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ADDENDUM NUMBER 1
TO
REQUEST FOR PROPOSALS NO. 2024-008
FOR
CORE HIV MEDICAL SERVICES FOR PERSONS LIVING WITH HIV

On August 27, 2024, the County of Los Angeles (County) Department of Public Health (Public Health) released a Request for Proposals (RFP) for Core HIV Medical Services for Persons Living with HIV. On September 11, 2024, Public Health held an optional Proposers' Conference. This Addendum Number 1 addresses both written questions received by the September 17, 2024 deadline and questions asked at the Proposers' Conference.

The addendum consists of two parts, as outlined below:

- **PART 1 – MODIFICATIONS TO THE RFP**
- **PART 2 – RESPONSES TO PROPOSER QUESTIONS**

PART 1 – MODIFICATIONS TO THE RFP

Pursuant to RFP Section 5.4, County's Right to Amend Request for Proposals, Public Health has the right to amend the RFP by written addendum. This Addendum Number 1 amends the RFP as indicated below, with new or revised RFP language in highlight and deleted language in ~~strikethrough~~ for easy reference.

1. RFP, Section 8.1, Truth and Accuracy of Representations, is amended as follows:

   8.1 Truth and Accuracy of Representations

   False, misleading, incomplete, or deceptively unresponsive statements in connection with a proposal will be sufficient cause for rejection of the proposal. The evaluation and determination in this area will be at Public Health's sole judgment, which will be final. All proposals are firm and final offers and may not be withdrawn for a period of ~~F~~ 180 days following the final proposal submission date.

2. Appendix A, Sample Contract, Exhibit A, Statement of Work, Section 3.15, Screen for Ryan White Program (RWP) Eligibility, is amended as follows:

3.15 Screen for Ryan White Program Eligibility

By law, Ryan White HIV/AIDS Treatment Modernization Act of 2009 is the payer of last resort. As such Contractor is required to determine and verify an individual's eligibility for services from all sources (See Attachment 4, Ryan White Program Eligibility Documentation and Verification) to ensure the individual is provided the widest range of needed medical and support services. This means Contractor must coordinate benefits and ensure that each client's eligibility for other private or public programs is determined. Contractor is expected to vigorously pursue enrollment into health care coverage for which clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer sponsored health insurance coverage, and/or other private health insurance), and document all efforts. If services are initiated prior to RWP eligibility being established, Contractor must conduct a formal eligibility determination within 60 days of establishing services. During the 60-day period, Contractor must assist each client with submission of documentation required to establish RWP eligibility. Contractor is expected to update client eligibility information into the established data system. For clients already enrolled in a health insurance plan, RWP funds may be used only when insurance coverage of necessary medical care services is denied.

Contractor and its subcontractors must ensure that reasonable efforts are made to use non-RWP resources whenever possible, including establishing, implementing, and monitoring policies and procedures to identify any other possible payers to extend finite RWP funds. Contractors and subcontractors must maintain policies and document their efforts to ensure that they assist clients to vigorously pursue enrollment in health care coverage and that clients have accessed all other available public and private funding sources for which they may be eligible. Contractor and subcontractors can continue providing services funded through RWP to a client who remains unenrolled in other health care coverage so long as there is rigorous documentation that such coverage was vigorously pursued. Contractor and subcontractors should conduct periodic checks to identify any potential changes to clients' healthcare coverage that may affect whether the RWP remains the payer of last resort and require clients to report any such changes.

3. Appendix A, Sample Contract, Exhibit A, Statement of Work, Attachment 2, Medical Care Coordination (MCC) Services, Subsection 2.2.2., MCC Services Team Staffing Requirements, Item A, The MCC Team Supervisor is amended as follows:

A. The MCC Team Supervisor

1. Oversees the daily operations of MCC teams, ensuring high-quality care and compliance with program guidelines.
2. Provides ongoing training, performance evaluations, and professional development opportunities.
3. Coordinates with internal and external partners and other stakeholders to enhance service delivery and provide high-quality, client-centered care that addresses the medical, social, and emotional needs of individuals living with HIV/AIDS.
4. Develops and implements policies and procedures that improve efficiency and effectiveness in care coordination, adhering to the latest health standards and regulations.

5. Monitors program metrics and client health outcomes to assess the effectiveness of MCC services and implements quality improvement initiatives based on data analysis, client feedback, and best practices in care coordination and case management.
6. Is a full-time (FTE) position and should ~~Should~~ not carry an active case load.
7. Must meet the following minimum qualifications:
   a. Has at least 3-5 years of experience working in a healthcare setting, with a strong preference for experience in public health, community health, or HIV patient care.

4. Appendix A, Sample Contract, Exhibit A, Statement of Work, Attachment 3, Patient Support Services (PSS), Subsection 2.2.2., PSS Staffing Requirements, Item B, PSS SW is amended as follows:

B. PSS SW:

1. Determines client resources and needs in regard to mental health services, substance use counseling and treatment, as well as housing and transportation issues in order to make appropriate referrals and linkages.
2. Holds counselling and psychotherapy sessions for individuals, couples, and families.
3. Provides support services utilizing housing-first, harm-reduction, and trauma-informed care principles.
4. Utilizes a sex positive framework including provision of patient education about U=U.
5. Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
6. Maintains knowledge of local, State, and federal services available.
7. Addresses clients' socioeconomic needs, and as part of the PSS team, assists with client monitoring, referrals, and linkages to services, as well as following up with clients and tracking outcomes.
8. Acts as the liaison between HIV counseling and testing sites and the medical clinic to ensure that new clients are enrolled in medical care seamlessly and in a timely fashion.
9. Performs home visits and other field outreach on a case-by-case basis.
10. Provides urgent services to clients not yet enrolled in PSS.
11. Participates in case conferences as needed.
12. Conducts a comprehensive assessment of the SDH using a cooperative and interactive face-to-face interview process. The assessment must be initiated within five working days of client contact and be appropriate for age, gender, cultural, and linguistic factors.
    a. The assessment will provide information about each client's social, emotional, behavioral, mental, spiritual, and environmental status, family and support systems, client's coping strategies, strengths and weaknesses, and adjustment to illness.
    b. SW will document the following details of the assessment in each client's chart:
       i. Date of assessment;

ii. Title of staff persons completing the assessment; and
iii. Completed assessment form.

~~14.~~ 13. Develops a PSS Intervention Plan

SW will, in consultation with each client, develop a comprehensive multi-disciplinary intervention plan (IP). PSS IPs should include information obtained from the SDH assessment. The behavioral, psychological, developmental, and physiological strengths and limitations of the client must be considered by the SW when developing the IP. IPs must be completed within five days and must include, but not be limited to the following elements:

a. *Identified Problems/Needs:* One or more brief statements describing the primary concern(s) and purpose for the client's enrollment into PSS as identified in the SDH assessment.
b. *Services and Interventions*: A brief description of PSS interventions the client is receiving, or will receive, to address primary concern(s), describe desired outcomes and identify all respective PSS Specialist(s) assisting the client.
c. *Disposition*: A brief statement indicating the disposition of the client's concerns as they are met, changed, or determined to be unattainable.
d. IPs will be signed and dated by the client and respective SW assisting the client.
e. IPs must be revised and updated, at a minimum, every six months.

~~15.~~ 14. Meets the following minimum qualifications:
a. Master's Degree in Social Work, Counseling, Psychology, or related field from an accredited ~~social work~~ program.
b. Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.
c. Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC.

~~16.~~ 15. Desirable Qualifications:
a. Have a minimum of two years of relevant work experience with clients in public health, community services or medical settings.
b. Knowledge of HIV disease, behaviors that transmit HIV, and those disease conditions that are co- morbid with HIV;
c. Ability to interact in a nonjudgmental and empathetic manner with PLWH and AIDS as well as their partners; and
d. Ability to hold counselling and psychotherapy sessions for individuals, couples, and families.

5. Appendix A, Sample Contract, Exhibit A, Statement of Work, Attachment 3, PSS, Subsection 2.2.2., PSS Staffing Requirements, Item F, Clinical Nursing Support Specialist is amended as follows:

F. Clinical Nursing Support Specialist:

1. Provides enhanced clinical nursing support, performed by a registered nurse or Licensed Pharmacist to facilitate:
   a. Administration and supervision of client injectable medications and vaccinations;
   b. Tracking of clients receiving long-acting injectable, multi-dose injectable treatments, or multi-dose vaccine series; monitors clients for side effects; makes appointments for subsequent nursing visits to ensure timely receipt of injections; and
   c. Coordinates care activities among care providers for patients receiving long-acting injectable medications, vaccinations, and other injectable medications to ensure appropriate delivery of HIV healthcare services.
2. Participates in case conferences as needed.
3. Collaborates with the HIV clinic team, conducts health assessments as needed, documents interactions, and contributes to program evaluation.
4. Meets the following minimum qualifications:
   a. Must possess a current license to practice as a registered nurse (RN) issued by the State of California Board of Registered Nursing or be a pharmacist with a license issued by the California State Board of Pharmacy.
   b. Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.
   c. Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC.
5. Desirable Qualifications:
   a. Knowledge of HIV disease, behaviors that transmit HIV, and those disease conditions that are co-morbid with HIV;
   b. Ability to interact in a nonjudgmental and empathetic manner with PLWH and AIDS as well as their partners;
   c. Have good interpersonal skills;
   d. Comfortable with field outreach; and
   e. Ability to advocate for clients.

PART 2 – RESPONSES TO PROPOSER QUESTIONS

Pursuant to RFP Section 8.2, Proposers' Questions, answers to questions received by the September 17, 2024 deadline are being issued as part of this Addendum. Proposers are reminded that the County has the right to group similar questions when providing answers.

SECTION 2.0 – INTRODUCTION

Subsection 2.4.1, Location of Services

Q1. Where can we find a map with the County's health districts (HD)?

A1. Proposers may visit http://publichealth.lacounty.gov/dhsp/HealthDistricts.htm for information and maps regarding the County's health districts.

SECTION 4.0 – MINIMUM MANDATORY REQUIREMENTS

Subsection 4.1, MMRs for all Categories, Item 4, Service Delivery Site

Q2a. Should we enter all proposed service delivery sites for any category in Appendix B Exhibit 6 – Proposer's Minimum Mandatory Requirements?

A2a. Yes. All service delivery sites should be listed in Appendix B, Required Forms, Exhibit 6, Minimum Mandatory Requirements.

Q2b. For example, if we were to propose AOM and MCC at Site 1 and only MCC at Site 2, we should list both Sites 1 and 2 on the form.

A2b. See response A2a.

SECTION 8.0 – PROPOSAL REQUIREMENTS AND EVALUATION

Subsection 8.4, Preparation of the Proposal

Q3a. When submitting proposals do we submit individual packets for AOM, MCC, and PSS (or whatever we are applying for). For example, an individual Proposer's Title Page (*pg29* 8.4.1 Proposer's Title Page) for each category we apply for?

A3a. Each Proposer may only submit one proposal, whether applying for one or more service categories outlined in the RFP. Proposals must be clearly labeled with RFP title: "COUNTY OF LOS ANGELES, DEPARTMENT OF PUBLIC HEALTH REQUEST FOR PROPOSALS FOR **CORE HIV MEDICAL SERVICES FOR PERSONS LIVING WITH HIV, RFP #2024-008, CATEGORY 1, AOM SERVICES, SPA____, and HD ____** and/or **CATEGORY 2, MCC SERVICES , SPA____, and HD ____** and/or **CATEGORY 3, PS, SPA____ and HD ____**", with the name of the Proposer's organization on the front cover.

Q3b. Is there an example of a completed submission to see the formatting?

A3b. No. Samples are not available.

Subsection 8.4.4.2, Proposer's List of References (Section A.2)

Q4. What if agency does not have a total of five references for each service category (AOM, MCC, PSS)?

A4. Proposers must provide a total of five references, with at least one reference per service category to which a Proposer is responding.

Q5a. Do we need to summit 5 letters of support from other agencies that will support our RFP?

A5a. No. Proposers will be evaluated on the verification of references provided in Appendix B, Required Forms, Exhibit 8, List of References. The RFP does not request for letters of support.

Q5b. And if we do, can Division of HIV and STD Program (DHSP) provide us with a support letter?

A5b. DHSP staff can be provided as one of the five references. The RFP does not request letters of support.

Q6. Since we are able to list DHSP as one of the five references, who should we list as the DHSP Contact, Telephone, and E-mail?

A6. Proposers must decide the references provided in Appendix B, Required Forms, Exhibit 8, List of References. Proposers may list any DHSP contact as a for reference.

Q7. Are the five references in EXHIBIT 8 our own references meaning the programs that we have currently?

A7. Proposers must provide five references (i.e. LAC departments; contracts with other counties; government contracts; and/or grant funded services) where the same or similar scope of services sought by this RFP are currently or were previously provided.

Subsection 8.4.5, Proposal Required Forms and Corporate Documents (Section B)

Q8. When applying for more than one service category, is a set of the required documents required for each category?

A8. No. Proposers must only submit one set of the required forms and corporate documents whether applying for one or more service categories.

Q9. If our organization is not certified as a Community Based Enterprise, do we have to complete Exhibit 5?

A9. Yes. Proposers must submit all forms identified in Appendix B, Required Forms.

Subsection 8.4.6.3, Proposer's Staffing Plan (Section E)

Q10. Could you please clarify whether we should provide a single organizational chart per service delivery site that includes all service categories AOM Services, MCC Services, and PSS within the same chart, or if we should create separate organizational charts for each service program and service delivery site?

A10. Proposers must provide an organizational chart, per service delivery site, detailing the positions to be funded for AOM and/or MCC and/or PSS services.

Subsection 8.4.6.4, Proposed Budget and Budget Justification (Section F)

Q11. When reviewing the RFP packet and items needed for budgets, I only see the Appendixes (E-1 AOM, F-1 MCC, & G-1 PSS) listed on the Contracts and Grants Division website. Do we need to provide anything else for budget?

A11. Yes. For AOM Services, Proposers must submit Appendix E-1, Budget Worksheet. For MCC Services, Proposers must submit Appendix F-1, Budget Worksheet, and Appendix F-2, Budget Justification. For PSS, Proposers must submit Appendix G-1, Budget Worksheet, and Appendix G-2, Budget Justification.

SECTION 9.0 – SELECTION PROCESS OVERVIEW

Subsection 9.4, Stage 3: Final Review and Selection

Q12. How much "funding" is predicted to be allocated to an organization?

A12. Proposals will be evaluated by service category and ranked from highest to lowest score. Funding allocations will be based on service category, geographic area needs, and the availability of funding. Refer to RFP Section 9.4, Stage 3: Final Review and Selection, Subsection 9.4.2.

Q13. How many awards for each category do you anticipate making?

A13. See response A12.

APPENDIX A – SAMPLE CONTRACT

Q14. We intend to propose providing services at multiple locations. We don't see that formal scopes of work are required as part of the proposal. Will the standard service delivery site forms only be requested if the contract is awarded?

A14. The standard Service Delivery Form is required when the contract is awarded. Refer to Appendix A, Exhibit A, Statement of Work, Attachments 1, 2, and 3, for specific work requirements.

APPENDIX A, EXHIBIT A – STATEMENT OF WORK

Q15. What are the FTE requirements for the AOM, MCC, and PSS Program Managers and the MCC supervisor? Can some or all be combined?

A15. There are no full-time requirements for AOM, MCC and PSS Program Managers. The same Program Manager can provide oversight for all three categories. However, there is a full-time requirement for the MCC Supervisor. Refer to this Addendum, Part 1 Modifications to RFP, Number 3.

Attachment 1, AOM Services

Q16. What is the minimum number of patients required for AOM proposal?

A16. There is no minimum number of patients required.

Q17a. For AOM and PSS - is a "Clinical Nursing Support Specialist" (RN) role mandatory?

A17a. Yes. For AOM Services, Clinical Nursing Support Specialist role is mandatory. The Contractor is required to provide enhanced clinical nursing support, which must be performed by an RN or a licensed pharmacist.

No. For PSS, the role of a Clinical Nursing Support Specialist is not mandatory. PSS is designed to offer supplementary services that are not already available through the agency.

Q17b. If so, do we need to have a full-time RN?

A17b. For AOM Services, contractors are required to provide enhanced clinical nursing support, which must be performed by an RN or licensed pharmacist. Contractors are not required to have a full-time RN or licensed pharmacist but may determine a need for a full-time RN or full-time licensed pharmacist based on the needs of their clinic.

Q17c. The organization's clinic manager is an RN, can they serve this role using partial FTE to fulfill duties?

A17c. Yes.

Q18a. Will the RWP reimburse for services rendered while patient eligibility is established?

A18a. Yes.

Q18b. Will the RWP reimburse for services rendered if the patient fails to seek/enroll for other public/private health insurance options?

A18b. No. Contractors have 60 days to determine a client's eligibility for public or private health insurance coverage and assist with enrollment in all applicable public/private insurance programs. RWP will not reimburse for services after eligibility for public/private insurance has been determined. It is each contractor's responsibility to assist clients in enrolling in any public or private health insurance for which they are eligible. Refer to this Addendum, Part 1 Modifications to RFP, Number 2.

Attachment 2, MCC Services

Q19a. The RFP lists the MCC team leader as a required position. Can the team leader also be the Program Manager?

A19a. No. The MCC Program Manager cannot serve as a MCC Supervisor (Team Leader).

Q19b. Can a team leader provide oversight of multiple MCC sites?

A19b. Yes. The MCC Supervisor (Team Leader) can provider oversight of multiple sites.

Q19c. Can they cover MCC position that are temporarily vacant?

A19c. The MCC Team Supervisor (Team Leader) may cover vacant positions for up to three months, provided they meet the minimum qualifications for the roles.

Q20a. Regarding the MCC Team Supervisor, there were multiple questions and answers about the Team Supervisor position, but we wanted to ask some of these again to make sure we had a clear understanding. Can the same person fulfill both the MCC Team Supervisor and MCC Program (Project) Manager positions?

A20a. See response A19a.

Q20b. If one person is fulfilling both roles, what is the maximum percentage of that person's salary that could be covered by direct funds?

A20b. See response A19a.

Q20c. Can the Team Supervisor, within their scope of practice, "cover" open positions (Medical Care Manager (MCM), Patient Care Manager (PCM), Case Worker (CW)) during staffing vacancies?

A20c. See response A19c.

Q20d. Can a Team Supervisor cover multiple sites? Or does each site need its own Team Supervisor?

A20d. See response A19b.

Q21a. May the MCC supervisor and the MCC program (project) manager be the same person?

A21a. See response A19a.

Q21b. Could MCC include a part-time pharmacy consultant to improve adherence to antiretroviral therapy medications?

A21b. No. A part-time pharmacy consultant may not be included as part of the MCC team.

Q22a. Can the MCC Program (Project) Manager and the PSS Program (Project) Manager be the same person?

A22a. Yes. The same individual can fulfill the MCC Program (Project) Manager and PSS Program (Project) Manager roles.

Q22b. If one person fulfilled the MCC Program (Project) Manager, PSS Program (Project) Manager, and MCC Team Supervisor roles, what is the maximum percentage of that person's salary that could be covered by direct funds?

A22b. The maximum allocation percentage of that person's salary will be established during contract negotiations.

Q23a. How do we determine whether to enroll a client in MCC or with a PSS social worker?

A23a. Clinical decision making should be utilized to determine whether a client is referred to MCC or PSS Social Worker.

Q23b. Can both services be provided to a client?

A23b. There is nothing that precludes a patient being referred to PSS and MCC, if clinically eligible for MCC. PSS services are not mandatory. PSS is intended to provide clients with supportive services that are not already offered by the contractor.

Q23c. Same question for Housing Specialist vs. agency's Housing Department Housing Specialists.

A23c. If a Proposer already has an available Housing Specialist, they do not have to apply for a Housing Specialist under this RFP. PSS services are not mandatory. PSS is intended to provide clients with supportive services that are not already offered by the contractor.

Q24. There seems to be an emphasis on field capabilities for all MCC roles. If the Retention Outreach Specialist (ROS) and or Data 2 Care is conducting field outreach, what other activities does DHSP expect MCC to complete in the field?

A24. For MCC, Personnel (MCM, PCM, CW) can perform home visits or do other field outreach as needed on a case-by-case basis. Refer to Appendix A, Exhibit A, Statement of Work, Attachment 2, MCC Services, Subsection 2.2.2, MCC Services Team Staffing Requirements, Items B, C, and D.

Q25. Under current MCC guidelines, a client who is assessed a[s] self-managed and who has no High or Severe needs would not require an integrated care plan. Would that continue to be the directive?

A25. This directive will be established in the MCC Guidelines which will be provided to successful Proposers.

Attachment 3, PSS

Q26. What commission standard will be used for PSS?

A26. Specific standards for PSS are not yet developed.

Q27a. This is covered by another RWP service category that is subject to payer of last resort requirement, so what is the difference?

A27a. [This question is related to the PSS service category] Applying for PSS is optional, not mandatory. PSS provides proposers the opportunity to select specialists from the list provided in the RFP to provide services at their respective programs. These specialists can offer services not currently available through the Proposer's program. If a Proposer already has similar positions funded through other contracts, they will not need to apply for those same specialist positions through PSS, as they are already covered under a different RWP contract.

Q27b. Will services under PSS by Social Worker (SW) are not subject to payer of last resort requirement?

A27b. [DHSP understand this question as related to payer of last resort and is answering as such] Since PSS is an RWP-funded service, all proposers funded to provide PSS must adhere to RWP regulations and guidelines, including the payer of last resort requirement.

Q28. For the PSS category, can the responsibilities of the "benefits and retention specialist" be assigned to one person who receive partial FTE for each position?

A28. Yes, the responsibilities of the Retention Outreach Specialist and the Benefits Specialist can be assigned to one individual who receives partial FTE for each role, as long as they meet the minimum qualifications for both positions.

Q29. The ROS role has been split off the MCC team and moved over to the PSS SOW. What is the reasoning behind that?

A29. PSS staff are intended to offer support to clients who need more specialized assistance than what MCC can offer and/or for clients not enrolled in MCC. PSS staff work closely with AOM and MCC providers/staff to identify clients who would benefit from these services. The ROS integrates with other HIV clinic team members to effectively identify, locate, and re-engage clients who have lapsed in their HIV care.

Q30a. Regarding the PSS SW: We're unclear if the PSS SW can work with MCC Teams to help clients or if the PSS SW should only work with clients that are not or cannot be enrolled in MCC at their medical home. What is the relationship between the PSS SW and the MCC Team?

A30a. PSS SWs should collaborate with MCC teams. Clinical decision making should be utilized to determine whether a client is referred to MCC or a PSS SW.

Q30b. How do we determine when to refer to PSS SW or to other PSS services?

A30b. PSS SWs should collaborate with MCC teams. The decision to refer a client to MCC or a PSS SW should be based on clinical judgment determined during these collaborations.

Q31a. What is the role of the benefits specialist?

A31a. Refer to Appendix A, Exhibit A, Statement of Work, Attachment 3, PSS, Subsection 2.2.2., PSS Staffing Requirements, Item C, Benefits Specialist (BS).

Q31b. Is this core service provided by benefits specialist meant to replace the BSS program services?

A31b. No. Core services provided by Benefits Specialists are not intended to replace Benefits Specialty Services. The Benefits Specialist position within PSS is optional. It is up to each contractor to determine the type and number of support specialists to include in their PSS teams.

Q32. It was confirmed at the Proposer's Conference that the PSS Housing Specialists would be able to submit Housing Opportunities for Persons with AIDS (HOPWA) applications, but we're not sure how that would work. Is there an expectation that agency's Housing would assign an existing Housing Specialist (HS) to this role in some way?

A32. Applying for PSS is optional, not mandatory. PSS allows Proposers the opportunity to select specialists from the list provided in the RFP to enhance their programs by offering services that may not be available through their current resources. If a Proposer already

has similar positions funded through other contracts, they do not need to apply for those same specialist positions through PSS, as they are already covered under a different RWP contract. Proposers should determine how to staff this role based on the needs of their clients.

Q33. How will productivity goals be calculated for PSS staff at each site?

A33. Productivity goals will be established during contract negotiations.

Q34 Can PSS staff cover multiple sites?

A34. Yes. PSS staff can cover multiple sites.

Q35. If a patient refuses either an MCC or PSS SW assessment and care plan, can they still be linked to any of the other PSS services (Benefits, Housing, etc.)?

A35. Yes. A patient who refuses either an MCC or PSS SW assessment and care plan can be linked to other PSS services.

Q36a. Do Proposers need to request all positions listed in the PSS Statement of Work?

A36a. No. Proposers do not need to request all positions listed in the PSS Statement of Work.

Q36b. Do Proposers have the option to apply for funding to positions to supplement AOM/MCC services (e.g., substance use disorder (SUD), housing, benefits, ROS, Clinical Nutrition Specialist)?

A36b. Some of the positions listed in this question are part of the PSS category. If a Proposer wants to provide those services, the Proposer can apply to the PSS category in response to the RFP. Clinical nutrition specialist is not part of PSS.

Q36c. How do the services offered by PSS SW differ from those offered under the RWP Mental Health Services contracts?

A36c. PSS are not mandatory. They are intended to provide the Proposer with supportive services that are not already offered by the Proposer. If a Proposer already has available Mental Health Specialists, they do not need to apply for a Mental Health Specialist under this RFP.

Q36d. Are the counseling and psychotherapy services offered by the PSS SW subject the payor of last resort requirements?

A36d. Yes. Counseling and psychotherapy services offered by the PSS SW are subject to payer of last resort requirements.

Q36e. Are the services offered by the SUD subject to the payor of last resort requirements?

A36e. All RWP services are subject to payer of last resort requirements.

Q36f. Could the clinical nursing support person who manages long acting injectables be a pharmacist?

A36f. Yes. The clinical nursing support person who manages long acting injectables can be a pharmacist. Refer to this Addendum, Part 1 Modifications to RFP, Number 5.

Q36g. Could the PSS SW be a Licensed Marriage and Family Therapist?

A36g. Yes. The PSS SW can be a Licensed Marriage and Family Therapist. Refer to this Addendum, Part 1 Modifications to RFP, Number 4.

Q37. If an agency chooses not to budget for a PSS staff position (e.g. Peer Navigator) is there an expectation that the position's role would have to be fulfilled by another agency?

A37. No. There is no expectation that the position's role would have to be fulfilled by another agency.

APPENDIX H – PROPOSER'S BACKGROUND AND EXPERIENCE

Q38. On the Proposer's Background and Experience Worksheet (Section C) on pg. 274 of the RFP, it asks for the "total number of HIV positive clients agency saw in its HIV medical clinic in 2023." Does this refer to only medical clients or ALL clients that received a service during 2023?

A38. This only refers to medical clients.

Pursuant to RFP, Subsection 5.4, County's Right to Amend Request for Proposals, Proposers are reminded that if this addendum requires additional information not previously requested, failure to address the requirements of this 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. This Addendum Number 1 has been made available on the Public Health Contracts and Grants website at http://publichealth.lacounty.gov/cg/index.htm and on the County's website at http://camisvr.co.la.ca.us/lacobids/BidLookUp/BidOpenStart.asp.

The recording of the Proposers' Conference and a copy of the Power Point Presentation have been made available on the Public Health DHSP website at http://publichealth.lacounty.gov/dhsp/DoingBusinessWithDHSP.htm

Thank you for your interest in contracting with the County of Los Angeles. Except for the revisions contained in this Addendum Number 1, there are no other revisions to the RFP. All other terms and conditions of the RFP remain in full force and effect.