not satisfied with County's resolution or decision with respect to the complaint of alleged discrimination, he or she may appeal the matter to the State Department of Health Services' Affirmative Action Division. At the time any person applies for services under this Contract, he or she shall be advised by Contractor of these procedures, as identified hereinabove, shall be posted by Contractor in a conspicuous place, available and open to the public, in each of Contractor's facilities where services are provided hereunder.

50. NONDISCRIMINATION IN EMPLOYMENT:

A. Contractor certifies and agrees, pursuant to the Americans with Disabilities Act, the Rehabilitation Act of 1973, and all other federal and State laws, as they now exist or may hereafter be amended, that it shall not discriminate against any employee or applicant for employment because of, race, color, religion, national origin, ethnic group identification, ancestry, sex, age, marital status, political affiliation or condition of physical or mental disability, or sexual orientation. Contractor shall take affirmative action to ensure that

qualified applicants are employed, and that employees are treated during employment, without regard to race, color, religion, national origin, ethnic group identification, ancestry, sex, age, marital status, political affiliation, condition of physical or mental disability, or sexual orientation in accordance with requirements of federal and State laws. Such action shall include, but shall not be limited to the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other form of compensation, and selection for training, including apprenticeship. Contractor shall post in conspicuous places in each of Contractor's facilities providing services hereunder, positions available and open to employees and applicants for employment, and notices setting forth the provision of this Paragraph.

B. Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of Contractor, state that all qualified applicants shall receive consideration for employment without regard to race, color, religion, national origin, ethnic group identification, ancestry, sex, age, marital status, political affiliation, condition of physical or mental disability, or sexual orientation, in accordance with requirements of federal and State laws.

C. Contractor shall send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract of understanding a notice advising the labor union or workers' representative of Contractor's commitments under this Paragraph.

D. Contractor certifies and agrees that it shall deal with its subcontractors, bidders, or vendors without regard to race, color, religion, national origin, ethnic group identification, ancestry, sex, age, marital status, political affiliation, condition of physical or mental disability, or sexual orientation, in accordance with requirements of federal and State laws.

E. Contractor shall allow federal, State, and County representatives, duly authorized by Director, access to its employment records during regular business hours in order to verify compliance with the anti-discrimination provision of this Paragraph. Contractor shall provide such other information and records as such representatives may require in order to verify compliance with the anti-discrimination provisions of this Paragraph.

F. If County finds that any provisions of the Paragraph have been violated, the same shall constitute a material breach of Contract upon which Director may suspend or County may determine to terminate this Contract. While County reserves the right to determine independently that the anti-discrimination provisions of this Contract have been violated, in addition, a determination by the California Fair Employment and Housing Commission or the Federal Equal Employment Opportunity commission that Contractor has violated Federal Equal Employment Opportunity Commission that Contractor has violated federal or State anti-discrimination laws shall constitute a finding by County that Contractor has violated the anti-discrimination provisions of this Contract.

G. The parties agree that in the event Contractor violates any of the anti-discrimination provisions of the Paragraph, County shall be entitled, at its

option, to the sum of Five Hundred Dollars ($500) pursuant to California Civil Code Section 1671 as liquidated damages in lieu of canceling, terminating, or suspending this Contract.

51. NON-EXCLUSIVITY: Nothing herein is intended nor shall be construed as creating any exclusive arrangement with the Contractor. This Contract shall not restrict the County from acquiring similar, equal, or like goods and/or services from other entities or sources.

52. NOTICE OF DELAYS: Except as otherwise provided under this Contract, when either party has knowledge that any actual or potential situation is delaying or threatens to delay the timely performance of this Contract, that party shall, within one (1) business day, give notice thereof, including all relevant information with respect thereto, to the other party.

53. NOTICE OF DISPUTES: The Contractor shall bring to the attention of the County's Project Manager and/or County's Project Director any dispute between the County and the Contractor regarding the performance of services as stated in this Contract. If the County's Project Manager or County's Project Director is not able to resolve the dispute, the Director shall resolve it.

54. NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT: The Contractor shall notify its employees, and shall require each Subcontractor to notify its employees, that they may be eligible for the Federal Earned Income Credit under the federal income tax laws. Such notice shall be provided in accordance with the requirements set forth in Internal Revenue Service Notice No. 1015.

55. NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW: The Contractor shall notify and provide to its employees, and shall require each Subcontractor to notify and provide to its employees, a fact sheet regarding the Safely Surrendered Baby Law, its implementation in Los Angeles County, and where and how to safely surrender a baby. The fact sheet is available on the Internet at www.babysafela.org for printing purposes.

56. PROHIBITION AGAINST INDUCEMENT OR PERSUASION: Notwithstanding the above, the Contractor and the County agree that, during the term of this Contract and for a period of one year thereafter, neither party shall in any way intentionally induce or persuade any employee of one party to become an employee or agent of the other party. No bar exists against any hiring action initiated through a public announcement.

57. PROHIBITION AGAINST PERFORMANCE OF SERVICES WHILE UNDER THE INFLUENCE: Contractor shall ensure that no employee or physician performs services while under the influence of any alcoholic beverage, medication, narcotic, or other substance that might impair his/her physical or mental performance.

58. PUBLIC RECORDS ACT:

A. Any documents submitted by the Contractor; all information obtained in connection with the County's right to audit and inspect the Contractor's documents, books, and accounting records pursuant to the RECORD RETENTION AND AUDITS Paragraph of this Contract; as well as those documents which were required to be submitted in response to the Request for Proposals (RFP) used in the solicitation process for this Contract, become the

exclusive property of the County. All such documents become a matter of public record and shall be regarded as public records. Exceptions will be those elements in the California Government Code Section 6250 et seq. (Public Records Act) and which are marked “trade secret”, “confidential”, or “proprietary”. The County shall not in any way be liable or responsible for the disclosure of any such records including, without limitation, those so marked, if disclosure is required by law, or by an order issued by a court of competent jurisdiction.

B. In the event the County is required to defend an action on a Public Records Act request for any of the aforementioned documents, information, books, records, and/or contents of a proposal marked “trade secret”, “confidential”, or “proprietary”, the Contractor agrees to defend and indemnify the County from all costs and expenses, including reasonable attorney’s fees, in action or liability arising under the Public Records Act.

59. PURCHASES:

A. Purchase Practices: Contractor shall fully comply with all federal, State, and County laws, ordinances, rules, regulations, manuals, guidelines, and directives, in acquiring all furniture, fixtures, equipment, materials, and supplies. Such items shall be acquired at the lowest possible price or cost if funding is provided for such purposes hereunder.

B. Proprietary Interest of County: In accordance with all applicable federal, State, and County laws, ordinances, rules, regulations, manuals, guidelines, and directives, County shall retain all proprietary interest, except for use during the term of this Contract, in all furniture, fixtures, equipment,

materials, and supplies, purchased or obtained by Contractor using any contract funds designated for such purpose. Upon the expiration or earlier termination of this Contract, the discontinuance of the business of Contractor, the failure of Contractor to comply with any of the provisions of this Contract, the bankruptcy of Contractor or its giving an assignment for the benefit of creditors, or the failure of Contractor to satisfy any judgment against it within thirty (30) calendar days of filing, County shall have the right to take immediate possession of all such furniture, removable fixtures, equipment, materials, and supplies, without any claim for reimbursement whatsoever on the part of Contractor. Contractor, in conjunction with County, shall attach identifying labels on all such property indicating the proprietary interest of County.

C. Inventory Records, Controls, and Reports: Contractor shall maintain accurate and complete inventory records and controls for all furniture, fixtures, equipment, materials, and supplies, purchased or obtained using any contract funds designated for such purpose. Annually, Contractor shall provide Director with an accurate and complete inventory report of all furniture, fixtures, equipment, materials, and supplies, purchased or obtained using any County funds designated for such purpose.

D. Protection of Property in Contractor's Custody: Contractor shall maintain vigilance and take all reasonable precautions, to protect all furniture, fixtures, equipment, materials, and supplies, purchased or obtained using any contract funds designated for such purpose, against any damage or loss by fire, burglary, theft, disappearance, vandalism, or misuse. Contractor shall contact

Director, for instructions for disposition of any such property which is worn out or unusable.

E. Disposition of Property in Contractor's Custody: Upon the termination of the funding of any program covered by this Contract, or upon the expiration or earlier termination of this Contract, or at any other time that County may request, Contractor shall: (1) provide access to and render all necessary assistance for physical removal by Director or his authorized representatives of any or all furniture, fixtures, equipment, materials, and supplies, purchased or obtained using any County funds designated for such purpose, in the same condition as such property was received by Contractor, reasonable wear and tear expected; or (2) at Director's option, deliver any or all items of such property to a location designated by Director. Any disposition, settlement, or adjustment connected with such property shall be in accordance with all applicable federal, State, and County laws, ordinances, rules, regulations, manuals, guidelines, and directives.

60. REAL PROPERTY AND BUSINESS OWNERSHIP DISCLOSURE:

A. Real Property Disclosure: If Contractor is renting, leasing, or subleasing, or is planning to rent, lease, or sublease, any real property where persons are to receive services hereunder, Contractor shall prepare and submit to Director within ten (10) calendar days following execution of this Contract, an affidavit sworn to and executed by Contractor's duly constituted officers, containing the following information:

(1) The location by street address and city of any such real property.

(2) The fair market value of any such real property as such value is reflected on the most recently issued County Tax Collector's tax bill.

(3) A detailed description of all existing and pending rental agreements, leases, and subleases with respect to any such real property, such description to include: the term (duration) of such rental agreement, lease or sublease; the amount of monetary consideration to be paid to the lessor or sublessor over the term of the rental agreement, lease or sublease; the type and dollar value of any other consideration to be paid to the lessor or sublessor over the term of the rental agreement, lease, or sublease; the full names and addresses of all parties who stand in the position of lessor or sublessor; if the lessor or sublessor is a private corporation and its shares are not publicly traded (on a stock exchange or over-the-counter), a listing by full names of all officers, directors, and stockholders thereof; and if the lessor or sublessor is a partnership, a listing by full names of all general and limited partners thereof.

(4) A listing by full names of all Contractor's officers, directors, members of its advisory boards, members of its staff and consultants, who have any family relationships by marriage or blood with a lessor or sublessor referred to in sub-paragraph (3) immediately above, or who have any financial interest in such lessor's or sublessor's business, or

both. If such lessor or sublessor is a corporation or partnership, such listing shall also include the full names of all Contractor's officers, members of its advisory boards, members of its staff and consultants, who have any family relationship, by marriage or blood, to an officer, director, or stockholder of the corporation, or to any partner of the partnership. In preparing the latter listing, Contractor shall also indicate the names (s) of the officer(s), director(s), stockholder(s), or partner(s), as appropriate, and the family relationship which exists between such person(s) and Contractor's representatives listed.

(5) If a facility of Contractor is rented or leased from a parent organization or individual who is a common owner (as defined by Federal Health Insurance Manual 15, Chapter 10, Paragraph 1002.2), Contractor shall only charge the program for costs of ownership. Costs of ownership shall include depreciation, interest, and applicable taxes.

True and correct copies of all written rental agreements, leases, and subleases with respect to any such real property shall be appended to such affidavit and made a part thereof.

B. Business Ownership Disclosure: Contractor shall prepare and submit to Director, upon request, a detailed statement, executed by Contractor's duly constituted officers, indicating whether Contractor totally or partially owns any other business organization that will be providing services, supplies, materials, or equipment to Contractor or in any manner does business with Contractor under this Contract. If during the term of this Contract the

Contractor's ownership of other businesses dealing with Contractor under this Contract changes, Contractor shall notify Director in writing of such changes within thirty (30) calendar days prior to the effective date thereof.

61. REPORTS: Contractor shall make reports as required by County concerning Contractor's activities and operations as they relate to this Contract and the provision of services hereunder. In no event, however may County require such reports unless Director has provided Contractor with at least thirty (30) calendar days' prior written notification thereof. Director's notification shall provide Contractor with a written explanation of the procedures for reporting the information required.

62. RECYCLED CONTENT BOND PAPER: Consistent with the Board of Supervisors' policy to reduce the amount of solid waste deposited at County landfills, Contractor agrees to use recycled-content bond paper to the maximum extent possible in connection with services to be performed by Contractor under this Contract.

63. SOLICITATION OF BIDS OR PROPOSALS: Contractor acknowledges that County, prior to expiration or earlier termination of this Contract, may exercise its right to invite bids or request proposals for the continued provision of the services delivered or contemplated under this Contract. County and its Department of Public Health (DPH) shall make the determination to re-solicit bids or request proposals in accordance with applicable County policies.

Contractor acknowledges that County may enter into a contract for the future provision of services, based upon the bids or proposals received, with a provider or providers other than Contractor. Further, Contractor acknowledges that it obtains no

greater right to be selected through any future invitation for bids or request for proposals by virtue of its present status as Contractor.

64. STAFFING AND TRAINING/STAFF DEVELOPMENT: Contractor shall operate continuously throughout the term of this Contract with at least the minimum number of staff required by County. Such personnel shall be qualified in accordance with standards established by County. In addition, Contractor shall comply with any additional staffing requirements which may be included in the Exhibits attached hereto.

During the term of this Contract, Contractor shall have available and shall provide upon request to authorized representatives of County, a list of persons by name, title, professional degree, salary, and experience who are providing services hereunder. Contractor also shall indicate on such list which persons are appropriately qualified to perform services hereunder. If an executive director, program director, or supervisorial position becomes vacant during the term of this Contract, Contractor shall, prior to filling said vacancy, notify County's Director. Contractor shall provide the above set forth required information to County's Director regarding any candidate prior to any appointment. Contractor shall institute and maintain appropriate supervision of all persons providing services pursuant to this Contract.

Contractor shall institute and maintain a training/staff development program pertaining to those services described in the Exhibit(s) attached hereto. Appropriate training/staff development shall be provided for treatment, administrative, and support personnel. Participation of treatment and support personnel in training/staff development should include in-service activities. Such activities shall be planned and scheduled in advance; and shall be conducted on a continuing basis. Contractor shall

develop and institute a plan for an annual evaluation of such training/staff development program.

65. SUBCONTRACTING:

A. For purposes of this Contract, subcontracts must be approved in advance in writing by Director or his/her authorized designee(s). Contractor's request to Director for approval of a subcontract shall include:

(1) Identification of the proposed subcontractor, (who shall be licensed as appropriate for provision of subcontract services), and an explanation of why and how the proposed subcontractor was selected, including the degree of competition involved.

(2) A detailed description of the services to be provided by the subcontract.

(3) The proposed subcontract amount and manner of compensation, if any, together with Contractor's cost or price analysis thereof.

(4) A copy of the proposed subcontract. (Any later modification of such subcontract shall take the form of a formally written subcontract amendment which also must be approved in writing by the Director in the same manner as described above, before such amendment is effective.)

(5) Any other information and/or certification(s) requested by Director.

B. Director shall review Contractor's request to subcontract and shall determine, in his/her sole discretion, whether or not to consent to such a request on a case-by-case basis.

C. Subcontracts shall be made in the name of Contractor and shall not bind nor purport to bind County. The making of subcontracts hereunder shall not relieve Contractor of any requirement under this Contract, including, but not limited to, the duty to properly supervise and coordinate the work of subcontractors. Further, Director's approval of any subcontract shall also not be construed to limit in any way, any of County's rights or remedies contained in this Contract.

D. In the event that Director consents to any subcontracting, Contractor shall be solely liable and responsible for any and all payments or other compensation to all subcontractors, and their officers, employees, and agents.

E. In the event that Director consents to any subcontracting, such consent shall be provisional, and shall not waive the County's right to later withdraw that consent when such action is deemed by County to be in its best interest. County shall not be liable or responsible in any way to Contractor, or any subcontractor, for any liability, damages, costs, or expenses, arising from or related to County's exercising of such a right.

F. The County's consent to subcontract shall not waive the County's right to prior and continuing approval of any and all personnel, including

Subcontractor employees, providing services under this Contract. The Contractor is responsible to notify its Subcontractors of this County right.

G. Subcontracts shall contain the following provision: "This contract is a subcontract under the terms of a prime contract with the County of Los Angeles and shall be subject to all of the provisions of such prime contract." Further, Contractor shall also reflect as subcontractor requirements in the subcontract form all of the requirements of the INDEMNIFICATION, GENERAL PROVISIONS FOR ALL INSURANCE COVERAGES, INSURANCE COVERAGE REQUIREMENTS, COMPLIANCE WITH APPLICABLE LAW, CONFLICT OF TERMS and ALTERATION OF TERMS Paragraphs and all of the provisions of this Contract.

Contractor shall deliver to Director a fully executed copy of each subcontract entered into by Contractor, as it pertains to the provision of services under this Contract, on or immediately after the effective date of the subcontract, but in no event, later than the date and any services are to be performed under the subcontract.

H. The Contractor shall obtain certificates of insurance which establish that the Subcontractor maintains all the programs of insurance required by the County from each approved Subcontractor.

I. Director is hereby authorized to act for and on behalf of County pursuant to this Paragraph, including but not limited to, consenting to any subcontracting.

J. The Contractor shall indemnify, defend, and hold the County harmless with respect to the activities of each and every Subcontractor in the same manner and to the same degree as if such Subcontractor(s) were the Contractor employees.

K. The Contractor shall remain fully responsible for all performances required of it under this Contract, including those that the Contractor has determined to subcontract, notwithstanding the County's approval of the Contractor's proposed subcontract.

66. TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM: Failure of the Contractor to maintain compliance with the requirements set forth in Paragraph 35, CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM, herein, shall constitute default under this Contract. Without limiting the rights and remedies available to the County under any other provision of this Contract, failure of the Contractor to cure such default within ninety (90) calendar days of written notice shall be grounds upon which the County may terminate this Contract pursuant to, Paragraph 67, TERMINATION FOR DEFAULT, herein, and pursue debarment of the Contractor, pursuant to County Code Chapter 2.202.

67. TERMINATION FOR CONVENIENCE: The performance of services under this Contract may be terminated, with or without cause, in whole or in part, from time to time when such action is deemed by County to be in its best interest. Termination of services hereunder shall be effected by delivery to Contractor of a thirty (30) calendar day advance Notice of Termination specifying the extent to which

performance of services under this Contract is terminated and the date upon which such termination becomes effective.

After receipt of a Notice of Termination and except as otherwise directed by County, Contractor shall:

A. Stop services under this Contract on the date and to the extent specified in such Notice of Termination; and

B. Complete performance of such part of the services as shall not have been terminated by such Notice of Termination.

Further, after receipt of a Notice of Termination, Contractor shall submit to County, in the form and with the certifications as may be prescribed by County, its termination claim and invoice. Such claim and invoice shall be submitted promptly, but not later than sixty (60) calendar days from the effective date of termination. Upon failure of Contractor to submit its termination claim and invoice within the time allowed, County may determine on the basis of information available to County, the amount, if any, due to Contractor in respect to the termination, and such determination shall be final. After such determination is made, County shall pay Contractor the amount so determined.

Contractor for a period of five (5) years after final settlement under this Contract, in accordance with Paragraph 15, RECORD RETENTION AND AUDITS, shall retain and make available all its books, documents, records, or other evidence, bearing on the costs and expenses of Contractor under this Contract in respect to the termination of services hereunder. All such books, records, documents, or other evidence shall be retained by Contractor at a

location in Los Angeles County and shall be made available within ten (10) calendar days of prior written notice during County's normal business hours to representatives of County for purposes of inspection or audit.

68. TERMINATION FOR DEFAULT: County may, by written notice of default to Contractor, terminate this Contract immediately in any one of the following circumstances:

A. If, as determined in the sole judgment of County, Contractor fails to perform any services within the times specified in this Contract or any extension thereof as County may authorize in writing; or

B. If, as determined in the sole judgment of County, Contractor fails to perform and/or comply with any of the other provisions of this Contract, or so fails to make progress as to endanger performance of this Contract in accordance with its terms, and in either of these two (2) circumstances, does not cure such failure within a period of five (5) calendar days (or such longer period as County may authorize in writing) after receipt of notice from County specifying such failure.

In the event that County terminates this Contract as provided hereinabove, County may procure, upon such terms and in such manner as County may deem appropriate, services similar to those so terminated, and Contractor shall be liable to County for any reasonable excess costs incurred by County for such similar services.

If, after the County has given notice of termination under the provisions of this paragraph, it is determined by the County that the Contractor was not in default under the provisions of this paragraph, the rights and obligations of the parties shall be the same as

if the notice of termination had been issued pursuant to Paragraph 66, TERMINATION FOR CONVENIENCE.

The rights and remedies of County provided in this Paragraph shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

69. TERMINATION FOR GRATUITIES AND/OR IMPROPER CONSIDERATION: County may, by written notice to Contractor, immediately terminate Contractor's right to proceed under this Contract, if it is found that gratuities or consideration in any form, were offered or given by Contractor, either directly or through an intermediary, to any County officer, employee, or agent, with the intent of securing the Contract or securing favorable treatment with respect to the award, amendment, or extension of the Contract, or making of any determinations with respect to the Contractor's performance pursuant to the Contract. In the event of such termination, County shall be entitled to pursue the same remedies against Contractor as it could in the event of default by Contractor.

Contractor shall immediately report any attempt by a County officer, employee, or agent, to solicit such improper gratuity or consideration. The report shall be made either to the County manager charged with the supervision of the employee or agent, or to the County Auditor-Controller's Employee Fraud Hotline at (800) 544-6861.

(Among other items, such improper gratuities and considerations may take the form of cash, discounts, services, the provision of travel or entertainment, or other tangible gifts.)

70. TERMINATION FOR INSOLVENCY: County may terminate this Contract immediately for default in the event of the occurrence of any of the following:

A. Insolvency of Contractor. Contractor shall be deemed to be insolvent if it has ceased to pay its debts at least sixty (60) calendar days in the ordinary course of business or cannot pay its debts as they become due, whether Contractor has committed an act of bankruptcy or not, and whether Contractor is insolvent within the meaning of the Federal Bankruptcy Law or not;

B. The filing of a voluntary or involuntary petition under the federal Bankruptcy Law;

C. The appointment of a Receiver or Trustee for Contractor;

D. The execution by Contractor of an assignment for the benefit of creditors.

In the event that County terminates this Contract as provided hereinabove, County may procure, upon such terms and in such manner as County may deem appropriate, services similar to those so terminated, and Contractor shall be liable to those so terminated, and Contractor shall be liable to County for any reasonable excess costs incurred by County, as determined by County, for such similar services. The rights and remedies of County provided in this Paragraph shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

71. TERMINATION FOR NON-APPROPRIATION OF FUNDS: Notwithstanding any other provision of this Contract, the County shall not be obligated for the Contractor's performance hereunder or by any provision of this Contract during any of the County's future fiscal years unless and until the County's Board of Supervisors

appropriates funds for this Contract in the County's Budget for each such future fiscal year. In the event that funds are not appropriated for this Contract, then this Contract shall terminate as of June 30 of the last fiscal year for which funds were appropriated. The County shall notify the Contractor in writing of any such non-allocation of funds at the earliest possible date.

72. NO INTENT TO CREATE A THIRD PARTY BENEFICIARY CONTRACT: Notwithstanding any other provision of this Contract, the parties do not in any way intend that any person shall acquire any rights as a third party beneficiary under this Contract.

73. TIME OFF FOR VOTING: The Contractor shall notify its employees, and shall require each subcontractor to notify and provide to its employees, information regarding the time off for voting law (Elections Code Section 14000). Not less than ten (10) days before every statewide election, every Contractor and subcontractors shall keep posted conspicuously at the place of work, if practicable, or elsewhere where it can be seen as employees come or go to their place of work, a notice setting forth the provisions of Section 14000.

74. UNLAWFUL SOLICITATION: Contractor shall require all of its employees performing services hereunder to acknowledge in writing understanding of and agreement to comply with the provisions of Article 9 of Chapter 4 of Division 3 (commencing with Section 6150) of the Business and Professions Code of the State of California (i.e., State Bar Act provisions regarding unlawful solicitation as a runner or capper for attorneys) and shall take positive and affirmative steps in its performance hereunder to ensure that there is no violation of such provisions by its employees.

Contractor shall utilize the attorney referral services of all those bar associations within Los Angeles County that have such a service.

75. VALIDITY: If any provision of this Contract or the application thereof to any person or circumstance is held invalid, the remainder of this Contract and the application of such provision to other persons or circumstances shall not be affected thereby.

76. WAIVER: No waiver by the County of any breach of any provision of this Contract shall constitute a waiver of any other breach or of such provision. Failure of the County to enforce at any time, or from time to time, any provision of this Contract shall not be construed as a waiver thereof. The rights and remedies set forth in this sub-paragraph shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

77. WARRANTY AGAINST CONTINGENT FEES:

A. The Contractor warrants that no person or selling agency has been employed or retained to solicit or secure this Contract upon any Contract or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by the Contractor for the purpose of securing business.

B. For breach of this warranty, the County shall have the right to terminate this Contract and, at its sole discretion, deduct from the Contract price or consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingent fee.

78. WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM:

Contractor acknowledges that County has established a goal of ensuring that all individuals and businesses that benefit financially from County through contract are current in paying their property tax obligations (secured and unsecured roll) in order to mitigate the economic burden otherwise imposed upon County and its taxpayers.

Unless Contractor qualifies for an exemption or exclusion, Contractor warrants and certifies that to the best of its knowledge it is now in compliance, and during the term of this Contract will maintain compliance, with Los Angeles County Code Chapter 2.206.

79. TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM: Failure of Contractor to maintain compliance with the requirements set forth in Paragraph 77, WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM, herein, shall constitute default under this Contract. Without limiting the rights and remedies available to County under any other provision of this Contract, failure of Contractor to cure such default within ten (10) days of notice shall be grounds upon which County may terminate this Contract and/or pursue debarment of Contractor, pursuant to County Code Chapter 2.206.

/

/

/

/

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Contract to be subscribed by its Interim Director of Public Health, and Contractor has caused this Contract to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
Cynthia A. Harding, M.P.H.
Interim Director

_____
Contractor

By _____
Signature

_____
Printed Name

Title_____
(AFFIX CORPORATE SEAL)

APPROVED AS TO FORM
BY THE OFFICE OF THE COUNTY COUNSEL
MARY C. WICKHAM
Interim County Counsel

APPROVED AS TO CONTRACT
ADMINISTRATION:

Department of Public Health

By_____
Patricia Gibson, Chief
Contracts and Grants Division

Revised XX-XX-14 – Approved by Counsel

SCOPE OF WORK

BUDGET

CONTRACTOR'S EEO CERTIFICATION

Contractor Name

Address

Internal Revenue Service Employer Identification Number

GENERAL CERTIFICATION

In accordance with Section 4.32.010 of the Code of the County of Los Angeles, the contractor, supplier, or vendor certifies and agrees that all persons employed by such firm, its affiliates, subsidiaries, or holding companies are and will be treated equally by the firm without regard to or because of race, religion, ancestry, national origin, or sex and in compliance with all anti-discrimination laws of the United States of America and the State of California.

CONTRACTOR'S SPECIFIC CERTIFICATIONS

1.	The Contractor has a written policy statement prohibiting discrimination in all phases of employment.	Yes ☐	No ☐
2.	The Contractor periodically conducts a self analysis or utilization analysis of its work force.	Yes ☐	No ☐
3.	The Contractor has a system for determining if its employment practices are discriminatory against protected groups.	Yes ☐	No ☐
4.	Where problem areas are identified in employment practices, the Contractor has a system for taking reasonable corrective action, to include establishment of goals or timetables.	Yes ☐	No ☐

Authorized Official's Printed Name and Title

Authorized Official's Signature

Date

CONTRACTOR ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENT

CONTRACTOR NAME _____ Contract No._____

GENERAL INFORMATION:

The Contractor referenced above has entered into a contract with the County of Los Angeles to provide certain services to the County. The County requires the Corporation to sign this Contractor Acknowledgement and Confidentiality Agreement.

CONTRACTOR ACKNOWLEDGEMENT:

Contractor understands and agrees that the Contractor employees, consultants, Outsourced Vendors and independent contractors (Contractor's Staff) that will provide services in the above referenced agreement are Contractor's sole responsibility. Contractor understands and agrees that Contractor's Staff must rely exclusively upon Contractor for payment of salary and any and all other benefits payable by virtue of Contractor's Staff's performance of work under the above-referenced contract.

Contractor understands and agrees that Contractor's Staff are not employees of the County of Los Angeles for any purpose whatsoever and that Contractor's Staff do not have and will not acquire any rights or benefits of any kind from the County of Los Angeles by virtue of my performance of work under the above-referenced contract. Contractor understands and agrees that Contractor's Staff will not acquire any rights or benefits from the County of Los Angeles pursuant to any agreement between any person or entity and the County of Los Angeles.

CONFIDENTIALITY AGREEMENT:

Contractor and Contractor's Staff may be involved with work pertaining to services provided by the County of Los Angeles and, if so, Contractor and Contractor's Staff may have access to confidential data and information pertaining to persons and/or entities receiving services from the County. In addition, Contractor and Contractor's Staff may also have access to proprietary information supplied by other vendors doing business with the County of Los Angeles. The County has a legal obligation to protect all such confidential data and information in its possession, especially data and information concerning health, criminal, and welfare recipient records. Contractor and Contractor's Staff understand that if they are involved in County work, the County must ensure that Contractor and Contractor's Staff will protect the confidentiality of such data and information. Consequently, Contractor must sign this Confidentiality Agreement as a condition of work to be provided by Contractor's Staff for the County.

Contractor and Contractor's Staff hereby agrees that they will not divulge to any unauthorized person any data or information obtained while performing work pursuant to the above-referenced contract between Contractor and the County of Los Angeles. Contractor and Contractor's Staff agree to forward all requests for the release of any data or information received to County's Project Manager.

Contractor and Contractor's Staff agree to keep confidential all health, criminal, and welfare recipient records and all data and information pertaining to persons and/or entities receiving services from the County, design concepts, algorithms, programs, formats, documentation, Contractor proprietary information and all other original materials produced, created, or provided to Contractor and Contractor's Staff under the above-referenced contract. Contractor and Contractor's Staff agree to protect these confidential materials against disclosure to other than Contractor or County employees who have a need to know the information. Contractor and Contractor's Staff agree that if proprietary information supplied by other County vendors is provided to me during this employment, Contractor and Contractor's Staff shall keep such information confidential.

Contractor and Contractor's Staff agree to report any and all violations of this agreement by Contractor and Contractor's Staff and/or by any other person of whom Contractor and Contractor's Staff become aware.

Contractor and Contractor's Staff acknowledge that violation of this agreement may subject Contractor and Contractor's Staff to civil and/or criminal action and that the County of Los Angeles may seek all possible legal redress.

SIGNATURE: _____ DATE: _____/_____/_____

PRINTED NAME: _____

POSITION: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

(CHOOSE THE APPROPRIATE HIPAA VERSION [1 of 3 options])

CONTRACTOR'S OBLIGATION AS A COVERED ENTITY UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996

The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"). Contractor understands and agrees that, as a provider of medical treatment services, it is a "covered entity" under HIPAA and, as such, has obligations with respect to the confidentiality, privacy and security of patient's medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

"CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH IS INDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSSARY ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY AND SECURITY. EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMELSS

THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA."

==========

OR

CONTRACTOR'S OBLIGATION AS OTHER THAN BUSINESS ASSOCIATE UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996

It is the intention of the parties that Contractor will provide the County with de-identified data. Contractor expressly acknowledges and agrees that the provision of services under this Contract does not require or permit access by Contractor or any of its officers, employees, or agents to any patient medical records. Accordingly, Contractor shall instruct its officers, employees, and agents that they are not to pursue or gain access to patient medical records for any reason whatsoever.

Notwithstanding the foregoing, the parties acknowledge that, in the course of the provision of services hereunder, Contractor or its officers, employees, or agents may have inadvertent access to patient medical records. Contractor understands and agrees that neither it not its officers, employees, and agents are to take advantage of such access for any purpose whatsoever. Additionally, in the event of such inadvertent access, Contractor and its employees shall maintain the confidentiality of any information obtained and shall notify the applicable DPH Program Director that such access has been gained immediately or upon the first reasonable opportunity to do so.

In the event of any access, whether inadvertent or intentional, Contractor shall indemnify, defend, and hold harmless County, its officers, employees, or agents from and against any and all liability, including but not limited to actions, claims, costs, demands, expenses, and fees (including attorney and expert witness fees) arising from or connected with Contractor's or its officers', employees', or agents' access to patient medical records. Contractor agrees to provide appropriate training to its employees regarding their obligation as described herein in this regard.

==========

OR

BUSINESS ASSOCIATE AGREEMENT UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

County is a Covered Entity as defined by, and subject to the requirements and prohibitions of, the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), and regulations promulgated thereunder, including the Privacy, Security, Breach Notification, and Enforcement Rules at 45 Code of Federal Regulation (C.F.R.) Parts 160 and 164 (collectively, the "HIPAA Rules").

Contractor performs or provides functions, activities or services to County that require Contractor in order to provide such functions, activities or services to create, access, receive, maintain, and/or transmit information that includes or that my include Protected Health Information as s defined by the HIPAA Rules and is therefore subject to those provisions of the HIPAA Rules that are applicable to Business Associates.

The HIPAA Rules require a written agreement ("Business Associate Agreement") between County and Contractor in order to mandate certain protections for the privacy and security of Protected Health Information, and these HIPAA Rules prohibit the disclosure to or use of Protected Health Information by Contractor if such an agreement is not in place.

This Business Associate Agreement and its provisions are intended to protect the privacy and provide for the security of Protected Health Information disclosed to or used by Contractor in compliance with the HIPAA Rules.

Therefore, the parties agree as follows:

1. DEFINITIONS

1.1 "Breach" has the same meaning as the term "breach" at 45 C.F.R. § 164.402.

1.2 "Business Associate" has the same meaning as the term "business associate" at C.F.R § 160.103. For the convenience of the parties, a "business associate" is a person or entity, other than a member of the workforce of covered entity, who performs functions or

activities on behalf of, or provides certain services to a covered entity that involve access by the business associate to Protected Health Information. A "business associate" also is a subcontractor that creates, receives, maintains or transmits Protected Health Information on behalf of another business associate. And in reference to the party to this Business Associate Agreement "Business Associate" shall mean Contractor.

1.3 "Covered Entity" has the same meaning as the term "covered entity" at 45 CFR § 160.103, and in reference to the party to this Business Associate Agreement, "Covered Entity" shall mean County.

1.4 "Data Aggregation" has the same meaning as the term "data aggregation at 45 C.F.R. Data Aggregation" has the same meaning as the term "data aggregation at 45 C.F.R. § 164.501. 164.501.

1.5 "De-identification" refers to the de-identification standard at 45 C.F.R. 164.514.

1.6 "Designated Record Set" has the same meaning as the term "designated record set" at 45 C.F.R. § 164.501.

1.7 "Disclose" and "Disclosure" mean, with respect to Protected Health Information the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to other than its workforce. (See 45 C.F.R. § 160.103.)

1.8 "Electronic Health Record" means an electronic record of health-related information on and individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff. (See 42 U.S.C. § 17921.)

1.9 "Electronic Media" has the same meaning as the term "electronic media" at 45 C.F.R. § 160.103. For the convenience of the parties, electronic media means (1) Electronic storage material on which data is or may be recorded electronically, including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; (2) Transmission media include, for example, the Internet, extranet or intranet, leased lines,

dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media if the information being exchanged did not exist in electronic form immediately before the transmission.

1.10 Electronic Protected Health Information" has the same meaning as the term "electronic protected health information" at 45 C.F.R. § 160.103, limited to Protected Health Information created or received by Business Associate from or on behalf of Covered Entity. For the convenience of the parties, Electronic Protected Health Information means Protected Health Information that is (i) transmitted by electronic media; (ii) maintained in electronic media.

1.11 "Health Care Operations" has the meaning as the term "health care operations" at 45 C.F.R. § 164.501.

1.12 "Individual" has the same meaning as the term "individual" at 45 C.F.R. § 160.103. For the convenience of the parties, Individual means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R § 164.502 (g).

1.13 "Law Enforcement Official" has the same meaning as the term "law enforcement official" at 45 C.F.R. § 164.103.

1.14 "Minimum Necessary" refers to the minimum necessary standard at 45 C.F.R. § 162.502 (b).

1.15 "Protected Health Information" has the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity. For the convenience of the parties, Protected Health Information includes information that (i) relates to the past, present or future physical or mental health or condition of an Individual; the provision of health care to an Individual, or the past, present or future payment for the provision of

health care to an Individual; (ii) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (iii) is created, maintained, or transmitted by Business Associate from or on behalf of Covered Entity, and includes Protected Health Information that is made accessible to Business Associate by Covered Entity. "Protected Health Information" includes Electronic Protected Health Information.

1.16 "Required By Law" has the same meaning as the term "required by law" at 45 C.F.R. § 164.103.

1.17 "Secretary" has the same meaning as the term "secretary" at 45 C.F.R. § 160.103.

1.18 "Security Incident" has the same meaning as the term "security incident" at 45 C.F.R. § 164.304.

1.19 "Services" means, unless otherwise specified, those functions, activities, or services in the applicable underlying Agreement, Contract, Master Agreement, Work Order, or Purchase Order or other service arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

1.20 "Subcontractor" has the same meaning as the term "subcontractor" at 45 C.F.R. § 160.103.

1.21 "Unsecured Protected Health Information" has the same meaning as the term "unsecured protected health information" at 45 C.F.R. § 164.402.

1.22 "Use" or "Uses" means, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate's internal operations. (See 45 C.F.R. § 164.103.)

1.23 Terms used, but not otherwise defined in this Business Associate Agreement, have the same meaning as those terms in the HIPAA Rules.

2. PERMITTED AND REQUIRED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

2.1 Business Associate may only Use and/or Disclose Protected Health Information as necessary to perform Services, and/or as necessary to comply with the obligations of this Business Associate Agreement.

2.2 Business Associate may Use Protected Health Information for de-identification of the information if de-identification of the information is required to provide Services.

2.3 Business Associate may Use or Disclose Protected Health Information as Required by Law.

2.4 Business Associate shall make Uses and Disclosures and requests for Protected Health Information consistent with the applicable Covered Entity's Minimum Necessary policies and procedures.

2.5 Business Associate may Use Protected Health Information as necessary for the proper management and administration of its business or to carry out its legal responsibilities.

2.6 Business Associate may Disclose Protected Health Information as necessary for the proper management and administration of its business or to carry out its legal responsibilities, provided the Disclosure is Required by Law.

2.7 Business Associate may provide Data Aggregation services relating to Covered Entity's Health Care Operations if such Data Aggregation services are necessary in order to provide Services.

3. PROHIBITED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

3.1 Business Associate shall not Use or Disclose Protected Health Information other than as permitted or required by this Business Associate Agreement or as Required by Law.

3.2 Business Associate shall not Use or Disclose Protected Health Information in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by Covered Entity, except for the specific Uses and Disclosures set forth in Sub-Paragraph 2.5 and 2.6 above.

3.3 Business Associate shall not Use or Disclose Protected Health Information for de-identification of the information except as set forth in Sub-Paragraph 2.2 above.

4. OBLIGATIONS TO SAFEGUARD PROTECTED HEALTH INFORMATION

4.1 Business Associate shall implement, use, and maintain appropriate safeguards to prevent the Use or Disclosure of Protected Health Information other than as provided for by this Business Associate Agreement.

4.2 Business Associate shall comply with Subpart C of 45 C.F.R. Part 164 with respect to Electronic Protected Health Information, to prevent the Use or Disclosure of such information other than as provided for by this Business Associate Agreement.

5. REPORTING NON-PERMITTED USES OR DISCLOSURES, SECURITY INCIDENTS, AND BREACHES OF UNSECURED PROTECTED HEALTH INFORMATION

5.1 Business Associate shall report to Covered Entity any Use or Disclosure of Protected Health Information not permitted by this Business Associate Agreement, any Security Incident, and/ or any Breach of Unsecured Protected Health Information as further described in Sub-Paragraph 5.1.1, 5.1.2 and 5.1.3 below.

5.1.1 Business Associate shall report to Covered Entity any Use or Disclosure of Protected Health Information by Business Associate, its employees, representatives, agents or Subcontractors not provided for by this Agreement of which Business Associate becomes aware.

5.1.2 Business Associate shall report to Covered Entity any Security Incident of which Business Associate becomes aware.

5.1.3 Business Associate shall report to Covered Entity any Breach by Business Associate, its employees, representatives, agents, workforce members, or Subcontractors of Unsecured Protected Health Information that is known to Business Associate or, by exercising reasonable diligence, would have been known to Business Associate. Business Associate shall be deemed to have knowledge of a Breach of Unsecured Protected Health Information if the Breach is known, or by

exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is an employee, officer, or other agent of Business Associate, including a Subcontractor, as determined in accordance with the federal common law of agency.

5.2 Except as provided in Sub-Paragraph 5.3, for any reporting required by Sub-Paragraph 5.1, Business Associate shall provide, to the extent available, all information required by, and within the time frames specified in, Sub-Paragraphs 5.2.1 and 5.2.2.

5.2.1 Business Associate shall make an immediate telephonic report upon discovery of the non-permitted Use or Disclosure of Protected Health Information, Security Incident or Breach of Unsecured Protected Health Information to **(562) 940-3335** that minimally includes:

(a) A brief description of what happened, including the date of the non-permitted Use or Disclosure, Security Incident, or Breach and the date of Discovery of the non-permitted Use or Disclosure, Security Incident, or Breach, if known;

(b) The number of Individuals whose Protected Health Information is involved;

(c) A description of the specific type of Protected Health Information involved in the non-permitted Use or Disclosure, Security Incident, or Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code or other types of information were involved);

(d) The name and contact information for a person highly knowledge of the facts and circumstances of the non-permitted Use or Disclosure of PHI, Security Incident, or Breach.

5.2.2. Business Associate shall make a written report without unreasonable delay and in no event later than three (3) business days from the date of discovery

by Business Associate of the non-permitted Use or Disclosure of Protected Health Information, Security Incident, or Breach of Unsecured Protected Health Information and to the **Chief Privacy Officer at: Chief Privacy Officer, Kenneth Hahn Hall of Administration, 500 West Temple Street, Suite 525, Los Angeles, California 90012, HIPAA@auditor.lacounty.gov,** that includes, to the extent possible:

(a) A brief description of what happened, including the date of the non-permitted Use or Disclosure, Security Incident, or Breach and the date of Discovery of the non-permitted Use or Disclosure, Security Incident, or Breach, if known;

(b) The number of Individuals whose Protected Health Information is involved;

(c) A description of the specific type of Protected Health Information involved in the non-permitted Use or Disclosure, Security Incident, or Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code or other types of information were involved);

(d) The identification of each Individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been, accessed, acquired, Used, or Disclosed;

(e) Any other information necessary to conduct an assessment of whether notification to the Individual(s) under 45 C.F.R. § 164.404 is required;

(f) Any steps Business Associate believes that the Individual(s) could take to protect him or herself from potential harm from the non-permitted Use or Disclosure, Security Incident, or Breach;

(g) A brief description of what Business Associate is doing to investigate, to mitigate harm to the Individual(s), and to protect against any further similar occurrences; and

(h) The name and contact information for a person highly knowledge of the facts and circumstances of the non-permitted Use or Disclosure of PHI, Security Incident, or Breach.

5.2.3 If Business Associate is not able to provide the information specified in Sub-paragraphs 5.2.1 or 5.2.2 at the time of the required report, Business Associate shall provide such information promptly thereafter as such information becomes available.

(a) Business Associate may delay the notification required by Sub-paragraph 5.1.3, if a law enforcement official states to Business Associate that notification would impede a criminal investigation or cause damage to national security.

(b) If the law enforcement official's statement is in writing and specifies the time for which a delay is required, Business Associate shall delay its reporting and/or notification obligation(s) for the time period specified by the official.

(c) If the statement is made orally, Business Associate shall document the statement, including the identity of the official making the statement, and delay its reporting and/or notification obligation(s) temporarily and no longer than 30 days from the date of the oral statement, unless a written statement as described in Sub-paragraph 5.3.1 is submitted during that time.

6. WRITTEN ASSURANCES OF SUBCONTRACTORS

6.1 In accordance with 45 C.F.R. § 164.502 (e)(1)(ii) and § 164.308 (b)(2), if applicable, Business Associate shall ensure that any Subcontractor that creates, receives,

maintains, or transmits Protected Health Information on behalf of Business Associate is made aware of its status as a Business Associate with respect to such information and that Subcontractor agrees in writing to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such information.

6.2 Business Associate shall take reasonable steps to cure any material breach or violation by Subcontractor of the agreement required by Sub-paragraph 6.1.

6.3 If the steps required by Sub-paragraph 6.2 do not cure the breach or end the violation, Contractor shall terminate, if feasible, any arrangement with Subcontractor by which Subcontractor creates, receives, maintains, or transmits Protected Health Information on behalf of Business Associate.

6.4 If neither cure nor termination as set forth in Sub-paragraphs 6.2 and 6.3 is feasible, Business Associate shall immediately notify County.

6.5 Without limiting the requirements of Sub-paragraph 6.1, the agreement required by Sub-paragraph 6.1 (Subcontractor Business Associate Agreement) shall require Subcontractor to contemporaneously notify Covered Entity in the event of a Breach of Unsecured Protected Health Information.

6.6 Without limiting the requirements of Sub-paragraph 6.1, agreement required by Sub-paragraph 6.1 (Subcontractor Business Associate Agreement) shall include a provision requiring Subcontractor to destroy, or in the alternative to return to Business Associate, any Protected Health Information created, received, maintained, or transmitted by Subcontractor on behalf of Business Associate so as to enable Business Associate to comply with the provisions of Sub-paragraph 18.4.

6.7 Business Associate shall provide to Covered Entity, at Covered Entity's request, a copy of any and all Subcontractor Business Associate Agreements required by Sub-paragraph 6.1.

6.8 Sub-paragraphs 6.1 and 6.7 are not intended by the parties to limit in any way the scope of Business Associate's obligations related to Subcontracts or Subcontracting in

the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

7. ACCESS TO PROTECTED HEALTH INFORMATION

7.1 To the extent Covered Entity determines that Protected Health Information is maintained by Business Associate or its agents or Subcontractors in a Designated Record Set, Business Associate shall, within two (2) business days after receipt of a request from Covered Entity, make the Protected Health Information specified by Covered Entity available to the Individual(s) identified by Covered Entity as being entitled to access and shall provide such Individuals(s) or other person(s) designated by Covered Entity with a copy the specified Protected Health Information, in order for Covered Entity to meet the requirements of 45 C.F.R. § 164.524.

7.2 If any Individual requests access to Protected Health Information directly from Business Associate or its agents or Subcontractors, Business Associate shall notify Covered Entity in writing within two (2) days of the receipt of the request. Whether access shall be provided or denied shall be determined by Covered Entity.

7.3 To the extent that Business Associate maintains Protected Health Information that is subject to access as set forth above in one or more Designated Record Sets electronically and if the Individual requests an electronic copy of such information, Business Associate shall provide the Individual with access to the Protected Health Information in the electronic form and format requested by the Individual, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to by Covered Entity and the Individual.

8. AMENDED OF PROTECTED HEALTH INFORMATION

8.1 To the extent Covered Entity determines that any Protected Health Information is maintained by Business Associate or its agents or Subcontractors in a Designated Record Set, Business Associate shall, within ten (10) business days after receipt of a

written request from Covered Entity, make any amendments to such Protected Health Information that are requested by Covered Entity, in order for Covered Entity to meet the requirements of 45 C.F.R. § 164.526.

8.2 If any Individual requests an amendment to Protected Health Information directly from Business Associate or its agents or Subcontractors, Business Associate shall notify Covered Entity in writing within five (5) days of the receipt of the request. Whether an amendment shall be granted or denied shall be determined by Covered Entity.

9. ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

9.1 Business Associate shall maintain an accounting of each Disclosure of Protected Health Information made by Business Associate or its employees, agents, representatives or Subcontractors, as is determined by Covered Entity to be necessary in order to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

9.1.1 Any accounting of disclosures provided by Business Associate under Sub-paragraph 9.1 shall include:

(a) The date of the Disclosure;

(b) The name, and address if known, of the entity or person who received the Protected Health Information;

(c) A brief description of the Protected Health Information Disclosed; and

(d) A brief statement of the purpose of the Disclosure.

9.1.2 For each Disclosure that could require an accounting under Sub-paragraph 9.1, Business Associate shall document the information specified in Sub-paragraph 9.1.1, and shall maintain the information for six (6) years from the date of the Disclosure.

9.2 Business Associate shall provide to Covered Entity, within ten (10) business days after receipt of a written request from Covered Entity, information collected in

accordance with Sub-paragraph 9.1.1 to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

9.3 If any Individual requests an accounting of disclosures directly from Business Associate or its agents or Subcontractors, Business Associate shall notify Covered Entity in writing within five (5) days of the receipt of the request, and shall provide the requested accounting of disclosures to the Individual(s) within 30 days. The information provided in the accounting shall be in accordance with 45 C.F.R. § 164.528.

10. COMPLIANCE WITH APPLICABLE HIPAA RULES

10.1 To the extent Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 C.F.R. Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity's performance of such obligation(s).

10.2 Business Associate shall comply with all HIPAA Rules applicable to Business Associate in the performance of Services.

11. AVAILABILITY OF RECORDS

11.1 Business Associate shall make its internal practices, books, and records relating to the Use and Disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity available to the Secretary for purposes of determining Covered Entity’s compliance with the Privacy and Security Regulations.

11.2 Unless prohibited by the Secretary, Business Associate shall immediately notify Covered Entity of any requests made by the Secretary and provide Covered Entity with copies of any documents produced in response to such request.

12. MITIGATION OF HARMFUL EFFECTS

Business Associate shall mitigate, to the extent practicable, any harmful effect of a Use or Disclosure of Protected Health Information by Business Associate in violation of the requirements of this Business Associate Agreement that is known to Business Associate.

13. BREACH NOTIFICATION TO INDIVIDUALS

13.1 Business Associate shall, to the extent Covered Entity determines that there has been a Breach of Unsecured Protected Health Information by Business Associate, its employees, representatives, agents or Subcontractors, provide breach notification to the Individual in a manner that permits Covered Entity to comply with its obligations under 45 C.F.R. § 164.404.

13.1.1 Business Associate shall notify, subject to the review and approval of Covered Entity, each Individual whose Unsecured Protected Health Information has been, or is reasonably believed to have been, accessed, acquired, Used, or Disclosed as a result of any such Breach.

13.1.2 The notification provided by Business Associate shall be written in plain language, shall be subject to review and approval by Covered Entity, and shall include, to the extent possible:

(a) A brief description of what happened, including the date of the Breach and the date of the Discovery of the Breach, if known;

(b) A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

(c) Any steps the Individual should take to protect him or herself from potential harm resulting from the Breach;

(d) A brief description of what Business Associate is doing to investigate the Breach, to mitigate harm to Individual(s), and to protect against any further Breaches; and

(e) Contact procedures for Individual(s) to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

13.2 Covered Entity, in its sole discretion, may elect to provide the notification required by Sub-paragraph 13.1 and/or to establish the contact procedures described in Sub-paragraph 13.1.2.

13.3 Business Associate shall reimburse Covered Entity any and all costs incurred by Covered Entity, in complying with Subpart D of 45 C.F.R. Part 164, including but not limited to costs of notification, internet posting, or media publication, as a result of Business Associate's Breach of Unsecured Protected Health Information; Covered Entity shall not be responsible for any costs incurred by Business Associate in providing the notification required by Sub-paragraph 13.1 or in establishing the contact procedures required by Sub-paragraph 13.1.2.

14. INDEMNIFICATION

14.1 Business Associate shall indemnify, defend, and hold harmless Covered Entity, its Special Districts, elected and appointed officers, employees, and agents from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, expenses (including attorney and expert witness fees), and penalties and/or fines (including regulatory penalties and/or fines), arising from or connected with Business Associate's acts and/or omissions arising from and/or relating to this Business Associate Agreement, including, but not limited to, compliance and/or enforcement actions and/or activities, whether formal or informal, by the Secretary or by the Attorney General of the State of California.

14.2 Sub-paragraph 14.1 is not intended by the parties to limit in any way the scope of Business Associate's obligations related to Insurance and/or Indemnification in the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase

Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

15. OBLIGATIONS OF A COVERED ENTITY

15.1 Covered Entity shall notify Business Associate of any current or future restrictions or limitations on the Use or Disclosure of Protected Health Information that would affect Business Associate's performance of the Services, and Business Associate shall thereafter restrict or limit its own Uses and Disclosures accordingly.

15.2 Covered Entity shall not request Business Associate to Use or Disclose Protected Health Information in any manner that would not be permissible under Subpart E of 45 C.F.R. Part 164 if done by Covered Entity, except to the extent that Business Associate may Use or Disclose Protected Health Information as provided in Sub-paragraphs 2.3, 2.5, and 2.6.

16. TERM

16.1 Unless sooner terminated as set forth in Sub-paragraph 17, the term of this Business Associate Agreement shall be the same as the term of the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order, or other service arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

16.2 Notwithstanding Sub-paragraph 16.1, Business Associate's obligations under Sub-paragraphs 4.1, 4.2, 5.1, 5.2, 6.1, and 9.1, 10.1, 11.1, 11.2, and 18.1 to 18.4 shall survive the termination or expiration of this Business Associate Agreement.

17. TERMINATION FOR CAUSE

17.1 In addition to and notwithstanding the termination provisions set forth in the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate, if either party determines that the other party has violated a material term of this Business Associate Agreement, and the breaching party

has not cured the breach or ended the violation within the time specified by the non-breaching party, which shall be reasonable given the nature of the breach and/or violation, the non-breaching party may terminate this Business Associate Agreement.

17.2 In addition to and notwithstanding the termination provisions set forth in the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order, or services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate, if either party determines that the other party has violated a material term of this Business Associate Agreement, and cure is not feasible, the non-breaching party may terminate this Business Associate Agreement immediately.

18. DEPOSITION OF PROTECTED HEALTH INFORMATION UPON TERMINATION OR EXPIRATION

18.1 Except as provided in Sub-paragraph 18.3, upon termination for any reason or expiration of this Business Associate Agreement, Business Associate shall return or, if agreed to by Covered entity, shall destroy as provided for in Section 18.2, all Protected Health Information received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, that Business Associate, including any Subcontractor, still maintains in any form. Business Associate shall retain no copies of the Protected Health Information.

18.2 Destruction for purposes of Section 18.2 and Section 6.1.2 shall mean that media on which the Protected Health Information is stored or recorded has been destroyed and/or electronic media have been cleared, purged, or destroyed in accordance with the use of a technology or methodology specified by the Secretary in guidance for rendering Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals.

18.3 Notwithstanding Sub-paragraph 18.1, in the event that Business Associate determines that any such Protected Health Information is necessary for Business Associate to continue its proper management and administration or to carry out its legal

responsibilities, Business Associate may retain that Protected Health Information which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities and shall return or destroy all other Protected Health Information.

18.3.1 Business Associate shall extend the protections of this Business Associate Agreement to such Protected Health Information, including continuing to use appropriate safeguards and continuing to comply with Subpart C of 45 C.F.R Part 164 with respect to Electronic Protected Health Information, to prevent the Use or Disclosure of such information other than as provided for in Sub-paragraphs 2.5 and 2.6 for so long as such Protected Health Information is retained, and Business Associate shall not Use or Disclose such Protected Health Information other than for the purposes for which such Protected Health Information was retained.

18.3.2 Business Associate shall return or, if agreed to by Covered entity, destroy the Protected Health Information retained by Business Associate when it is no longer needed by Business Associate for Business Associate's proper management and administration or to carry out its legal responsibilities.

18.4 Business Associate shall ensure that all Protected Health Information created, maintained, or received by Subcontractors is returned or, if agreed to by Covered entity, destroyed as provided for in Sub-paragraph 18.2.

19. AUDIT, INSPECTION, AND EXAMINATION

19.1 Covered Entity reserves the right to conduct a reasonable inspection of the facilities, systems, information systems, books, records, agreements, and policies and procedures relating to the Use or Disclosure of Protected Health Information for the purpose determining whether Business Associate is in compliance with the terms of this Business Associate Agreement and any non-compliance may be a basis for termination of this Business Associate Agreement and the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order or other services arrangement, with or

without payment, that gives rise to Contractor's status as a Business Associate, as provided for in Sub-paragraph 17.

19.2 Covered Entity and Business Associate shall mutually agree in advance upon the scope, timing, and location of any such inspection.

19.3 At Business Associate's request, and to the extent permitted by law, Covered Entity shall execute a nondisclosure agreement, upon terms and conditions mutually agreed to by the parties.

19.4 That Covered Entity inspects, fails to inspect, or has the right to inspect as provided for in Sub-paragraph 19.1 does not relieve Business Associate of its responsibility to comply with this Business Associate Agreement and/or the HIPAA Rules or impose on Covered Entity any responsibility for Business Associate's compliance with any applicable HIPAA Rules.

19.5 Covered Entity's failure to detect, its detection but failure to notify Business Associate, or its detection but failure to require remediation by Business Associate of an unsatisfactory practice by Business Associate, shall not constitute acceptance of such practice or a waiver of Covered Entity's enforcement rights under this Business Associate Agreement or the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

19.6 Sub-paragraph 19.1 is not intended by the parties to limit in any way the scope of Business Associate's obligations related to Inspection and/or Audit and/or similar review in the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

20. MISCELLANEOUS PROVISIONS

20.1 Disclaimer. Covered Entity makes no warranty or representation that compliance by Business Associate with the terms and conditions of this Business Associate

Agreement will be adequate or satisfactory to meet the business needs or legal obligations of Business Associate.

20.2 HIPAA Requirements. The Parties agree that the provisions under HIPAA Rules that are required by law to be incorporated into this Amendment are hereby incorporated into this Agreement.

20.3 No Third Party Beneficiaries. Nothing in this Business Associate Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

20.4 Construction. In the event that a provision of this Business Associate Agreement is contrary to a provision of the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate, the provision of this Business Associate Agreement shall control. Otherwise, this Business Associate Agreement shall be construed under, and in accordance with, the terms of the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

20.5 Regulatory References. A reference in this Business Associate Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

20.6 Interpretation. Any ambiguity in this Business Associate Agreement shall be resolved in favor of a meaning that permits the parties to comply with the HIPAA Rules.

20.7 Amendment. The parties agree to take such action as is necessary to amend this Business Associate Agreement from time to time as is necessary for Covered Entity or Business Associate to comply with the requirements of the HIPAA Rules and any other privacy laws governing Protected Health Information.

CHARITABLE CONTRIBUTIONS CERTIFICATION

_____
Company Name

_____
Address

_____
Internal Revenue Service Employer Identification Number

_____
California Registry of Charitable Trusts "CT" number (if applicable)

The Nonprofit Integrity Act (SB 1262, Chapter 919) added requirements to California's Supervision of Trustees and Fundraisers for Charitable Purposes Act which regulates those receiving and raising charitable contributions.

Check the Certification below that is applicable to your company.

☐ Proposer or Contractor has examined its activities and determined that it does not now receive or raise charitable contributions regulated under California's Supervision of Trustees and Fundraisers for Charitable Purposes Act. If Proposer engages in activities subjecting it to those laws during the term of a County contract, it will timely comply with them and provide County a copy of its initial registration with the California State Attorney General's Registry of Charitable Trusts when filed.

OR

☐ Proposer or Contractor is registered with the California Registry of Charitable Trusts under the CT number listed above and is in compliance with its registration and reporting requirements under California law. Attached is a copy of its most recent filing with the Registry of Charitable Trusts as required by Title 11 California Code of Regulations, sections 300-301 and Government Code sections 12585-12586.

_____ _____
Signature Date

_____
Name and Title of Signer (please print)

LIVING WAGE ORDINANCE (INTENTIONALLY OMITTED)

MONTHLY CERTIFICATION FOR APPLICABLE HEALTH BENEFIT PAYMENTS (INTENTIONALLY OMITTED)

PAYMENT STATEMENT OF COMPLIANCE
(INTENTIONALLY OMITTED)

EXHIBIT K

CONTRACTOR'S ASSIGNMENT AND TRANSFER OF COPYRIGHT

For good and valuable consideration, receipt of which is hereby acknowledged, the undersigned, _____, a _____, ("Grantor") does hereby assign, grant, convey and transfer to the County of Los Angeles, California ("Grantee") and its successors and assigns throughout the world in perpetuity, all of Grantor's right, title and interest of every kind and nature in and to all materials, documents, software programs and documentation, written designs, plans, diagrams, reports, software development tools and aids, diagnostic aids, computer processable media, source codes, object codes, conversion aids, training aids, training documentation and aids, and other information and/or tools of all types (including, without limitation, those items listed on Schedule A, attached hereto and incorporated herein by reference) developed or acquired, in whole or in part, under the Agreement described below, including, but not limited to, all right, title and interest in and to all copyrights and works protectable by copyright and all renewals and extensions thereof (collectively, the "Works"), and in and to all copyrights and right, title and interest of every kind or nature, without limitation, in and to all works based thereon, incorporated in, derived from, incorporating or relating to, the Works or from which the Works are derived.

Without limiting the generality of the foregoing, the aforesaid conveyance and assignment shall include, but is not limited to, all prior choices-in-action, at law, in equity and otherwise, the right to recover all damages and other sums, and the right to other relief allowed or awarded at law, in equity, by statute or otherwise.

Grantor and Grantee have entered into County of Los Angeles Agreement Number _____

for _____,

dated _____, as amended by Amendment Number _____, dated _____,

{NOTE to Preparer: reference all existing Amendments} as the same hereafter may be amended or otherwise modified from time to time (the "Agreement").

_____ _____

Grantor's Signature Date

Grantor's Printed Name: _____

Grantor's Printed Position: _____

APPENDIX B-1
STATEMENT OF WORK

For

CATEGORY 1 - HIV AND STD PREVENTION SERVICES FOR YOUNG AFRICAN AMERICAN AND LATINO MEN WHO HAVE SEX WITH MEN

PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs
RFP NO.: 2015-003

TABLE OF CONTENTS

PART III: MISCELLANEOUS ADDITIONAL REQUIREMENTS

APPENDIX B-1

STATEMENT OF WORK

1.0 SCOPE OF WORK - OVERVIEW

The County of Los Angeles, Department of Public Health (DPH), Division of HIV and STD Programs (DHSP) requires HIV and STD prevention programs address multiple sociocultural, environmental, and economic challenges faced by young African American and Latino men who have sex with men (YMSM) ages 12 – 29 (target population). These challenges known as social determinants of health (SDoH) affect the well-being of YMSM and are associated with poor health outcomes such as an elevated risk of HIV infection and sexually transmitted diseases (STD).

HIV and STD prevention services may be more successful for YMSM when their needs are addressed in the larger context of their lives, such as confronting broader issues of oppression, stigma, homophobia, racism, poverty, homelessness, low self-esteem, limited positive peer influence, and lack of health care access, and when strengths such as social networks are used as resources for disease prevention. HIV prevention research and reports have also indicated that combining HIV prevention with other services, such as integrating prevention with faith-based programs, job training programs, housing programs, crime reduction programs, and empowerment programs may lead to better health outcomes and more positive sexual relationships, more consistent use of condoms, and regular health maintenance, including HIV and STD screening and treatment.

HIV and STD prevention techniques should be integrated into a larger health initiative for YMSM, going far beyond addressing sexual and substance use risk behaviors and instead integrating larger social, physical, and mental health interventions. A single focus on HIV and STDs will not yield a sufficient or adequate intervention.

The Contractor's intervention program(s) must address the goals and objectives outlined in Section 1.1, Goals and Objectives and summarized in Table 1**,** DHSP Primary Goals and Objectives and Table 2**,** DHSP Program Goals and Objectives as they relate to YMSM and the changing landscape of HIV and STD prevention and care services.

1.1 Goals and Objectives

The DHSP goals and objectives of the HIV and STD prevention programs is divided into: (a) *Primary goals* and objectives and (b) *Program* goals and objectives. The *Primary* goals and objectives are foundational in nature to the program, while the *Program* goals and objectives relate to the Social Determinants of Health (SDoH) and resiliency factors that will be addressed in order to help

achieve these goals and objectives.

Both sets of goals and objectives are designed to ensure HIV and STD prevention programs including, screening, treatment and care services for YMSM are comprehensively and effectively addressed. Additionally, the Contractor must provide HIV and STD prevention program services that are holistic and broadly incorporate the social context of YMSM's life, by designing the scope of work to include an in-depth response to the goals and their objectives as discussed below, with the understanding that educating and engaging individuals in health care and healthy relationships are key HIV and STD prevention strategies.

1.1.1 Primary Goals and Objectives

The Primary goals for HIV and STD prevention programs which must be addressed when supported with DHSP funding are:

1. To decrease new HIV and STD infections among YMSM; and
2. To increase linkage to care among HIV positive YMSM not currently in HIV medical care.

These goals can be accomplished by creating prevention interventions that work to achieve the primary objectives (A-D) listed in Table 1.

Table 1. DHSP Primary Goals and Objectives

PRIMARY GOALS:	**1.** *Decrease new HIV and STD infection among YMSM* **2.** *Increase linkage to care among HIV positive YMSM not currently in HIV medical care.*
PRIMARY OBJECTIVES:	A. Increase the number of YMSM testing for HIV and STD infections B. Increase in the number of newly identified, previously undiagnosed HIV positive YMSM C. Prevent and reduce the transmission of HIV and STDs among YMSM D. Increase in the number of YMSM linked to medical care

1.1.2 Program Goals and Objectives

In addition to the Primary goals and objectives for prevention programs (Section 1.1.1), the Contractor must also consider and address more specific Program goals and objectives (Table 2, DHSP Program Goals and Objectives) that are related to SDoH and resiliency factors: improving health care literacy, health care access and social connectedness. Successful attainment of the Program goals will be dependent on achievement of the Program objectives listed in Table 2.

Table 2. DHSP Program Goals and Objectives

PROGRAM GOALS:	1. Improve health literacy among YMSM 2. Improve health care access among YMSM 3. Improve social connectedness between YMSM and the larger community	
PROGRAM GOAL 1: IMPROVE HEALTH LITERACY	**Program Objective 1.1:** INCREASE HEALTH KNOWLEDGE	Increase overall health knowledge and awareness of HIV and STDs, high risk behaviors, and HIV and STD prevention techniques (both mental and physical).
PROGRAM GOAL 2: IMPROVE HEALTH CARE ACCESS	**Program Objective 2.1:** IMPROVE HEALTH CARE AVAILABILITY	Ensure necessary resources and care services, such as personnel and technology and medical transition care are available and meet the needs of YMSM.
	Program Objective 2.2: IMPROVE HEALTH CARE ACCESSIBILITY	Reduce geographic barriers for YMSM and link them with the newly funded programs and services.
	Program Objective 2.3: IMPROVE HEALTH CARE ACCOMMODATION	Ensure YMSM consider services accommodating, such as providing an unbiased and youth-friendly atmosphere, having an understanding of unique YMSM needs, maintaining appropriate hours of operation, using acceptable methods of sharing information and communication devices/tools, and allowing for flexibility in service delivery.
	Program Objective 2.4: IMPROVE HEALTH CARE ACCEPTABILITY	Improve the acceptance of provider services and service delivery to YMSM by providing health care services (e.g. STD and HIV screening and treatment, HIV biomedical prevention services) that are attractive, convenient and respectful to youth.
PROGRAM GOAL 3: IMPROVE SOCIAL CONNECTEDNESS	**Program Objective 3.1:** FOSTER HEALTHY RELATIONSHIPS	Provide a mechanism by which YMSM can start to develop and foster healthy relationships.

2.0 ADDITION AND/OR DELETION OF FACILITIES, SPECIFIC TASKS AND/OR WORK HOURS

2.1 Contractor must obtain permission from the Director, DHSP, at least sixty (60) days prior to the addition/deletion of service facilities, specific tasks and or work hour adjustments.

2.2 All changes must be made in accordance with Paragraph 8.0, Alteration of Terms/Amendments of the Contract.

3.0 QUALITY CONTROL

The Contractor shall establish and utilize a comprehensive Quality Control Plan to assure clients receive a consistently high level of service throughout the term of the Contract. The Plan shall be submitted to the County Contract Program Manager for review. The plan shall include, but may not be limited to the following:

3.1 Indicators to be used to measure process, outputs, and outcomes; data sources, collection methods, and frequency; plan for data quality assessment; and plan for data use for continual program improvement.

3.2 Elements and methods of quality control plan, which assure that Contract requirements are consistently being met.

3.3 How HIV and STD testing, linkage to care, and follow-up numbers will be captured, tracked, and reported to DHSP on a consistent and ongoing basis.

3.4 How the Community Advisory Board (CAB) input will be captured, tracked and reported to DHSP on a consistent and ongoing basis.

3.5 A record of all quality control activities conducted by the Contractor, any corrective action taken, the time a problem was first identified, a clear description of the problem, and the time elapsed between identification and completed corrective action, shall be provided to the County upon request.

4.0 QUALITY ASSURANCE PLAN

The County will evaluate the Contractor's performance under this Contract using the quality assurance procedures as defined in the Additional Provisions of this Contract, Paragraph 37, County's Quality Assurance Plan.

4.1 Quarterly Meetings

Contractor is required to attend all scheduled Provider meetings.

4.2 County Observations

In addition to departmental contracting staff, other County personnel may observe performance, activities, and review documents relevant to this Contract at any time during normal business hours. However, these personnel may not unreasonably interfere with the Contractor's performance.

5.0 DEFINITIONS

5.1 Community Advisory Board (CAB): Advisory group of subject matter experts (SME) drawn from local community members who collaborate with the Contractor to design and continue to provide input to improve programs that are appealing and effective with YMSM from the local community.

5.2 Contract: Agreement executed between County and Contractor. It sets forth the terms and conditions for the issuance and performance of the Statement of Work (SOW).

5.3 Contractor: The sole proprietor, limited liability partnership, or corporation that has entered into a contract with the County to perform or execute the work covered by the Statement and Scope of Work.

5.4 Contractor Project Manager: The Contractor's designee responsible to administer the Contract operations and to liaise with the County after the Contract award.

5.5 County Contract Project Monitor: Person with responsibility to oversee the day to day activities of this Contract. Responsibility for inspections of any and all tasks, deliverables, goods, services and other work provided by the Contractor.

5.6 County Project Director: Person designated by County with authority for County on contractual or administrative matters relating to this Contract that cannot be resolved by the County's Program Manager.

5.7 County Program Manager: Person designated by County's Project Director to manage the operations under this Contract.

5.8 Day(s): Calendar day(s) unless otherwise specified.

5.9 Evidence-based intervention: Interventions that have been proven effective (to some degree) through scientific processes including rigorous outcome evaluations. Implementation of such interventions hold a higher degree of success if implemented with fidelity to the original design.

5.10 Fiscal Year: The twelve (12) month period beginning July 1st and ending the following June 30th.

5.11 High-risk for HIV infection: An individual who is at-risk for acquiring or transmitting HIV and STD infection and is the target of the HIV and STD prevention services; for the purposes of the Contract this high risk group is further defined as young African

American and Latino men who have sex with men, ages 12 – 29, who reside in Los Angeles County.

5.12 MSM: Term used to encompass men who have sex with men behaviorally but may identify their sexuality as either gay, straight, bisexual, same gender loving, down low, pansexual, etc. or some other identity.

5.13 Screening Services: The process during which an HIV or STD client receives a screening test for HIV and/or STD infection. Generally, a screening test only acts as an indicator of infection and requires a confirmatory test. Sometimes this process is referred to as HIV or STD testing; however, in the Contract and related documents it is always listed as screening.

5.14 Subcontractor/consultant: An agency contracted or providing in-kind or consultative services to Contractor to accomplish specific work requirements of the Appendix B-1, Statement of Work. All agreements must be in writing and approved by the Director, DHSP.

5.15 YMSM: Term used to encompass young men who have sex with men who are 12-29 years old.

5.16 Young/Youth: People ages 12-29 years old.

6.0 RESPONSIBILITIES

The County's and the Contractor's responsibilities are as follows:

COUNTY

6.1 Personnel

The County will administer the Contract according to the Contract, Paragraph 23, Administration of Contract - County. Specific duties will include:

6.1.1 Monitoring the Contractor's performance in the daily operation of this Contract.

6.1.2 Providing direction to the Contractor in areas relating to policy, information and procedural requirements.

6.1.3 Preparing Amendments in accordance with the Contract, Paragraph 8.0, Alteration of Terms and Amendments.

CONTRACTOR

6.2 Project Manager

6.2.1 Contractor shall provide a full-time Project Manager and designated alternate. County must have access to the Project Manager during normal working hours as designated in Section 7.0, Days/Hours of Work. Contractor shall provide a telephone number where the Project Manager may be reached on an eight (8) hour per day basis during those hours.

6.2.2 Project Manager shall act as a central point of contact with the County.

6.2.3 Project Manager shall have at least three (3) years of experience providing HIV/AIDS prevention (e.g., health education/risk reduction services or HIV screening) services within the previous five (5) years.

6.2.4 Project Manager/alternate shall have full authority to act for Contractor on all matters relating to the daily operation of the Contract. Project Manager/alternate shall be able to effectively communicate, in English, both orally and in writing.

6.3 Personnel

6.3.1 Contractor shall be required to perform background checks of their employees as set forth in Administration of Contract, Paragraph 23, sub-paragraph D – Background & Security Investigations, of the Contract. All costs associated with the background and security investigation shall be borne by the Contractor.

6.3.2 Contractor's HIV and STD screening services must be provided by a certified counselor and who further has at least three (3) years in the last five (5) specializing in HIV and STD prevention services.

6.3.3 Contractor's prevention providers (e.g., health educators, group facilitators) must have demonstrated ability through training and experience dealing with issues affecting those at risk of acquiring an STD or HIV infection and HIV-infected persons, youth, and men who have sex with men (MSM) including but not limited to STD/HIV/AIDS stigma, cultural sensitivity, and gender identity issues, and must be experienced in identifying high risk individuals.

6.3.4 Contractor's STD treatment services must be provided by California-licensed and credentialed medical providers and allied health professionals, as applicable.

6.4 Approval of Contractor's Staff and Subcontractors

6.4.1 County has the absolute right to approve or disapprove all of Contractor's staff performing work hereunder and any proposed changes in Contractor's staff, including, but not limited to, Contractor's Program Director.

6.4.2 Contractor shall remove and replace personnel performing services under this Contract within thirty (30) days of the written request of the County. Contractor shall send County written confirmation of the removal of the personnel in question.

6.4.3 County has the absolute right to approve or disapprove all of Contractor's subcontractors or consultants performing work hereunder and any proposed changes in subcontractor.

6.4.4 Contractor shall obtain approval of DHSP Director or his designee prior to signing any subcontractor or consultant agreement and shall give DHSP Director thirty (30) days prior notice to review proposed subcontract or consultant agreement.

6.4.5 Subcontractor shall remove and replaced personnel performing services under this Contract within thirty (30) days of the written request of the County. Contractor shall send County written confirmation of the removal of the personnel in question.

6.5 Uniforms/Identification Badges

6.5.1 Dress code is business professional as defined by the Contractor.

6.5.2 Contractor shall ensure their employees are appropriately identified as set forth in Paragraph 23, Administration of Contract, sub-paragraph C– Contractor's Staff Identification, of the Contract.

6.6 Materials and Equipment

The purchase of all materials/equipment to provide the needed services is the responsibility of the Contractor. Reimbursement shall be provided for such materials as are necessary for the day to day administration of prevention services in a clinic and/or community setting. Contractor shall use materials and equipment that are safe for the environment and safe for use by the employee.

6.7 Training

6.7.1 Contractor shall provide training programs for all new employees and continuing in-service training for all employees.

6.7.2 All employees shall be trained in their assigned tasks and in the safe handling of equipment. All equipment shall be checked daily for safety. All employees must wear safety and protective gear according to the OSHA standards for their specific duties.

6.8 Contractor's Office

Contractor shall maintain an office with a telephone in the company's name where Contractor conducts business. The office shall be staffed during the hours of 8 a.m. to 5 p.m., Monday through Friday, by at least one employee who can respond to inquiries and/or concerns which may be received about the Contractor's performance of the Contract. When the office is closed, an answering service shall be provided to receive calls. The Contractor shall answer calls received by the answering service within *twenty-four (24) hours* of receipt of the call.

6.8.1 **Contractor's Facility:**

Contractor shall maintain each facility in good repair and sufficient to facilitate high-quality, appropriate services.

Contractor's facility and location shall satisfy each of the following requirements:

a. Meets American's with Disabilities Act requirements for accessibility;

b. Is near public transportation;

c. Open during client-friendly hours (e.g., evenings, weekends);

d. Free parking is available;

e. All equipment needed is in working order;

f. Easy to enter site (e.g. required to go through security guard, cross multiple gates).

g. Privacy at the front (sign-in area) or reception desk;

h. Free of graffiti and trash on grounds and in facility;

i. Designated room for HIV and STD screening services (Note: room does not have to be operational; however it must be currently available for use);

j. Security provided outside and inside the facility

k. Confidential exam, treatment and interview rooms present and available for use;

l. Clear, distinct outside signage; and

m. Facilities are clean, well-lit, clearly marked indicating location of services.

7.0 HOURS/DAY OF WORK

The Contractor shall be required to provide prevention services during the hours that are the most effective and convenient for YMSM. Hours may be the standard Monday through Friday, between 8:00 a.m. to 5:00 p.m., but may also include alternate hours such as evenings, late nights, and weekends. County will provide a list of County-recognized holidays.

8.0 WORK SCHEDULES

8.1 Contractor shall submit for review and approval a work schedule for each location/facility to the County Program Manager within sixty (60) days prior to starting work. Said work schedules shall be set on an annual calendar identifying all the required on-going maintenance tasks and task frequencies. The schedules shall list the time frames by day of the week, morning, afternoon, and/or evening the tasks will be performed.

8.2 Contractor shall submit revised schedules when actual performance differs substantially from planned performance. Said revisions shall be submitted to the County Program Manager for review and approval within thirty (30) working days prior to scheduled time for work.

9.0 SPECIFIC WORK REQUIREMENTS

Primary responsibilities and/or services to be provided by the Contractor shall include, but not be limited to, the following:

PART I. TECHNICAL PROGRAM REQUIREMENTS

9.1 Provision of HIV and STD Prevention Services: Contractor shall provide HIV and STD prevention services to young African American and/or Latino MSM between the ages of 12-29 in one (1) of the five (5) HIV and STD Syndemic Cluster Areas in Los Angeles County.

PART II. PROGRAM REQUIREMENTS

A. PROGRAM CONCEPTS: SECTIONS 9.2 TO 9.4

9.2 Holistic Approach to Services: Contractor shall leverage opportunities and collaborate with other community partners in order to provide comprehensive, holistic services to YMSM population.

9.3 Community Advisory Board (CAB) Duties: Contractor shall recruit and maintain a CAB with the following duties:

9.3.1 Staffing: Contractor shall ensure that the CAB is fully staffed by individuals able to provide administrative and technical support to CAB members during and between meetings, while working independently and in groups or committees on projects or with special project-related issues.

9.3.2 Membership Requirements: Contractor shall recruit and maintain a CAB whose membership complies with the following requirements:

a. Comprised of five (5) to eight (8) community members, two (2) shall be designated as co-chairs;
b. Members must reside in Los Angeles County;
c. Members must be16 to 29 years of age;
d. Consist of 75 percent youth of color (African American or Latino);
e. Consist of 50 percent 16 to 24 years of age; and
f. Consist of 60 percent YMSM.

9.3.3 Scheduling, Promotion and Meeting Requirements: Contractor shall schedule and announce CAB meetings as directed by CAB co-chairs, but no less than four (4) times per year.

9.3.4 Staff Requirements Regarding CAB Members and Subcommittee Meetings: Contractor's CAB support staff shall facilitate CAB and subcommittee meetings and respond to requests for information from CAB members.

9.3.5 Dissemination of Minutes and Other Documents: Contractor's CAB support staff shall disseminate CAB and subcommittee meeting minutes, any reports and all recommendations to:

a. Co-chairs;
b. CAB members;
c. Agency Executive Director and agency staff as directed; and
d. Director of DHSP, or designee.

9.4 Contractor – CAB On-going Collaboration Requirements: Contractor shall collaborate and consult on an ongoing, consistent basis with a community advisory

board (CAB) comprised of the target population to inform and improve intervention(s).

B. PROGRAM COMPONENTS: SECTIONS 9.5 TO 9.8

9.5 Focused on Youth Development: Contractor shall provide services that are focused on youth development.

9.6 Social Determinants of Health (SDoH): Contractor shall implement the selected evidence-based intervention(s) to be used to mitigate the impact of the selected SDoH for YMSM.

9.7 Promoting Resiliency and Protective Factors: Contractor shall implement the selected evidence-based intervention(s) to promote the proposed resiliency and protective factors for each SDoH addressed.

9.8 Utilizing Technology: Contractor shall utilize social and digital media currently used by YMSM, to stay socially connected Such technologies include, but are not limited to: social media, smart phone and/or internet apps, online dating sites, chat rooms, gaming (behavior change focused) sites, texting, etc.

C. HIV AND STD PROGRAM COMPONENTS: SECTIONS 9.9 TO 9.17

9.9 Benefits Screening Program: Contractor shall implement a benefits screening program that assesses client's eligibility for public and social services, promotes enrollment in those services for which a client qualifies and maximizes payment from third-party payer sources.,

9.10 On-site HIV Screening Services: Contractor/subcontractor or consultant shall provide HIV screening services on-site with all HIV and STD prevention program services, consistent with federal, State, and local guidelines and policies and ensure appropriate medical oversight of HIV screening services.

9.11 On-site STD Screening and Treatment Services: Contractor/subcontractor or consultant shall provide on-site STD screening and treatment services with appropriate medical oversight and consistent with California and local guidelines and policies; and, if on-site treatment is not available, then ensure verifiable, appropriate linkage to off-site treatment services is made.

9.12 Identify Undiagnosed HIV and STD Infection: Contractor or subcontractor/consultant shall identify undiagnosed HIV and STD infection among YMSM in the selected location(s) of services.

9.13 Ensure Access to Educational Services for Pre-exposure Prophylaxis Programs (PrEP): Contractor must ensure one hundred percent (100%) of YMSM who request services are provided access to counseling, educational and referral services to PrEP.

9.14 Counsel and Refer to Post-exposure Prophylaxis Program (PEP) as Appropriate: Contractor shall counsel and refer YMSM exposed non-occupationally to HIV within a 72 hour time period for evaluation to a PEP program as appropriate.,

9.15 Link to Care Services: Contractor shall link all YMSM who test positive for HIV with HIV-related medical care consistent with guidelines from the Centers for Disease Control and Prevention and local guidelines.

9.16 Re-engage and Retain in Care Services: Contractor shall re-engage and work to retain in care HIV positive YMSM known to be out of medical care back into HIV medical care and treatment services.

9.17 Ensure Linkage to Partner Services: Contractor shall ensure that one hundred percent (100%) of YMSM who test positive for HIV, syphilis, or gonorrhea are linked to LAC DHSP Partner Counseling and Referral Services.

PART III. MISCELLANEOUS ADDITIONAL REQUIREMENTS

9.18 Comply with State Reporting Requirements: All State HIV, STD, and hepatitis reporting requirements must be followed and can be located at: http://publichealth.lacounty.gov/dhsp/ReportCase.htm

9.19 Staff Retention Policies and Procedures: Contractor shall provide County a staff retention policies and procedures plan within thirty (30) days of the Contract start date.

9.20 CLIA Eligible/Covered Provider: Where rapid HIV tests are performed, Contractor must ensure that the responsible provider submits a Quality Management Yearly Plan and a California issued certificate indicating the site is a Clinical Laboratory Improvement Act (CLIA) eligible/covered provider.

APPENDIX B-2
STATEMENT OF WORK

For

CATEGORY 2 - HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS

PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs
RFP NO.: 2015-003

TABLE OF CONTENTS

APPENDIX B-2

STATEMENT OF WORK

1.0 SCOPE OF WORK - OVERVIEW

The County of Los Angeles, Department of Public Health (DPH), Division of HIV and STD Programs (DHSP) requires HIV and STD prevention programs address multiple sociocultural, environmental, and economic challenges faced by transgender individuals living in Los Angeles County (target population). These circumstances known collectively as social determinants of health (SDoH) affect the well-being of transgender individuals and are associated with poor health outcomes such as an elevated risk of HIV infection and sexually transmitted diseases (STD).

Interventions must be comprehensive in design as HIV and STD prevention is likely to be more successful when broader issues of oppression, stigma, transphobia and racism are addressed, and when strengths such as social networks are utilized as resources for disease prevention. HIV prevention research and information indicates that combining HIV prevention with other services, such as integrating prevention with faith-based programs, job training programs, housing programs, crime reduction programs, and empowerment programs may lead to better health outcomes. It is expected that this could also hold true for STD prevention.

HIV and STD prevention techniques should be integrated into a larger health initiative for the transgender community, going far beyond addressing sexual and substance use risk behavior reduction interventions and instead integrating larger social, physical, and mental health interventions. A single focus on HIV and STDs will not yield a sufficient or adequate intervention.

The Contractor's intervention programs(s) must address the goals and objectives outlined in Section 1.1, Goals and Objectives and summarized in Table 1, DHSP Primary Goals and Objectives and Table 2, DHSP Program Goals and Objectives, as they relate to transgender individuals and the changing landscape of HIV and STD prevention and care services.

1.1 Goals and Objectives

The DHSP goals and objectives of the HIV and STD prevention programs are divided into: (a) *Primary goals* and objectives and (b) *Program* goals and objectives. The *Primary* goals and objectives are foundational in nature to the program, while the *Program* goals and objectives relate to the Social Determinants of Health (SDoH) and resiliency factors that will be addressed in order to help achieve these goals and objectives.

Both sets of goals and objectives are designed to ensure HIV and STD prevention programs including screening, treatment and care services for transgender persons are comprehensively and effectively addressed. Additionally, the Contractor must provide HIV and STD prevention program services that are holistic and broadly incorporate the social context of a transgender individual's life, by designing the scope of work to include an in-depth response to the goals and their objectives as discussed below, with the understanding that educating and engaging individuals in health care and healthy relationships are key HIV and STD prevention strategies.

1.1.1 Primary Goals and Objectives

The Primary goals for HIV and STD prevention programs which must be addressed when supported with DHSP funding are:

1. To decrease new HIV and STD infections among transgender individuals; and
2. To increase linkage to care among HIV positive transgender individual not currently in HIV medical care.

These goals can be accomplished by creating prevention interventions that work to achieve the primary objectives (A-D) listed in Table 1.

Table 1. DHSP Primary Goals and Objectives

PRIMARY GOALS:	*1. Decrease new HIV and STD infection among transgender individuals* *2. Increase linkage to HIV medical care among HIV positive transgender individuals currently not in care*
PRIMARY OBJECTIVES:	A. Increase in the number of transgender individuals testing for HIV and STD infections B. Increase in the number of newly identified, previously undiagnosed HIV positive transgender individuals C. Increase in the number of transgender individuals accessing care and prevention services D. Increase in the number of transgender individuals linked to medical care

1.1.2 Program Goals and Objectives

In addition to the Primary goals and objectives for prevention programs (Section 1.1.1), the Contractor must also consider and address more specific Program goals and objectives (Table 2, DHSP Program Goals and

Objectives) that are related to SDoH and resiliency factors: improving health care access and housing opportunities for transgender individuals, promoting economic empowerment among transgender individuals, and increasing service provider's cultural awareness and sensitivity about the transgender community. Successful attainment of the Program goals will be dependent on achievement of the Program objectives listed in Table 2.

Table 2. DHSP Program Goals and Objectives

PROGRAM GOALS:	1. Improve health care access among transgender individuals 2. Improve housing opportunities for transgender individuals 3. Advance economic empowerment among transgender individuals 4. Improve cultural competency and sensitivity about the transgender community in LAC	
PROGRAM GOAL 1: IMPROVE HEALTH CARE ACCESS	**Program Objective 1.1:** IMPROVE HEALTH CARE AVAILABILITY	Ensure necessary resources and care services, such as personnel, technology, and medical transition care are available and meet the needs of transgender individuals.
	Program Objective 1.2: IMPROVE HEALTH CARE ACCESSIBILITY	Reduce geographic barriers for the Transgender community and link them with the newly funded programs and services.
	Program Objective 1.3: IMPROVE HEALTH CARE ACCOMMODATION	Ensure transgender individuals consider services accommodating , such as providing an unbiased and trans-friendly atmosphere, having an understanding of unique transgender needs, maintaining appropriate hours of operation, using acceptable methods of sharing information and communication devices/tools, and allowing for flexibility in service delivery.
	Program Objective 1.4: IMPROVE HEALTH CARE ACCEPTABILITY	Improve the acceptance of provider services and service delivery to transgender persons by providing health care services (e.g. STD and HIV screening and treatment, HIV biomedical prevention services) that are attractive, respectful and welcoming to transgender individuals.
PROGRAM GOAL 2: IMPROVE HOUSING OPPORTUNITIES	**Program Objective 2.1:** PROVIDE HOUSING ASSISTANCE	Provide assistance to transgender individuals to help locate and obtain safe, stable and affordable housing.
PROGRAM GOAL 3:	**Program Objective 3.1:** PROMOTE ECONOMIC EMPOWERMENT	Provide interventions to promote economic empowerment for transgender persons by offering such services or programs as job

ADVANCE ECONOMIC EMPOWERMENT		training, assistance with schools or academic program registrations, tutoring, business startup workshops, etc.
PROGRAM GOAL 4: IMPROVE CULTURAL COMPETENCY	**Program Objective 4.1:** FOCUS ON CULTURAL COMPETENCY	Program services must be acceptable to the transgender community. The program must incorporate and respect the socio-cultural beliefs, values, and situations of transgender individuals in its service development and delivery.

2.0 ADDITION AND/OR DELETION OF FACILITIES, SPECIFIC TASKS AND/OR WORK HOURS

2.1 Contractor must obtain permission from the Director, DHSP, at least sixty (60) days prior to the addition/deletion of service facilities, specific tasks and or work hour adjustments.

2.2 All changes must be made in accordance with Paragraph 8.0 Alteration of Terms/Amendments of the Contract.

3.0 QUALITY CONTROL

The Contractor shall establish and utilize a comprehensive Quality Control Plan to assure clients receive a consistently high level of service throughout the term of the Contract. The Plan shall be submitted to the County Contract Program Manager for review. The plan shall include, but may not be limited to the following:

3.1 Indicators to be used to measure process, outputs, and outcomes; data sources, collection methods, and frequency; plan for data quality assessment; and plan for data use for continual program improvement.

3.2 Elements and methods of quality control plan, which assure that Contract requirements are consistently being met.

3.3 How HIV and STD testing, linkage to care, and follow-up numbers will be captured, tracked, and reported to DHSP on a consistent and ongoing basis.

3.4 How the Community Advisory Board (CAB) input will be captured, tracked and reported to DHSP on a consistent and ongoing basis.

3.5 A record of all quality control activities conducted by the Contractor, any corrective action taken, the time a problem was first identified, a clear description of the problem, and the time elapsed between identification and completed corrective action, shall be provided to the County upon request.

4.0 QUALITY ASSURANCE PLAN

The County will evaluate the Contractor's performance under this Contract using the quality assurance procedures as defined in the Additional Provisions of this Contract, Paragraph 37, County's Quality Assurance Plan.

4.1 Quarterly Meetings

Contractor is required to attend all scheduled Provider meetings.

4.2 County Observations

In addition to departmental contracting staff, other County personnel may observe performance, activities, and review documents relevant to this Contract at any time during normal business hours. However, these personnel may not unreasonably interfere with the Contractor's performance.

5.0 DEFINITIONS

5.1 Community Advisory Board (CAB): Advisory group of subject matter experts (SME) drawn from local community members who collaborate with the Contractor to design and continue to provide input to improve programs that are appealing and effective with individuals from the local transgender community.

5.2 Contract: Agreement executed between County and Contractor. It sets forth the terms and conditions for the issuance and performance of the Statement of Work (SOW).

5.3 Contractor: The sole proprietor, limited liability partnership, or corporation that has entered into a contract with the County to perform or execute the work covered by the Statement and Scope of Work.

5.4 Contractor Project Manager: The Contractor's designee responsible to administer the Contract operations and to liaise with the County after the Contract award.

5.5 County Contract Project Monitor: Person with responsibility to oversee the day to day activities of this Contract. Responsibility for inspections of any and all tasks, deliverables, goods, services and other work provided by the Contractor.

5.6 County Project Director: Person designated by County with authority for County on contractual or administrative matters relating to this Contract that cannot be resolved by the County's Program Manager.

5.7 County Program Manager: Person designated by County's Project Director to manage the operations under this Contract.

5.8 Day(s): Calendar day(s) unless otherwise specified.

5.9 Evidence-based intervention: Interventions that have been proven effective (to some degree) through scientific processes including rigorous outcome evaluations. Implementation of such interventions hold a higher degree of success if implemented with fidelity to the original design.

5.10 Fiscal Year: The twelve (12) month period beginning July 1st and ending the following June 30th.

5.11 High-risk for HIV infection: An individual who is at-risk for acquiring or transmitting HIV and STD infection and is the target of the HIV and STD prevention services; for the purposes of this Contract, this high risk group is further defined as transgender individuals who reside in Los Angeles County.

5.12 Screening Services: The process during which an HIV or STD client receives a screening test for HIV and/or STD infection. Generally, a screening test only acts as an indicator of infection and requires a confirmatory test. Sometimes this process is referred to as HIV or STD testing; however, in the Contract and related documents it is always listed as screening.

5.13 Subcontractor/consultant: An agency contracted or providing in-kind or consultative services to Contractor to accomplish specific work requirements of the Appendix B-2, Statement of Work. All agreements must be in writing and approved by the Director, DHSP.

5.14 Transgender: Terminology used to refer to transgender people is imperfect. While there is no universally accepted definition of the word "transgender," the National Center for Transgender Equality's definition will be used for this contract: "an umbrella term for people whose gender identity, expression or behavior is different from those typically associated with their assigned sex at birth.[1]"

5.15 Young/Youth: People ages 12-29 years old.

6.0 RESPONSIBILITIES

The County's and the Contractor's responsibilities are as follows:

COUNTY

6.1 Personnel

The County will administer the Contract according to the Contract, Paragraph 23, Administration of Contract - County. Specific duties will include:

6.1.1 Monitoring the Contractor's performance in the daily operation of this Contract.

6.1.2 Providing direction to the Contractor in areas relating to policy, information and procedural requirements.

6.1.3 Preparing Amendments in accordance with the Contract, Paragraph 8.0, Alteration of Terms/Amendments.

CONTRACTOR

6.2 Project Manager

6.2.1 Contractor shall provide a full-time Project Manager and designated alternate. County must have access to the Project Manager during normal working hours as designated in Section 7.0, Days/Hours of Work. Contractor shall provide a telephone number where the Project Manager may be reached on an eight (8) hour per day basis during those hours.

6.2.2 Project Manager shall act as a central point of contact with the County.

6.2.3 Project Manager shall have at least three (3) years of experience providing HIV/AIDS prevention services (e.g., health education/risk reduction services or HIV screening) services within the previous five (5) years.

6.2.4 Project Manager/alternate shall have full authority to act for Contractor on all matters relating to the daily operation of the Contract. Project Manager/alternate shall be able to effectively communicate, in English, both orally and in writing.

6.3 Personnel

6.3.1 Contractor shall be required to perform background checks of their employees as set forth in Administration of Contract, Paragraph 23, sub-paragraph D – Background & Security Investigations, of the Contract. All costs associated with the background and security investigation shall be borne by the Contractor.

6.3.2 Contractor's HIV and STD screening services must be provided by a licensed counselor and who further has at least three (3) years in the last five (5) specializing in HIV and STD prevention services.

6.3.3 Contractor's prevention providers (e.g., health educators, group facilitators) must have demonstrated ability through training and experience addressing issues affecting those at risk for STD or HIV infection and HIV-infected persons, youth, and transgender individuals including but not limited to

STD/HIV/AIDS stigma, transphobia and cultural awareness and sensitivity regarding the transgender community, and must be experienced in identifying risk factors associated with an elevated risk for HIV or STD infection.

6.3.4 Contractor's STD treatment services must be provided by California-licensed and credentialed medical providers and allied health professionals, as applicable.

6.4 Approval of Contractor's Staff and Subcontractors

6.4.1 County has the absolute right to approve or disapprove all of Contractor's staff performing work hereunder and any proposed changes in Contractor's staff, including, but not limited to, Contractor's Program Director.

6.4.2 Contractor shall remove and replace personnel performing services under this Contract within thirty (30) days of the written request of the County. Contractor shall send County written confirmation of the removal of the personnel in question.

6.4.3 County has the absolute right to approve or disapprove all of Contractor's subcontractors or consultants performing work hereunder and any proposed changes in subcontractor.

6.4.4 Contractor shall obtain approval of DHSP Director or his designee prior to signing any subcontractor or consultant agreement and shall give DHSP Director thirty (30) days prior notice to review proposed subcontract or consultant agreement.

6.4.5 Subcontractor shall remove and replaced personnel performing services under this Contract within thirty (30) days of the written request of the County. Contractor shall send County written confirmation of the removal of the personnel in question.

6.5 Uniforms/Identification Badges

6.4.1 Dress code is business professional as defined by the Contractor.

6.4.2 Contractor shall ensure their employees are appropriately identified as set forth in Paragraph 23, Administration of Contract, sub-paragraph C Contractor's Staff Identification, of the Contract.

6.6 Materials and Equipment

The purchase of all materials/equipment to provide the needed services is the responsibility of the Contractor. Reimbursement shall be provided for such materials

as are necessary for the day to day administration of prevention services in a clinic and/or community setting. Contractor shall use materials and equipment that are safe for the environment and safe for use by the employee.

6.7 Training

6.6.1 Contractor shall provide training programs for all new employees and continuing in-service training for all employees.

6.6.2 All employees shall be trained in their assigned tasks and in the safe handling of equipment. All equipment shall be checked daily for safety. All employees must wear safety and protective gear according to the OSHA standards for their specific duties.

6.8 Contractor's Office

Contractor shall maintain an office with a telephone in the company's name where Contractor conducts business. The office shall be staffed during the hours of 8 a.m. to 5 p.m., Monday through Friday, by at least one employee who can respond to inquiries and/or concerns which may be received about the Contractor's performance of the Contract. When the office is closed, an answering service shall be provided to receive calls. The Contractor shall answer calls received by the answering service within *twenty-four (24) hours* of receipt of the call.

6.8.1 **Contractor's Facility:** Contractor shall maintain each facility in good repair and sufficient to facilitate high-quality, appropriate services.

Contractor's facility and location shall satisfy each of the following requirements:

a. Meets American's with Disabilities Act requirements for accessibility;

b. Is near public transportation;

c. Open during client-friendly hours (e.g., evenings, weekends);

d. Free parking is available;

e. All equipment needed is in working order;

f. Easy to enter site (e.g. required to go through security guard, cross multiple gates).

g. Privacy at the front (sign-in area) or reception desk;

h. Free of graffiti and trash on grounds and in facility;

i. Designated room for HIV and STD screening services (Note: Room does not have to be operational; however it must be currently available for use);

j. Security provided outside and inside the facility

k. Confidential exam, treatment and interview rooms present and available for use;

l. Clear, distinct outside signage; and

m. Facilities are clean, well-lit, clearly marked indicating location of services.

7.0 HOURS/DAY OF WORK

The Contractor shall be required to provide prevention services during the hours that are the most effective and convenient for transgender individuals. Hours may be the standard Monday through Friday, between 8:00 a.m. to 5:00 p.m., but may also include alternate hours such as evenings, late nights, and weekends. County will provide a list of County-recognized holidays.

8.0 WORK SCHEDULES

8.1 Contractor shall submit for review and approval a work schedule for each location/facility to the County Program Manager within sixty (60) days prior to starting work. Said work schedules shall be set on an annual calendar identifying all the required on-going maintenance tasks and task frequencies. The schedules shall list the time frames by day of the week, morning, afternoon, and/or evening the tasks will be performed.

8.2 Contractor shall submit revised schedules when actual performance differs substantially from planned performance. Said revisions shall be submitted to the County Program Manager for review and approval within thirty (30) working days prior to scheduled time for work.

9.0 SPECIFIC WORK REQUIREMENTS

Primary responsibilities and/or services to be provided by the Contractor shall include, but not be limited to, the following:

PART I. TECHNICAL PROGRAM REQUIREMENTS

9.1 Provision of HIV and STD Prevention Services: Contractor shall provide HIV and STD prevention services to transgender individuals who reside in Los Angeles County within one (1) targeted area of service; or at a location of service within Los Angeles County, proposed and approved by the Director, DHSP.

PART II. PROGRAM REQUIREMENTS

A. PROGRAM CONCEPTS: SECTIONS 9.2 TO 9.4

9.2 Holistic Approach to Services: Contractor shall leverage opportunities and collaborate with other community partners in order to provide comprehensive, holistic services to the transgender community.

9.3 Community Advisory Board (CAB) Duties: Contractor shall recruit and maintain a CAB with the following duties:

9.3.1 Staffing: Contractor shall ensure that the CAB is fully staffed by individuals able to provide administrative and technical support to CAB members during and between meetings, while working independently and in groups or committees on projects or with special project-related issues.

9.3.2 Membership Requirements: Contractor shall recruit and maintain a CAB whose membership complies with the following requirements:

a. Comprised of five (5) to eight (8) community members; two (2) shall be designated as co-chairs;
b. Members must reside in Los Angeles County; and
c. A majority of whose members must be transgender people who are reflective of the community the proposed program is intended to serve.

9.3.3 Scheduling, Promotion and Meeting Requirements: Contractor shall schedule and announce CAB meetings as directed by CAB co-chairs, but no less than four (4) times per year.

9.3.4 Staff Requirements Regarding CAB Members and Subcommittee Meetings: Contractor CAB support staff shall facilitate CAB and subcommittee meetings and respond to requests for information from CAB members.

9.3.5 Dissemination of Minutes and Other Documents: Contractor CAB support staff shall disseminate CAB and subcommittee meeting minutes, any reports and all recommendations to:

a. Co-chairs;
b. CAB members;
c. Agency Executive Director and agency staff as directed; and
d. Director of DHSP, or designee.

9.4 Contractor – CAB On-going Collaboration Requirements: Contractor shall collaborate and consult on an ongoing, consistent basis with the CAB (see SOW Section 9.3) to inform and improve intervention(s).

B. PROGRAM COMPONENTS: SECTIONS 9.5 TO 9.8

9.5 Incorporating Youth Development Component: Contractors shall incorporate a youth-development component designed to meet needs of young transgender people, ages 12-29 years.

9.6 Social Determinants of Health (SDoH): Contractor shall implement selected evidence-based intervention(s) to be used to mitigate the impact of the selected SDoH for transgender persons.

9.7 Promoting Resiliency and Protective Factors: Contractor shall implement the selected evidence-based intervention(s) to promote the proposed resiliency and protective factors for each SDoH addressed.

9.8 Utilizing Technology: Contractor shall utilize social and digital media currently used by transgender individuals to stay socially connected. Such technologies include, but are not limited to: social media, smart phone and/or internet apps, online dating sites, chat rooms, gaming (behavior change focused) sites, texting, etc.

C. HIV AND STD SCREENING PROGRAM COMPONENTS: SECTIONS 9.9 TO 9.17

9.9 Benefits Screening Program: Contractor shall implement a benefits screening program that assesses client's eligibility for public and social services, promotes enrollment in those services for which a client qualifies and maximizes payment from third-party payer sources.

9.10 On-site HIV Screening Services: Contractor/subcontractor or consultant shall provide HIV screening services on-site with all HIV and STD prevention program services, consistent with federal, State, and local guidelines and policies and ensure appropriate medical oversight of HIV screening services.

9.11 On-site STD Screening and Treatment Services: Contractor/subcontractor or consultant shall provide on-site STD screening and treatment services with appropriate medical oversight and consistent with California and local guidelines and policies; and, if on-site treatment is not available, then ensure verifiable, appropriate linkage to off-site treatment services is made.

9.12 Identify Undiagnosed HIV and STD Infection: Contractor shall identify undiagnosed HIV and STD infection among transgender individuals in the selected location(s) of services.

9.13 Ensure Access to Educational Services for Pre-exposure Prophylaxis Programs (PrEP): Contractor must ensure one hundred percent (100%) of transgender persons who request services are provided access to counseling, educational and referral services to PrEP.

9.14 Counsel and Refer to Post-exposure Prophylaxis Program (PEP) as Appropriate: Contractor shall counsel and refer transgender individuals exposed non-occupationally to HIV within a 72 hour time range for evaluation to a PEP program as appropriate.

9.15 Link to Care Services: Contractor shall link all transgender persons who test positive for HIV with HIV-related medical care consistent with guidelines from the Centers for Disease Control and Prevention and local guidelines.

9.16 Re-engage and Retain in Care Services: Contractor shall re-engage and work to retain in care HIV positive transgender persons known to be out of medical care back into HIV medical care and treatment services.

9.17 Ensure Linkage to Partner Services: Contractor shall ensure that one hundred percent (100%) of transgender individuals who test positive for HIV, syphilis, or gonorrhea are linked to LAC DHSP Partner Counseling and Referral Services.

PART III. MISCELLANEOUS ADDITIONAL REQUIREMENTS SECTIONS 9.19 TO 9.21

9.18 Comply with State Reporting Requirements: All State HIV, STD, and hepatitis reporting requirements must be followed and can be located at: http://publichealth.lacounty.gov/dhsp/ReportCase.htm

9.19 Staff Retention Policies and Procedures: Contractor shall provide County a staff retention policies and procedures plan within thirty (30) days of the Contract start date.

9.20 CLIA Eligible/Covered Provider: Where rapid HIV tests are performed, Contractor must ensure that the responsible provider submits a Quality Management Yearly Plan and a California issued certificate indicating the site is a Clinical Laboratory Improvement Act (CLIA) eligible/covered provider.

APPENDIX C - BUDGET INSTRUCTIONS

PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs
RFP NO.: 2015-003

OVERALL INSTRUCTIONS AND GUIDELINES

Appendix C, Budget Instructions provides overall instructions/guidelines that are designed to assist the Proposer in completing the below budget forms for: 1) Program Concept and Component Related Costs and 2) HIV and STD Program Related Costs. Proposer must submit the following required budget templates for **each** proposal under Category 1 **and/or** Category 2 Proposer will be applying for funding (unless instructed otherwise).

1. Budget Forms: Program Concept and Component Related Costs

- Appendix C-1A: 1-Page Budget Narrative for Program Concept and Component Related Costs
- Appendix C-1B: Line Item Budget for Program Concept and Component Related Costs
- Appendix C-1C: Budget Summary Justification for Program Concept and Component Related Costs

2. Budget Forms: HIV and STD Program Related Costs

- Appendix C-1D: Category 1: 1-Page Narrative for HIV and STD Program Related Costs
- Appendix C-1E: Line Item Budget for HIV and STD Program Related Costs
- Appendix C-1F: Budget Summary Justification for HIV and STD Program Related Costs

3. Budget Forms: Disclosure of Additional Resources for HIV and STD Prevention Services

- Appendix D, Required Forms – Exhibit 29: Proposer's Funding Disclosure Form
- Appendix C-1G: 1-Page Exhibit 29 Supplemental

4. Budget Forms: Total Program Costs

- Appendix C-1H: Total Program Costs

Each of Proposer's budget forms should only reflect costs associated with its proposed program(s) and must:

1) Be feasible and cost effective for the proposed quantity and quality of activities pursuant to Appendix B, Statement of Work for Category 1 and/or Appendix B-2, Statement of Work for Category 2 **and** each applicable Exhibit 27, Sample Scope of Work and Template;
2) Include staffing patterns that are appropriate for the proposed program services;
3) Provide operating costs that are consistent with the quantity and type of services proposed;

4) Include justification that is detailed and has adequate rationale for each line item expenditure; and
5) Be submitted utilizing the budget format provided and with the correct calculations.

Proposer is advised that budget forms referenced above <u>are the only budget formats acceptable.</u> Any other formats will be <u>not be</u> accepted and shall result in Proposer receiving zero/no points for this section of the evaluation.

BUDGET RESTRICTIONS FOR CATEGORY 1 – HIV AND STD PREVENTION SERVICES FOR YMSM

Tier Level 1 Restrictions: Proposal(s) for Tier Level 1 eligible cluster areas (Central and South Cluster Areas) with requested annual budgets in excess of seven hundred fifty thousand dollars ($750,000) will be deemed **non-responsive and will be disqualified** from further consideration.

Tier Level 2 Restrictions: Proposal(s) for Tier Level 2 eligible cluster areas (East, North and Northwest Cluster Areas) with requested annual budgets in excess of two hundred fifty thousand dollars ($250,000) will be deemed **non-responsive and will be disqualified** from further considerations.

NOTE: If selected for funding, the selected Proposer will be required to provide a more detailed line item budget and budget summary justification using different budget templates that will be provided to the selected Proposer at the time of contract negotiations.

BUDGET RESTRICTIONS FOR CATEGORY 2 - HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS

Proposal(s) with requested annual budgets submitted in excess of one million dollars ($1,000,000) will be deemed **non-responsive and will be disqualified** from further consideration consistent with RFP Sub-paragraph 1.3.6, Availability of Funding.

NOTE: If selected for funding, the selected Proposer will be required to provide a more detailed line item budget and budget summary justification using different budget templates that will be provided to the selected Proposer at the time of contract negotiations.

1-PAGE BUDGET NARRATIVE – INSTRUCTIONS

Proposer must submit a **separate and completed** 1-Page Budget Narrative for a) Program Concept and Component Related Costs **and** b) HIV and STD Program Component Related Costs **for each proposal submitted under Category 1 and/or 2.** Each 1-Page Budget Narrative **must** explain how **each** of the costs fiscally supports the activities of the proposed program, staffing requirements, organizational requirements, necessary supplies, etc.

LINE ITEM BUDGET – INSTRUCTIONS

Proposer must submit a **separate and completed** Line Item Budget for: a) Program Concept and Component Related Costs **and** b) HIV and STD Program Component Related Costs **for each proposal submitted under Category 1 and/or 2.** Proposer's Line Item Budget must be for a **12-**

month period and should reflect all of the significant activities described in **each** submitted proposal, Appendix B-1, Statement of Work for Category 1 and/or Appendix B-2, Statement of Work for Category 2 **and** each applicable Exhibit 27, Sample Scope of Work and Template. Proposer may use additional sheets as necessary; however **each** of Proposer's Line Item Budgets must be formatted and provide all the information as required in the template as well as all applicable budget instructions.

Each of Proposer's Line Item Budgets **must** address **each** of the Line Item Budget Categories below (A-H) for a **12-month period.** This will serve as the Proposer's assessment of its total costs to provide the services described in the RFP, Appendix B, Statement of Work for Category 1 and/or Appendix B-2, Statement of Work for Category 2 **and** each applicable Exhibit 27, Sample Scope of Work and Template.

Please note that Proposer's budget is subject to an overall administrative cap. Administrative costs included in any of the Line Item Budget Categories must not exceed 10% of the total budget. Administrative costs can be direct or indirect and are defined as the costs incurred for usual and recognized overhead, including established indirect rates for agencies; management and oversight of specific programs; and other types of program support such as quality assurance, quality control and related activities.

LINE ITEM BUDGET CATEGORIES

A. Full-Time and Part-Time Salaries

Full-Time Salaries: List each employee by position. Staff members and other employees are determined by the fact that agency reports and pays payroll taxes (SUI, FICA, etc.) and pays employees' income taxes as basic legal requirements. Include the name of the staff person filling each position. Specify vacant if staff have not been identified.

- Full-Time Salaries: Enter the position title for each full-time equivalent that will provide services under the proposed program.
- Monthly Salaries: For each position, enter the monthly salary based on full-time equivalent.
- Number (#) of Months: For each position, indicate budgeted number of months for a 12-month period.
- Percentage (%) of Time: Enter the total percentage of time that each employee will work for the proposed services. If all employee's time will be spent on the proposed services, enter 100% (100% means 40 hours per week). If less than 40 hours per week will be spent on the proposed services, enter the appropriate percentage of time. If an employee is a part-time staff (working for the agency less than 40 hours a week and only for the proposed services) list them under part-time staff.
- Requested Amount: Enter the salary amount being requested as it applies to the proposed program. (Example: For each full-time position, multiply monthly salary by the number of months by percent of time, then enter amount in the Requested Amount column.
- Administrative (Admin) Costs: Enter the associated administrative costs related to each salary (if applicable).
- Total: Enter the total for each salary by adding the Requested Amount and Admin

Costs together.

- Subtotal Full-Time Salaries: Add the subtotal amounts for Full-Time Salaries in the Amount Requested column. For the Total column, enter the total sum for each salary by adding the Requested Amount and Admin Costs together.

Part-Time Salaries: Part-time staff are individuals who work for the agency on a part-time basis only for the proposed services, and are paid on an hourly basis. **NOTE:** If an employee works 40 hours per week but only 40% of their time is charged to the project and 60% charged to another project within the agency, they should be listed under full-time staff.

- Part-Time Salaries: Enter the position title for each part-time position that will provide services under the proposed program.
- Hourly Salary: For each part-time position, enter the hourly salary rate.
- Annual Salary: For each part-time, enter the positon's annual salary.
- Percentage (%) of Time: Enter the total percentage of time that each part-time employee will work for the proposed services.
- Requested Amount: Enter the salary amount being requested as it applies to the proposed program. (Example: For each part-time staff, multiply number of hours per year by the hourly salary and enter amount in the Requested Amount column.)
- Administrative (Admin) Costs: Enter the associated administrative costs related to each salary (if applicable).
- Total: Enter the total for each salary by adding the Requested Amount and Admin Costs together.
- Subtotal Part-Time Salaries: Add the amounts for Part-Time Salaries in the Requested Amount column. For the Total column, enter the total sum for each salary by adding the Requested Amount and Admin Costs together.

Total Salaries: Add Subtotal Full-Time and Subtotal Part-Time Salaries and enter the amount in the Requested Amount column. For the Total column, enter the total sum for the salaries by adding the Requested Amount and Admin Costs together.

B. Employee Benefits

- **Employee Benefits for Full-Time Salaries**: Indicate the estimated total employee benefit percentage rate for which the agency is responsible (e.g., FICA, SUI, Worker's Compensation, retirement, etc.). Multiply Subtotal Salaries by the Employee Benefits Rate and enter amount in the Requested Amount column. For the Total column, enter the total sum by adding the Requested Amount and Admin Costs together.

- **Employee Benefits for Part-Time Salaries**: Indicate the estimated total employee benefit percentage rate for which the agency is responsible (e.g., FICA, SUI, Worker's Compensation, retirement, etc.). Multiply Subtotal Salaries by the Employee Benefits Rate and enter amount in the Requested Amount column. For the Total column, enter the total sum by adding the Requested Amount and Admin Costs together.

- **Total Employee Benefits**: Add Total Full-Time and Total Part-Time Employee Benefits and enter in the Requested Amount column. For the Total column, enter the total sum by adding the Requested Amount and Admin Costs together.

C. Operating Expenses

Identify the costs that will be necessary for the performance of the contract and enter the amounts (e.g., office supplies, printing/reproduction, telephone, etc.) in the Requested Amount column. For the Total column, enter the total sum by adding the Requested Amount and Admin Costs together. The costs for operating expenses should conform to your proposed program objectives.

D. Mileage and Travel

Identify the travel costs associated with each sponsored training and/or meeting and enter the amount (e.g. registration, hotel, airfare, etc.) in the Requested Amount column. For the Total column, enter the total sum by adding the Requested Amount and Admin Costs together. The costs for travel should conform to your proposed program objectives.

Identify the mileage from the office to the worksite for each employee, multiply by $0.54 and enter the amount in the Requested Amount column. For the Total column, enter the total sum by adding the Requested Amount and Admin Costs together. The costs for mileage should conform to your proposed program objectives.

E. Other Costs (including Consultant/Contractor)

Identify the costs that will be necessary for the performance of the contract and enter the amounts (e.g., office supplies, testing materials, brochures, incentives, condoms, etc.) in Requested Amount column. For the Total column, enter the total sum by adding the Requested Amount and Admin Costs together. The other costs should conform to your proposed program objectives.

F. Total Direct Costs: Add total of expense categories A through E and provide amounts for the Requested Amount, Admin Costs, and Total columns. For the Total column, enter the total sum by adding the Requested Amount and Admin Costs together.

G. Indirect Costs

Enter the total amount of Indirect Costs along with the Indirect Cost rate to be charged to the contracted program. **Total Indirect Costs may not exceed 15% of an agency's total Salary and Employee Benefits cost.** The total of Indirect Costs and Administrative costs cannot exceed 10% of the contract award. Include amounts for the Requested Amount, Admin Costs, and Total columns. For the Total column, enter the total sum by adding the Requested Amount and Admin Costs together.

To request funds for an Indirect Cost rate, agency must have one of the following: Federally Negotiated Indirect Cost Rate Agreement (NICRA) or an Auditor Certified Indirect Cost Rate (from the past three (3) years or no earlier than agency fiscal year 2012).

H. Total Program Budget: Add total of expense categories F through G and provide amounts for the Requested Amount, Admin Costs, and Total columns. For the Total column, enter the total sum by adding the Requested Amount and Admin Costs together.

BUDGET SUMMARY JUSTIFICATION - INSTRUCTIONS

Proposer must submit a **separate and completed** Budget Summary Justification **for each proposal submitted under Category 1 and/or 2 for a 12-month period**, for: a) Program Concept and Component Related Costs **and** b) HIV and STD Program Component Related Costs

that provides detailed budget justifications for all program services. Proposer must provide a brief budget justification narrative for each of the amounts entered for **each** Line Item Budget. Also, Proposer must identify any one-time costs. Budget Justification narratives must be detailed, specific, and explain: (1) what type of services will be provided; (2) who will provide the services; and (3) how the services will be provided. Proposer may use additional sheets as necessary; however **each** of Proposer's Budget Justification Summary(ies) must be formatted and provide all the information as required in the template as well as all applicable budget instructions.

A. Full-Time and Part-Time Salaries

List each position by job title and briefly justify each position and duties by relating it to specific program objectives.

B. Employee Benefits

Identify the method to calculate the employee benefits percentage rate. List each employee benefit, its appropriate percentage rate, and the total Employee Benefits rate for full-time and part-time employees. (Example: FICA 7%, SUI 3%, Workers' Compensation 1%, Medical/Dental 5%, Retirement 2%, Other 1%, etc. for a total Employee Benefits rate of 19%.)

C. Operating Expenses

Identify and briefly describe the costs necessary for the performance of the program. The narrative should describe how the costs will relate to the program objectives including: telephone, postage, utilities, office supplies, printing/reproduction, computer connection, rent, etc. The costs must be used specifically for the delivery of the proposed services and should assist your agency in meeting the scope of work objectives. Include cost calculations.

D. Mileage & Travel

Travel pertains to in-state (other than County of Los Angeles) trips. Briefly describe all travel-related costs. Give the purpose of the trip, destination, and the title(s) of persons who will be taking the trip.

Mileage pertains to local travel (within County of Los Angeles). Mileage example: Reimbursement is requested at $0.54 per mile for mileage incurred by project staff traveling to outreach and enrollment sites within the County.

E. Other Costs (including Consultant/Contractor)

Briefly describe and justify any non-routine, occasional or onetime expenses needed for the performance of the program. The narrative should describe how the costs will relate to the program objectives including any materials or incentives for clients, supplies, condoms, etc. The costs must be used specifically for the delivery of the proposed services and should assist your agency in meeting the scope of work objectives. Include cost calculations.

APPENDIX D, REQUIRED FORMS – EXHIBIT 29: PROPOSER'S FUNDING DISCLOSURE FORM – INSTRUCTIONS

Proposer is advised that funding made available as a result of this RFP shall only be used to fund new or enhanced HIV and STD prevention services **and** shall in no way supplant existing resources. To assure this, Proposer must disclose all currently available or committed revenue

and funding resources available (as those described in this RFP for Category 1 and/or Category 2) in which Proposer now provides services **and** for which Proposer requests funding through this RFP. Therefore, Proposer **must** submit a completed Appendix D, Required Forms, Exhibit 29, Proposer's Funding Disclosure Form in order to provide this information. A single completed Exhibit 29 is required for all proposal submissions under Category 1 and/or 2. Proposer is advised that the information provided on its Exhibit 29 is subject to verification and/or failure to provide a completed Exhibit 29 may result in automatic disqualification.

1-PAGE EXHIBIT 29 SUPPLEMENTAL – INSTRUCTIONS

If Proposer is requesting new or enhanced funding for HIV and STD services under this RFP, Proposer must submit a completed Appendix C-1G, 1-Page Exhibit 29 Supplemental. Proposer's Appendix C-1G **must** explain how the new/enhanced funding will be used in conjunction with current funding for existing services. **A single completed Appendix C-1G is required for all proposal submissions under Category 1 and all proposal submissions under Category 2 as applicable.**

TOTAL PROGRAM COSTS – INSTRUCTIONS

Proposer must submit a **separate and completed** Total Program Costs that combines Proposer's Program Concept and Component Related Costs **and** Proposer's HIV and STD Program Component Related Costs **for each proposal submitted under Category 1 and/or 2.** Proposer's Total Program Costs must be for a **12-month period** and should only reflect Proposer's total costs for its Program Concept and Component Related Costs **and** Proposer's HIV and STD Program Component Related Costs Proposer may use additional sheets as necessary; however **each** of Proposer's Total Program Costs must be formatted and provide all the information as required in the template as well as all applicable budget instructions. Include amounts for the Requested Amount, Admin Costs, and Total columns. For the Total column, enter the total sum by adding the Requested Amount and Admin Costs together.

PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs, RFP NO.: 2015-003

APPENDIX C-1A
1-PAGE BUDGET NARRATIVE FOR PROGRAM CONCEPT AND COMPONENT RELATED COSTS

PROPOSER'S NAME:	
PROGRAM NAME:	
1-PAGE BUDGET NARRATIVE FOR (CATEGORY OF SERVICE):	
TIER LEVEL (IF APPLICABLE):	
CLUSTER AREA/TARGET AREA:	

PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs, RFP NO.: 2015-003

EXHIBIT C-1B
LINE ITEM BUDGET FOR PROGRAM CONCEPT AND COMPONENT RELATED COSTS

PROPOSER'S NAME:	
PROGRAM NAME:	
BUDGET TERM:	12 Months
LINE ITEM BUDGET FOR (CATEGORY OF SERVICE):	
TIER LEVEL (IF APPLICABLE):	
CLUSTER AREA/TARGET AREA:	

A.	FULL-TIME and PART-TIME SALARIES	Monthly Salary	# of Months	% of Time	Requested Amount	Admin Costs	Total
	Full-Time Salaries						
	1. _____	$_____	_____	_____%	$_____	$_____	$_____
	2. _____	$_____	_____	_____%	$_____	$_____	$_____
	3. _____	$_____	_____	_____%	$_____	$_____	$_____
	Subtotal Full-Time Salaries				**$**_____	**$**_____	**$**_____
	Part-Time Salaries	Hourly Salary	Annual Salary				
	1. _____	$_____	**$**_____	_____%	$_____	$_____	$_____
	Subtotal Part-Time Salaries				$_____	$_____	$_____
	Total Salaries				**$**_____	**$**_____	**$**_____
B.	**BENEFITS**						
	Full-Time Employee Benefits @ ____%				$_____	$_____	$_____
	Part-Time Employee Benefits @ ____%				$_____	$_____	$_____
	Total Employee Benefits				$_____	$_____	$_____
	TOTAL SALARIES & EMPLOYEE BENEFITS				**$**_____	**$**_____	**$**_____

C.	**OPERATING EXPENSES**						
	1. _____				$_____	$_____	$_____
	2. _____				$_____	$_____	$_____
	3. _____				$_____	$_____	$_____
	4. _____				$_____	$_____	$_____
	TOTAL OPERATING EXPENSES				**$**_____	**$**_____	**$**_____
D.	**MILEAGE & TRAVEL**						
	1. _____				$_____	$_____	$_____
	2. _____				$_____	$_____	$_____
	TOTAL MILEAGE & TRAVEL				**$**_____	**$**_____	**$**_____
E.	**OTHER COSTS** (including Consultants/Contractors)						
	1._____				$_____	$_____	$_____
	2._____				$_____	$_____	$_____
	TOTAL OTHER COSTS				**$**_____	**$**_____	**$**_____
F.	**TOTAL DIRECT COSTS (A-E)**				**$**_____	**$**_____	**$**_____
G.	**INDIRECT COSTS** Indirect Cost Rate _____% (Note: Indirect Costs is a maximum 15% of Total Salary and Employee Benefits Costs)				**$**_____	**$**_____	**$**_____
H.	**TOTAL PROGRAM BUDGET**				**$**_____	**$**_____	**$**_____

PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs, RFP NO.: 2015-003

APPENDIX C-1C
BUDGET SUMMARY JUSTIFICATION FOR PROGRAM CONCEPT AND COMPONENT RELATED COSTS

PROPOSER'S NAME:	
PROGRAM NAME:	
BUDGET TERM:	12 Months
BUDGET SUMMARY JUSTIFICATION FOR (CATEGORY OF SERVICE):	
TIER LEVEL (IF APPLICABLE):	
CLUSTER AREA/TARGET AREA:	

A. FULL-TIME AND PART-TIME SALARIES

Full-Time Position and Job Title	Job Duties Related to Specific Program Objectives
Part-Time Position and Job Title	**Job Duties Related to Specific Program Objectives**

B. EMPLOYEE BENEFITS

Full-Time Employee Benefit	Percentage Rate
Total Full-Time Employee Benefits Rate	
Part-Time Employee Benefit	**Percentage Rate**
Total Part-Time Employee Benefits Rate	

C.	OPERATING EXPENSES
Item	**Item Justification**

D.	MILEAGE AND TRAVEL
Item	**Item Justification**

E.	OTHER COSTS (Including Consultant/Contractor)
Item	**Item Justification**

PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs, RFP NO.: 2015-003

APPENDIX C-1D
1-PAGE BUDGET NARRATIVE FOR PROGRAM HIV AND STD PROGRAM COMPONENT RELATED COSTS

PROPOSER'S NAME:	
PROGRAM NAME:	
1-PAGE BUDGET NARRATIVE FOR (CATEGORY OF SERVICE):	
TIER LEVEL (IF APPLICABLE):	
CLUSTER AREA/TARGET AREA:	

PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs, RFP NO.: 2015-003

EXHIBIT C-1E
LINE ITEM BUDGET FOR HIV AND STD PROGRAM COMPONENT RELATED COSTS

PROPOSER'S NAME:	
PROGRAM NAME:	
BUDGET TERM:	12 Months
LINE ITEM BUDGET FOR (CATEGORY OF SERVICE):	
TIER LEVEL (IF APPLICABLE):	
CLUSTER AREA/TARGET AREA:	

A.	FULL-TIME and PART-TIME SALARIES	Monthly Salary	# of Months	% of Time	Requested Amount	Admin Costs	Total
	Full-Time Salaries						
	1. _____	$_____	_____	_____%	$_____	$_____	$_____
	2. _____	$_____	_____	_____%	$_____	$_____	$_____
	3. _____	$_____	_____	_____%	$_____	$_____	$_____
	Subtotal Full-Time Salaries				**$**_____	**$**_____	**$**_____
	Part-Time Salaries	Hourly Salary	Annual Salary				
	1. _____	$_____	**$**_____	_____%	$_____	$_____	$_____
	Subtotal Part-Time Salaries				$_____	$_____	$_____
	Total Salaries				**$**_____	**$**_____	**$**_____
B.	**BENEFITS**						
	Full-Time Employee Benefits @ ____%				$_____	$_____	$_____
	Part-Time Employee Benefits @ ____%				$_____	$_____	$_____
	Total Employee Benefits				$_____	$_____	$_____
	TOTAL SALARIES & EMPLOYEE BENEFITS				**$**_____	**$**_____	**$**_____

C.	**OPERATING EXPENSES**						
	1. _____				$_____	$_____	$_____
	2. _____				$_____	$_____	$_____
	3. _____				$_____	$_____	$_____
	4. _____				$_____	$_____	$_____
	TOTAL OPERATING EXPENSES				**$**_____	**$**_____	**$**_____
D.	**MILEAGE & TRAVEL**						
	1. _____				$_____	$_____	$_____
	2. _____				$_____	$_____	$_____
	TOTAL MILEAGE & TRAVEL				**$**_____	**$**_____	**$**_____
E.	**OTHER COSTS** (including Consultants/Contractors)						
	1._____				$_____	$_____	$_____
	2._____				$_____	$_____	$_____
	TOTAL OTHER COSTS				**$**_____	**$**_____	**$**_____
F.	**TOTAL DIRECT COSTS (A-E)**				**$**_____	**$**_____	**$**_____
G.	**INDIRECT COSTS** Indirect Cost Rate _____% (Note: Indirect Costs is a maximum 15% of Total Salary and Employee Benefits Costs)				**$**_____	**$**_____	**$**_____
H.	**TOTAL PROGRAM BUDGET**				**$**_____	**$**_____	**$**_____

PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs, RFP NO.: 2015-003

APPENDIX C-1F
BUDGET SUMMARY JUSTIFICATION FOR HIV AND STD PROGRAM COMPONENT RELATED COSTS

PROPOSER'S NAME:	
PROGRAM NAME:	
BUDGET TERM:	12 Months
BUDGET SUMMARY JUSTIFICATION FOR (CATEGORY OF SERVICE):	
TIER LEVEL (IF APPLICABLE):	
CLUSTER AREA/TARGET AREA:	

A. FULL-TIME AND PART-TIME SALARIES

Full-Time Position and Job Title	**Job Duties Related to Specific Program Objectives**
Part-Time Position and Job Title	**Job Duties Related to Specific Program Objectives**

B. EMPLOYEE BENEFITS

Full-Time Employee Benefit	**Percentage Rate**
Total Full-Time Employee Benefits Rate	
Part-Time Employee Benefit	**Percentage Rate**
Total Part-Time Employee Benefits Rate	

C.	OPERATING EXPENSES
Item	**Item Justification**

D.	MILEAGE AND TRAVEL
Item	**Item Justification**

E.	OTHER COSTS (Including Consultant/Contractor)
Item	**Item Justification**

PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs, RFP NO.: 2015-003

APPENDIX C-1G
1-PAGE EXHIBIT 29 SUPPLEMENTAL FOR HIV AND STD PROGRAM COMPONENT RELATED COSTS

PROPOSER'S NAME:	
PROGRAM NAME:	
1-PAGE BUDGET NARRATIVE FOR (CATEGORY OF SERVICE):	
TIER LEVEL (IF APPLICABLE):	
CLUSTER AREA/TARGET AREA:	

PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs, RFP NO.: 2015-003

EXHIBIT C-1H
TOTAL PROGRAM COSTS

PROPOSER'S NAME:	
PROGRAM NAME:	
BUDGET TERM:	12 Months
LINE ITEM BUDGET FOR (CATEGORY OF SERVICE):	
TIER LEVEL (IF APPLICABLE):	
CLUSTER AREA/TARGET AREA:	

PART 1: TOTAL COST - PROGRAM CONCEPT AND COMPONENT RELATED COSTS

LINE ITEM BUDGET CATEGORY	AMOUNT REQUESTED	ADMIN COSTS	TOTAL
A. Salaries	$_____	$_____	$_____
B. Benefits	$_____	$_____	$_____
C. Operating Costs	$_____	$_____	$_____
D. Mileage & Travel	$_____	$_____	$_____
E. Other Costs	$_____	$_____	$_____
F. Direct Costs	$_____	$_____	$_____
G. Indirect Costs	$_____	$_____	$_____
H. **Total Cost – Program Concept and Component Related Costs**	**$**_____	**$**_____	**$**_____

PART 2: TOTAL COST – HIV AND STD PROGRAM COMPONENT RELATED COSTS

LINE ITEM BUDGET CATEGORY	AMOUNT REQUESTED	ADMIN COSTS	TOTAL
A. Salaries	$_____	$_____	$_____
B. Benefits	$_____	$_____	$_____
C. Operating Costs	$_____	$_____	$_____

D. Mileage & Travel	$_____	$_____	$_____
E. Other Costs	$_____	$_____	$_____
F. Direct Costs	$_____	$_____	$_____
G. Indirect Costs	$_____	$_____	$_____
H. **Total Cost – Program Concept and Component Related Costs**	**$**_____	**$**_____	**$**_____

PART 3: TOTAL PROGRAM COSTS			
RELATED COST	**AMOUNT REQUESTED**	**ADMIN COSTS**	**TOTAL**
A. Total Cost - Program Concept and Component Related Costs	$_____	$_____	$_____
B. Total Cost – HIV and STD Program Component Related Costs	$_____	$_____	$_____
C. **TOTAL PROGRAM COSTS**	**$**_____	**$**_____	**$**_____

APPENDIX D

REQUIRED FORMS

FOR

PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs

RFP NO.: 2015-003

APPENDIX D

TABLE OF CONTENTS

REQUIRED FORMS

EXHIBITS

REQUIRED FORMS - EXHIBIT 1A

PROPOSER'S ORGANIZATION QUESTIONNAIRE/AFFIDAVIT
CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR YMSM

Please complete, date and sign this form and place it as the first page of your proposal. The person signing the form must be authorized to sign on behalf of the Proposer and to bind the applicant in a Contract.

1. If your firm is a corporation or limited liability company (LLC), state its legal name (as found in your Articles of Incorporation) and State of incorporation:

Name:	State:	Year Inc.:

2. If your firm is a limited partnership or a sole proprietorship, state the name of the proprietor or managing partner:

3. If your firm is doing business under one or more DBA's, please list all DBA's and the County(s) of registration:

Name:	County Registration:	Year became DBA:

Name:	County Registration:	Year became DBA:

4. Is your firm wholly or majority owned by, or a subsidiary of, another firm? ☐ YES .... ☐ NO

If yes, Name of parent firm:

State of incorporation or registration of parent firm:

5. Please list any other names your firm has done business as within the last five (5) years.

Name:	Year of Name Change:

Name:	Year of Name Change:

6. Indicate if your firm is involved in any pending acquisition/merger, including the associated company name. If not applicable, so indicate below.

Proposer acknowledges and certifies that it meets and will comply with all of the Minimum Mandatory Qualifications listed in Paragraph 3.0 - Minimum Mandatory Qualifications, subparagraph 3.1 – Category 1 (HIV and STD Prevention Services for YMSM) Minimum Mandatory Qualifications of this Request for Proposal (RFP), as listed below. **All requirements must be met on the day that proposals are due.**

3.1.1 Experience: Proposer, or consultant/subcontractor, must have a minimum of three (3) years of experience, within the last five (5) years, working with Men who have Sex with Men and providing youth services for African Americans and/or Latinos, ages 12 – 29, in Los Angeles County.

Does Proposer, or consultant/subcontractor, meet the experience requirement?	☐**YES** ☐**NO**

3.1.2 Data Collection: Proposer, or consultant/subcontractor, must have a minimum of two (2) years of experience, within the last five (5) years, collecting data for the purpose of evaluation and reporting.

Does Proposer, or consultant/subcontractor, meet the date collection requirement?	☐**YES** ☐**NO**

3.1.3 Service Delivery Site: Proposer, or consultant/subcontractor, must have a service delivery site located within an eligible cluster area for service as described in RFP subparagraph 1.2.4, Location of Service(s) within 90 days from contract execution. (**Note:** No consideration will be given to proposals for services outside of the eligible cluster service areas or which serve more than one cluster area in the same proposal.)

Does Proposer, or consultant/subcontractor, meet the service delivery requirement?	☐**YES** ☐**NO**

3.1.4 Community Advisory Board (CAB): Proposer's CAB must meet the requirements specified under Table 10 - CAB Minimum Requirements for Category 1. Proposer must submit a completed Exhibit 30A, Community Advisory Board Affidavit of Appendix D, Required Forms with its proposal affirming that its CAB meets the requirements specified in Table 10. (***Note:*** One (1) CAB is sufficient for submission in response to Category 1).

Table 10. Community Advisory Board (CAB) Minimum Requirements for Category 1: HIV and STD Prevention Services for YMSM

MINIMUM REQUIREMENTS
• Include five (5) to eight (8) members, two assigned as co-chairs;
• Members must reside in Los Angeles County;
• Members must be 16 to 29 years of age;
• CAB must consist of 75 percent youth of color (African American or Latino);
• CAB must consist of 50 percent 16 to 24 years of age; and
• CAB must consist of 60 percent YMSM.

Does Proposer's CAB meet the specified requirements?	☐**YES** ☐**NO**

3.1.5 Maximum Annual Budgets

Tier Level 1 (Central and South Cluster Areas): Tier Level 1 proposal submitted must not exceed an annual amount of seven hundred fifty thousand dollars ($750,000). (Proposals submitted in excess of this amount will be deemed non-responsive and will be disqualified from further consideration consistent with RFP sub-paragraph 1.2.6, Availability of Funding.)

Tier Level 2 (East, North and Northwest Cluster Areas): Tier Level 2 proposals submitted must not exceed an annual amount of two hundred fifty thousand dollars ($250,000). (Proposals submitted in excess of this amount will be deemed non-responsive and will be disqualified from further consideration consistent with RFP sub-paragraph 1.2.6, Availability of Funding.)

Does Proposer's <u>Tier Level 1 proposal(s)</u> meet the maximum annual budget amount?	☐**YES** ☐**NO** ☐**NOT APPLICABLE**

Does Proposer's <u>Tier Level 2 proposal(s)</u> meet the maximum annual budget amount?	☐**YES** ☐**NO** ☐**NOT APPLICABLE**

3.1.6 Mandatory Intent to Apply: Proposer that intends to respond to this RFP must submit a completed "Mandatory Intent to Apply Form for Category 1" (Exhibit 25A, of Appendix D, Required Forms) form for **each Category 1 proposal** Proposer intends to submit by the date and time specified in Paragraph 7.2, RFP Timetable or

Did Proposer submit a completed Mandatory Intent to Apply form as specified within the requirement?	☐**YES** ☐**NO**

3.1.7 Mandatory Proposer Conference: Proposer must attend the Mandatory Proposer Conference (MPC) on the date, time, and location specified pursuant to RFP Paragraph 7.6, Mandatory Proposer Conference.

Did Proposer attend the MPC as specified within the requirement?	☐**YES** ☐**NO**

3.1.8 Letter of Concurrence: Proposer must submit a completed Appendix D, Required Forms, Exhibit 31, Letter of Concurrence (LOC) **for each Category 1 proposal submission.** Each of Proposer's LOC must be signed by each CAB member, confirming that the CAB member supports and participated in the development of the proposed program(s) submitted by the Proposer in response to this RFP.

Did Proposer submit a Letter of Intent as specified within the requirement?	☐**YES** ☐**NO**

Proposer's Name:

Address:

E-mail address:	Telephone number:

Fax number:

On behalf of _____ (Proposer's name), I

_____ (Name of Proposer's authorized representative), certify that the information contained in this Proposer's Organization Questionnaire/Affidavit is true and correct to the best of my information and belief.

Signature:	Internal Revenue Service Employer Identification Number:
Title:	California Business License Number:
Date:	County WebVen Number:

REQUIRED FORMS - EXHIBIT 1B
PROPOSER'S ORGANIZATION QUESTIONNAIRE/AFFIDAVIT

CATEGORY 2: HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS

Please complete, date and sign this form and place it as the first page of your proposal. The person signing the form must be authorized to sign on behalf of the Proposer and to bind the applicant in a Contract.

1. If your firm is a corporation or limited liability company (LLC), state its legal name(as found in your Articles of Incorporation) and State of incorporation:

Name:	State:	Year Inc.:

2. If your firm is a limited partnership or a sole proprietorship, state the name of the proprietor or managing partner:

3. If your firm is doing business under one or more DBA's, please list all DBA's and the County(s) of registration:

Name:	County Registration:	Year became DBA:

Name:	County Registration:	Year became DBA:

4. Is your firm wholly or majority owned by, or a subsidiary of, another firm? ☐ YES .... ☐ NO

If yes, Name of parent firm:

State of incorporation or registration of parent firm:

5. Please list any other names your firm has done business as within the last five (5) years.

Name:	Year of Name Change:

Name:	Year of Name Change:

6. Indicate if your firm is involved in any pending acquisition/merger, including the associated company name. If not applicable, so indicate below.

Proposer acknowledges and certifies that it meets and will comply with all of the Minimum Mandatory Qualifications listed in Paragraph 3.0 - Minimum Mandatory Qualifications, subparagraph 3.2 – Category 2 (HIV and STD Prevention Services for Transgender Individuals) Minimum Mandatory Qualifications of this Request for Proposal (RFP), as listed below. **All requirements must be met on the day that proposals are due.**

3.2.1 Experience: Proposer, or consultant/subcontractor, must have a minimum of three (3) years of experience, within the last five (5) years, providing transgender services in Los Angeles County.

Does Proposer, or consultant/subcontractor, meet the experience requirement?	☐**YES** ☐**NO**

3.2.2 Data Collection: Proposer, or consultant/subcontractor, must have a minimum of two (2) years of experience, within the last five (5) years, collecting data for the purpose of evaluation and reporting.

Does Proposer, or consultant/subcontractor, meet the date collection requirement?	☐**YES** ☐**NO**

3.2.3 Community Advisory Board (CAB): Proposer's CAB must meet the requirements specified under Table 11 - CAB Minimum Requirements for Category 2. Proposer must submit a completed Exhibit 30B, Community Advisory Board Affidavit for Category 2 of Appendix D, Required Forms with its proposal affirming that its CAB meets the requirements specified in Table 11. (***Note:*** One (1) CAB is sufficient for submission in response to Category 2).

Table 11. Community Advisory Board (CAB) Minimum Requirements for Category 2: HIV and STD Prevention Services Transgender Individuals

MINIMUM REQUIREMENTS
• Include five (5) to eight (8) members, two (2) assigned as co-chairs;
• Members must reside in Los Angeles County; and
• A majority of members must be transgender people who are reflective of the community the proposed program is intended to serve.

Does Proposer's CAB meet the specified requirements?	☐**YES** ☐**NO**

3.2.4 Maximum Annual Budgets: Proposals submitted must not exceed an annual amount of one million dollars ($1,000,000). (Proposals submitted in excess of this amount will be deemed non-responsive and will be disqualified from further consideration consistent with RFP Sub-paragraph 1.3.6, Availability of Funding.)

Does Proposer's budget meet the maximum annual budget amount?	☐**YES** ☐**NO**

3.2.5 Mandatory Intent to Apply: Proposer that intends to respond to this RFP must submit a completed "Mandatory Intent to Apply Form for Category 2" (Exhibit 25B, of Appendix D, Required Forms) form for **each Category 2 proposal** Proposer intends to submit by the date and time specified in Paragraph 7.2, RFP Timetable.

Did Proposer submit a completed Mandatory Intent to Apply form as specified within the requirement?	☐**YES** ☐**NO**

3.2.6 Mandatory Proposer Conference: Proposer must attend the Mandatory Proposer Conference (MPC) on the date, time, and location specified pursuant to RFP Paragraph 7.6, Mandatory Proposer Conference.

Did Proposer attend the MPC as specified within the requirement?	☐**YES** ☐**NO**

3.2.7 Letter of Concurrence: Proposer must submit a completed Appendix D, Required Forms, Exhibit 31, Letter of Concurrence (LOC) **for each Category 2 proposal submission.** Each of Proposer's LOC must be signed by each CAB member, confirming that the CAB supports and participated in the development of the proposed program(s) submitted by the Proposer in response to this RFP.

Did Proposer submit a Letter of Intent as specified within the requirement?	☐**YES** ☐**NO**

Proposer's Name:

Address:

E-mail address:	Telephone number:

Fax number:

On behalf of _____ (Proposer's name), I

_____ (Name of Proposer's authorized representative), certify that the information contained in this Proposer's Organization Questionnaire/Affidavit is true and correct to the best of my information and belief.

Signature:	Internal Revenue Service Employer Identification Number:
Title:	California Business License Number:
Date:	County WebVen Number:

PROSPECTIVE CONTRACTOR REFERENCES

Prospective Contractor's Name: _____

List Five (5) References where the same or similar scope of services were provided. Please do not list DHSP or DHSP staff as references.

1. Name of Firm	Address of Firm	Contact Person	Telephone #	Fax #

Name or Contract No.	# of Years / Term of Contract	Type of Service	Dollar Amt.

2. Name of Firm	Address of Firm	Contact Person	Telephone #	Fax #

Name or Contract No.	# of Years / Term of Contract	Type of Service	Dollar Amt.

3. Name of Firm	Address of Firm	Contact Person	Telephone #	Fax #

Name or Contract No.	# of Years / Term of Contract	Type of Service	Dollar Amt.

PROSPECTIVE CONTRACTOR REFERENCES

4. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #**	**Fax #**

Name or Contract No.	# of Years / Term of Contract	Type of Service	Dollar Amt.

5. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #**	**Fax #**

Name or Contract No.	# of Years / Term of Contract	Type of Service	Dollar Amt.

PROSPECTIVE CONTRACTOR LIST OF CONTRACTS

Prospective Contractor's Name:_____

List of all non-profit and/or public entities for which the Contractor has provided service within the last five (5) years. Use additional sheets if necessary. Please do not list DHSP or DHSP staff as references.

1. Name of Firm	Address of Firm	Contact Person	Telephone #	Fax #

Name or Contract No.	# of Years / Term of Contract	Type of Service	Dollar Amt.

2. Name of Firm	Address of Firm	Contact Person	Telephone #	Fax #

Name or Contract No.	# of Years / Term of Contract	Type of Service	Dollar Amt.

3. Name of Firm	Address of Firm	Contact Person	Telephone #	Fax #

Name or Contract No.	# of Years / Term of Contract	Type of Service	Dollar Amt.

PROSPECTIVE CONTRACTOR LIST OF CONTRACTS

4. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #**	**Fax #**

Name or Contract No.	# of Years / Term of Contract	Type of Service	Dollar Amt.

5. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #**	**Fax #**

Name or Contract No.	# of Years / Term of Contract	Type of Service	Dollar Amt.

PROSPECTIVE CONTRACTOR LIST OF TERMINATED CONTRACTS

Prospective Contractor's Name:_____

List of all contracts that have been terminated (i.e., due to lack of funding, performance, expiration of term, etc.) within the last five (5).

1. Name of Firm	Address of Firm	Contact Person	Telephone #	Fax #

Name or Contract No. _____ Reason for Termination: _____

2. Name of Firm	Address of Firm	Contact Person	Telephone #	Fax #

Name or Contract No. _____ Reason for Termination: _____

3. Name of Firm	Address of Firm	Contact Person	Telephone #	Fax #

Name or Contract No. _____ Reason for Termination: _____

PROSPECTIVE CONTRACTOR LIST OF TERMINATED CONTRACTS

4. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #**	**Fax #**

Name or Contract No.	Reason for Termination:

REQUIRED FORMS - EXHIBIT 5

CERTIFICATION OF NO CONFLICT OF INTEREST

The Los Angeles County Code, Section 2.180.010, provides as follows:

CONTRACTS PROHIBITED

Notwithstanding any other section of this Code, the County shall not contract with, and shall reject any proposals submitted by, the persons or entities specified below, unless the Board of Supervisors finds that special circumstances exist which justify the approval of such contract:

1. Employees of the County or of public agencies for which the Board of Supervisors is the governing body;

2. Profit-making firms or businesses in which employees described in number 1 serve as officers, principals, partners, or major shareholders;

3. Persons who, within the immediately preceding 12 months, came within the provisions of number 1, and who:

    a. Were employed in positions of substantial responsibility in the area of service to be performed by the contract; or

    b. Participated in any way in developing the contract or its service specifications; and

4. Profit-making firms or businesses in which the former employees, described in number 3, serve as officers, principals, partners, or major shareholders.

Contracts submitted to the Board of Supervisors for approval or ratification shall be accompanied by an assurance by the submitting department, district or agency that the provisions of this section have not been violated.

Proposer Name:
Proposer Official Title:
Official's Signature:

REQUIRED FORMS - EXHIBIT 6

FAMILIARITY WITH THE COUNTY LOBBYIST ORDINANCE CERTIFICATION

The Proposer certifies that:

1) it is familiar with the terms of the County of Los Angeles Lobbyist Ordinance, Los Angeles Code Chapter 2.160;

2) that all persons acting on behalf of the Proposer organization have and will comply with it during the proposal process; and

3) it is not on the County's Executive Office's List of Terminated Registered Lobbyists.

Signature:	Date:

REQUIRED FORMS - EXHIBIT 7

Use this form for County Solicitations which **are not** subject to the Federal Restriction

Request for Local SBE Preference Program Consideration and CBE Firm/Organization Information Form

INSTRUCTIONS: All proposers/bidders responding to this solicitation must complete and return this form for proper consideration of the proposal/bid.

I. LOCAL SMALL BUSINESS ENTERPRISE PREFERENCE PROGRAM:

FIRM NAME:

COUNTY VENDOR NUMBER:

☐ As a Local SBE, certified by the County of Los Angeles, Department of Consumer and Business Affairs, I request this proposal/bid be considered for the Local SBE Preference.

☐ Attached is my Local SBE Certification letter issued by the County

II. FIRM/ORGANIZATION INFORMATION: The information requested below is for statistical purposes only. On final analysis and consideration of award, contractor/vendor will be selected without regard to race/ethnicity, color, religion, sex, national origin, age, sexual orientation or disability.

Business Structure: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Non-Profit ☐ Franchise

☐ Other (Please Specify) _____

Total Number of Employees (including owners)**:**

_____

Race/Ethnic Composition of Firm. Please distribute the above total number of individuals into the following categories:

Race/Ethnic Composition	Owners/Partners/Associate Partners		Managers		Staff	
Black/African American	Male ☐	Female ☐	Male ☐	Female ☐	Male ☐	Female ☐
Hispanic/Latino	Male ☐	Female ☐	Male ☐	Female ☐	Male ☐	Female ☐
Asian or Pacific Islander	Male ☐	Female ☐	Male ☐	Female ☐	Male ☐	Female ☐
American Indian	Male ☐	Female ☐	Male ☐	Female ☐	Male ☐	Female ☐
Filipino	Male ☐	Female ☐	Male ☐	Female ☐	Male ☐	Female ☐
White	Male ☐	Female ☐	Male ☐	Female ☐	Male ☐	Female ☐

III. PERCENTAGE OF OWNERSHIP IN FIRM: Please indicate by percentage (%) how ownership of the firm is distributed.

	Black/African American	Hispanic/ Latino	Asian or Pacific Islander	American Indian	Filipino	White
Men	_____%	_____%	_____%	_____%	_____%	_____%
Women	_____%	_____%	_____%	_____%	_____%	_____%

IV. CERTIFICATION AS MINORITY, WOMEN, DISADVANTAGED, AND DISABLED VETERAN BUSINESS ENTERPRISES:
If your firm is currently certified as a minority, women, disadvantaged or disabled veteran owned business enterprise by a public agency, complete the following and attach a copy of your proof of certification. (Use back of form, if necessary.)

Agency Name	Minority	Women	Dis-advantaged	Disabled Veteran	Expiration Date

V. DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE.

Print Authorized Name	Authorized Signature	Title	Date

REQUIRED FORMS - EXHIBIT 7
Use this form for County Solicitations which **are** subject to the Federal Restriction

Request for Local SBE Preference Program Consideration and CBE Firm/Organization Information Form

INSTRUCTIONS: All proposers/bidders responding to this solicitation must complete and return this form for proper consideration of the proposal/bid.

I. LOCAL SMALL BUSINESS ENTERPRISE PREFERENCE PROGRAM:

FIRM NAME:

CAGE CODE:

NAICS CODE:

☐ As a business registered as 'Small' on the federal Central Contractor Registration (CCR) data base, I request this proposal/bid be considered for the Local SBE Preference.

☐ The NAICS Code shown corresponds to the services in this solicitation.

☐ Attached is my CCR certification page.

II. FIRM/ORGANIZATION INFORMATION: The information requested below is for statistical purposes only. On final analysis and consideration of award, contractor/vendor will be selected without regard to race/ethnicity, color, religion, sex, national origin, age, sexual orientation or disability.

Business Structure: ☐Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Non-Profit ☐ Franchise

☐Other (Please Specify) _____

Total Number of Employees (including owners)**:**

_____

Race/Ethnic Composition of Firm. Please distribute the above total number of individuals into the following categories:

Race/Ethnic Composition	Owners/Partners/ Associate Partners		Managers		Staff	
Black/African American	Male ☐	Female ☐	Male ☐	Female ☐	Male ☐	Female ☐
Hispanic/Latino	Male ☐	Female ☐	Male ☐	Female ☐	Male ☐	Female ☐
Asian or Pacific Islander	Male ☐	Female ☐	Male ☐	Female ☐	Male ☐	Female ☐
American Indian	Male ☐	Female ☐	Male ☐	Female ☐	Male ☐	Female ☐
Filipino	Male ☐	Female ☐	Male ☐	Female ☐	Male ☐	Female ☐
White	Male ☐	Female ☐	Male ☐	Female ☐	Male ☐	Female ☐

III. PERCENTAGE OF OWNERSHIP IN FIRM: Please indicate by percentage (%) how ownership of the firm is distributed.

	Black/African American	Hispanic/ Latino	Asian or Pacific Islander	American Indian	Filipino	White
Men	_____%	_____%	_____%	_____%	_____%	_____%
Women	_____%	_____%	_____%	_____%	_____%	_____%

IV. CERTIFICATION AS MINORITY, WOMEN, DISADVANTAGED, AND DISABLED VETERAN BUSINESS ENTERPRISES: *If your firm is currently certified as a minority, women, disadvantaged or disabled veteran owned business enterprise by a public agency, complete the following and attach a copy of your proof of certification. (Use back of form, if necessary.)*

Agency Name	Minority	Women	Dis-advantaged	Disabled Veteran	Expiration Date

V. DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE.

Print Authorized Name	Authorized Signature	Title	Date

REQUIRED FORMS - EXHIBIT 8

PROPOSER'S EEO CERTIFICATION

Company Name:

Address:

Internal Revenue Service Employer Identification Number:

GENERAL

In accordance with provisions of the County Code of the County of Los Angeles, the Proposer certifies and agrees that all persons employed by such firm, its affiliates, subsidiaries, or holding companies are and will be treated equally by the firm without regard to or because of race, religion, ancestry, national origin, or sex and in compliance with all anti-discrimination laws of the United States of America and the State of California.

CERTIFICATION

1. Proposer has written policy statement prohibiting discrimination in all phases of employment.	☐YES ☐NO
2. Proposer periodically conducts a self-analysis or utilization analysis of its work force.	☐YES ☐NO
3. Proposer has a system for determining if its employment practices are discriminatory against protected groups.	☐YES ☐NO
4. When problem areas are identified in employment practices, Proposer has a system for taking reasonable corrective action to include establishment of goal and/or timetables.	☐YES ☐NO

Signature:	Date:
Name and Title of Signer (please print):	

REQUIRED FORMS - EXHIBIT 9

ATTESTATION OF WILLINGNESS TO CONSIDER GAIN/GROW PARTICIPANTS

As a threshold requirement for consideration for contract award, Proposer shall demonstrate a proven record for hiring GAIN/GROW participants or shall attest to a willingness to consider GAIN/GROW participants for any future employment opening if they meet the minimum qualifications for that opening. Additionally, Proposer shall attest to a willingness to provide employed GAIN/GROW participants access to the Proposer's employee mentoring program, if available, to assist these individuals in obtaining permanent employment and/or promotional opportunities.

To report all job openings with job requirements to obtain qualified GAIN/GROW participants as potential employment candidates, Contractor shall email: GAINGROW@dpss.lacounty.gov.

Proposers unable to meet this requirement shall not be considered for contract award.

Proposer shall complete all of the following information, sign where indicated below, and return this form with their proposal.

A. Proposer has a proven record of hiring GAIN/GROW participants.	☐YES (subject to verification by County) ☐NO
B. Proposer is willing to provide DPSS with all job openings and job requirements to consider GAIN/GROW participants for any future employment openings if the GAIN/GROW participant meets the minimum qualifications for the opening. "Consider" means that Proposer is willing to interview qualified GAIN/GROW participants.	☐YES ☐NO
C. Proposer is willing to provide employed GAIN/GROW participants access to its employee-mentoring program, if available.	☐YES ☐NO ☐N/A (Program not available)

Proposer's Organization:	
Signature:	
Print Name:	
Title:	Date:
Telephone No:	Fax No:

REQUIRED FORMS - EXHIBIT 10

COUNTY OF LOS ANGELES CONTRACTOR EMPLOYEE JURY SERVICE PROGRAM
CERTIFICATION FORM AND APPLICATION FOR EXCEPTION

The County's solicitation for this Invitation for Bids is subject to the County of Los Angeles Contractor Employee Jury Service Program (Program), Los Angeles County Code, Chapter 2.203. All Bidders, whether a contractor or subcontractor, must complete this form to either certify compliance or request an exception from the Program requirements. Upon review of the submitted form, the County department will determine, in its sole discretion, whether the Bidder is excepted from the Program.

Company Name:		
Company Address:		
City:	State:	Zip Code:
Telephone Number:		
Solicitation For _____ Services:		

If you believe the Jury Service Program does not apply to your business, check the appropriate box in Part I (attach documentation to support your claim); or, complete Part II to certify compliance with the Program. Whether you complete Part I or Part II, please sign and date this form below.

Part I: Jury Service Program is Not Applicable to My Business

☐ My business does not meet the definition of "contractor," as defined in the Program, as it has not received an aggregate sum of $50,000 or more in any 12-month period under one or more County contracts or subcontracts (this exception is not available if the contract itself will exceed $50,000). I understand that the exception will be lost and I must comply with the Program if my revenues from the County exceed an aggregate sum of $50,000 in any 12-month period.

☐ My business is a small business as defined in the Program. It 1) has ten or fewer employees; and, 2) has annual gross revenues in the preceding twelve months which, if added to the annual amount of this contract, are $500,000 or less; and, 3) is not an affiliate or subsidiary of a business dominant in its field of operation, as defined below. I understand that the exception will be lost and I must comply with the Program if the number of employees in my business and my gross annual revenues exceed the above limits.

"Dominant in its field of operation" means having more than ten employees and annual gross revenues in the preceding twelve months, which, if added to the annual amount of the contract awarded, exceed $500,000.

"Affiliate or subsidiary of a business dominant in its field of operation" means a business which is at least 20 percent owned by a business dominant in its field of operation, or by partners, officers, directors, majority stockholders, or their equivalent, of a business dominant in that field of operation.

☐ My business is subject to a Collective Bargaining Agreement (attach agreement) that expressly provides that it supersedes all provisions of the Program.

OR

Part II: Certification of Compliance

☐ My business has and adheres to a written policy that provides, on an annual basis, no less than five days of regular pay for actual jury service for full-time employees of the business who are also California residents **or** my company will have and adhere to such a policy prior to award of the contract.

I declare under penalty of perjury under the laws of the State of California that the information stated above is true and correct.

Print Name:	Title:
Signature:	Date:

REQUIRED FORMS - EXHIBITS 11- 14

COST FORMS

(Intentionally Omitted)

REQUIRED FORMS - EXHIBITS 15- 19

LIVING WAGE

(Intentionally Omitted)

REQUIRED FORMS - EXHIBIT 20

CHARITABLE CONTRIBUTIONS CERTIFICATION

Company Name:

Address:

Internal Revenue Service Employer Identification Number:

California Registry of Charitable Trusts "CT" number (if applicable):

The Nonprofit Integrity Act (SB 1262, Chapter 919) added requirements to California's Supervision of Trustees and Fundraisers for Charitable Purposes Act which regulates those receiving and raising charitable contributions.

Check the Certification below that is applicable to your company.

☐ Proposer or Contractor has examined its activities and determined that it does not now receive or raise charitable contributions regulated under California's Supervision of Trustees and Fundraisers for Charitable Purposes Act. If Proposer engages in activities subjecting it to those laws during the term of a County contract, it will timely comply with them and provide County a copy of its initial registration with the California State Attorney General's Registry of Charitable Trusts when filed.

OR

☐ Proposer or Contractor is registered with the California Registry of Charitable Trusts under the CT number listed above and is in compliance with its registration and reporting requirements under California law. Attached is a copy of its most recent filing with the Registry of Charitable Trusts as required by Title 11 California Code of Regulations, sections 300-301 and Government Code sections 12585-12586.

Signature:	Date:
Name and Title of Signer (please print):	

REQUIRED FORMS - EXHIBIT 21

TRANSITIONAL JOB OPPORTUNITIES PREFERENCE PROGRAM APPLICATION

(INTENTIONALLY OMITTED)

REQUIRED FORMS - EXHIBIT 22

CERTIFICATION OF COMPLIANCE WITH THE COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM

Company Name:		
Company Address:		
City:	State:	Zip Code:
Telephone Number:	Email address:	
Solicitation For _____ Services:		

The Proposer/Bidder/Contractor certifies that:

☐ It is familiar with the terms of the County of Los Angeles Defaulted Property Tax Reduction Program, Los Angeles County Code Chapter 2.206; **AND**

To the best of its knowledge, after a reasonable inquiry, the Proposer/Bidder/Contractor is not in default, as that term is defined in Los Angeles County Code Section 2.206.020.E, on any Los Angeles County property tax obligation; **AND**

The Proposer/Bidder/Contractor agrees to comply with the County's Defaulted Property Tax Reduction Program during the term of any awarded contract.

- OR -

☐ I am exempt from the County of Los Angeles Defaulted Property Tax Reduction Program, pursuant to Los Angeles County Code Section 2.206.060, for the following reason:

I declare under penalty of perjury under the laws of the State of California that the information stated above is true and correct.

Print Name:	Title:
Signature:	Date:

REQUIRED FORMS - EXHIBIT 23

REQUEST FOR DISABLED VETERANS BUSINESS ENTERPRISE PREFERENCE PROGRAM CONSIDERATION

(INTENTIONALLY OMITTED)

REQUIRED FORMS - EXHIBIT 24 – PROPOSER'S PENDING LITIGATION AND/OR JUDGMENTS

Name of Proposer: _____

Complete the following if appropriate. Identify by name, date, case and court jurisdiction any pending litigation in which Proposer is involved, or judgments against Proposer in the past five (5) years. Provide a statement describing the size and scope of any pending or threatening litigation against the Proposer or principals of the Proposer. Attach additional sheets if necessary. If a Proposer has no Pending Litigation and/or Judgments, please check the box below.

Name	Date	Case	Court Jurisdiction	Pending Litigation	Statement Describing the Size and Scope of the Pending or Threatening Litigation

Check if applicable:

☐ **Proposer has no Pending Litigation and/or Judgments.**

Print Name:	**Title:**
Signature:	**Date:**

APPENDIX D, REQUIRED FORMS, EXHIBIT 25A
CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR YMSM
MANDATORY INTENT TO APPLY FORM

Proposer's Name:

1. Proposer that intends to respond to this RFP must submit a completed "Mandatory Intent to Apply" (Exhibit 25A) form **for each Category 1 proposal** Proposer intends to submit. There are three (3) categories of service, outlined in the below table, which will be funded as a result of this RFP. **Proposer may submit multiple proposals within the three (3) categories of service, however each category and/or cluster area constitutes a separate proposal.**
2. **Each** form must be must be submitted by 3:00 PM Pacific Time on or before 10/28/2015 by e-mail transmission (PDF format only), to the following County Representative: Maritza Recinos, Contract Analyst, Department of Public Health, Contracts and Grants Division, Email: MRecinos@ph.lacounty.gov
3. **Each** form must identify the specific category, target population, cluster or target area (s) in which Proposer plans to submit a proposal(s). Proposer understands that each form is a non-binding commitment, but merely serves to provide DPH with the Proposer's interest in the RFP for planning and evaluation purposes.

CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR YMSM		
CATEGORY	**TARGET POPULATION**	**CLUSTER/TARGET AREA(S)**
1A	☐ African American YMSM, 12 – 29 years of age	☐ Central ☐ South ☐ East ☐ North ☐ Northwest
1B	☐ Latino YMSM, 12 – 29 years of age	☐ Central ☐ South ☐ East ☐ North ☐ Northwest
1C	☐ African American **and** Latino YMSM, 12 – 29 years of age	☐ Central ☐ South ☐ East ☐ North ☐ Northwest

Form must be signed by the Executive Director, Chief Executive Officer, President or designated Board Member of the proposing agency.		
Agency/Proposer's Name:		
Name:	Title:	
Email:	Fax #:	Phone #:
Mailing Address:	City, State, Zip Code:	
Signature (blue ink):	Date of Signature:	
For County Use only:		
Received By:	Date/Time	

APPENDIX D, REQUIRED FORMS, EXHIBIT 25B
CATEGORY 2: HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIUDALS
MANDATORY INTENT TO APPLY FORM

Proposer's Name:

1. Proposer that intends to respond to this RFP must submit a completed "Mandatory Intent to Apply" (Exhibit 25B) form **for each Category 2 proposal** Proposer intends to submit. Proposed services for the transgender community must be geographically relevant to transgender individuals; therefore DPH, DHSP is targeting two suggested areas for services, outlined in the table below. Proposer may suggest alternate service locations outside the Central and South target areas, but still within Los Angeles County.
2. Proposer cannot propose to serve more than one target area in a single proposal. Separate proposals are necessary to serve more than one area.
3. **Each** form must be must be submitted by 3:00 PM Pacific Time on or before 10/28/2015 by e-mail transmission (PDF format only), to the following County Representative: Maritza Recinos, Contract Analyst, Department of Public Health, Contracts and Grants Division, Email: MRecinos@ph.lacounty.gov
4. **Each** form must identify the specific service location(s) in which Proposer plans to submit a proposal(s). Proposer understands that each form is a non-binding commitment, but merely serves to provide DPH with the Proposer's interest in the RFP for planning and evaluation purposes.

CATEGORY 2 HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS			
Category	**Target Population**	**Target Area**	**Service Location Should Be In or Near***
2	Transgender Individuals	Central	☐ 1. Downtown Los Angeles area and/or ☐ 2. Hollywood/Santa Monica Boulevard area
		South	☐ 3. City of Long Beach
		Proposer's Alternate Service Location	Identify Alternate Service Location below: ☐ 4.

***In or near is defined as being proximate to those locations. This definition is intended to be flexible with the goal of providing services in areas frequented and attractive to transgender individuals. As long as Proposer has a strong, well-justified rationale for the site, it will be considered for approval.*

Form must be signed by the Executive Director, Chief Executive Officer, President or designated Board Member of the proposing agency.		
Agency/Proposer's Name:		
Name:	Title:	
Email:	Fax #:	Phone #:
Mailing Address:	City, State, Zip Code:	
Signature (blue ink):	Date of Signature:	
For County Use only:		
Received By:	Date/Time:	

REQUIRED FORMS - EXHIBIT 26A
PROPOSER'S MINIMUM MANDATORY QUALIFICATIONS FORM
CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR YMSM

Instructions: Proposer must submit a completed Appendix D, Required Forms - Exhibit 26A, Proposer's Minimum Mandatory Qualifications Form for Category 1. Proposer's Exhibit 26A **must** clearly demonstrate that the Proposer/Subcontractor meets the applicable experience, data collection, and service delivery minimum mandatory qualifications, outlined below, pursuant to RFP Paragraph 3.0, Proposer's Minimum Mandatory Qualifications, subparagraph 3.1, Category 1 Minimum Mandatory Qualifications **on the day that proposals are due.** Proposer should ensure that information provided in its Exhibit 26A supports Proposer's responses provided in its Appendix D, Required Forms, Exhibit 1A - Proposer's Organization Questionnaire/Affidavit for Category 1.

PROPOSER'S NAME: _____

RFP Ref.	RFP Requirement
3.1.1	**Experience:** Proposer, or consultant/subcontractor, must have a minimum of three (3) years of experience, within the last five (5) years, working with Men who have Sex with Men and providing youth services for African Americans and/or Latinos, ages 12 – 29, in Los Angeles County.

Please check the appropriate box:

1. ☐ Proposer meets the above-referenced requirement.

2. ☐ Subcontractor/consultant meets the above-referenced requirement.
(Name of subcontractor/consultant:_____)

Please document the experience below that clearly demonstrates that Proposer or consultant/subcontractor meets the above-referenced requirement. Please provide dates, name(s) of each agency/department in which Proposer or subcontractor/consultant provided the required services that substantiates Proposer/Subcontractor meets the above-referenced requirement. (Attach additional sheets as necessary).

REQUIRED FORMS - EXHIBIT 26A
PROPOSER'S MINIMUM MANDATORY QUALIFICATIONS FORM
CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR YMSM

RFP Ref.	RFP Requirement
3.1.2	**Data Collection:** Proposer, or consultant/subcontractor, must have a minimum of two (2) years of experience, within the last five (5) years, collecting data for the purpose of evaluation and reporting.

Please check the appropriate box:

1. ☐ Proposer meets the above-referenced requirement.

2. ☐ Subcontractor/consultant meets the above-referenced requirement.
(Name of subcontractor/consultant:_____)

Please document the experience below that clearly demonstrates that Proposer or consultant/subcontractor meets the above-referenced requirement. Please provide dates, name(s) of each agency/department in which Proposer or subcontractor/consultant provided the required services that substantiates Proposer/Subcontractor meets the above-referenced requirement. (Attach additional sheets as necessary).

REQUIRED FORMS - EXHIBIT 26A
PROPOSER'S MINIMUM MANDATORY QUALIFICATIONS FORM
CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR YMSM

RFP Ref.	RFP Requirement
3.1.3	**Service Delivery Site:** Proposer, or consultant/subcontractor, must have a service delivery site located within an eligible cluster area for service as described in RFP Paragraph 1.2.4, Location of Service(s) within 90 days from contract execution. (***Note:*** No consideration will be given to proposals for services outside of the eligible cluster service areas or which serve more than one cluster area in the same proposal.)

Please check the appropriate box:

1. ☐ Proposer meets the above-referenced requirement.

2. ☐ Subcontractor/consultant meets the above-referenced requirement.
(Name of subcontractor/consultant: _____)

Please provide the following information:

Name of Delivery Site:

Delivery Site Address:

Delivery Site Telephone Number:

Name of Delivery Site Contact Person:

Eligible Cluster Area of Delivery Site:

(Select only one)

☐ Central

☐ South

☐ East

☐ North

☐ Northwest

REQUIRED FORMS - EXHIBIT 26B

PROPOSER'S MINIMUM MANDATORY QUALIFICATIONS FORM
CATEGORY 2: HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS

Instructions: Proposer must submit a completed Appendix D, Required Forms - Exhibit 26B, Proposer's Minimum Mandatory Qualifications Form for Category 2. Proposer's Exhibit 26B **must** clearly demonstrate that the Proposer/Subcontractor meets the applicable experience and data collection minimum mandatory qualifications, outlined below, pursuant to RFP Paragraph 3.0, Proposer's Minimum Mandatory Qualifications, subparagraph 3.2, Category 2 Minimum Mandatory Qualifications **on the day in that proposals are due.** Proposer should ensure that information provided in its Exhibit 26B supports Proposer's responses provided in its Appendix D, Required Forms, Exhibit 1B - Proposer's Organization Questionnaire/Affidavit for Category 2.

PROPOSER'S NAME: _____

RFP Ref.	RFP Requirement
3.2.1	**Experience:** Proposer, or consultant/subcontractor, must have a minimum of three (3) years of experience, within the last five (5) years, providing transgender services in Los Angeles County.

Please check the appropriate box:

1. ☐ Proposer meets the above-referenced requirement.

2. ☐ Subcontractor/consultant meets the above-referenced requirement.
(Name of subcontractor/consultant: _____)

Please document the experience below that clearly demonstrates that Proposer or consultant/subcontractor meets the above-referenced requirement. Please provide dates, name(s) of each agency/department in which Proposer or subcontractor/consultant provided the required services that substantiates Proposer/Subcontractor meets the above-referenced requirement. (Attach additional sheets as necessary).

REQUIRED FORMS - EXHIBIT 26B

PROPOSER'S MINIMUM MANDATORY QUALIFICATIONS FORM
CATEGORY 2: HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS

RFP Ref.	RFP Requirement
3.2.2	**Data Collection:** Proposer, or consultant/subcontractor, must have a minimum of two (2) years of experience, within the last five (5) years, collecting data for the purpose of evaluation and reporting.

Please check the appropriate box:

1. ☐ Proposer meets the above-referenced requirement.

2. ☐ Subcontractor/consultant meets the above-referenced requirement.
(Name of subcontractor/consultant: _____)

Please document the experience below that clearly demonstrates that Proposer or consultant/subcontractor meets the above-referenced requirement. Please provide dates, name(s) of each agency/department in which Proposer or subcontractor/consultant provided the required services that substantiates Proposer/Subcontractor meets the above-referenced requirement. (Attach additional sheets as necessary).

REQUIRED FORMS – EXHIBIT 27
PROPOSER'S SAMPLE SCOPE OF WORK AND TEMPLATE
PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs
RFP NO. 2015-003

INSTRUCTIONS FOR COMPLETING PROPOSER'S EXHIBIT 27: Proposer must submit a completed Scope of Work for each proposed program. Proposer's Scope of Work should outline the Proposer's Measureable Objectives; Implementation Activities; Timeline; and Methods of Evaluating Objective(s) and Documentation for a twelve month period. Proposer should develop a plan that incorporates activities which will address all of the specific work requirements covered in Appendix B, Statement of Work, Section 9.0, Specific Work Requirements. Proposer establishing partnerships and formal agreements with other subcontractors or consultants to accomplish specific work requirements should clearly identify which activities the subcontractor or consultant will accomplish. Proposer's Scope of Work Template should indicate exactly how the program design will be implemented in practice. To assist Proposer's in developing their Scope of Work, a "Sample Scope of Work" is provided below and should only be used by the Proposer as a guideline. Proposer is advised that no other format and/or template will be accepted other than Exhibit 27.

"SAMPLE SCOPE OF WORK"

Goal No. 1: To provide HIV/STD Prevention Services to African American and Latino Young Men Who Have Sex With Men in Syndemic Cluster Area(s) (Central Cluster) of Los Angeles County.

MEASURABLE OBJECTIVE(S)	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATING OBJECTIVE(S) AND DOCUMENTATION
1.0 By 12/31/15, a minimum of 100 YMSM will attend one event at the youth drop in center or YMSM coffeehouse	1.1 Develop recruitment protocol, referral and linked referral protocol, brief risk screener forms, brief HIV risk assessment, and educational pamphlets. Submit to Division of HIV and STD Programs (DHSP) for approval.	By 03/01/15	1.1 Letter(s) of DHSP approval and materials will be kept on file.
	1.2 Schedule recruitment encounters and maintain a calendar with sites, dates, and times.	01/01/15 and ongoing	1.2 Documents will be kept on file and submitted with monthly reports to DHSP.
	1.3 Conduct recruitment and brief HIV risk assessment maintain encounter logs including but not limited to: client identification information, sites, dates, demographic information, and materials presented.	01/01/15 and ongoing	1.3 Completed materials will be kept on file and number of participants documented in monthly reports to DHSP.
	1.4 Schedule events at center or coffeehouse and maintain a calendar with dates, and times.	01/01/15 and ongoing	1.4 Documents will be kept on file and submitted with monthly reports to DHSP.
	1.5 Conduct events and brief risk screener maintain sign-in sheets and risk screeners.	01/01/15 and ongoing	1.5 Completed materials will be kept on file and number of participants documented in monthly reports to DHSP.

REQUIRED FORMS – EXHIBIT 27
PROPOSER'S SAMPLE SCOPE OF WORK AND TEMPLATE
PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs
RFP NO. 2015-003

Proposer:

Goal No. 1: To provide HIV/STD Prevention Services to African American and Latino Young Men Who Have Sex With Men in Syndemic Cluster Area(s) (Central Cluster) of Los Angeles County.

MEASURABLE OBJECTIVE(S)	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATING OBJECTIVE(S) AND DOCUMENTATION
2.0 By 12/31/15, a minimum of 50 YMSM will participate in at least three (3) risk-reduction case management sessions. Risk reduction case management sessions must be face-to-face and at least 20 minutes in length. Follow-up sessions shall be conducted after the last session. Follow-up sessions can be conducted face-to-face, online, via phone, and/or twitter, Facebook, etc.	2.1 Develop risk-reduction case management protocol, and forms to include, but not be limited to: client intake form (name or unique identifier, demographics etc.), HIV risk assessment form, client centered service plan form, progress notes forms, case closure summary form, Partner Services (PS). Submit to DHSP for approval. 2.2 Schedule risk-reduction case management sessions and maintain a calendar of sites, dates, and times. 2.3 Conduct risk-reduction case management activities and obtain sign-in sheets.	By 3/01/15 01/01/15 and ongoing 01/01/15 and ongoing	2.1 Letter(s) of DHSP approval and materials will be kept on file. 2.2 Documents will be kept on file and submitted in monthly reports to DHSP. 2.3 Documents will be kept on file and submitted in monthly reports to DHSP.

REQUIRED FORMS – EXHIBIT 27
PROPOSER'S SAMPLE SCOPE OF WORK AND TEMPLATE
PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs
RFP NO. 2015-003

Proposer's Name:

Goal No. 1: To provide HIV/STD Prevention Services to African American and Latino Young Men Who Have Sex With Men in Syndemic Cluster Area(s) (Central Cluster) of Los Angeles County.

MEASURABLE OBJECTIVE(S)	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATING OBJECTIVE(S) AND DOCUMENTATION
3.0 By 12/31/15, a minimum of 95% of YMSM with unknown HIV status or high risk HIV negatives will receive an HIV test.	3.1 Develop Counseling and Testing Services Quality Assurance Plans for each site. Plan should include, but not be limited to, information on client flow, testing process, testing algorithm, partner services plan, and linkage to care, Submit materials to DHSP for approval.	By 3/01/15	3.1 Letter(s) of DHSP approval and related material will be kept on file.
	3.2 Schedule HTS activities and maintain calendar of sites, dates, and times.	01/01/15 and ongoing	3.2 Calendar will be kept on file and submitted with monthly reports to DHSP.
	3.3 Administer DHSP approved consent form and medical release form. Complete client logs	01/01/15 and ongoing	3.3 Completed materials will be kept on file and results documented in monthly reports to DHSP.
	3.4 Administer HIV test. Document test results on data forms. Enter data into database. Analyze results and report to DHSP as follows: • Form A: For all HIV-negative testers, on a weekly basis. • Form A & B: For all HIV-positive testers, within 72 hours of the testing session. • Form C: Within two weeks of testing session, or as directed by DHSP.	01/01/15 and ongoing	3.4 Completed materials will be kept on file and results documented in monthly reports to DHSP.

REQUIRED FORMS – EXHIBIT 27
PROPOSER'S SAMPLE SCOPE OF WORK AND TEMPLATE
PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs
RFP NO. 2015-003

Proposer's Name:

Goal No. 1: To provide HIV/STD Prevention Services to African American and Latino Young Men Who Have Sex With Men in Syndemic Cluster Area(s) (Central Cluster) of Los Angeles County.

MEASURABLE OBJECTIVE(S)	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATING OBJECTIVE(S) AND DOCUMENTATION
4.0 By 12/31/15, a minimum of 85% of High Risk-negative, and 95% of HIV positive tested will receive a Disclosure Counseling Session	4.1 Conduct Disclosure Counseling Session. Document topics discussed. Send data to DHSP.	01/01/15 and ongoing	4.1 Documents will be kept on file and results documented in monthly reports to DHSP.
5.0 By 12/31/2015, a minimum of 85% of those testing HIV positive will be linked to medical care. • A Linkage to care is the direction of an HIV-positive client to medical care. For all clients identified as HIV-positive, Contractor shall complete a medical care referral within 72 hours of diagnosis, but not longer than ninety (90) days. Staff is expected to provide the client with a medical appointment, unless the client explicitly requests to do it him/her self. Staff shall ensure that the client attends the first medical visit and follow up with client if referral was not completed.	5.1 Develop a Linked Referral Plan to be included in the site specific QA Plan. Documentation should include, but not be limited to; the procedures to verify and document successful referrals to medical care, including the referring agency name, the name and contact information for person verifying the linked medical visit. Submit plan to DHSP for approval.	By 3/01/15	5.1 Letter(s) of DHSP approval and related material will be kept on file.
	5.2 Conduct Referral Counseling Session. Document referrals made on testing forms. Analyze results and report to DHSP.	01/01/15 and ongoing	5.2 Documents will be kept on file and results documented in monthly reports to DHSP.
6.0 By 12/31/15, 100% of HIV positive clients who access services through this program will be referred to Partner Services (PS).	6.1 Document PS referrals and report to DHSP within 72 hours of testing session.	01/01/15 and ongoing	6.1 Documents will be kept on file and results documented in monthly reports to DHSP.

REQUIRED FORMS – EXHIBIT 27
PROPOSER'S SAMPLE SCOPE OF WORK AND TEMPLATE
PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs
RFP NO. 2015-003

Proposer's Name:

Category of Service:

Cluster Area/Target Area:

Goal No. 1:

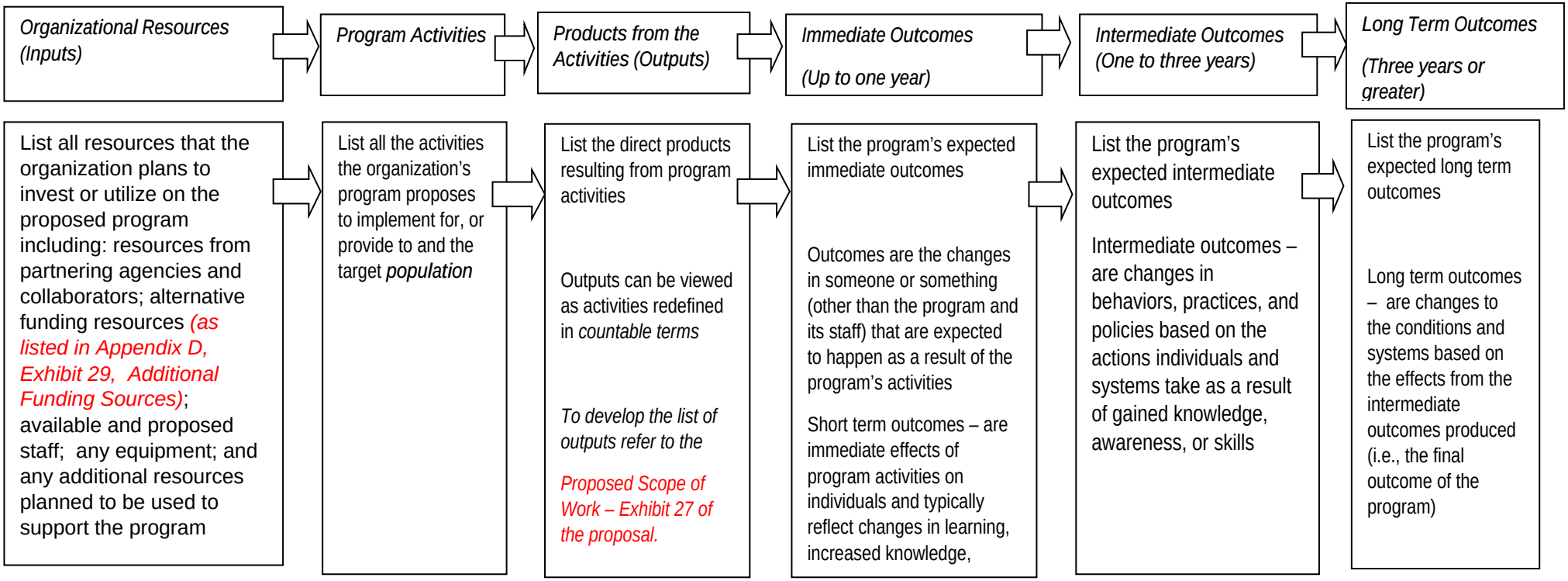
MEASURABLE OBJECTIVE(S)	IMPLEMENTATION ACTIVITIES	TIMELINE	METHOD(S) OF EVALUATING OBJECTIVE(S) AND DOCUMENTATION

Overview: A logic model is a one page summary which provides a visual depiction of the proposed program's activities – supported by the organization's resources or "inputs" – which will yield certain "outputs" that will then yield in programmatic or health-related "outcomes". Additional resources on logic models can be found at: *http://www.uwex.edu/ces/pdande/evaluation/evallogicbiblio.html*.

Components of a Logic Model

Instructions: Proposer must submit a completed Exhibit 28 for **each** proposed program. In responding to Exhibit 28, Proposer should use the instructions provided herein as a guide to create a logic model for **each** proposed program.

Narrative Box Component: Proposer's Narrative Box is limited to two (2) paragraphs only with context that further clarifies the conditions that the Proposer's program will function in along with a broad description of how the proposed program's activities will lead to the outcomes listed in the model. Proposer's Narrative Box should: (1) indicate the target population (see RFP Paragraph 1.2.5 and 1.3.5, Categories of Service) **and** state the need for the proposed program; (2) provide a brief description of the proposed program's main goals and expected outcomes; 3) state one or more social determinants of health (see RFP Paragraph 1.2.2, and 1.3.2 Program Components, Social Determinants of Health) that the proposed program will address; (4) state at least two resiliency and protective factors (see RFP Paragraph 1.2.2 and 1.3.2 , Program Components, Promoting Resiliency and Protective Factors) that will be promoted as part of the proposed program activities; and (5) mention previous work, published materials, or other evidence that support a rationale for the proposed program's intended activities.

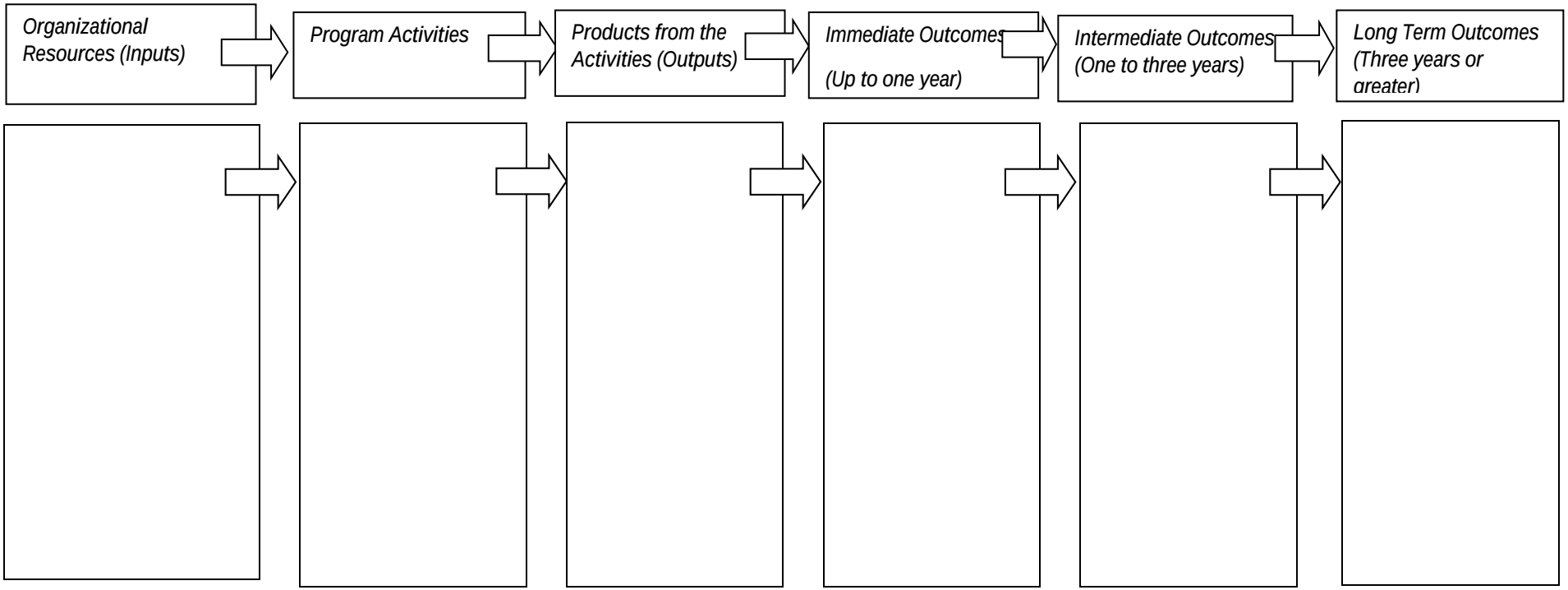


Proposer's Name:

Category of Service:

Cluster/Target Area:

Narrative Component:



COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC HEALTH

APPENDIX D – REQUIRED FORMS – EXHIBIT 29
PROPOSER'S FUNDING DISCLOSURE FORM

Proposer's Name:	
Category of Service:	
Cluster/Target Area:	
RFP # 2015-003	**PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs**

1.0 Background/Instructions:

Resources made available as a result of this RFP shall only be used to fund new or enhanced HIV and STD prevention services. They shall in no way supplant existing resources. To assure this, Proposer must disclose all *currently* available or *committed* revenue and funding resources available in each service category in which Proposer now provides services and, for which, Proposer requests funding through this RFP. **Failure to disclose may result in automatic disqualification. Responses are subject to verification.**

2.0 Definitions:

CY: The abbreviation "CY" stands for Calendar year which is the annual year that begins January 1 of any year and ends December 31 of the same year for example January 1, 2016 – December 31, 2016 is a single Calendar Year or CY.

FY: "FY" stands for Fiscal Year which is defined as the year term from July 1 of one year through June 30 of the subsequent year, for example July 1, 2016 – June 30, 2017 is a single Fiscal Year or FY.

Currently: For the purposes of this form "currently" is defined as the current County FY 15-16 (July 1, 2015 – June 30, 2016) or if the agency is on CY for its fiscal year it would be the current calendar year, CY 2016 (January 1, 2016 – December 31, 2016). All current resources must be disclosed in Table 1. If none available, state, "Not applicable."

Committed: "Committed" means those resources already budgeted for, and committed to similar services described in this RFP. This includes forthcoming grant awards or other expected funding awards/sources.

APPENDIX D – REQUIRED FORMS – EXHIBIT 29
PROPOSER'S FUNDING DISCLOSURE FORM

Resources: "Resources" include, but are not limited to, patient/client fees, third-party payer sources, grant resources and agency-raised funds (e.g. individual donations, fundraising activities).

3.0 Instructions – Table 1: Current Resources Disclosure

This section addresses current resources and how they are now used. Please complete Table 1 using the following instructions. Attach additional sheets as needed.

1. **Current resources:** Type in the specific HIV and STD prevention resources *currently* available in FY 2015-16 or CY 16 (e.g. CDC Community HIV grant [specify grant name/number], Foundation grant [specify which foundation], private donations). If a resource provides funding to more than one category of service list the resource twice and answer the remaining information. If your agency has no other HIV and STD prevention resources available, please indicate so by stating, "Not applicable".

2. **Current annual amount is:** Enter the annual amount for current services.

3. **Current resources are expected to be available until:** Choose the appropriate fiscal or calendar year from the drop-down menu. If none of the menu choices apply, choose "other" from the drop-down menu and explain your choice in comments.

4. **Comments:** Explain funding details including (if applicable): 1) if current resources are about to end, 2) why "other" was chosen under the prior column, and/or 3) any other significant funding details that should be taken into consideration during the evaluation stage.

COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC HEALTH

APPENDIX D – REQUIRED FORMS – EXHIBIT 29
PROPOSER'S FUNDING DISCLOSURE FORM

Table 1. Current Resources Disclosure

Current resources	The current annual amount is	Current resources are expected to be available until	Comments
		FY 2016-2017	
		FY 2016-2017	
		FY 2016-2017	
		FY 2016-2017	
		FY 2016-2017	

APPENDIX D – REQUIRED FORMS – EXHIBIT 29
PROPOSER'S FUNDING DISCLOSURE FORM

4.0 Instructions – Table 2: Committed Resources Disclosure

This section addresses committed resources and how they are currently budgeted for use. Please complete Table 2 using the following instructions. Attach additional sheets as needed.

1. **Committed revenue or funding source:** Type in the specific resources *committed* to be available (FY 2015-16, CY 15 or beyond) (e.g. CDC Community HIV grant (specify grant name/number), Foundation grant (specify which foundation), private donations).

2. **Committed annual amount is:** Enter the annual amount initially committed.

3. **Revenue committed to be available until:** Choose the appropriate fiscal or calendar year from the drop-down menu. If none of the menu choices apply, choose "other" from the drop-down menu and explain your choice in comments.

4. **Comments:** Explain funding details including (if applicable): 1) if expected resources are short term, 2) why "other" was chosen under the prior column, and/or 3) any other significant funding details that should be taken into consideration during the evaluation stage.

COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC HEALTH

APPENDIX D – REQUIRED FORMS – EXHIBIT 29
PROPOSER'S FUNDING DISCLOSURE FORM

Table 2. Committed Resources Disclosure

Committed revenue or funding source	The Committed annual amount is	Revenue Committed to be available until	Comments
		FY 2016-2017	
		FY 2016-2017	
		FY 2016-2017	

5.0 Affirmation and Attestation

Affirmation for the Use of DHSP Funds:

This section is designed to affirm that the resources made available by DHSP through this RFP will enhance, and not supplant, existing resources. By checking the box next to the following statement, Proposer agrees to abide by this statement.

☐ Proposer affirms that the funding made available through this RFP will only be used to fund new or expanded services for the duration of the contract period.

Attestation of Full and Complete Disclosure:

☐ As a Proposer, I certify that all the information contained in this form, Exhibit 29 is correct and is a full and complete disclosure and that agency will abide by the affirmation for use of funds.

COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC HEALTH

APPENDIX D – REQUIRED FORMS – EXHIBIT 29
PROPOSER'S FUNDING DISCLOSURE FORM

6.0 Agency Information and Signature:

Agency Name (Full Legal Name):

Agency Name (Full Legal Name):

Name of Contact Person:

Title of Contact Person:	Contact Person: ☐ Mr. ☐ Mrs. ☐ Ms.

Phone Number:	**Fax Number:**

E-mail Address:

Signature of Executive Director, CEO, or designated Board Member:

Signature:	Date:
Print Name:	Print Title:

REQUIRED FORMS APPENDIX D - EXHIBIT 30A
COMMUNITY ADVISORY BOARD AFFIDAVIT FOR CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR YMSM

Proposer:	

INSTRUCTIONS: Proposer must submit a completed Exhibit 30A, Community Advisory Board Affidavit for Category 1 with its proposal affirming that its Community Advisory Board meets the requirements listed below. (***Note:*** One (1) CAB is sufficient for all Proposer submissions in response to Category 1)

Community Advisory Board (CAB) – Category 1
Proposer's CAB must meet the requirements, as outlined in the table below:

MINIMUM REQUIREMENTS
• Include five (5) to eight (8) members, two assigned as co-chairs;
• Members must reside in Los Angeles County;
• Members must be 16 to 29 years of age;
• CAB must consist of 75 percent youth of color (African American or Latino);
• CAB must consist of 50 percent 16 to 24 years of age; and
• CAB must consist of 60 percent YMSM.

List the names of all the CAB members (including the co-chairs)

No.	Name
1	
2	
3	
4	
5	
6	
7	
8	

Proposer affirms that the Proposer's Community Advisory Board meets the minimum requirements referenced above. Proposer's Exhibit 30A must be signed by the Executive Director, CEO, or designated Board Member.

Printed Name and Title:	
Signature:	Date:

REQUIRED FORMS APPENDIX D - EXHIBIT 30B
COMMUNITY ADVISORY BOARD AFFIDAVIT FOR CATEGORY 2: HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS

Proposer:	

INSTRUCTIONS: Proposer must submit a completed Exhibit 30B, Community Advisory Board Affidavit for Category 2 with its proposal affirming that its Community Advisory Board meets the requirements listed below. (***Note:*** One (1) CAB is sufficient for all Proposer submissions in response to Category 2)

Community Advisory Board (CAB) – Category 2
Proposer's CAB must meet the requirements, as outlined in the table below:

MINIMUM REQUIREMENTS
• Include five (5) to eight (8) members, two (2) assigned as co-chairs;
• Members must reside in Los Angeles County; and
• A majority of members must be transgender people who are reflective of the community the proposed program is intended to serve.

List the names of all the CAB members (including the co-chairs)

No.	Name
1	
2	
3	
4	
5	
6	
7	
8	

Proposer affirms that the Proposer's Community Advisory Board meets the minimum requirements referenced above. Proposer's Exhibit 30B must be signed by the Executive Director, CEO, or designated Board Member.

Printed Name and Title:	
Signature:	Date:

REQUIRED FORMS - APPENDIX D - EXHIBIT 31

LETTER OF CONCURRENCE

Name of Proposer:	
Category of Service:	
Cluster Area/Target Area:	

INSTRUCTIONS: Proposer must submit a completed Exhibit 31, Letter of Concurrence (LOC) for **each** Category 1 and/or Category 2 proposal submission. **Each** Exhibit 31 **must** be signed by **each** Community Advisory Board (CAB) member confirming that each CAB member supports and participated in the development of the proposed program(s) submitted by the Proposer in response to this RFP.

CAB Member's Affirmation

CAB Member hereby confirms that member supports and participated in the development of the proposed program(s) submitted by the Proposer in response to this RFP.

No.	Name of CAB Member	CAB Member's Signature
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.*		
9.		
10.		
11.		
12.**		

By signing this letter, Proposer affirms that the each of the CAB members supports and participated in the development of the proposed program(s) submitted by the Proposer in response to this RFP.

Signature of Executive Director, CEO, or designated Board Member:

Printed Name and Title:	
Signature:	Date:

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH

APPENDIX D, REQUIRED FORMS EXHIBIT 32A
PROGRAM COMPONENT CHECKLIST FOR CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR YMSM

PROPOSER'S NAME:	
CATEGORY OF SERVICE:	
CLUSTER AREA:	

INSTRUCTIONS: Proposer must submit a completed Exhibit 32A for **each** proposal submitted under Category 1. For each Program Component, Proposer should check the "Yes" "No," or "N/A" (Not Applicable), checkbox below. For "No" or "N/A" responses, Proposer should provide a justification in the "Explanation Section" of this Exhibit (**limited to the space on this form only**) that supports why specific Program Component is not addressed or is not applicable. Proposer only needs to provide the **initial page number** where the program component is **first listed** on the submitted proposal – subsequent page numbers and/or references are not needed.

CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR YMSM PROGRAM COMPONENTS	
Program Component	**Proposal Page Number**
1. Does the proposed program have a component focused on youth development?	
☐**Yes** ☐**No** ☐**N/A**	
2. Is the proposed program addressing a minimum of one social determinants of health (SDoH)?	
☐**Yes** ☐**No** ☐**N/A**	
3. Is the proposed program promoting at least two (2) resiliency and protective factors for that impact each SDoH Proposer selected to address?	
☐**Yes** ☐**No** ☐**N/A**	
4. Does the proposed program state how it effectively utilizes technology?	
☐**Yes** ☐**No** ☐**N/A**	

Explanation Narrative:

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH

APPENDIX D, REQUIRED FORMS EXHIBIT 32A
PROGRAM COMPONENT CHECKLIST FOR CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR YMSM

Proposer Executive Director Signature:	Date:

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH

APPENDIX D, REQUIRED FORMS EXHIBIT 32B
PROGRAM COMPONENT CHECKLIST FOR CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS

PROPOSER'S NAME:	
CATEGORY OF SERVICE:	
TARGET AREA:	

INSTRUCTIONS: Proposer must submit a completed Exhibit 32B for **each** proposal submitted under Category 2. For each Program Component, Proposer should check the "Yes" "No," or "N/A" (Not Applicable), checkbox below. For "No" or "N/A" responses, Proposer should provide a justification in the "Explanation Section" of this Exhibit (**limited to the space on this form only**) that supports why specific Program Component is not addressed or is not applicable. Proposer only needs to provide the **initial page number** where the program component is **first listed** on the submitted proposal – subsequent page numbers and/or references are not needed.

CATEGORY 2: HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS PROGRAM COMPONENTS	
Program Component	**Proposal Page Number**
1. Does the proposed program have a component incorporating youth development? ☐**Yes** ☐**No** ☐**N/A**	
2. Is the proposed program addressing a minimum of one (1) social determinants of health (SDoH)? ☐**Yes** ☐**No** ☐**N/A**	
3. Is the proposed program promoting at least two (2) resiliency and protective factors that impact each SDoH Proposer selected to address? ☐**Yes** ☐**No** ☐**N/A**	
4. Does the proposed program state how it effectively utilizes technology? ☐**Yes** ☐**No** ☐**N/A**	

Explanation Narrative:

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH

APPENDIX D, REQUIRED FORMS EXHIBIT 32B
PROGRAM COMPONENT CHECKLIST FOR CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS

Proposer Executive Director Signature:	Date:

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
APPENDIX D, REQUIRED FORMS
EXHIBIT 33- PROPOSAL SUBMISSION CHECKLIST

PROPOSER'S NAME:	

INSTRUCTIONS: Proposer must submit Proposal Submission Checklist (Exhibit 33) with their proposal to ensure that all required sections, documents, forms, exhibits, appendices, etc. are included in its proposal as required by the RFP. Proposer is to check off the appropriate box indicating that Proposer has completed and submitted the following:

PREPARATION OF THE PROPOSAL		
RFP Reference	**RFP Requirement**	**Submitted/Included?**
Paragraph 7.7	1 (one) original single-sided proposal.	☐Yes ☐No
Paragraph 7.7	Four (4) double-sided copies of the original proposal.	☐Yes ☐No
PROPOSAL FORMAT		
Paragraph 7.8.1, A	Proposal Title Page	☐Yes ☐No
Paragraph 7.8.1, B	Cover Letter	☐Yes ☐No
Paragraph 7.8.2	Table of Contents	☐Yes ☐No
Paragraph 7.8.3	Exhibit 33: Proposal Submission Checklist	☐Yes ☐No
PART 1: ADMINISTRATIVE SECTION		
Proposers submitting multiple proposals under Category 1 and/or 2 only need to submit a single response to Part 1 sections – unless otherwise indicated. Proposers should refer to RFP Paragraph 7.8.4, Part 1: Administration Section for further information regarding the proposal format for Part 1.		
Paragraph 7.8.4.1	**Proposer's Qualification (Section A)**	
	Exhibit 1A: Proposer's Organization Questionnaire/Affidavit for Category 1; **and/or**	☐Yes ☐No ☐N/A
	Exhibit 1B: Proposer's Organization Questionnaire/Affidavit for Category 2	☐Yes ☐No ☐N/A
	Required Support Documents: Corporations or Limited Liability Company (LLC)	
	Copy: Certificate of Good Standing; **or**	☐Yes ☐No ☐N/A
	Conformed Copy: Statement of Information	☐Yes ☐No ☐N/A
	Determination Letter (granting tax exemption under IRS Section 501(c)(3) status) – if applicable	☐Yes ☐No ☐N/A
	Required Support Documents: Limited Partnership	
	Conformed Copy: Certificate of Limited Partnership; **or**	☐Yes ☐No ☐N/A
	Application for Registration of Foreign Limited Partnership	☐Yes ☐No ☐N/A
	Proposer's Background and Experience (Section A.2)	

7.8.4.1, B	Exhibit 26A: Proposer's Minimum Mandatory Qualifications Form for Category 1; **and/or**	☐Yes ☐No ☐N/A
	Exhibit 26B: Proposer's Minimum Mandatory Qualifications Form for Category 2	☐Yes ☐No ☐N/A
	1-Page Narrative for Category 1; **and/or**	☐Yes ☐No ☐N/A
	1-Page Narrative for Category 2	☐Yes ☐No ☐N/A
7.8.4.1, C	**Proposer's References (Section A.3)**	
	Exhibit 2: Prospective Contractor References;	☐Yes ☐No ☐N/A
	Exhibit 3: Prospective Contractor List of Contracts; **and**	☐Yes ☐No
	Exhibit 4: Prospective Contractor List of Terminated Contracts	☐Yes ☐No
7.8.4.1, D	**Proposer's Pending Litigation and Judgments (Section A.4)**	
	Exhibit 24: Proposer's Pending Litigation and/or Judgments	☐Yes ☐No
7.8.4.2	**Financial Capability (Section B)**	
	Copies: Most current **and** prior two (2) fiscal years (for example 2012 and 2013) financial statements.	☐Yes ☐No
7.8.4.3	**Terms and Conditions in Sample Contract, and Requirements of the Statement of Work (SOW): Acceptance of / or Exceptions to (Section C)**	
	Acceptance Statement: Appendix A, Sample Contract.	☐Yes ☐ No ☐ N/A
	Acceptance Statement: Appendix B-1, Statement of Work for Category 1 and/or Appendix B-2, Statement of Work for Category 2; **and**	☐Yes☐ No ☐ N/A
	Exception Statement	☐Yes ☐ No ☐ N/A
7.8.4.4	**Required Forms (Section D)**	
	Exhibit 1A: Proposer's Organization Questionnaire/Affidavit for Category 1 **(Include in Section A of proposal)**	☐Yes ☐ No
	Exhibit 1B: Proposer's Organizational Questionnaire / Affidavit for Category 2 **(Include in Section A of proposal)**	☐Yes ☐ No
	Exhibit 2: Prospective Contractor References **(Include Section A.3 of proposal)**	☐Yes ☐ No
	Exhibit 3: Prospective Contractor List of Contracts **(Include in Section A.3 of proposal)**	☐Yes ☐ No
	Exhibit 4: Prospective Contractor List of Terminated Contracts **(Include in Section A.3 of proposal)**	☐Yes ☐ No
	Exhibit 5: Certification of No Conflict of Interest	☐Yes ☐ No
	Exhibit 6: Familiarity with the County Lobbyist Ordinance Certification	☐Yes ☐ No
	Exhibit 7: Request for Local SBE Preference Program Consideration and CBE Firm/Organization Information Form	☐Yes ☐ No
	Exhibit 8: Proposer's EEO Certification	☐Yes ☐ No

	Exhibit 9: Attestation of Willingness to Consider GAIN/GROW Participants	☐Yes ☐ No
	Exhibit 10: Contractor Employee Jury Service Program – Certification Form and Application for Exception	☐Yes☐ No
	Exhibits 11-14: Cost Forms **(Intentionally Omitted)**	NOT APPLICABLE
	Exhibits 15 –19: Living Wage Forms **(Intentionally Omitted)**	NOT APPLICABLE
	Exhibit 20: Charitable Contribution Certification	☐Yes ☐ No
	Exhibit 21: Transitional Job Opportunities Preference Program Application **(Intentionally Omitted)**	NOT APPLICABLE
	Exhibit 22: Certification of Compliance with County's Default Property Tax Reduction Program	☐Yes ☐ No
	Exhibit 23: Request for DVBE Preference Program Consideration **(Intentionally Omitted)**	NOT APPLICABLE
	Exhibit 24: Proposer's Pending Litigation and/or Judgments **(Include in Section A.4 of proposal)**	☐Yes ☐ No
	Exhibit 25A: Mandatory Intent to Apply Form for Category 1	☐Yes ☐ No
	Exhibit 25B: Mandatory Intent to Apply Form for Category 2	☐Yes ☐ No
	Exhibit 26A: Proposer's Minimum Mandatory Qualifications Form for Category 1 **(Include in Section A.2 of proposal)**	☐Yes ☐ No
	Exhibit 26B: Proposer's Minimum Mandatory Qualifications Form for Category 2 **(Include in Section A.2 of proposal)**	☐Yes ☐ No
	Exhibit 27: Sample Scope of Work and Template **(Include in Section F.5 of proposal)**	☐Yes ☐ No
	Exhibit 28: Logic Model Instructions and Template **(Include in Section F.1 of proposal)**	☐Yes ☐ No
	Exhibit 29: Proposer's Funding Disclosure Form for Category 1 **(Include in Section H of proposal)**	☐Yes ☐ No
	Exhibit 30A: Community Advisory Board Affidavit for Category 1 (Include in Section F.3.1 of proposal)	☐Yes ☐ No
	Exhibit 30B: Community Advisory Board Affidavit for Category 2 (Include in Section F.3.1 of proposal)	☐Yes ☐ No
	Exhibit 31: Letter of Concurrence (Include in Section F.3.1 of proposal)	☐Yes ☐ No
	Exhibit 32A: Program Components Checklist for Category 1 **(Include in Section F.3.1 of proposal)**	☐Yes ☐ No
	Exhibit 32B: Program Components Checklist for Category 2 **(Include in Section F.3.1 of proposal)**	☐Yes ☐ No
	Exhibit 33: Proposal Submission Checklist **(Include after the proposal's Table of Contents)**	☐Yes ☐ No

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
APPENDIX D, REQUIRED FORMS
EXHIBIT 33- PROPOSAL SUBMISSION CHECKLIST

PROPOSER'S NAME:	

PART 2: PROPOSED PROGRAM AND BUDGET SECTION – CATEGORY 1: HIV AND STD PREVENTION SERVICES FOR YMSM

For Part 2 of the proposal, Proposer must note that Proposer s applying for more than one (1) service category and/or cluster area, under Category 1, Proposer must provide a separate "Part 2" for each service category and/or cluster area for which Proposer is applying for funding. Proposer should refer to RFP Paragraph 7.8.5, Part 2: Proposed Program and Budget Section – Category 1: HIV and STD Prevention Services for YMSM for further information regarding the proposal format for this section. .

RFP Reference	RFP Requirement	Submitted/Included?
7.8.5.1	Executive Summary – Category 1 (Section E)	☐Yes ☐ No
7.8.5.2	Proposer's Approach to Providing Required Services Category 1 (Section F)	☐Yes ☐ No
7.8.5.2, A	Logic Model Template – Category 1 (Section F.1), **must also include:**	☐Yes ☐ No
	1) Exhibit 28: Logic Model Instructions and Template	☐Yes ☐ No
7.8.5.2, B	Statement of Need – Category 1 (Section F.2)	☐Yes ☐ No
7.8.5.2, C	Program Plan – Category 1 (Section F.3)	☐Yes ☐ No
7.8.5.2, C, 1)	Program Design – Category 1 (Section F.3.1), **must also include:**	☐Yes ☐ No
	1) Exhibit 32A: Program Components Checklist for Category 1	☐Yes ☐ No
7.8.5.2, C, 2)	Expected Outcomes – Category 1 (Section F.3.2)	☐Yes ☐ No
7.8.5.2, D)	Management Plan – Category 1 (Section F.4)	☐Yes ☐No
7.8.5.2, D, 1)	Organizational Capacity and Relationships – Category 1 (Section F.4.1), **must also include:**	☐Yes ☐No
	1) Resumes of key staff	☐Yes ☐ No
	2) Organizational Chart	☐Yes ☐ No
7.8.5.2, D, 2)	Staffing and In-kind Support Plan – Category 1 (Section F.4.2)	☐Yes ☐ No
7.8.5.2, D, 3)	Community Advisory Support Plan – Category 1 (Section F.4.3)	☐Yes ☐ No
7.8.5.2, D,4)	Data Reporting Plan – Category 1 (Section F.4.4)	☐Yes ☐ No
7.8.5.2, E	Scope of Work - Units of Service – Category 1 (Section F.5), must also include: 1) Exhibit 27: Sample Scope of Work and Template	☐Yes ☐ No
7.8.5.3	Evaluation and Quality Management Plan – Category 1 (Section G)	☐Yes ☐ No
	Program Budget – Category 1 (Section H), **must also include:**	☐Yes ☐ No

7.8.5.4	Program Concept and Component Related Costs:	
	1) Appendix C-1A: 1-Page Budget Narrative	☐Yes ☐No
	2) Appendix C-1B: Line Item Budget	☐Yes ☐No
	3) Appendix C-1C: Budget Summary Justification	☐Yes ☐No
	HIV and STD Program Component Related Costs:	
	1) Appendix C-1D: 1-Page Budget Narrative	☐Yes ☐No
	2) Appendix C-1E: Line Item Budget	☐Yes ☐No
	3) Appendix C-1F: Budget Summary Justification	☐Yes ☐No
	Disclosure of Additional Resources for HIV and STD Prevention Services	
	1) Exhibit 29: Proposer's Funding Disclosure Form for Category 1	☐ Yes ☐ No
	2) Appendix C-1G: 1-Page Exhibit 29 Supplemental	☐ Yes ☐ No
7.8.5.4	1) Appendix C-1H: Total Program Cost	☐ Yes ☐No

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
APPENDIX D, REQUIRED FORMS
EXHIBIT 33- PROPOSAL SUBMISSION CHECKLIST

PROPOSER'S NAME:	

PART 2: PROPOSED PROGRAM AND BUDGET SECTION – CATEGORY 2: HIV AND STD PREVENTION SERVICES FOR TRANSGENDER INDIVIDUALS

RFP Reference	RFP Requirement	Submitted/Included?
7.8.6.1	Executive Summary – Category 2 (Section E)	☐Yes ☐ No
7.8.6.2, A	Proposer's Approach to Providing Required Services Category 2 (Section F)	☐Yes ☐ No
	Logic Model Template – Category 2 (Section F.1), **must also include:**	☐Yes ☐ No
	1) Exhibit 28: Logic Model Instructions and Template	☐Yes ☐ No
7.8.6.2, B	Statement of Need – Category 2 (Section F.2)	☐Yes ☐ No
7.8.6.2, C, 1)	Program Plan – Category 2 (Section F.3)	☐Yes ☐ No
	Program Design – Category 2 (Section F.3.1), **must also include:**	☐Yes ☐ No
	1) Exhibit 32B: Program Components Checklist for Category 2	☐Yes ☐ No
7.8.6.2, C, 2)	Expected Outcomes – Category 2 (Section F.3.2)	☐Yes ☐ No
7.8.6.2, D	Management Plan – Category 2 (Section F.4)	☐Yes ☐ No
7.8.6.2, D, 1)	Organizational Capacity and Relationships – Category 2 (Section F.4.1), **must also include:**	☐Yes ☐ No
	1) Resumes of key staff	☐Yes ☐ No
	2) Organizational Chart	☐Yes ☐ No
7.8.6.2, D, 2)	Staffing and In-kind Support Plan – Category 2 (Section F.4.2)	☐Yes ☐ No
7.8.6.2, D, 3)	Community Advisory Support Plan – Category 2 (Section F.4.3)	☐Yes ☐No
7.8.6.2, D, 4)	Data Reporting Plan – Category 1 (Section F.4.4)	☐Yes ☐No
7.8.6.2, E)	Scope of Work - Units of Service – Category 2 (Section F.5), must also include: 1) Exhibit 27: Sample Scope of Work and Template	☐Yes ☐ No
7.8.6.3	Evaluation and Quality Management Plan – Category 2 (Section G)	☐Yes ☐ No
	Program Budget – Category 1 (Section H), **must also include:**	☐Yes ☐No
	Program Concept and Component Related Costs:	

7.8.6.4	1) Appendix C-1A: Page Budget Narrative	☐ Yes ☐ No
	2) Appendix C-1B: Line Item Budget	☐ Yes ☐ No
	3) Appendix C-1C: Budget Summary Justification	☐ Yes ☐ No
	HIV and STD Program Component Related Costs:	
	1) Appendix C-1D: 1-Page Budget Narrative	☐ Yes ☐ No
	2) Appendix C-1E: Line Item Budget	☐ Yes ☐ No
	3) Appendix C-1F: Budget Summary Justification	☐ Yes ☐ No
	Disclosure of Additional Resources for HIV and STD Prevention Services	
	1) Exhibit 29: Proposer's Funding Disclosure Form for Category 2	☐ Yes ☐ No
	2) Appendix C-1G: 1-Page Exhibit 29 Supplemental	☐ Yes ☐ No
7.8.6.4	1) Appendix C-1H: Total Program Costs	☐ Yes ☐ No

Signature of Authorized Representative of Proposing/Contracting Entity:	Date:
Print Name:	Title:

REQUEST FOR PROPOSALS (RFP) TRANSMITTAL TO REQUEST A SOLICITATION REQUIREMENTS REVIEW

A Solicitation Requirements Review must be received by the County within 10 business days of issuance of the solicitation document

Proposer Name:	Date of Request:
Project Title: PROMOTING HEALTH CARE ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs	Project No. RFP No.: 2015-003

A **Solicitation Requirements Review** is being requested because the Proposer asserts that they are being unfairly disadvantage for the following reason(s): *(check all that apply)*

- ☐ Application of **Minimum Requirements**
- ☐ Application of **Evaluation Criteria**
- ☐ Application of **Business Requirements**
- ☐ Due to **unclear instructions**, the process may result in the County not receiving the best possible responses

I understand that this request must be received by the County within **10 business days** of issuance of the solicitation document.

For each area contested, Proposer must explain in detail the factual reasons for the requested review. *(Attach additional pages and supporting documentation as necessary.)*

Request submitted by:

_____ _____

(Name) *(Title)*

For County use only

Date Transmittal Received by County: _____ Date Solicitation Released:_____

Reviewed by:

Results of Review - Comments:

Date Response sent to Proposer:_____

COUNTY OF LOS ANGELES
POLICY ON DOING BUSINESS WITH SMALL BUSINESS

Forty-two percent of businesses in Los Angeles County have five or fewer employees. Only about four percent of businesses in the area exceed 100 employees. According to the Los Angeles Times and local economists, it is not large corporations, but these small companies that are generating new jobs and helping move Los Angeles County out of its worst recession in decades.

WE RECOGNIZE. . . .

The importance of small business to the County. . .

- in fueling local economic growth
- providing new jobs
- creating new local tax revenues
- offering new entrepreneurial opportunity to those historically under-represented in business

The County can play a positive role in helping small business grow. . .

- as a multi-billion dollar purchaser of goods and services
- as a broker of intergovernmental cooperation among numerous local jurisdictions
- by greater outreach in providing information and training
- by simplifying the bid/proposal process
- by maintaining selection criteria which are fair to all
- by streamlining the payment process

WE THEREFORE SHALL:

1. Constantly seek to streamline and simplify our processes for selecting our vendors and for conducting business with them.

2. Maintain a strong outreach program, fully-coordinated among our departments and districts, as well as other participating governments to: a) inform and assist the local business community in competing to provide goods and services; b) provide for ongoing dialogue with and involvement by the business community in implementing this policy.

3. Continually review and revise how we package and advertise solicitations, evaluate and select prospective vendors, address subcontracting and conduct business with our vendors, in order to: a) expand opportunity for small business to compete for our business; and b) to further opportunities for all businesses to compete regardless of size.

4. Insure that staff who manage and carry out the business of purchasing goods and services are well trained, capable and highly motivated to carry out the letter and spirit of this policy.

2.203.010 Findings.

The board of supervisors makes the following findings. The county of Los Angeles allows its permanent, full-time employees unlimited jury service at their regular pay. Unfortunately, many businesses do not offer or are reducing or even eliminating compensation to employees who serve on juries. This creates a potential financial hardship for employees who do not receive their pay when called to jury service, and those employees often seek to be excused from having to serve. Although changes in the court rules make it more difficult to excuse a potential juror on grounds of financial hardship, potential jurors continue to be excused on this basis, especially from longer trials. This reduces the number of potential jurors and increases the burden on those employers, such as the county of Los Angeles, who pay their permanent, full-time employees while on juror duty. For these reasons, the county of Los Angeles has determined that it is appropriate to require that the businesses with which the county contracts possess reasonable jury service policies. (Ord. 2002-0015 § 1 (part), 2002)

2.203.020 Definitions.

The following definitions shall be applicable to this chapter:

A. "Contractor" means a person, partnership, corporation or other entity which has a contract with the county or a subcontract with a county contractor and has received or will receive an aggregate sum of $50,000 or more in any 12-month period under one or more such contracts or subcontracts.

B. "Employee" means any California resident who is a full-time employee of a contractor under the laws of California.

C. "Contract" means any agreement to provide goods to, or perform services for or on behalf of, the county but does not include:

1. A contract where the board finds that special circumstances exist that justify a waiver of the requirements of this chapter; or

2. A contract where federal or state law or a condition of a federal or state program mandates the use of a particular contractor; or

3. A purchase made through a state or federal contract; or

4. A monopoly purchase that is exclusive and proprietary to a specific manufacturer, distributor, or reseller, and must match and inter-member with existing supplies, equipment or systems maintained by the county pursuant to the Los Angeles County Purchasing Policy and Procedures Manual, Section P-3700 or a successor provision; or

5. A revolving fund (petty cash) purchase pursuant to the Los Angeles County Fiscal Manual, Section 4.4.0 or a successor provision; or

6. A purchase card purchase pursuant to the Los Angeles County Purchasing Policy and Procedures Manual, Section P-2810 or a successor provision; or

7. A non-agreement purchase with a value of less than $5,000 pursuant to the Los Angeles County Purchasing Policy and Procedures Manual, Section A-0300 or a successor provision; or

8. A bona fide emergency purchase pursuant to the Los Angeles County Purchasing Policy and Procedures Manual, Section PP-1100 or a successor provision.

D. "Full time" means 40 hours or more worked per week, or a lesser number of hours if:

1. The lesser number is a recognized industry standard as determined by the chief administrative officer, or

2. The contractor has a long-standing practice that defines the lesser number of hours as full time.

E. "County" means the county of Los Angeles or any public entities for which the board of supervisors is the governing body. (Ord. 2002-0040 § 1, 2002: Ord. 2002-0015 § 1 (part), 2002)

2.203.030 Applicability.

This chapter shall apply to contractors who enter into contracts that commence after July 11, 2002. This chapter shall also apply to contractors with existing contracts which are extended into option years that commence after July 11, 2002. Contracts that commence after May 28, 2002, but before July 11, 2002, shall be subject to the provisions of this chapter only if the solicitations for such contracts stated that the chapter would be applicable. (Ord. 2002-0040 § 2, 2002: Ord. 2002-0015 § 1 (part), 2002)

2.203.040 Contractor Jury Service Policy.

A contractor shall have and adhere to a written policy that provides that its employees shall receive from the contractor, on an annual basis, no less than five days of regular pay for actual jury service. The policy may provide that employees deposit any fees received for such jury service with the contractor or that the contractor deduct from the employees' regular pay the fees received for jury service. (Ord. 2002-0015 § 1 (part), 2002)

2.203.050 Other Provisions.

A. Administration. The chief administrative officer shall be responsible for the administration of this chapter. The chief administrative officer may, with the advice of county counsel, issue interpretations of the provisions of this chapter and shall issue written instructions on the implementation and ongoing administration of this chapter. Such instructions may provide for the delegation of functions to other county departments.

B. Compliance Certification. At the time of seeking a contract, a contractor shall certify to the county that it has and adheres to a policy consistent with this chapter or will have and adhere to such a policy prior to award of the contract. (Ord. 2002-0015 § 1 (part), 2002)

2.203.060 Enforcement and Remedies.

For a contractor's violation of any provision of this chapter, the county department head responsible for administering the contract may do one or more of the following:

1. Recommend to the board of supervisors the termination of the contract; and/or,

2. Pursuant to chapter 2.202, seek the debarment of the contractor. (Ord. 2002-0015 § 1 (part), 2002)

2.203.070. Exceptions.

A. Other Laws. This chapter shall not be interpreted or applied to any contractor or to any employee in a manner inconsistent with the laws of the United States or California.

B. Collective Bargaining Agreements. This chapter shall be superseded by a collective bargaining agreement that expressly so provides.

C. Small Business. This chapter shall not be applied to any contractor that meets all of the following:

1. Has ten or fewer employees during the contract period; and,

2. Has annual gross revenues in the preceding twelve months which, if added to the annual amount of the contract awarded, are less than $500,000; and,

3. Is not an affiliate or subsidiary of a business dominant in its field of operation.

"Dominant in its field of operation" means having more than ten employees and annual gross revenues in the preceding twelve months which, if added to the annual amount of the contract awarded, exceed $500,000.

"Affiliate or subsidiary of a business dominant in its field of operation" means a business which is at least 20 percent owned by a business dominant in its field of operation, or by partners, officers, directors, majority stockholders, or their equivalent, of a business dominant in that field of operation. (Ord. 2002-0015 § 1 (part), 2002)

2.203.090. Severability.

If any provision of this chapter is found invalid by a court of competent jurisdiction, the remaining provisions shall remain in full force and effect. (Ord. 2002-0015 § 1 (part), 2002)

LISTING OF CONTRACTORS DEBARRED IN LOS ANGELES COUNTY

List of Debarred Contractors in Los Angeles County may be obtained by going to the following website:

http://doingbusiness.lacounty.gov/DebarmentList.htm

IRS NOTICE 1015

Latest version is available from IRS website at
http://www.irs.gov/pub/irs-pdf/n1015.pdf

Department of the Treasury
Internal Revenue Service

Notice 1015

(Rev. December 2013)

Have You Told Your Employees About the Earned Income Credit (EIC)?

What is the EIC?

The EIC is a refundable tax credit for certain workers.

Which Employees Must I Notify About the EIC?

You must notify each employee who worked for you at any time during the year and from whom you did not withhold income tax. However, you do not have to notify any employee who claimed exemption from withholding on Form W-4, Employee's Withholding Allowance Certificate.

Note. You are encouraged to notify each employee whose wages for 2013 are less than $51,567 that he or she may be eligible for the EIC.

How and When Must I Notify My Employees?

You must give the employee one of the following:

- The IRS Form W-2, Wage and Tax Statement, which has the required information about the EIC on the back of Copy B.
- A substitute Form W-2 with the same EIC information on the back of the employee's copy that is on Copy B of the IRS Form W-2.
- Notice 797, Possible Federal Tax Refund Due to the Earned Income Credit (EIC).
- Your written statement with the same wording as Notice 797.

If you are required to give Form W-2 and do so on time, no further notice is necessary if the Form W-2 has the required information about the EIC on the back of the employee's copy. If a substitute Form W-2 is given on time but does not have the required information, you must notify the employee within 1 week of the date the substitute Form W-2 is given. If Form W-2 is required but is not given on time, you must give the employee Notice 797 or your written statement by the date Form W-2 is required to be given. If Form W-2 is not required, you must notify the employee by February 7, 2014.

You must hand the notice directly to the employee or send it by first-class mail to the employee's last known address. You will not meet the notification requirements by posting Notice 797 on an employee bulletin board or sending it through office mail. However, you may want to post the notice to help inform all employees of the EIC. You can get copies of the notice from IRS.gov or by calling 1-800-829-3676.

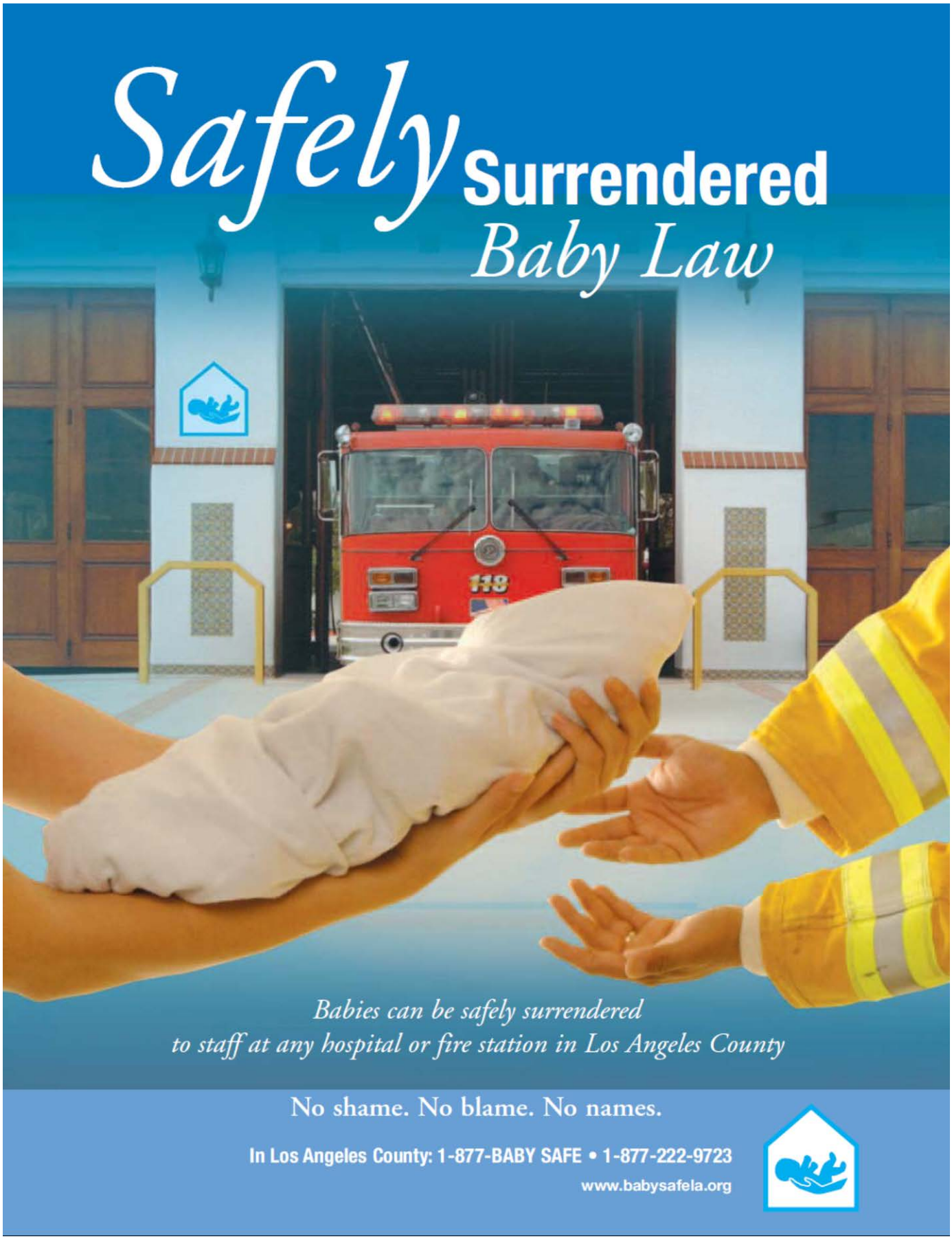
How Will My Employees Know If They Can Claim the EIC?

The basic requirements are covered in Notice 797. For more detailed information, the employee needs to see Pub. 596, Earned Income Credit (EIC), or the instructions for Form 1040, 1040A, or 1040EZ.

How Do My Employees Claim the EIC?

Eligible employees claim the EIC on their 2013 tax return. Even employees who have no tax withheld from their pay or owe no tax can claim the EIC and get a refund, but they must file a tax return to do so. For example, if an employee has no tax withheld in 2013 and owes no tax but is eligible for a credit of $800, he or she must file a 2013 tax return to get the $800 refund.

Notice 1015 (Rev. 12-2013)
Cat. No. 20599I


Safely Surrendered
Baby Law
Babies can be safely surrendered
to staff at any hospital or fire station in Los Angeles County
No shame. No blame. No names.
In Los Angeles County: 1-877-BABY SAFE • 1-877-222-9723
www.babysafela.org

Safely Surrendered Baby Law

In Los Angeles County: 1-877-BABY SAFE • 1-877-222-9723
www.babysafela.org

What is the Safely Surrendered Baby Law?

California's Safely Surrendered Baby Law allows parents or other persons, with lawful custody, which means anyone to whom the parent has given permission to confidentially surrender a baby. As long as the baby is three days (72 hours) of age or younger and has not been abused or neglected, the baby may be surrendered without fear of arrest or prosecution.

Every baby deserves a chance for a healthy life. If someone you know is considering abandoning a baby, let her know there are other options. For three days (72 hours) after birth, a baby can be surrendered to staff at any hospital or fire station in Los Angeles County.

How does it work?

A distressed parent who is unable or unwilling to care for a baby can legally, confidentially, and safely surrender a baby within three days (72 hours) of birth. The baby must be handed to an employee at a hospital or fire station in Los Angeles County. As long as the baby shows no sign of abuse or neglect, no name or other information is required. In case the parent changes his or her mind at a later date and wants the baby back, staff will use bracelets to help connect them to each other. One bracelet will be placed on the baby, and a matching bracelet will be given to the parent or other surrendering adult.

What if a parent wants the baby back?

Parents who change their minds can begin the process of reclaiming their baby within 14 days. These parents should call the Los Angeles County Department of Children and Family Services at **1-800-540-4000**.

Can only a parent bring in the baby?

No. While in most cases a parent will bring in the baby, the Law allows other people to bring in the baby if they have lawful custody.

Does the parent or surrendering adult have to call before bringing in the baby?

No. A parent or surrendering adult can bring in a baby anytime, 24 hours a day, 7 days a week, as long as the parent or surrendering adult surrenders the baby to someone who works at the hospital or fire station.

Does the parent or surrendering adult have to tell anything to the people taking the baby?

No. However, hospital or fire station personnel will ask the surrendering party to fill out a questionnaire designed to gather important medical history information, which is very useful in caring for the baby. The questionnaire includes a stamped return envelope and can be sent in at a later time.

What happens to the baby?

The baby will be examined and given medical treatment. Upon release from the hospital, social workers immediately place the baby in a safe and loving home and begin the adoption process.

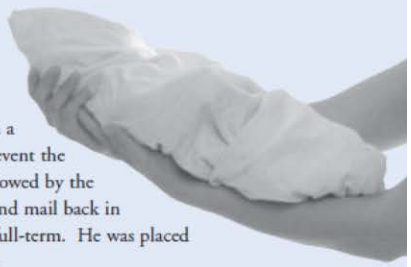
What happens to the parent or surrendering adult?

Once the parent or surrendering adult surrenders the baby to hospital or fire station personnel, they may leave at any time.

Why is California doing this?

The purpose of the **Safely Surrendered Baby Law** is to protect babies from being abandoned, hurt or killed by their parents. You may have heard tragic stories of babies left in dumpsters or public bathrooms. Their parents may have been under severe emotional distress. The mothers may have hidden their pregnancies, fearful of what would happen if their families found out. Because they were afraid and had no one or nowhere to turn for help, they abandoned their babies. Abandoning a baby is illegal and places the baby in extreme danger. Too often, it results in the baby's death. The **Safely Surrendered Baby Law** prevents this tragedy from ever happening again in California.

A baby's story



Early in the morning on April 9, 2005, a healthy baby boy was safely surrendered to nurses at Harbor-UCLA Medical Center. The woman who brought the baby to the hospital identified herself as the baby's aunt and stated the baby's mother had asked her to bring the baby to the hospital on her behalf. The aunt was given a bracelet with a number matching the anklet placed on the baby; this would provide some identification in the event the mother changed her mind about surrendering the baby and wished to reclaim the baby in the 14-day period allowed by the Law. The aunt was also provided with a medical questionnaire and said she would have the mother complete and mail back in the stamped return envelope provided. The baby was examined by medical staff and pronounced healthy and full-term. He was placed with a loving family that had been approved to adopt him by the Department of Children and Family Services.


Ley de Entrega de Bebés Sin Peligro
Los recién nacidos pueden ser entregados en forma segura al personal de cualquier hospital o cuartel de bomberos del Condado de Los Ángeles
Sin pena. Sin culpa. Sin nombres.
En el Condado de Los Ángeles: 1-877-BABY SAFE • 1-877-222-9723
www.babysafela.org

En el Condado de Los Ángeles: 1-877-BABY SAFE • 1-877-222-9723
www.babysafela.org

Ley de Entrega de Bebés *Sin Peligro*

¿Qué es la Ley de Entrega de Bebés sin Peligro?

La Ley de Entrega de Bebés sin Peligro de California permite la entrega confidencial de un recién nacido por parte de sus padres u otras personas con custodia legal, es decir cualquier persona a quien los padres le hayan dado permiso. Siempre que el bebé tenga tres días (72 horas) de vida o menos, y no haya sufrido abuso ni negligencia, pueden entregar al recién nacido sin temor de ser arrestados o procesados.

Cada recién nacido se merece la oportunidad de tener una vida saludable. Si alguien que usted conoce está pensando en abandonar a un recién nacido, infórmele que tiene otras opciones. Hasta tres días (72 horas) después del nacimiento, se puede entregar un recién nacido al personal de cualquier hospital o cuartel de bomberos del condado de Los Angeles.

¿Cómo funciona?

El padre/madre con dificultades que no pueda o no quiera cuidar de su recién nacido puede entregarlo en forma legal, confidencial y segura dentro de los tres días (72 horas) del nacimiento. El bebé debe ser entregado a un empleado de cualquier hospital o cuartel de bomberos del Condado de Los Ángeles. Siempre que el bebé no presente signos de abuso o negligencia, no será necesario suministrar nombres ni información alguna. Si el padre/madre cambia de opinión posteriormente y desea recuperar a su bebé, los trabajadores utilizarán brazaletes para poder vincularlos. El bebé llevará un brazalete y el padre/madre o el adulto que lo entregue recibirá un brazalete igual.

¿Qué pasa si el padre/madre desea recuperar a su bebé?

Los padres que cambien de opinión pueden comenzar el proceso de reclamar a su recién nacido dentro de los 14 días. Estos padres deberán llamar al Departamento de Servicios para Niños y Familias (Department of Children and Family Services) del Condado de Los Ángeles al **1-800-540-4000**.

¿Sólo los padres podrán llevar al recién nacido?

No. Si bien en la mayoría de los casos son los padres los que llevan al bebé, la ley permite que otras personas lo hagan *si tienen custodia legal.*

¿Los padres o el adulto que entrega al bebé deben llamar antes de llevar al bebé?

No. El padre/madre o adulto puede llevar al bebé en cualquier momento, las 24 horas del día, los 7 días de la semana, siempre y cuando entreguen a su bebé a un empleado del hospital o cuartel de bomberos.

¿Es necesario que el padre/madre o adulto diga algo a las personas que reciben al bebé?

No. Sin embargo, el personal del hospital o cuartel de bomberos le pedirá a la persona que entregue al bebé que llene un cuestionario con la finalidad de recabar antecedentes médicos importantes, que resultan de gran utilidad para cuidar bien del bebé. El cuestionario incluye un sobre con el sello postal pagado para enviarlo en otro momento.

¿Qué pasará con el bebé?

El bebé será examinado y le brindarán atención médica. Cuando le den el alta del hospital, los trabajadores sociales inmediatamente ubicarán al bebé en un hogar seguro donde estará bien atendido, y se comenzará el proceso de adopción.

¿Qué pasará con el padre/madre o adulto que entregue al bebé?

Una vez que los padres o adulto hayan entregado al bebé al personal del hospital o cuartel de bomberos, pueden irse en cualquier momento.

¿Por qué se está haciendo esto en California? ?

La finalidad de la **Ley de Entrega de Bebés sin Peligro** es proteger a los bebés para que no sean abandonados, lastimados o muertos por sus padres. Usted probablemente haya escuchado historias trágicas sobre bebés abandonados en basureros o en baños públicos. Los padres de esos bebés probablemente hayan estado pasando por dificultades emocionales graves. Las madres pueden haber ocultado su embarazo, por temor a lo que pasaría si sus familias se enteraran. Abandonaron a sus bebés porque tenían miedo y no tenían nadie a quien pedir ayuda. El abandono de un recién nacido es ilegal y pone al bebé en una situación de peligro extremo. Muy a menudo el abandono provoca la muerte del bebé. La **Ley de Entrega de Bebés sin Peligro** impide que vuelva a suceder esta tragedia en California.

Historia de un bebé

A la mañana temprano del día 9 de abril de 2005, se entregó un recién nacido saludable a las enfermeras del Harbor-UCLA Medical Center. La mujer que llevó el recién nacido al hospital se dio a conocer como la tía del bebé, y dijo que la madre le había pedido que llevara al bebé al hospital en su nombre. Le entregaron a la tía un brazalete con un número que coincidía con la pulsera del bebé; esto serviría como identificación en caso de que la madre cambiara de opinión con respecto a la entrega del bebé y decidiera recuperarlo dentro del período de 14 días que permite esta ley. También le dieron a la tía un cuestionario médico, y ella dijo que la madre lo llenaría y lo enviaría de vuelta dentro del sobre con franqueo pagado que le habían dado. El personal médico examinó al bebé y se determinó que estaba saludable y a término. El bebé fue ubicado con una buena familia que ya había sido aprobada para adoptarlo por el Departamento de Servicios para Niños y Familias.

APPENDIX K
LIVING WAGE ORDINANCE

INTENTIONALLY OMITTED

Title 2 ADMINISTRATION
DETERMINATIONS OF CONTRACTOR NON-RESPONSIBILITY
AND CONTRACTOR DEBARMENT

2.202.010 - Findings and declarations.

A. The board of supervisors finds that, in order to promote integrity in the county's contracting processes and to protect the public interest, the county's policy shall be to conduct business only with responsible contractors. The board of supervisors further finds that debarment is to be imposed only in the public interest for the county's protection and not for the purpose of punishment.

B. Determinations of contractor non-responsibility and contractor debarment shall be made in accordance with the procedures set forth in the ordinance codified in this chapter and implementation instructions issued by the Internal Services Department.

(Ord. 2014-0035 § 1, 2014: Ord. 2005-0066 § 1, 2005: Ord. 2000-0011 § 1 (part), 2000.)

2.202.020 - Definitions.

For purposes of this chapter, the following definitions apply:

A. "Contractor" means a person, partnership, corporation, or other entity who has contracted with, or is seeking to contract with, the county or a nonprofit corporation created by the county to provide goods to, or perform services for or on behalf of, the county or a nonprofit corporation created by the county. A contractor includes a contractor, subcontractor, vendor, or any of their respective officers, directors, owners, co-owners, shareholders, partners, managers, employees, or other individuals associated with the contractor, subcontractor, or vendor who participated in, knew of, or should reasonably have known of conduct that results in a finding of non-responsibility or debarment.

B. "Contract" means any agreement to provide goods to, or perform services for or on behalf of, the county or a nonprofit corporation created by the county.

C. "Debarment" means an action taken by the county which results in a contractor being prohibited from bidding or proposing on, being awarded and/or performing

work on a contract with the county. A contractor who has been determined by the county to be subject to such a prohibition is "debarred."

D. "Department head" means either the head of a department responsible for administering a particular contract for the county or the designee of same.

E. "County" means the county of Los Angeles, any public entities for which the board of supervisors is the governing body, and any joint powers authorities of which the county is a member that have adopted county contracting procedures.

F. "Contractor hearing board" means the persons designated to preside over contractor debarment hearings and make recommendations on debarment to the board of supervisors.

G. Determination of "non-responsibility" means an action taken by the county which results in a contractor who submitted a bid or proposal on a particular contract being prohibited from being awarded and/or performing work on that contract. A contractor who has been determined by the county to be subject to such a prohibition is "non-responsible" for purposes of that particular contract.

H. "Bid or proposal" means a bid, proposal, or any other response to a solicitation submitted by or on behalf of a contractor seeking an award of a contract.

(Ord. 2014-0035 § 2, 2014: Ord. 2005-0066 § 2, 2005: Ord. 2004-0009 § 1, 2004: Ord. 2000-0011 § 1 (part), 2000.)

2.202.030 - Determination of contractor non-responsibility.

A. Prior to a contract being awarded by the county, the county may determine that a contractor submitting a bid or proposal is non-responsible for purposes of that contract. In the event that the county determines that a contractor is non-responsible for a particular contract, said contractor shall be prohibited from being awarded and/or performing work on that contract.

B. The county may declare a contractor to be non-responsible for purposes of a particular contract if the county, in its discretion, finds that the contractor has done any of the following: (1) violated a term of a contract with the county or a nonprofit corporation created by the county; (2) committed an act or omission which negatively reflects on the contractor's quality, fitness, or capacity to perform a contract with the county, any other public entity, or a nonprofit corporation created by the county, or engaged in a pattern or practice which negatively reflects on same; (3) committed an act or omission which indicates a lack of business integrity or business honesty; or (4) made or submitted a false claim against the county or any other public entity.

C. The decision by the county to find a contractor non-responsible for a particular contract is within the discretion of the county. The seriousness and extent of the contractor's acts, omissions, patterns, or practices as well as any relevant mitigating or aggravating factors, including those described in Subsection

2.202.040 (E) below, may be considered by the county in determining whether a contractor should be deemed non-responsible.

D. Before making a determination of non-responsibility pursuant to this chapter, the department head shall give written notice to the contractor of the basis for the proposed non-responsibility determination, and shall advise the contractor that a non-responsibility hearing will be scheduled on a date certain. Thereafter, the department head shall conduct a hearing where evidence on the proposed non-responsibility determination is presented. The contractor and/or attorney or other authorized representative of the contractor shall be afforded an opportunity to appear at the non-responsibility hearing and to submit documentary evidence, present witnesses, and offer rebuttal evidence. After such hearing, the department head shall prepare a proposed decision, which shall contain a recommendation regarding whether the contractor should be found non-responsible with respect to the contract(s) at issue. A record of the hearing, the proposed decision, and any recommendation shall be presented to the board of supervisors. The board of supervisors may, in its discretion, limit any further hearing to the presentation of evidence not previously presented. The board of supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the department head. A non-responsibility finding shall become final upon approval by the board of supervisors.

(Ord. 2005-0066 § 3, 2005: Ord. 2004-0009 § 2, 2004: Ord. 2000-0011 § 1 (part), 2000.)

2.202.040 - Debarment of contractors.

A. The county may debar a contractor who has had a contract with the county in the preceding three years and/or a contractor who has submitted a bid or proposal for a new contract with the county.

B. The county may debar a contractor if the county finds, in its discretion, that the contractor has done any of the following: (1) violated a term of a contract with the county or a nonprofit corporation created by the county; (2) committed an act or omission which negatively reflects on the contractor's quality, fitness, or capacity to perform a contract with the county, any other public entity, or a nonprofit corporation created by the county, or engaged in a pattern or practice which negatively reflects on same; (3) committed an act or omission which indicates a lack of business integrity or business honesty; or (4) made or submitted a false claim against the county or any other public entity.

C. The decision by the county to debar a contractor is within the discretion of the county. The seriousness and extent of the contractor's acts, omissions, patterns, or practices as well as any relevant mitigating or aggravating factors, including those described in Subsection (E) below, may be considered by the county in determining whether to debar a contractor and the period of debarment.

Generally, the period of debarment should not exceed five years. However, if circumstances warrant, the county may impose a longer period of debarment up to and including permanent debarment.

D. To impose a debarment period of longer than five years, and up to and including permanent debarment, in addition to the grounds described in Subsection (B) above, the county shall further find that the contractor's acts or omissions are of such an extremely serious nature that removal of the contractor from future county contracting opportunities for the specified period is necessary to protect the county's interests.

E. Mitigating and aggravating factors that the county may consider in determining whether to debar a contractor and the period of debarment include but are not limited to:

(1) The actual or potential harm or impact that results or may result from the wrongdoing.

(2) The frequency and/or number of incidents and/or duration of the wrongdoing.

(3) Whether there is a pattern or prior history of wrongdoing.

(4) A contractor's overall performance record. For example, the county may evaluate the contractor's activity cited as the basis for the debarment in the broader context of the contractor's overall performance history.

(5) Whether a contractor is or has been debarred, found non-responsible, or disqualified by another public entity on a basis of conduct similar to one or more of the grounds for debarment specified in this Section.

(6) Whether a contractor's wrongdoing was intentional or inadvertent. For example, the county may consider whether and to what extent a contractor planned, initiated, or carried out the wrongdoing.

(7) Whether a contractor has accepted responsibility for the wrongdoing and recognizes the seriousness of the misconduct that led to the grounds for debarment and/or has taken corrective action to cure the wrongdoing, such as establishing ethics training and implementing programs to prevent recurrence.

(8) Whether and to what extent a contractor has paid or agreed to pay criminal, civil, and administrative liabilities for the improper activity, and to what extent, if any, has the contractor made or agreed to make restitution.

(9) Whether a contractor has cooperated fully with the county during the investigation, and any court or administrative action. In determining the extent of cooperation, the county may consider when the cooperation

began and whether the contractor disclosed all pertinent information known to the contractor.

(10) Whether the wrongdoing was pervasive within a contractor's organization.

(11) The positions held by the individuals involved in the wrongdoing.

(12) Whether a contractor participated in, knew of, or tolerated the offense.

(13) Whether a contractor brought the activity cited as a basis for the debarment to the attention of the county in a timely manner.

(14) Whether a contractor has fully investigated the circumstances surrounding the cause for debarment and, if so, made the result of the investigation available to the county.

(15) Whether a contractor had effective standards of conduct and internal control systems in place at the time the questioned conduct occurred.

(16) Whether a contractor has taken appropriate disciplinary action against the individuals responsible for the activity which constitutes the cause for debarment.

(17) Other factors that are appropriate to the circumstances of a particular case.

(Ord. 2014-0035 § 4, 2014: Ord. 2005-0066 § 4, 2005: Ord. 2004-0009 § 3, 2004: Ord. 2000-0011 § 1 (part), 2000.)

F. Before making a debarment determination pursuant to this chapter, the department head shall give written notice to the contractor of the basis for the proposed debarment, and shall advise the contractor that a debarment hearing will be scheduled on a date certain. The contractor hearing board shall conduct a hearing where evidence on the proposed debarment is presented. The contractor and/or attorney or other authorized representative must be given an opportunity to appear at the debarment hearing and to submit documentary evidence, present witnesses, and offer rebuttal evidence at that hearing. After such hearing, the contractor hearing board shall prepare a proposed decision, which shall contain a recommendation regarding whether the contractor should be debarred and, if so, the appropriate length of time for the debarment. A record of the hearing, the proposed decision, and any recommendation shall be presented to the board of supervisors. The board of supervisors may, in its discretion, limit any further hearing to the presentation of evidence not previously presented. The board of supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the contractor hearing board. A debarment finding shall become final upon the approval of the board of supervisors.

G. In making a debarment determination, the board of supervisors may also, in its discretion and consistent with the terms of any existing contracts that the

contractor may have with the county, terminate any or all such existing contracts. In the event that any existing contract is terminated by the board of supervisors, the county shall maintain the right to pursue all other rights and remedies provided by the contract and/or applicable law.

H. With respect to a contractor who has been debarred for a period longer than five years, the contractor may, after the debarment has been in effect for at least five years, request that the county review the debarment determination to reduce the period of debarment or terminate the debarment. The county may consider a contractor's request to review a debarment determination based upon the following circumstances: (1) elimination of the grounds for which the debarment was imposed; (2) a bona fide change in ownership or management; (3) material evidence discovered after debarment was imposed; or (4) any other reason that is in the best interests of the county. A request for review shall be in writing, supported by documentary evidence, and submitted to the chair of the contractor hearing board. The chair of the contractor hearing board may either: 1) determine that the written request is insufficient on its face and deny the contractor's request for review; or (2) schedule the matter for consideration by the contractor hearing board which shall hold a hearing to consider the contractor's request for review, and, after the hearing, prepare a proposed decision and a recommendation to be presented to the board of supervisors. The board of supervisors may, in its discretion, limit any further hearing to the presentation of evidence not previously presented. The board of supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the contractor hearing board. A reduction of the period of the debarment or termination of the debarment shall become final upon the approval of the board of supervisors. (Ord. 2005-0066 § 4, 2005: Ord. 2004-0009 § 3, 2004: Ord. 2000-0011 § 1 (part), 2000.)

2.202.050 - Pre-emption.

In the event any contract is subject to federal and/or state laws that are inconsistent with the terms of the ordinance codified in this chapter, such laws shall control.

(Ord. 2000-0011 § 1 (part), 2000.)

2.202.060 - Severability.

If any section, subsection, subpart or provision of this chapter, or the application thereof to any person or circumstances, is held invalid, the remainder of the provisions of this chapter and the application of such to other persons or circumstances shall not be affected thereby.

(Ord. 2000-0011 § 1 (part), 2000.

APPENDIX M

GUIDELINES FOR ASSESSMENT OF PROPOSER LABOR LAW/PAYROLL VIOLATIONS

INTENTIONALLY OMITTED

BACKGROUND AND RESOURCES: CALIFORNIA CHARITIES REGULATION

There is a keen public interest in preventing misuse of charitable contributions. California's "Supervision of Trustees and Fundraisers for Charitable Purposes Act" regulates those raising and receiving charitable contributions. The "Nonprofit Integrity Act of 2004" (SB 1262, Chapter 919) tightened Charitable Purposes Act requirements for charitable organization administration and fundraising.

The Charitable Purposes Act rules cover California public benefit corporations, unincorporated associations, and trustee entities. They may include similar foreign corporations doing business or holding property in California. Generally, an organization is subject to the registration and reporting requirements of the Charitable Purposes Act if it is a California nonprofit public benefit corporation or is tax exempt under Internal Revenue Code § 501(c)(3), and not exempt from reporting under Government Code § 12583. Most educational institutions, hospitals, cemeteries, and religious organizations are exempt from Supervision of Trustees Act requirements.

Key new Charitable Purposes Act requirements affect executive compensation, fund-raising practices and documentation. Charities with over $2 million of revenues (excluding grants and service-contract funds a governmental entity requires to be accounted for) have new audit requirements. Charities required to have audits must also establish an audit committee whose members have no material financial interest in any entity doing business with the charity.

Organizations or persons that receive or raise charitable contributions are likely to be subject to the Charitable Purposes Act. A Proposer on Los Angeles County contracts must determine if it is subject to the Charitable Purposes Act and certify either that:

- It is not presently subject to the Act, but will comply if later activities make it subject, or,
- If subject, it is currently in compliance.

RESOURCES

The following references to resources are offered to assist Proposers who engage in charitable contributions activities. Each Proposer, however, is ultimately responsible to research and determine its own legal obligations and properly complete its compliance certification (Exhibit 20).

In California, supervision of charities is the responsibility of the Attorney General, whose website, **http://ag.ca.gov/** contains much information helpful to regulated charitable organizations.

1. LAWS AFFECTING NONPROFITS

The "Supervision of Trustees and Fundraisers for Charitable Purposes Act" is found at California Government Code §§ 12580 through 12599.7. Implementing regulations are found at Title 11, California Code of Regulations, §§ 300 through 312. In California, charitable solicitations ("advertising") are governed by Business & Professions Code §§ 17510 through 17510.95. Regulation of nonprofit corporations is found at Title 11, California Code of Regulations, §§ 999.1 through 999.5. (Amended regulations are pending.) Links to all of these rules are at: **http://ag.gov/charities/statutes.php/**

BACKGROUND AND RESOURCES: CALIFORNIA CHARITIES REGULATION

2. SUPPORT FOR NONPROFIT ORGANIZATIONS

Several organizations offer both complimentary and fee-based assistance to nonprofits, including in Los Angeles, the *Center for Nonprofit Management,* 606 S. Olive St #2450, Los Angeles, CA 90014 (213) 623-7080 **http://www.cnmsocal.org/**., and statewide, the *California Association of Nonprofits,* **http://www.canonprofits.org/**. Both organizations' websites offer information about how to establish and manage a charitable organization.

The above information, including the organizations listed, provided under this sub-section of this Appendix N is for informational purposes only. Nothing contained in this sub-section shall be construed as an endorsement by the County of Los Angeles of such organizations.

2.206.010 Findings and declarations.

The Board of Supervisors finds that significant revenues are lost each year as a result of taxpayers who fail to pay their tax obligations on time. The delinquencies impose an economic burden upon the County and its taxpayers. Therefore, the Board of Supervisors establishes the goal of ensuring that individuals and businesses that benefit financially from contracts with the County fulfill their property tax obligation. (Ord. No. 2009-0026 § 1 (part), 2009.)

2.206.020 Definitions.

The following definitions shall be applicable to this chapter:
A. “Contractor” shall mean any person, firm, corporation, partnership, or combination thereof, which submits a bid or proposal or enters into a contract or agreement with the County.
B. “County” shall mean the county of Los Angeles or any public entities for which the Board of Supervisors is the governing body.
C. “County Property Taxes” shall mean any property tax obligation on the County's secured or unsecured roll; except for tax obligations on the secured roll with respect to property held by a Contractor in a trust or fiduciary capacity or otherwise not beneficially owned by the Contractor.
D. “Department” shall mean the County department, entity, or organization responsible for the solicitation and/or administration of the contract.
E. “Default” shall mean any property tax obligation on the secured roll that has been deemed defaulted by operation of law pursuant to California Revenue and Taxation Code section 3436; or any property tax obligation on the unsecured roll that remains unpaid on the applicable delinquency date pursuant to California Revenue and Taxation Code section 2922; except for any property tax obligation dispute pending before the Assessment Appeals Board.
F. “Solicitation” shall mean the County’s process to obtain bids or proposals for goods and services.
G. “Treasurer-Tax Collector” shall mean the Treasurer and Tax Collector of the County of Los Angeles. (Ord. No. 2009-0026 § 1 (part), 2009.)

2.206.030 Applicability.

This chapter shall apply to all solicitations issued 60 days after the effective date of the ordinance codified in this chapter. This chapter shall also apply to all new, renewed, extended, and/or amended contracts entered into 60 days after the effective date of the ordinance codified in this chapter. (Ord. No. 2009-0026 § 1 (part), 2009.)

2.206.040 Required solicitation and contract language.

All solicitations and all new, renewed, extended, and/or amended contracts shall contain language which:
A. Requires any Contractor to keep County Property Taxes out of Default status at all times during the term of an awarded contract;
B. Provides that the failure of the Contractor to comply with the provisions in this chapter may prevent the Contractor from being awarded a new contract; and
C. Provides that the failure of the Contractor to comply with the provisions in this chapter may constitute a material breach of an existing contract, and failure to cure the breach within 10 days of notice by the County by paying the outstanding County Property Tax or making payments in a manner agreed to and approved by the Treasurer-Tax Collector, may subject the contract to suspension and/or termination. (Ord. No. 2009-0026 § 1 (part), 2009.)

2.206.050 Administration and compliance certification.

A. The Treasurer-Tax Collector shall be responsible for the administration of this chapter. The Treasurer-Tax Collector shall, with the assistance of the Chief Executive Officer, Director of Internal Services, and County Counsel, issue written instructions on the implementation and ongoing administration of this chapter. Such instructions may provide for the delegation of functions to other departments.
B. Contractor shall be required to certify, at the time of submitting any bid or proposal to the County, or entering into any new contract, or renewal, extension or amendment of an existing contract with the County, that it is in compliance with this chapter is not in Default on any County Property Taxes or is current in payments due under any approved payment arrangement. (Ord. No. 2009-0026 § 1 (part), 2009.)

2.206.060 Exclusions/Exemptions.

A. This chapter shall not apply to the following contracts:
1. Chief Executive Office delegated authority agreements under $50,000;
2. A contract where federal or state law or a condition of a federal or state program mandates the use of a particular contractor;
3. A purchase made through a state or federal contract;
4. A contract where state or federal monies are used to fund service related programs, including but not limited to voucher programs, foster care, or other social programs that provide immediate direct assistance;
5. Purchase orders under a master agreement, where the Contractor was certified at the time the master agreement was entered into and at any subsequent renewal, extension and/or amendment to the master agreement.
6. Purchase orders issued by Internal Services Department under $100,000 that is not the result of a competitive bidding process.
7. Program agreements that utilize Board of Supervisors' discretionary funds;
8. National contracts established for the purchase of equipment and supplies for and by the National Association of Counties, U.S. Communities Government Purchasing Alliance, or any similar related group purchasing organization;
9. A monopoly purchase that is exclusive and proprietary to a specific manufacturer, distributor, reseller, and must match and inter-member with existing supplies, equipment or systems maintained by the county pursuant to the Los Angeles Purchasing Policy and Procedures Manual, section P-3700 or a successor provision;
10. A revolving fund (petty cash) purchase pursuant to the Los Angeles County Fiscal Manual, section 4.6.0 or a successor provision;

11. A purchase card purchase pursuant to the Los Angeles County Purchasing Policy and Procedures Manual, section P-2810 or a successor provision;
12. A non-agreement purchase worth a value of less than $5,000 pursuant to the Los Angeles County Purchasing Policy and Procedures Manual, section A-0300 or a successor provision; or
13. A bona fide emergency purchase pursuant to the Los Angeles County Purchasing Policy and Procedures Manual section P-0900 or a successor provision;
14. Other contracts for mission critical goods and/or services where the Board of Supervisors determines that an exemption is justified.
B. Other laws. This chapter shall not be interpreted or applied to any Contractor in a manner inconsistent with the laws of the United States or California. (Ord. No. 2009-0026 § 1 (part), 2009.)

2.206.070 Enforcement and remedies.

A. The information furnished by each Contractor certifying that it is in compliance with this chapter shall be under penalty of perjury.
B. No Contractor shall willfully and knowingly make a false statement certifying compliance with this chapter for the purpose of obtaining or retaining a County contract.
C. For Contractor's violation of any provision of this chapter, the County department head responsible for administering the contract may do one or more of the following:
1. Recommend to the Board of Supervisors the termination of the contract; and/or,
2. Pursuant to chapter 2.202, seek the debarment of the contractor; and/or,
3. Recommend to the Board of Supervisors that an exemption is justified pursuant to Section 2.206.060.A.14 of this chapter or payment deferral as provided pursuant to the California Revenue and Taxation Code. (Ord. No. 2009-0026 § 1 (part), 2009.)

2.206.080 Severability.

If any provision of this chapter is found invalid by a court of competent jurisdiction, the remaining provisions shall remain in full force and effect. (Ord. No. 2009-0026 § 1 (part), 2009.)

APPENDIX P, P-1, P2, P-3, P-4

AND P-5

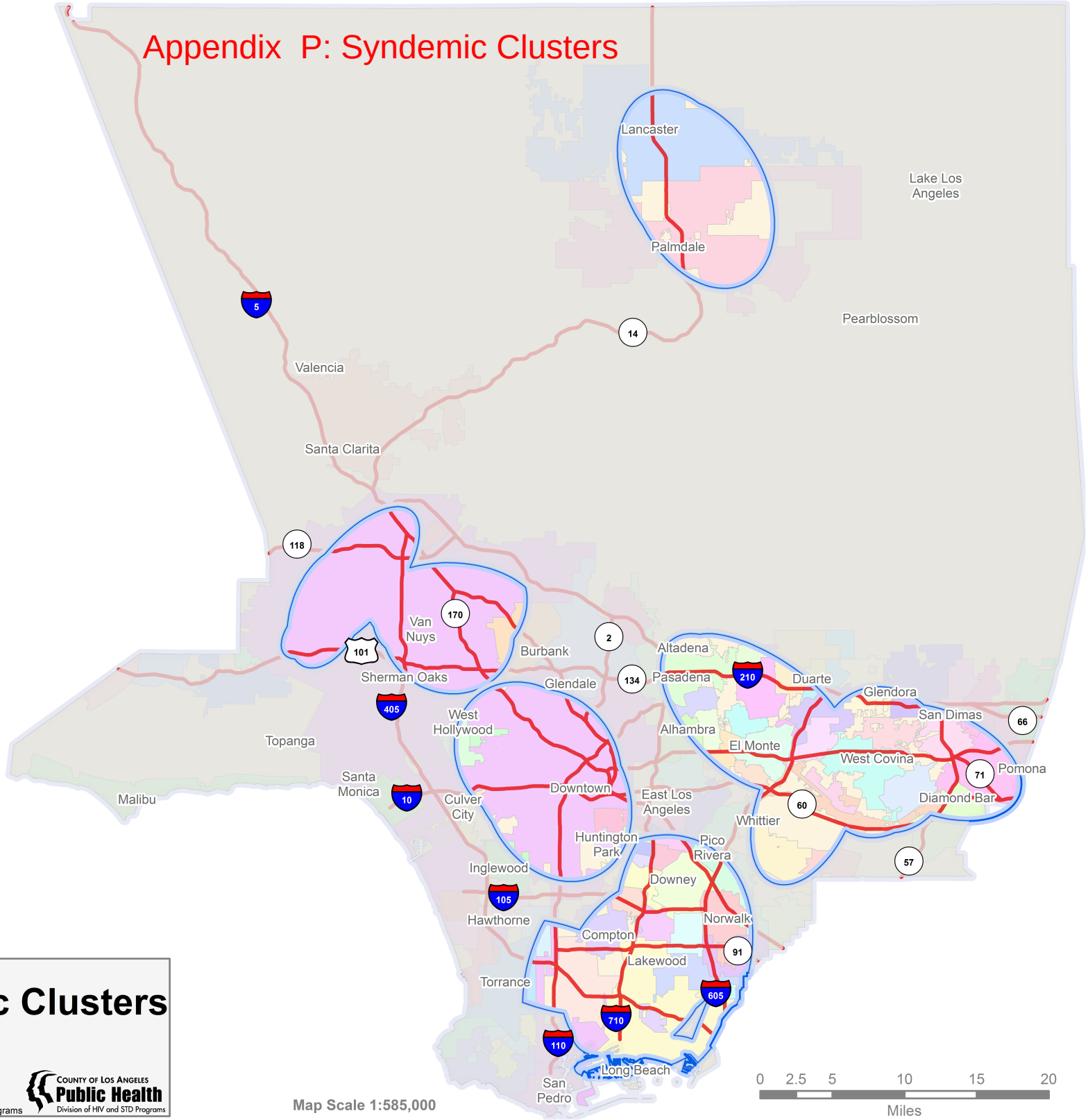
HEALTH CLUSTER AREA MAPS

PROMOTING HEALTH ENGAGEMENT AMONG VULNERABLE TARGET POPULATIONS AT RISK FOR OR LIVING WITH HIV AND STDs,

RFP NO.: 2015-003

Revised: 4/1/2015

Appendix P: Syndemic Clusters



HIV & STD Syndemic Clusters

Syndemic Clusters

Data Source: 2010 U.S. Census Tract Data U.S. Dept. of Commerce
HIV/STD Surveillance Data LA County Dept. of Public Health Division of HIV & STD Programs

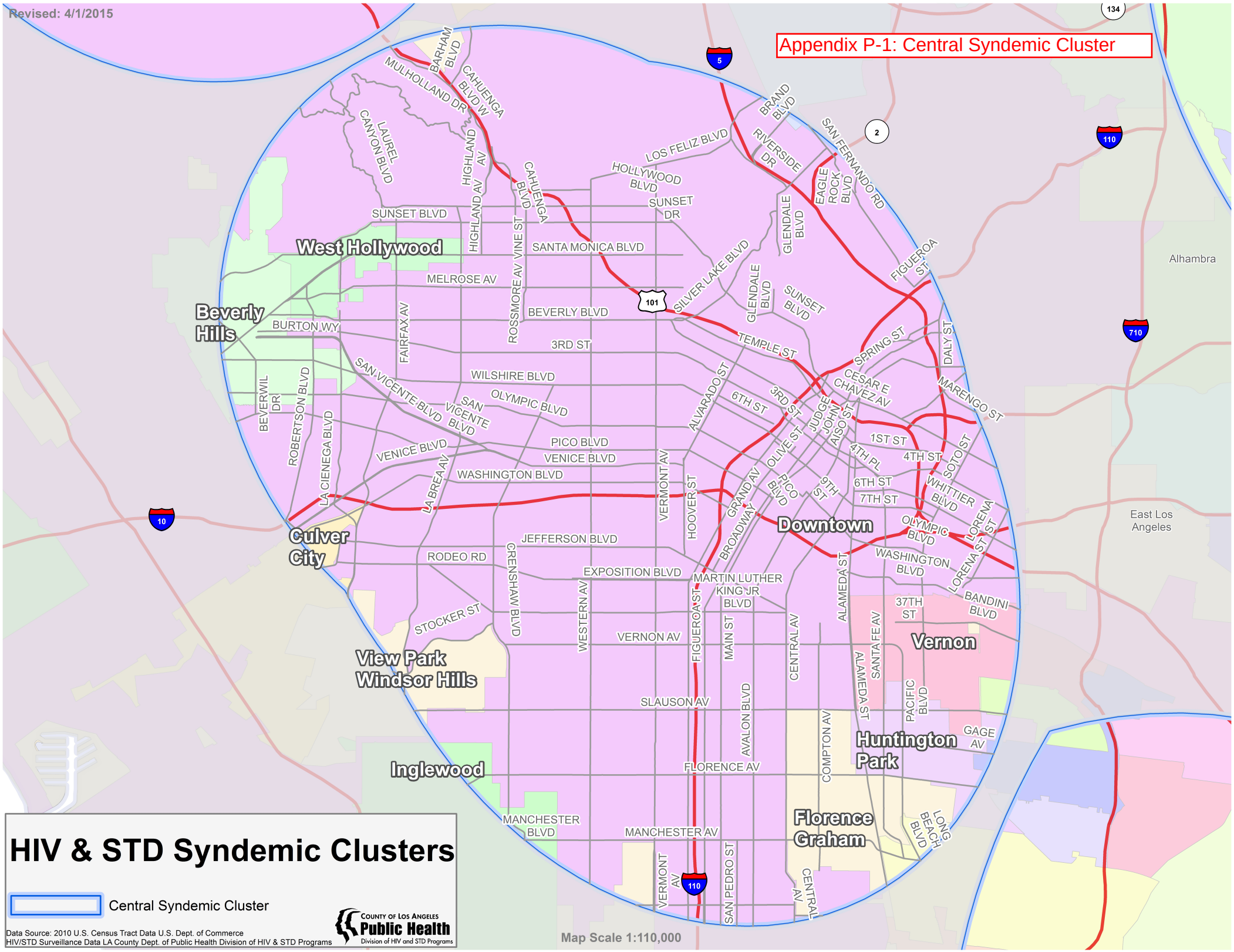
County of Los Angeles Public Health
Division of HIV and STD Programs

Map Scale 1:585,000

0 2.5 5 10 15 20
Miles

Revised: 4/1/2015

Appendix P-1: Central Syndemic Cluster



HIV & STD Syndemic Clusters

Central Syndemic Cluster

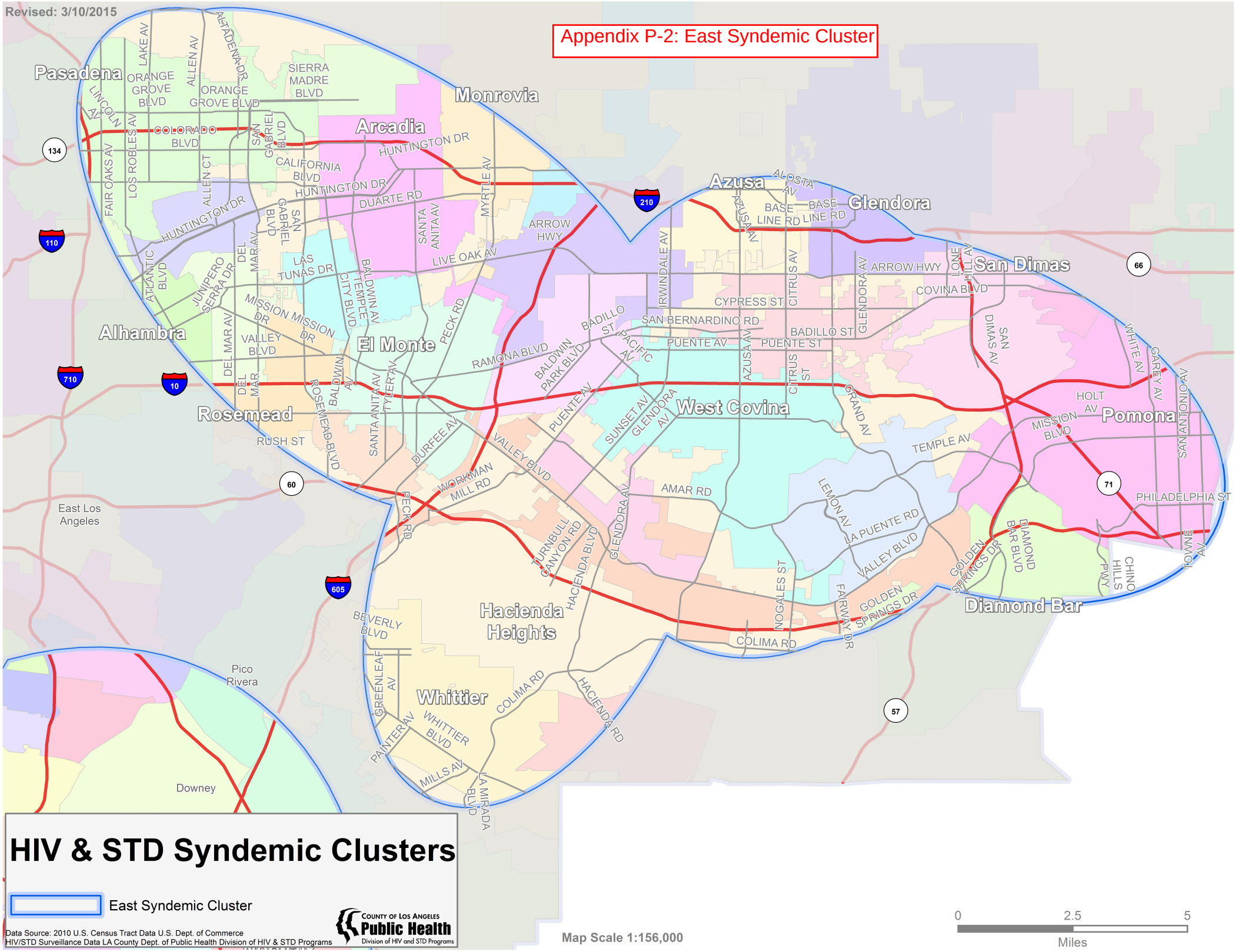
Data Source: 2010 U.S. Census Tract Data U.S. Dept. of Commerce
HIV/STD Surveillance Data LA County Dept. of Public Health Division of HIV & STD Programs

County of Los Angeles Public Health
Division of HIV and STD Programs

Map Scale 1:110,000

Revised: 3/10/2015

Appendix P-2: East Syndemic Cluster



HIV & STD Syndemic Clusters

East Syndemic Cluster

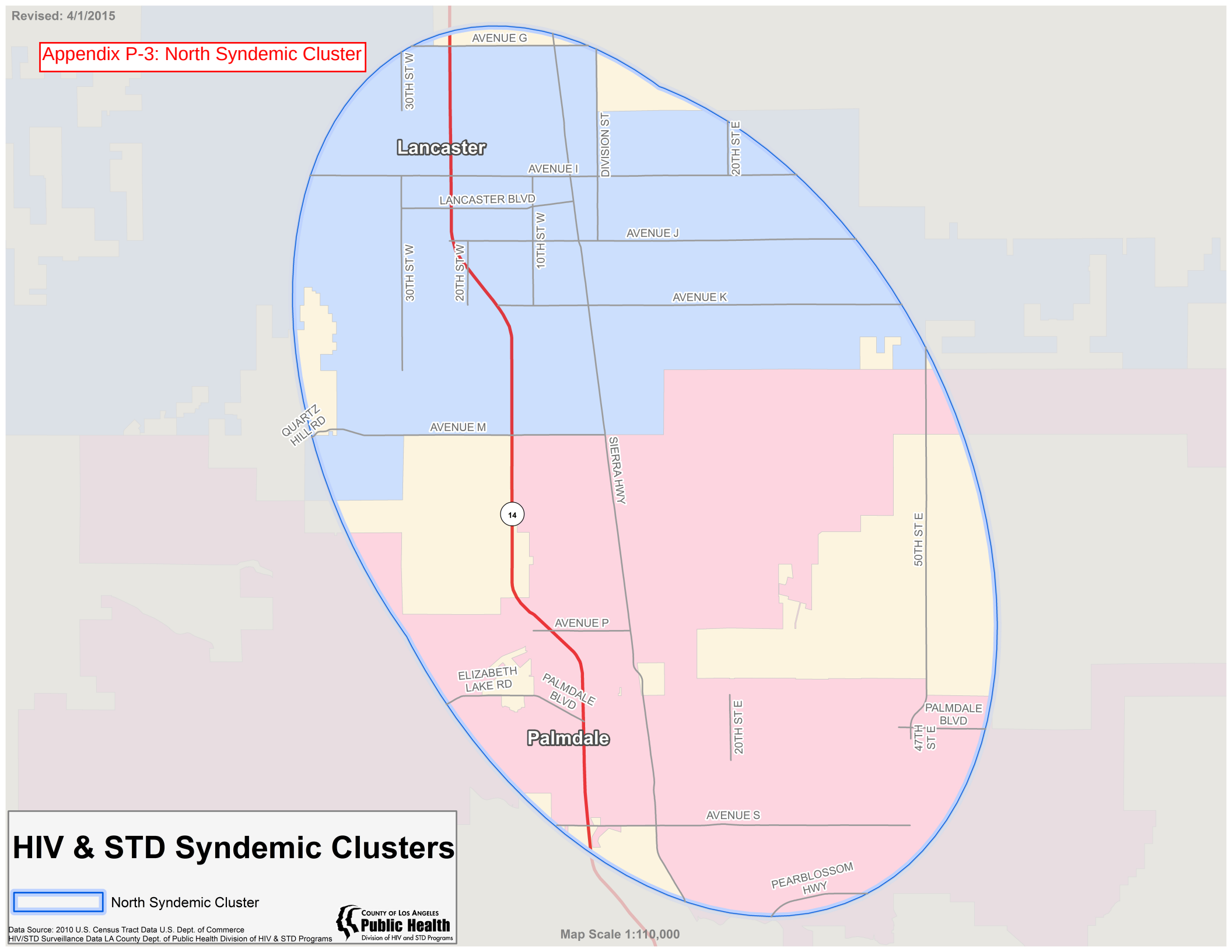
Data Source: 2010 U.S. Census Tract Data U.S. Dept. of Commerce
HIV/STD Surveillance Data LA County Dept. of Public Health Division of HIV & STD Programs

County of Los Angeles Public Health
Division of HIV and STD Programs

Map Scale 1:156,000

Revised: 4/1/2015

Appendix P-3: North Syndemic Cluster



HIV & STD Syndemic Clusters

North Syndemic Cluster

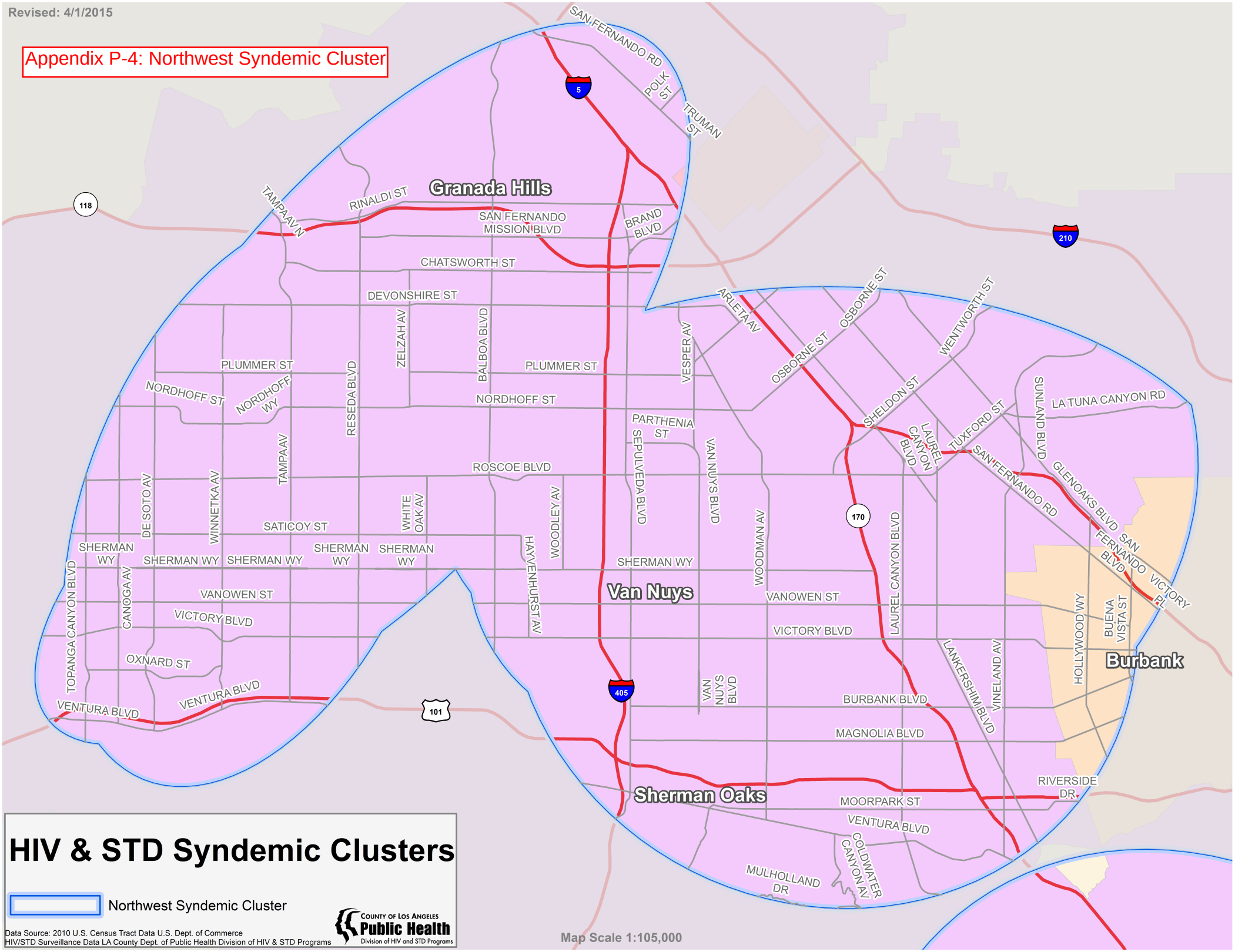
Data Source: 2010 U.S. Census Tract Data U.S. Dept. of Commerce
HIV/STD Surveillance Data LA County Dept. of Public Health Division of HIV & STD Programs

County of Los Angeles Public Health
Division of HIV and STD Programs

Map Scale 1:110,000

Revised: 4/1/2015

Appendix P-4: Northwest Syndemic Cluster



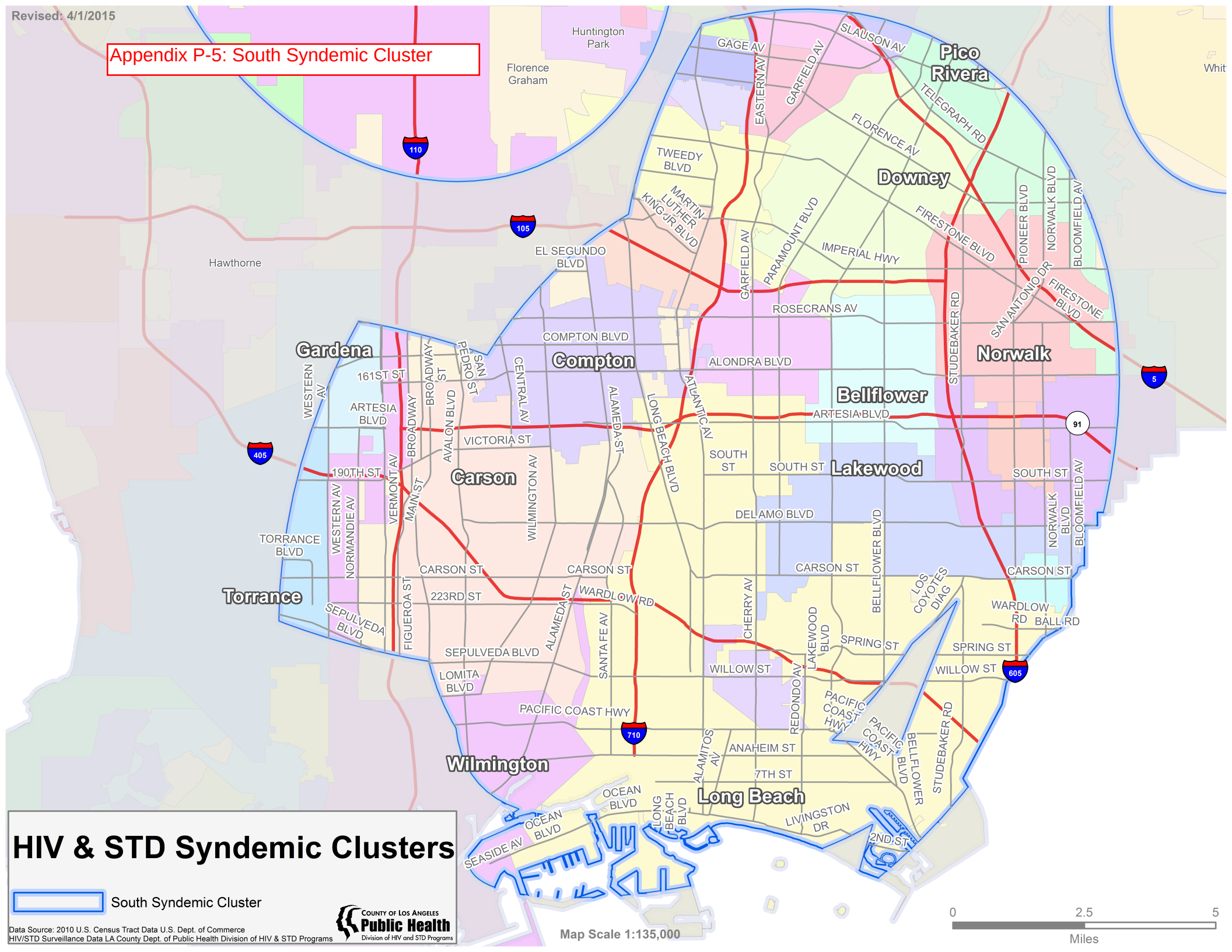
HIV & STD Syndemic Clusters

Northwest Syndemic Cluster

Data Source: 2010 U.S. Census Tract Data U.S. Dept. of Commerce
HIV/STD Surveillance Data LA County Dept. of Public Health Division of HIV & STD Programs

County of Los Angeles Public Health
Division of HIV and STD Programs

Map Scale 1:105,000


Revised: 4/1/2015
Appendix P-5: South Syndemic Cluster
Huntington Park
Florence Graham
Hawthorne
Gardena
Compton
Carson
Torrance
Wilmington
Long Beach
Lakewood
Bellflower
Norwalk
Downey
Pico Rivera
GAGE AV
SLAUSON AV
EASTERN AV
GARFIELD AV
TELEGRAPH RD
FLORENCE AV
TWEEDY BLVD
MARTIN LUTHER KING JR BLVD
PARAMOUNT BLVD
FIRESTONE BLVD
PIONEER BLVD
NORWALK BLVD
BLOOMFIELD AV
IMPERIAL HWY
EL SEGUNDO BLVD
ROSECRANS AV
SAN ANTONIO DR
STUDEBAKER RD
COMPTON BLVD
ALONDRA BLVD
161ST ST
ARTESIA BLVD
VICTORIA ST
190TH ST
DEL AMO BLVD
SOUTH ST
CARSON ST
223RD ST
WARDLOW RD
SPRING ST
WILLOW ST
LOMITA BLVD
PACIFIC COAST HWY
ANAHEIM ST
7TH ST
OCEAN BLVD
SEASIDE AV
LIVINGSTON DR
2ND ST
BALL RD
TORRANCE BLVD
SEPULVEDA BLVD
WESTERN AV
NORMANDIE AV
VERMONT AV
BROADWAY
MAIN ST
AVALON BLVD
SAN PEDRO ST
CENTRAL AV
WILMINGTON AV
ALAMEDA ST
LONG BEACH BLVD
ATLANTIC AV
SANTA FE AV
FIGUEROA ST
CHERRY AV
LAKEWOOD BLVD
REDONDO AV
ALAMITOS AV
BELLFLOWER BLVD
LOS COYOTES DIAG
110
105
405
710
91
5
605
HIV & STD Syndemic Clusters
South Syndemic Cluster
Data Source: 2010 U.S. Census Tract Data U.S. Dept. of Commerce
HIV/STD Surveillance Data LA County Dept. of Public Health Division of HIV & STD Programs
County of Los Angeles Public Health
Division of HIV and STD Programs
Map Scale 1:135,000
0
2.5
5
Miles

APPENDIX Q
Category 1: HIV and STD Epidemiological Data and Program Research on Young African American and Latino Men who have Sex with Men

1.0 State of the Epidemic

1.1 Overview

Los Angeles County (LAC or County) spans over 4,000 square miles and includes 88 cities. The County has a mix of both urban and rural populations, and includes some of the country's most affluent and impoverished residents. LAC has an estimated population of 10 million (27% of California's population).[1]

LAC is among the most ethnically diverse regions in the nation. Most communities in LAC are multiethnic and multilingual, with a population consisting of 48% Hispanic, 28% White, 13% Asian/Pacific Islander, 8% African American, 2% other or multiracial, and less than 1% Native American. Approximately 60% of residents were born outside of the United States, and English is the language spoken at home by slightly less than 60% of all residents.

Due to the County's large geographic size, the Department of Public Health's (DPH) Division of HIV and STD Programs (DHSP) has targeted smaller regions of the County where innovative HIV and STD prevention interventions and services can be the most impactful. The largest proportion of people living with HIV is in the LA Metro, South LA, and South Bay areas. In 2013, the LA Metro area had approximately 35% of all newly diagnosed HIV cases.[2] The second highest percentage (13%) of new HIV cases resided in South LA followed by 16% of persons diagnosed with HIV in 2013 residing in the South Bay.[3] Combined, these three areas account for approximately 64% of all newly diagnosed HIV cases in 2013.

1.2 MEN WHO HAVE SEX WITH MEN (MSM) and HIV and STDs

In conjunction with targeting specific geographical areas, it is important to direct services to populations with the greatest need in order to reduce HIV burden. As of 2013, there were approximately 60,000 people living with HIV/AIDS in LAC.[2] Among this population, MSM (including MSM injection drug users) account for 83% of all reported HIV and AIDS cases.[2] Put another way, MSM bear the largest disease burden of any population in LAC with four of every five people living with HIV/AIDS (PLWHA) identifying as MSM.

HIV has also significantly impacted communities of color, especially Latino and African American MSM. As of 2011, African American MSM had the highest prevalence of HIV, at 27%, while Latino MSM had the second highest prevalence at 19%.[4]

In addition, MSM in LAC have high rates of STDs relative to other subgroups. Data on STD positivity among patients presenting for STD care at the 12 DPH STD Clinics in LAC for 2012 show the highest STD positivity for MSM compared to Men who have Sex with Women (MSW) and women. MSM testing for STDs at the STD clinics in 2012 had a gonorrhea testing positivity of 17.3%, 13.4% for Chlamydia

and 2.2% for primary and secondary syphilis. Additionally, in 2012, approximately 52% of all MSM with primary and secondary syphilis in LAC were co-infected with HIV.[5]

Finally, primary and secondary syphilis rates have increased 11% in LAC between 2008 and 2011 and the majority of this increase is in the Metro Service Planning Area (SPA) that includes the communities of Hollywood and West Hollywood where a large proportion of LAC's MSM population reside. Other pockets of syphilis in the Metro SPA include parts of downtown and the skid row area of LAC.

1.3 YOUNG MEN WHO HAVE SEX WITH MEN (YMSM) and HIV and STDs

An analysis of the HIV care cascade among youth in the United States showed that approximately 41% of HIV-infected youth were aware of their diagnosis, while only 62% of those diagnosed engaged in medical care within 12 months of diagnosis. Of the youth who initiated antiretroviral therapy, only 54% achieved viral suppression, and 57% were not retained in care. The study estimated that less than 6% of HIV-infected youth in the United States are virally suppressed.[6]

Similar disparities for HIV positive youth have been observed in LAC where 38% of new HIV diagnoses in 2012 were among young adults ages 18-29.[3] In addition, data from the DHSP LAC HIV Incidence Surveillance Project estimated new HIV infection rates of 25 per 1000 for African American MSM ages 18-29 and rates of 8 and 9 per 1000 for Latino and white MSM ages 18-29 respectively. The rate for 18-29 year old African American MSM was statistically higher than that for Latino and white MSM. These data highlight the disparities in HIV incidence for young African American MSM in LAC.[7]

There are not only relatively high numbers of person living with HIV in the Metro, South, and South Bay SPAs, but there is also a relatively large proportion of HIV-positive YMSM in these areas. In 2011, 27% of YMSM were living in the Metro SPA.[3] This is followed by South LA with 21% of all YMSM living with HIV, finally, 20% of all YMSM living with HIV were residing in the South Bay SPA.[3] Combined, these three areas accounted for 68% of YMSM living with HIV in 2011 in LAC.

In 2011, YMSM between 13-24 years old comprised about 69% of all youth living with HIV underscoring the prevention services needs for this population. A large majority of the total youth living with HIV in LAC are from communities of color (86%). Specifically for HIV positive YMSM, 43% are Latino and 37% are African American. Data for LAC show that African American MSM are generally at an increased risk of new HIV infection across all age groups, but in particular, African American YMSM, ages 18 – 24 years, experience the most dramatic disparity in risk compared to their Latino and white peers.[3]

Results from the HIV Prevention Trials Network 061 study among 279 African American MSM in LAC support these alarming statistics, showing that young African American MSM were at particularly high risk for HIV, and experienced concomitant unemployment and incarceration, with 77% unemployed and nearly

13% jailed over the yearlong study.[8] Thirty-five percent of the sample was 18-30 years old, and nearly 7% were HIV positive, with one-half of the positive males sero-converting during the course of the study.[8] A critical finding was that 89% of the newly infected MSM were under age 30, and 78% were youth ages 19-24.[8]

LAC also has a high STD burden among youth. In 2012, there were a total of 62,062 cases of STDs (Chlamydia, Gonorrhea, and early syphilis) reported in LAC and over half (55%) of all cases were among 15-24 year olds.[9] Chlamydia represented the overwhelming majority of cases in this age group (85%), followed by gonorrhea (14%) and syphilis (1%).[9]

Significant STD disparities are present for youth of color. In 2012, African American males ages 20-24 had rates of chlamydia and gonorrhea that were 5 times greater compared to their white counterparts. Among Latinos, rates were 4 times greater for chlamydia and 6 times greater for Gonorrhea compared to whites.[9] Similarly, compared to whites, rates of early syphilis among young African American males were 8 times higher, and almost 6 times higher for Latinos.[9]

STDs increase the risk for acquiring HIV and STD prevention is a critical part of a comprehensive HIV prevention approach.

2.0 Statement of Need

2.1 Background

The number of people living with HIV in LAC is increasing steadily as people are living longer with HIV. Approximately 1,500 to 2,400 people are newly infected each year, including a large proportion of YMSM. African American and Latino YMSM face significant barriers to health and well-being that includes higher rates of poverty, lack of health insurance, and increased cultural rejection when compared to whites. In addition, language barriers are prevalent among MSM who are immigrants.[10] Gender role expectations, homophobia, stigma, social isolation and rejection from friends, family, and community can create overwhelming emotional pressures, especially for YMSM. In particular, African American MSM continues to exhibit low linkage to care and retention rates, as well as low viral load suppression.

New services/programs must address these issues and develop new paradigms for prevention, testing, linkage and retention in care in order to curtail the spread of HIV infection among YMSM. New planning tools and strategies, such as syndemic planning; geospatial analysis; high-impact interventions; aggressive testing; early identification of undiagnosed HIV-positive persons; linkage to care services; biomedical interventions like non-occupational Post-Exposure Prophylaxis (PEP) and Pre-Exposure Prophylaxis (PrEP), new provisions for health insurance under the Affordable Care Act; and targeted efforts to engage, re-engage, and retain PLWHA in care are integral components of LAC's HIV prevention plan and are necessary to achieve both the goals outlined in the National HIV/AIDS Strategy (NHAS). NHAS goals are:

(1) Reducing new HIV infections;
(2) Increasing access to care and improving health outcomes of people living with HIV; and
(3) Reducing HIV-related disparities and health inequities.[7]

LAC is moving beyond the behaviorally-focused health education and risk reduction models to focus on improving the whole context of people's lives. A review of the empirical literature and recent data on trends in adolescent culture has suggested four new directions, to consider when developing interventions. Family-based interventions, addressing health disparities and understanding the social determinants of health for adolescents, expanding the theoretical models that are relied on in developing interventions, and utilization of new technologies each have promise for successfully assisting adolescents to reduce their risk behaviors and enhance protective factors.[8]

2.2 Structural and Individual Interventions

Structural interventions presume a certain degree of social causation of public health problems and attempt to change social, economic, political or physical environments that shape and constrain health behaviors or otherwise affect outcomes. Individual-level approaches assume that the relationship between individuals and society is one in which individuals have considerable autonomy to make and act on their choices. Adequately addressing HIV involves a multilevel approach with both structural and individual interventions tackling different factors influencing HIV transmission and infection. According to Syndemic Theory, raising levels of health across any or all psychosocial health conditions can have a positive impact on levels of HIV risk and HIV prevalence.[13]

The following sections highlight some important factors, goals, objectives and research to consider when developing innovative HIV prevention interventions for African American and Latino YMSM.

2.3 Social Determinants of Health

It is important to identify and address social determinants of health among African American and Latino YMSM. Social determinants are those factors that contribute to a person's current state of health. Scientists generally recognize five determinants of health of a population: biological (i.e., gender and age), individual behaviors, social/economic environment, physical environment, and access to health care. Inequitable distribution of these conditions across various populations is a significant contributor to persistent and pervasive health disparities. Poverty, income and wealth inequality, poor quality of life, racism, sex discrimination, and low socioeconomic conditions are the major risk factors for ill health and health inequalities.

Emphasis on social determinants requires developing partnerships with groups that traditionally may not have been part of public health initiatives, including

community organizations and representatives from government, academia, business, and civil society.[14]

2.4 Resiliency and Protective Factors

Identifying and addressing social determinants of health among African American and Latino YMSM is imperative, but it's just as important to simultaneously promote resiliency and protective factors. Resilience is "an individual's ability to recover from or adjust to misfortune, adversity, or change."[13] Resilience becomes essential to African American and Latino YMSM as they have reported dealing with homophobia (internal and external), machismo, racism, prejudice, and injustices along with other 'minority stressors' on a constant basis.[33] LGBT youth in particular tend to experience higher rates of victimization and criminalization than their non-LGBT counterparts.[13] These types of experiences as part of 'minority stress,' can result in psychological distress that can lead to risky sexual behaviors putting this population at higher risk for HIV and STDs.[34]

Protective factors *reduce the likelihood of* certain danger or harm. Protective factors are certain characteristics (social, structural, cultural, individual) that can protect African American and Latino YMSM from becoming infected with HIV or other STDs. A comparison between HIV-positive and HIV-negative YMSM discovered that HIV-negative YMSM who reported positive peer norms for condom use were 1.13 times less likely to be engaged in risky sexual behaviors compared to those who lacked positive peer norms.[35] In addition, those who reported high levels of social support for safer sex were 1.17 times more likely to have abstained from risky sexual behavior than those reporting low levels of support.[35]

A successful HIV prevention intervention with gay Latino men in San Francisco tackled the underlying factors that may be associated with HIV risk. The intervention focused on reducing internalized homophobia, increasing sexual self-observation (self-awareness), and providing social support along with a sense of family to its participant.[10]

It is evident that promoting resilience via protective factors may assist in the prevention of HIV and STDs. Some protective factors for youth, including LGBT youth, may include: family/peer support, positive peer groups, a connection to spirituality/religiosity, strong sense of self and self-esteem, along with effective engagement in school and community activities.[36] In addition, the Centers for Disease Control and Prevention's Injury Prevention Center adds that a connection with parents, ability to discuss problems with parents and other adults, along with a consistent parental presence in the home are also important or key factors in adolescent development.

3.0 Background Research for the DHSP Program Goals and Objectives

3.1 Health Literacy

Health literacy is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[15] Specific skills needed for health literacy include evaluating information for credibility and quality, analyzing relative risks and benefits, calculating dosages, interpreting test results and locating health information. Health literacy can be affected by belief systems, communication styles, and understanding and response to health information. In order to accomplish these tasks, individuals may need to be: visually literate, computer literate, information literate and numerically or computationally literate.[16] "Social media may offer the potential for new and improved methods to deliver health education among Young MSM of color with low literacy skills."[17]

3.2 Access to Healthcare

LA County has one of the highest rates of uninsured individuals in the nation, with significant disparities in coverage among minorities and youth. In 2011, over 17% of all LAC residents were uninsured.[18] Thirty-six percent of LAC residents between 18-29 years of age were uninsured sometime during 2012. One-half of the uninsured population (51%) between 18-29 years was Latino and nearly 4% were African American.[19]

Many Californian's have recently become insured under the health care reforms mandated by the Affordable Care Act, both through expanded Medi-Cal or subsidized private insurance through an affordable health insurance exchange. However, about 1.3 million people (13% of LAC's population) are projected to remain uninsured through 2019, including the undocumented, as well as those who are eligible for Medi-Cal or insurance exchanges but remain un-enrolled due to enrollment barriers.[20]

For young MSM, the most significant challenge to experiencing better health outcomes is their reluctance to initially access care. Data from the Los Angeles County Health Needs Assessment suggests that YMSM experience much larger gaps across many services compared to other MSM.[21] Aggressive outreach and early intervention for both young and adult MSM are crucial.

In 1981, Penchansky and Thomas argued in the article*, "The Concept of Access: Definition and Relationship to Consumer Satisfaction"* that good access to healthcare must reflect the fit between characteristics and expectations of the providers and the clients.[22] They grouped these characteristics into five "*A*s" of access to care: affordability, availability, accessibility, accommodation, and acceptability. All DPH funded HIV and STD prevention services must be provided to County residents (who are program eligible) at no cost, therefore DPH's dictates the focus shall be on availability, accessibility, accommodation, and acceptability. *Availability* measures the extent to which the provider has the necessary resources, such as personnel and technology, to meet the needs of the client. *Accessibility* refers to geographic convenience, which is determined by how easily the client can physically reach the provider's location. *Accommodation* reflects the

extent to which the provider's operation is organized in ways that meet the constraints and preferences of the client (i.e. hours of operation, how electronic communications are handled, ability to receive care without prior appointment, etc.). A*cceptability* captures how comfortable the client is with characteristics of the provider, such as age, gender, sexual orientation, socio-economic status, ethnicity, and cultural competency.

Due to the expanse of LAC's geography and the diversity of the population, availability, accessibility, accommodation, and acceptability are all areas that need improvement to facilitate individuals finding healthcare, utilizing existing available benefits, and making health checkups and maintenance routine.

3.3 Social Connectedness

Social connectedness and the cohesion of the community have been shown to have a direct relationship to good health and lower mortality rates. These factors can also encourage civic participation, and lead to community development and greater social and economic equality.[23]

"Where are the Young Men in HIV Prevention Efforts? Comments on HIV Prevention Programs and Research from Young Men Who Sex with Men in Los Angeles County" by Ian W. Holloway, et al, explained that among YMSM who had previously attended an HIV prevention program, the most frequently mentioned barriers to participation were being ''too busy", not perceiving themselves to be at ''high risk'', and believing that they already knew ''the basics'' so they did not need further education.[24] Participants emphasized a desire to receive HIV prevention information and skills at social gatherings that they were already attending with friends. Many indicated that they had done their own research about HIV on the Internet and that they liked the ability to access information through technology (e.g., mobile devices). These participants also stated a desire to receive HIV prevention messages through their social networks rather than through formal workshops.

Additionally, family cohesion is an important determinant of health. A study found that higher rates of family rejection were significantly associated with poorer health outcomes.[25] Lesbian, gay, and bisexual young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection.[25] Latino men reported the highest number of negative family reactions to their sexual orientation in adolescence.[26]

More information is needed to more fully understand how, for example, ethnicity/ racial pride and *familismo* (e.g., family closeness, interconnection, loyalty, and solidarity) can be used in HIV programs and interventions to eliminate health disparities among African American and Latino adolescents.[12]

Family cohesion is an important determinant of health. Providers who serve these populations should assess and help educate families about the negative impact of rejecting behaviors on their loved one. Counseling families, providing anticipatory guidance, and referring families for counseling and support will help make a critical difference in decreasing risk and increasing well-being for YMSM.

4.0 Technology

Marguerita Lightfoot states in *HIV Prevention for Adolescents: Where Do We Go From Here* that, "adolescent use of technologies, including computers and the Internet, social networking platforms, and cell phones, are near ubiquitous and provide a unique opportunity for HIV prevention."[12]

Lightfoot continues, "technology may be a viable way to deliver disease prevention information and promote skills development to all adolescents; most importantly for those who respond poorly to didactic instruction or experience difficulty in engaging or gaining insight in therapeutic processes.[17] Technology has the potential for enhancing intrinsic motivation, providing individualized feedback, and encouraging active engagement, thereby offering certain advantages over traditional therapeutic strategies.[12]

Utilizing technology with YMSM is further supported and considered crucial in HIV prevention outreach given the widespread use of the Internet, social networking, and mobile technology within the youth population. It is estimated that over 93% of adolescents between the ages of 12-15 years are online, while 63% "go-online" on a daily basis.[37]

These numbers are similar across racial/ethnic and socioeconomic groups. Further, the Internet is becoming a primary resource for health information, with 31% of online adolescents accessing health, dieting, or physical fitness information from the Internet.[37] Seventeen percent of adolescents report going online to find information about health topics that are challenging to discuss with others, such as drug use. Similarly, the use of socially interactive technologies (e.g. social networking sites) is common among adolescents. Social networking happens across a number of platforms and includes sites such as Facebook, YouTube, and Twitter; gaming and virtual worlds, such as Second Life, the Sims, and World of Warcraft; video and photograph sites such as YouTube, Pinterest, and Instagram; and blogs. Engaging with these technologies is a routine activity for adolescents as 82% of 14- to 17-year-olds use social networking sites, a dramatic increase from 55% in 2006.[37] These sites are a portal for adolescents' entertainment, communication, and connection.

Social networking is being considered a promising prevention tool. A study that used Facebook to deliver an HIV prevention intervention found small to moderate short-term impact on condom use and protected sex acts.[38] Another more recent study, *Social Networking Technologies as an Emerging Tool for HIV Prevention: A Cluster Randomized Trial* in the Annals of Internal Medicine, conducted by Young, Cumberland, Lee, Jaganath, Szekeres, and Coates, found that targeted interventions launched via Facebook group are an effective way to communicate health information, particularly in relation to HIV testing and safe sex practices among African American and Latino MSM 18 years and older.[39].

Mobile technology is another medium with incredible potential as a tool for HIV prevention. Upwards of 82% of 12- to 19-year-olds in the United States own a cell phone, and use increases with age.[37]

The use of mobile phones has become a centerpiece of adolescent communication, with text messaging becoming a preferred mode of contact with peers. In the United States, 89% of adolescents use text messages, and the monthly average number of text messages sent and received is 2,899.[40] Over half of adolescents (54%) text-message daily, and two thirds of adolescent "texters" say they are more likely to text friends than to talk to them via a cell phone.[37]

The general feedback by YMSM received in listening sessions conducted by DHSP in 2012, was that current HIV prevention is not convenient nor provided in a manner in which young people receive information.[33] It is important to change the way we communicate HIV prevention messaging to young people so that they hear it, understand it, and actively engage in protective activities.

5.0 Testing and Linkage to Care

5.1 HIV Testing and Linkage to Care

The geographical regions in LAC most significantly impacted by the HIV/AIDS and STD epidemic are the central and southern corridors. These areas are where the highest number and concentration of African American and Latino YMSM reside. These target populations present the highest disparities of new HIV infections, linkage to care, and viral suppression.

According to DHSP's, "Los Angeles County Five-Year Comprehensive HIV Plan 2013-2017" approximately 90% of youth newly diagnosed with HIV (ages 18-29) were identified as MSM. Among those who had at least one viral load or CD4 test within three months after an HIV diagnosis, defined as "linked-to-care," youth ages 13-24 had a lower care linkage rate (75%), compared to other demographics (e.g., 84% for adults 45-64 years of age, and 79% for adults 25-44 years of age). Youth and African American MSM also had significantly lower retention rates—at 50% and 54% respectively, compared with 56% for overall newly diagnosed individuals. The most serious challenge was with viral suppression. The overall proportion of viral suppression for the newly diagnosed PLWHA in 2010 who had at least one viral load test was 79%; however, the viral suppression rates for youth and African American MSM were low—at 59% and 66% respectively.[3] These disparities present serious challenges in reducing the number of new HIV infections.

Among certain age groups of PLWHA in LAC, youth (13-24 years) are more likely than older populations to be out of care. In "What Youth Need-Adapting HIV Care Models to Meet the Lifestyles and Special Needs of Adolescents and Young Adults" some possible reasons for this include: health system factors; therapeutic factors; psychosocial factors; and social factors. All these barriers must be

addressed in order to successfully link youth into HIV care and then to subsequently keep them in care once engaged.[41]

DHSP has supported a variety of HIV testing and linkage to care models including: targeted HIV testing services (HTS) in storefronts, clinics, emergency departments, substance abuse clinics, courts, mobile units, and in commercial sex venues (bathhouses and sex clubs); social network testing; and multiple morbidity testing to assist with identifying undiagnosed HIV and STD infection, as well as counseling and educating those at elevated risk for acquiring HIV. HTS focus on areas/zip codes highly impacted by the HIV/AIDS epidemic and priority target populations at elevated risk for HIV transmission.

In 2011, the New Directions HIV Testing Program was launched to begin the process of streamlining and improving HTS conducted by LAC community partners in addition to aligning services with the local goals (see STATEMENT OF WORK, Appendix B). DHSP estimates that the PLWHA population in LAC accounts for 5% of all PLWHA in the U.S. Therefore, in order to meet the prescribed national goal of conducting 3.1 million HIV tests annually, DHSP estimates that 155,000 test events will need to be conducted annually by LAC testing providers. In 2012, DHSP contracted agencies conducted approximately 130,000 HIV tests. In 2013, contracted agencies nearly met the goal, conducting 145,000 tests.

5.2 STD Testing and Treatment

A high prevalence of other STDs and high rates of undiagnosed/untreated STDs contribute to the HIV epidemic. STDs are associated with an increased risk of HIV transmission.[42] In addition, having additional STDs can complicate HIV treatment and care for PLWHA. Youth often face a host of barriers to accessing quality STD services, including lack of health insurance or ability to pay, long waiting times, inconvenient clinic hours, lack of transportation, discomfort with facilities and services designed for adults, and concerns about confidentiality.[43,44] Additional barriers that can impact access to care include the stigma that accompanies STDs; and judgmental and discriminatory behavior on the part of clinicians.[45,46] For MSM youth in particular, these concerns may be especially relevant.

APPENDIX Q
Category 1: HIV and STD Epidemiological Data and Program Research on Young African American and Latino Men who have Sex with Men

1. US Census Bureau Public Information Office. Growth in Urban Population Outpaces Rest of Nation, Census Bureau Reports - 2010 Census - Newsroom - U.S. Census Bureau. Available at: http://www.census.gov/newsroom/releases/archives/2010_census/cb12-50.html. Accessed December 11, 2013.

2. Division of HIV and STD Programs - Los Angeles County Department of Public Health. *2013 Annual HIV Surveillance Report*.; 2014:12. Available at: http://publichealth.lacounty.gov/wwwfiles/ph/hae/hiv/2013AnnualSurveillanceReport.pdf. Accessed September 2, 2014.

3. Division of HIV and STD Programs, Los Angeles County Department of Public Health, the Los Angeles County Commission on HIV and the LACHPPC. *Los Angeles County Five-Year Comprehensive HIV Plan*. Los Angeles; 2013. Available at: http://publichealth.lacounty.gov/dhsp/Reports/HIV/LAC-ComprehensiveHIVPlan2013-2017.pdf.

4. CDC. HIV in the United States. 2013. Available at: http://www.cdc.gov/hiv/statistics/basics/ataglance.html. Accessed September 2, 2014.

5. Division of HIV and STD Programs - Los Angeles County Department of Public Health. *2011/2012 STD Surveillance Data: US, California, and Los Angeles County*.; 2014. Available at: http://publichealth.lacounty.gov/dhsp/Reports/STD/STDsurveillance2012-5-19-14.pdf. Accessed September 2, 2014.

6. Zanoni BC, Mayer KH. The Adolescent and Young Adult HIV Cascade of Care in the United States: Exaggerated Health Disparities. *AIDS Patient Care STDS*. 2014;28(3):128–135.

7. Office of National AIDS Policy. National HIV/AIDS Strategy: Federal Implementation Plan. 2010..

8. Shoptaw S, Williams J, Victorianne G, et al. Findings from HIV Prevention Trials Network 061 Study: Using Data to Set HIV Prevention Priorities in Los Angeles. 2013. Available at: http://www.uclacbam.org/wp-content/uploads/2013/04/PPC-Colloquia-Shoptaw-4-11-13.pdf.

9. Division of HIV and STD Programs. *Sexually Transmitted Diseases Morbidity Report 2011*. Los Angeles; 2011. Available at: http://publichealth.lacounty.gov/std/docs/2011STDReport.pdf.

10. Marín BV. HIV Prevention in the Hispanic Communinty: Sex, Culture, and Empowerment. *J Transcult Nurs*. 2003;14:186. doi:10.1177/1043659603253549.

11. The White House. *National HIV/AIDS Strategy for the United States*. Washington DC; 2010. Available at: http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf.

12. Lightfoot M. HIV Prevention for Adolescents : Where Do We Go From Here ? *Am Pyschologist*. 2012;53(November):348–356. doi:10.1016/j.

13. Herrick AL, Lim SH, Wei C, et al. Resilience as an untapped resource in behavioral intervention design for gay men. *AIDS Behav*. 2011;15 Suppl 1:S25–9. doi:10.1007/s10461-011-9895-0.

14. Centers for Disease Control and Prevention. Social Determinants of Health. 2012. Available at: http://www.cdc.gov/socialdeterminants/Definitions.html. Accessed December 11, 2013.

15. U.S. Department of Health of Human Services. Improving Health Literacy. 2013. Available at: http://www.health.gov/communication/literacy/.

16. Almader-Douglas D. Culture in the Context of Health Literacy. *Natl Netw Libr Med*. Available at: http://nnlm.gov/outreach/consumer/hlthlit.html#A1.

17. Navarra A-M. Health Literacy and Adherence to Antiretroviral Treatment among Human Immunodeficiency Virus (HIV) Infected Youth. 2011.

18. UCLA Center for Health Policy Research. California Health Interview Survey. *2012*. Available at: http://healthpolicy.ucla.edu/CHIS/Pages/default.aspx.

19. NCHHSTP. *Today's HIV/AIDS Epidemic Factsheet*.; 2013. Available at: http://www.cdc.gov/nchhstp/newsroom/docs/HIVFactSheets/TodaysEpidemic-508.pdf.

20. UC Berkeley Center for Labor Research and Education UC for H and PR. *After millions of Californians gain health coverage under the affordable care act, who will remain uninsured?* 2012. Available at: http://laborcenter.berkeley.edu/healthcare/aca_uninsured12.pdf.

21. Division of HIV and STD Programs, Los Angeles County Department of Public Health, the Los Angeles County Commission on HIV and the LACHPPC. *Los Angeles Coordinated HIV Needs Assessment - Care (LACHNA) 2011 Final Report*.; 2011. Available at: http://hivcommission-la.info/cms1_173837.pdf.

22. Penchansky R, Thomas JW. The concept of access: definition and relationship to consumer satisfaction. *Med Care*. 1981;19(2):127–40. Available at: http://www.ncbi.nlm.nih.gov/pubmed/7206846. Accessed December 11, 2013.

23. Work Group for Community Health and Development. Section. 5 Addressing Social Determinants of Health. 2013. Available at: http://ctb.ku.edu/en/table-of-contents/analyze/analyze-community-problems-and-solutions/social-determinants-of-health/main. Accessed December 12, 2013.

24. Holloway IW, Cederbaum JA, Ajayi A, Shoptaw S. Where are the young men in HIV prevention efforts? Comments on HIV prevention programs and research from young men who sex with men in Los Angeles county. *J Prim Prev*. 2012;33(5-6):271–8. doi:10.1007/s10935-012-0282-z.

25. Ryan C, Huebner D, Diaz RM, Sanchez J. Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*. 2009;123(1):346–52. doi:10.1542/peds.2007-3524.

26. Darrow WW, Montanea JE, Gladwin H. AIDS-related stigma among Black and Hispanic young adults. *AIDS Behav*. 2009;13(6):1178–88. doi:10.1007/s10461-009-9601-7.

27. United Way of Greater Los Angeles. *LA County ten years later: a tale of two cities one future*.; 2011. Available at: http://unitedwayla.org/wp-content/uploads/2011/11/TaleOfTwoCities_Feb2010.pdf.

28. Center on Juvenile and Criminal Justice. Los Angeles County - California Sentencing Institute. *2012*. Available at: http://casi.cjcj.org/Adult/Los-Angeles.

29. Preston DB, D'Augelli AR, Kassab CD, Cain RE, Schulze FW, Starks MT. The influence of stigma on the sexual risk behavior of rural men who have sex with men. *AIDS Educ Prev*. 2004;16(4):291–303. doi:10.1521/aeap.16.4.291.40401.

30. Guillermo P, Lightfoot M, Brown H. Macro-Level Approaches to HIV Prevention Among Ethnic Minority Youth: State of the Science, Opportunities, and Challenges. *NIH Public Access*. 2013;68(4):286–299. doi:10.1037/a0032917.Macro-Level.

31. Kubicek K, McNeeley M, Holloway IW, Weiss G, Kipke MD. "It's like our own little world": resilience as a factor in participating in the Ballroom community subculture. *AIDS Behav*. 2013;17(4):1524–39. doi:10.1007/s10461-012-0205-2.

32. U.S. Census Bureau. 2007-2011 American Community Survey 5-Year Estimates: Los Angeles County. *2007-2011 Am Community Surv*. 2011. Available at: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk.

33. Division of HIV and STD Programs, Los Angeles County Department of Publlic Health. DHSP Listening Sessions with Young Gay Men of Color. 2012.

34. Díaz RM, Ayala G, Bein E, Henne J, Marin B V. The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: findings from 3 US cities. *Am J Public Health*. 2001;91(6):927–32. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1446470&tool=pmcentrez&rendertype=abstract. Accessed December 10, 2013.

35. Forney JC, Miller RL. Risk and protective factors related to HIV-risk behavior: a comparison between HIV-positive and HIV-negative young men who have sex with men. *AIDS Care*. 2012;24(5):544–52. doi:10.1080/09540121.2011.630341.

36. Department of Health and Human Services. LGB Youth : Challenges , Risks and Protective Factors. 2012;92(2009). Available at: http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/training/tip_sheets/lgb-youth-508.pdf.

37. Lenhart A, Purcell K, Smith A, Zickuhr K. *Social Media and Mobile Internet Use Among Teens and Young Adults*. Washington DC; 2010. Available at: http://web.pewinternet.org/~/media/Files/Reports/2010/PIP_Social_Media_and_Young_Adults_Report_Final_with_toplines.pdf.

38. Bull SS, Breslin LT, Wright EE, Black SR, Levine D, Santelli JS. Case study: An ethics case study of HIV prevention research on Facebook: the Just/Us study. *J Pediatr Psychol*. 2011;36(10):1082–92. doi:10.1093/jpepsy/jsq126.

39. Young SD, Cumberland WG, Lee S-J, Jaganath D, Szekeres G. Social Networking Technologies as an Emerging Tool for HIV Prevention: A Cluster Randomized Trial. *Ann Intern Med*. 2013;159(5).

40. Cole-Lewis H, Kershaw T. Text messaging as a tool for behavior change in disease prevention and management. *Epidemiol Rev*. 2010;32(1):56–69. doi:10.1093/epirev/mxq004.

41. Akin L, Ozcebe H, Alexander CS, et al. Abuelo D, See Harel A Adams CD, Perkins KC, Lumley V, Hughes C, Burns JJ, Omar HA. Validation of the Perkins Adolescent Risk Screen (PARS), 462. *J Adolesc Heal*. 2003;33:509–512.

42. Cohen MS. HIV and sexually transmitted diseases: lethal synergy. *Top HIV Med*. 12(4):104–7. Available at: http://www.ncbi.nlm.nih.gov/pubmed/15516707. Accessed December 12, 2013.

43. Tilson EC, Sanchez V, Ford CL, et al. Barriers to asymptomatic screening and other STD services for adolescents and young adults: focus group discussions. *BMC Public Health*. 2004;4(1):21.

44. CDC. CDC - STD Surveillance, 2011 - Adolescents and Young Adults. 2012. Available at: http://www.cdc.gov/std/stats11/adol.htm. Accessed September 2, 2014.

45. Malek AM, Chang C-CH, Clark DB, Cook RL. Delay in Seeking Care for Sexually Transmitted Diseases in Young Men and Women Attending a Public STD Clinic. *Open AIDS J*. 2013;7:7.

46. Ginsburg KR, Winn RJ, Rudy BJ, Crawford J, Zhao H, Schwarz DF. How to reach sexual minority youth in the health care setting: The teens offer guidance. *J Adolesc Heal*. 2002;31(5):407–416.

APPENDIX R

ISSUE REPORT

Addressing the Social Determinants of Health Inequities Among Gay Men and Other Men Who Have Sex With Men in the United States

DECEMBER 2014

Trust for America's Health
WWW.HEALTHYAMERICANS.ORG

Acknowledgements

Trust for America's Health is a non-profit, non-partisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority.

This report was supported by a grant from the **M·A·C AIDS Fund**. The opinions expressed are those of the authors and do not necessarily reflect the views of the foundation. TFAH would like to thank M·A·C AIDS Fund for their generous support of this report.

REPORT AUTHORS

Derek Hodel
Independent Consultant

Jeffrey Levi, PhD.
Executive Director
Trust for America's Health
and Professor of Health Policy
Milken Institute School of Public Health at the George Washington University

Anne De Biasi, MHA
Director, Policy Development
Trust for America's Health

Foreword

With support from the M·A·C AIDS Fund, Trust for America's Health (TFAH) undertook a literature review and convened a one-day consultation to consider strategies to mitigate the social determinants of health inequities among gay men and other men who have sex with men (MSM).† Invited participants included research scientists, lesbian, gay, bisexual and transgender (LGBT) health service providers, public policy advocates, and federal officials.* After reviewing current research pertaining to health inequities among MSM (including HIV epidemiology) and theoretical constructs to explain disparities, the remainder of the meeting focused on identifying opportunities for the federal government to intervene. Two caveats underpinned the discussion: 1) the need for additional research was stipulated, and 2) it was acknowledged that, while the evidence base to support interventions to address social determinants of health (SDH) among MSM is slim, health disparities (particularly HIV) are sufficiently grave to warrant taking immediate action. As such, meeting participants were charged with articulating ways in which the federal government could respond now to continuing health inequities among MSM based upon existing data. While this report reflects those conversations, the views expressed are solely those of Trust for America's Health.

Addressing Health Inequities: *Gay Men & MSM in the U.S.*

ISSUE REPORT

Executive Summary

In the United States, gay men and other MSM continue to be more profoundly impacted by HIV than any other group. Though representing approximately 2 percent of the population, MSM comprise a majority of new HIV infections (66 percent in 2010) and represent more than half (56 percent) of all persons living with an HIV diagnosis. HIV incidence is disproportionately higher among Black MSM than any other risk group.

MSM also face a variety of other mental, physical and sexual health disparities, including substance abuse and depression, both of which correlate with high-risk behaviors for HIV infection, as well as suicide. MSM also have elevated rates of syphilis, gonorrhea, and other sexually transmitted diseases (STDs), which are associated with an increased risk for HIV infection as well. Young MSM are more likely than their heterosexual counterparts to report emotional distress, depression, or self-harm, and are at higher risk of suicidal ideation or attempts and becoming homeless.

The many health inequities experienced by MSM constitute a *syndemic* — i.e. multiple social determinants that each independently influence health outcomes, and which mutually reinforce and amplify each other. Among MSM, the *syndemic* comprising HIV, STDs, mental health, substance abuse, and violence has profound implications for HIV prevention — as numerous health challenges may overwhelm the capacity of some MSM to reduce their sexual risks. Moreover, for MSM who are also racial minorities, social determinants of health may intersect in various, overlapping domains, including not only sexual orientation, but race, poverty, educational attainment and immigration status.

Strategies to address health inequities among MSM — including, but not limited to, HIV — include interventions to 1) increase individual resiliency, 2) foster a supportive community, 3) improve access to quality healthcare, and 4) transform the environmental context in which people live. While new biomedical interventions such as pre-exposure prophylaxis or treatment-as-prevention show promise, their uptake will also be affected by social determinants. Addressing social determinants at every stage of life will require an array of linked individual, biomedical and structural interventions throughout the life course. To account for environmental factors, community-level and structural interventions must include health policy and legislation, economic and social interventions, and cross-sector collaborations. Federal coordination will be essential — the National Prevention, Health Promotion and Public Health Council (NPC) is well positioned to provide leadership.

In the long term, however, reducing societal oppression and marginalization of LGBT people will diminish the need for individual and community-level interventions. The increasing recognition that for MSM, HIV constitutes but one of many health challenges provides an opportunity to refocus efforts to fight HIV by incorporating interventions within the context of MSM health and wellness promotion.

Introduction

In the United States, gay men and other men who have sex with men continue to be more profoundly impacted by HIV than any other group. Though representing approximately 2 percent of the population aged 13 years or older, MSM (including MSM who inject drugs) comprise a majority of new HIV infections (66 percent in 2010)[1] and represent more than half (56 percent) of all persons living with an HIV diagnosis.[2] Since the epidemic began, more than 350,000 MSM with AIDS have died, 55 percent of the overall total.[3]

Studies have shown that MSM face a variety of health disparities, including increased rates of substance abuse, depression and suicide, all of which significantly correlate with high-risk behaviors for HIV infection. Recent studies have also shown that *social determinants* of such risk behaviors include multiple and intersecting factors, including individual (peer pressure, social and sexual networks, social support, and access to care), as well as sociocultural (race/ethnicity, educational level, socio-demographic position, and religion) and environmental (poverty, violence, stigma, discrimination and homophobia, and acculturation to the gay community) contexts, many of which may be of greater consequence for MSM. Continuing progress against HIV among MSM will require strategies to address other psychosocial health disparities, including how these outcomes interrelate with one another and with multilevel factors to mediate HIV transmission and acquisition risks.[4]

SECTION 1:

Addressing Health Inequities: *Gay Men & MSM in the U.S.*

HEALTH DISPARITIES

Health Disparities Among MSM

An increasing body of research over the past 25 years has shown that LGBT individuals experience significant health disparities, compared to heterosexuals.‡

In 2000, for the first time, the U.S. Department of Health and Human Services (HHS) included gay men and lesbians as a population group in the federal government's decennial effort to articulate science-based, 10-year national objectives for improving American's health, *Healthy People 2010: Understanding and Improving Health*, for which a key goal was reducing health disparities.[5]

In 2011, the Institute of Medicine (IOM) published a landmark study: *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding*.[6] That same year, as mandated by the Affordable Care Act (ACA), LGBT populations were added to the *National Healthcare Disparities Report*.[7] Overall, LGBT individuals experience a higher prevalence of many Healthy People indicators, including substance abuse, obesity, depression and anxiety, tobacco use, injuries and violence, responsible sexual behaviors, and access to care.

MENTAL HEALTH

A number of probability studies have shown that lesbian, gay or bisexual (LGB) individuals are more frequently diagnosed with mental health disorders, primarily depression and anxiety.[8, 9] MSM experience higher rates of suicidal ideation or attempts over their lifetimes than do heterosexuals.[10] LGB youth are more likely than their heterosexual counterparts to report emotional distress, depression or self-harm[11] and are at higher risk of suicidal ideation or attempts than their heterosexual peers, even after controlling for substance abuse and depression.[12, 13, 14] In an analysis of data from the Youth Risk Behavior Surveillance System (YRBS), prevalence among LGB youth was higher than among heterosexual youth for seven of 10 risk categories (behaviors that contribute to violence, behaviors related to attempted suicide, tobacco use, alcohol use, other drug use, sexual behaviors, and weight management).[15]

PHYSICAL HEALTH

With a few exceptions, rates of chronic physical diseases appear similar in heterosexuals and sexual minority populations, which may be counter-intuitive, in light of increased prevalence of substance abuse, heavy alcohol use, smoking and (among lesbians) obesity. For example, though LGB individuals were more likely to report risk behaviors, over their lifetimes, they are not more likely to receive a diagnosis of diabetes or heart disease. They were, however, more likely to receive a diagnosis for asthma.[16] Though studies have failed to show differences in most cancer rates (an analysis made more challenging by a lack of sexual orientation data in most cancer registries), multiple studies have shown that MSM are at increased risk for anal neoplasia, largely as a result of a high prevalence of human papilloma virus among men who engage in receptive anal intercourse.[17]

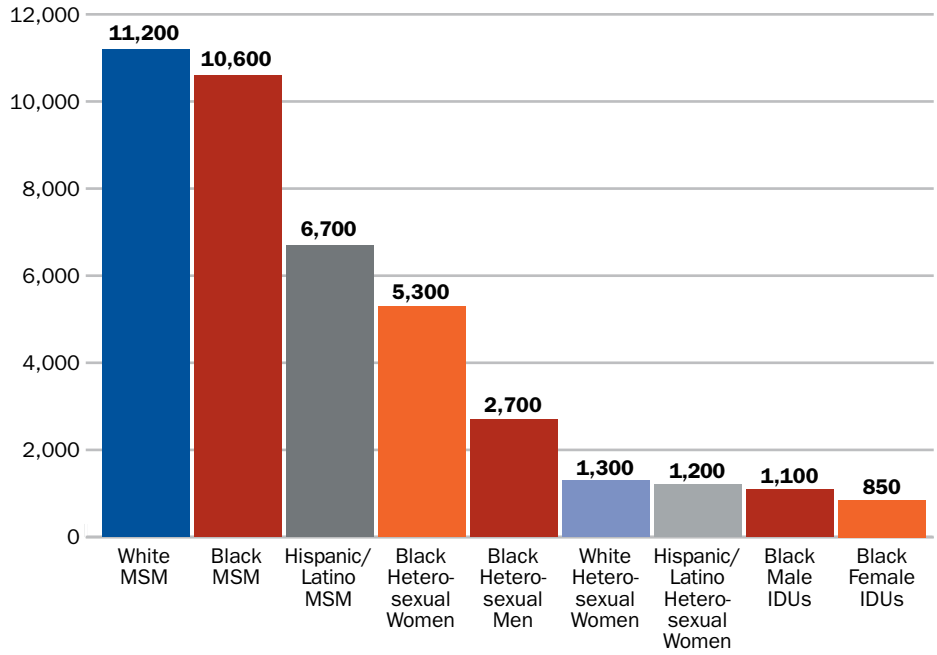
SEXUAL HEALTH

Sexually transmitted diseases. With respect to sexual health, disparities among MSM are pronounced. Compared to heterosexual men, MSM have elevated rates of syphilis, gonorrhea, lymphogranuloma venereum (LGV), human herpesvirus (HHV-8), and hepatitis B (HBV). MSM who are living with HIV are particularly susceptible. [18] In 2012, MSM accounted for 75 percent of all primary- and secondary-syphilis diagnoses in the United States.[19] In an analysis conducted by the U.S. Centers for Disease Control and Prevention (CDC) using data from states with confidential names reporting, in 2007, MSM were 61 times more likely than heterosexual men and 93 times more likely than women to be diagnosed with syphilis.[20]

HIV. Nowhere are health disparities among MSM greater than with respect to HIV. Among MSM overall, HIV prevalence is extraordinarily high. In 2011, 18 percent of MSM who received an HIV test in 20 cities participating in the National HIV Behavioral Surveillance System (NHBS) were HIV-positive, with prevalence increasing with age.[21]

In an analysis conducted by CDC using 2007 data from states with confidential names reporting, MSM were 60 times more likely than heterosexual men and 54 times more likely than women to be diagnosed with HIV.[22] In 2010, 66 percent of all new HIV infections (83 percent of new infections among men) were among MSM or men who have sex with men and inject drugs (MSM/IDU).[23] But, while historically MSM in the United States have always comprised the largest proportion of HIV cases, they are the only group for whom risk appears to be increasing. New infections among MSM increased by 12 percent from 2008 to 2010, and, among young MSM (ages 13 to 24), new HIV infections increased 22 percent.[24]

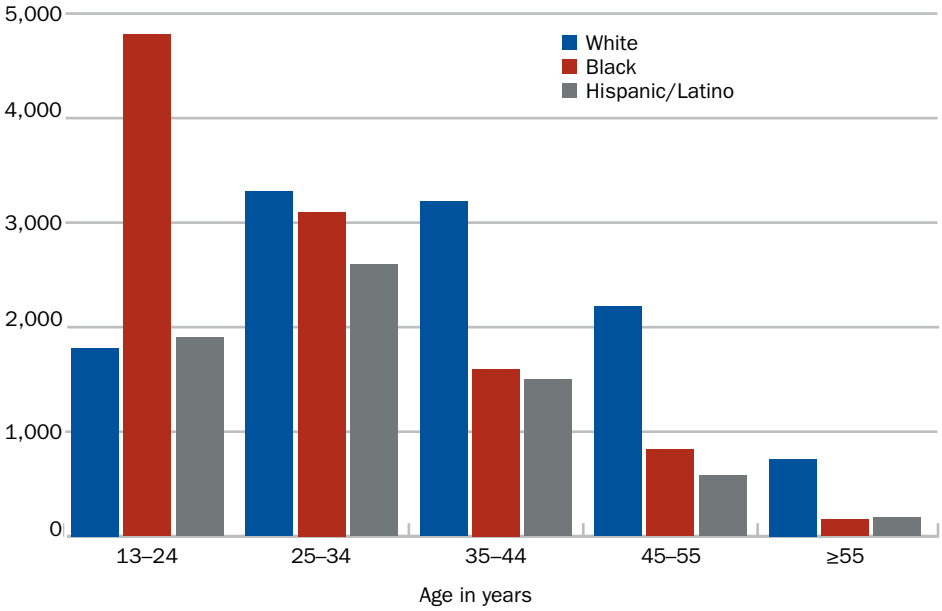
NUMBER OF NEW HIV INFECTIONS



Subpopulations representing 2% or less of the overall U.S. epidemic are not reflected in this chart.

SOURCE: CDC. Estimated HIV incidence among adults and adolescents in the United States, 2007–2010. HIV Surveillance Supplemental Report, 2012;17(4).

NUMBER OF NEW HIV INFECTIONS AMONG MSM



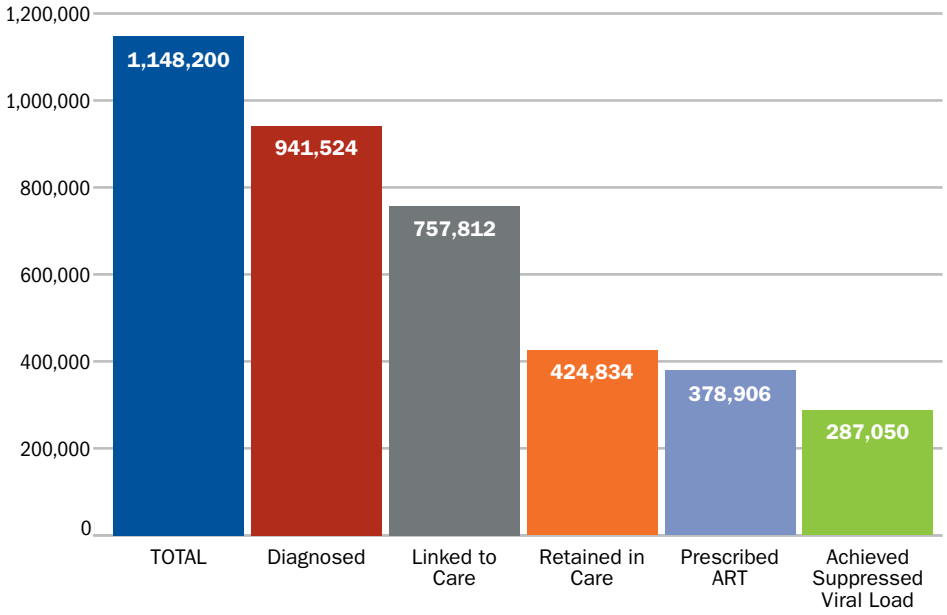
SOURCE: CDC. Estimated HIV incidence among adults and adolescents in the United States, 2007–2010. HIV Surveillance Supplemental Report, 2012;17(4).

Among Black MSM, the crisis is sobering. HIV incidence is disproportionately higher among Black MSM compared to White MSM. In 2010, an estimated 10,600 new HIV infections (36 percent of all new infections among MSM) occurred among Black men — nearly the same number that occurred among White MSM (11,200, 38 percent), even though Whites outnumber Blacks in the population by more than a factor of five.[25]

Young Black MSM are especially affected. While, among Whites, the largest number of new infections (3,300 or 29 percent) occurred among men ages 25 to 34, among Black MSM, the largest number of new infections (4,800 or 45 percent) occurred among young men ages 13 to 24.[26] And, while HIV incidence is increasing among young MSM overall, the rate of increase is much higher among young Black MSM. Between 2006 and 2009, while remaining stable or declining among all other racial and risk groups, HIV incidence increased by 21 percent among young people (ages 13 to 29), driven by a large increase (34 percent) among young MSM, which, in turn, was driven almost exclusively by a 48 percent increase among young Black MSM.[27]

Among people living with HIV, there are significant disparities in access to care and treatment. Though antiretroviral therapy (ART) has rendered HIV a potentially manageable, chronic condition, successful treatment — as indicated by the suppression of viral load below a detectable level — requires a sequence of events that has become known as the "treatment cascade."§ HIV-infected individuals must be diagnosed, linked into care, initiated on ART, retained in care, re-engaged in care (if necessary), and then they must successfully adhere to their treatment regimen. Analyses employing the treatment cascade model suggest that ART uptake

Estimated Numbers of Persons Living With HIV in 2009 and Percentage in the Continuum of Care by Selected Characteristics, United States



Adapted from Hall HI, Frazier EL, Rhodes P et al. Differences in human immunodeficiency virus care and treatment among subpopulations in the United States. JAMA Intern Med 2013; 173(14):1337-1344.

remains far below ideal levels — among the 1,148,200 persons living with HIV in the United States in 2009, 82 percent had been diagnosed, 66 percent were linked to care, 37 percent were retained in care, 33 percent received ART, and 25 percent had suppressed viral load (Figure 1).

From a different perspective, as of 2009, approximately 18 percent of all people living with HIV remain unaware of their infection, while 50 percent of those who have been diagnosed remain without appropriate care. More than 850,000 people living with HIV in the United States– 79 percent of Blacks, 74 percent of Latinos, and 70 percent of Whites — do not have a successfully suppressed viral load, indicating no or substandard treatment and a missed prevention opportunity. A review of disparities by race, gender, age and transmission category at each point along the treatment continuum, however, did not find statistically significant differences, with the exception of age: younger people ages 25 to 34 and 35 to 44 were less likely than persons ages 55 to 64 to be retained in care, prescribed ART, or to have a suppressed viral load ($p<.001$).[28]

Generally, HIV-positive MSM experience better linkage and retention to care than do young people, females, those who inject drugs, and racial/ethnic minorities.[29] But disparities related to race are observed among MSM. In two meta-analyses, HIV-positive Black MSM were less likely to be diagnosed, to have a CD4>200, to attend clinical visits, to access or adhere to ART, or to be virally suppressed.[30, 31] Moreover, Black MSM experience higher rates of disease progression and mortality than other MSM.[32, 33]

Determinants Of MSM Health (Including HIV)

A variety of complementary conceptual frameworks have been proposed to explain the disparities noted in MSM health indicators.

Determinants of population health are generally considered to fall within five overlapping domains: 1) individual behaviors (e.g. alcohol or drug use, smoking and unprotected sex); 2) biology and genetics; 3) social environment (e.g. discrimination, poverty, education level, marital status and stigma); 4) physical environment (e.g. place of residence, incarceration, crowding conditions and built environment); and 5) health services (e.g. access to care and insurance). The last three constitute the immediate and visible circumstances in which people live, or social determinants of health. As factors that may significantly affect an individual's environment, but that fall outside individual control, the influence of SDH on health and health disparities has been increasingly recognized.[34] Moreover, the effects of SDH may accumulate over a lifetime and persist across generations.[35] The interplay of these five factors (i.e. individual behavior + biological factors + social determinants), each of which may affect and be experienced very differently among LGBT populations compared to heterosexuals, influences physical and mental health — including HIV.

Individual Behaviors

Some behaviors that compromise mental and physical health are more common among LGBT youth and adults, while the correlation of certain risk behaviors with HIV transmission, morbidity and mortality have been long established.

Substance abuse. Many studies have shown an association between LGBT orientation and an increased risk for substance abuse, which in turn has been linked to a variety of negative outcomes and has been well established to be a determinant of HIV risk. For example, a meta-analysis of studies of mental disorders among LGB people found that these populations have a 1.5 times greater risk for alcohol or substance dependence over the previous 12 months.[36] An analysis of data from the Urban Men's Health Study found substantial rates of current recreational drug use (52 percent) and alcohol use (85 percent) among MSM, with 8 percent reporting heavy drinking, 18 percent using three or more recreational drugs, and 19 percent reporting recreational drug use at least once per week.[37] While there are occasional studies showing otherwise — one analysis of data from the National Epidemiological Survey on Alcohol and Related Conditions showed the risk for substance abuse or dependence to be significantly higher among bisexual men and women, but not among gay men, compared to other groups[38] — many studies suggest that MSM exhibit higher rates of substance abuse than do their heterosexual counterparts, especially if lifetime use rates are compared.[39] Population studies have also shown that marijuana use is more common among MSM compared to heterosexual men,[40] and that lesbians and gay men have a higher prevalence of tobacco use.[41, 42, 43]

Among Black MSM, however, substance abuse rates were generally lower than among White MSM — in a meta-analysis of studies conducted in Canada, the United Kingdom, and the United States, Black MSM were less likely to report any substance abuse, including methamphetamine, or to use drugs or alcohol during sex.[44]

Among youth, in national population studies, LGB adolescents in North America had higher rates of smoking, alcohol use and other drug use (including injecting) compared with heterosexual teens, were more likely to begin drinking earlier, and had higher levels of risky drinking.[45] Compared to their heterosexual counterparts, in a meta-analysis, LGB youth were more than three times as likely to report use of any substance, with substantial differences for cigarettes, injection drugs and polydrug use.[46]

Sexual Risk Behaviors. In a recent analysis of data from the Urban Men's Health Study, a much higher proportion of MSM were found to recruit new sexual partners well into their thirties (compared to heterosexuals, for whom more than half reported no new partners in the previous five years), to have a much higher prevalence of concurrent partners, and to more frequently partner with men of a different age group — all of which could magnify the potential for HIV transmissions within sexual networks.[47] Similarly, adolescent MSM may be at greater risk than their heterosexual counterparts, as LGB youth have higher rates of early sexual debut and report a higher number of lifetime or recent sexual partners.[48] In probability samples among youth in British Columbia, young MSM were more likely than heterosexual males to have ever had intercourse, to report two or more sexual partners, and to have had first intercourse before age 14.[49] Sexual risk-taking does not appear to differ by race, however. In a meta-analysis of studies conducted in the United States, Black MSM had significantly fewer partners than White MSM, though they were less likely to identify as gay or to disclose their homosexuality to others.[50]

Adolescent MSM may be at greater risk than their heterosexual counterparts, as LGB youth have higher rates of early sexual debut and report a higher number of lifetime or recent sexual partners.

Biology and Genetics

The disparities in HIV incidence among MSM are significantly affected by biological and epidemiologic factors, including background HIV prevalence, sexually transmitted disease prevalence, sexual mixing patterns, and the relative risk for HIV transmission of various sexual practices. Because MSM are more likely to find sex partners locally, if HIV prevalence in the surrounding community is high, the probability of encountering a sex partner who is HIV-positive is significantly enhanced. Sexually transmitted diseases increase the probability of HIV infection, and as noted above, STD prevalence among MSM is far higher than among heterosexual men.[51] Both factors are magnified significantly among Black MSM, among whom HIV and STD prevalence is higher than among White MSM. In a meta analysis of studies conducted in the United States, Canada and the United Kingdom, compared to White MSM, Black MSM were more likely overall to have a current or lifetime STD diagnosis, three times as likely to be HIV-positive, and six times as likely to have an undiagnosed HIV infection — in spite of lower rates of sexual risk taking and substance abuse, and higher rates of preventive behaviors.[52]

Because the risk of HIV infection via anal sex is approximately 18 times higher than via vaginal sex, MSM are at proportionally higher risk than heterosexuals even with the same number of sex partners. And because MSM who engage in anal sex sometimes switch roles (between insertive and receptive), the population risk is further elevated.[53]

Social Environment

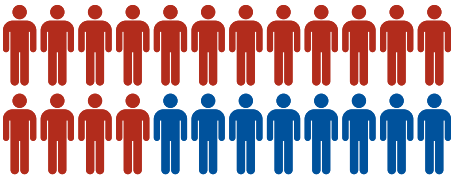
Stigma and discrimination. The minority stress model has been used as a framework to understand the impact of select social determinants — i.e. those stemming from stigma and discrimination — on health disparities among LGB individuals.[54] The model proposes that LGB individuals suffer from excess and disproportionate stress related to their stigmatized social category, and that such stress leads to adverse health outcomes. It is premised on the "heterosexual assumption," wherein everyone is assumed to be heterosexual, where sexual minorities remain generally invisible and unacknowledged by society's institutions, or, when they are made visible, are problematized. Stigma rooted in homophobia results in social marginalization and discrimination, which are expressed in four ways:

- **Enacted stigma** refers to overt acts of personal ostracism or rejection; discrimination (in housing or employment, for example); criminal victimization, violence or hate crimes — leading to a reduced sense of order and security;
- **Felt stigma** comprises a range of overt manifestations of anti-gay sentiment (e.g. antigay violence, antigay "religious freedom" legislative campaigns and hate crimes), which, even when not personally experienced, contribute to a climate of stigmatization;
- **Structural stigma** refers to laws, policies or regulations that have a discriminatory or stigmatizing effect, such as the denial of the right to marry or serve in the military; disenfranchisement from religious or spiritual resources (e.g. rejection from institutional religion); anti-discrimination provisions that fail to protect LGB people; or workplace practices that impede the hiring or promotion of gay people, thus exerting negative economic stress; and
- **Self-stigma** or internalized homophobia that results from individuals absorbing and believing pervasive negative portrayals.

In the model, as a consequence of persistent social marginalization and discrimination, LGB individuals cope in ways that are adaptive but ultimately stressful, and therefore injurious to health, including by concealing their sexual orientation through passing (i.e. pretending to be heterosexual) or covering (i.e. suppressing characteristics or information from which others might infer their sexual orientation), or by being out but only implicitly, by telling the truth but using only ambiguous language. Such strategies require constant vigilance, and also discourage forming relationships that might otherwise confer protective health benefits or accessing community social support resources. Like social determinants in general, minority stress is additive (i.e. it requires adaptive responses above and beyond those required by the everyday stresses encountered by others); chronic, in that it is based on relatively fixed social ideas and cultural structures; and socially based (i.e. it comprises social structures rather than biologic, genetic, or nonsocial characteristics of the individual or group).[55]

The disproportionate experience among MSM of discrimination and other prejudice, and the adverse health consequences of such experiences, has been repeatedly demonstrated. For example, LGB individuals were twice as likely as heterosexuals to experience a major life event, such as being fired, related to prejudice.[56] In population studies, LGB individuals were all more likely than heterosexuals to experience sexual assault.[57] In a recent poll, two-thirds of LGBT adults had experienced discrimination based upon their sexual

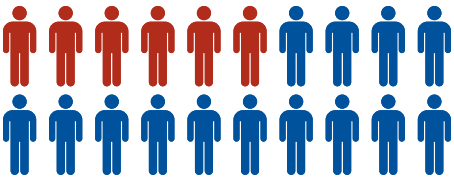
LGBT ADULTS AND DISCRIMINATION



Two-Thirds of LGBT adults have experienced discrimination because of their sexual orientation

Youth are even more likely than adults to be the victims of antigay prejudice or victimization, and may suffer greater consequences.

LGBT ADULTS AND PHYSICAL THREATS



30% of LGBT adults have been physically threatened or attacked

orientation; and nearly one-third (30 percent) had been physically threatened or attacked.[58] Moreover, harassment, victimization, and a history of childhood sexual abuse have been shown to negatively affect physical and mental health and have been associated with HIV infection.[59]

Multiple population studies have demonstrated that LGB youth are more likely than their heterosexual peers to be targeted for violence, to report physical violence or sexual abuse, to experience forced sex or dating violence, or to endure harassment, bullying or physical assault at school.[60, 61, 62] A number of studies have demonstrated a link between enacted stigma experienced by LGBT youth and higher rates of mental health problems, including depression and suicidal ideation, substance abuse and risky sexual behaviors.[63, 64, 65]

Family rejection may be a particularly important determinant of health among LGB youth. Youth who were rejected by their families after coming out have significantly higher rates of depression, suicide attempts, substance abuse and risky sex behaviors.[66] Family rejection may also contribute to higher rates of homelessness or street-involvement among LGB youth, which may in turn contribute to higher rates of survival sex or prostitution.[67]

Both LGBT adults and youth may be subject to disproportionate sanctions from school disciplinary or criminal justice systems. For example, in longitudinal studies conducted among adolescents, sexual-minority adolescents were 1.25 to 3.0 times more likely to receive punishments from their schools, police or courts.[68] In a study conducted in New York City, LGB youth were more likely to experience negative verbal, physical or legal contact with the police, and more than twice as likely to experience negative sexual contact in the preceding six months.[69]

In addition to the deleterious effects of enacted or felt stigma, there is emerging evidence that structural stigma may also be an important determinant of health. For example, LGB individuals who live in states with constitutional amendments banning same-sex marriage have higher rates of psychiatric disorders and are more likely to attempt suicide than those who live in states without such pernicious policies.[70] Recently, a population-based analysis of mortality data found that sexual minority residents of communities with high levels of antigay prejudice died an average of 12 years sooner than those who lived in communities with low levels of antigay prejudice, even after controlling for multiple risk factors at the individual and community level. The findings showed that sexual minorities were more likely to die by suicide in high stigma communities, and that completed suicides among this group occurred at a significantly lower age (average 18 years earlier).[71]

MSM living with HIV may experience additive stigma related to their infection. Among people living with HIV, stigma has been shown to increase depression, psychological stress, and shame, to increase a sense of hopelessness, and is associated with poorer mental and physical health outcomes and diminished social support.[72] People with HIV report much higher levels of childhood sexual abuse than does the general population, which in turn has been shown to predict other problems (e.g. alcoholism, substance abuse and recurring STDs) that might adversely affect HIV

progression.[73] Trauma severity predicts HIV mortality, and individuals who experience more traumatic events are three times more likely to die compared to those who report few such incidents.[74]

Poverty, educational level.

While the links between socioeconomic class (e.g., poverty and educational level) and LGB health have received less attention, analyses of data from the American Community Survey showed that individuals in same-sex couples have higher unemployment rates, even though they also have higher rates of college completion, compared to heterosexual couples.[75] As poverty rates increased during the recession, LGB Americans were more likely to be poor than heterosexual people — among Black same-sex couples, poverty rates were more than twice that of heterosexual married Blacks.[76] In a new analysis of population surveys, 29 percent of LGBT adults experienced a time in the last year when they did not have enough money to feed themselves or their family.[77]

CDC reports that HIV prevalence is highest among those at or below the poverty line, those with less than a high school education and those who are unemployed.[78] The effects of poverty on HIV health outcomes are profound. As many as half of people living with HIV in U.S. inner cities experience food insecurity, which is in turn related to reduced medication adherence and poor health outcomes. Studies have shown that for impoverished people with HIV, food insecurity and housing instability have a greater impact on overall health than medication adherence.[79] While the introduction of highly potent ART more than a decade ago unquestionably improved survival and quality of life among people with HIV, it may have increased inequalities in AIDS-related mortality, as those with more resources have increasingly positive health outcomes — while those at the bottom of the socioeconomic scale do not.[80]

Racial differences in HIV rates among those in the same socioeconomic classes suggest that the nexus between race and poverty may amplify the effects of SDH, which influence not only the underlying HIV prevalence of communities (increasing the risk for HIV acquisition among residents), but also individual risk taking within those communities. For example, those for whom stable relationships are imperiled by the stress of stigma, discrimination, violence, incarceration and other factors may be more likely to engage in sexual mixing patterns (i.e. more partners, more frequent episodes, unprotected sex) that can foster HIV transmission. Because many sexual networks are tight and racially homogenous (i.e. sexual encounters are more likely among individuals of the same race and socioeconomic class), the HIV risk within minority communities is even higher than might be attributable to socioeconomic factors alone.[81] Racial disparities in HIV determinants generally are consistent among MSM — in a meta-analysis conducted in Canada, the United Kingdom and the United States, Black MSM were more likely to be low income, have less than high school education, have ever been incarcerated or to be currently unemployed than their White peers.[82]

As noted above, sexual minority youth are disproportionately represented among homeless youth populations and, compared to heterosexual youth, homeless LGBT youth are at significantly higher risk for behavioral health conditions or to have been physically or sexually abused while homeless,[83] to engage in survival sex and to acquire HIV infection.[84]

It has been well established that among heterosexuals in the United States, HIV is predominantly a disease of the poor.

Physical Environment.

Little research has been undertaken to examine the relationship between geography and LGBT health, though small studies have suggested that isolation associated with rural residency may negatively affect health. The U.S. HIV epidemic is highly concentrated among urban centers on the East and West coasts, and in cities and towns across the South, where in each instance, poor neighborhoods are affected far more than rich ones. While many chronic health conditions (e.g. diabetes, heart disease and cervical cancer) are more prevalent among those lower on the socioeconomic scale, social stressors related to economic survival, the threat of violence, poorer health, and social discrimination may be even more acute in cities with high income disparities, such as New York, Washington, D.C. and San Francisco, where very affluent neighborhoods abut areas with HIV infection rates comparable to those in sub-Saharan Africa. In an examination of county-level data in 40 states, HIV diagnosis rates were significantly correlated with income inequality. Underscoring the intersection between race and socioeconomic class, HIV diagnoses were inversely correlated with the proportion of Whites who lived in the county — with racial segregation likely leading to disparities in health resources.[85] Neighborhoods blighted with abandoned buildings and elevated crime rates also have higher rates of HIV infection, often associated with injection drug use.[86] Low social capital — i.e. the value of a group's social network, as indicated by community organizational life, involvement in public affairs, volunteerism, informal sociability and social trust — is associated with higher HIV rates, above and beyond the effects of poverty and disease.[87]

With the exception of LGBT-focused HIV and STD prevention measures, public health interventions targeting LGBT communities for cancer prevention, alcohol, tobacco cessation, asthma or cardiovascular disease have been largely non-existent.[88]

Health Services

LGBT populations may experience disproportionate barriers to accessing quality healthcare services, as a result of: 1) reluctance to disclose sexual orientation or gender identify for fear of prejudiced reactions, being stigmatized, or confidentiality breaches, or based on negative past experiences; 2) a paucity of providers competent to manage LGBT health issues; 3) structural barriers that impede access to health insurance (which is often denied to unmarried domestic partners, even in jurisdictions that do not recognize same-sex marriage) or limit visiting and medical decision-making; and 4) a lack of culturally appropriate prevention programs (e.g. violence victimization, substance abuse and mental health). In spite of these barriers, some population-based studies have failed to detect differences in access to healthcare among MSM.[89] Measures may be too crude to detect quality of care, however, and some studies conducted among providers show wide variability in attitudes about working with sexual minority patients,[90] while studies among patients showed that many LGB individuals fail to disclose their sexual orientation to their provider, which may compromise their care.[91]

With respect to access to HIV care, sharp disparities among racial/ethnic groups have been noted, and these persist among MSM. In a meta-analysis of studies conducted in Canada, the United Kingdom and the United States, HIV-positive Black MSM were less likely than their White counterparts to have been diagnosed, to have initiated ART, or to have health insurance.[92]

While implementation of the Affordable Care Act has increased access to care among young adults, who may now be covered by their parents' health insurance until a later age, LGBT youth who are not cared for by their families may not benefit.[93] Moreover, family physicians, who provide care to the majority of youth ages 15 to 24, are insufficiently trained to provide care for LGBT youth.[94]

Syndemics in the Context of Biological And Structural Determinants Of Health

While multiple social determinants of MSM health may each independently influence physical and mental health outcomes, it has been increasingly apparent that they may also mutually reinforce and amplify each other.

In an analysis of data from the Urban Men's Health Study, determinants including childhood abuse, depression, intimate partner violence and polydrug use were highly inter-correlated and positively associated with high-risk sexual behaviors and HIV infection. This syndemic, fueled by cultural marginalization, comprises an additive interplay of health epidemics of HIV, STDs, mental health, substance abuse and violence, each reinforcing each other. With respect to HIV prevention among MSM, this concept has profound implications — as men who are challenged by the combined effects of depression, substance abuse and violence may not have the capacity to reduce their sexual risks, underscoring the need for community-level or structural interventions.[95]

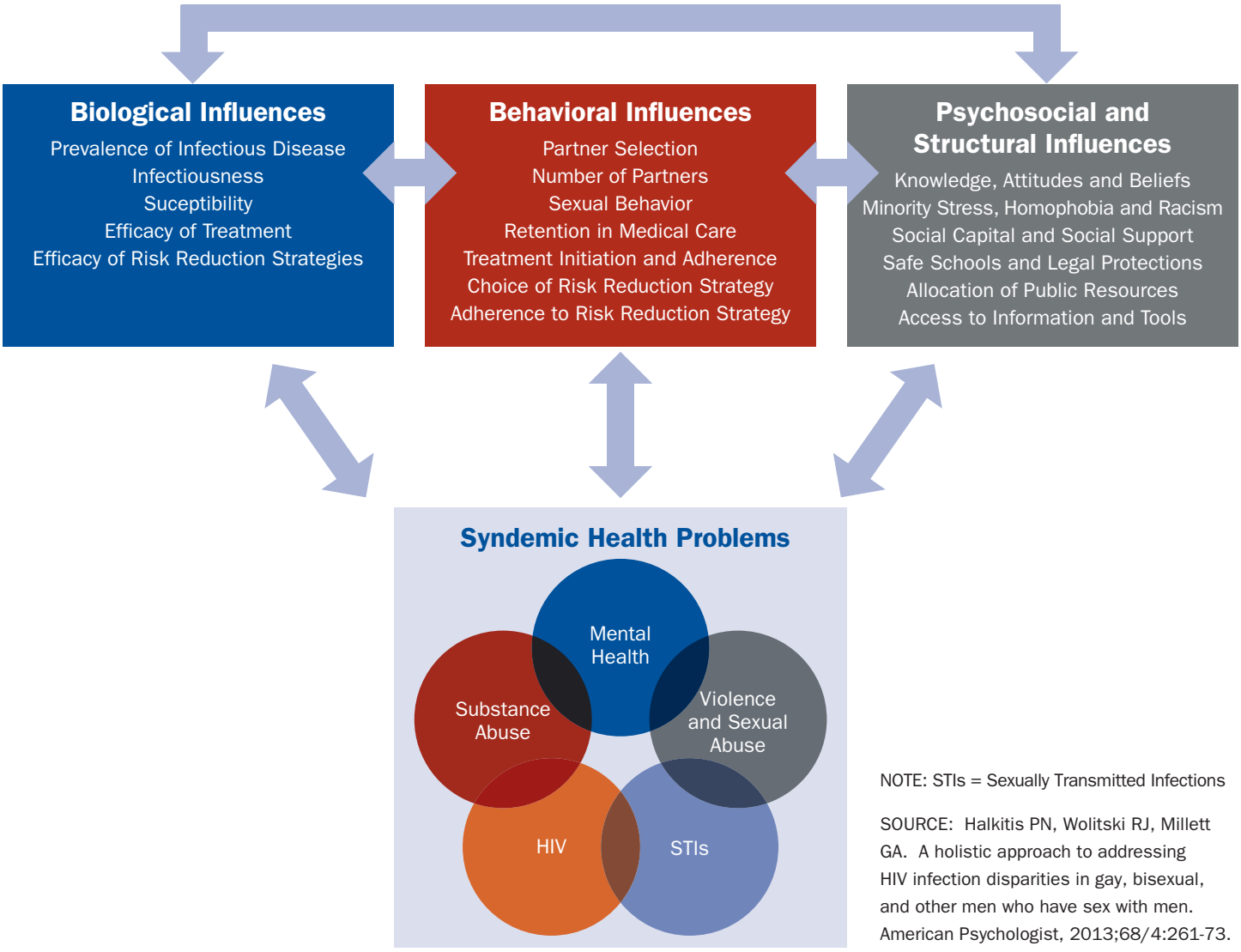
The production of syndemic conditions among MSM may occur over the life course, suggesting the possibility of early intervention. For MSM, many of the individual health problems (e.g. depression and anxiety, substance abuse and HIV) that together comprise an adult syndemic condition are characterized by their early onset, often during adolescence. Researchers have theorized that masculine socialization — during which many young MSM experience rejection, ostracism, harassment, or even physical violence — combined with additional stresses associated with initiation into a gay culture marked by high prevalence of STDs, HIV and substance abuse — contribute to later syndemic production among urban MSM.[96]

A recent study explored the concept of syndemic development over the life-course — i.e. as the consequence of lifelong adversity — among the Multicenter AIDS Cohort Study (MACS), a long-term progressive cohort of MSM living with HIV. Among participants, early childhood satisfaction, victimization (e.g. bullying or ostracism), perceptions of inadequate attainment of masculinity norms and low social connectedness were associated with the development of syndemic conditions later in life.[97] An analysis of Black MSM among the same cohort showed similar results. Black MSM who experienced gay-specific childhood or adolescent stressors (particularly parental abuse, victimization, perceptions of failed attainment of masculinity norms or internalized homophobia) were significantly more likely to develop syndemic conditions later in life.[98] Childhood or adolescent

adversity has been long associated with adverse health outcomes later in life, raising the possibility that addressing the victimization experienced by young MSM might interrupt the development of syndemic conditions later in life, thus contributing to better adult health outcomes.

Compounding syndemic production, many MSM, particularly racial minorities, experience determinants of health related to multiple, overlapping domains, including not only sexual orientation, but race, poverty, educational attainment and immigration status. While there is significant research examining the impact of each domain on LGBT health (including HIV progression and survival), there are few studies with sufficient power to examine the intersectionality of domains.[99] Moving forward, additional research to examine the interplay of domains will be critical, as will the development of individual, biomedical, structural and policy interventions that address the reality that MSM health is mediated by biological, behavioral and structural drivers.[100, 101]

Biopsychosocial Drivers of the Syndemic in Gay, Bisexual and Other Men Who Have Sex With Men



NOTE: STIs = Sexually Transmitted Infections

SOURCE: Halkitis PN, Wolitski RJ, Millett GA. A holistic approach to addressing HIV infection disparities in gay, bisexual, and other men who have sex with men. American Psychologist, 2013;68/4:261-73.

Protective Factors and Resiliency

These studies and others exploring syndemic conditions and their production have also foregrounded the concept of resilience, often described as healthy development in the face of adversity — i.e., the capacity to avoid or overcome the negative outcomes associated with repeated exposures to risk. For example, another analysis from the MACS cohort showed that the majority of adult MSM who had resolved previously internalized homophobia had significantly higher odds of positive health outcomes.[102] Importantly, most theories of resilience describe it is a process, rather than an inherent trait — i.e. individuals develop resilience over time.

There has been relatively little research to examine factors that may increase resiliency to protect or promote health among LGBT individuals, though protective factors may be inferred from deficit-based studies. For example, it has been increasingly noted that most MSM exhibit substantial resilience, and researchers have begun to explore the resiliency factors that characterize the majority of MSM who experience adversity associated with minority stress who do not develop syndemic conditions, or the majority of MSM who endure syndemic conditions who do not acquire HIV.[103, 104] For example, in the seminal *Urban Men's Health Study* syndemics analysis described above, while the relatively high proportions of MSM experiencing multiple health problems were HIV positive (22 percent) or had recently engaged in high-risk behaviors (23 percent) — 78 percent had not engaged in risk behaviors and 77 percent had remained HIV-negative, in spite of the adversity they experienced.[105]

MOVING FORWARD: Intervening to Address Determinants of MSM Health

To date, most individual-level HIV prevention interventions targeting MSM have been based upon a deficit-based approach that attempts to reduce risk factors. While such approaches are effective and have reduced HIV transmission, their impact may be limited and ultimately insufficient to manage the HIV epidemic. Moreover, while framing behavioral risks for HIV infection as failures that must be avoided or corrected, this "broken person" approach neglects the potential value of MSM's inherent resiliencies. Moving beyond a deficit-based approach will require interventions not only to reduce the negative consequences of determinants of MSM health, but also to enhance men's natural resiliencies and support healthy living.

Over the past decade, mitigating the social determinants of health inequities has become a national and international priority, and it is increasingly acknowledged that social determinants are not merely coincidental, but rather are mediated by public and social policy: "This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programs, unfair economic arrangements, and bad politics."[106] As such, addressing social determinants of health inequities among MSM (including HIV) will require a combination approach that includes individual (behavioral) and biomedical interventions, but also community-level and structural interventions, including health policy and legislation, economic and social interventions, and cross-sector collaborations. Moreover, it seems possible that if a culture of stigmatization produces health inequities, then a culture of acceptance and integration might promote positive health outcomes. Achieving such an affirming environment for MSM will require changes at many levels, including society, community, family and social network.

MARRIAGE EQUALITY

The recognition of same-sex marriage provides one example of how public policy mediates systemic stigma, positively and negatively, which in turn can affect health outcomes. While structural stigma (such as constitutional amendments banning same-sex marriage) has been associated with increased morbidity and mortality, LGB individuals residing in jurisdictions without such laws or policies had no increased adverse health outcomes.[107,108] Considerable research has documented the positive health outcomes associated with heterosexual marriage derived from the economic impact of benefits, rights and privileges.[109, 110] Preliminary results suggest that similar benefits are conferred by same-sex marriage. In an analysis of data from the California Health Interview study, being in a legally recognized same-sex relationship reduced the mental health disparities between LGB and heterosexual couples.[111]

It has been widely noted that improving health outcomes and reducing disparities will require efforts that transcend the health sector.[112] Non-health policies and programs – including education, job training and income support, transportation, land use, criminal justice and housing, to name only a few — clearly have an impact on health outcomes and health inequities. In one analysis, as little as 10 percent of the variability in premature deaths was associated with differences in healthcare, while 60 percent was attributed to social, environmental or behavioral factors.[113] A "health-in-all-policies" approach, which prospectively assesses and takes into account potential health outcomes associated with non-health related policies and programs, has been employed in some sectors and may be useful in efforts to improve MSM health.[114] Such an approach attempts to balance health concerns with other imperatives and offers an opportunity to collaborate across sectors, particularly among non-traditional partners.

The recommendations that follow are the synthesis of a literature review, interviews with key informants, and the expert consultation convened by Trust for America's Health in July 2014.

Federal leadership

The federal government will have a strong role to play, though intergovernmental coordination is never easy, and will require high-level leadership. The Obama administration has undertaken important beginning efforts in this regard. Addressing SDH constitutes an important part of the HHS Healthy People 2020 framework[115] and is included as an objective in CDC's National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention's Strategic Plan 2010 to 2015.[116] In 2013, the President issued an executive order establishing the HIV Care Continuum Initiative, designed to mobilize and coordinate federal efforts to take advantage of recent HIV prevention and treatment advances, via further integration of HIV prevention and care efforts; expand successful HIV testing and service delivery models; encourage innovative approaches to address barriers to accessing testing and treatment; and ensure that federal resources are focused on evidence-based interventions. A working group comprising the Departments of Justice, Labor, HHS, Housing and Urban Development (HUD), Veterans Affairs and the Office of Management and Budget was established.[117]

With respect to health disparities, however, while there have been significant strides in cross-agency collaboration, data-sharing, and evaluation focusing on other populations (including women and racial minorities), such efforts have been rarer with respect to sexual orientation. At the request of the President, HHS established an LGBT Issues Coordinating Committee, which, in 2013, prioritized federal recognition of same-sex spouses, LGBT enrollment outreach in the health insurance marketplace, LGBT-specific research and data collection and the development of resources for families of and providers serving LGBT youth.

Across the federal government, the National Prevention, Health Promotion, and Public Health Council is perhaps best positioned to address social determinants of MSM health inequities. The NPC, the creation of which was mandated by the Affordable Care Act, is charged with coordinating efforts of 20 federal departments and agencies** to "ensure the health, well-being and resilience of the American people." In 2011, the NPC released the National Prevention Strategy (NPS), which "envisions a prevention-oriented society where all sectors recognize the

value of health for individuals, families, and society and work together to achieve better health for Americans." Notwithstanding, while noting the disproportionate incidence of health inequities and their correlation with social determinants, the NPS includes sexual orientation only among various sub-populations that suffer disparities.[118]

Overall, the NPS employs four strategic directions to guide actions that will demonstrably improve health, all leading to the goal of "increasing the number of Americans who are healthy at every stage of life": 1) Healthy and Safe Community Environments; 2) Clinical and Community Preventive Services; 3) Empowered People; and 4) Elimination of Health Disparities. In addition to the strategic directions, the NPS provides evidence-based recommendations most likely to reduce the leading causes of preventable death and major illness, in seven priority areas (most of which dovetail with health inequities experienced by MSM): tobacco free living, preventing drug abuse and excessive alcohol use, healthy eating, active living, mental and emotional well-being, reproductive and sexual health, and injury and violence-free living. The NPC is chaired by the acting Surgeon General, who leads the U.S. Public Health Service, and meets regularly to oversee agency initiatives associated with NPS implementation. The NPC reports progress on meeting NPS goals on a yearly basis to the President and Congress. The Advisory Group on Prevention, Health Promotion, and Integrative and Public Health, which comprises non-federal members, advises the NPC in developing public, private, and nonprofit partnerships.

FEDERAL LEADERSHIP IN ADDRESSING HEALTH INEQUITIES AMONG MSM.

The recommendations that follow fit easily with the NPS framework, and offer the opportunity to integrate efforts to mitigate MSM health inequities across government programs. The Office of National AIDS Policy (ONAP) should immediately initiate the collaborations described below:

- **FEDERAL LEADERSHIP AND COORDINATION.** Emphasizing the connection between other social determinants of MSM health inequities and HIV, ONAP and the Presidential Advisory Council on HIV/AIDS (PACHA) should partner with the NPC to delineate an agenda that incorporates MSM health priorities across federal agencies, including but not limited to HIV programs. As the National Prevention Strategy is updated, it should emphasize the need to address health disparities related to sexual orientation or gender identity, including those among MSM. ONAP and the National Prevention Council should also promote public/private partnerships focusing on MSM health, or incorporate MSM health issues into existing partnerships. For example, ONAP recently convened LGBT funders to ensure that young MSM were specifically included in President Obama's My Brother's Keeper initiative, which strives to connect young people to mentoring and support networks.

- **NATIONAL HIV/AIDS STRATEGY.** While ONAP is charged with coordinating the HIV response across the federal government, no such mechanism exists for MSM health. As such, while the National HIV/AIDS Strategy strongly emphasizes the need to address prevention and treatment among MSM, it mentions social determinants only in passing, calling for a "more holistic approach to health."[119] Insofar as MSM are disproportionately impacted by HIV, ONAP should provide leadership in promoting MSM health across federal HIV programs, facilitating cross-agency collaborations, disseminating best practices, and sharing information and data among agencies. As the National HIV/AIDS Strategy is updated, it should embrace an agenda to address social determinants of health inequities among various subpopulations disproportionately affected by HIV, but certainly among MSM. It should emphasize a life course approach to MSM health, which will require a greater focus on youth.

- **FEDERAL DISCRETION (and the Bully Pulpit).** Though many equality issues may appear intractable, including some structural social determinants such as the recognition of same-sex marriage, the overall status of LGBT people has improved measurably over the past few years. And while President Obama certainly has his critics (among those who favor and those who oppose LGBT equality), the current administration deserves substantial credit — for declining to defend the Defense of Marriage Act, and upon its demise, for aggressively implementing regulations throughout the government that recognized same-sex unions; for executive orders

prohibiting discrimination in federal programming; for interpreting discrimination based on sexual orientation or gender identity to apply under federal anti-discrimination statutes, such as the Civil Rights Act or the Fair Housing Act, none of which explicitly prohibit such practices; for programming designed explicitly for sexual and gender minorities; for ensuring the Affordable Care Act's positive approach to LGBT health; for developing the first National HIV/AIDS Strategy; and importantly, for the President and his cabinet publicly and unapologetically defending LGBT equality in a wide range of settings, including the State of the Union address. Advancing LGBT equality — and by extension reducing MSM health inequities — will require continued, sustained federal leadership.

- **FINANCING DATA.** The extent to which federal HIV programs target key populations, specifically including MSM, should be tracked and updated with every budget cycle. While certain programs are not population specific and others target only the general population, it is essential to disaggregate population-specific programs in order to demonstrate how well federal funding aligns with epidemiologic data.

- **SERVICE UTILIZATION DATA.** Health service utilization data should capture information related to sexual orientation and gender identity. Many programs — even those with obviously high numbers of MSM, including HIV programs such as the AIDS Drug Assistance Program (ADAP) — fail to collect sexual orientation data, foreclosing the possibility of additional analyses to assess sexual orientation and gender identity-specific health disparities. As the government refines meaningful use standards for electronic health records (EHR), it is imperative that sexual orientation and gender identify fields be included (see also healthcare section, below).

- **EPIDEMIOLOGICAL RESEARCH.** As detailed by the Institute of Medicine, MSM health programming has been significantly hobbled by a lack of research. It is critical that sexual minorities be included in population studies. In 1995, the YRBS was the first CDC survey to include sexual minority questions — while initially optional, these questions were recently added to the national questionnaire and to the standard core questionnaire used by states and cities. The National Healthcare Disparities Report included LGBT populations for the first time in 2011.[120] In 2013, CDC included a sexual-orientation specific question in the National Health Interview Survey for the first time,[121] while the Substance Abuse and Mental Health Services Administration (SAMHSA) added two questions, one on sexual attraction and one on sexual identity, to the National Survey on Drug Use and Health dress rehearsal, in contemplation of including them in the 2015 survey. The Office of the Assistant Secretary for Health expanded Healthy People 2020 LGBT topic areas to include two national objectives aimed at increasing the number of population studies that include LGBT populations.[122] Other important surveys only include such questions on an optional basis, or in a limited way. For example, only a handful of states (13 and the District of Columbia in 2009) asked sexual orientation questions in their annual Behavioral Risk Factor Surveillance System (BRFSS) survey.[123] Virtually no longitudinal studies have followed young MSM as they grow older or adult MSM as they transition to middle- and old-age. Few HIV interventions have been specifically evaluated among young MSM, while virtually no interventions addressing other social determinants of health among this population have been tested.

Population data are essential to understanding MSM health. As such, where they have yet to do so, CDC, SAMHSA and other federal agencies should add questions pertaining to sexual orientation, identity and behaviors to core instruments for national health surveys. The National HIV Behavioral Surveillance system should be expanded both geographically (it is currently conducted in 20 cities) and to include participants ages 13 to 18. To better understand the life course of MSM health inequities, the NIH should immediately support longitudinal research examining HIV and other health issues among a broad cohort of young MSM.

A LIFE COURSE APPROACH TO INTERVENTIONS TO INCREASE RESILIENCY

Nationally, there is increased attention on the long-term health and social consequences of early childhood trauma. In the Adverse Childhood Experiences (ACE) Study, childhood abuse, neglect, or exposure to other traumatic stressors (e.g. familial substance abuse, mental health disorders, sexually transmitted infections and violence) were linked to a number of short- and long-term health and social problems.[124] That MSM suffer disproportionate rates of many early childhood traumas, and that such traumas have been linked with later development of syndemic conditions, argues for interventions to address social determinants of MSM health inequities early in life and throughout the life course.[125]

Young MSM in schools.

Sadly, schools are among the most hostile environments encountered by LGBT youth, and even supportive families are insufficient to counter bullying and victimization that many LGBT adolescents experience in and out of schools. Though bullying per se does not violate federal laws, students are protected from discriminatory harassment when it is based on race, national origin, color, sex, age, disability or religion. While sexual orientation is not a protected class, the U.S. Department of Justice and U.S. Department of Education (DOE) have made it clear that harassment based on sex and sexual orientation are not mutually exclusive, and that when LGBT students are harassed based on their actual or perceived sexual orientation, they may also be subjected to forms of sex discrimination recognized under Title IX (1972 Education Amendments to the 1964 Civil Rights Act). Recent DOE guidance made clear that Title IX extends to claims of discrimination based on gender identity.[126]

Though anti-bullying policies are becoming more commonplace, many such policies are generic (i.e. they fail to account for gay-specific bullying), and in some cases, anti-gay bias combined with very strict anti-bullying policies may actually punish victims who fight back or defend themselves in the face of homophobic abuse. Beyond bullying, LGBT students are more likely to encounter school discipline, and to be suspended, often as a result of dress codes that enforce gender conformity or policies that suppress behaviors that would be considered normal among different sex couples, such as holding hands or kissing.

Students must not only feel safe from violence, harassment, or other abuse in schools, but also valued, respected and accepted by school professionals and peers. A population study in Massachusetts showed that LGB youth in schools with supportive staff, anti-bullying policies and Gay/Straight Alliance (GSA) clubs reported lower rates of victimization, skipping school and suicide attempts.[127] In a recent analysis of data from the Youth Risk Behavioral Surveillance System, LGB students living in states and cities with more protective school climates reported fewer past-year suicidal thoughts.[128]

In a truly safe school climate, students, teachers, administrators, parents and board members alike would be unafraid to disclose their sexual orientation. Schools with supportive environments for LGBT youth are characterized by safety and consistently enforced anti-bullying policies. To establish positive norms, employment policies protect teachers and administrators against LGBT-related discrimination, and school policies welcome alternative family configurations. Professional training instills in teachers and other professionals the importance of LGBT issues and prepares them for conversations about LGBT topics, and to develop supportive relationships with all students, regardless of their sexual orientation.[129]

SUPPORTING ADOLESCENT MSM IN SCHOOL

Federal education policies and programs should consistently support school environments that are welcoming and supportive of all students, including sexual minorities and gender non-conforming youth. For example:

- Develop and promulgate **BEST PRACTICES for SCHOOLS and SCHOOL DISTRICTS** to support LGBT children. A number of resources are available that outline approaches for schools to achieve an environment that is safe and supportive for LGBT students.[130,131] SAMHSA publishes Top Health Issues for LGBT Populations, an information and resource kit targeting prevention professionals, healthcare providers and educators.[132] Training for teachers and administrators, including continuing education requirements, are essential components.

- Provide comprehensive **SEXUALITY EDUCATION** in schools. To ensure that LGBT students feel included, it is essential that sexuality education be gender neutral and non-shaming. It is also critical to employ a life-course approach — i.e. one that recognizes that the needs of 13- to 15-year-olds are very different from those of 15- to 18-year-olds. One resource, the Family and Youth Service's Bureau's National Clearinghouse on Families and Youth's online training module, "Creating a Safe Space for LGBTQ Teens," was designed to help those who deliver teen pregnancy prevention programming to understand sexual orientation and gender identity, the challenges lesbian, gay, bisexual, transgender and queer and/or questioning (LGBTQ) youth face, the importance of prevention messages being inclusive of all youth, why it is critical that teen pregnancy and sexually transmitted infection/HIV prevention messages and projects are inclusive of all youth, and strategies for creating a safe and inclusive classroom setting. Through the Division of Adolescent and School Health (DASH), CDC provides funding for state and local education agencies to help districts and schools deliver exemplary sexual health education emphasizing HIV and other STD prevention; increase adolescent access to key sexual health services; and establish safe and supportive environments for students and staff. Such initiatives should include LGBT specific programming and be expanded nationally.

- **SCHOOL SAFETY**. Implement policies to ensure that all students are safe from violence. Resources are available from many organizations, including the S.A.F.E Classrooms project, a collaboration of Teach For America, The Trevor Project and GLSEN, which provides resources and toolkits to help teachers create learning environments that are safe and affirming for everyone.[133] Similarly, the American Federation of Teachers has partnered with GLAAD on the *See a bully, Stop a bully* campaign, which includes events and activities to educate teachers, parents and students on bullying and provides them with resources to effectively handle and prevent harassment at school.[134] While many schools have anti-bullying policies, it is important that such policies specifically reference sexual orientation, gender identity, and gender non-conforming youth. It is imperative that federal initiatives, such as Safe Schools/Healthy Students, a SAMHSA led initiative that supports community-level partnerships that are designed to address youth violence and promote the wellness of children, youth and families,[135] incorporate policies that consider the needs of LGBT youth. Because the effectiveness of bullying prevention programs has not been well demonstrated, the Suicide Prevention Resource Center recommends that school programs include strategies to identify LGBT youth at risk for suicide and referrals to mental health services.[136]

- **SEXUAL HEALTH.** Birth control, STD screening and treatment are critical for adolescents who are learning about their sexuality, and youth may have fewer resources for sexual health services, given the erosion of the public STD clinic system. Where possible, co-location of health clinics within schools may facilitate access — for example, in Washington, D.C., Unity Health Care operates a student health center in Eastern High School, offering a full range of healthcare and supportive services throughout the year, including summer and vacations.

- **WELCOMING LGBT PARENTS.** Parent involvement in education can have a positive impact on schools and student achievement. To expose adolescents to a diverse range of positive adult role models — and to demonstrate to LGBT youth that sexual minorities are respected and valued — policies and protocols to involve parents in schools must be welcoming and inclusive of both parents of LGBT youth, as well as LGBT parents.

- **POSITIVE LGBT ROLE MODELS.** Adolescents learn from positive role models in schools, but also from how adults are treated. Schools that provide a safe and inclusive environment for LGBT teachers and administrators demonstrate to youth that sexual minorities are valued and protected. It is essential that anti-discrimination and other employment policies include sexual orientation and gender non-conformity.
- **PEER SUPPORT.** Gay/Straight Alliance clubs provide a safety net for students during the coming out process, educate teachers and student peers to reduce slurs, and work with school administrations to implement policies that prevent harassment and violence. Strong, well-supported GSAs can have a major impact on the education environment and possess the power to transform individuals, school cultures and educational institutions. While most such groups are started by students and are youth-led, school sanction and support is critical.
- **GENDER NON-CONFORMING YOUTH.** For some LGBT youth, the outward communication of gender through their behavior or appearance may differ from expectations associated with their sex. Like all young people, gender non-conforming students are entitled to bias-free attention to their unique needs and to be safe in their school. They should be supported in their gender identity and never required to conform to gender stereotypes in order to receive appropriate education. As young people's sexual orientation and gender identify is often more fluid than adults, professionals should be educated about transgender issues and should understand that gender identity may or may not correlate with sexual orientation.
- **SCHOOL DISCIPLINE.** School behavior policies should eliminate provisions that punish the expression of sexual orientation or non-gender conforming dress. Disciplinary officials should receive training to support LGBT students and to discern homophobic harassment or abuse.

Young MSM outside of schools.

While school-based policies and services are essential for LGBT youth, it is important to acknowledge that many young MSM encounter substantial challenges outside of school. As discussed above, LGBT youth are more likely to become homeless than their heterosexual peers, often after being rejected by their families — tellingly, they are sometimes referred to as "throwaway" youth. As such, they are more susceptible to substance abuse and sexual and physical victimization. LGBT and non-gender conforming youth are more likely to encounter problems with school discipline or the criminal justice system, as they turn to sex work, drug trade, or petty crime to survive and are more likely to be harassed by police. They are more frequently criminalized, sanctioned by schools, labeled as sex offenders, detained for minor offenses, and denied due process, and are consequently over-represented in the juvenile justice system, accounting for 13 to 15 percent of youth who come in contact with the system. Policies that detain or remove LGBT youth from their homes for status offenses (such as "willful defiance," "incorrigibility," or "ungovernability") or divert them into alternative schools or day-placement settings may derail their education, setting off a lifelong cascade of economic insecurity.[137]

And, LGBT youth are much more likely to be placed in foster care, though the system is poorly equipped to meet their needs and many suffer homophobic abuse. In a recently completed study in Los Angeles County, approximately one in five foster youth identified as LGBTQ, and LGBTQ foster youth were twice as likely to report poor treatment and more likely to live in group homes and to have more foster care placements. More than 18 percent reported experiencing discrimination related to their perceived sexual orientation or gender identity/expression, including some who didn't identify as LGBTQ. The percentage of LGBTQ youth who were hospitalized for emotional reasons (13.5 percent) was nearly triple the percentage of similar hospitalizations for non-LGBTQ youth (4.2 percent).[138]

SUPPORTING MSM YOUTH OUTSIDE OF SCHOOLS

- **ORGANIZED ACTIVITIES.** Among all youth, idleness provides an environment that facilitates risky behaviors. MSM youth, who are often excluded from extracurricular activities, may face additional risks. It is essential that LGBT youth have access to after-school activities that provide a safe and welcoming environment.
- **YOUTH CENTERS.** While some youth may feel comfortable at or prefer LGBT-specific venues, for others it is important to have access to non-LGBT-identified venues that are welcoming. In particular, homeless MSM youth may be reluctant to attend LGBT-identified services, but need drop-in sites where they can receive services and referrals.
- **GED PROGRAMS.** Completing secondary education is a powerful determinant of health consequences later in life, and helping young MSM to finish high school, particularly those who may have interrupted their education after having been rejected by their families, may yield substantial benefits. Co-locating GED programs within programs providing other services to LGBT youth may enhance their accessibility — for example, Chicago's Howard Brown Health Center operates a GED program at their Broadway Youth Center.
- **SEX WORKERS.** MSM sex workers may be at significant risk for HIV, STDs, physical abuse or violence. Moreover, males are often not well served at programs targeting commercial sex workers, though significant numbers of young MSM, particularly those who are homeless, may rely on survival sex.
- **CROSS-GENERATIONAL PARTNERING.** Young MSM may be more likely than their heterosexual counterparts to have older sexual partners, and young Black MSM are more likely to partner with older men that their White counterparts. Outreach programs should instill in older men the importance of HIV prevention for younger men, while teaching young MSM how to negotiate safer sex and condom use, even in the face of differential power dynamics associated with differences in age.
- **LAW ENFORCEMENT PRACTICES.** Federal guidance to law enforcement, juvenile justice and child welfare agencies should encourage policies that protect LGBT youth, and discourage forced gender conformity or punishment for expressions of sexual orientation. Sensitivity training for law enforcement personnel who encounter homeless or truant LGBT youth should be widely available and implemented. For example, the Office of Juvenile Justice and Delinquency Prevention offers an online training, "Understanding and Overcoming the Challenges Faced by Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex Youth in Schools and Communities," designed to instill in practitioners the importance of becoming an ally to sexual minority youth, of teaching children to be tolerant and accepting, and changing the culture of schools and communities to be safer for sexual minority youth.
- **FOSTER CARE.** Though the Administration on Children, Youth and Families issued guidance to child welfare agencies on the support of LGBT youth in their care, additional training is sorely needed for practitioners and foster parents alike. Exclusions against foster parents based on sexual orientation should be prohibited as a condition of federal support, and anti-discrimination and confidentiality provisions should be implemented to protect foster care facilities and placements.

Young MSM and their families. Particularly for LGBT youth, who must confront a corrosive, stigmatizing environment just as they become aware of their sexual orientation, individual and community initiatives that facilitate sexual minority youth's self-acceptance of their sexual orientation and integration of their sexual identity into a self-concept (i.e. coming out) without fear of victimization or marginalization are central to promoting health.[139]

Positive social support and validation of relationships is clearly important. Earlier convenience samples have suggested the protective mental and physical health benefits from family support for relationships[140] and social networks.[141] In a community sample among LGBT youth, those whose families were more accepting and supportive had significantly lower rates of depression, substance abuse, suicidal ideation and attempts.[142]

SUPPORT FOR FAMILIES OF MSM YOUTH

Federal programs that address family needs should promote acceptance of LGBT children by their families, and provide support to families with LGBT children. For example:

- **PARENTING SKILLS-BUILDING** — All parents should foster a safe environment for their children and be prepared to offer support and guidance as their children develop sexual identities. While many parents may not anticipate raising LGBT children, it is important that those adults serving as role models for youth (including but not limited to parents) are aware of the possibility and prepared to be supportive. Parents of LGBT youth may have particular needs for resources, tools, support and skills-building in order to best support their children.
- In crisis situations, consider LGBT-friendly **CASE MANAGEMENT SERVICES** designed to meet the needs of families with gay children.
- Develop and promulgate **PROFESSIONAL BEST PRACTICES** for professionals to support parents of gay or gender non-conforming children in a variety of contexts: schools, healthcare and justice systems. For example, SAMSHA recently published best practices for mental health and substance abuse practitioners on how to support parents with LGBT children.[143]
- In programs that provide support for families, consider employing a **BROADER DEFINITION OF POSITIVE ROLE MODELS** for LGBT youth. In particular, youth whose parents do not accept their sexuality may turn to other relatives or trusted acquaintances for familial support.
- Employ social marketing to **PROMOTE POSITIVE ROLE MODELS** of successful or prominent parents of LGBT children; consider recruiting celebrities such as Magic Johnson, Cher and others.
- Work with **FAITH COMMUNITIES** to support families with gay children, particularly among communities of color. For example, the Human Rights Campaign's Faith and Religion initiative's A La Familia project provides trainings to promote the inclusion of LGBT people within Latino congregations.

Young Adult MSM.

While physical and sexual child abuse is more prevalent among MSM than their heterosexual counterparts, many men do not confront memories of early traumas until their twenties. Moreover, many of the health inequities experienced by young or adolescent MSM, such as depression, substance abuse and HIV, may persist or even worsen during early adulthood, particularly among MSM who migrate to urban "gay ghettos." Young MSM who have been raised in an environment that stigmatizes homosexuality may have difficulty forming relationships, may devalue gay men or experience internalized homophobia, all of which may predispose them for relationship difficulties, depression, or physical or sexual violence. While initiation within gay culture may provide their first experience of social acceptance of their sexual orientation, it may also present challenges in forming relationships in the context of high background prevalence rates of HIV, STD, substance abuse, depression and violence. Among young MSM who are susceptible to health problems, such challenges can snowball, producing syndemic conditions that may overwhelm whatever resilience and social capital they otherwise possess.[144] LGBT-specialized agencies such as the Howard Brown Health Center report seeing high numbers of MSM ages 14 to 25 with severe needs. Ironically, young and adolescent MSM may have more services available to them than do MSM in their early- to mid-20's.

SUPPORTING YOUNG ADULT MSM

- **RELATIONSHIP SKILLS.** Young adult MSM may experience substantial difficulties in finding romantic partners and establishing relationships, particularly at an age where only a minority of men may be open about their sexual orientation, and encounters via commercial venues (bars, clubs and bookstores) or the Internet may pose health and safety risks. Young adult MSM would benefit from community settings that provide a safe means to meet, socialize and form developmentally appropriate relationships.[145]
- **POSITIVE ROLE MODELS.** While the mental and physical health benefits of heterosexual marriage are well established, for young adult MSM, the evolving landscape of same-sex marriage instills a degree of uncertainly related to societal acceptance of their relationships. While the eventual uniform legality of same-sex marriage in every state will go far to change community norms, increased visibility of same-sex relationships and marriages — in families, communities and the media — help youths to identify positive role models.
- **ALCOHOL AND SUBSTANCE ABUSE, HARM REDUCTION.** Young adulthood is a time that for many MSM is characterized by exploration, partying and establishing an identity for the first time within an openly gay culture. For many MSM, the decade between ages 25 and 35 represents one of substantial experimentation with and uptake of drugs and alcohol use. As such, and particularly in light of elevated background prevalence rates of alcohol and substance abuse among MSM in general, direct and truthful information concerning alcohol and drug use is essential. To avoid excessive risks, young adult MSM need plain, non-judgmental information concerning drug dosing, effects and interactions.
- **SPIRITUAL SUPPORT.** For many young adult men, their twenties represent a time where they are struggling to find meaning in their lives and seeking spiritual support. Insofar as attitudes toward homosexuality largely align with degree and type of religious affiliation, many young adult MSM may become disconnected with the institutional religion in which they were raised. Strengthening the viability of gay-positive faith-based organizations might be especially beneficial, particularly for young adult MSM, including those from Black, Latino and fundamentalist communities, whose histories may have been profoundly shaped by religion.[146]
- **ECONOMIC, HOUSING SUPPORT.** Particularly in settings with high unemployment, young adults are at particular risks from the effects of economic disadvantage, which for MSM correlates with elevated risks for HIV infection. To the extent that many gay-identified communities in the United States have witnessed unprecedented gentrification over the past two decades, lower socio-economic MSM may be at particular risk. Socio-economic challenges may also exacerbate other stressors, and LGBT-competent job training, skills building and housing support may help reduce overall health inequities among MSM, including HIV.
- **TRAUMA-INFORMED APPROACH.** As previously discussed, many MSM experience trauma early in life related to violence, abuse, neglect or other emotionally harmful experiences, which, if unaddressed, can lead to health disparities. In particular, MSM may be re-traumatized in public institutions and systems (such as healthcare, foster care, juvenile justice, the behavioral health system and others) that are intended to provide services and support. It is important that such systems incorporate a trauma-informed approach that is designed to ease an individual's capacity to cope with traumatic experiences.[147]

Older adult MSM.

Older MSM experienced a very different developmental trajectory than younger MSM. Many came of age, and some spent a significant part of their adult lives during a period when stigmatization of homosexuality was more pronounced than today, and when the majority of gay men hid their sexual orientation. Moreover, older MSM lived through the beginning years of the AIDS epidemic, losing large numbers of friends and colleagues to an unknown disease that emerged from nowhere, and for which at least initially, causality was unknown and there were no effective treatments. LGBT elders report discrimination, stigma and victimization throughout their lives, though many report less during their youth than current young people do. Many older MSM report experiencing dual stigmatization — as a result of rejection among the heterosexual world for being gay, and among the gay world for being old. The experience of growing older as a minority or lower-socioeconomic status gay man may be less well understood — even more so than among young populations, research on older MSM tends to skew towards White, well-educated and middle- to higher-socioeconomic class populations.[148]

Among older MSM, depression and suicidality are elevated, compared to their heterosexual counterparts, while LGBT elders may be less likely to seek health services, in some instances because of fear of discrimination. HIV remains a significant concern among older MSM, though it receives far less attention and there are fewer targeted interventions.[149] In a population study, LGB older adults were at greater risk for disability, poor mental health, smoking and excessive drinking, while gay and bisexual men had a higher risk of poor physical health and were more likely to live alone than heterosexuals.[150] Lifetime victimization, financial hardship, obesity and a sedentary lifestyle are significant predictors of poor health outcomes, while internalized homophobia predicts depression and disability.[151] In 2020, it is estimated that 50 percent of people living with HIV will be 50+ years of age or older. The support of friends and community may be even more important for older LGBT adults, who are more likely to be disengaged from their biological family and to rely on families of choice for support in times of crisis.

SUPPORTING OLDER ADULT MSM

- **FELLOWSHIP.** Many older MSM are interested in contributing to their community, either as a means of finding fellowship or leaving a legacy. Organizations such as Gay For Good, which has affiliates in many cities, San Francisco's Bridgemen, or Washington D.C.'s Burgundy Crescent, provide volunteer opportunities for social welfare, environmental service, and other community development projects. Organizations like Let's Kick Ass (AIDS Survivor Syndrome) seek to honor and contextualize the experience of those who survived — HIV positive and negative — the worst days of the AIDS epidemic.
- **MENTORSHIP AND PARENTING.** Particularly in light of the isolation experienced by older and younger MSM alike, there may be significant opportunities for older MSM to mentor or even care for younger MSM. As previously discussed, disproportionate numbers of young MSM are rejected by their families and risk becoming "throwaway" kids — it would be tragic not to take advantage of older, more experienced MSM who might not only provide a loving home, but be better positioned than many heterosexual parents to support young MSM in confronting the developmental issues they may face. Adoption and foster care rules should encourage, rather than discourage such arrangements.
- **HOUSING:** As older MSM retire, they may find challenges in finding a welcoming retirement community, as housing discrimination against LGBT people persists. (A recent HUD study found that heterosexual couples who inquired about advertised housing were favored by 16 percent over LGB couples, with all other factors being equal.[152]) In some parts of the country, developers have constructed LGBT-welcoming (but still inclusive) senior housing, such as the John C. Anderson apartments in Philadelphia. Particularly for men who may have spent much of their life in the closet.

BUILDING A STRONG AND SUPPORTIVE COMMUNITY

Insofar as MSM health inequities are the product of a hostile environment, creating a safe and supportive cultural context may offset the impact of marginalization and promote resilience among young, middle-aged and older MSM alike.

Positive cultural messages may instill individual or community pride, which in turn may serve as a protective factor, counteracting internalized homophobia and promoting resilience. For sexual minority youth, coming out may also provide access to a shared history and subculture, instilling pride, which may constitute a protective factor.[153] Strong communities may facilitate links with individuals who can serve as mentors, establish and model healthy behavioral norms, provide emotional support, and safe spaces to congregate, meet people and establish relationships. For example, in some urban centers, young, Black MSM, some homeless, have formed "ball communities" (underground LGBT subcultures focused on competitions among "houses" or "families," most of which are led by a "house mother" or "house father") that provide them with familial support, addressing their physical and emotional needs.[154] Stronger community structures may provide individuals with greater social capital — connections among social networks that establish and reinforce norms of trustworthiness and reciprocity, and establish standards of behavior — which may in turn increase individual resiliency.[155] Such standards have the potential to reduce alcohol or substance abuse and sexually risky behaviors.

It is important to anticipate that for some MSM, paradoxically, integration into the larger gay community may increase their risks, at least initially. For men who have been systematically harassed for their entire lives, the discovery of an environment with less approbation may be an incentive to increase the frequency of sexual contacts. The relatively higher background HIV and STD prevalence rates, as well as higher rates of substance abuse, smoking and sexual risk taking among MSM communities further increases their risks. While in the long term, for individuals to escape the constant victimization of a stigmatizing environment will benefit their health, some men may need support to manage the initial transition to a very different environment.

For MSM who are living with HIV, stigmatization is a problem within the gay community, as well. On gay social networking sites, which among many MSM have become a common means of meeting partners, men routinely post profiles with designations proclaiming "disease free," and some HIV-positive men report a community climate so hostile that they characterize their experience of it as "HIV apartheid." As a consequence, many HIV-positive men may be reluctant to disclose their status, increasing the possibility of unsafe encounters.

SUPPORTING A STRONG COMMUNITY

- **COMMUNITY SUPPORT.** Particularly for MSM who have migrated to an urban gay ghetto from a smaller community, support for healthy social interactions that could help establish support networks could help forestall syndemic production, even among those otherwise predisposed. Community organizations that encourage the development of friendships — such as sports teams, social groups, faith-based groups, neighborhood coalitions and others — may help vulnerable MSM cope with health related stressors.

- **HEALTH EQUITY.** Among the LGBT community, there is less broad awareness of health equity issues, compared to other equality concerns, such as marriage. Promoting the concept of health equity may serve to enhance community cohesion. Some suggest that the decision to "live healthy" may itself constitute a political action — i.e., the pursuit of individual and community health as an agent of change.

- **POLITICAL, COMMUNITY MOBILIZATION.** Having access to LGBT social and political organizations may also be an important factor in overcoming the adversity posed by social stigma and discrimination. Among marginalized communities, group identity — i.e., affiliation with an oppressed group and its collective struggle — may enhance individual resiliency.[156]

- **SUPPORT FOR HIV DISCLOSURE.** For MSM who are living with HIV, being able to disclose their serostatus requires sufficient confidence that colleagues, family and community will be supportive and non-judgmental. Programs that encourage acceptance of HIV-positive individuals may help educate people and facilitate greater acceptance. In 2012, the President's Advisory Council on HIV/AIDS and the CDC/Health Resources and Services Administration (HRSA) Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC) jointly convened a Disclosure Workgroup, which developed policy recommendations and principles to address structural barriers to safe and voluntary HIV disclosure.[157] CDC's new "Start Talking — Stop HIV" campaign encourages open discussion about a range of HIV prevention strategies and related sexual health issues.

HEALTHCARE ACCESS AND QUALITY

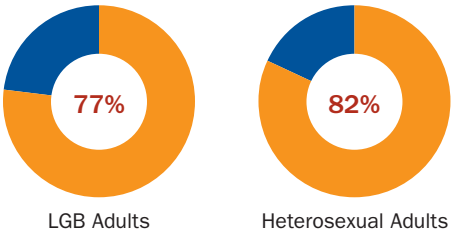
Though the extent to which access to quality healthcare is associated with health inequities in MSM is not well understood, barriers to quality care clearly correlate with poorer health outcomes in the general population. Moreover, MSM have unique healthcare needs as a result of increased susceptibility to adverse outcomes associated with stigma and discrimination, as discussed previously.

MSM are more likely to contract HIV or STDs, both because of the relatively higher prevalence in the communities in which they live, but also related to increased risk associated with common sexual practices, particularly receptive anal intercourse.[158] If MSM are reluctant to disclose their same-sex attraction to their provider due to perceived stigma, they may be less likely to receive appropriate care, including screening for HIV or STDs.[159] They may also be less likely to report substance abuse, particularly related to drugs commonly associated with MSM, such as methamphetamine or anabolic steroids.

MSM sometimes face a variety of structural barriers to care, as well, including inequalities in access to health insurance or workplace benefits. LGBT individuals with insurance are less likely to be covered by their employer and more likely to be enrolled in Medicaid. For example, in the 2008 California Health Interview Study, LGB adults were less likely to have health insurance than heterosexuals (77 percent v. 82 percent).[160]

Though many public health prevention interventions are designed to address a range of interpersonal and community dynamics (e.g. triggers, social supports and others), few substance abuse treatment providers, tobacco cessation programs, or the like have programs tailored to meet the specific needs of MSM. The association of substance abuse with other health problems (e.g. HIV and depression) among MSM suggests that integrated services could be of benefit.

Likelihood of Having Health Insurance – 2008



IMPROVING ACCESS TO QUALITY HEALTHCARE AMONG MSM.

The federal government plays an important role in the delivery and regulation of healthcare. As such, it is essential that federal policies support and encourage wider access to culturally competent services for MSM. Recently, there have been substantial improvements in federal policies. For example, in 2013, the HHS Office of Minority Health published LGBT-inclusive National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) that provide a more inclusive definition of culture that includes sexual orientation and gender identity.[161] While other government and non-government organizations also have efforts underway, significant progress is still needed. For example:

- **BEST PRACTICES IN MSM CLINICAL CARE.** It is important to document best HIV clinical care practices in general and specifically among MSM populations. For example, while significant racial disparities in HIV diagnosis, linkage to care, treatment and adherence to medications have been documented in a variety of settings, some clinics have developed practices where such disparities virtually disappear — such as the Moore Clinic for HIV Care, an outpatient unit supervised by the Johns Hopkins University AIDS Service.

- **PROVIDER INCENTIVES.** Billing, reimbursement and professional accreditation protocols should incentivize practices that are likely to improve MSM health or reduce health inequities. For example, sexual health screenings are too often overlooked and could be of significant benefit among this population. With respect to HIV care, appropriate incentives might serve to enhance patient retention in care.

- **PROFESSIONAL TRAINING, CULTURAL COMPETENCE.** Providers who are able to establish trusting relationships with MSM patients are better equipped to promote healthy behaviors. Providers must be sensitive to MSM-specific health needs, as well as alternate expressions of sexuality and family structures. Medical training should incorporate LGBT health-specific modules, while continuing medical education programs should reinforce skills. Medical practices should solicit participation from LGBT community representatives in planning and quality-improvement meetings. Leadership programs in MSM healthcare may further incentivize professional development. In addition to training materials promulgated by a range of Community-based organizations, SAMHSA and HRSA have developed a list of LGBT curricula that train behavioral health and primary care practitioners, for which continuing medical education and continuing education unit credits are available.[162] Through a cooperative agreement with Fenway Health, HRSA supports the National LGBT Health Education Center, designed to help community health centers improve the health of LGBT populations. Following the overturn of DOMA, HHS Divisions revised federal regulations and policies across its programs to recognize same-sex spousal relationships.

- **DISCRIMINATION PROTECTION.** In 2012, HHS developed a sexual orientation and gender identity-inclusive non-discrimination policy applicable to all HHS-funded programs. Culturally competent care can be delivered by any provider, and it is important that MSM receive appropriate care in any setting, rather than segregating specialty service providers. In fact, in a small cross-sectional survey among LGBT youth, provider qualities and interpersonal skills were as important as knowledge and experience and more important than gender and sexual orientation.[163] Nonetheless, visible positive role models among authority figures are important and hiring and promotion procedures at healthcare facilities should protect LGBT personnel from discrimination.

- **MSM-SPECIFIC CASE MANAGEMENT.** Case management services have proven effective in the management of HIV and other patients with complex needs. It may be that such practices can be adopted to meet the spectrum of needs presented by social determinants of MSM health inequities.

- **INSURANCE ENROLLMENT.** Particularly with the rollout of the Affordable Care Act, there are increased needs for LGBT-specific outreach to facilitate insurance enrollment, particularly among younger MSM ages 20 to 35, who are less likely to have employment-based insurance. For example, Trust for America's Health recently published an Action Plan designed to explain to providers and the young MSM they serve the importance of health coverage, facilitate enrollment in coverage, address structural barriers to care, and support the engagement of young MSM with the health system once they obtain coverage.[164] Managed care organizations for which new patients are auto-enrolled should be required to conduct specific outreach among MSM and other patients — potentially via subcontract with Congressional Budget Office (CBO) providers, who may be better equipped to reach target populations.

- **ELECTRONIC HEALTH RECORDS.** Increasingly, the use of electronic health records comprises an important strategy to improve healthcare safety and quality. Too often, however, the standardization of electronic records is based on a "heterosexual assumption" that assumes that patients fall within a normative (i.e. heterosexual) profile and fail to capture the lived experi-

ence of sexual minorities. Without sexual orientation data, clinicians may fail to offer appropriate screening or care to LGBT patients, while analyses of aggregated data may fail to recognize disparities or unique needs of LGBT populations. As the Office of the National Coordinator for Health IT (ONC) implements EHR meaningful use standards, which govern the type and nature of data collected, it is important that data fields capture information relevant to sexual minorities, including preferred name, sexual orientation and gender identity. ONC should collaborate with industry to ensure the inclusion of sexual orientation and gender identity data, but also to implement sufficient privacy protections to guarantee that such data are protected.

- **CONFIDENTIALITY.** Particularly among young MSM, the provision of confidential health services is essential. For example, young MSM need access to HIV and STD prevention and screening without such services appearing on their parents' explanation of insurance benefits.

- **MEDICAID EXPANSION ADVOCACY.** While implementation of the Affordable Care Act promises to increase access to healthcare for many disadvantaged populations, realizing the Act's potential is dependent on the expansion of the Medicaid program, which a number of states, disproportionately in the South, have declined to endorse. MSM who live in states that do not expand Medicaid will have fewer options for health coverage, and, in some instances, higher income thresholds for subsidized coverage. Sustained advocacy efforts will be needed to ensure that, ultimately, all states choose to expand their Medicaid program.

- **PATIENT ACTIVATION MEASURE.** The Howard Brown Health Center in Chicago has employed the Patient Activation Measure — a validated scale that reflects the stages of patient activation — to assess patient readiness for ART, and to tailor care and support accordingly. Such measures could be further adapted for MSM-specific care.

- **CONSUMER EDUCATION.** Particularly in light of changes to the healthcare system, it is increasingly important for MSM (particularly young men) to understand and advocate for quality healthcare services. Those who have not previously had insurance, for example, may require assistance in understanding how to obtain coverage and how health insurance can be used to support healthy living. Provider and non-government organization outreach to the LGBT community may help consumers locate LGBT-competent providers or medical facilities. Systems that allow consumers to rate providers based on cultural competency may be a useful strategy.

- **FEDERALLY QUALIFIED HEALTH CENTERS.** Community-based and patient-directed Federally Qualified Health Centers (FQHC) serve populations with limited access to healthcare and provide comprehensive primary and preventative care, including oral health and mental health/substance abuse services to persons regardless of their ability to pay or health insurance status. Of the more than 1,000 FQHCs, however, only about a dozen LGBT clinics have been designated. While these clinics provide culturally appropriate and targeted services to thousands of LGBT patients, their relative scarcity means that many patients do not have easy access. Moreover, other "mainstream" FQHCs may simply refer sexual minority patients to other providers rather than develop competent services. As a primary healthcare provider for disadvantaged communities, it is important that FQHCs develop competence to meet the needs of all their patients, including MSM.

- **POSITIVE HEALTHCARE NORMS.** As a result of longstanding health inequities, many communities may have come to rely on sporadic, emergency-driven healthcare. For young MSM in particular, it is important to normalize routine preventive care, and to encourage healthy living. Venues where young people socialize may provide one opportunity — for example, Boys/Girls Clubs or YMCAs could be supported to conduct outreach and health education among MSM. Another idea would be to support healthcare professionals, such as physicians or nurses, to visit schools, similar to how law enforcement officers visit schools in an effort to establish positive relationships with young people and discourage drug abuse. The LGBT community itself must play a greater role in normalizing risk-reduction and health promotion — importantly, this must include a nuanced discussion that considers the relative risk of various sexual and drug behaviors in a non-judgmental way, rather than a one-size-fits-all approach.

- **HEALTH DEPARTMENT OUTREACH.** For some MSM with HIV, retaining consistent care and remaining adherent to ARTs pose significant challenges. In the two-thirds of states that collect viral load data, it may be possible to identify individuals who are failing on ART therapy and follow up with community health workers, who could proactively attempt to dismantle barriers and facilitate healthcare. Such an approach would require significant consent and confidentiality protections, but similar models exist — for example, the San Francisco Homeless Outreach Team (SF HOT) consists of 20 experienced outreach professionals who engage chronically homeless "super-utilizers" in services that would get them off the streets and into stabilized situations.

BIOMEDICAL INTERVENTIONS

Treatment as Prevention.

The potential of "treatment as prevention" has gained significant attention recently. Studies conducted among sero-discordant heterosexual couples demonstrate that the early initiation of ART reduces the risk of HIV transmission to the uninfected partner by 96 percent.[165] Theoretically, were such early use of ART to be widespread among HIV-infected individuals, community viral load would decrease. In San Francisco, overall reductions in community viral load were associated with fewer HIV infections.[166] Mathematical models have suggested the possibility that widely deployed early detection and treatment to lower community viral load could substantially eliminate new HIV transmissions.[167]

Notwithstanding, as has been amply demonstrated in the treatment cascade model, successful HIV treatment requires a continuous sequence of events, from diagnosis to adherence, and the interruption of any step may preclude viral suppression. As such, "treatment-as-prevention" strategies are susceptible to a range of behavioral and structural factors that pose similar uptake challenges. In fact, in one mathematical model, an improvement in any single component of the cascade (diagnosis, linkage, retention, treatment, persistence or adherence) would yield only a marginal decline in community viral load. [168] Similar to health inequities overall, addressing disparities in health outcomes among MSM along the treatment cascade will require mitigating the adverse effects of social determinants of MSM health — particularly among MSM who face intersecting determinants, including socio-economic status and race/ethnicity.

Pre-Exposure Prophylaxis (PrEP).

The CDC recently recommended PrEP — i.e. the use of anti-HIV medications among uninfected individuals to prevent infection — for those who are HIV-negative and at substantial risk for HIV infection.[169] In the iPrEx study among MSM and transgender persons, a once-daily dose of tenofovir/FTC (Truvada®) delivered in the context of comprehensive HIV prevention services was associated with a 44 percent overall reduction in HIV incidence. Adherence varied substantially among participants, however. Among those self-reporting more than 90 percent adherence, risk was reduced by 73 percent; among those for whom blood drug levels were confirmed by assay, the reduction was 92 percent. Participants in both treatment and placebo arms reported significantly lower risk behaviors during the course of the trial.[170] As with treatment as prevention strategies, the successful implementation of PrEP will also depend on mitigating a range of adverse effects of social determinants of health.

THE WIDESPREAD USE OF PrEP AS A PREVENTION INTERVENTION POSES SUBSTANTIAL CHALLENGES.

- **PrEP GUIDANCE.** There are substantial knowledge gaps among both providers and patients related to the use and efficacy of PrEP, and broad-based outreach efforts will be needed to ensure appropriate implementation. A number of community-based resources have been developed by the San Francisco AIDS Foundation (www.prepfacts.org), the AIDS Vaccine Advocacy Coalition (www.prepwatch.org), and others. While the CDC has issued guidelines for the use of PrEP among individuals at risk for HIV, it will be important to refine and expand official guidelines and to promote community norms to address how at-risk populations should incorporate biomedical with other prevention interventions (i.e. condoms) in a more nuanced way.

- **UNDERSTANDING THE IMPACT OF PrEP ON SEXUAL NORMS.** Anecdotal reports suggest that the use of PrEP may be changing sexual behavior norms in ways that are not well understood — for example, there is some evidence of non-prescription PrEP use (i.e. with drugs obtained from friends or acquaintances), and, among social networks that facilitate sexual partnering, HIV positive and negative MSM are advertising their use of PrEP, suggesting a misunderstanding between HIV prophylaxis and treatment. As the use of PrEP becomes more common, it is essential to study how its uptake may affect the epidemiology of HIV transmission.

- **ACCESS DISPARITIES.** While it is too early to know how PrEP is or will be prescribed, early experience with ART suggests that access will be related to insurance coverage, provider knowledge, patient knowledge and motivation, community standards, and other factors. And, without paying careful attention to communities with less healthcare access, implementation of PrEP could exacerbate health inequities. While Medicaid covers PrEP in some states (e.g. New York and Florida), coverage policies are set at the state level, and sustained advocacy will be necessary to ensure uniform coverage. Even with coverage, some providers remain unsure how such services should be billed. The possibility that the ADAP could be expanded to subsidize the cost of PrEP has been raised, but this would require a statutory change as ADAP can now serve only those already infected with HIV. Out-of-pocket costs for PrEP can be as high as $13,000 per year.

- **NON-OCCUPATIONAL POST-EXPOSURE PROPHYLAXIS (NPEP).** CDC issued guidelines some time ago for non-occupational post-exposure HIV prophylaxis — the temporary provision of antiretroviral drugs following an unexpected sexual, injection-drug or other nonoccupational exposure to HIV.[171] Anecdotal experience suggests that the availability and provision of NPEP in hospital and emergency room settings is inconsistent, however. LGBT clinics who offer NPEP report that its provision is complex (as NPEP patients typically present as an emergency), expensive and disruptive. In addition to greater provider and community education, over-the-counter availability of NPEP regimens should be considered.

Conclusion

Though stigma and discrimination against LGBT people are diminishing at an unprecedented pace, the effects of historical and continuing marginalization persist. MSM continue to suffer health inequities, not the least of which are dramatic disparities in HIV rates, many related to social determinants that include pervasive stigma and discrimination. As a result, a minority of MSM experience a syndemic of overlapping adverse health outcomes including depression, substance abuse, STDs, violence and HIV. Ultimately, addressing the social determinants of MSM health inequities will require a greater emphasis on community-level and structural interventions to improve the environment in which sexual minorities, including MSM, live. In the near term, helping MSM to avoid or overcome immediate challenges will require focused interventions to mitigate adverse determinants and increase resiliency. An approach that fosters MSM health and well-being — and which includes HIV interventions — is essential. But, while increasing individual resiliency among MSM will undoubtedly be important, as one researcher noted: "resilience in the face of adversity is not the same as health equality."[172] In the long term, reducing societal oppression and marginalization of LGBT people will reduce the need for individual and community-level interventions.

Endnotes

* Federal officials were invited to participate in the meeting as a resource and not in their official capacities.

† In this paper, the term "MSM" is used to designate gay men and other men who have sex with men, a group that includes both men who do and those who do not self-identify as gay, and which includes men who also have sex with women. For purposes of the paper, this group does not include transgender men or women, who may be heterosexual, homosexual or bisexual in their orientation. Though data pertaining to transgender health are extremely limited, studies show that transgender people experience significant health inequities, and there are differences in health outcomes between transgender men and women, who are at far greater risk for HIV (a meta-analysis of 29 studies found an estimated HIV prevalence rate of 27.7 percent among transgender women — see Herbst JH, Jacobs ED, Finlayson TJ et al. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. AIDS Behav, 2008;12:1-7). Additional research to better understand transgender-specific health issues, as well as policy approaches to address transgender health inequities, are warranted in their own right and are urgently needed.

‡ In this paper, the term LGBT (lesbian, gay, bisexual and transgender) is used, as it often is both colloquially and in the published literature, to refer to the community of people who share the fact that, and who are frequently stigmatized because, their sexual orientation is not exclusively heterosexual — but who are otherwise diverse in terms of gender, race, socioeconomic status, age, and other characteristics. LGBT health research is in a formative phase and has been limited by a lack of systematic population data collection, as questions pertaining to sexual orientation have appeared only recently in most national surveys. LGBT health research also poses numerous methodological challenges (see "Conducting research on the health status of LGBT populations" [chapter 3], in: Institute of Medicine. The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding. Washington, D.C.: The National Academy Press, 2011), not the least of which is that for research purposes, these four populations are imperfectly and variously defined, separately and collectively, by attraction, behavior, and identity, designations that themselves sometimes overlap and in many cases cannot be considered fixed. For example, due to challenges in obtaining sufficient statistical power, research designs sometimes treat the four populations as a single "LGBT" group, though in studies that are able to distinguish among them, significant differences in health outcomes have sometimes been shown among these populations. Given these limitations, whenever possible, this paper references research conducted specifically among MSM. Research that examines the LGB or LGBT populations as a whole is also cited here to the extent that it refers to MSM specifically or draws conclusions that can be understood to apply to MSM — these references should not be interpreted to imply that the conclusions cited necessarily apply equally, or at all, to lesbian, bisexual (except to the extent that they fall within the definition of MSM, above) or transgender people.

§ The "treatment cascade" was first extrapolated to a national level (see: Gardner EM, McLees MP, Steiner JF, Del Rio C, Burman WJ. The spectrum of engagement in HIV care and is relevance to test-and-treat strategies for prevention of HIV infection. Clin Infect Dis 2011;52:793-800) based upon a framework originally developed to illustrate treatment uptake in Washington, D.C. (see: Greenberg AE, Hader SL, Masur H, Young AT, Skillicorn J, Dieffenbach CW. Fighting HIV/AIDS in Washington, D.C. *Health Affairs* (Millwood) 2009;28:1677-87).

** Department of Health and Human Services; Department of Agriculture; Department of Education; Federal Trade Commission; Department of Transportation; Department of Labor; Department of Homeland Security; Environmental Protection Agency; Office of National Drug Control Policy; Domestic Policy Council; Bureau of Indian Affairs, Department of the Interior; Department of Justice; Corporation for National and Community Service; Department of Defense; Department of Veterans Affairs; Department of Housing and Urban Development; Office of Management and Budget; Department of the Interior; General Services Administration; Office of Personnel Management.

1 CDC. Estimated HIV incidence in the United States, 2007–2010. HIV Surveillance Supplemental Report, 2012;17(No. 4). http://www.cdc.gov/hiv/topics/surveillance/resources/reports/#supplemental (accessed May 26, 2014).

2 CDC. HIV Surveillance Report, 2011;23. http://www.cdc.gov/hiv/topics/surveillance/resources/reports/ (accessed May 26, 2014).

3 Ibid. CDC. HIV Surveillance Report, 2011;23. http://www.cdc.gov/hiv/topics/surveillance/resources/reports/ (accessed May 26, 2014).

4 Guadamuz TE, Friedman MS, Marshal MP, Herrick AL, Lim SH, Wei C, Stall R. Health, sexual health, and syndemics: toward a better approach to STI and HIV preventive interventions for men who have sex with men (MSM) in the United States [chapter], in Aral SO, Fenton KA, Lipshutz JA (eds). The New Public Health and STD Prevention. New York, NY: Springer, 2013.

5 Healthy People 2010: Understanding and Improving Health. Washington, DC: U.S. Department of Health and Human Services, 2000.

6 Institute of Medicine. The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding. Washington, DC: The National Academy Press, 2011.

7 U.S. Department of Health and Human Services. National Healthcare Disparties Report 2013. http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/2013nhdr.pdf (accessed June 4, 2014).

8 Cochran SD, Mays VM, Sullivan JC. Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. J Consult Clin Psychol, 2003;71:53-61.

9 Gilman SE, Cochran SD, Mays VM, Huges M, Ostrow D, Kessler RC. Risk of psychiatric disorders among individuals reporting same-sex partners in the National Comorbidity Survey. *Am J Public Health*, 2001;91:933-999.

10 Cochran SD,Mays VM. Lifetime prevalence of suicide symptoms and affective disorders among men reporting same-sex partners: results from NHANES III. *Am J Public Health*, 2000;90:573-578.

11 Coker TR, Austin SB, Schuster MA. The health and health care of lesbian, gay and bisexual adolescents. *Annual Review of Public Health*, 2010;31:457-477.

12 Silenzio VMB, Pena JB, Deberstein PR, Cerel J, Knox KL. Sexual orientation and risk factors for suicidal ideation and suicide attempts among adolescents and young adults. *Am J Public Health*, 2007;97:2017-2019.

13 Saewyc EM, Skay CL, Hynds P et al. Suicidal ideation and attempts among adolescents in North American school-based surveys: are bisexual youth at increasing risk? *Journal of LGBT Research*, 2007;3:25-36.

14 Garofalo RR, Wolf RC, Wissow LS, Woods ER, Goodman E. Sexual orientation and risk of suicide attempts among a representative sample of youth. *Arch Pediat Adol Med*, 1999; 153:487-493.

15 Kann L, O'Malley Olsen E, McManus T et al. Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12 — *Youth Risk Behavior Surveillance*, selected sites, United States, 2001-2009. MMWR, 2011;60:1-133.

16 Conron KJ, Mimiaga MJ, Landers SJ. A population based study of sexual orientation identity and gender differences in adult health. *Am J Public Health*, 2010;100:19531-960.

17 Koblin BA, Hessol NA, Zauber AG et al. Increased incidence of cancer among homosexual men, New York City and San Francisco, 1978-1990. *Am J Epidem*, 1996;144:916-923.

18 Wolitski RJ, Fenton KA. Sexual health, HIV and sexually transmitted infections among gay, bisexual, and other men who have sex with men in the United States. *AIDS Behav*, 2011;15:S9-S17.

19 CDC. *CDC Fact Sheet: Reported STDs in the United States: 2012* national data for chlamydia, gonorrhea, and syphilis. http://www.cdc.gov/nchhstp/newsroom/docs/STD-Trends-508.pdf (accessed May 21, 2014).

20 Purcell DW, Johnson C, Lansky A et al. Calculating disease rates for risk groups: estimating the national population size of men who have sex with men. In program and abstracts of the 2010 National STD Prevention Conference; March 10, 2010; Atlanta, GA. https://cdc.confex.com/cdc/std2010/webprogram/Paper22896.html (accessed May 21, 2014).

21 CDC. HIV Testing and Risk Behaviors Among Gay, Bisexual, and Other Men Who Have Sex with Men — United States. *MMWR*, November 29, 2013;62:958-962.

22 Purcell DW, Johnson C, Lansky A et al. Calculating disease rates for risk groups: estimating the national population size of men who have sex with men. In program and abstracts of the 2010 National STD Prevention Conference; March 10, 2010; Atlanta, GA. https://cdc.confex.com/cdc/std2010/webprogram/Paper22896.html (accessed May 21, 2014).

23 Ibid. Estimated HIV incidence in the United States, 2007–2010. *HIV Surveillance Supplemental Report*, 2012; 17(No. 4). http://www.cdc.gov/hiv/topics/surveillance/resources/reports/#supplemental (accessed May 26, 2014).

24 CDC. Estimated HIV incidence among adults and adolescents in the United States, 2007–2010. *HIV Surveillance Supplemental Report*, 2012;17(4).

25 Ibid. CDC. Estimated HIV incidence among adults and adolescents in the United States, 2007–2010. *HIV Surveillance Supplemental Report*, 2012;17(4).

26 Ibid. CDC. Estimated HIV incidence among adults and adolescents in the United States, 2007–2010. *HIV Surveillance Supplemental Report*, 2012;17(4).

27 Prejean J et al. Estimated HIV incidence in the United States, 2006-2009. *PLoS ONE* 6(8): e17502.

28 Hall HI, Frazier EL, Rhodes P et al. Differences in human immunodeficiency virus care and treatment among subpopulations in the United States. *JAMA Intern Med* 2013; 173(14):1337-1344.

29 Christopoulos KA, Das M, Colfax G. Linkage and retention in HIV care among men who have sex with men in the United States. *Clinical Infectious Diseases* 2011;52(S2):S214-22.

30 Maulsby C, Millett G, Lindsey K et al. HIV among black men who have sex with men (MSM) in the United States: a review of the literature. *AIDS Behav*, 2014;18:10-25.

31 Millett GA, Peterson JL, Flores SA et al. Comparisons of disparities and risks of HIV infection in black and other men who have sex with men in Canada, UK and USA: a meta-analysis. *Lancet*, 2012:380;341-348.

32 Blair JM, Fleming PL, Karon JM. Trends in AIDS incidence and survival among racial/ethnic minority men who have sex with men. *J Acquir Immune Defic Syndr*, 2002;31-339-347.

33 Hall HI, Byers RH, Ling Q, Espinoza L. Racial/ethnic disparities in HIV prevalence and disease progression among men who have sex with men in the United States. *Am J Public Health*, 2007;97:1060-1066.

34 CDC. Establishing a holistic framework to reduce inequities in HIV, viral hepatitis, STDs, and tuberculosis in the United States, 2010. http://www.cdc.gov/social-determinants/ (accessed March 4, 2014).

35 Ibid. Sadana R, Blas E.

36 King M, Semlyen J, Tai SS et al. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*, 2008;8:70.

37 Stall R, Paul JP, Greenwood G et al. Alcohol use, drug use and alcohol-related problems among men who have sex with men: the Urban Men's Health Study. *Addiction*, 2001;96:1589-1601.

38 McCabe SE, Hughes TL, Bostwick WB, West BT, Boyd CJ. Sexual orientation, substance abuse behaviors and substance dependence in the United States. *Addiction*, 2009;104:1333-1345.

39 Ostrow DG, Stall R. "Alcohol, tobacco, and drug use among gay and bisexual men" [chapter] in: Wolitski RJ, Stall R, Valdiserri RO (eds). *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the United States*. New York: Oxford Univesity Press, 2008.

40 Trocki KF, Drabble LA, Midanik LT. Tobacco, marijuana, and sensation seeking: comparisons across gay, lesbian, bisexual, and heterosexual groups. *Psychol Addict Behav*, 2009;23:620-631.

41 Bye L, Gruskin E, Greenwood G, Albright V, Krotki K. California lesbians, gays, bisexuals and transgender (LGBT) tobacco use survey — 2004. Sacramento, CA: California Department of Health Services, 2005. http://www.cdph.ca.gov/programs/tobacco/Documents/CTCP-LGBTTobaccoStudy.pdf (accessed May 21, 2014).

42 Greenwood GL, Paul JP, Pollack LM et al. Tobacco use and cessation among a household-based sample of US urban men who have sex with men. *Am J Public Health*, 2005;95:145-151.

43 RyanH, Wortley PM, Easton A, Pederson L, Greenwood G. Smoking among lesbians, gays, and bisexuals: a review of the literature. *Am J Prev Med*, 2001;21:142-149.

44 Ibid. Millett GA, Peterson JL, Flores SA et al. Comparisons of disparities and risks of HIV infection in black and other men who have sex with men in Canada, UK and USA: a meta-analysis. *Lancet*, 2012:380;341-348.

45 Ibid. Coker TR, Austin SB, Schuster MA. The health and health care of lesbian, gay and bisexual adolescents. *Annual Review of Public Health*, 2010;31:457-477.

46 Marshal MP, Friedman MS, Stall R et al. Sexual orientation and adolescent substance abuse: a meta-analysis and methodological review. *Addiction*, 2008;103:546-556.

47 Glick SN, Morris M, Foxman B et al. A comparison of sexual behavior patterns among men who have sex with men and heterosexual men and women. *J Acquir Immune Defic Syndr*, 2012;60:83-90.

48 Ibid. Coker TR, Austin SB, Schuster MA. The health and health care of lesbian, gay and bisexual adolescents. *Annual Review of Public Health*, 2010;31:457-477.

49 Saewyc EM, Poon CS, Homma Y, Skay CL. Stigma management? The links between enacted stigma and teen pregnancy trends among gay, lesbian, and bisexual students in British Columbia. *Canadian Journal of Human Sexuality*, 2008;17:123-139.

50 Millett G, Flores SA, Peterson JL, Bakeman R. Explaining disparities in HIV infection among black and white men who have sex with men: a meta-analysis of HIV risk behaviors. *AIDS*, 2007;21:2083-2091.

51 Beyrer C, Baral SD, van Griensven F et al. Global epidemiology of HIV infection in men who have sex with men. *Lancet*, 2012;380:367-3777.

52 Ibid. Millett GA, Peterson JL, Flores SA et al. Comparisons of disparities and risks of HIV infection in black and other men who have sex with men in Canada, UK and USA: a meta-analysis. *Lancet*, 2012:380;341-348.

53 Ibid. Beyrer C, Baral SD, van Griensven F et al. Global epidemiology of HIV infection in men who have sex with men. *Lancet*, 2012;380:367-3777.

54 Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psych Bulletin*, 2003;129:674-697.

55 Herek GM. Confronting sexual stigma and prejudice: theory and practice. *J Soc Issues*, 2007:63:905-925.

56 Mays VM, Cochran SD. Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *Am J Public Health*, 2001;91:1869-1876.

57 Ibid. Conron KJ, Mimiaga MJ, Landers SJ. A population based study of sexual orientation identity and gender differences in adult health. *Am J Public Health*, 2010;100:19531-960.

58 Pew Research Center. A survey of LGBT Americans: Attitudes, experiences, and values in changing times, June 2013. http://www.pewsocialtrends.org/files/2013/06/SDT_LGBT-Americans_06-2013.pdf (accessed June 4, 2014).

59 Friedman MS, Marshal MP, Stall R, Cheong J, Wright ER. Gay-related development, early abuse and adult health outcomes among gay males. *AIDS and Behavior*, 2008;12:891-902.

60 Ibid. Coker TR, Austin SB, Schuster MA. The health and health care of lesbian, gay and bisexual adolescents. *Annual Review of Public Health*, 2010;31:457-477.

61 Saewyc EM, Skay CL, Reis E et al. Hazards of stigma: the sexual and physical abuse of gay, lesbian, and bisexual adolescents in the U.S. and Canada. *Child Welfare*, 2006;58:196-213.

62 Freedner N, Freed LH, Yang YW, Austin SB. Dating violence among gay, lesbian and bisexual adolescents: results from a community survey. *Adolescent Health*, 2002;31:469-474.

63 Saewyc EM. Research on adolescent sexual orientation: development, health disparities, stigma, and resilience. *J Res Adolescence*, 2011;21:256-272.

64 Almeida J, Johnson RM, Corliss HL, Molnar BE, Azrael D. Emotional distress among LGBT youth: the influence of perceived discrimination based on sexual orientation. *J Youth Adolescence*, 2009;38:1001-1014.

65 Birkett M, Espelage DL, Koenig B. LGB and questioning students in schools: the moderating effects of homophobic bullying and school climate on negative outcomes. *J Youth Adolescence*, 2009:38: 989-1000.

66 Ryan C, Huebner D, Diaz RM, Sanchez J. Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 2009;123:346-352.

67 Ibid. Coker TR, Austin SB, Schuster MA. The health and health care of lesbian, gay and bisexual adolescents. *Annual Review of Public Health*, 2010;31:457-477.

68 Himmelstein KEW, Bruckner H. Criminal justice and school sanctions against nonheterosexual youth: a national longitudinal study. *Pediatrics*, 2010: 2009-2306.

69 Stoudt BG, Fine M, Fox M. Growing up policed in the age of aggressive policing policies. *New York School of Law Review*, 2011;56:1331-1370.

70 Hatzenbuehler ML, McLaughlin KA, Keyes KM, Hasin DS. The impact of institutional discrimination on pysychiatric disorders in lesbian, gay, and bisexual populations: a prospective study. *Am J Public Health*, 2010;100:452-459.

71 Hatzenbuehler ML, Bellatorre A, Lee Y, Finch BK, Muennig P, Fiscella K. Structural stigma and all-cause mortality in sexual minority populations. *Soc Sci Med*, 2014;103:33-41.

72 Logie C, Gadalla TM. Meta-analysis of health and demographic correlates of stigma toward people living with HIV. *AIDS Care*, 2009; 21:742–753.

73 Lloyd S, Operario D. HIV risk among men who have experienced childhood sexual abuse: systematic review and meta-analysis. *AIDS Educ Prev*, 2012;24:228-241.

74 Leserman J, Pence BW, Whetten K et al. Relation of lifetime trauma and depressive symptoms to mortality in HIV. *American Journal of Psychiatry*, 2007;164:1707-1713.

75 The Williams Institute. Race/ethnicity, gender and socioeconomic wellbeing of individuals in same-sex couples, 2014. http://williamsinstitute.law.ucla.edu/wp-content/uploads/Census-Compare-Feb-2014.pdf (accessed June 6, 2014).

76 Badgett MVL, Durso LE, Schneebaum A. New patterns of poverty in the lesbian, gay, and bisexual community, 2013. http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGB-Poverty-Update-Jun-2013.pdf (accessed June 6, 2014).

77 Gates GJ. Food insecurity and SNAP (food stamps) participation in LGBT communities, February 2014. http://williamsinstitute.law.ucla.edu/wp-content/uploads/Food-Insecurity-in-LGBT-Communities.pdf (accessed June 6, 2014).

78 CDC. Characteristics associated with HIV among heterosexuals in urban areas with high AIDS prevalence — 24 cities, United States, 2006-2007. *MMWR* 2011;60:1045-49.

79 Weiser SD, Bangsberg DR, Kegeles S, Ragland K, Kushel MB, Fongillo EA. Food insecurity among homeless and marginally housed individuals living with HIV/AIDS in San Francisco. *AIDS and behavior*, 2009;13:841-48.

80 Rubin MS, Colen CG, Link BG. Examination of inequalities in HIV/AIDS mortality in the United States from a fundamental cause perspective. *AJPH* 2009;100:1053-59.

81 Pellowski J, Kalichman SC, Matthews KA, Adler N. A pandemic of the poor: social disadvantage and the U.S. HIV epidemic. *American psychologist*, 2013;68/4:197-209.

82 Millett GA, Peterson JL, Flores SA et al. Comparisons of disparities and risks of HIV infection in black and other men who have sex with men in Canada, UK and USA: a meta-analysis. *Lancet*, 2012:380;341-348.

83 Cochran BN, Stewart AJ, Ginzler JA, Cauce AM. Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual and transgender homes adolescents with their heterosexual counterparts. *Am J Public Health*, 2002;92:773-777.

84 Gangamma R, Slesnick N, Toviessi P, Serovich J. Comparison of HIV risks among gay, lesbian, bisexual and heterosexual homeless youth. *J Youth Adolescence*, 2008;37:456-464.

85 Gant Z, Lomotey M, Hall HI, Hu X, Guo X, Song R. A county-level examination of the relationship between HIV and social determinants of health: 40 states, 2006-2008. *Open AIDS Journal* 2012;6:1-7.

86 Fuller CM, Borrell LN, Latkin CA, Galea S, Ompad DC, Strathdee SA, Vlahov D. Effects of race, neighborhood, and social network on age at initiation of injection drug use. *AJPH* 2005;95:689-95.

87 Holtgrave DR, Crosby RA. Social capital, poverty, and income inequality as predictors of gonorrhea, syphilis, Chlamydia and AIDS case rates in the United States. *Sexually Transmitted Infections*, 2003;79:62-64.

88 Mayer KH, Bradford JB, Makadon HJ, Stall R, Goldhammer H, Landers S. Sexual and gender minority health: what we know and what needs to be done. *Am J Public Health*, 2008;98:989-995.

89 Ibid. Conron KJ, Mimiaga MJ, Landers SJ. A population based study of sexual orientation identity and gender differences in adult health. *Am J Public Health*, 2010;100:19531-960.

90 Cochran BN, Peavy KM, Cauce AM. Substance abuse treatment providers' explicit and implicit attitudes regarding sexual minorities. *J Homosexual*, 2007;53:181-207.

91 Eliason MJ, Schope RD. Does "don't ask, don't tell" apply to health care? Lesbian, gay and bisexual people's disclosure to health care providers. *Journal of the Gay and Lesbian Medical Association*, 2001;5:125-134.

92 Ibid. Millett GA, Peterson JL, Flores SA et al. Comparisons of disparities and risks of HIV infection in black and other men who have sex with men in Canada, UK and USA: a meta-analysis. *Lancet*, 2012:380;341-348.

93 Institute of Medicine. *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: The National Academy Press, 2011.

94 Insitute of Medicine. *Adolescent Health Services: Missing Opportunities*. Washington, DC: The National Academies Press, 2009.

95 Stall R, Mills TC, Willamson J et al. Association of co-occuring pychosocial health problems and increased vulnberability to HIV/AIDS among urban men who have sex with men. *Am J Public Health*, 2003; 93:939-942.

96 Stall R, Friedman M, Catania JA. "Interacting epidemics and gay men's health: a theory of syndemic production among urban gay men" [chapter] in: Wolitski RJ, Stall R, Valdiserri RO (eds). *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the United States*. New York: Oxford University Press, 2008.

97 Herrick AL, Lim SH, Plankey MW et al. Adversity and syndemic production among men participating in the Multicenter AIDS Cohort Study: a life-course approach. *Am J Public Health*, 2013;103:79-85.

98 Dyer TP, Shoptaw S, Guadamuz TE et al. Application of syndemic theory to black men who have sex with men in the Multicenter AIDS Cohort Study. *J Urban Health*, 2012;89:697-708.

99 Ibid. Institute of Medicine. *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: The National Academy Press, 2011.

100 Halkitis PN, Wolitski RJ, Millett GA. A holistic approach to addressing HIV infection disparities in gay, bisexual, and other men who have sex with men. *American Psychologist*, 2013;68/4:261-73.

101 Ibid. Guadamuz TE, Friedman MS, Marshal MP, Herrick AL, Lim SH, Wei C, Stall R. Health, sexual health, and syndemics: toward a better approach to STI and HIV preventive interventions for men who have sex with men (MSM) in the United States [chapter], in Aral SO, Fenton KA, Lipshutz JA (eds). *The New Public Health and STD Prevention*. New York, NY: Springer, 2013.

102 Herrick AL, Stall R, Chmiel J et al. It gets better: resolution of internalized homophobia over time and associations with positive health outcomes among MSM. *AIDS Behav*, 2013;17:1423-1430.

103 Ibid. Herrick AL, Lim SH, Wei C et al. Resilience as an uptapped resource in behavioral intervention design for gay men. *AIDS Behav*, 2011;15:S25-S29.

104 Herrick AL, Stall R, Goldhammer H, Egan JE, Mayer KH. Resilience as a research framework and as a cornerstone of prevention research for gay and bisexual men: theory and evidence. *AIDS Behav*, 2014;18:1-9.

105 Herrick AL, Lim SH, Wei C et al. Resilience as an uptapped resource in behavioral intervention design for gay men. *AIDS Behav*, 2011;15:S25-S29.

106 WHO Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health, 2008. http://www.who.int/social_determinants/thecommission/finalreport/en/ (accessed on March 4, 2014).

107 Ibid. Hatzenbuehler ML, McLaughlin KA, Keyes KM, Hasin DS. The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: a prospective study. *Am J Public Health*, 2010;100:452-459.

108 Ibid. Hatzenbuehler ML, Bellatorre A, Lee Y, Finch BK, Muennig P, Fiscella K. Structural stigma and all-cause mortality in sexual minority populations. *Soc Sci Med*, 2014;103:33-41.

109 King M, Bartlett A. What same sex civil partnerships may mean for health. *J Epidemiol Community Health*, 2006;60:188-191.

110 Herek GM. Legal recognition of same-sex relationships in the United States. *Am Psych*, 2006;61:607-621.

111 Wight RG, LeBlanc AJ, Badgett MVL. Same-sex legal marriage and psychological well-being: findings from the California Health Interview Survey. *Am J Public Health*, 2013;103:339-346.

112 Institute of Medicine. *For the public's health: revitalizing law and policy to meet new challenges*. Washington, DC: The National Academies Press, 2011.

113 McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Aff* (Millwood), 2002;21:787-93.

114 Gase LN, Pennotti R, Smith KD. "Health in all policies": taking stock of emerging practices to incorporate health in decision making in the United States. *J Public Health Management Practice*, 2013;19:529-540.

115 See http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39 (accessed March 4, 2014).

116 Allen J, Jennings R, Taylor RS, Shipp M. The NCHHSTP 2010–2015 strategic plan and the pursuit of health equity: a catalyst for change and a step in the right direction. *Public Health Reports* 2011;suppl 3/126: 31-37.

117 White House. Executive Order — HIV Care Continuum Initiative [press release], July 15, 2013. http://www.whitehouse.gov/the-press-office/2013/07/15/executive-order-hiv-care-continuum-initiative (accessed September 23, 2014).

118 National Prevention Council. National prevention strategy: America's plan for better health and wellness, June 2011. http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf (accessed September 23, 2014).

119 White House. National HIV/AIDS Strategy for the United States, 2010. http://aids.gov/federal-resources/national-hiv-aids-strategy/nhas.pdf (accessed September 23, 2014).

120 Agency for Healthcare Research and Quality. Lesbian, Gay, Bisexual, and Transgender Populations in the *2011 National Healthcare Disparities Report* [fact sheet], April 2012. http://www.ahrq.gov/qual/nhqrdr11/nhdrlgbt11.htm (accessed September 23, 2014).

121 Ward BW, Dahlhamer JM, Galinsky AM, Joestl SS. Sexual orientation and health among U.S. adults: National Health Interview Survey, 2013. *National Health Statistics Reports*, July 15, 2014;77: 1-12.

122 Healthy People.gov. Lesbian, Gay, Bisexual and transgender health [webpage]. http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=25 (accessed September 23, 2014).

123 Fenway Institute. Gathering sexual orientation data on statewide behavioral risk factor surveillance surveys: a call to action for states, March 2014. http://fenwayfocus.org/wp-content/uploads/2014/03/BRFSS-brief-March-20-2014-final.pdf (accessed September 7, 2014).

124 Edwards VJ, Anda RF, Dube SR, Dong M, Chapman DF, Felitti VJ. The wide-ranging health consequences of adverse childhood experiences. In Kendall-Tackett K and Giacomoni S (eds.) *Victimization of Children and Youth: Patterns of Abuse, Response Strategies*. Kingston, NJ: Civic Research Institute, 2005.

125 Ibid. Stall R, Friedman M, Catania JA. "Interacting epidemics and gay men's health: a theory of syndemic production among urban gay men" [chapter] in: Wolitski RJ, Stall R, Valdiserri RO (eds). *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the United States*. New York: Oxford University Press, 2008.

126 DOE Office for Civil Rights. Questions and answers on Title IX and sexual violence, April 29, 2014. http://www2.ed.gov/about/offices/list/ocr/docs/qa-201404-title-ix.pdf (accessed September 16, 2014).

127 Goodenow C, Szalacha L, Westheimer K. School support groups, other school factors, and the safety of sexual minority adolescents. *Psychol Schools*, 2006;43:573-589.

128 Hatzenbeuhler ML, Birkett M, Van Wagenen, A, Meyer IH. Protective school climates and reduced risk for suicide ideation in sexual minority youths. Am J Public Health, 2014;104:297-286.

129 Mustanski B, Birkett M, Greene GJ, Hatzenbuehler ML, Newcomb ME. Envisioning an America without sexual orientation inequities in adolescent health. *Am J Public Health*, 2014;104:218-225.

130 Saewyc E, Marshall S. Reducing homophobia in high school: the effect of The Laramie Project" play and an integrated curriculum. *J Adolesc Health*, 2011;48:S111.

131 Kissen RM. *Getting Ready for Benjamin: Preparing Teachers for Sexual Diversity in the Classroom.* Lanham, MD: Rowman & Littlefield, 2002.

132 SAMHSA. Top health issues for LGBT populations: information & resource kit. http://store.samhsa.gov/product/SMA12-4684 (accessed August 21, 2014).

133 S.A.F.E. Classrooms. http://www.safeclassrooms.org/resources (accessed August 22, 2014).

134 American Federation of Teachers. *Bullying* [webpage] http://www.aft.org/yourwork/tools4teachers/bullying/index.cfm (accessed September 16, 2014).

135 Safe Schools, Healthy Students. A collaborative and comprehensive approach to youth violence prevention. http://sshs.samhsa.gov/initiative/about.aspx (accessed August 22, 2014).

136 Suicide Prevention Resource Center. Issue brief: suicide and bullying. http://www.sprc.org/sites/sprc.org/files/library/Suicide_Bullying_Issue_Brief.pdf (accessed August 21, 2014).

137 Hanssens C, Moodie-Mills AC, Ritchie AJ, Spade D, Vaid U. A roadmap for change: federal policy recommendations for addressing the criminalization of LGBT people and people living with HIV, May 2014. https://web.law.columbia.edu/sites/default/files/microsites/gender-sexuality/files/roadmap_for_change_full_report.pdf (accessed August 22, 2014).

138 Williams Institute. Sexual and gender minority youth in foster care: assessing disproportionality and disparities in Los Angeles, 2014. http://williamsinstitute.law.ucla.edu/wp-content/uploads/LAFYS_report_final-aug-2014.pdf (accessed September 5, 2014).

139 Herrick AL, Egan JE, Coulter RWS, Friedman MR, Stall R. Raising sexual minority youths' health levels by incorporating resiliencies into health promotion efforts. *Am J Public Health*, 2014;104:206-210.

140 Blair KL, Holmberg D. Perceived social network support and well-being in same-sex versus mixed-sex romantic relationships. *J Soc Pers Relat*, 2008;25:769-791.

141 Willoughby BL, Lai BS, Doty ND, Mackey ER, Malik NM. Peer crowd affiliations of adult gay men: linkages with health risk behaviors. *Psychology of Men and Masculinity*, 2008;9:2345-247.

142 Ryan C, Russell ST, Huebner DM, Diaz R, Sanchez J. Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, 2010;23:205-213.

143 SAMSHA. A practioner's resource guide: Helping families to support their LGBT children, Feb 2014. http://store.samhsa.gov/product/A-Practitioner-s-Resource-Guide-Helping-Families-to-Support-Their-LGBT-Children/PEP14-LGBTKIDS (accessed August 21, 2014).

144 Ibid. Stall R, Friedman M, Catania JA. "Interacting epidemics and gay men's health: a theory of syndemic production among urban gay men" [chapter] in: Wolitski RJ, Stall R, Valdiserri RO (eds). *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the United States.* New York: Oxford University Press, 2008.

145 Ibid. Mustanski B, Birkett M, Greene GJ, Hatzenbuehler ML, Newcomb ME. Envisioning an America without sexual orientation inequities in adolescent health. *Am J Public Health*, 2014;104:218-225.

146 Ibid. Stall R, Friedman M, Catania JA. "Interacting epidemics and gay men's health: a theory of syndemic production among urban gay men" [chapter] in: Wolitski RJ, Stall R, Valdiserri RO (eds). *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the United States.* New York: Oxford University Press, 2008.

147 SAMHSA. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

148 Grossman AH. "The unique experiences of older gay and bisexual men: associations with health and well-being" [chapter] in: Wolitski RJ, Stall R, Valdiserri RO (eds). *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the United States.* New York: Oxford University Press, 2008.

149 Ibid. Institute of Medicine. *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding.* Washington, DC: The National Academy Press, 2011.

150 Fredriksen-Goldsen, Kim H-J, Barkan SE, Muraco A, Hoy-Ellis CP. Health disparities among lesbian, gay and bisexual older adults: results from a population study. *Am J Public Health*, 2013;103:1802-1809.

151 Fredriksen-Goldsen KA, Emlet CA, Kim H-J et al. The physical and mental health of lesbian, gay male and bisexual (LGB) older adults: the role of key health indicators and risk and protective factors. *The Gerontologist*, 2012;53:664-675.

152 HUD. An estimate of housing discrimination against same-sex couples, June 2013. http://www.huduser.org/portal/Publications/pdf/Hsg_Disc_against_SameSexCpls_v3.pdf (accessed September 23, 2014).

153 Ibid. Herrick AL, Egan JE, Coulter RWS, Friedman MR, Stall R. Raising sexual minority youths' health levels by incorporating resiliencies into health promotion efforts. *Am J Public Health*, 2014;104:206-210.

154 Ibid. Herrick AL, Egan JE, Coulter RWS, Friedman MR, Stall R. Raising sexual minority youths' health levels by incorporating resiliencies into health promotion efforts. *Am J Public Health*, 2014;104:206-210.

155 Davis R, Cook D, Cohen L. A community resilience approach to reducing ethnic and racial disparities in health. *Am J Public Health*, 2005;95:2168-2173.

156 Wexler LM, DiFluvio G, Burke TK. Resilience and marginalized youth: making a case for personal and collective meaning-making as part of resilience research in public health. *Soc Sci Med*, 2009;69:565-570.

157 Joint Presidential Advisory Council on HIV/AIDS and CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Care. HIV Disclosure Summit, June 28-29, 2012. http://aids.gov/federal-resources/pacha/meetings/2013/feb-2013-hiv-disclosure-summit.pdf (accessed November 4, 2014).

158 Mayer KH, Bekker L-G, Stall R, Grulich AE, Colfax G, Lama JR. Comprehensive clinical care for men who have sex with men: an integrated approach. *Lancet*, 2012;380:378-387.

159 Bernstein KT, Liu K-L, Begier EM, Koblin B, Karpati A, Murrill C. Same-sex attraction disclosure to health care providers among New York City men who have sex with men: implications for HIV testing approaches. *Arch Intern Med*, 2008;168:1458-1464.

160 Kaiser Family Foundation. Health and access to care and coverage for lesbian, gay, bisexual, and transgender individuals in the U.S. [issue brief], January 2014. http://kff.org/report-section/health-and-access-to-care-and-coverage-for-lgbt-individuals-in-the-u-s-the-lgbt-community/ (accessed August 27, 2014).

161 HHS Office of Minority Health. National standards for culturally and linguistically appropriate services in health and health care: a blueprint for advancing and sustaining CLAS policy and practice, April 2013. https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf (accessed September 23, 2014).

162 SAMHSA. LGBT training curricula for behavioral health and primary care practitioners. http://beta.samhsa.gov/behavioral-health-equity/lgbt/curricula (accessed August 27, 2014).

163 Hoffman ND, Freeman K, Swann S. Healthcare preferences of lesbian, gay, bisexual, transgender and questioning youth. *J Adolescent Health*, 2009;45:222-229.

164 Trust for America's Health. *Building on the Affordable Care Act to make the health system work for young gay men: an action plan*, March 2014. http://www.tfah.org/health-issues/wp-content/uploads/2014/04/MAC-AIDS-4.pdf (accessed September 23, 2014).

165 Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 Infection with Early Antiretroviral Therapy. *NEJM* 2011;365/6:493-505.

166 Das M, Chu PL, Santos GM, et al. Decreases in community viral load are accompanied by reductions in new HIV infections in San Francisco. *PLoS One* 2010;5/6:e11068.

167 Granich RM, et al. Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model. *Lancet*. 2009; 373: 48–57.

168 Gardner EM, McLees MP, Steiner JF, del Rio C, Burman WJ. The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection. *Clin Infect Dis*. (2011) 52 (6): 793-800.

169 US Public Health Service. Preexposure prophylaxis for the prevention of HIV infection in the United States - 2014: a clinical practice guideline. http://www.cdc.gov/hiv/pdf/PrEPguidelines2014.pdf (accessed May 27, 2014).

170 Grant RM, Lama JR, Anderson PL et al. Pre-exposure chemoprophylaxis for HIV prevention in men who have sex with men. *NEJM* 363/27: 2587-2599.

171 Smith DK, Grohskopf LA, Black RJ et al. Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States. *MMWR*, 2005:54(RR02);1-20.

172 Ibid. Mustanski B, Birkett M, Greene GJ, Hatzenbuehler ML, Newcomb ME. Envisioning an America without sexual orientation inequities in adolescent health. *Am J Public Health*, 2014;104:218-225.

1730 M Street, NW, Suite 900
Washington, DC 20036
(t) 202-223-9870
(f) 202-223-9871

APPENDIX S
Category 2: HIV and STD Epidemiological Data and Program Research on Transgender Individuals

1.0 State of the Epidemic

1.1 Overview

Los Angeles County (LAC or County) is a large county with over 4,000 square miles that includes 88 cities. The County has a mix of both urban and rural populations, and includes some of the country's most affluent and impoverished residents. LAC has an estimated population of 10 million (27% of California's population).[1]

LAC is among the most ethnically diverse regions in the nation. Most communities in LAC are multiethnic and multilingual, with a population consisting of 48% Hispanic, 28% White, 13% Asian/Pacific Islander, 8% African American, 2% other or multiracial, and less than 1% Native American. Approximately 60% of residents were born outside of the United States, and English is the language spoken at home by slightly less than 60% of all residents.

Due to the County's large geographic size, Department of Public Health's (DPH) Division of HIV and STD Programs (DHSP) has targeted smaller regions of the County where innovative HIV/STD prevention interventions and services can be the most impactful. The largest proportion of people living with HIV is in the L.A. Metro, South L.A., and South Bay areas. In 2013, the L.A. Metro area had approximately 35% of all newly diagnosed HIV cases.[2] This is followed by 13% of all newly diagnosed HIV cases existing in South LA and 16% in the South Bay.[2] Combined, these three areas account for approximately 64% of all newly diagnosed HIV cases in 2013.

1.2 Transgender Individuals and the HIV/STD Epidemic in LAC

LAC also sees disturbing trends in the transgender community. DHSP estimates that as of 2013, there are 14,428 transgender individuals living in LAC, with a range of 7,214 to 21, 642 and a one-to-one ratio of transgender women (7,214) to transgender men (7,214).[3]

The estimated HIV prevalence in LAC of transgender women is 15.1% and 0.6% for transgender men. This data complements findings from national studies of HIV prevalence among female transgender individuals, with rates that range from 22% to 35%.[4] The predominant mode of HIV infection among transgender females is unprotected receptive anal intercourse.[5,6] National studies point to significant racial/ethnic disparities in HIV prevalence among the transgender population, with African American transgender women reporting the highest percentage of new HIV-positive test results (CDC, 2013). Similarly, in LAC, the highest percentages are among African Americans (48.3%), followed by Native Americans (26.9%), Latinas (17.1%), Whites (4.6%) and Asian/ Pacific Islanders (3.7%). Consistent with those estimates, data on STD prevalence among transgender individuals showed that in 2011, 15.8% of female transgender individuals who were tested at a County public health center tested positive for syphilis.[3]

APPENDIX S
Category 2: HIV and STD Epidemiological Data and Program Research on Transgender Individuals

2.0 Statement of Need

2.1 Background

Transgender individuals face a high prevalence of HIV infection which may be attributable to the significant barriers they face maintaining their overall health and wellbeing, including lack of heath care access, homelessness, high unemployment and poverty. Gender role expectations, transphobia, stigma, violence, social isolation and rejection from friends, family, and community can create additional challenges causing overwhelming emotional pressures when dealing with an HIV diagnosis, especially for transgender individuals. Feelings of non-acceptance, fear of stigma and isolation drives up risk for infection by exacerbating risky behaviors.

New services/programs must address these issues and develop new paradigms for prevention, testing, linkage to care and care in order to curtail the spread of HIV infection among transgendered individuals. New planning tools and strategies, such as: syndemic planning; geospatial analysis; high-impact interventions; aggressive testing; early identification of undiagnosed HIV-positive persons; linkage to care services; new provisions under the Affordable Care Act; and targeted efforts to engage, re-engage, and retain PLWHA in care are integral components of LAC's HIV prevention plan and are necessary to achieve the goals outlined in the National HIV/AIDS Strategy (NHAS). NHAS goals are:

(1) Reducing new HIV infections;
(2) Increasing access to care and improving health outcomes of people living with HIV; and
(3) Reducing HIV-related disparities and health inequities.[11]

LAC is moving beyond the behaviorally-focused health education and risk reduction models to focus on improving the whole context of people's lives. A review of the empirical literature and recent data on trends in adolescent culture has suggested four new directions to consider when developing interventions. Family-based interventions, addressing health disparities and understanding the social determinants of health for adolescents, expanding the theoretical models that are relied on in developing interventions, and utilization of new technologies each have promise for successfully assisting adolescents to reduce their risk behaviors and enhance protective factors.[8]

2.2 Structural and Individual Interventions

Structural interventions presume a certain degree of social causation of public health problems and attempt to change social, economic, political or physical environments that shape and constrain health behaviors or otherwise affect outcomes. Individual-level approaches assume that the relationship between individuals and society is one in which individuals have considerable autonomy to make and act on their choices. Adequately addressing HIV involves a multilevel approach with both structural and individual interventions tackling different factors

influencing HIV transmission and infection. According to Syndemic Theory, raising levels of health across any or all psychosocial health conditions can have a positive impact on levels of HIV risk and HIV prevalence.[9]

The following sections highlight some important factors, goals, objectives and research to consider when developing innovative HIV prevention interventions for transgender individuals.

2.3 Social Determinants of Health

Social determinants are those factors that contribute to a person's current state of health. Scientists generally recognize five determinants of health of a population: biological (i.e., gender and age), individual behaviors, social/economic environment, physical environment and access to health care. Inequitable distribution of these conditions across various populations is a significant contributor to persistent and pervasive health disparities. Poverty, income and wealth inequality, poor quality of life, racism, sex discrimination, and low socioeconomic conditions are the major risk factors for ill health and health inequalities especially amongst transgender women (Male to Female (MTF)). Particular to transgender women, Poteat's et al review suggests that in addition to racism and discrimination; lack of social and legal recognition of their affirmed gender, and exclusion from employment and educational opportunities are drivers of HIV risk and other health disparities in transgender women.[10]

Garofalo et al conducted a survey study with young ethnic-minority MTF transgender youth on real life challenges and HIV-risk behaviors. The study concluded that MTF transgender; especially youth, face the following stressors placing them at high-risk for HIV infection:

- History of incarceration
- Homelessness
- Sex in exchange for resources
- Forced sexual activity
- Difficulty finding a job
- Difficulty accessing healthcare[11]

Though these stressors were found for MTF transgender youth, the concurrent literature suggests that these stressors also apply to adult MTF transgender individuals. These stressors are part of the social determinants of health that place transgender individuals at high risk for HIV/STD infection.[11]

Emphasis on social determinants requires developing partnerships with groups that traditionally may not have been part of public health initiatives, including community organizations and representatives from government, academia, business, and civil society.[12]

2.3.1 Social Connectedness

Social connectedness and the cohesion of the community have been

shown to have a direct relationship to good health and lower mortality rates. These factors can also encourage civic participation, and lead to community development and greater social and economic equality.[37]

In a 2013 report, *Getting to Wellness: A Roadmap for Improving the Health of Transgender Individuals in Los Angeles County* (2013), the authors cite findings from adolescent and young adult transgender females who participated in the Transgender Research Youth Project (TRYP).[16,31] Findings suggested that HIV-related risk behaviors were closely linked to parental support. Many transgender youth in the TRYP reported having no parental support and that their parents engaged in violence towards them because of their gender identity. Discrimination and violence from parents has been linked to a host of challenges for transgender youth, including homelessness, isolation and increased sexual risk behaviors.[38]

Stevens et al described the connectedness that exists in a 'gay family.' A gay family refers to a family that is organized around choice, rather than biology, who provide emotional and tangible support to its members, usually consisting of LGBT youth. Participants in Stevens et al focus group described their gay families as "an important part of their lives, often influencing their decisions."[39]

Nuttbrock, et al note that because they transgress basic gender norms, many female transgender individuals are verbally and/or physically abused by family members, neighbors, coworkers, or strangers, and that this abuse is linked to depression which may impede prevention practices such as condom use.[4] The authors also conclude that among younger female transgender individuals between 19-30 years old, gender abuse predicted depressive symptoms. Further, it was found that gender abuse combined with depressive symptoms predicted both high-risk sexual behavior such as unprotected receptive anal sex and new cases of HIV/STD infections. These associations were independent of socioeconomic status, ethnicity, sexual orientation, hormone therapy, and sexual reassignment surgery.

The authors conclude that interventions for these transgender youth are needed to reduce the psychological impact of gender abuse and limit the effects of such abuse on high-risk sexual behavior. Age differences among peers are significant in the impact of gender abuse on the rate of HIV/STD infection; the authors suggest there is evidence that peer-based interventions in which older female transgender individuals teach their younger counterparts how to cope with this abuse can be effective.[4]

Family cohesion is an important determinant of health. Providers who serve these populations should assess and help educate families about the negative impact of rejecting behaviors on their loved one. Counseling families, providing anticipatory guidance, and referring families for counseling and support and help make a critical difference in decreasing risk and increasing well-being for transgender people, specifically, transgender youth.

2.4 Resiliency and Protective Factors

Identifying and addressing social determinants of health amongst transgender individuals is imperative, but it's just as important to simultaneously promote resiliency and protective factors. Resilience is "an individual's ability to recover from or adjust to misfortune, adversity, or change."[9] Resilience becomes essential to transgender individuals as they have reported dealing with transphobia, machismo, racism, prejudice, and injustices along with other 'minority stressors' on a constant basis.[40] LGBT youth in particular tend to experience higher rates of victimization and criminalization than their non-LGBT counterparts.[9] These types of experiences as part of 'minority stress,' can result in psychological distress that can lead to risky sexual behaviors putting this population at higher risk for HIV and STDs.[41]

Protective factors reduce the likelihood of certain danger or harm. Protective factors are certain characteristics (social, structural, cultural, individual) that can protect transgender individuals from becoming infected with HIV or other STDs. One study demonstrated this idea among young MSM (Transgender individuals weren't included, but it may be safe to assume that these protective factors might also apply in the transgender community). A comparison between HIV-positive and HIV-negative YMSM discovered that HIV-negative YMSM who reported positive peer norms for condom use were 1.13 times less likely to be engaged in risky sexual behaviors compared to those who lacked positive peer norms.[42] In addition, those who reported high levels of social support for safer sex were 1.17 times more likely to have abstained from risky sexual behavior than those reporting low levels of support.[42]

Promoting resilience via protective factors may assist in the prevention of HIV and STDs. Some protective factors for youth, including LGBT youth, may include: family/peer support, positive peer groups, a connection to spirituality/religiosity, strong sense of self and self-esteem, along with effective engagement in school and community activities.[43] The Centers for Disease Control and Prevention's Injury Prevention Center adds connection with parents, ability to discuss problems with parents/adults, along with a consistent parental presence in the home are also important or key factors in adolescent development.

3.0 Background Research for the DHSP Program Goals and Objectives

3.1 Access to Healthcare

LAC has one of the highest rates of uninsured individuals in the nation, with significant disparities in coverage among minorities and youth. In 2011, over 17% of all LAC residents were uninsured.[13] Thirty-six percent of LAC residents between 18-29 years of age were uninsured sometime during 2012. One-half of the uninsured population (51%) between 18-29 years was Latino and nearly 4% were African American.[14]

APPENDIX S
Category 2: HIV and STD Epidemiological Data and Program Research on Transgender Individuals

As California implements health care reforms under the Affordable Care Act, more LAC residents are expected to become insured in 2014 through expanded Medi-Cal or subsidized private insurance through an affordable health insurance exchange. However, about 1.3 million people (13% of LAC's population) are projected to remain uninsured through 2019, including the undocumented, as well as those who are eligible for Medi-Cal or insurance exchanges but remain un-enrolled due to enrollment barriers.[15]

For transgender individuals, the most significant barrier to HIV/STD prevention and overall good health is having access to health care that is free of stigma and discrimination and which meets their unique needs.[16] In the National Transgender Discrimination, Survey 6 respondents faced serious hurdles to accessing heath care, including refusal of care and lack of provider knowledge.[17] Nineteen percent of participants reported being refused care due to their transgender or gender non-conforming status; 50% of the sample reported having to teach their medical providers about transgender care.

Data from the Los Angeles Transgender Health Study found that 50% or more of transgender women in LAC did not have health insurance, had injected hormones, silicone, or oil, and had obtained hormones off the street. Additionally, data from Getting to Wellness: A Roadmap for Improving Health of Transgender Individuals in LAC indicated that of 29 health care agencies inventoried in LAC, ten reported providing transgender-inclusive primary care – two clinics reported providing primary care without hormone therapy; the seven other clinics reported providing primary care with hormone therapy.[16] Only two clinics reported providing transgender-specific primary care including hormones. The study also looked at the number of Federally Qualified Health Centers (FQHCs) and FQHC look-alikes in LAC, which totaled 277, and concluded that the lack of primary care providers adequately serving transgender individuals is not attributable to clinic scarcity.[16]

In 1981, Penchansky and Thomas argued in the article*, "The Concept of Access: Definition and Relationship to Consumer Satisfaction"* that good access to healthcare must reflect the fit between characteristics and expectations of the providers and the clients.[18] They grouped these characteristics into five "*A*s" of access to care: affordability, availability, accessibility, accommodation, and acceptability. All DPH funded HIV and STD prevention services must be provided to County residents (who are program eligible) at no cost, therefore DPH's dictates the focus shall be free to the client, so the focus will be on availability, accessibility, accommodation, and acceptability. *Availability* measures the extent to which the provider has the necessary resources, such as personnel and technology, to meet the needs of the client. *Accessibility* refers to geographic convenience, which is determined by how easily the client can physically reach the provider's location. *Accommodation* reflects the extent to which the provider's operation is organized in ways that meet the constraints and preferences of the client (i.e. hours of operation, how electronic communications are handled, ability to receive care without prior appointment, etc.). A*cceptability* captures how comfortable the client is with characteristics of the provider, such as age, gender, sexual orientation, socio-economic status, ethnicity, and cultural competency.

Due to the expanse of LAC's geography and the diversity of the population, availability, accessibility, accommodation, and acceptability are all areas that need improvement to facilitate individuals finding healthcare, utilizing existing available benefits, and making health checkups and maintenance routine.

3.2 Housing and Economic Empowerment

Poverty and Incarceration in LA County

Over 2 million adults, or 27%, of County residents, lived in poverty in 2011, including 1 in 5 children.[19] The poverty rate in LAC is higher than the nation as a whole. Over 1.47 million or 15% of people in LAC are living in poverty, defined as an income of $22,000 per year for a family of 4, compared to 13% for the nation.[20] As such, many residents are incapable of meeting their family's necessities such as food, housing, transportation, and health care. In addition, 53% of LAC's working-age population, or 3.8 million people, have low literacy skills, a serious barrier to employability and workforce productivity.[19] Low literacy is also associated with incarceration; LAC's prison population rate of 746/100,000 is significantly higher than for the state as a whole of 584/100,000.[21]

Unemployment and Homelessness in the Transgender Community

Data suggest HIV prevalence is higher among people who are poor.[22,23] The pathway between HIV infection and poverty may be mapped by decreased access to care and reduced treatment for HIV and other STIs.[24] Further, when examining economic, social and structural factors, it was found that income inequality and social capital were significantly correlated with AIDS case rates.[23,25]

"Injustice at Every Turn: A Report of the National Transgender Discrimination Survey" documents the impact of anti-transgender bias nationally. This survey highlighted the ways in which social and economic disparities due to gender identity discrimination create barriers to good health.[17]

Respondents reported experiencing unemployment at twice the rate of the general population, with rates for transgender people of color up to four times the national unemployment. Those who were currently unemployed experienced nearly double the rates of working in the street economy (e.g. sex work and drug dealing), twice the homelessness, 85% higher incarceration rates, double the HIV infection rate, and double the rate of drinking and drug abuse.[17]

Approximately 19% of respondents reported experiencing homelessness at some point in their lives due to being transgender or gender non-conforming; 55% of respondents who tried to access a homeless shelter were harassed by shelter staff or residents, 29% were turned away altogether, and 22% were sexually assaulted by staff or residents.[17]

At the state and local level, it looks much the same. "The State of Transgender California: Results from a 2008 California Transgender Economic Health Survey" found that despite legal protections in place prohibiting discrimination based on

gender identity in California, the transgender population remains marginalized and continues to experience discrimination and denial of basic services such as health and housing.[26] Seventeen percent of respondents to this survey came from Los Angeles County.

In the California study, twenty percent of respondents indicated that they have been homeless at some point since they first identified as transgender.[26] Thirty-one percent of homeless transgender respondents who tried to stay in shelters reported being denied access. Thirty percent reported postponing care for illness or preventative care due to disrespect or discrimination from doctors or other health care providers.[26]

Important program goals for HIV and STD prevention programs include to assist transgender people find stable housing and to develop strategies that will assist the transgender community to be economically empowered, thereby pulling themselves out of poverty and away from activities that can result in incarceration.

3.3 Cultural Competency

Cultural competency can only be achieved when organizations working with these populations acknowledge and understand that a host of social and environmental factors contribute to HIV/STD risks among transgender individuals.

Stigma, violence, transphobia, fear of rejection, discrimination, and racism continue to be pervasive forces. All deplete health in multiple ways. A person who faces racism and experiences discrimination may engage in high risk behaviors for HIV/STDs, may undertake sex work as a means of survival, may not seek healthcare when needed, and can suffer from psychological distress. Racism also has oppressive effects on sexuality.[27] PLWH who experience racism and discrimination may not be able or feel comfortable seeking/receiving needed care, education, and services to manage their HIV infection and prevent further transmission.

For transgender individuals, family rejection and domestic violence can result in immediate homelessness. Survival sex work and substance use heighten their HIV risks, and getting screened for HIV is a lower priority than immediate survival needs. Stigma, discrimination and internalized homophobia [transphobia] have also been associated with higher rates of unprotected sexual intercourse.[23,28] Further, higher levels of this stigma were associated with not being tested for HIV, inaccurately assessing one's risk for HIV, and not participating in HIV prevention programs.[23,29]

The National Transgender Discrimination Survey found that 63% of respondents reported experiencing a serious act of discrimination that had a major impact on their life and ability to sustain themselves financially and emotionally. Research examining the impact of exposure to transphobia on HIV risk behavior suggests that exposure to transphobia yields a powerful effect among younger transgender women.[30] Youth with a history of sex work were more likely to report having experienced discrimination in school settings than youth without a history of sex

work.[31] There is also evidence to suggest a syndemic relationship between sex work, substance use, homelessness and HIV infection, in particular for young transgender women. A syndemic is more than the interaction of diseases; it's the mutually reinforcing interaction of disease and social condition.[32,33] Preliminary evidence suggests that multiple health-related psychosocial factors, including low self-esteem, lifetime poly-substance use and victimization are highly associated with sexual risk behavior and self-reported HIV infection among young transgender women.[34] Hotton et al suggests that life stressors, described previously, were associated with elevated sexual risk among young transgender women (MTF) and that this relationship between stressors and risk is mediated by alcohol and substance use; as young transgender women may seek these substances to cope with life stressors they experience in the absence of social support.[35]

A 2001 study of 244 transgender women in LAC found an HIV seroprevalence of 22% among study participants, while nearly 60% reported a history of incarceration, a known risk factor for HIV.[14,34] Forty-seven percent were physically abused or beaten as a result of their gender presentation. As a result, nearly half of respondents reported high risk behaviors including (48%) having sex in the past six months with an exchange partner, defined as a partner with whom they traded sex for money, drugs, shelter, food or other tangible things they needed. Of those that reported receptive anal sex with an exchange partner, 29% did not always use a condom.

Acknowledgement and understanding of these multiple social factors in the lives of transgender individuals will help improve cultural competency and lead to innovative strategies to combat this epidemic in these populations.

Non-citizens and Language barriers
Additionally, cultural competency takes into account concerns over deportation and language barriers as additional contributors to the HIV epidemic in LAC. According to the 2011 American Community Survey, approximately 35% of LAC residents are foreign born, and 53% of foreign born residents are undocumented.[36] The ACS also reports that 57% of LAC's population over five years old speaks a language other than English at home, and 26% of this population speaks English less than "very well."[36] It is crucial that these populations are able to access health care services and have a level of health literacy that allows them to understand and acknowledge health care information and instructions. Therefore, interventions with specific target populations must consider possible language barriers that inhibit health literacy and access to testing, treatment, and care.

4.0 Technology

Program designs proposed in response to this RFP must include use of advanced technology (refer to Appendix B, Statement of Work). Marguerita Lightfoot states in *HIV Prevention for Adolescents: Where Do We Go From Here* that, "adolescent use of technologies, including computers and the Internet, social networking platforms, and cell phones, are near ubiquitous and provide a unique opportunity for HIV prevention."[8]

Lightfoot continues, "technology may be a viable way to deliver disease prevention information and promote skills development to all adolescents; most importantly for those who respond poorly to didactic instruction or experience difficulty in engaging or gaining insight in therapeutic processes. Technology has the potential for enhancing intrinsic motivation, providing individualized feedback, and encouraging active engagement, thereby offering certain advantages over traditional therapeutic strategies.[8]

Utilizing technology with transgender individuals, particularly young transgender individuals is further supported and considered crucial in HIV prevention outreach given the widespread use of the Internet, social networking, and mobile technology within the youth population. It is estimated that over 93% of adolescents between the ages of 12-15 years are online while 63% "go-online" on a daily basis.[44] In addition utilizing technology to find others for sexual encounters has been an increasing trend with youth in particular with young gay and transgender women.[39]

These numbers are similar across racial/ethnic and socioeconomic groups. Further, the Internet is becoming a primary resource for health information, with 31% of online adolescents accessing health, dieting, or physical fitness information from the Internet. [44] Seventeen percent of adolescents report going online to find information about health topics that are challenging to discuss with others, such as drug use. Similarly, the use of socially interactive technologies (e.g. social networking sites) is common among adolescents. Social networking happens across a number of platforms and includes sites such as Facebook, YouTube, and Twitter; gaming and virtual worlds, such as Second Life, the Sims, and World of Warcraft; video and photograph sites such as YouTube, Pinterest, and Instagram; and blogs. Engaging with these technologies is a routine activity for adolescents as 82% of 14- to 17-year-olds use social networking sites, a dramatic increase from 55% in 2006.[44] These sites are a portal for adolescents' entertainment, communication, and connection.

Social networking is being considered a promising prevention tool. A study that used Facebook to deliver an HIV prevention intervention found small to moderate short-term impact on condom use and protected sex acts.[45] Another more recent study, *Social Networking Technologies as an Emerging Tool for HIV Prevention: A Cluster Randomized Trial* in the Annals of Internal Medicine, conducted by Young, Cumberland, Lee, Jaganath, Szekeres, and Coates, found that targeted interventions launched via Facebook group are an effective way to communicate health information, particularly in relation to HIV testing and safe sex practices among African American and Latino MSM 18 years and older [46].

Mobile technology is another medium with incredible potential as a tool for HIV prevention. Upwards of 82% of 12- to 19-year-olds in the United States own a cell phone, and use increases with age.[44]

The use of mobile phones has become a centerpiece of adolescent communication, with text messaging becoming a preferred mode of contact with peers. In the United States, 89% of adolescents use text messages, and the monthly average number of text messages sent and received is 2,899.[47] Over half of adolescents (54%) text-message daily, and two thirds of adolescent 'texters' say they are more likely to text friends than to talk to them via a cell phone.[44] In addition, the use of mobile technologies has begun to play a prominent role in their sexual lives of transgender youth as a focus group study with young African American gay men and transgender women describes, "mobile phones

were cited [by participants' as common tools for escorting and 'hooking up'" The use of these technologies to participate in high risk behavior can be mitigated with technologies that promote protective behaviors.[39]

5.0 Testing and Linkage to Care

5.1 HIV Testing and Linkage to Care

The geographical regions in LAC most significantly impacted by the HIV/AIDS and STD epidemic are the central and southern corridors. These areas are where the highest number and concentration of transgender individuals reside. The transgender community has one of the highest disparities of new HIV infections, linkage to care, and viral suppression.

The estimated HIV prevalence in LAC of transgender women is 15.1% and 0.6% for transgender men. The highest percentages are among African Americans (48.3%), followed by Native Americans (26.9%), Latinas (17.1%), Whites (4.6%) and Asian/ Pacific Islanders (3.7%).

Among age groups for PLWHA in LAC, youth (13-24 years) are more likely than older populations to be out of care. In "What Youth Need-Adapting HIV Care Models to Meet the Lifestyles and Special Needs of Adolescents and Young Adults" some possible reasons for this include: health system factors; therapeutic factors; psychosocial factors; and social factors. All these barriers must be addressed in order to successfully link youth into HIV care and then to subsequently keep them in care once engaged.[48]

DHSP has supported a variety of HIV testing and linkage to care models including: targeted HIV testing services (HTS) in storefronts, clinics, emergency departments, substance abuse clinics, courts, mobile units, and in commercial sex venues (bathhouses and sex clubs); social network testing; and multiple morbidity testing to assist with identifying undiagnosed HIV/STD infection, as well as counseling and educating those at elevated risk for acquiring HIV. HTS focus on areas/zip codes highly impacted by the HIV/AIDS epidemic and priority target populations at elevated risk for HIV transmission.

In 2011, the New Directions HIV Testing Program was launched to begin the process of streamlining and improving HTS conducted by LAC community partners in addition to aligning services with the National HIV/AIDS Strategy and local goals. DHSP estimates that the PLWHA population in LAC accounts for 5% of all PLWHA in the U.S. Therefore, in order to meet the prescribed national goal of conducting 3.1 million HIV tests annually, DHSP estimates that 155,000 test events will need to be conducted annually by LAC testing providers. In 2012, DHSP contracted agencies conducted approximately 130,000 HIV tests. In 2013, contracted agencies nearly met the goal, conducting 145,000 tests.

APPENDIX S
Category 2: HIV and STD Epidemiological Data and Program Research on Transgender Individuals

5.2 STD Testing and Treatment

A high prevalence of other STDs and high rates of undiagnosed/untreated STDs contribute to the HIV epidemic. STDs are associated with an increased risk of HIV transmission.[49] In addition, having additional STDs can complicate HIV treatment and care amongst PLWHA.

Data on STD prevalence among transgender individuals showed that in 2011, 15.8% of female transgender individuals who were tested at a LAC Public Health center tested positive for syphilis.[3]

In particular, LAC has a high burden of STDs among youth. In 2011, there were a total of 60,040 cases of STDs reported in LAC; over half (57%) of all cases were among 15-24 year olds.[50] Chlamydia represented the overwhelming majority of cases in this age group (86%) followed by gonorrhea (13%) and syphilis (1%).[50]

Significant STD disparities exist among youth of color. Compared to their White counterparts, African American males between ages 20-24 had reported rates of chlamydia and gonorrhea that were 7 times higher than for Whites and 8 times higher than for Hispanics.[49] Similarly, rates of early syphilis among young African American males were almost 4 times higher than for Whites, and 2.8 times higher than for Hispanics.[49]

APPENDIX S
Category 2: HIV and STD Epidemiological Data and Program Research on Transgender Individuals

1. US Census Bureau Public Information Office. Growth in Urban Population Outpaces Rest of Nation, Census Bureau Reports - 2010 Census - Newsroom - U.S. Census Bureau. Available at: http://www.census.gov/newsroom/releases/archives/2010_census/cb12-50.html. Accessed December 11, 2013.

2. Division of HIV and STD Programs - Los Angeles County Department of Public Health. *2013 Annual HIV Surveillance Report*.; 2014:12. Available at: http://publichealth.lacounty.gov/wwwfiles/ph/hae/hiv/2013AnnualSurveillanceReport.pdf. Accessed September 2, 2014.

3. T B, Carlos-Henderson J. *Los Angeles County Transgender Population Estimates 2012*. Los Angeles; 2012.

4. Nuttbrock L, Bockting W, Rosenblum A, et al. Gender abuse, depressive symptoms, and HIV and other sexually transmitted infections among male-to-female transgender persons: A three-year prospective study. *Am J Public Health*. 2013;103(2):300–307.

5. Bockting WO, Robinson BE, Rosser BR. Transgender HIV prevention: a qualitative needs assessment. *AIDS Care*. 1998;10(4):505–25. doi:10.1080/09540129850124028.

6. Nemoto T, Operario D, Keatley J, Han L, Soma T. HIV Risk Behaviors Among Male-to-Female Transgender Persons of Color in San Francisco. *Am J Public Health*. 2004;94(7):1193–1199. doi:10.2105/AJPH.94.7.1193.

7. The White House. *National HIV/AIDS Strategy for the United States*. Washington DC; 2010. Available at: http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf.

8. Lightfoot M. HIV Prevention for Adolescents : Where Do We Go From Here ? *Am Pyschologist*. 2012;53(November):348–356. doi:10.1016/j.

9. Herrick AL, Lim SH, Wei C, et al. Resilience as an untapped resource in behavioral intervention design for gay men. *AIDS Behav*. 2011;15 Suppl 1:S25–9. doi:10.1007/s10461-011-9895-0.

10. Poteat T, Reisner SL, Radix A. HIV epidemics among transgender women. *Curr Opin HIV AIDS*. 2014;9(2):168–173.

11. Garofalo R, Deleon J, Osmer E, Doll M, Harper GW. Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *J Adolesc Heal*. 2006;38(3):230–236.

12. Centers for Disease Control and Prevention. Social Determinants of Health. 2012. Available at: http://www.cdc.gov/socialdeterminants/Definitions.html. Accessed December 11, 2013.

13. UCLA Center for Health Policy Research. California Health Interview Survey. *2012*. Available at: http://healthpolicy.ucla.edu/CHIS/Pages/default.aspx.

14. NCHHSTP. *Today's HIV/AIDS Epidemic Factsheet*.; 2013. Available at: http://www.cdc.gov/nchhstp/newsroom/docs/HIVFactSheets/TodaysEpidemic-508.pdf.

15. UC Berkeley Center for Labor Research and Education UC for H and PR. *After millions of Californians gain health coverage under the affordable care act, who will remain uninsured?* 2012. Available at: http://laborcenter.berkeley.edu/healthcare/aca_uninsured12.pdf.

16. Center for HIV Identification Prevention and Treatment Services (CHIPTS). *Getting to Wellness: A Roadmap to Improving the Health of Transgender Inviduals in Los Angeles County*.; 2013.

17. Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington DC; 2011.

18. Penchansky R, Thomas JW. The concept of access: definition and relationship to consumer satisfaction. *Med Care*. 1981;19(2):127–40. Available at: http://www.ncbi.nlm.nih.gov/pubmed/7206846. Accessed December 11, 2013.

19. United Way of Greater Los Angeles. *LA County ten years later: a tale of two cities one future*.; 2011. Available at: http://unitedwayla.org/wp-content/uploads/2011/11/TaleOfTwoCities_Feb2010.pdf.

20. Division of HIV and STD Programs, Los Angeles County Department of Public Health, the Los Angeles County Commission on HIV and the LACHPPC. *Los Angeles Coordinated HIV Needs Assessment - Care (LACHNA) 2011 Final Report*.; 2011. Available at: http://hivcommission-la.info/cms1_173837.pdf.

21. Center on Juvenile and Criminal Justice. Los Angeles County - California Sentencing Institute. *2012*. Available at: http://casi.cjcj.org/Adult/Los-Angeles.

22. Denning P, DiNenno E. Communities in Crisis: Is There a Generalized HIV Epidemicin Impoverished Urban Areas of the United States? 2010.

23. Guillermo P, Lightfoot M, Brown H. Macro-Level Approaches to HIV Prevention Among Ethnic Minority Youth: State of the Science, Opportunities, and Challenges. *NIH Public Access*. 2013;68(4):286–299. doi:10.1037/a0032917.Macro-Level.

24. Aral SO. Sexual network patterns as determinants of STD rates: paradigm shift in the behavioral epidemiology of STDs made visible. *Sex Transm Dis*. 1999;26(5):262–4. Available at: http://www.ncbi.nlm.nih.gov/pubmed/10333278. Accessed December 12, 2013.

25. Holtgrave D, Crosvy R. Social capital, poverty, and income inequality as predictors of gonorrhoea, syphilis, chlamydia and AIDS case rates in the United States. *Sex Transm Infect*. 2003;79:62–65.

APPENDIX S
Category 2: HIV and STD Epidemiological Data and Program Research on Transgender Individuals

26. Hartzell E, M.S., Wertz K, Davis M. *The State of Transgender California: Results from the 2008 California Transgender Economic Health Survey*. San Francisco, CA; 2009.

27. Marín BV. HIV Prevention in the Hispanic Communinty: Sex, Culture, and Empowerment. *J Transcult Nurs*. 2003;14:186. doi:10.1177/1043659603253549.

28. Preston DB, D'Augelli AR, Kassab CD, Cain RE, Schulze FW, Starks MT. The influence of stigma on the sexual risk behavior of rural men who have sex with men. *AIDS Educ Prev*. 2004;16(4):291–303. doi:10.1521/aeap.16.4.291.40401.

29. Darrow WW, Montanea JE, Gladwin H. AIDS-related stigma among Black and Hispanic young adults. *AIDS Behav*. 2009;13(6):1178–88. doi:10.1007/s10461-009-9601-7.

30. Sugano E, Nemoto T, Operario D. The impact of exposure to transphobia on HIV risk behavior in a sample of transgendered women of color in San Francisco. *AIDS Behav*. 2006;10(2):217–25. doi:10.1007/s10461-005-9040-z.

31. Wilson EC, Garofalo R, Harris RD, et al. Transgender female youth and sex work: HIV risk and a comparison of life factors related to engagement in sex work. *AIDS Behav*. 2009;13(5):902–913.

32. Singer M. Pathogen-pathogen interaction A syndemic model of complex biosocial processes. 2010.

33. Singer MC, Erickson PI, Badiane L, et al. Syndemics, sex and the city: understanding sexually transmitted diseases in social and cultural context. *Soc Sci Med*. 2006;63(8):2010–2021.

34. Brennan J, Kuhns LM, Johnson AK, Belzer M, Wilson EC, Garofalo R. Syndemic theory and HIV-related risk among young transgender women: the role of multiple, co-occurring health problems and social marginalization. *Am J Public Health*. 2012;102(9):1751–1757.

35. Hotton AL, Garofalo R, Kuhns LM, Johnson AK. Substance use as a mediator of the relationship between life stress and sexual risk among young transgender women. *AIDS Educ Prev*. 2013;25(1):62–71.

36. U.S. Census Bureau. 2007-2011 American Community Survey 5-Year Estimates: Los Angeles County. *2007-2011 Am Community Surv*. 2011. Available at: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk.

37. Work Group for Community Health and Development. Section. 5 Addressing Social Determinants of Health. 2013. Available at: http://ctb.ku.edu/en/table-of-contents/analyze/analyze-community-problems-and-solutions/social-determinants-of-health/main. Accessed December 12, 2013.

38. Grossman AH, D'augelli AR. Transgender youth: Invisible and vulnerable. *J Homosex*. 2006;51(1):111–128.

APPENDIX S
Category 2: HIV and STD Epidemiological Data and Program Research on Transgender Individuals

39. Stevens R, Bernadini S, Jemmott JB. Social environment and sexual risk-taking among gay and transgender African American youth. *Cult Health Sex*. 2013;15(10):1148–1161.

40. Division of HIV and STD Programs, Los Angeles County Department of Publlic Health. DHSP Listening Sessions with Young Gay Men of Color. 2012.

41. Díaz RM, Ayala G, Bein E, Henne J, Marin B V. The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: findings from 3 US cities. *Am J Public Health*. 2001;91(6):927–32. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1446470&tool=pmcentrez&rendertype=abstract. Accessed December 10, 2013.

42. Forney JC, Miller RL. Risk and protective factors related to HIV-risk behavior: a comparison between HIV-positive and HIV-negative young men who have sex with men. *AIDS Care*. 2012;24(5):544–52. doi:10.1080/09540121.2011.630341.

43. Department of Health and Human Services. LGB Youth : Challenges , Risks and Protective Factors. 2012;92(2009). Available at: http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/training/tip_sheets/lgb-youth-508.pdf.

44. Lenhart A, Purcell K, Smith A, Zickuhr K. *Social Media and Mobile Internet Use Among Teens and Young Adults*. Washington DC; 2010. Available at: http://web.pewinternet.org/~/media/Files/Reports/2010/PIP_Social_Media_and_Young_Adults_Report_Final_with_toplines.pdf.

45. Bull SS, Breslin LT, Wright EE, Black SR, Levine D, Santelli JS. Case study: An ethics case study of HIV prevention research on Facebook: the Just/Us study. *J Pediatr Psychol*. 2011;36(10):1082–92. doi:10.1093/jpepsy/jsq126.

46. Young SD, Cumberland WG, Lee S-J, Jaganath D, Szekeres G. Social Networking Technologies as an Emerging Tool for HIV Prevention: A Cluster Randomized Trial. *Ann Intern Med*. 2013;159(5).

47. Cole-Lewis H, Kershaw T. Text messaging as a tool for behavior change in disease prevention and management. *Epidemiol Rev*. 2010;32(1):56–69. doi:10.1093/epirev/mxq004.

48. Akin L, Ozcebe H, Alexander CS, et al. Abuelo D, See Harel A Adams CD, Perkins KC, Lumley V, Hughes C, Burns JJ, Omar HA. Validation of the Perkins Adolescent Risk Screen (PARS), 462. *J Adolesc Heal*. 2003;33:509–512.

49. Cohen MS. HIV and sexually transmitted diseases: lethal synergy. *Top HIV Med*. 12(4):104–7. Available at: http://www.ncbi.nlm.nih.gov/pubmed/15516707. Accessed December 12, 2013.

50. Division of HIV and STD Programs. *Sexually Transmitted Diseases Morbidity Report 2011*. Los Angeles; 2011. Available at: http://publichealth.lacounty.gov/std/docs/2011STDReport.pdf.

Getting to Wellness:

A Roadmap for Improving the Health of Transgender Individuals in Los Angeles County

June 2013

AUTHORS

AJ King, MPH

Kiesha McCurtis, MPH

CHIPTS TRANSGENDER CONSORTIUM MEMBERS

Israel Amrani, LMFT
Shiloh Bentacourt
Madeline B. Deutsch, MD
Michelle Enfield
E. Jaye Johnson, DBA, CCHt, MERt, TEt
Marie Keller, MA, LMFT
Kimberly A. Kisler, MPH, Ph.D
Mark A. Malek, MD, MPH
Miguel Martinez, MSW, MPH
Prue Mendiola
Chandi Moore
Ezak Perez
Cathy J. Reback, Ph.D
Isabella Rodriguez

ACKNOWLEDGEMENT

Our sincere appreciation to Mary Jane Rotheram-Borus and Maya Lazar, without whose vision and assistance this project would not have been possible.

Our thanks also go to the many individuals and agencies who participated in project-related interviews and who responded to inquiries during the report development process.

SUGGESTED CITATION

Center for HIV Identification, Prevention and Treatment Services (CHIPTS). Getting to Wellness: A Roadmap for Improving the Health of Transgender Individuals in Los Angeles County, June 2013.

SOURCES OF FUNDING

This study was funded through generous support from NIH grant #P30MH58108.

Overview

Introduction

The advent of healthcare reform via the Patient Protection and Affordable Care Act, coupled with the release of the National HIV/AIDS Strategy in 2010 have begun to dramatically change the healthcare industry and the HIV prevention and care landscape, locally and beyond. Emerging policies and evolving social consciousness call for increased attention to the health and wellness of transgender individuals. This new context demands innovative models of health and social service delivery and the creation of new partnerships to ensure successful implementation and longevity.

This document outlines the status of transgender health and wellness in Los Angeles County (LAC), particularly with respect to HIV disease and its antecedent and co-occurring social determinants and drivers. It also provides an overview of some of the services available to transgender people in LAC, identifying those that are tailored specifically for transgender individuals as well as those not tailored specifically for transgender individuals but that are overtly inclusive of these community members. Subsequently we describe what we see as gaps in services and opportunities to both strengthen and transform LAC's response to the health and wellness needs of transgender people.

It is our vision that the ideas put forth will result in innovative models of health and social service integration and delivery for transgender communities, representing an attempt to provide access for a population of people that experience a multitude of health disparities, including their disproportionate representation in the HIV epidemic, and their under-representation in HIV prevention and care services systems.

TERMINOLOGY

Terminology used to refer to transgender people is imperfect. As such, there is a wide divergence of opinion with respect to the most appropriate and affirming terms to use when describing an individual whose sex assigned at birth is in conflict with their gender identification. For the purposes of this report, select key definitions and concepts are outlined below. While there is no universally accepted definition of the word "transgender" we rely on the National Center for Transgender Equality's definition, "an umbrella term for people whose gender identity, expression or behavior is different from those typically associated with their assigned sex at birth."[1]

Background: White Paper Development and Process

In early 2013, the University of California, Los Angeles (UCLA) Center for HIV Identification, Prevention and Treatment Services (CHIPTS) convened an independent time-limited consortium of fourteen individuals to meet for the purpose of identifying best practices and potential models to address the health and wellness needs of transgender people in LAC. Consortium members were selected based on their response to an earlier pilot call or were voted in by a nominating group. These individuals were asked to participate as members of the Consortium given their professional and/or personal knowledge of local transgender communities. The majority of the members were

The term transgender includes people whose sex was assigned as male at birth but identify themselves as "female" or as "a woman;" people whose sex was assigned as female at birth but identify themselves as "male" or as "a man" as well as others who may not identify as either male or female because they do not subscribe to society's binary gender paradigm. Instead they may identify as "genderqueer," "gender non-conforming," or any other number of identities that represent the lived experiences of gender-diverse people. Many people who technically fit this definition of transgender may not identify as such for a variety of reasons, because of their cultural or religious beliefs, or because the term does not adequately describe their current reality. Some transgender individuals have had, plan to have or hope to have medical interventions to feminize or masculinize their bodies (e.g. hormone therapy and/or gender reconstructive surgery), while others have no interest in such medical interventions.

Although often categorized together under another umbrella term LGBT (Lesbian, Gay, Bisexual and Transgender), sexual identification and gender identity are two distinct domains. Transgender people, just like non-transgender people, may be sexually attracted to men, women, other transgender people, or any combination thereof.

transgender identified and collectively represented a cross-section of the community with respect to gender identity, age range and racial/ethnic background. The Consortium met weekly over the course of two months, building upon foundational work that had previously been conducted by others in the transgender and service provision communities. Specifically, over the past few years, a number of Los Angeles–based events and processes had taken place that resulted in recommendations regarding the provision of HIV prevention and care and related health and social services for transgender people. These included:

- **Beyond the Basics: *A Comprehensive Approach to Advancing Transgender HIV Prevention and Care*** (2008): A one-day forum organized via a County-Community partnership, that brought together representatives of the transgender community and their allies to strategize new ways to advance HIV prevention and care services for transgender persons seeking HIV services in LAC. The goals were 1) to identify and clarify key issues that impact the quality of HIV-related prevention and care services consumed by transgender persons, and 2) to develop recommendations to improve the quality of services. The event focused specifically on the following areas: data; professional/leadership development; immigration; program practices and transgender men.
- **The LAC HIV Prevention Planning Committee's Transgender Task Force Recommendations** (2009): The Task Force developed specific recommendations and strategies regarding HIV prevention for transgender persons in LAC. Fueled in part by the findings from *Beyond the Basics*, a total of thirty recommendations were developed with respect to data; program practices; human resources/leadership; and legal issues.
- **The Transgender Service Provider Network (TSPN) Transgender Wellness Center Recommendations** (2012): These recommendations were created in response to a meeting convened in 2011 by the Director of LAC Public Health Department's Division of HIV and STD Programs (DHSP) to discuss DHSP's vision of a transgender wellness center in LAC, and to call for best practices towards its development. Generated by conducting a limited community assessment and convening a series of meetings to discuss findings and key issues, these

HEALTH AND WELNESS

The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[2] For the purposes of this report, we define "wellness" similarly, as a state of being that encompasses optimal health in its many dimensions, resulting in enhanced quality of life.

recommendations addressed core operating principles and values, and general program ideas. Although these initial recommendations were well received by DHSP, they were limited in their scope and specificity. As a result, DHSP asked the group to reconvene, conduct additional research and provide further details in the form of a written strategic plan. To that end, and so as not to duplicate efforts, five TSPN representatives were selected to participate on the Consortium.

Status of Transgender Health and Wellness

Context for Understanding Transgender Health

To understand the health of transgender people in LAC, it is important to first understand the social and environmental factors that impact their everyday lives. These factors are social determinants of health, or the conditions and circumstances into which people are born, grow, live, work, socialize, and form relationships and the systems that are in place to deal with health and wellness.[3] These complex and overlapping community, social, economic, and environmental factors influence an individual's and a collective community's risk for health inequities and include the effects of stigma, discrimination, and violence.[4] Social determinants play an important role in facilitating or impeding one's optimal health and well-being. Populations that are disproportionately impacted by detrimental social determinants experience greater health disparities. This is true of the transgender population.

Findings from various reports illustrate the unique health disparities that transgender individuals experience. The modest body of knowledge on transgender health that has been developed emphasizes the increasing appreciation of the ways in which social and structural factors influence health. Two publications highlighted below provide particular insight.

DEMOGRAPHICS

Although the term "transgender" is typically thought of as an umbrella term, there are distinct populations of transgender people with respect to race/ethnicity, socioeconomic status, educational level, gender identity, sexual orientation, age, geographic location, and other demographic characteristics, each with its own health concerns. Although they may share many common experiences, sometimes, the only thing that transgender people have in common is the fact that they are transgender.

Injustice at Every Turn: A Report of the National Transgender Discrimination Survey documents in detail the impact of anti-transgender bias.[6] This national survey of 6,456 transgender and gender non-conforming people highlights the ways in which social and economic marginalization due to gender identity discrimination creates barriers to good health. The published report illustrates the disproportionate impact of social determinants on the transgender population, including the following key findings:

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are the conditions and circumstances into which people are born, grow, live, work, socialize, and form relationships and the systems that are in place to deal with health and wellness.[3]

LACK OF DATA

Although transgender people represent a distinct population with its own health concerns, the health needs of the community are often grouped together with the needs of lesbian, gay and bisexual men and women under the LGBT umbrella. Furthermore, among transgender people, there are subpopulations based on race, ethnicity, socioeconomic status, geographic location, age and other factors. Although a sizable body of knowledge on gay men's health and HIV risk has been developed, the transgender population, as a stigmatized gender minority, has been the subject of relatively little health research.[5]

The health data that do exist have been largely limited to HIV, an important health issue but not the only health concern for transgender individuals in LAC. In some municipalities, HIV-related data incorrectly record transgender women as men who have sex with men (MSM). In other municipalities, including LAC, the data on transgender men are lacking. Transgender men and women may experience similar issues, however, circumstances and outcomes may differ. More data are needed.

- Survey respondents experienced unemployment at twice the rate of the general population, with rates for people of color up to four times the national unemployment rate.
- Respondents who were currently unemployed experienced debilitating negative outcomes, including nearly double the rate of working in the street economy (e.g. sex work, selling drugs), twice the homelessness, 85% more incarceration, double the HIV infection rate, and double the rate of current drinking or drug misuse to cope with mistreatment, compared to those who were employed.
- Almost one-fifth (19%) of respondents reported experiencing homelessness at some point in their lives because they were transgender or gender non- conforming; 55% of respondents who tried to access a homeless shelter were harassed by shelter staff or residents, 29% were turned away altogether, and 22% were sexually assaulted by residents or staff.
- Respondents reported over four times the national average of HIV infection, with rates higher among transgender people of color.
- Nineteen percent of survey respondents reported being refused medical care due to their transgender or gender non-conforming status, with even higher numbers among respondents of color in the survey.

The State of Transgender California: Results from the 2008 California Transgender Economic Health Survey presents key findings from the first California-wide survey documenting the economic status of transgender Californians.[7] Similar to the National Transgender Discrimination Survey results, the data gleaned from this report demonstrate that despite legal protections in place in California prohibiting discrimination on the basis of gender identity, the transgender population remains marginalized and continues to experience discrimination and denial of basic services such as health and housing. This survey included 646 respondents, with 17% coming from LAC. The following are key examples of the report findings:

- Twenty percent of respondents indicated that they have been homeless at some point since they first identified as transgender. Thirty-one percent of homeless transgender respondents who tried to stay at shelters reported having been denied access.

TRANSPHOBIA

Transphobia refers to societal discrimination and stigma of individuals who do not conform to traditional norms of sex and gender.[13]

Exposure to transphobia may manifest itself through experiences with discrimination when applying for employment and housing, violence, harassment and barriers to health care.[14, 15, 16]

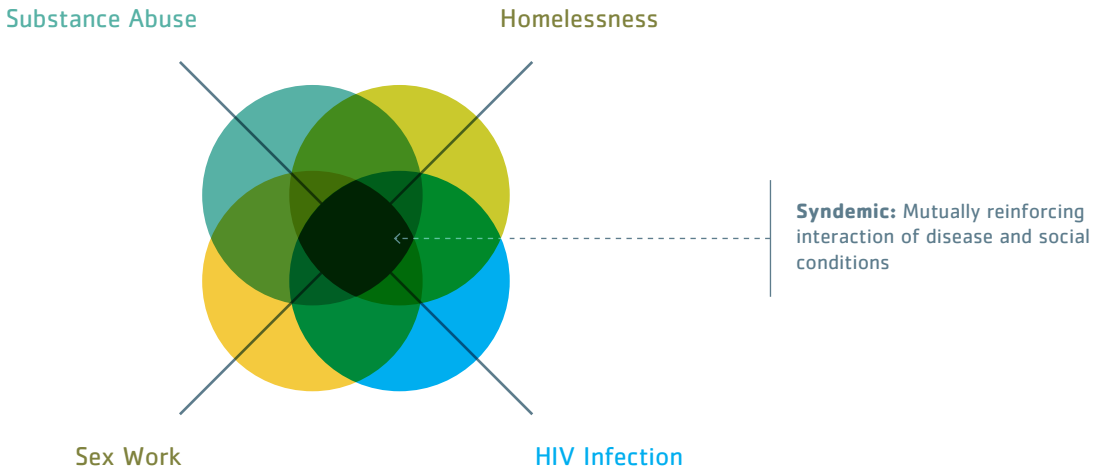
- Thirty percent of transgender Californians reported postponing care for illness or preventive care due to disrespect or discrimination from doctors or other health care providers.

In addition to these two reports, the available research literature also indicates that structural factors, such as poverty, homelessness or lack of stable housing, and unemployment/underemployment, contribute to health disparities and increase HIV risk.

- Poverty can limit access to health care, HIV testing and medications that can lower levels of HIV and help prevent transmission. Poverty can also lead to inadequate housing, which in turn causes or contributes to many preventable diseases. Research consistently demonstrates housing status as one of the strongest predictors of health outcomes for people living with HIV/AIDS. Lack of housing is a barrier to care, while increased housing stability facilitates adherence to care and life-saving antiretroviral therapy.[8, 9] In particular, homeless and marginally housed transgender women have been found to display a high-risk profile for HIV infection and transmission.[10]

- Job loss and chronic underemployment are hazardous to health. Unemployment is a major social stressor that may disrupt social connections and communities. Those who cannot afford basic necessities may end up in circumstances that increase their HIV risk. Qualitative research has explored and revealed that socioeconomic and psychological adversity can contribute to a high prevalence of HIV-related risk factors among male-to-female transgender persons.[11] Many transgender women lack employment, live below the poverty threshold, and engage in high-risk sex work because of discrimination and stigma.[12] Economic hardship due to transphobia is one reason why some transgender women rely on sex work to earn income.[24]

Anti-transgender bias and stigma are critical issues for transgender individuals. Sixty-three percent of respondents in the *National Transgender Discrimination Survey* reported experiencing a serious act of discrimination that had a major impact on their life and ability to sustain themselves financially or emotionally.[6] Research examining the impact of exposure to transphobia on HIV risk behavior suggests a developmental context where exposure to transphobia yields a powerful effect among younger adults.[13] This effect is evident among transgender female youth; in recent findings youth with a history of sex work were more likely to report having experienced discrimination in school settings than youth without a history of sex work.[17] There is also evidence to suggest a syndemic relationship between sex work, substance use, homelessness and HIV infection, in particular for young transgender women. A syndemic describes more than the interaction of diseases, but rather the mutually reinforcing interaction of disease and social conditions.[18, 19] There are data providing preliminary evidence suggesting that multiple health-related psychosocial



factors, including low self-esteem, lifetime poly-substance use and victimization may be additive in their association with sexual risk behavior and self-reported HIV infection among young transgender women.[20]

Another critical issue prevalent for many transgender persons, and part of the ecological context of HIV vulnerability, is involvement with the criminal justice system. The data reveal a history of negative interactions with law enforcement by transgender persons as well as negative interactions with inmates and correctional facility staff in jail and prison experiences.[21, 22] Nearly one in six transgender people (16%) have been incarcerated at some point in their lives—far higher than the rate for the general population.[6] Among Black transgender people, nearly half (47%) have been incarcerated at some point.[6] These high rates of incarceration are driven by disproportionate poverty, homelessness, discrimination, participation in street economies, and in some cases, law enforcement bias. Transgender people are also at high risk of abuse in prisons, jails and juvenile detention.[23, 24] Similarly, prisoners' return to the community from prison can also be stressful as former inmates try to obtain housing, reintegrate into their families and communities, find employment and gain access to health care. Although not specific to transgender persons, retrospective studies suggest that the reentry process contributes to excess mortality among former inmates.[25]

This connection between social determinants, including transphobia and stigma, combined with specific comorbidities, outlined below, fuel LAC's complex HIV epidemic.[26]

HIV and Comorbidities in LAC

Population Size: Given that the U.S. Census does not include transgender as a gender category, it has been difficult to determine the actual population size of the transgender community in Los Angeles.

LAC MEN'S CENTRAL JAIL

LAC Men's Central Jail houses transgender women (male-to-female transgender persons) in a protective custody unit, called "keep-away designation 6G" or K6G. Transgender women who enter the K6G unit are provided hormones during their incarceration, but lack any sustainable, long-term post-incarceration transition support, such as job training or assistance procuring legal documents consistent with their gender identity, and often cycle (back) to criminalized activities for survival upon release. Transgender inmates also lose access to hormone therapy upon release and may rely on non-medically prescribed and unmonitored street sources for hormones.

K6G inmates are assigned transitional case managers. Case managers provide placement for substance abuse treatment, counseling programs, and housing upon release. Inmates are also offered a variety of education programs through the Education-Based Incarceration Initiative. These programs range from financial courses and anger management programs to GED certifications. HIV health education and empowerment programs are also provided by local agency staff working in the jail.

Some transgender women may access treatment, care and case management support for the first time when they enter the LAC Men's Central Jail.

Using a deliberate community-feedback process and existing public health data, LAC DHSP estimates that as of 2013 there are 14,428 transgender individuals living in LAC, with a range of 7,214 to 21, 642 and a one-to-one ratio of transgender women (7,214) to transgender men (7,214).[27]

HIV: Overall, HIV prevalence for transgender women was estimated to be 15.2% and 0.6% for transgender men. DHSP calculated HIV prevalence estimates for transgender women stratified by race and ethnicity and observed the highest HIV prevalence for African American/Black transgender women (48.3%), followed by Native Americans (26.9%), Latinas (17.1%), Whites (4.6%) and Asian/Pacific Islanders (3.7%).[18]

Although research about transgender people and HIV is limited compared to other populations, the estimated prevalence of HIV is significant, especially among certain sub-populations (e.g. African American/Black transgender women). Local behavioral risk studies and needs assessments provide insight into contextual factors associated with HIV acquisition and transmission. *The Los Angeles Transgender Health Study*, the first epidemiological study of transgender women in LAC, found that among the 244 enrolled transgender women, 50% or more reported that they had a history of incarceration; relied on sex work as their main source of income; did not have health insurance; had injected hormones, silicone or oil; had gotten hormones off the street; and had been high on either alcohol or other drugs while having sex in the last six months.[28] Nearly half of respondents (48%) also reported receptive anal sex with an exchange partner; of those, 29% reported not consistently using a condom.[24]

Findings from qualitative data of a subsample of adolescent and young adult transgender females from the Transgender Research Youth Project (TRYP) suggest that HIV-related risk behaviors are closely linked to parental support.[29] Many transgender youth in the TRYP reported having no parental support and that their parents were discriminatory and had even been violent because of their gender identity. Discrimination and violence from parents has been linked to a host of challenges for transgender youth, including homelessness, isolation and increased sexual risk behaviors.[30]

Table 1: Estimated HIV Prevalance for Transgender Women by Race/Ethnicity (LAC)			
Race/Ethnicity	Estimated # of HIV Cases	Estimated Population Size	Estimated HIV Prevalence
Black	324	671	48.3%
Latina	595	3,470	17.1%
White	88	1,912	4.6%
Asian/Pacific Islander	39	1,053	3.7%
Native American	29	108	26.9%
Total	**1,088**	**7,214**	**15.1%**

Additional studies of transgender populations in cities across the country have consistently shown high levels of substance abuse and mental health problems, often highlighting their interconnectedness and correlation with HIV/AIDS.

Substance Abuse: The connections between substance use and HIV risks include lowered inhibitions resulting in unprotected sex, the sharing of needles to inject substances and poor treatment adherence rates. Locally, transgender women report high rates of substance use, especially alcohol and methamphetamine.[25] A study comparing the HIV seroprevalence and risk behaviors of transgender women who exchanged sex with those who did not in LAC found that while exchange sex was not associated with increased HIV seroprevalence, substance use during sex was associated with increased seroprevalence.[31] Transgender individuals represent 1.7% of clients accessing Ryan White–funded services for HIV-positive people in LAC, and 4.1% of clients accessing residential substance abuse treatment.[32]

Hormone Misuse: An additional HIV risk related to transgender people is the practice of sharing injection paraphernalia to self-administer hormones and/or silicone. Insurance exclusion and the lack of access to affordable, competent care contribute to high rates of medically unsupervised hormone use.[33] Twenty-seven percent of transgender Californians reported being denied hormones, a basic health care service, by providers or insurance companies.[7] In attempts to feminize their bodies, transgender women may also inject silicone as an alternative or a supplement to taking estrogen. The majority of respondents (74%) in a California survey of health and social services for transgender women of color reported being prescribed hormones from a doctor, 32% reported acquiring hormones from friends, 21% reported acquiring hormones from Mexico (where hormones are sold without a prescription) and 9% reported receiving hormones from another non-prescription, unregulated source (usually street vendors).[34] Whether on the street or at "pumping parties," where non-medically prescribed and unmonitored substances are injected without medical supervision, syringes for administering these substances may

be shared by transgender people, with results ranging from disfigurement to HIV disease and sometimes death.

Mental Health: Transgender people face systemic and pervasive challenges and experience significant mental health concerns including anxiety, depression and suicidality. Reported suicidal ideation rates, attributed mostly to gender identity issues, have been as high as 65%, with suicide-attempt rates ranging from 16% to 32%. The prevalence of depression is also startlingly high, typically ranging from one-half to two-thirds of study samples of transgender women and men.[16, 35, 36, 37, 38] Like substance abuse, mental health problems ranging from low self-esteem to severe psychiatric disorders can often interfere with medication adherence and/or increase the likelihood of engaging in high-risk behaviors. Recent findings from a transgender-specific HIV Prevention Case Management (PCM) intervention implemented in a community HIV prevention setting in LAC suggest that adding a culturally appropriate PCM intervention in a community setting is beneficial in addressing co-factors for HIV infection as well as psychological and emotional distress symptoms, including depression.[39]

Overview of Available Services for Transgender People in LAC

Spanning 4,083 square miles, LAC encompasses eighty-eight distinct cities and is home to over ten million residents, making it the most populous county in the United States, more populous, in fact than forty-two individual U.S. states.

LAC is also home to a complex system of health and social services, charged with meeting the multiple needs of its ethnically and culturally diverse residents. Although it's difficult to determine exactly how many social services are available to Angelinos, local resource guides consistently contain listings in the tens of thousands, ranging from literacy to housing programs. Health care services are also voluminous, and include services provided by LAC's public clinics and hospitals; private health maintenance organizations (HMOs), clinics and physicians; the Department of Veterans Affairs; Federally Qualified Health Center (FQHC) or FQHC look-alike stationary and mobile sites; Ryan White–funded sites; and LAC's Indian Health Service-funded clinics.

Indicative of the disproportionate disease burden shouldered by this community, most of the services offered specifically for transgender people in LAC are HIV-related. Established in 2005, the Transgender Service Provider Network (TSPN) of LAC is a formal network consisting of service providers from across the county representing various disciplines that wish to better serve transgender clients and communities. The TSPN is largely comprised of agencies involved in HIV care

and prevention activities and actively works to address increasing the capacity of non-transgender specific services to service transgender people.

Given the sheer volume of services in LAC, it is impractical to assess them all with respect to their adequacy, capacity and quality in meeting transgender-related needs. Instead, the Consortium focused on the services across the county that were either targeted for or frequently utilized by transgender people. The Consortium then listed the organizations that they knew provided services for transgender clients by service category. These categories included primary care; substance use/abuse; mental health; housing; legal; employment; and HIV-specific services.

Consortium members then identified the services listed as either transgender-specific (i.e., designed specifically for transgender people) or transgender-inclusive (i.e., not designed specifically for transgender people, but open to their participation). Members identified one mental health organization, one legal organization, and one community-based organization that were designed specifically and primarily to meet the needs of transgender clients. To their knowledge, the only other services or programs that were designed specifically for transgender people in LA County were HIV-related services.

The Consortium then developed and utilized a brief survey to query the identified agencies regarding their services for transgender people including: 1) type of service(s) provided (e.g. primary care, hormone provision, substance use/abuse, mental health, housing, etc.); 2) whether their services were transgender-specific or transgender-inclusive; 3) where they referred transgender clients if they didn't provide the service(s) themselves; and 4) what they believed were the greatest barriers transgender clients faced in accessing their services.

Service Inventory Results

The survey was conducted with twenty-nine different agencies, including ten agencies represented on the Consortium. Table 2 provides a snapshot of the types of services that address some of the needs of transgender people in LAC.

For every service type queried, a minimum of two agencies reported providing transgender inclusive services. Of the twenty-nine agencies surveyed, sixteen reported providing transgender-inclusive substance use services. Fifteen agencies reported providing transgender-inclusive mental health services and four agencies reported transgender- specific mental health services. These data highlight significant gaps in service provision for two key categories: housing and primary care.

Table 2: Service Inventory Results			
Service Category	✔ Yes		✖ No
	Transgender Specific	Transgender Inclusive	
Primary Care	2	10	17
Substance Use	0	16	13
Mental Health	4	15	10
HIV Testing	0	16	13
HIV Case Management/Navigation	3	13	13
Health Education/Risk Reduction	6	11	12
Housing	0	9	20
Legal	3	6	20
Employment	2	2	25

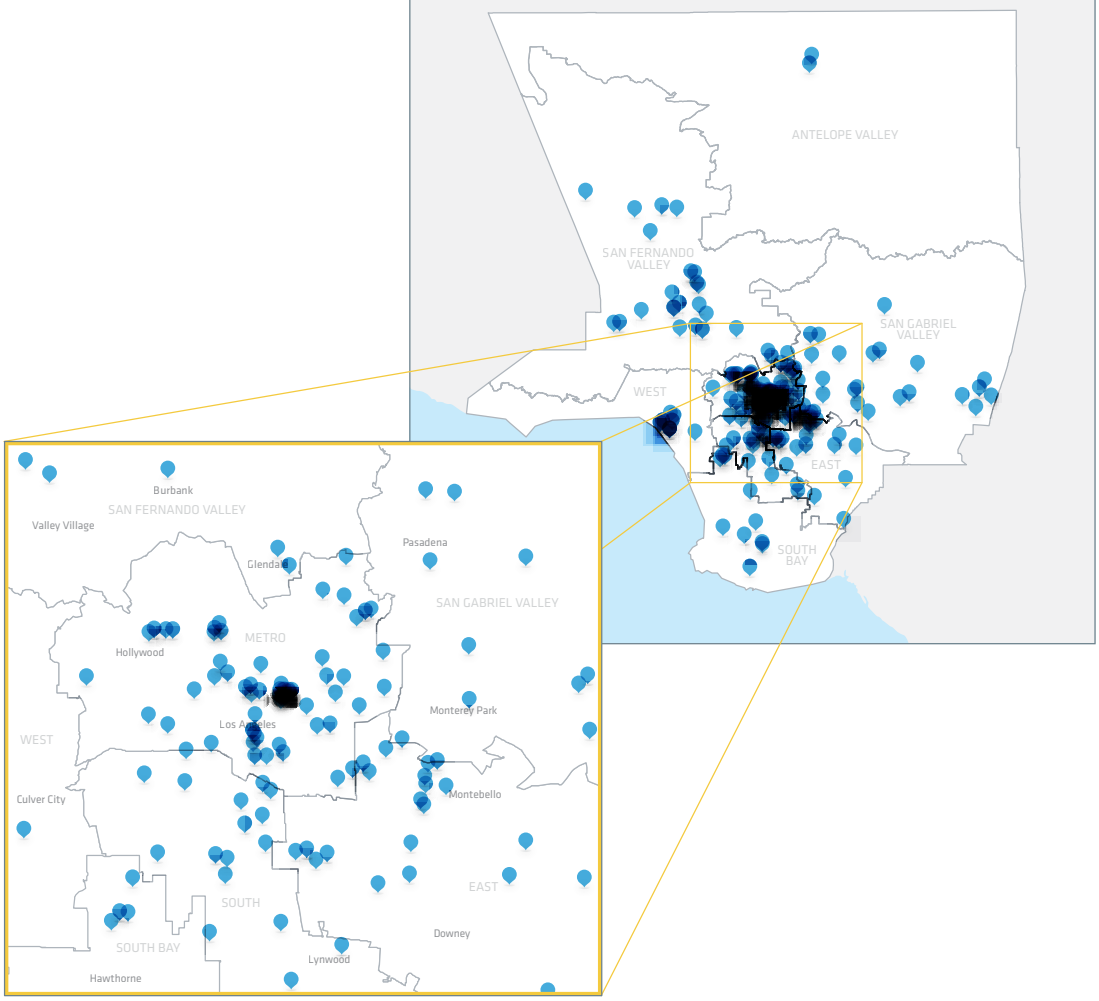
Housing

As noted previously, transgender women report high levels of housing discrimination.[13, 16, 40] Numerous socio-cultural circumstances place transgender women at an increased risk for homelessness.[41] Despite evidence indicating a great need, only nine agencies reported providing transgender-inclusive housing services. Given the association between housing status and HIV risk behaviors, HIV prevention interventions for transgender women should include information on, or possibly support for rent subsidy programs and other means of obtaining stable housing.[10]

Primary Care

Map 1 below depicts the 277 FQHCs and FQHC look-alike clinics spread throughout LAC.*

Map 1: FQHC clinics and FQHC look-alike clinics in Los Angeles County



* Federally Qualified Health Centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHC Look-Alikes are organizations that meet PHS Section 330 eligibility requirements, but do not receive grant funding. FQHCs and Look-Alikes share many benefits, including enhanced reimbursement rates from Medicare and Medicaid; eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost; and access to National Health Service Corps.

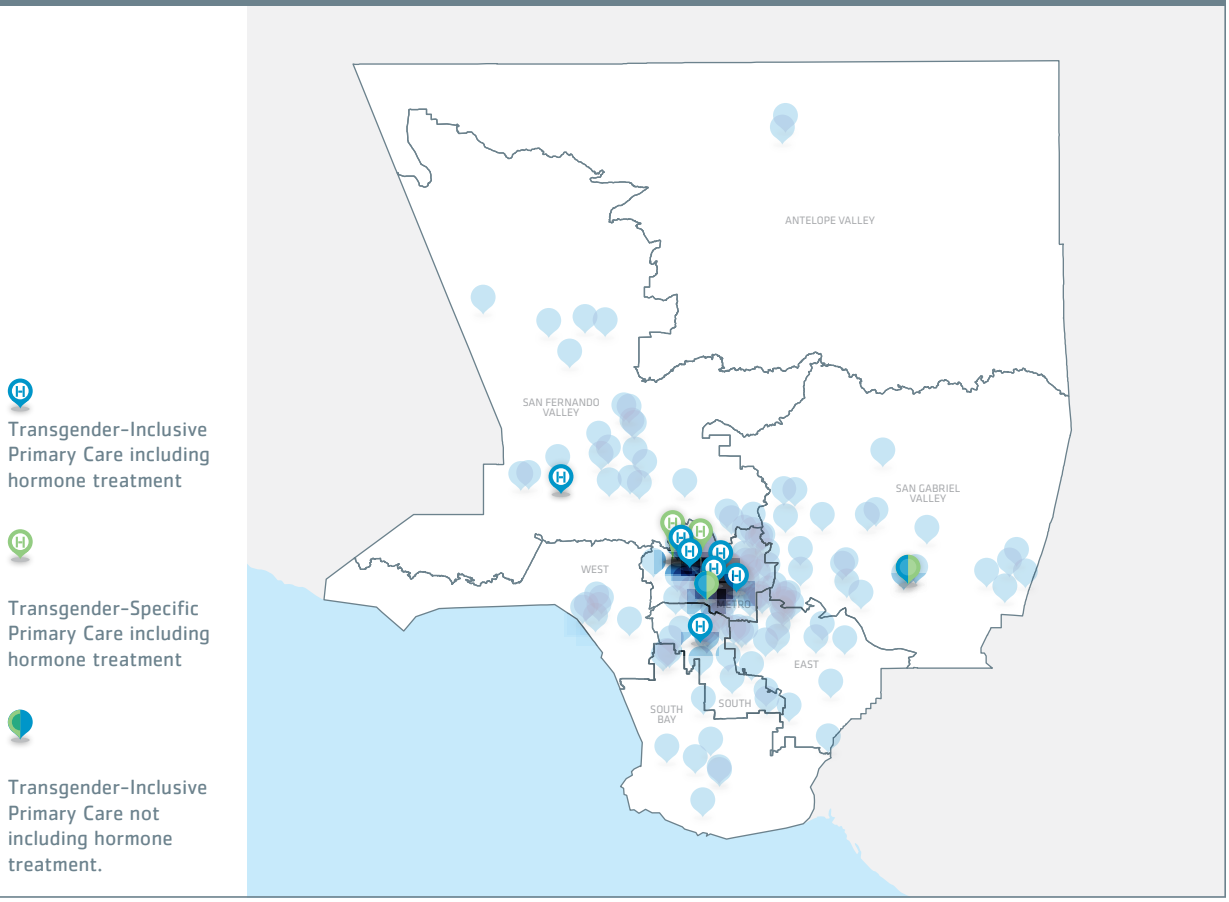
FQHCs and Look-Alikes are well-suited to provide care to transgender individuals because they:

- Are required to provide—on site or by arrangement with another provider—comprehensive services including preventive health services; dental services, mental health and substance abuse services; hospital and specialty care and transportation services necessary for adequate patient care.
- Emphasize the ability to manage patients with multiple health care needs via coordinated primary and preventive services or a "medical home" that promotes reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities and other underserved populations.
- Address geographic, cultural, linguistic and other barriers through a team-based approach to care that include physicians, nurse practitioners, physician assistants, nurses, dental providers, midwives, behavioral health care providers, social workers, health educators, and many others.
- Will receive 11 billion dollars over 5 years via the ACA.

Source: www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/

Map 2 below illustrates the findings from the service inventory. Of the twenty-nine agencies inventoried, ten reported providing transgender-inclusive primary care—two clinics reported providing primary care without hormone therapy; the seven other clinics reported providing primary care with hormone therapy.* Only two clinics reported providing transgender-specific primary care including hormone treatment. These data are layered on top of Map 1 depicting all 277 FQHCs and look-alike FQHCs in LAC. The dearth of primary care providers/clinics serving the transgender community is not attributable to clinic scarcity.

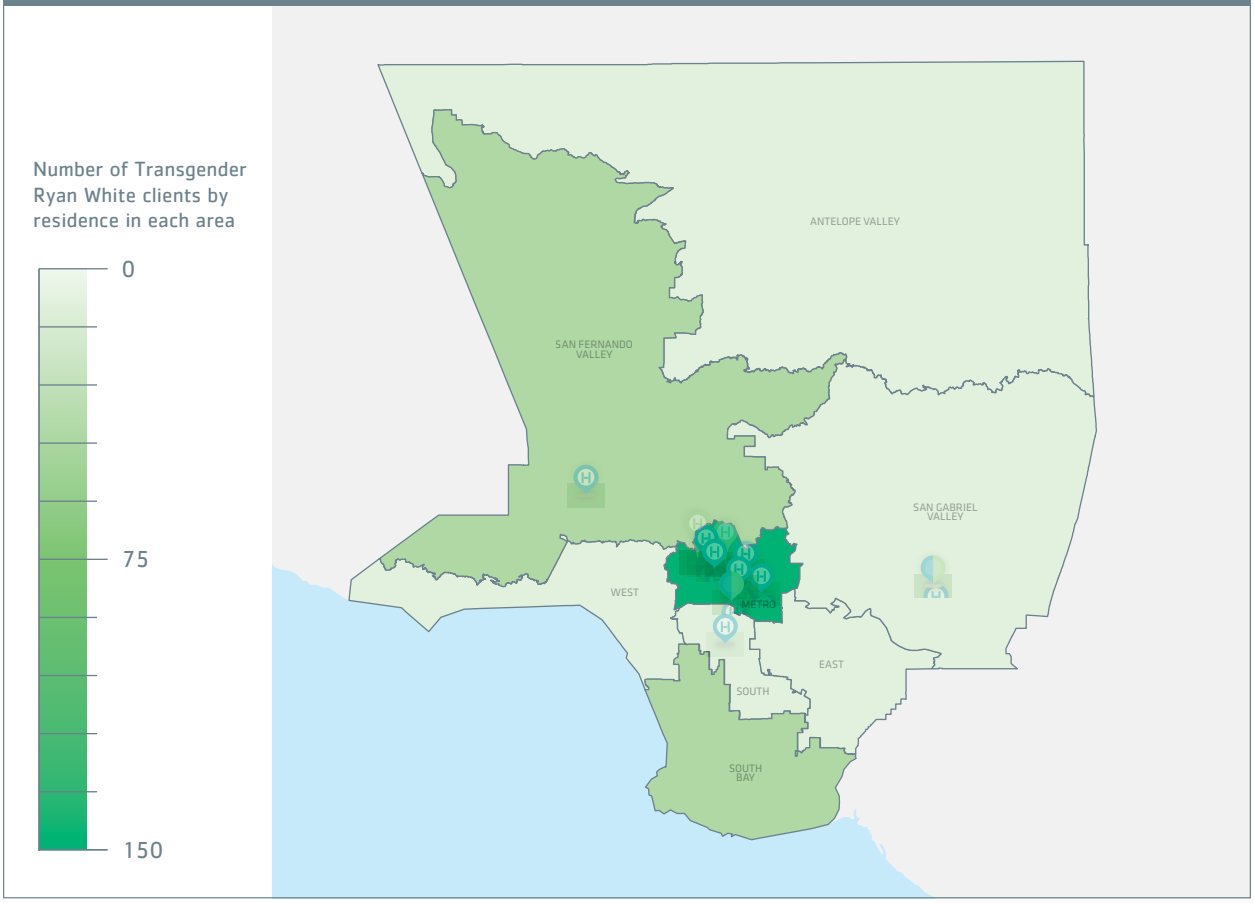
Map 2: Primary Care sites serving transgender individuals in Los Angeles County



* The term primary care was not defined for survey respondents. Therefore, we cannot conclude with any certainty which clinics provide limited primary care and which clinics provide comprehensive primary care.

Map 3 below illustrates the distribution of transgender Ryan White clients by residence in 2011.[32] These data are layered with the service inventory data specifying the geographic location of clinics that serve the transgender community in Los Angeles. Although the transgender population in LAC is certainly larger than the sum of its HIV-positive community members, it is especially important to engage and maintain these community members in care in order to impact the HIV treatment cascade (described in more detail in the implementation plan).

Map 3: Map 2 + Distribution of transgender Ryan White clients by residence, 2011



National Transgender Discrimination Survey respondents faced serious hurdles to accessing health care, including refusal of care and lack of provider knowledge.[6] Nineteen percent of participants reported being refused care due to their transgender or gender non-conforming status; 50% of the sample reported having to teach their medical providers about transgender care. Similarly, results from the 2008 *Transgender Economic Health Survey* indicate a clear need for more training and awareness in the medical community of the rights and needs of the transgender community.[7] Thirty-five percent of California transgender respondents recounted

having to teach their doctor or care provider about transgender people in order to get appropriate care. The data gathered in these two surveys indicate that discrimination in the health care system presents major barriers to care for transgender people. Although the Consortium service inventory was not as robust an instrument, the data collected seem to suggest a similar pattern of structural barriers to access.

Service Inventory Limitations

Survey limitations include the fact that some survey items may have been unclear to respondents. The Consortium timeline did not allow for pre-testing the survey instrument; however, Consortium members familiar with the agencies identified and queried provided substantial feedback. Nevertheless, concern emerged that some survey respondents reported information more relevant to their ideal service provision rather than the true agency standard of practice. Socially desirable responding is a special concern, as most agencies surveyed are part of a small network of providers serving the transgender community. These responses were not eliminated, but the Consortium did discuss the survey data at length, in an attempt to understand and control for wildly distorted information.

The survey results indicate some service areas of great depth, particularly those related to HIV prevention and treatment, including HIV testing, HIV case management/navigation and Health Education/Risk Reduction. The results also indicate clear opportunities for further development in service provision of housing and primary care. Despite its limitations, the survey provides important information and highlights the need for both increased quantity of services as well as improved quality of existing services.

Implementation Plan

Transgender Wellness Center (TWC) in Context

The overall health census and service inventory described previously in this report highlight the need for transgender-inclusive primary care and transgender-specific comprehensive support services in LAC. The Consortium recognizes the impact the Patient Protection and Affordable Care Act (ACA)[42] will have on the lives of transgender individuals and strongly recommends that the TWC implement a service delivery model that harnesses the full potential of the ACA to meet these needs.

The National HIV AIDS Strategy (NHAS)[43] released in July 2010 coupled with the passage of the ACA have shifted the landscape of HIV prevention and healthcare for transgender communities. One of the goals of the NHAS is to increase access to care and improve health outcomes for people living with HIV by:

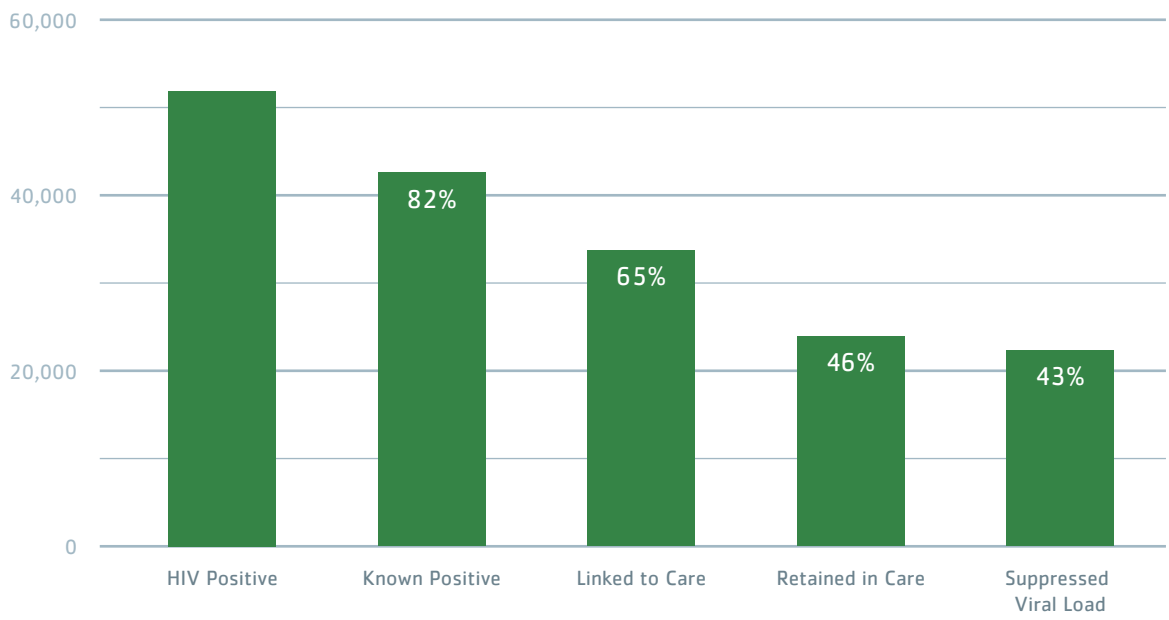
- Establishing a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.
- Taking deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV.
- Supporting people living with HIV and co-occurring health conditions and those who have challenges meeting their basic needs, such as housing.

The HIV treatment cascade, also known as the HIV spectrum of engagement in care, in recent years has become a popular tool to measure progress towards the goals of the NHAS. The treatment cascade depicts the estimated number of people living with HIV, of those, the number that are aware of their diagnosis, linked to care, retained in care, and having achieved a suppressed viral load (see next page for the LAC treatment cascade). Local data demonstrate that one of the characteristics associated with people who are not linked to care in LAC is being transgender.[44] Transgender people are challenged to access and remain engaged in care as there is a lack of supportive services necessary to address their comprehensive needs.

The ACA in particular marks a crucial turning point for our HIV service delivery system and the basic health care rights of transgender people and will help make affordable, high-quality care accessible to millions of Americans. Specifically:

- The ACA increases access to health insurance coverage and health services for all Americans, including transgender people living with HIV/AIDS (PLWH), through a number of private market reforms, an expansion of Medicaid eligibility and the establishment of Health Insurance Marketplaces. PLWH who obtain insurance through Health Insurance Marketplaces or through Medicaid will be ensured coverage of a core package of items and services known as “essential health benefits” (EHB). EHB will include items and services within at least the following categories: ambulatory patient

Los Angeles County Treatment Cascade, 2010*



HIV Positive
Includes PLHW diagnosed by 12/31/09 and living as of 12/31/10 *plus* 18.1% estimated to be unaware of their status per CDC methodology.

Linked to Care
≤ 3 months of diagnosis among 2,192 persons diagnosed in 2010.

Retained in Care
≥2 Viral Loads reported in 2010 at least 3 months apart.

Suppressed Viral Load
Defined as Viral Load <200.

* Adapted from *Surveillance and Epidemiology of HIV and AIDS in Los Angeles County Presentation to the Los Angeles County Commission on HIV March 7, 2013* Douglas Frye Division of HIV and STD Programs.

services, emergency services, hospitalization, mental health and substance use disorder services (including behavioral health treatment), prescription drugs and chronic disease management.

- The ACA brings Title VII federal nondiscrimination protections to the health care field by prohibiting gender-based discrimination by federally-funded health care providers. Gender-based discrimination includes discrimination based on gender identity and gender stereotypes, which provides critical protections for transgender individuals. It is no longer legal for medical providers to refuse to treat patients simply because they are transgender or to discriminate against transgender people in other ways because of their identity. The law also prohibits insurers from denying or canceling insurance because an individual is transgender or HIV-positive. Additionally,

the California Department of Managed Health Care (DMHC) has ordered California's health plans to remove blanket exclusions of coverage based on gender identity or gender expression. The DMHC letter directs health plans to remove benefit and coverage exclusions related to gender transition as well as limitations based on gender identity or gender expression. This development will ensure parity in coverage, and significantly increase medically necessary services available to transgender people.[45]

- The ACA will also provide funding for LGBT cultural competency trainings. The law provides financial assistance directly to LGBT-friendly community health centers and, to better assess the needs of transgender patients, mandates that HHS includes sexual orientation and gender identity in its national data collection efforts starting in 2013.

For transgender persons who may have faced serious hurdles in accessing health care, including harassment in the medical setting and lack of provider knowledge, the ACA, if implemented as planned, will create access to basic health care and introduces tangible protections. Because gaps in access to safe, appropriate primary care that currently exist are detrimental to the transgender population, harnessing the potential of the ACA will be important to the long-term sustainability and impact of a TWC in LAC.

The ACA, however, will not be equally beneficial to everyone. For example, one outstanding concern is that of health care access and adequate coverage for undocumented individuals and those living legally in California for less than five years. Although local bureaucracies are currently working to address this issue, a final solution has yet to be determined.

Vision and Values

The Consortium's ultimate vision for the TWC is *to ensure the health and wellness of the transgender community in LAC by responding to the immediate needs of individuals while creating an environment where transgender people can flourish*. In this respect the term "wellness center" refers not only to a physical space but to a set of programs or a comprehensive social and health services system. To realize this vision, the Transgender Wellness Center must operationalize the following values and perspectives:

VISION

To ensure the health and wellness of the transgender community in LAC by responding to the immediate needs of individuals while creating an environment where transgender people can flourish.

Collaboration and coordination of services: The TWC must strive to *enhance*—not replace—the organizations and programs that have historically served transgender people, often with little or no resources. This is best done by communicating openly and

transparently with existing entities to plan service delivery whenever feasible. When doing so, duplication of services is minimized and a complimentary and comprehensive service system can begin to evolve.

Meaningful community input: The TWC should incorporate feedback from community members, whenever possible. Engaging content-matter experts in the development of services and programs is a priority, where *expertise* is inclusive of both professional skills and lived experiences.

Whole-person health and wellness: The TWC must approach service delivery from a whole-person perspective, understanding that true wellness cannot be achieved without attending to physical, mental, emotional and spiritual health. This does not mean that the TWC itself should be charged with providing services in each of these arenas, rather that the TWC should promote the perspective of multi-dimensional health and wellness whenever possible.

Strengths-based perspective: The nature of health and social services provision has traditionally revolved around addressing the needs of individuals and communities. As such, communities, like the transgender community, that have multiple needs as a result of oppression and marginalization, may inadvertently be seen only through the lens of deficiency. Within the transgender community, in addition to the many challenges that exist, there are also many strengths and much resilience. To help empower the community, the TWC must position itself to address community needs in a way that both summons and enhances community strengths. This can be accomplished by utilizing the talents and skills that are present in the community in the design and implementation of programs and services.

Inclusivity and accessibility: The TWC must be a welcoming and accessible environment to all those who identify as transgender, as well as those who make up their immediate support network. Because LAC's transgender community is extremely diverse with respect to race/ethnicity, socioeconomic status, geographic representation, age, gender-identity, immigration status and language, this will be especially challenging. Because there is such a large number of Spanish-speaking transgender individuals residing in LAC, the TWC must ensure that services are provided in both English and Spanish. Similarly, the slate of services provided or promoted must be as comprehensive as possible to meet the needs of a wide range of individuals and experiences. For example, while services for HIV-positive transgender individuals should be a component of County-wide programming for transgender people, so too should services for those with negative or unknown HIV serostatus. Additionally, services should address needs across the lifespan, including the needs of transgender youth and transgender seniors.

Address individual and environment needs with equal effort: Many transgender individuals in LAC have immediate health and social needs that must be addressed in the pursuit of wellness. To be truly impactful, however, the root causes of these

problems (e.g., transphobia, stigma, etc.) also must be addressed. To whatever degree feasible, the TWC should implement or support community efforts that address individual needs as well as efforts that are designed to change the environment from one that manifests in multiple health and social problems to one that facilitates overall wellness.

Sustainability: Given our resource-strained environment, the TWC must be designed to endure financial and other challenges in the years ahead. In order for the TWC to have long-lasting and far-reaching impact on the transgender community and the community beyond, sustainability—the ability to pursue one's mission, in spite of multiple internal and external pressures—must be a constant organizational goal.

Models of Service Delivery

The Consortium explored a variety of programs and agencies throughout the planning process, including: People Assisting The Homeless (PATH)[46], Magnolia Place Family Center and Community Initiative[47], Homeboy Industries[48] and Chicago House[49], among others. After researching multiple organizational models, the Consortium designed two models to serve as potential blueprints for the first ever TWC in LAC. In consideration of many different stakeholders and environmental factors, these models were constructed with the following criteria in mind. The TWC model(s) that the Consortium recommends should:

- Meet the immediate needs of transgender individuals in LAC;
- Address structural barriers to health and wellness (e.g. transphobia) and co-factors to HIV risk behaviors;
- Complement and/or enhance existing successful services for transgender individuals;
- Take advantage of funding opportunities (e.g. such as those created by the Affordable Care Act and those potentially offered by DHSP);
- Maximize cost-efficiency; and
- Incorporate sustainable practices.

In light of these criteria, the Consortium identified key components or services that could serve as building blocks for one or more models. These included:

A physical space for transgender people to gather: Early on, the Consortium discussed the need for a space that the community could "call their own." A physical space, even a very small one, could address the community's need to be recognized as distinct from (although still related to) the larger lesbian, gay and bisexual

community. Having a physical space or center could also be useful in securing additional funding, knowing that it is challenging for some to invest in a cause or agency that is not tangible. First and foremost, the Consortium felt that a physical space would provide some type of safe harbor, a place where transgender people could just "be" without having to defend or explain themselves. The Consortium recommends utilizing space within existing agencies that serve the transgender community to the extent possible. Any new space developed to house the wellness center should explore under-utilized or vacant County space in-kind. The two most important criteria when considering appropriate location are accessibility and safety. The Consortium identified the following areas as viable locations for the wellness center:

- Downtown, not adjacent to Skid Row or LAC Jail
- Mid-Wilshire
- Santa Monica and Vermont
- Hollywood/East Hollywood

Decentralized services: Many wellness center models that exist in other parts of the state and country successfully utilize one structure that houses multiple services. In a county as large and ethnically diverse as Los Angeles, however, having just one of any type of service is challenging. Since LAC spans 4,083 square miles, encompasses eighty-eight distinct cities, and is home to an estimated 14,000 transgender individuals, the Consortium recommends a decentralized model that enables access to quality services throughout the County, and not just in one brick-and-mortar space. The idea of decentralization may appear to conflict with the need for a physical space as described above, however, there are many successful models that utilize one structure or space as a hub or headquarters, and other satellite spaces for service delivery.

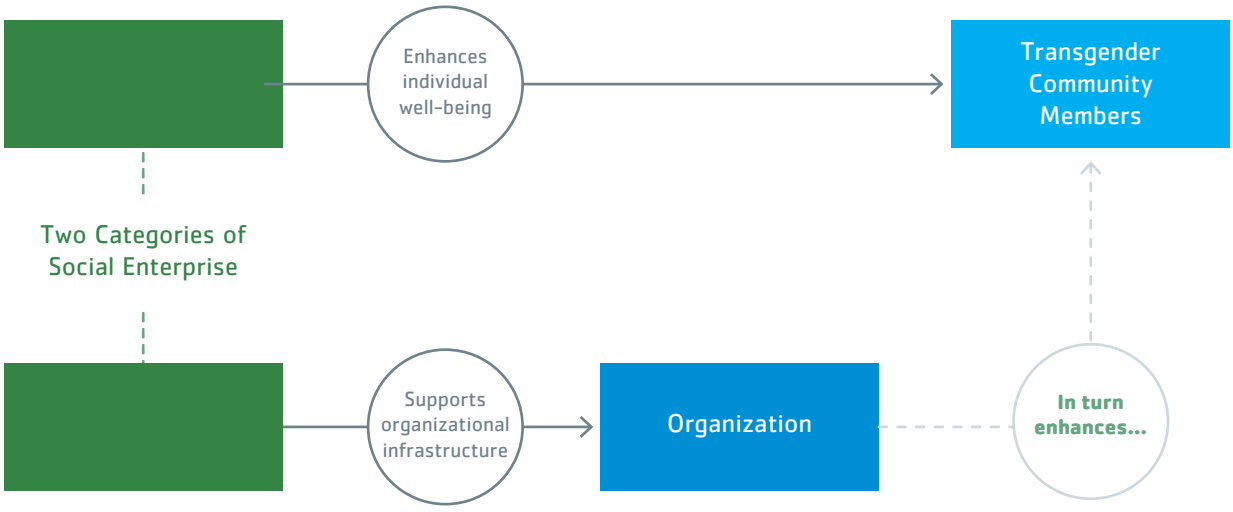
Organizational structure: To the degree possible, the TWC should be an entity that is independent from other existing agencies. Independence does not preclude fiscal sponsorship by an existing agency, nor does it preclude utilizing existing space within an agency.

Address the gaps in services for transgender people: Although there are certainly quality programs that exist to serve the needs of transgender people, there still remain large gaps in those services. Gaps in services are identified when community needs are not matched or adequately addressed by existing services. Gaps can be related to *quantity* (there isn't enough of a given service); *quality* (the services exist but they are not necessarily culturally competent or otherwise of high-quality); or *appropriateness* (services that are designed in response to problems that are not fully understood, and that therefore miss the mark). Therefore, appropriate TWC models should be designed to address those gaps by either increasing the capacity of a given service; improving the quality of a given service; and/or developing new or adapting existing services to best meet needs.

Utilize mobile services: The sheer size of LAC coupled with a weak public transportation system means clients' ability to access services at specific fixed sites can be challenging. For this reason, the Consortium was drawn to services that could "meet clients where they were at." Additionally, the use of mobile services could also help alleviate the problem of overburdened providers serving the community. For example, one of the identified needs of the transgender community is increased access to hormones. Unfortunately, the two primary care sites that have transgender specific medical services have surpassed their capacity to provide hormones to all those who need them given current funding, reimbursement models, and provider availability. One potential solution to this problem of demand exceeding supply, is to incorporate a mobile health team into an organizational model. The mobile health team could visit existing social service agencies and other sites that transgender people frequent, and prescribe/provide/monitor hormones and basic preventive care as is deemed appropriate. This model has been successful in extending access for other vulnerable and underserved communities.

Social Enterprise: Another promising organizational component that the Consortium members expressed much interest in was the practice of social enterprise, defined as a "business operated by non-profits with the dual purpose of generating income by selling a product or service in the marketplace *and* creating a social, environmental or cultural value."[50]

Social enterprises differ from traditional businesses in that, rather than monetary profit, addressing a social need for the common good is its primary purpose. Social enterprises differ from traditional non-profits in that they address those social needs through the selling of products and services and/or through providing employment opportunities, rather than the provision of services.



Examples of successful social enterprise models are found in a variety of industries including food service and catering (e.g. Homeboy Industries in Los Angeles, CA[48]); retail (e.g. Housing Works in Brooklyn, NY[51]); and energy (e.g. Rising Sun Energy Center in Berkeley, CA[52]).

The idea of incorporating social enterprise models into non-profit organizations has become increasingly popular in the United States. Largely due to the economic downturn, governmental and philanthropic funding sources have diminished substantially over the past few years. In addition to diversifying a non-profit's revenue base, the benefits of social enterprise are numerous and can generally be thought of in two categories: those that enhance individual well-being; and those that enhance organizational infrastructure (which in turn enhance individual well-being):

Enhancing Organizational Infrastructure & Capacity

- Sustainability
- Unrestricted use of funds
- Greater publicity and enhanced image/branding

Enhancing Individual Well-Being

- New employment and economic opportunities
- Job training skills
- Enhanced public image of transgender people

Although the potential benefits of social enterprise are many, so too are the risks. These risks may be of financial nature (e.g. IRS limitations on earnings) or organizational (e.g. "mission creep," when the social enterprise grows at a different rate than the rest of the organization and ultimately takes away from the organization's original mission).

Especially given the lack of employment opportunities that exist for transgender people and the myriad social and health problems that consequently arise, the Consortium sees great promise in incorporating a social enterprise component into a future wellness center. However, due diligence, including the careful consideration of potential benefits, challenges and costs, is required of any organization to do so. The choice to incorporate social enterprise, therefore, should be encouraged, but not mandated.

Economic Empowerment: As detailed above, transgender people, especially transgender people of color, struggle greatly with issues of poverty and lack of economic opportunities. The *elimination* of these problems, of course, would call for multi-faceted reform, which is clearly beyond the capacity of a local wellness center to

enact. However, the Consortium does believe that alleviating the burden of poverty and increasing economic opportunities are noble goals and ones within the power of a wellness center to realize. Based upon successful economic empowerment models for transgender people in Chicago[49], San Francisco[53]; and Los Angeles[54], the Consortium recommends the incorporation of activities that address both the job-training and career-training needs of individuals as well as the training and sensitivity needs of potential employers. These activities may include:

- Résumé Workshops: Assistance with creating and/or enhancing individual résumés.
- Job Interviewing Workshops: Coaching clients on how to effectively present their skills and experience and the basics of interviewing etiquette.
- Career Counseling: Helping clients identify and pursue meaningful jobs and career paths.
- Short and Long-Term Employment Readiness Trainings: From 3-hour workshops to 4-week intensive trainings, employment readiness learning content may cover a range of topic areas including disclosure of transgender identity; confidentiality issues; transitioning on the job; navigating benefits; dealing with discrimination; understanding legal rights, etc.
- Mentoring: Pairing first-time or returning transgender job-seekers with other transgender individuals who are or who have been successfully employed.
- Job Fairs: Matching potential employers to potential transgender employees.
- Employer Leadership Trainings: Working with organizations across all industries to increase their capacity to hire, train and supervise transgender employees; and decrease workplace bias and institutionalized transphobia.

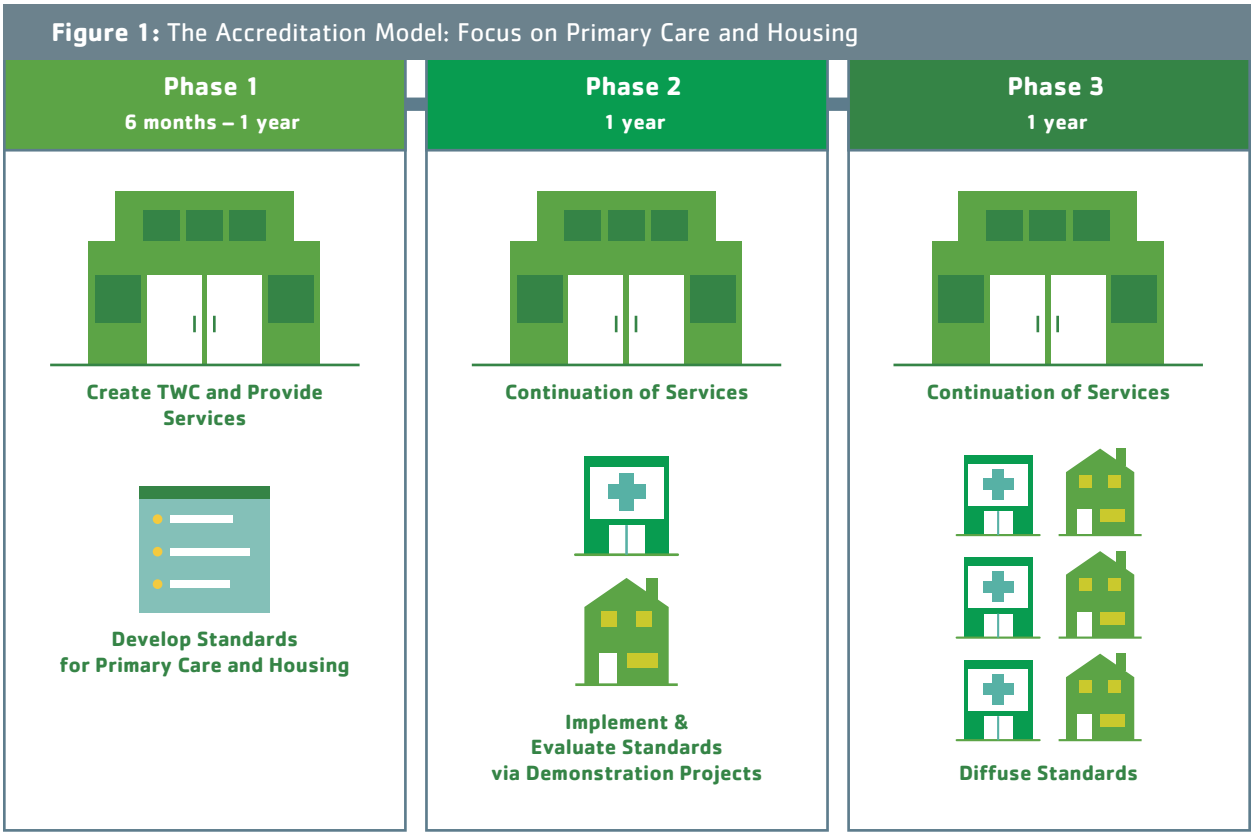
The two Consortium-designed models are described below. The Consortium recommends Model 1A, Model 1B or Model 2 for implementation in LAC , with preference given to Model 1A or Model 1B. Two of the models are described in phases; however, a cafeteria approach, implementing different components of the proposed models, could be implemented if the building block services, described earlier in this report, were incorporated.

Model 1A: The Accreditation Model: Focus on Primary Care and Housing

This model includes a small TWC space that would provide a drop-in center, health insurance enrollment assistance, and a few computers for Internet use. The Center would rely on existing organizations and programs to commit to providing a variety of services, including mental health groups and individual therapy, substance abuse treatment, HIV/STI testing, health education/risk reduction, legal services and economic empowerment.

In addition to these services, the TWC would be charged with overseeing the development of standards for the provision of quality primary care and housing, as well as a certification process for those entities who demonstrate the ability to meet the standards. Once the standards are developed, one primary care site and one housing organization would be selected as demonstration projects, where the standards would be implemented and evaluated. Lessons learned from the demonstration projects will lead to the further enhancement of the standards and will then be diffused to additional primary care and housing sites.

Figure 1: The Accreditation Model: Focus on Primary Care and Housing



These services and components would be implemented in four phases: the creation of the TWC and the development of primary care and housing standards in Phase 1; the implementation and evaluation of quality standards in Phase 2; the diffusion of primary care and housing services in Phase 3 and the development and diffusion of standards for other key services in Phase 4. These phases are depicted in Figure 1 and described in more detail below.

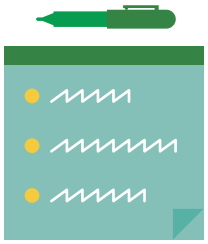
Phase 1

Phase 1 consists of opening the physical TWC space and providing a drop-in center, enrollment assistance, computer/Internet access, coordinating in-house service delivery by visiting providers and completing the accreditation process for primary care and housing. Phase 1 would last six months to one year.

Phase 1: Transgender Wellness Center (TWC) Programming & Development of Standards for Primary Care and Housing

Programs & Services

- Drop-in Center
- Enrollment Assistance
- Computers/Internet Use
- Visiting Services



Develop Standards for Quality Transgender Services

Two accreditation teams develop standards for the provision of quality primary care and housing for transgender individuals

- **Drop-In Space:** Minimally, the drop-in space will be a room where people can sit and talk to one another in a lounge-like setting. Ideally the room will likely be equipped with books, resources, and a small kitchen area.
- **Enrollment Assistance:** By the time the TWC opens, the Affordable Care Act (ACA) will be in full-swing, with thousands of Angelinos qualifying for Medi-Cal for the first time ever, and thousands more needing to access health care via the health marketplace known as Covered California. In addition, it is likely that those not covered by the ACA (e.g. undocumented immigrants) will still be able to access health care through Healthy Way LA, the County's

Low-Income Health Program. Transgender individuals will benefit greatly from enrollment assistance, which will consist of working individually with providers who understand eligibility issues and enrollment processes and who can match each individual consumer to the plan that best meets their needs. Such enrollment assisters will be trained, certified, and registered with Covered California to enroll consumers in quality health plans (QHPs) or link them to other appropriate insurance programs. Once certified, these enrollment assisters may be compensated by Covered California for each successful enrollment, or they may be affiliated with an enrollment entity (e.g. health department or 501(c)(3)) and, therefore, be compensated by other sources.

- **Computer/Internet Access:** The TWC will also be equipped with a work station that will include computers with Internet access. These computers will be available free of charge to community members who otherwise have minimal access to computers or the Internet.
- **Coordinating Visiting Providers:** The TWC will request that services currently being offered to transgender individuals throughout LA County, and certainly DHSP-funded services, provide their specialized services at the TWC on a regular basis. Although agencies represented on the Consortium were enthusiastic about providing their services at the TWC on a visiting basis, additional resources from either TWC funds or DHSP funds may provide added incentive to do so. See Table 1, below, for a mock schedule of visiting programs.

Table 1: Mock Schedule of Visiting Programs at the TWC

	Monday	Tuesday	Wednesday	Thursday	Friday
9 am		Support Group			HIV/STI Testing & Health Education
10 am	Legal Clinic		CRCS	Substance Abuse Group	
11 am					
12 pm			Employment Workshop		
1 pm		Mental Health Appointments			Mental Health Appointments
2 pm	Employment Workshop		Support Group		
3 pm				Legal Clinic	
4pm					
5 pm	Substance Abuse Group	HIV/STI Testing		CRCS	
6 pm					
7 pm					

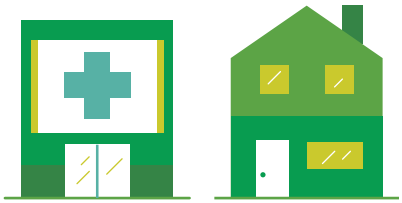
- **Development of Standards/Accreditation Process:** A major component of the TWC would be the coordination and oversight of the development of standards and performance measures for both quality primary care and housing services for transgender individuals. The consortium envisions two accreditation teams (one to develop primary care standards and one to develop housing standards) to be chosen via a competitive application process; with the final group composition decided upon by more than one person or entity. These accreditation teams would meet on a regular basis, over the course of six months to one year to develop their respective standards. These standards would build upon existing protocols and standards developed by the University of California San Francisco's Center of Excellence for Transgender Health (COE), the World Professional Association for Transgender Health (WPATH), and existing community health centers and clinics.

Phase 2

Phase 2 of the Accreditation Model 1A includes the continuation of the services implemented in Phase 1 (i.e. drop-in center; enrollment assistance; computers/Internet; and the coordination of visiting services), in addition to the implementation of two demonstration projects.

Phase 2: TWC + Demonstration Projects

Maintain Programs & Services from Phase 1



Accreditation Teams Monitor and Evaluate Implementation of Standards

One existing primary care site and one existing housing organization will be funded to implement the standards developed during Phase 1

- **Demonstration Projects:** One existing primary care site and one existing housing organization will be funded by DHSP through a Request for Proposals (RFP) process to implement the standards developed during Phase 1. During this phase, the teams that developed the standards would now assume the role of monitoring the implementation of the standards and evaluating the outcomes.

- **Certification:** To become certified, organizations funded for the demonstration projects would be required to complete a comprehensive evaluation; to maintain certification, they would have to report on their performance annually and continue to meet the stated standards. For transgender consumers, the certification would be a strong indicator that an organization has taken the necessary steps to deliver high quality care and services. Once certified, primary care sites and housing organizations would be designated as "transgender-qualified" and would become eligible for future transgender-related County funding.

Phase 2 would last for one year.

Phase 3

Phase 3 includes the continuation of the services implemented at TWC in Phase 1 in addition to the diffusion of standards and the marketing of the certification process.

- **Diffusion of Standards:** Following Phase 2, the accreditation teams will make any necessary adjustments to the standards based on lessons learned during the demonstration projects. Funding will then become available for up to two additional primary care sites and two additional housing organizations that wish to incorporate the service standards and become certified as a transgender-qualified site.

Phase 3: TWC + the Diffusion of Standards to Multiple Sites

Maintain Programs & Services from Phase 1

Accreditation Teams Adjust Standards As Necessary

Funding will then become available for up to two additional primary care sites and two additional housing organizations

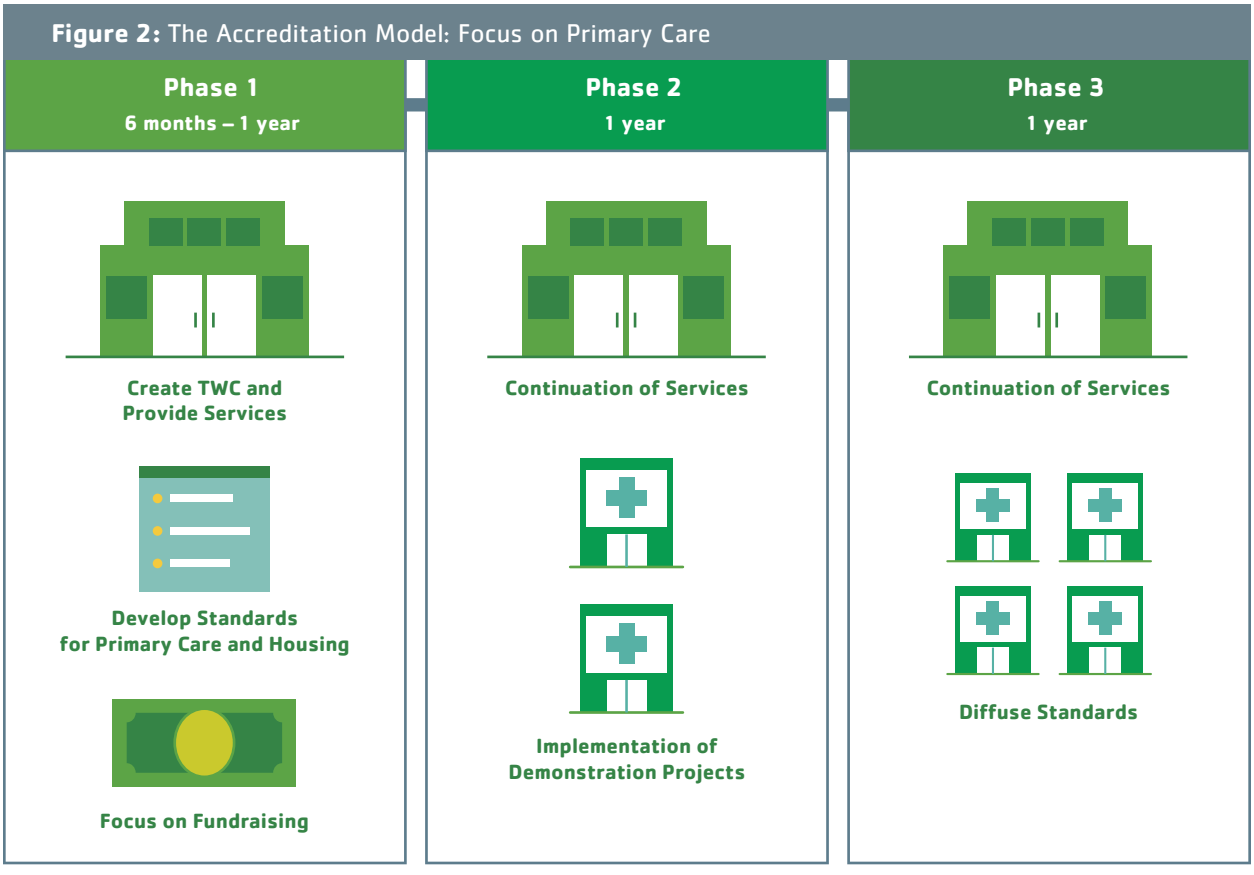
Phase 4:

Phase 4 occurs in year four and beyond. The expectation is that the process by which quality standards for primary care were developed and diffused during Phases 1–3 could be duplicated in order to create standards for a variety of other service areas that impact transgender health and well-being. Those areas include mental health and economic development.

Model 1B: The Accreditation Model: Focus on Primary Care

This model is similar to Model 1A in that it also includes a small TWC space that would provide a drop-in center, health insurance enrollment assistance, and a few computers for Internet use. As in Model 1A, the Center would rely on existing organizations and programs to commit to providing a variety of services, including mental health groups and individual therapy, substance abuse treatment, HIV/STI testing, health education/risk reduction, legal services and economic empowerment.

Figure 2: The Accreditation Model: Focus on Primary Care



In addition, this model also incorporates the development of standards for quality primary care for transgender individuals and a certification process for those organizations that meet the standards. These standards would include best practices in the provision of mobile health teams (described in more detail below).

This model differs from Model 1A in that it would focus on intensive fund-raising with a goal of raising $250,000/year in order to secure an additional $250,000/year from DHSP (see matching funds description in the Financial Projections section). After additional funds are secured, two to four primary care sites would be funded as demonstration projects to implement the standards. Based upon lessons learned from the demonstration projects, the standards would be adjusted as necessary and then diffused to other primary care sites across the county. Beyond the first three years of initial DHSP funding, this model calls for additional standards to be developed and implemented for a variety of other services, including housing and mental health.

These services and components would be implemented in four phases: the creation of the TWC and the development of primary care standards in Phase 1; the implementation and evaluation of quality standards in Phase 2; the diffusion of primary care services in Phase 3 and the development and diffusion of standards for other key services in Phase 4. These phases are depicted in Figure 2 and described in more detail below.

Phase 1

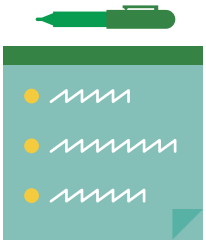
Phase 1 consists of opening the physical TWC space and providing a drop-in center, enrollment assistance, computer/Internet access, coordinating in-house service delivery by visiting providers, the development of quality standards for primary care and intensive fund-raising efforts. Phase 1 would last for six months to one year.

- **Drop-In Space:** Minimally, the drop-in space would be a room where people can sit and talk to one another in a lounge-like setting. Ideally, the room will likely be equipped with books, resources, and a small kitchen area.
- **Enrollment Assistance:** By the time the TWC opens, the Affordable Care Act (ACA) will be in full-swing, with thousands of Angelinos qualifying for Medi-Cal for the first time ever, and thousands more needing to access health care via the health marketplace known as Covered California. In addition, it is likely that those not covered by the ACA (e.g. undocumented immigrants) will still be able to access health care through Healthy Way LA, the County's Low-Income Health Program. Transgender individuals will benefit greatly from enrollment assistance, which will consist of working individually with providers who understand issues relative to eligibility and the enrollment processes, who can match each individual consumer to the plan that best meets their needs. Such enrollment assisters will be trained,

Phase 1: Transgender Wellness Center (TWC) Programming & Development of Standards for Primary Care

Programs & Services

- Drop-in Center
- Enrollment Assistance
- Computers/Internet Use
- Visiting Services



Develop Standards for Quality Transgender Care

Accreditation team develops standards for the provision of quality primary care and mobile health teams for transgender individuals

Focus on Fundraising

TWC staff focus on meeting DHSP offer of matching funds

TWC staff seek to raise $250,000 per year

certified, and registered with Covered California to enroll consumers in quality health plans (QHPs) or link them to other appropriate insurance programs. Once certified, these enrollment assisters may be compensated by Covered California for each successful enrollment, or they may be affiliated with an enrollment entity (e.g. health department or 501(c)(3)) and therefore be compensated by other sources.

- **Computer/Internet Access:** The TWC will also be equipped with a work station that will include computers with Internet access. These computers will be available free of charge to community members who otherwise have minimal access to computers or the Internet.
- **Coordinating Visiting Providers:** The TWC will request that services currently being offered to transgender individuals throughout LAC, and certainly DHSP-funded services, provide their specialized services at the TWC on a regular basis. See Table 1, above, for a mock schedule of visiting programs.
- **Development of Standards/Accreditation Process:** In Phase 1, a major component of TWC would be the coordination and oversight of the development of standards and performance measures for quality primary care for transgender individuals. The Consortium envisions the accreditation team to be chosen via a competitive application process, with the final group composition decided upon by more than one person or entity. The accreditation team would meet on a regular basis, over the course of six months to one year to develop standards. These standards would build upon existing protocols and

standards developed by the University of California San Francisco's Center of Excellence for Transgender Health (COE), the World Professional Association for Transgender Health (WPATH), and existing community health centers and clinics. The standards would include best practices in the provision of a mobile health team described below:

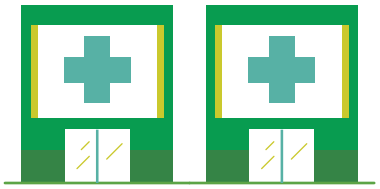
- **Mobile Health Team:** A mobile health team would consist minimally of a medical provider (e.g. physician, physician assistant or nurse practitioner), an enroller/ case manager (CM) and a nurse or medical assistant. The medical team would work two days per week – one day a week they would be stationed at the TWC and the other day they would visit existing agencies serving the transgender population and other sites that transgender individuals may frequent. Their role would be to enroll clients in health care, to prescribe, distribute and monitor hormones and to provide basic prevention and care. They would also encourage the transgender clients they encounter to access their agency for comprehensive primary care services.

Phase 2

Phase 2 of the Accreditation Model 1B includes the continuation of the services implemented in Phase 1 (i.e. drop-in center, enrollment assistance, computers/ Internet and the coordination of visiting services), in addition to the implementation of demonstration projects.

Phase 2: TWC + Demonstration Projects

Maintain Programs & Services from Phase 1



Accreditation Teams Monitor and Evaluate Implementation of Standards

Two primary care sites are funded as demonstration projects to implement the standards for one year

Continue Focus on Fundraising

- **Demonstration Projects:** Two existing primary care sites will be funded by DHSP through a RFP process to implement the standards developed during Phase 1. During this phase, the accreditation team that developed the standards would now assume the role of monitoring the implementation of the standards and evaluating the outcomes.

- **Certification:** To become certified, organizations funded for the demonstration projects would be required to complete a comprehensive evaluation; to maintain certification, they would have to report on their performance annually and continue to meet the stated standards. For transgender consumers, the certification would be a strong indicator that an organization has taken the necessary steps to deliver high quality care and services. Once certified, primary care sites would be designated as "transgender-qualified" and would become eligible for future transgender-related county funding.

Phase 2 would last for one year.

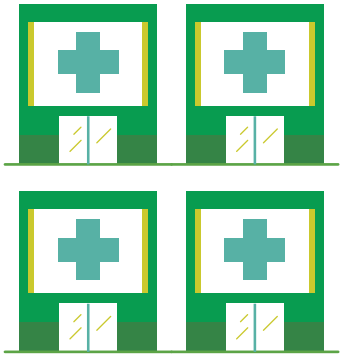
Phase 3

- **Diffusion of Standards:** Following Phase 2, the accreditation team will make any necessary adjustments to the standards based on lessons learned during the demonstration projects. Funding will then become available for up to four additional primary care sites that wish to incorporate the service standards and become certified as a transgender-qualified site. Future increases in funding will allow for expansion of services and programs that had been demonstrated to be effective in phases 2 and 3.

Phase 3: TWC and the Diffusion of Standards to Multiple Sites

Maintain Programs & Services from Phase 1

Continue Focus on Fundraising



Accreditation Teams Adjust Standards As Necessary

Funding will then become available for up to four additional primary care sites

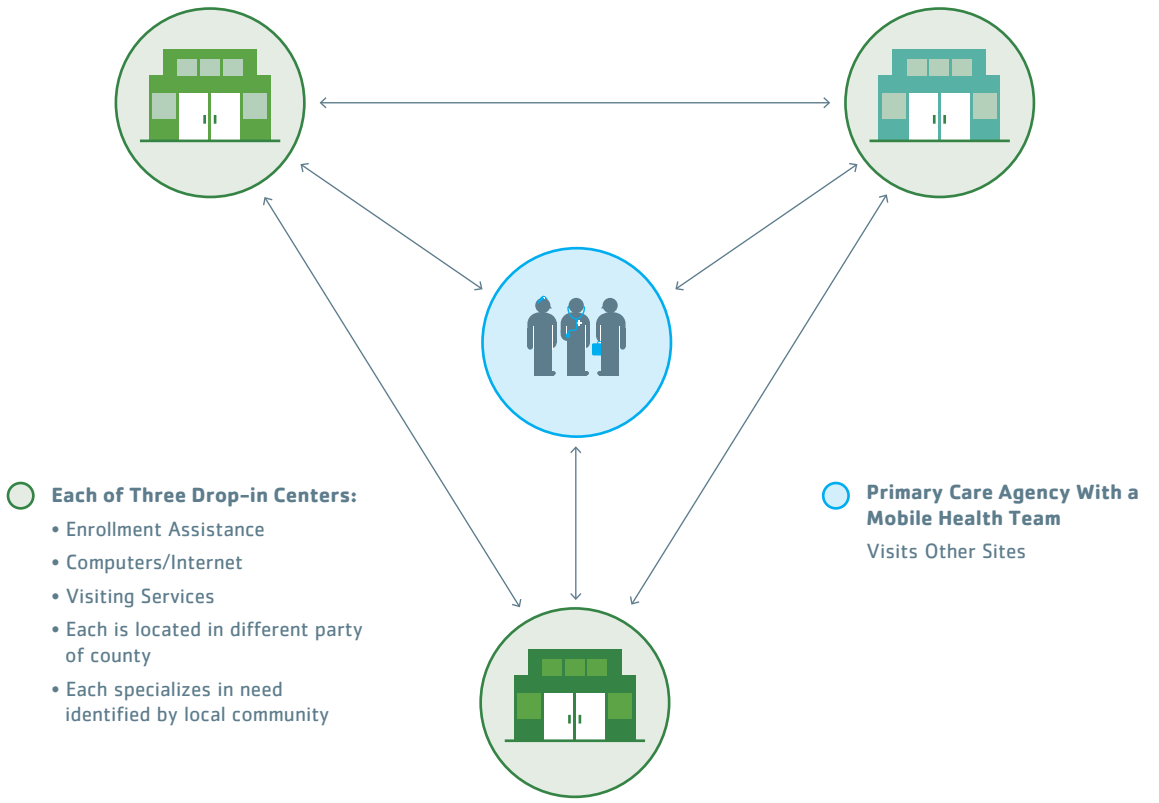
Phase 4

Phase 4 occurs in year four and beyond. The expectation is that the process by which quality standards for primary care were developed and diffused during Phases 1–3 could be duplicated in order to create standards for a variety of other service areas that impact transgender health and well-being. Those areas include mental health, housing and economic development.

Model 2: The Centers for Transgender Wellness: Focus on Decentralization

As outlined earlier in this document, LAC differs from many other counties across the state and the country in that it is extremely large (containing eighty-eight cities spanning 4,083 square miles), extremely populous (over ten million residents) and extremely diverse. This model is developed in response to the challenges of providing necessary services, inherent in a county of such size and with such complexity.

Figure 3: The Centers for Transgender Wellness Model: Focus on Decentralization



Rather than one central wellness center, this model presents four different wellness centers located throughout the county. Three of the four centers would provide a drop-in space, enrollment assistance and computer/Internet access. They would also coordinate in-house service delivery by visiting providers (including providers from the other centers). In addition, each center would specialize in the provision of a specific service prioritized by the local community. The fourth "center" would be a primary care agency and would provide a mobile health team that visits the other centers as well as existing agencies serving the transgender population and sites that transgender individuals may frequent. Their role would primarily be to prescribe, distribute and monitor hormones. Each of these components is described in more detail below:

- **Drop-In Space:** Minimally, the drop-in space found in three of the four centers (all but the primary care agency) would be a room where people can sit and talk to one another in a lounge- like setting. Ideally, the room will likely be equipped with books, resources, and a small kitchen area.

- **Enrollment Assistance:** By the time the TWC opens, the Affordable Care Act (ACA) will be in full-swing, with thousands of Angelinos qualifying for Medi-Cal for the first time ever, and thousands more needing to access health care via the health marketplace known as Covered California. In addition, it is likely that those not covered by the ACA (e.g. undocumented immigrants) will still be able to access health care through Healthy Way LA, the County's Low-Income Health Program. Transgender individuals will benefit greatly from enrollment assistance, which will consist of working individually with providers who understand issues relative to eligibility and the enrollment processes, who can match each individual consumer to the plan that best meets their needs. Such enrollment assisters will be trained, certified, and registered with Covered California to enroll consumers in quality health plans (QHPs) or link them to other appropriate insurance programs. Once certified, these enrollment assisters may be compensated by Covered California for each successful enrollment, or they may be affiliated with an enrollment entity (e.g. health department or 501(c)(3)) and therefore be compensated by other sources.

- **Computer/Internet Access:** The centers will also be equipped with a work station that will include computers with Internet access. These computers will be available free of charge to community members who otherwise have minimal access to computers or the Internet.

- **Coordinating Visiting Providers:** The centers will request that services currently being offered to transgender individuals throughout LA County, and certainly DHSP- funded services, provide their specialized services at their site on a regular basis. See Table 1, above, for a mock schedule of visiting programs. Because this model calls for visiting services at three different centers across the county, rather than one center in previous models, a great

deal of coordination will be necessary. For this reason, there should be one primary services coordinator that oversees all of the centers' activities. This coordinator should work closely with each centers' office manager.

- **Mobile Health Team:** The primary care agency would provide a mobile health team consisting minimally of a medical provider (e.g. physician, physician assistant or nurse practitioner), an enroller/ case manager (CM) and a nurse or medical assistant. The medical team would travel to the three transgender wellness centers and one day a week they would be stationed at the primary care agency. They would also visit other existing agencies serving the transgender population and other sites that transgender individuals may frequent. Their role would be to enroll clients in health care, to prescribe, distribute and monitor hormones and to provide basic prevention and care. They would also encourage the transgender clients they encounter to access the primary care agency for comprehensive primary care services.

- **Specialized and Coordinated Services:** Each center would be asked to specialize in a particular service that is prioritized by the local transgender community and that is not offered by other existing organizations. For example, one center might focus on transitional housing services, and another might focus on the development of a social enterprise. The sites could also sponsor larger events together and people could travel to various sites for workshops, groups, etc. that they were interested in. Staff from the teams and the sites would travel to the other wellness center sites to provide services and would meet regularly to coordinate services.

- **Use of Volunteers:** Each site would develop a strong volunteer pool consisting of peers and allies. Volunteers would be supported to work, facilitate groups, and do outreach within their own local communities. To keep costs down, licensed mental health professionals might volunteer and supervise interns from local schools. Other supportive services (e.g. meditation and yoga classes) could be offered by volunteer teachers, when possible. Developing a strong volunteer base that would work to find other resources, funding, volunteers with expertise, etc. could bring a feeling of cohesion and purpose to communities and allies as they work together.

Given limited resources, each center would start out small; however, in time, these services could grow if the need was documented and the resources were expanded. The Consortium believes that there is a lot that could grow out of small centers that are local but supported by a larger umbrella. Given the enormity of Los Angeles and the specific communities within the city, a decentralized model might be a very practical alternative.

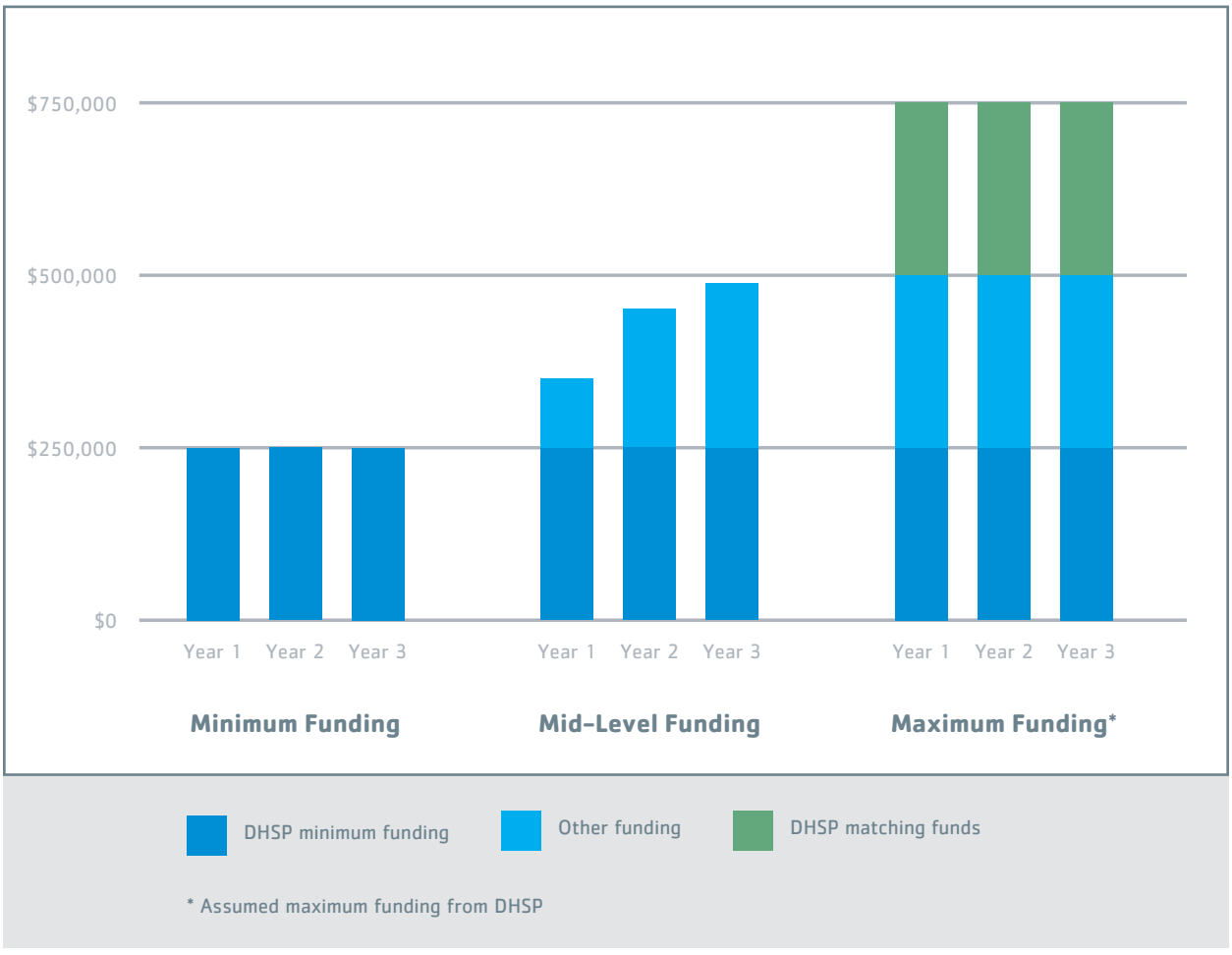
Financial and Administrative Considerations

DHSP Potential Funding Opportunity

Based on previous public statements made by the leadership of DHSP, model development and financial projections assume the following level of funding:

- DHSP would fund a base level of $250,000 per year for three years.
- If the TWC can raise an additional $250,000 per year from other sources, DHSP would match that amount and contribute an additional $250,000 per year.

Minimally, the TWC would receive $250,000 per year for three years and maximally, the TWC would receive $750,000 per year for three years ($500,000 per year from DHSP plus $250,000 from other sources).



Potential Sources of Funding

In addition to DHSP, funds for the TWC may be solicited from many sources including: in-house fundraising efforts, state and federal government funds, foundation grants, and corporate and individual donations.

The following philanthropic foundations are known for their generous support of LGBT organizations. Many of these foundations recognize the need to specifically support programs for transgender and gender non-conforming people; thus they may prove to be excellent funding sources for a transgender wellness center.

- Liberty Hill Foundation
- Evelyn and Walter Haas, Jr. Fund
- Tides Foundation
- Ford Foundation
- California Endowment
- Open Society Foundation
- Wells Fargo Foundation
- California Wellness Foundation
- David Bohnett Foundation
- Levi Strauss Foundation
- M.A.C. AIDS Fund
- Verizon Foundation
- PepsiCo Foundation
- American Express Foundation
- JP Morgan Chase Foundation
- Chrysler Foundation
- Bank of America Foundation
- Macy's Foundation

Competitive Edge

The TWC has three distinct competitive edges that will be leveraged to make it a successful service provider with sufficient financial resources:

- Enhancement, not duplication, of existing services
- A distinct physical space for transgender people to gather
- Culturally competent services including health insurance enrollment assistance

Utilizing a Fiscal Sponsor

The Consortium envisions two different types of funding scenarios: those individuals who implement the TWC activities are part of an established 501(c)(3) and are funded directly; or those who implement the TWC activities are a project of an established 501(c)(3) that would serve as a fiscal sponsor.

Financial Projections

Model 1A: The Accreditation Model: Focus on Primary Care and Housing

Start-Up Costs

The TWC will likely require the following space and equipment for the start-up phase.

- Assorted furniture, furnishings, and appliances for the lounge; resource/computer station; two counseling rooms; one office; bathroom and kitchenette.
- Three computers for client use and four computers for office staff.
- Computer server, laser printer, broadband Internet connection, and a copier.

Personnel Plan

- Executive Director—Nonprofit management, fundraising, marketing, staff supervision and other activities.
- Office Coordinator (2)—Responsible for coordinating visiting services, assisting clients in the drop-in center, providing clients with peer navigation and linkage to supportive systems and services, and other administrative duties. At least one office coordinator should be bilingual.
- Enrollment Assister (2)—Assists clients with determining healthcare insurance eligibility and enrollment. At least one enrollment assister should be bilingual.

Personnel Plan			
	Year 1	**Year 2**	**Year 3**
Executive Director	$75,000	$75,000	$75,000
Office Coordinator 1	$35,000	$35,000	$35,000
Office Coordinator 2	$35,000	$35,000	$35,000
Enrollment Assister 1	In-Kind	In-Kind	In-Kind
Enrollment Assister 2	In-Kind	In-Kind	In-Kind
Total Personnel	**5**	**5**	**5**
Total Payroll	**$145,000**	**$145,000**	**$145,000**

Budget

The budget is based on a number of assumptions:

1. Taxes and benefits are estimated to cost fifteen and twenty percent, respectively, of salaries.
2. There will be no cost for renting the TWC building because a no-cost, vacant, County-owned space will be utilized.
3. There will be a total of ten accreditation team members (five for primary care and five for housing) who will each receive a $5,000 stipend in the first year to develop standards; and a $2,500 stipend in Years 2 and 3 to monitor the implementation of standards.*

Budget			
	Year 1	**Year 2**	**Year 3**
Funding	**$250,000**	**$250,000**	**$250,000**
Expenses			
Salaries	$145,000	$145,000	$145,000
Taxes (15%)	$21,750	$21,750	$21,750
Benefits (20%)	$29,000	$29,000	$29,000
Total Salaries and Wages Expense	**$195,750**	**$195,750**	**$195,750**
Depreciation	$2,000	$2,000	$2,000
Leased Building	$0	$0	$0
Utilities	$4,500	$4,500	$4,500
Advertising and Promotion	$1,000	$1,000	$1,000
Office Expenses	$5,000	$5,000	$5,000
Furniture and Equipment	$10,000	$2,000	$2,000
Phone and Internet	$4,000	$4,000	$4,000
Legal Fees	$2,500	$2,500	$2,500
Stipends for Accreditation Members	$50,000	$25,000	$25,000
Total Operating Expenses	**$79,000**	**$46,000**	**$46,000**
Total Expenses	**$274,750**	**$241,750**	**$241,750**
Net Surplus	**($24,750)**	**$8,250**	**$8,250**
Net Surplus/Funding	**–9.9%**	**3.3%**	**3.3%**

* $5,000 should be the minimum amount for stipends. Additional funds may be called for given the amount of work that may be involved.

4. This model calls for additional funds to be made available by DHSP in an RFP process for the demonstration projects in Phase Two and the diffusion of standards in Phase Three.

5. There is no fiscal sponsor. If there were to be one, it is estimated that they would cost $25,000/year (10% of the TWC's total revenue).

Model 1B: The Accreditation Model: Focus on Primary Care

Start-Up Costs

The TWC will likely require the following space and equipment for the start-up phase.

- Assorted furniture, furnishings, and appliances for the lounge; resource/computer station; two counseling rooms; one office; bathroom and kitchenette.
- Three computers for client use and four computers for office staff.
- Computer server, laser printer, broadband Internet connection, and a copier.

Personnel Plan

- Executive Director—Nonprofit management, fundraising, marketing, staff supervision and other activities.
- Development Director—Secures additional funding for the TWC.
- Office Coordinator (2)—Responsible for coordinating visiting services, assisting clients in the drop-in center, providing clients with peer navigation and linkage to supportive systems and services, and other administrative duties. At least one office coordinator should be bilingual.

Personnel Plan			
	Year 1	**Year 2**	**Year 3**
Executive Director	$75,000	$75,000	$75,000
Development Director	$65,000	$65,000	$65,000
Office Coordinator 1	$35,000	$35,000	$35,000
Office Coordinator 2	$35,000	$35,000	$35,000
Enrollment Assister 1	In-Kind	In-Kind	In-Kind
Enrollment Assister 2	In-Kind	In-Kind	In-Kind
Total Personnel	**6**	**6**	**6**
Total Payroll	**$210,000**	**$210,000**	**$210,000**

- Enrollment Assister (2)—Assists clients with determining healthcare insurance eligibility and enrollment. At least one enrollment assister should be bilingual.

Budget

The budget is based on a number of assumptions:

1. The TWC will raise an additional $250,000 per year in Years 2 and 3, thus adding DHSP matching funds of $250,000 per year for a total of $750,000 in revenue in Years 2 and 3.
2. Taxes and benefits are estimated to cost fifteen and twenty percent, respectively, of salaries.

Budget			
	Year 1	**Year 2**	**Year 3**
Funding	**$250,000**	**$750,000**	**$750,000**
Expenses			
Salaries	$210,000	$210,000	$210,000
Taxes (15%)	$31,500	$31,500	$31,500
Benefits (20%)	$42,000	$42,000	$42,000
Total Salaries and Wages Expense	**$283,500**	**$283,500**	**$283,500**
Depreciation	$2,000	$2,000	$2,000
Leased Building	$0	$0	$0
Utilities	$4,500	$4,500	$4,500
Advertising and Promotion	$1,000	$1,000	$1,000
Office Expenses	$5,000	$5,000	$5,000
Furniture and Equipment	$10,000	$2,000	$2,000
Phone and Internet	$4,000	$4,000	$4,000
Legal Fees	$2,500	$2,500	$2,500
Stipends for Accreditation Members	$25,000	$12,500	$12,500
Total Operating Expenses	**$54,000**	**$33,500**	**$33,500**
Total Expenses	**$337,500**	**$317,000**	**$317,000**
Net Surplus	**($87,500)**	**$433,000**	**$433,000**
Net Surplus/Funding	**–35%**	**58%**	**58%**

3. There will be no cost for renting the TWC building because a no-cost, vacant, County-owned space will be utilized.

4. There will be a total of five accreditation team members who will each receive a $5,000 stipend in the first year to develop standards; and a $2,500 stipend in Years 2 and 3 to monitor the implementation of standards.*

5. The matching funds made available in Phase Two and Phase Three will be applied to the demonstration projects and diffusions standards via a DHSP RFP process.

6. There is no fiscal sponsor. If there were to be one, it is estimated that they would cost $25,000 for the first year; and $75,000 per year for Years 2 and 3 (10% of the TWC's total revenue).

* $5,000 should be the minimum amount for stipends. Additional funds may be called for given the amount of work that may be involved.

Citations

1 National Center for Transgender Equality. (2009). Transgender Terminology. Retrieved from transequality.org/Resources/NCTE_TransTerminology.pdf.

2 World Health Organization. (1946, June 19-22). Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference. Official Records of the World Health Organization, no. 2, p. 100. Retrieved from www.who.int/about/definition/en/print.html.

3 Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Final report on social determinants of health. Geneva: World Health Organization.

4 Center for HIV Identification, Prevention and Treatment Services and Center for Strengthening Youth Prevention Paradigms. (2012). *HIV prevention at the structural level: The role of social determinants of health and HIV*. Los Angeles, CA.

5 Institute of Medicine. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: The National Academies Press.

6 Grant, J.M., Mottet, L.A., Tanis, J., Harrison, J., Herman, J.L., Keisling, M. (2011). *Injustice at Every Turn: A report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force.

7 Hartzell, E., Frazer, M.S., Wertz, K., Davis, M. (2009). *The State of Transgender California: Results from the 2008 California transgender economic health survey*. San Francisco, CA: Transgender Law Center.

8 Kidder D.P., Wolitski R.J., Campsmith M.L,, Nakamura G.V. (2007). Health status, health care use, medication use, and medication adherence among homeless and housed people living with HIV/AIDS. *American Journal of Public Health*, 97: 2238-2245.

9 National AIDS Housing Coalition (2005). *Housing and HIV/AIDS: National Housing Summit Policy Paper*. Washington, DC: National AIDS Housing Coalition.

10 Reback, C.J., Fletcher, J.B., Kisler, K.A. (2012) *Associations between HIV sexual risk behavior, substance use, hormone misuse and housing status among transgender women*. Poster presented at the International AIDS Conference. Washington, DC.

11 Bockting, W.O., Robinson, B.E., Rosser, B.R.S. (1998). Transgender HIV prevention: A qualitative needs assessment. *AIDS Care 10*, 505-526.

12 Nemoto, T., Operario, D., Keatley, J., Han, L., Soma, T. (2004). HIV Risk behaviors among male-to-female transgender persons of color in San Francisco. *American Journal of Public Health, 94*(7), 1193-1199.

13 Sugano, E., Nemoto, T., Operario, D. (2006). The impact of exposure to transphobia on HIV risk behavior in a sample of transgendered women of color in San Francisco. *AIDS and Behavior, 10*(2), 217-225.

14 Clements, K., Willy, W., Kitano, K., Marx, R. (1999). HIV prevention and health services needs of the transgender community in San Francisco. *International Journal of Transgenderism, 3*(1 and 2).

15 Lombardi, E.L., Wilchins, R.A., Priesing, D., Malouf, D. (2001). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality, 42*(1), 89-101.

16 Xavier, J.M., Simmons, R. (2000). *The Washington transgender needs assessment survey*. Washington, DC: District of Columbia Government Administration for HIV & AIDS.

17 Wilson, E. C., Garofalo, R., Harris, R.D., Herrick, A., Martinez, M., Martinez, J., Belzer, M., The Transgender Advisory Committee and the Adolescent Medicine Trials Network for HIV/AIDS Interventions. (2009). Transgender female youth and sex work: HIV risk and a comparison of life factors related to engagement in sex work. *AIDS Behavior 13*, 902-913.

18 Singer M. (2010). Pathogen-pathogen interaction: A syndemic model of complex biosocial processes in disease. *Virulence.* 1(1):10–18.

19 Singer M.C., Erickson, P.I., Badiane L., Diaz R., Ortiz D., Abraham, T, Nicolaysen, A.M. (2006). Syndemics, sex and the city: Understanding sexually transmitted diseases in social and cultural contest. *Journal of Social Science and Medicine, 63*:2010–2021.

20 Brennan, J., Kuhns, L.M., Johnson, A.K., Belzer, M., Wilson, E.C., Garofalo, R., the Adolescent Medicine Trials Network for HIV/AIDS Interventions. (2012). *American Journal of Public Health, 102*(9), 1751-1757.

21 Galvan, F., Bazargan, M. (2012). *Interactions of Latina transgender women with law enforcement.* Los Angeles, CA: Bienestar Human Services, Inc.

22 Emmer, P., Lowe, A., Marshall, R.B. (2011). *This is a prison, glitter is not allowed: Experiences of trans and gender variant people in Pennsylvania's prison systems.* Philadelphia, PA: Hearts on a Wire Collective.

23 Jenness, V., Maxson, C., Matsuda, K., Sumner, J.M. (2007). *Violence in California correctional facilities: An empirical examination of sexual assault.* Irvine, CA: Center for Evidence-Based Corrections, Department of Criminology, Law and Society, University of California, Irvine.

24 Mogul, J.L., Ritchies, A. J., Whitlock, K. (2011). *Queer injustice: The criminalization of LGBT people in the United States*. Boston, MA: Beacon Press.

25 Binswanger, B., Stern, M.F., Deyo, R.A., Heagerty, P.J., Cheadle, A., Elmore, J.G., Koepsell, T.D. (2007). Release from prison—A high risk death for former inmates. *New England Journal of Medicine 356*(2), 157-165.

26 Husted, C. (2013). *Los Angeles County Five-Year Comprehensive HIV Plan* (2013-2017). Los Angeles, CA: Division of HIV and STD Programs, Los Angeles County Department of Public Health, the Los Angeles County Commission on HIV, and the Los Angeles County HIV Prevention Planning Committee.

27 Bingham, T., Carlos-Henderson, J. (2013) *Los Angeles County Transgender Population Estimates 2012.* Los Angeles, CA: Division of HIV and STD Programs, Los Angeles County Department of Public Health.

28 Reback, C.J., Simon, P.A., Bemis, C.C., Gaston, B. (2001). *The Los Angeles Transgender Health Study: Community Report*. Los Angeles, CA.

29 Wilson, E.C., Iverson, E., Garofalo, R., Belzer, M. (2012). Parental support and condom use among transgender female youth. *Journal of the Association of Nurses in AIDS Care, 23*(4), 306-317.

30 Grossman, A.H., D'Augelli, A.R., (2006). Transgender youth: Invisible and vulnerable. *Journal of Homosexuality, 51*(1), 111-128.

31 Reback, C.J., Lombardi, E.L., Simon, P.A., Frye, D.M. (2005). HIV seroprevalence and risk behaviors among transgendered women who exchange sex in comparison with those who do not. *Journal of Psychology and Human Sexuality, 17*(1/2), 5-22.

32 Division of HIV and STD Programs, Los Angeles County Department of Health, HIV Care and Treatment Service Utilization: 2011 Year End Report, March 2013.

33 Healthy People 2020. (2010). *Transgender health factsheet*. Washington, DC: U.S. Department of Health and Human Services. Retrieved from www.lgbttobacco.org/files/TransgenderHealthFact.pdf.

34 Nemoto, T., Operario, D., Keatley, J. (2005). Health and social services for male-to-female transgender persons of color in San Francisco. *International Journal of Transgenderism, 8*(2/3), 5-19.

35 Singer, T.B., Cochran, M., Adamec, R. (1997). *Final report by the transgender health action coalition (THAC) to the Philadelphia Foundation Legacy Fund* (for the) Needs Assessment Survey Project (A.K.A the Delaware Valley Transgender Survey). Philadelphia, PA: Transgender Health Action Coalition.

36 Kenagy, G., Bostwick, W. (2001). *Health and social service needs of transgendered people in Chicago*. Chicago, IL: Jane Addams College of Social Work, University of Illinois at Chicago.

37 Clements-Nolle, K., Marx, R., Guzman, R., Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health, 91*(6), 915-921.

38 Nemoto, T., Keatley, J., Operario, D., Soma, T. (2002). *Psychosocial factors affecting HIV risk behaviors among male to female transgenders in San Francisco*. Poster session at the International AIDS Conference, Barcelona, Spain.

39 Reback, C.J., Shoptaw, S., Downing, M.J. (2012). Prevention case management improves socioeconomic standing and reduces symptoms of psychological and emotional distress among transgender women. *AIDS Care 24*(9), 1136-1144.

40 Cochran, B. N., Stewart, A. J., Ginzler, J. A., Cauce, A. M. (2002). Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual and transgender homeless adolescents with their heterosexual counterparts. *American Journal of Public Health, 92*, 773-777.

41 Wolitski, R., Kidder, D., Fenton, K. (2007). HIV, homelessness, and public health: Critical issues and a call for increased action. *AIDS and Behavior, 11*, 167-171.

42 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §2702, 124 Stat. 119, 318-319 (2010).

43 Office of National AIDS Policy. (2010). *National HIV/AIDS Strategy for the United States*. Washington, DC: The White House Office of National AIDS Policy.

44 Pérez, M.J. (2012, May). *Los Angeles County's HIV Epidemic: Current State and Future Directions*. Presented at the UCLA Fielding School of Public Health; Epidemiology 227: AIDS, A Major Public Health Challenge Course, Los Angeles, CA.

45 Transgender Law Center. transgenderlawcenter.org/archives/4273

46 People Assisting The Homeless (PATH) www.epath.org/site/main.html

47 Magnolia Place Family Center and Community Initiative www.magnoliaplacela.org/

48 Homeboy Industries www.homeboyindustries.org

49 Chicago House: www.chicagohouse.org

50 www.enterprisingnonprofits.ca/about_social_enterprise/definitions

51 www.housingworks.org

52 www.risingsunenergy.org

53 Transgender Economic Empowerment Initiative; a collaborative program of the SF LGBT Community Center, the SF Transgender Empowerment, Advocacy and Mentorship Program, and the Transgender Law Center www.teeisf.org

54 Transgender Economic Empowerment Project of the Los Angeles Gay and Lesbian Center; www.lagaycenter.com

Center for HIV Identification, Prevention and Treatment Services

UCLA • Charles Drew University • RAND • Friends Research