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ADDENDUM NUMBER 2
TO
REQUEST FOR PROPOSALS NO. 2024-014
FOR
COMPREHENSIVE HIV AND STD PREVENTION SERVICES
IN LOS ANGELES COUNTY

On December 3, 2024, the County of Los Angeles (County) Department of Public Health (Public Health) released a Request for Proposals (RFP) for Comprehensive HIV and STD Prevention Services in Los Angeles County.

This Addendum Number 2 is being issued to make modifications to the RFP.

This 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 2 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 2.2, Comprehensive HIV and STD Prevention Services (Prevention Services), is amended as follows:

   2.2 Comprehensive HIV and STD Prevention Services (Prevention Services)

   Prevention Services funded through this solicitation may complement a contractor's existing HIV and STD Prevention Services. Categories for this RFP are listed below:

   - Category 1: Clinic-Based Prevention Services - Comprehensive

HIV and STD Testing, Screening, and Treatment in Clinic-Based Settings;

- Category 2: Non-Clinic-Based Prevention Services - HIV Testing and Linkage to HIV Treatment and Linkage to STD Screening, and Treatment in Non-Clinic-Based Settings; and
- Category 3: High Impact Prevention Programs (HIPP).

NOTE: PROPOSERS ARE PERMITTED TO APPLY TO EITHER CATEGORY 1 OR CATEGORY 2, BUT NOT BOTH. TO BE ELIGIBLE TO APPLY FOR CATEGORY 3, PROPOSERS MUST APPLY AND QUALIFY FOR EITHER CATEGORY 1 OR CATEGORY 2.

Category 1: Clinic-Based Prevention Services
Selected contractor(s) will provide:

- HIV testing, as well as linkage to medical care for those diagnosed with HIV;
- STD testing, as well as screening and treatment for those diagnosed with one or more STD(s);
- Prevention navigation services, including providing linkage to resources and care, for individuals at high risk of STDs and HIV infection;
- Biomedical services, including access to pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and Doxycycline Post- Exposure Prophylaxis (DoxyPEP);
- Patient-delivered partner therapy (PDPT); and
- Benefits screening.

Services must be provided in licensed medical clinics or affiliated satellite locations convenient to the targeted population(s). Services must target individuals at high risk for HIV infection in Los Angeles County (LAC), with an emphasis on:

- MSM;
- Transgender persons;
- Cisgender women of color;
- African American persons of all ages;
- Latinx persons of all ages;
- American Indian/Alaskan Native persons of all ages;
- Youth and young adults (under 30 years of age);
- Persons who use/inject drugs (PWUID); and
- Persons aged 50 and older.

Category 2 - Non-Clinic-Based Prevention Services

Selected contractor(s) will provide:

- HIV testing, documented and confirmed linkage to medical care for those diagnosed with HIV;
- Documented and confirmed linkage to STD, screening, and treatment, as needed;
- Biomedical prevention navigation services for individuals at high risk of STD and/or HIV infection, including access to PrEP, PEP, and DoxyPEP; and
- Benefits screening.

Services must be offered in non-clinic-based settings with drop-in availability that ~~are~~ is convenient for the targeted population(s) served. DHSP funds allocated to Category 2: Non-Clinic-Based Prevention Services may not be used to cover lab costs associated with the processing of specimens for STD screening. Services must target individuals at high risk for HIV infection in LAC, with an emphasis on:

- MSM;
- Transgender persons;
- Cisgender women of color;
- African American persons of all ages;
- Latinx persons of all ages;
- American Indian/Alaskan Native persons of all ages;
- Youth and young adults (under 30 years of age);
- PWUID; and
- Persons aged 50 and older.

High Impact Prevention Programs (HIPP)

High Impact Prevention Programs (HIPP) are intended to supplement Clinic-Based Prevention Services and Non-Clinic-Based Prevention Services. Contractor can select up to ~~two~~ three of the following prevention supportive services to enhance prevention activities conducted as a part of Clinic-Based or Non-Clinic-Based Services:

1. **Social connectedness:** Facilitate social gatherings or events that promote interpersonal communication and encourage relationship building.

2. **Job skills development/job training:** Conduct job skills development and training sessions to equip individuals with essential skills for the workforce.

3. **Financial literacy:** Educate individuals on financial literacy to help them understand and manage their finances effectively.

4. **Educational/English as a Second Language classes:** Teach educational classes, including English as a Second Language, to enhance language proficiency and learning opportunities.

5. **Contingency management:** Implement contingency management strategies to motivate positive behavior changes.

6. **Emergency Housing/hotel vouchers:** Distribute emergency housing and/or hotel vouchers to provide immediate shelter for individuals in crisis situations.

Services must be ~~provided~~ offered in a location ~~(~~with drop-in ~~service)~~ availability that ~~are~~ is convenient ~~to~~ for the targeted population(s). Services must target individuals at high risk for STD and/or HIV infection in LAC, with an emphasis on the following target populations:

- African American and Latinx MSM with emphasis on young MSM (YMSM);
- Transgender persons with emphasis on transgender women;
- Cis-gender women experiencing homelessness, who use/inject drugs or have experienced intimate partner violence;
- PWUID with emphasis on opioids and/or stimulants; and
- Youth and young adults (under 30 years of age).

2. RFP, Section 2.4, Program and Technical Requirements, Subsection 2.4.1, Location of Services, is amended as follows:

2.4.1 Location of Services

To ensure that services are available and accessible to individuals at high-risk for HIV infection in LAC, DHSP is prioritizing services provided in Health Districts (HD) with high HIV/STD morbidity. Proposers must indicate in the Proposal in which HD and Service Planning Area (SPA) within the County the Proposer's services will be provided. Proposers may visit http://publichealth.lacounty.gov/dhsp/HealthDistricts.htm to determine HD location and http://gis.lacounty.gov/districtlocator /to determine SPA location.

Below are the areas DHSP has identified as having high HIV/STD morbidity:

Tier 1 - HDs experiencing high HIV and/or syphilis morbidity:

1. Hollywood/Wilshire (HD 34)
2. Central (HD 9)
3. Southeast (HD 72)
4. South (HD 69)
5. Southwest (HD 75)

Tier 2 - ~~DHs~~ HDs experiencing high HIV and/or syphilis morbidity:

1. Northeast (HD 47)
2. Inglewood (HD 37)
3. East Valley (HD 19)

3. RFP, Section 8.4, Preparation of the Proposal, is amended as follows:

8.4 Preparation of the Proposal

Proposals must be submitted electronically in one volume, in the prescribed format and order outlined below. Any proposal that deviates from this format may be rejected as non-responsive without review at the County's sole discretion.

1. Proposal must be typewritten in English, with no less than 11-point font on 8½" by 11" paper, with the 8½" ends of the paper as the top and bottom of the page, and 1" margins. Tables and figures may have no less than 9-point font. The footer on each page must include Proposer's name.

2. Proposal pages must be numbered sequentially including attachments, from beginning to end, and provide a complete Table of Contents for the proposal and its attachments, to ensure there are no duplicate or missing pages.

3. Proposals must be organized by applicable parts and/or sections, with proper titles, and in the correct order as described herein. The narrative of the proposal, where indicated, must not exceed the page limits identified in Paragraph 8.5 (Proposal Format) below. Any pages beyond the allotted page limits will not be read or scored.

4. Proposals must be clearly labeled with RFP title: "COUNTY OF LOS ANGELES, DEPARTMENT OF PUBLIC HEALTH REQUEST FOR PROPOSALS FOR COMPREHENSIVE HIV and STD PREVENTION SERVICES (RFP #2024-014) CATEGORY 1, CLINIC-BASED PREVENTION SERVICES, SPA, and HD or CATEGORY 2, NON-CLINIC-BASED PREVENTION SERVICES, SPA, and HD and CATEGORY 3, HIGH IMPACT PREVENTION PROGRAMS" as

applicable, with the name of the Proposer's organization on the front cover.

5. Other than the attachments specified in this RFP, no other exhibits or attachments should be submitted with the proposal.

Proposal Format:

Proposers are required to respond to all sections of this RFP, including each sub-section, if applicable. The sequence of the proposal must be as follows and include content as described in further detail below:

1. Title Page
2. Cover Letter
3. Table of Contents
4. Proposer's Qualifications (Section A)
   a. Proposer's Adherence to Minimum Mandatory Requirements (Section A.1)
   b. Proposer's List of References (Section A.2)
   c. Proposer's Debarment History and List of Terminated Contracts (Section A.3)
   d. Proposer's Financial Capability (Section A.4)
   e. Proposer's Pending Litigation and Judgements (Section A.5)
   ~~d. Proposer's Pending Litigation and Judgments (Section A.4)~~
   ~~e. Proposer's Financial Capability (Section A.5)~~
5. Proposal Required Forms and Corporate Documents (Section B)
6. Proposer's Background and Experience ~~and Appendix E~~ (Section C)
7. Proposer's Approach to Provide Required Services (Section D)
8. Proposer's Staffing Plan (Section E)

4. RFP, Section 8.4, Preparation of the Proposal, Subsection 8.4.6.2, Proposer's Approach to Providing Required Services (Section D), is amended as follows:

8.4.6.2 Proposer's Approach to Providing Required Services (Section D) (850 possible points for each service category)

If a Proposer is applying for Category 3 in additional to Category 1 or Category 2, the Proposer must provide a **separate "Section D" for each service category being proposed**. Proposers must answer the question(s) relevant to the category(ies) for which the Proposer is responding to. Question 1 is for Category 1: Clinic-Based Prevention Services. Question 2 is for Category 2: Non-Clinic-Based Prevention Services. Question 3 is for Category 3: HIPP services.
Proposers must provide a narrative explaining their approach to required services for each respective category being applied for in this RFP:

1. Proposer's Approach to Category 1: Clinic-Based Prevention Services (Page Limit: 10 Pages)

Provide a narrative describing how Prevention Services will be performed to meet the requirements outlined in Exhibit A (SOW) and Attachment I of Appendix A (Sample Contract).

i. Proposer's narrative must address the following:

a. List LAC SPA(s) and HD(s) where Proposer intends to provide Prevention Services (reference Section 2.4.1 Location of Services).

1. How will services be tailored to the unique needs of each identified area?

b. Number of clients Proposer intends to serve per clinic location. Proposer's narrative must describe:

1. Each clinic's testing capacity.
2. Any discrepancies between this capacity and the clinic's most recent 12 month testing performance.
3. How does the current testing capacity compare to community needs?
4. How would Proposer scale up testing capacity if needed?

c. How will Proposer recruit individuals at highest risk for acquiring and/or transmitting HIV and STDs in LAC for testing and/or screening?

1. What specific strategies will be employed to engage each high-risk target population (e.g., MSM, people who use drugs)?

2. How will the effectiveness of these recruitment strategies be measured and adjusted?

d. How will Proposer identify and recruit individuals who have never utilized Prevention Services?

1. What outreach methods will be used to reach individuals who have not previously engaged in Prevention Services?

2. How will Proposer address barriers to accessing Prevention Services, including stigma, unawareness of services, financial and geographic challenges, fragmented healthcare, fear of diagnosis, language barriers, immigration status, and psychosocial factors?

3. How will Proposer track the effectiveness of recruitment efforts and ensure retention in the Prevention Services program?

4. What procedures will be in place to follow up with clients who may be at risk of falling out of care?

e. What follow-up procedures has Proposer established for clients who test positive HIV and/or STDs?

1. What strategies will be employed for confirmatory testing if initial HIV test is positive?

~~1.~~ **2.** What strategies will be employed to ensure linkage to care for newly diagnosed HIV patients?

~~2.~~ **3.** How will Proposer increase uptake and adherence to biomedical prevention methods (e.g., PrEP)?

f. What role will telehealth play in enhancing the accessibility and effectiveness of Proposer's counseling and prevention navigation efforts?

1. How will telehealth services be integrated into the overall prevention and testing strategy?

2. How will telehealth capabilities be expanded to support Prevention Services?

g. How will DHSP funding be utilized to enhance existing HIV and STD Prevention Services, and what specific improvements or expansions can be expected?

1. How will funding from DHSP supplement existing revenue sources that already support HIV, STD Prevention Services?

2. What specific aspects of service delivery will be enhanced or expanded with DHSP funding?

h. How will Proposer implement the following activities with existing funding or with funding from DHSP:

1. HIV testing and linkage to treatment;
2. STD (including syphilis, chlamydia, gonorrhea, trichomoniasis) screening, diagnosis, and treatment;
3. PrEP (oral and long-acting injectable), PEP, and DoxyPEP navigation;
4. PDPT;
5. Benefits screening and
6. Access to vaccines related to sexual health, including, but not limited to: Mpox, Hepatitis A, Hepatitis B, Meningitis, and Human Papilloma Virus (HPV).

2. Proposer's Approach to Category 2: Non-Clinic-Based Prevention Services (Page Limit: 10 Pages)

Provide a detailed narrative describing how Prevention Services will be performed to meet the requirements outlined in Exhibit A (SOW) and Attachment II of Appendix A (Sample Contract).

i. Proposer's summary must address the following:

a. List LAC SPA(s) and HD(s) where Proposer intends to provide Prevention Services (reference Section 2.4.1 Location of Services).

1. How will services be tailored to the unique needs of each identified area?

b. Number of clients Proposer intends to serve per service location. Proposer's narrative must describe:

1. Each location's testing capacity.
2. Any discrepancies between this capacity and the location's most recent 12 month testing performance.
3. How does the current testing capacity compare to community needs?
4. How will Proposer scale up testing capacity if needed?

c. How will Proposer recruit individuals at highest risk for acquiring and/or transmitting HIV and STDs in LAC?

1. What specific strategies will be employed to engage each high-risk population (e.g., MSM, people who use drugs)?

2. How will the effectiveness of these recruitment strategies be measured and adjusted?

d. How will Proposer identify and recruit individuals who have never utilized Prevention Services?

1. What outreach methods will be used to reach individuals who have not previously engaged in Prevention Services?

2. How will Proposer address barriers to accessing Prevention Services, including stigma, unawareness of services, financial and geographic challenges, fragmented healthcare, fear of diagnosis, language barriers, immigration status, and psychosocial factors?

3. How will Proposer track the effectiveness of recruitment efforts and ensure retention in the Prevention Services program?

4. What procedures will be in place to follow up with clients who may be at risk of missing appointments or not completing necessary testing follow-up?

e. What follow-up procedures has Proposer established for clients who test positive HIV and/or STDs?

1. What strategies will be employed for confirmatory testing if initial HIV test is positive?

~~1.~~ **2.** What strategies will be employed to ensure linkage to care for newly diagnosed HIV patients?

~~2.~~ **3.** How will Proposer increase uptake and adherence to biomedical prevention methods (e.g., PrEP)?

f. How will DHSP funding be utilized to enhance existing HIV and STD Prevention Services, and what specific improvements or expansions can be expected?

1. How will funding from DHSP supplement existing revenue sources that already support HIV and STD Prevention Services?

2. What specific aspects of service delivery will be enhanced or expanded with DHSP funding?

g. How will Proposer implement the following activities with existing funding or with funding from DHSP:

1. HIV testing, counseling and linkage to treatment;
2. STD documented linkage to testing, screening and treatment;
3. Outreach to communities at risk for HIV and STDs;
4. PrEP (oral and long-acting injectable),

PEP, and DoxyPEP navigation; and

5. Benefits screening.

3. Proposer's Approach to Category 3: HIPP Services (Page Limit: 10 Pages)

Provide a detailed narrative describing how Proposer's HIPP Services program has been designed to enhance HIV/STD testing and related services within the organization in order to meet the requirements outlined in Exhibit A (SOW) and Attachment III of Appendix A (Sample Contract).

i. Proposer's summary must address the following:

a. List LAC SPA(s) and HD(s) where Proposer intends to provide HIPP Services (reference Section 2.4.1 Location of Services).

1. How will services be tailored to the unique needs of each identified area?

b. Number of clients Proposer intends to serve per service location.

1. What are the projected client demographics (age, gender, risk factors) for each service location?

2. How will Proposer adjust service delivery based on variations in client needs across different locations?

c. How will Proposer's HIPP services be tailored to meet the needs of individuals at the highest risk for acquiring and/or transmitting HIV and STDs? Proposer's approach should specifically address one or more of the target populations:

1. African American and Latinx MSM, with a specific emphasis on YMSM
2. Transgender individuals, with a particular focus on transgender women

3. Cisgender women experiencing homelessness, who use or inject drugs, or who have experienced intimate partner violence;
4. Persons who use or inject drugs, particularly opioids and/or stimulants; and
5. Youth and young adults (under 30 years of age).

d. How will Proposer address barriers to accessing Prevention Services, including stigma, unawareness of services, financial and geographic challenges, fragmented healthcare, fear of diagnosis, language barriers, immigration status, and psychosocial factors?

1. How will Proposer implement solutions to overcome identified barriers?

e. How will Proposer's HIPP Services complement testing programs and address the various sociocultural, environmental, and economic challenges faced by individuals at high risk of STDs and HIV infection in LAC? Proposer should describe the HIPP interventions Proposer plans to provide. Proposer can select up to ~~two~~ three of the following prevention supportive services to supplement and enhance prevention activities conducted as a part of Category 1 (Clinic-Based Prevention Services) or Category 2 (Non-Clinic-Based Prevention Services):

1. Social connectedness
2. Job skills development/job training
3. Financial literacy
4. Educational/English as a Second Language classes
5. Contingency management
6. Emergency housing/hotel vouchers

f. How will Proposer's HIPP Services foster linkage to PrEP, PEP, and DoxyPEP services as well as general medical care, housing, mental health, substance use, an/or legal services, in addition to similar social services?

1. How will HIPP Services be integrated into overall care and prevention efforts?

2. What specific resources will be provided to clients to support linkage to comprehensive care?

g. How will Proposer ensure that target populations remain engaged and in care over time?

h. What mechanisms will be used to engage the target populations in the development and continuous improvement of Proposer's HIPP Services?

1. How will feedback from clients be solicited and incorporated into service delivery improvements?

2. What role will community advisory boards or similar groups play in shaping and refining services?

i. What methods will be used to evaluate the effectiveness of Proposer's HIPP Services?

1. What criteria will be used to assess the impact of these supportive services?

j. What is Proposer's approach to implementing Community Advisory Boards (CAB), including how the following key areas will be addressed (reference Section 3.2 of Attachment III of Appendix A, Sample Contract).

1. How will Proposer provide administrative and technical support to CAB members during and between meetings?

2. What specific strategies will Proposer employ to recruit and maintain a diverse CAB membership that meets the specified criteria (including co-chairs, residency, and community representation)?

3. How will Proposer ensure that a majority of CAB members reflect the community Proposer's program intends to serve? What criteria will guide Proposer's selection process?

4. Describe Proposer's approach to scheduling and promoting CAB meetings. What methods will be

used to ensure high attendance and engagement from community members?

5. What systems will Proposer implement to maintain thorough documentation of CAB activities, including membership, meeting dates, minutes, and bylaws?

6. How will Proposer ensure timely dissemination of CAB minutes and other documents to all relevant stakeholders within seven business days after meetings?

7. Which specific client input mechanisms (e.g., satisfaction surveys, focus groups) will Proposer implement through the CAB, and how will Proposer utilize the results to inform services?

8. What ongoing strategies will Proposer use to collaborate with the CAB to continually inform and improve interventions? How will Proposer ensure that CAB feedback is integrated into program planning and implementation?

5. Appendix A, Sample Contract, Exhibit A, Statement of Work, Attachment I, Category 1: Clinic-Based Prevention Services, Section 2.0 Responsibilities, Subsection 2.2.1 Contractor's Medical Director, is amended as follows:

2.2.1 Contractor's Medical Director

A. Contractor must identify a Medical Director and designated alternate within 30 Days of Contract execution. The Medical Director ~~must~~ may be the same individual identified as Contractor's Project Manager assuming all roles described in section 3.2 of the Statement of Work, as well as listed below. The Medical Director must be ~~appropriately trained and~~ knowledgeable and demonstrate a high level of competency with respect to HIV testing and STD screening and treatments.

Responsibilities of the Medical Director include, but are not limited to:

1. Participate in quarterly Medical Advisory Committee meetings held by DHSP;

2. Provide leadership and oversight for HIV and STD clinical services, ensuring high-quality care and adherence to clinical guidelines and contractual requirements;
3. Develop and implement policies and protocols for the prevention, testing, treatment, and management of HIV and STDs;
4. Monitor and evaluate clinical outcomes, patient satisfaction, and service delivery, implementing quality improvement initiatives as needed;
5. Collaborate with other healthcare and social services providers, and community organizations, to enhance integrated care for patients; and
6. Advocate for resources and policies that support the needs of clients with HIV and STDs.

B. Minimum Qualifications:

Must be a medical provider (Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner, or Physician Assistant) licensed in the State of California.

6. Appendix A, Sample Contract, Exhibit A, Statement of Work, Attachment I, Category 1: Clinic-Based Prevention Services, Section 3.0 Specific Work Requirements, Subsection 3.3 HIV Risk Assessment and Counseling, is amended as follows:

3.3 HIV Risk Assessment and Counseling:

Contractor must conduct an HIV risk assessment and when appropriate, a counseling session ~~(when appropriate)~~ for clients identified as needing a high-risk intervention.

3.3.1 Conduct an HIV risk assessment that assists clients in identifying the risk behaviors that place them at risk for HIV/AIDS.

3.3.2 As needed, provide a client-centered counseling session that engages the client in a dialogue that encourages the disclosure of unique individual needs and concerns related to HIV risk and emphasizes personal options that limit or prevent transmission of HIV. The client-centered counseling session should accomplish the following:

a. Improve the client's self-perception of risk;
b. Support behavior change previously accomplished or attempted by the client;

c. Negotiate a workable short-term and long-term risk reduction plan based on the client's perceived ability to change their behavior;
d. Support informed decision-making about whether to be tested; and
e. Review the nexus between HIV and STD infections and between alcohol and drug use; and
f. For clients who choose a rapid test, Contractor staff will assess client's potential reaction to receiving a reactive rapid test prior to administering the test.

During these sessions, Contractor must provide the following information:

g. The process related to each of the testing options, such as how the test is done, duration of the process, the timeframes for getting results, the meaning of test results including preliminary results in the case of rapid HIV testing; and

h. Relevant information regarding the window period*.

*Contractor staff must clearly explain that the rapid HIV test only refers to obtaining results from the time between exposure (less than three months) and their last non-reactive test. Clients must be counseled to re-test three months from the potential exposure.

If a client decides to have a rapid test, Contractor staff will:

i. Ensure that the client understands the meaning of test results, including that a reactive preliminary positive result requires confirmatory testing;
j. Ensure that the client completes a DHSP-approved consent form (for confidential testing) signed by the client and maintained in the client's file in accordance with the California Code of Regulations. The consent form must also include a commitment by the client for the collection of a second specimen (serum or oral fluid) for individuals testing preliminary positive;
k. Follow local guidelines and recommendations pertaining to HIV counseling and testing, HIV rapid testing, and phlebotomy (both venipuncture and finger stick). Contractor staff will collect client demographic information using the designated reporting form as provided by DHSP. All information reported on the approved HIV Test Reporting Form(s) must be voluntarily disclosed by the client;
l. Ensure that a sufficient amount of specimen is collected to allow for initial, repeat, and supplemental HIV antibody tests. All non-

rapid specimens must be delivered to and processed by a State-approved laboratory, with prior approval from DHSP;

m. Review the client's Counseling Information Form, provided by DHSP, before the disclosure; ~~and~~
n. Disclose the result, interpret the test result, and assess the client's emotional state~~*~~. Contractor staff must evaluate counseling needs, client's understanding of the test results, client's need to be re-tested based on the window period, and the client's understanding of and commitment to risk reduction guidelines as well as the strength of social support and plans for and consequences of disclosure to others. Test results must be given in person only to the client and in accordance with applicable law~~;~~.

~~*For clients testing HIV-positive, a minimum of 45 minutes must be allocated to the disclosure counseling session and the following additional topics must be covered and conducted in the disclosure session:~~

o. Importance of HIV medical care to optimize one's health and the likelihood of a normal life expectancy with adherence to medications;
p. Information regarding the past or future risk of HIV transmission to sexual and drug using partners, the risk of transmission to the fetus or newborn during pregnancy, during labor and delivery, and during postpartum period;
q. The active elicitation of past sexual and drug using partners and descriptive contact information and/or linkage to Partner Services (PS); and
r. A written assessment of the client's reaction to the positive HIV test result to determine whether referral for psychosocial support services is needed.

7. Appendix A, Sample Contract, Exhibit A, Statement of Work, Attachment I, Category 1: Clinic-Based Prevention Services, Section 3.0 Specific Work Requirements, Subsection 3.10 Conduct Patient-Delivered Partner Therapy (PDPT), is amended as follows:

3.10 Conduct Patient-Delivered Partner Therapy (PDPT):

3.10.1 Contractor must ensure that exposed sex partners of patients diagnosed with STD(s) have access to STD treatment through PDPT.

3.10.2 Pursuant to applicable law, including California Health and Safety Code section 120582 (a), Contractor's clinical staff must provide

medication to the diagnosed patient, who in turn can deliver the medication to their sex partner(s), when clinically appropriate.

3.10.3 Contractor must adhere to all up-to-date laws, regulations, and guidelines of the State of California related to PDPT and EPT. PDPT and EPT guidance for medical providers in California can be accessed through the California Department of Public Health at: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/ClinicalGuidelines_CA-STD-PDPT-Guidelines.pdf and Expedited Partner Therapy (EPT) for STIs – What is EPT and Why should I Prescribe it?

~~**3.10.4** Contractor must be an Essential Access Health Network provider. For more information please visit (https://www.essentialaccess.org/pdpt).~~

8. Appendix A, Sample Contract, Exhibit A, Statement of Work, Attachment II, Non-Clinic-Based Prevention Services, Subsection 2.2.1, Prevention Services Counselor, is amended as follows:

2.2.1 Prevention Services Counselor

A. Contractor will have at least one certified HIV Counselor to conduct HIV testing and linkage to STD screening and treatment.
B. Responsibilities include but are not limited to:

1. Conduct HIV testing, ensuring accurate results and maintaining confidentiality;
2. Provide pre-test counseling to educate clients about the testing process, risk factors, and the implications of testing and only provide for repeat clients as needed;
3. Deliver ~~post-~~test results in a supportive manner, providing emotional support and guidance based on the outcome;
4. Assist clients in navigating the healthcare system to access necessary treatment and support services, including referrals to medical providers;
5. Provide a documented linkage to STD screening and treatment, as needed;
6. Maintain accurate records of client interactions, test results, and referrals in compliance with rules and regulations;
7. Conduct follow-up calls or appointments to check on clients, address any concerns, and reinforce the importance of continued care and prevention; and
8. Participate in outreach activities to promote testing services and raise awareness about HIV and STDs in the community.

C. Minimum Qualifications:

1. High School Diploma (or GED equivalent); AND
2. Three years of relevant experience including any specialized training in providing HIV and STD services.

D. Desired Qualifications:

1. Strong interpersonal and communication skills;
2. Ability to build trust with clients, demonstrate empathy, and provide non-judgmental support;
3. Excellent organizational and record-keeping skills; and
4. Thorough understanding of STDs and HIV/AIDS, the impact on individuals and communities, and current treatment and prevention strategies.

9. Appendix A, Sample Contract, Exhibit A, Statement of Work, Attachment II: Non-Clinic-Based Prevention Services, Subsection 2.2.2, Prevention Services Navigator (Navigator), is amended as follows:

2.2.2 Prevention Services Navigator (Navigator)

A. Contractor will have at least one Navigator to facilitate access to Prevention Services for individuals at high risk of HIV and STDs.

B. Responsibilities of the Navigator include but are not limited to:

1. Managing client cases~~, including risk behavior screening~~;
2. Brief interventions;
3. Providing PrEP, PEP, and DoxyPEP educational activities;
4. ~~Assist with making appointments and linkages with providers for PrEP, PEP, and DoxyPEP services~~ Ensuring the linked referrals for appointments and linkages with providers for PrEP, PEP, and DoxyPEP services conducted by the HIV counselor are successfully completed; and
5. Follow-up with clients to remind them of non-medical and medical appointments.
6. ~~Provide linkages to services and primary medical care.~~

C. Minimum Qualifications:

1. High School Diploma (or GED equivalent) and a minimum of 12 months of experience providing HIV health education or risk reduction counseling; OR

2. A minimum of 12 months' experience as a biomedical HIV prevention navigator with demonstrated understanding of PrEP, PEP, and DoxyPEP and strong socio-cultural identification with one or more of the target populations.

10. Appendix A, Sample Contract, Exhibit A, Statement of Work, Attachment II: Non-Clinic-Based Prevention Services, Subsection 3.5, HIV Risk Assessment and Counseling, is amended as follows:

3.5 HIV Risk Assessment and Counseling:

Contractor's Prevention Services Counselor must conduct an HIV risk assessment and counseling session (when appropriate) for clients identified as needing a high-risk intervention.

3.5.1 Conduct an HIV risk assessment that assists clients in identifying the risk behaviors that place them at risk for HIV/AIDS.

3.5.2 As needed, provide a client-centered counseling session that engages the client in a dialogue that encourages the disclosure of unique individual needs and concerns related to HIV risk and emphasizes personal options that limit or prevent transmission of HIV. The client-centered counseling session should accomplish the following:

a. Improve the client's self-perception of risk;
b. Support behavior change previously accomplished or attempted by the client;
c. Negotiate a workable short-term and long-term risk reduction plan based on the client's perceived ability to change their behavior;
d. Support informed decision-making about whether to be tested;
e. Review the nexus between HIV and STD infections and between alcohol and drug use; and
f. For clients who choose a rapid test, Contractor staff will assess client's potential reaction to receiving a reactive rapid test prior to administering the test.

During these sessions, Contractor must provide the following information:

g. The process related to each of the testing options, such as how the test is done, duration of the process, the timeframes for getting results, the meaning of test results

including preliminary results in the case of rapid HIV testing; and

h. Relevant information regarding the window period*.

*Contractor staff must clearly explain that the rapid HIV test only refers to obtaining results from the time between exposure (less than three months) and their last non-reactive test. Clients must be counseled to re-test three months from the potential exposure.

If a client decides to have a rapid test, Contractor staff will:

i. Ensure that the client understands the meaning of test results, including that a reactive preliminary positive result requires confirmatory testing;
j. Ensure that the client completes a DHSP-approved consent form (for confidential testing) signed by the client and maintained in the client's file in accordance with the California Code of Regulations. The consent form must also include a commitment by the client for the collection of a second specimen (serum or oral fluid) for individuals testing preliminary positive;
k. Follow local guidelines and recommendations pertaining to HIV counseling and testing, HIV rapid testing, and phlebotomy (both venipuncture and finger stick). Contractor staff will collect client demographic information using the designated reporting form as provided by DHSP. All information reported on the approved HIV Test Reporting Form(s) must be voluntarily disclosed by the client;
l. Ensure that a sufficient amount of testing specimen is collected to ensure that initial, repeat, and supplemental HIV antibody tests may be performed. All non-rapid specimens must be delivered to and processed by a State-approved laboratory, with prior approval from DHSP;
m. Review the client's Counseling Information Form, provided by DHSP, before the disclosure; ~~and~~
n. Disclose the result, interpret the test result, and assess the client's emotional state. Contractor staff must evaluate counseling needs, client's understanding of the test results, client's need to be re-tested based on the window period, and the client's understanding of and commitment to risk reduction guidelines as well as the strength of social support and plans for and consequences of disclosure to others. Test results must be given in person only to the client, and in accordance with applicable law;~~.~~

~~*For clients testing HIV-positive, a *minimum* of 45 minutes must be spent in the disclosure counseling session and the following *additional* topics must be covered and conducted in the disclosure session:~~

o. Importance of HIV medical care to optimize one's health and the likelihood of a normal life expectancy with adherence to medications;
p. Information regarding the past or future risk of HIV transmission to sexual and drug using partners, the risk of transmission to the fetus or newborn during pregnancy, during labor and delivery, and during postpartum period;
q. The active elicitation of past sexual and drug using partners and descriptive contact information and/or linkage to Partner Services (PS); and
r. A written assessment of the client's reaction to the positive HIV test result to determine whether referral for psychosocial support services is needed.

11. Appendix A, Sample Contract, Exhibit A, Statement of Work, Attachment III, High Impact Prevention Programs, Section 1.0, Description, is amended as follows:

1.0 DESCRIPTION

High Impact Prevention Programs (HIPP) are intended to supplement Clinic-Based and Non-Clinic-Based Prevention Services.

Contractor can select up to ~~two~~ three of the following prevention supportive services to enhance prevention activities conducted as a part of Clinic-Based Services or Non-Clinic-Based Services:

1. **Social connectedness:** Facilitate social gatherings or events that promote interpersonal communication and encourage relationship building.

2. **Job skills development/job training:** Conduct job skills development and training sessions to equip individuals with essential skills for the workforce.

3. **Financial literacy:** Educate individuals on financial literacy to help them understand and manage their finances effectively.

4. **Educational/English as a Second Language classes:** Teach educational classes, including English as a Second Language, to enhance language proficiency and learning opportunities.

5. **Contingency management:** Implement contingency management strategies to motivate positive behavior changes.

6. **Emergency Housing/hotel vouchers:** Distribute emergency housing and/or hotel vouchers to provide immediate shelter for individuals in crisis situations.

Services must be ~~provided~~ offered in a location ~~(~~with drop-in ~~service)~~ availability that ~~are~~ is convenient ~~to~~ for the targeted population(s). Services must target individuals at high risk for STD and/or HIV infection in LAC, with an emphasis on the following target populations:

- African American and Latinx men who have sex with men (MSM) with emphasis on young men who have sex with men (YMSM);
- Transgender persons with emphasis on transgender women;
- Cis-gender women experiencing homelessness, who use/inject drugs, or have experienced intimate partner violence;
- Persons who use/inject drugs (PWUID) with emphasis on opioids and/or stimulants; and
- Youth and Young Adults (under 30 years of age).

12. Appendix B, Required Forms, Exhibit i, Proposer's Submission Checklist is deleted in its entirety and replaced with the attached revised Exhibit i, Proposer's Submission Checklist. Proposers are <u>required</u> to use the attached revised form when submitting their proposals.

13. Appendix B, Required Forms, Exhibit 6, Minimum Mandatory Requirements are replaced with the attached revised Exhibit 6, Minimum Mandatory Requirements. Proposers are <u>required</u> to use the attached revised form when submitting their proposal.

14. Appendix B, Required Forms, Exhibit 11, Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions (45 C.F.R. Part 76) is deleted in its entirety and replaced with the attached revised Exhibit 11, Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions (45 C.F.R. Part 76). Proposers are <u>required</u> to use the attached revised form when submitting their proposal.

15. Appendix B, Required Forms, Exhibit 12, Declaration Form are replaced with the attached revised Exhibit 13, Declaration Form. Proposers are <u>required</u> to use the attached revised form when submitting their proposal.

<u>PART 2 – RESPONSES TO PROPOSER QUESTIONS</u>

Pursuant to RFP Section 8.2, Proposers' Questions, answers to questions received by the 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.

GENERAL QUESTIONS

Q1. The deadline for the conference had passed and we were not able to attend. Would we still be able to apply?

A1. Yes. Attendance at the Proposer's Conference is not a requirement to submit a proposal under the RFP. To view the recording of the conference, please visit: http://publichealth.lacounty.gov/dhsp/DoingBusinessWithDHSP.htm.

Q2. In general, sections of the solicitation appear to suggest that the Department is moving away from some of its recent innovations particularly in the areas of HIV/STD testing/screenings and High Impact Prevention Programs. This is reflected by inconsistencies in various sections of the proposal. These inconsistencies appear to suggest that Public Health is moving away from the express clinics model. Also, the RFP lists 14 separate requirements for the HIV counseling session. Do these expansive requirements represent a move by the County away from an express testing model?

A2. Express clinic services are not required under this RFP; however, they are permitted.

Q3. The RFP does not provide budget instructions or templates, nor does it specify allowable and non-allowable expenses. How are bidders to communicate budget information in a manner that does not disqualify proposals? The RFP doesn't mention the number of awards to be made by service category.

A3. The omission of budget instructions including templates is intentional. Budgets will be determined during contract negotiations with successful proposer(s). Proposers should detail in their service proposals the process they will utilize to meet their program goals understanding that the final budget details will be addressed during contract negotiations with successful proposer(s). The RFP does not specify the number of awards per service category at this stage.

Q4. Will this new RFP replace all current contracts (e.g., STD Screening, Diagnosis and Treatment Services; PrEP, CEDIS; HIV Testing Services – Storefront; HIV Testing Services – Social and Sexual Network Testing; Biomedical HIV Prevention) including both base awards and any supplemental funding that we may currently receive?

A4. This RFP will replace all Prevention Services contracts currently in place. Contracts include CEDIS program, STD Screening, Diagnosis and Treatment, HIV Testing (Storefront testing and Social and Sexual Network testing), Integrated HIV and STD screening and treatment in the City of Long Beach, Health Education/Risk Reduction services, Vulnerable Populations contracts, PrEP and Biomedical Prevention contracts.

Q5. There is no specific page/section it references other than the Contractor Requirements for Personnel for each category of service: Are there Full-Time Equivalent (FTE) requirements for any required personnel?

A5. The FTE requirements for any required personnel will be discussed during contract negotiations with successful proposer(s).

Q6. What is the expected number of clients to be served for each category?

A6. Expected number of clients to be served by each contractor will be finalized as part of contract negotiations with successful proposer(s).

Q7. What is the reasoning for not allowing applicants to apply for both Category 1 and Category 2? Currently, we provide services for both.

A7. The restriction on applying for both Category 1 and Category 2 is due to the distinct service delivery models and funding structures associated with each category. Organizations are encouraged to apply for the category that best aligns with their service focus and delivery models.

Q8. Will there be a ramp-up period factored in for new service delivery at the start of the new contracts?

A8. Yes. A ramp-up period for the new service delivery at the start of the contract has been factored in. The specifics of this period will be discussed and negotiated during contract negotiations with successful proposer(s). Public Health will not fund any new sites, only those already in existence.

SECTION 2.0 – INTRODUCTION

Q9. Can one entity apply for multiple sites in one proposal, or are separate proposals required?

A9. Proposers may apply for multiple sites under one proposal. For Category 3, proposers must clearly specify the populations to be served as well as the tailored interventions for each respective population.

Subsection 2.2, Comprehensive HIV and STD Prevention Services (Prevention Services)

Q10. On page 6 of the RFP under Category 2 – Non-Clinic-Based Prevention Services (paragraph 6), there is a statement that says, "Services must be provided in non-clinic-based settings." Our agency has an HIV/STI testing clinic in house as part of our larger community-based services. Since we're technically a clinic, does this mean we would not be eligible to apply under Category 2 because services must be provided in non-clinic-based settings under that funding category?

A10. It is up to Proposers to decide which category they are proposing for services after reviewing the RFP packet.

Subsection 2.4.1, Location of Services

Q11. On page 9 of the RFP, Section 2.4 Program and Technical Requirements, Subsection 2.4.1 Location of Services, it states, LAC-DHSP is prioritizing services in the HD with high HIV/STD morbidity. Our facility is not in a priority HD, would that bar us from applying for this RFP?

A11. No.

Q12. Is an agency primarily serving City of Long Beach residents ineligible to apply?

A12. No.

Q13. Can we identify all SPAs as our service area or do you only want the SPAs and HDs that our physical offices are located in? Would our Location Tier be based on the individual clinic where our HIV-prevention program is located, or can it be based on our organization's entire service area?

A13. The Location Tier should be based on the entire service area where the HIV/STD prevention program will be provided, rather than the individual clinic location.

Q14. Is there a preference (priority) in terms of funding levels between the Location Tiers?

A14. Yes. The Location Tiers represent priority areas where HIV and STD transmission rates are highest. Funding allocations will be prioritized by Tiers. Tier 1 HDs will take precedence over Tier 2, and Tier 2 will be prioritized over other regions of Los Angeles County. This allocation ensures resources are directed to the areas with the greatest need for HIV/STD prevention and intervention.

Q15. Can we propose for services in multiple HDs and Tiers?

A15. Only one proposal for Category 1 or Category 2 will be accepted. Proposers can apply for multiple HDs and Tiers on the same proposal.

Subsection 2.5, Availability of Funding

Q16. What are the funding ranges for each category?

A16. Final budget details will be addressed during contract negotiations with successful proposer(s). The RFP does not specify the number of awards per service category.

SECTION 4.0 – MINIMUM MANDATORY REQUIREMENTS

Subsection 4.2, Additional MMRs for Category 1: Clinic-Based Prevention Services

Q17. On page 12 of the RFP, Section 4.0 Minimum Mandatory Requirements, Subsection 4.2, Additional MMRs for Category 1: Clinic-Based Prevention Services, item 1, Experience, it states that an agency must have diagnosed at least 40 new HIV cases over the past 3 years. Can you clarify the exact definition of the word "new"? Could this include persons who may have been previously diagnosed but have recently been diagnosed and linked to care through our testing program?

A17. In this context, "new" refers to unduplicated clients—those who have not previously been in contact with the proposer. This includes individuals who may have been diagnosed with HIV in the past by a different Service Provider but have only recently been identified and linked to care through the proposer's testing program. The focus is on clients who are newly engaged with a proposer's services, not those who have been previously known to the proposer.

Q18. On page 12 of the RFP, Section 4.0 Minimum Mandatory Requirements, Subsection 4.2, Additional MMRs for Category 1: Clinic-Based Prevention Services, item 1, Experience, "Proposers must have diagnosed no less than 40 new HIV positive individuals over the last three years"? Is it calendar years 2021-23 or fiscal years July 2021 to June 2024?

A18. The three-year period refers to calendar years 2021-2023.

Q19. On page 12 of the RFP, Section 4.0 Minimum Mandatory Requirements, Subsection 4.2, Additional MMRs for Category 1: Clinic-Based Prevention Services, item 1, Experience, states that Proposers must have diagnosed no less than 40 new HIV positive individuals. Our agency has diagnosed 28 new

HIV positive individuals in the last 3 years. Does this prevent us from being considered?

A19. To apply for any Category of service, Proposers must meet all MMRs related to the service category.

Subsection 4.3, Additional MMRs for Category 2: Non-Clinic-Based Prevention Services

Q20. Can you provide clarification on the requirement for non-clinic CBO's to bill third party payers for Category 2 (Non-Clinic Prevention)? Do CBOs who partner with telemedicine providers that conduct third party billing for their clients meet this qualification? Will you be providing guidance or technical assistance for non-clinic CBOs to third party billing?

A20. The requirement to bill third-party payers is no longer applicable for non-clinic-based settings. Refer to Addendum 1, Number 3.

Q21. Regarding RFP, Section 4.0 Minimum Mandatory Requirements, Subsection 4.3 Additional MMRs for Category 2: Non-Clinic-Based Prevention Services, Item 2 Service Delivery Site, do all services have to be provided from brick-and-mortar sites or can it be a combination with mobile service sites?

A21. Refer to RFP Section 4.3, Additional MMRs for Category 2: Non-Clinic-Based Prevention Services, Item 2. All services must be provided from a brick-and-mortar location that meets the criteria listed. While mobile service sites may be used as an additional option for service delivery, they cannot replace the requirement for a brick-and-mortar location.

Subsection 4.4, Additional MMRs for Category 3: HIPP Services

Q22. Do we have to apply and qualify for category 1 or 2 in order to apply for Category 3?

A22. Yes.

Q23. Are subcontractors allowed to do Category 3, High Impact Prevention Program services?

A23. Subcontractors are allowed for service provision, but not to meet the MMRs.

SECTION 6.0 – NOTIFICATION TO PROPOSERS

Subsection 6.2, Contact with County Personnel

Q24. For the RFP under Section 8.0 Proposal Requirements and Evaluation, Subsection 8.3 Virtual Proposers' Conference, it says to email the county representatives identified in RFP, Section 6.2 Contact with County Personnel, however there aren't any contacts in 6.2. Is it supposed to be 8.2?

A24. No. Refer to Section 6.2 of the RFP, Contact with County Personnel, for contact information.

SECTION 8.0 – PROPOSAL REQUIREMENTS AND EVALUATION

Subsection 8.4, Preparation of the Proposal

Q25. Where should the Exhibit 12, Prevention Services Proposer Capacity form be placed in the submission? Should it be placed in both Sections B and C of the submission?

A25. Exhibit 12, Prevention Services Proposer Capacity form should be placed in Section C. Refer to this Addendum, Part 1 Modifications to RFP, Number 13.

Q26. If we have services in SPA 1 and SPA 2, should they be included in the same proposal?

A26. Yes. Only one proposal for Category 1 or Category 2 will be accepted. Proposers can apply for multiple Service Planning Areas, HDs, and Tiers on the same proposal.

Q27. Does this RFP include Benefits?

A27. Insufficient information to respond to this question. The County cannot determine what benefits are being referred to here, whether employee benefits or client benefits.

Q28. What alignment should our agency name be in the footer?

A28. For format requirements, refer to RFP Section 8.4, Preparation of the Proposal. There are no specific requirements for the alignment of the footer.

Q29. Is there a separate proposal for this or do we cut and paste from the RFP into our own proposal?

A29. Refer to RFP Section 8.4, Preparation of the Proposal.

Subsection 8.4.2, Cover Letter

Q30. Who should the cover letter be addressed to?

A30. Refer to RFP Section 6.2, Contact with County Personnel.

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

Q31. Will our current DHSP STD, BIOMEDICAL, and BENEFITS SPECIALTY contracts be counted as three separate references out of the five that are required? Would we just count that as one reference or multiple references (based on number of contracts we hold)? Can we include LA County DHSP as a reference?

A31. DHSP or DHSP staff can be provided as one of the five references.

Q32. For Proposer's List of References, please clarify as to what constitutes the same or similar scope of services sought by this RFP.

A32. Scope of services is listed in the statement of work.

Q33. Will proposer be disqualified or penalized or receive a reduction in points if there are less than 5 references?

A33. Refer to RFP Section 9.3, Stage 2 Proposal Evaluation and Criteria, Subsection 9.3.1 Proposer's Qualifications, Number 2 Proposer's References.

Q34. Under RFP, Section 8.0 Proposal Requirements and Evaluation, Subsection 8.4.4.2 Proposer's List of References (Section A.2), please clarify if a reference needs to be a grant maker or someone we have a contract with such as a coalition that we work with providing similar scope of services but there is no funding provided?

A34. The list of references is up to the proposer. Consideration should be given to references that can speak to the agency's capacity to provide the services being proposed.

Q35. If we have a grant for HIV where similar work is conducted. The Project Officer for that grant will not complete the reference survey – stating they are not allowed to do so. They can only provide a basic letter stating we are a grantee in good standing. Is there a way we can use the grant's Project Officer for the reference and have them provide the letter and then we provide our Notice of Grant Award and reports, etc. to substantiate our work?

A35. No. Proposers will be evaluated on the verification of references provided in Appendix B, Required Forms, Exhibit 8, List of References.

Q36. In the RFP, Attachment B, Required Forms, Exhibit 8, List of References, do we list the contact details of other agencies that we have contracted with the same or similar scope of services?

A36. Yes.

Q37. For Exhibit 8 – List of References, our agency does not contract out and DHSP is the only funder for the services in this RFP. Will the references we provided for our Core HIV Services proposal suffice? If not, can you provide any further guidance on what to include?

A37. See response A19d.

Subsection 8.4.6.2 Proposer's Approach to Providing Required Services (Section D)

Q38. There are 6 services listed; however, on page 44 there are 9 services listed. Which list should we use in developing our response?

A38. Reference Addendum 1, Part 1 Modifications to RFP, Number 5.

Q39. Do we have to develop SOW from these questions or can it be number driven like:
Obj 1: By 12/31/25 a minimum of 2,400 HIV tests will be conducted.
Obj 2: By 12/31/25 a minimum of 960 (40%) STI tests will be conducted. ETC

A39. Scopes of Work will be developed and finalized as part of the contract negotiation process. When submitting proposals, Proposers must provide responses in a narrative format. Refer to RFP Section 8.4.6.2, Proposer's Approach to Providing Required Services (Section D).

Subsection 8.4.6.2, Proposer's Approach to Category 3: HIPP Services

Q40. Do HIPP support services have to be offered at all clinic sites proposed in Category 1 or can they be offered at a centralized site?

A40. No. High Impact Prevention Programs do not have to be offered at all clinic sites proposed in Category 1. They can be offered at a centralized site.

SECTION 9.0 – SELECTION PROCESS OVERVIEW

Subsection 9.4.2, Stage 3: Final Review and Selection

Q41. If service Category 1 is ranked higher than service Category 3, would a recommendation for funding be made for Category 3? Similarly, if a service category ranking is higher for Category 3 than Category 1 would a funding

recommendation be made for Category 1? What data will be used to recommend funding? Exhibit 12 and/or Section 8.4.6.2, Proposer's Approach to Category 1: Clinic-Based Prevention Services Page 38, b. Number of clients Proposer intends to serve per location?

A41. Refer to RFP Section 9.0, Selection Process Overview, Subsection 9.4.2.

Section 9.4.3, Recommended Funding Allocation Review

Q42. Will there be an opportunity to negotiate the final funding allocation?

A42. Yes. Funding allocations will be determined with successful proposers during the contract negotiation process.

Q43. Is there a budget template or any guidance on the average or maximum award per category?

A43. Refer to RFP Section 9.0, Selection Process Overview, Subsection 9.4.3 Recommended Funding Allocations Review.

SECTION 10.0 – PROTEST PROCESS OVERVIEW

Subsection 10.1, Solicitation Requirements Review

Q44. Is the Solicitation Requirements Review (SRR) mandatory or only if we are requesting a review?

A44. A Solicitation Requirements Review is mandatory if a proposer is requesting a review.

APPENDIX A, EXHIBIT A – SAMPLE CONTRACT

Q45. Where is the Quality Management Section?

A45. The specifics in Appendix A, Sample Contract, Exhibit A, Statement of Work Quality Management Section will be discussed and finalized during contract negotiations with successful proposer(s).

APPENDIX A, EXHIBIT A – STATEMENT OF WORK

Q46. The Statement of Work for Non-Clinic Prevention programs states that providers must offer STD screening themselves. Addendum 1 makes clear that Non-Clinic Prevention programs for STD screening and treatment may be provided via linkage. The changes made via Addendum 1 apply to the

Statement of Work even if it was not included in Addendum 1. Is this a correct assumption to make?

A46. No. All documents, including Attachment II - Non-Clinic-Based Prevention Services include updates that reflect the changes made in Addendum 1.

Subsection 3.2, County's Project Manager

Q47. There is a discrepancy between language included on Exhibit A Statement of Work, Section 3.0 Work Requirements, Subsection 3.2.3 and Attachment I Category I: Clinic-Based Prevention Services, Subsection 2.2.1 requiring that the Medical Director be designated the contractor's Program Manager.

A47. Refer to Part 1 of this Addendum, Modifications to RFP, Number 5. The Medical Director may serve as the contractor's Program Manager at the contractor's discretion but is not required to do so.

Q48. Please clarify why a medical provider would be required to complete the HIV Counselor Certification training. If a non-licensed individual is allowable as Project Manager, will DHSP allow individuals whose primary duty is not testing to attend the tester training?

A48. If the Project Manager is other than the Medical Director, they must complete the training required. Medical Directors do not need to complete required trainings.

Subsection 3.7, Materials, Supplies, and/or Equipment

Q49. Is Public Health not providing HIV tests for testing services? If so, what are Public Health's expectations regarding point-of-care test (POCT) for HIV in rapid/express testing settings? Is third generation integrase strand transfer inhibitor (INSTI) acceptable or should we use the 4th generation POCT?

A49. Point-of-Care (POC) rapid test kits (such as INSTI) will be distributed by DHSP to contractors.

Attachment I, Clinic-Based Services

Q50. Under Category 1, can we budget incentives related to outreach?

A50. Yes.

Q51. Under Category 1, can we include an outreach worker in the budget?

A51. Additional staffing needs can be determined during contract negotiations with successful proposer(s).

Q52. Is it expected that HIV testing will be a blood draw or can Proposers utilize rapid testing (i.e. 4th Generation rapid test) to support the HIV testing deliverable?

A52. Proposers should detail whether they will conduct point of care tests or blood draws.

Q53. If we offer testing services at more than one clinic site, do we have to submit required documents from each affiliate site or just the main site? For example, the documents under MMR.

A53. Yes. If testing services are offered at multiple clinic sites, the required documents must be submitted for each affiliate site, not just the main site.

Subsection 2.2.1, Contractor's Medical Director

Q54. Does the Project Manager have to be the Proposer's Medical Director or can it be our HIV Program Administrator?

A54. No. The Project Manager does not have to be the Medical Director. Refer to Part 1 of this Addendum, Modifications to RFP, Number 5.

Q55. Please confirm that Public Health requires the medical director be a medical provider AND act as administrative manager for the project?

A55. The Medical Director may serve as the contractor's Program Manager at the contractor's discretion but is not required to do so.

Q56. Are these minimum staffing patterns? Can a bidder propose additional staff to efficiently and effectively run a high-volume HIV/STD screening and STD treatment clinic? Are all of the positions listed herein required? Can the duties be combined into one position (e.g. prevention navigator and biomedical prevention navigator)?

A56. Yes, additional staffing patterns provided in the contract represent the minimum requirements. Additional staffing needs can be assessed and determined during contract negotiations with successful proposer(s), based on volume and specific operational requirements. While all positions listed in the contract are required, duties may be combined into a single position if the minimum qualifications and responsibilities for each role are met.

Q57. Please clarify the desired scope of the case management services to be provided by the Prevention Services Navigator?

A57. The required scope of the case management services to be provided by the Prevention Services Navigator is stated in Exhibit A, Statement of Work, Attachment 1, Section 2.2.4 Prevention Services Navigator (Navigator).

Subsection 2.2.2, Certified Medical Assistant or Licensed Vocational Nurse

Q58. For Category 1: Section 2.2.2. Certified Med Assist or LVN for HIV testing. Can a certified HIV Counselor and Tester fulfill the role of Certified Medical Assistant or Licensed Vocational Nurse? If we have more than one site, can we have a certified Counselor & Tester at each site?

A58. For Category 1, an HIV Certified Tester cannot provide services related to STD screening and/or treatment that a Certified Medical Assistant (Med Assist) or Licensed Vocational Nurse (LVN) can. Therefore, the HIV Certified Tester cannot replace the requirement of a Med Assist or LVN. Regarding multiple sites, yes, it is possible to have a certified HIV Counselor and Tester at each site, as long as the required personnel qualifications for each site are met and align with the guidelines set forth in the RFP.

Subsection 3.3, HIV Risk Assessment and Counseling

Q59. Will there be changes to some requirements (e.g., risk assessments) to give the opportunity to streamline operations?

A59. Potential changes to requirements, including risk assessments, will be addressed during contract negotiations with successful proposer(s).

Q60. Does Public Health envision 20-30 minute HIV counseling sessions?

A60. As written, the requirement of a client-centered counseling session is on an as needed basis according to client need.

Q61. In reference to Appendix A Statement of Work, Attachment I Clinic Based Prevention Services, Section 3.0 Specific Work Requirements, Subsection 3.3 HIV Risk Assessment and Counseling, Item m, what is the Counseling Information Form and how will it be provided by Public Health?

A61. All data collection requirements will be identified and discussed with successful proposer(s) during contract negotiations.

Q62. In reference to Appendix A Statement of Work, Attachment I Clinic Based Prevention Services, Section 3.0 Specific Work Requirements, Subsection 3.3 HIV Risk Assessment and Counseling, Item n, please provide additional information on Public Health's expectation regarding this evaluation? Should

it be conducted by the provider? How should it be documented? Is there a standardized instrument that Public Health expects contractors to use?

A62. Evaluations will be conducted based on forms provided by DHSP. Disclosure of results must be done by either medical staff or trained non-medical HIV testing counselors. All interactions with the client will be documented in the DHSP data collection system and/or forms.

Q63. What is the 45-minute Counseling Session based on?

A63. The specific time frame has been removed. Refer to Part 1 of this Addendum, Modifications to RFP, Number 6. All services should be client centered and adjusted to meet each client's needs.

Q64. In reference to Appendix A Statement of Work, Attachment I Clinic Based Prevention Services, Section 3.0 Specific Work Requirements, Subsection 3.3 HIV Risk Assessment and Counseling, does the Counseling Session not apply to young gay men who've just tested positive for HIV?

A64. Counseling sessions apply to all clients as needed.

Q65. In reference to Appendix A Statement of Work, Attachment I Clinic Based Prevention Services, Section 3.0 Specific Work Requirements, Subsection 3.3 HIV Risk Assessment and Counseling, Item r, does Public Health have any additional information on what this written assessment should look like or whom it should be performed by?

A65. Documentation expectations will be defined during contract negotiations with successful proposer(s).

Subsection 3.5, Compliance with Current STD Guidelines

Q66. Please confirm Public Health expects contractors to provide Mpox treatment on site as part of this program and if this cost is reimbursable using grant funds?

A66. Mpox treatment is expected to be provided. Refer to Attachment 1, Category 1: Clinic-Based Prevention Services, Subsection 3.5.3. Prevention Services contracts are structured as cost-reimbursement contracts, subject to payer of last resort and third-party payer rules.

Subsection 3.6, Biomedical Prevention Navigation (Navigation) Services

Q67. Are these separate from the prevention navigation services? Are these different positions? Can the duties be combined?

A67. Staffing needs will be determined during contract negotiations with successful proposer(s).

Subsection 3.10, Conduct Patient-Delivered Partner Therapy (PDPT)

Q68. If we are a clinic that already provides PDPT, do we still need to be an Essential Access Health Network provider?

A68. No. If your clinic already provides PDPT, you do not need to be an Essential Access Health Network provider. Please refer to Part 1 of this Addendum, Modifications to RFP, Number 7.

Subsection 3.11, Screen for Benefits

Q69. What about patients that are uninsured? Are there other required services that can be provided by referral?

A69. Refer to Attachment 1, Category 1: Clinic-Based Prevention Services, Section 3.11 Screen for Benefits. DHSP funds should be considered as a last resort, and it is each contractor's responsibility to document all efforts made to screen and enroll clients in any public or private insurance plans for which they are eligible. As outlined in Section 4.4, Part 2 of the RFP, all providers under Category 1—Clinic-Based Prevention Services must be eligible to bill third-party payers and must exhaust these resources before utilizing DHSP funds.

Attachment II, Non-Clinic-Based Services

Q70. How do you define a "drop-in" center and what are the expectations?

A70. A "drop-in" center is defined as a service location where clients can access services without the need for a prior appointment or scheduled visit. The non-clinic-based settings should provide flexible hours and be easily accessible to the target population, allowing individuals to come in at their convenience to receive services, support, and resources.

Q71. What components should the pop-up location have for the Category 2 Non Clinic based option?

A71. Services must be offered in non-clinic-based settings with drop-in availability that are convenient for the targeted population(s) served. The specific components will be discussed and finalized with successful proposer(s) during contract negotiations. Please note “pop-up” locations that are one-time only sites are not allowed. Sites must be existing, established brick and mortar sites.

Q72. Since we are a new agency, could we be considered for this contract opportunity?

A72. Potential proposers are welcome to submit a proposal if they meet all requirements listed in the RFP. All Proposers must register on the County's WebVen, which contains the Vendor's business profile and identifies the goods/services the business provides. Registration can be accomplished online by accessing the County's homepage at http://camisvr.co.la.ca.us/webven/.

Q73. What is the definition of "documented linkage"?

A73. "Documented linkage" refers to a formal, written process that verifies that clients have been successfully connected to appropriate STD screening and treatment services. Documentation of the client's first appointment with the provider should be included.

Q74. Will rapid tests for either HIV or STIs be provided by DHSP?

A74. POC rapid test kits (for HIV and STD) will be distributed by DHSP to successful proposers as they become available.

Q75. Will laboratory testing costs be paid for by DHSP through PHL or will they be paid for contractors as part of the budget?

A75. STD screening will not be conducted under Category 2.

Q76. Will the contract reimburse for vaccines?

A76. This will be negotiated with successful proposer(s) during contract negotiations.

Q77. Is telemedicine allowed for referring clients to linkage to care? Will it be a billable expense? Will it be an option?

A77. No. Telemedicine is not allowed for referring clients to linkage to care. A successful in-person visit with a medical provider is required before linkage to HIV care. Documentation confirming the completion of this visit is necessary. Final budgets will be discussed during contract negotiations with successful proposer(s).

Q78. Can we reference our Storefront testing contract as in-kind modality for paying for the HIV testing services.

A78. No. The existing Storefront testing contracts will expire on June 30, 2025.

Section 2.0 Responsibilities

Q79. Is a Benefits Specialist still a required staff member for Non-Clinic Prevention programs?

A79. Yes, a Benefits Specialist is a required staff member for Non-Clinic Prevention programs. Refer to Attachment II, Category 2: Non-Clinic-Based Prevention Services, Subsection 2.2.3 Benefits Specialist.

Subsection 3.4, HIV Risk Assessment and Counseling

Q80. May a Category 2 applicant partner with a clinic -- like a substance use treatment center -- to offer HIV and STD screening onsite at the treatment center?

A80. Partnerships under Category 2 are allowed. However, the lead contractor must be the agency submitting the proposal and must meet all MMRs listed in the RFP.

Q81. Will there be changes to some requirements (e.g., risk assessments) to give the opportunity to streamline operations?

A81. There will be no changes to requirements.

Attachment III, High-Impact Prevention Programs

Q82. Do we have to be funded for Category 2 to be funded for Category 3?

A82. Yes. Proposers must be successful under Category 1 or Category 2 in order to receive a funding award under Category 3.

Q83. What are the guidelines for the distribution of the emergency housing/hotel vouchers? Are housing and/or hotel vouchers provided by DHSP for us to distribute or would we be required to pay for them out of the contract's funding? Can we use this funding to pay for staff who will distribute the vouchers as well as offer ongoing support to the client?

A83. The guidelines for the distribution of emergency housing or hotel vouchers will be discussed and finalized during contract negotiations with successful proposer(s). Funds should only be used for the distribution of emergency housing/hotel vouchers and not staff.

Q84. Can an applicant submit multiple proposals under category 3?

A84. Yes. Applicants may submit multiple proposals under Category 3.

Q85. Regarding the Emergency Housing/Hotel Vouchers, would it be limited to only people experiencing homelessness? Are there any specific criteria that would be applied?

A85. Eligibility criteria, including factors such as vulnerability and housing instability, will be specified in the contract and finalized during contract negotiations with successful proposer(s).

Q86. Could further clarification be provided regarding the priority populations to be served? Do at least 2 priority populations need to be identified for Category 3? (Exhibit A, Attachment 3: Category 3, 1.0).

A86. Category 3 allows flexibility in selecting priority populations, with no specific limit. However, up to three interventions may be provided. The target populations should reflect the communities being served, with interventions tailored to their needs and aligned with program goals and contract requirements.

Q87. Reference to Exhibit A Statement of Work, Attachment III Category 3: High Impact Services Approach, Section 1.0 Description, why is there a limitation to select only two prevention supportive services since it would counter a holistic approach mentioned in Section 3.0 Specific Work Requirements, Subsection 3.1 Holistic Approach to Services?

A87. Refer to Part 1 of this Addendum, Modifications to RFP, Numbers 1 and 11. Limiting the number of interventions is intended to maintain focus, ensure quality, and stay within the scope and budget of the contract. This approach allows for a more effective assessment of outcomes.

Q88. Under Category 3, will the program directly fund hotel vouchers?

A88. Proposers selecting to offer this intervention will need to describe how this will be implemented. Guidelines for funding and distributing vouchers will be finalized during contract negotiations with successful proposer(s), with detailed allocation and usage instructions provided at that time.

APPENDIX B, REQUIRED FORMS

Exhibit 6, Minimum Mandatory Requirements

Q89. What document(s) should be submitted to demonstrate evidence of current and valid Medi-Cal certification?

A89. Refer to RFP Section 4.2, Additional MMRs for Category 1: Clinic-Based Prevention Services. There are several acceptable forms of evidence a clinic can provide to confirm that they have a Medi-Cal Certification including:

- Medi-Cal Certification Documents - Clinics receive a formal certification or approval letter from DHCS once they are enrolled in the program. This letter is official proof of Medi-Cal certification.
- Medi-Cal Provider Identification Number - The clinic should have a unique provider ID number issued by the California Department of Health Care Services (DHCS), which confirms that they are enrolled in the Medi-Cal program.
- Medi-Cal Contracts and Agreements - A clinic may present a copy of their current signed contract or agreement with Medi-Cal, confirming their participation in the program.

Q90. Please provide more information about the Quality Assurance (QA) plan. Is this specific to laboratory only?

A90. No. A Quality Assurance Plan is required for anyone that will be conducting HIV testing and STD screening and treatment.

Q91. The Exhibits were similarly not altered by Addendum 1. Exhibit 6 still has a check box for Eligibility to Bill Third-party Payer in the Non-Clinic Prevention section, but this is no longer a Mandatory Minimum Qualification for Non-Clinic Prevention. Exhibit 6b seems not to apply to Non-Clinic Prevention. How should we handle these Exhibits.

A91. Refer to Part 1 of this Addendum, Modifications to RFP, Number 13. Revised forms are attached to this Addendum.

Exhibit 6A, Eligibility to Bill Third-party Payers

Q92. May Health Plan contracts title page and signature page be used as supporting documentation to show evidence of the eligibility and ability to bill third-party payers? Or should proposers submit the entire contract?

A92. Yes. The health plan title and signature pages are sufficient supporting documentation.

Q93. If proposer is applying for Category 1 only – Clinic Based-Prevention Services, do we only submit Section 4.2 and NOT 4.3. and NOT 4.4 for Exhibit 6?

A93. Yes. Only submit for the section that is applicable to the proposal.

Q94. Do you require all health plans/third party-payer sources our agency bills for these services to be included in Exhibit 6A?

A94. Yes. All health plans and third-party payer sources that the provider bills for these services must be included in Exhibit 6A.

Q95. Please clarify as to what constitutes providing "evidence of eligibility to bill any third-party payer sources".

A95. Evidence of eligibility to bill third-party payer sources refers to documentation that verifies the provider's authorization or ability to submit claims to various insurance or reimbursement entities. This can include, but is not limited to, copies of provider contracts with insurance companies, certifications, or approval letters from Medicaid, Medicare, or other third-party payer sources that show the provider is eligible to bill them for services.

Q96. Please clarify as to what a designation letter is.

A96. A designation letter is an official letter issued by a health plan or third-party payer that designates a provider or organization as an authorized entity to deliver services under that plan. This letter typically confirms that the provider has been approved to submit claims and receive reimbursements from that specific health plan.

Q97. Please clarify as to what is meant by documentation related to "Individual Practice Agreements indicating which health plans the provider is participating in."

A97. Individual Practice Agreements refer to formal agreements between the provider and health plans that outline the terms and conditions under which services will be provided and billed. These agreements should specify the health plans the provider is contracted with and the scope of services covered under each plan.

Exhibit 7, Public Entities

Q98. Can you explain the difference between the List of Public Entities (Exhibit 7) and the List of References (Exhibit 8).

A98. In Exhibit 7, Public Entities, Proposers must provide a list of all public entity contracts for the last three years where the same or similar scope of services was provided. Exhibit 8, List of References may include those listed in Public Entities, but are references that will be contacted by email with an electronic survey.

Q99. Is the List of Public Entities (Exhibit 7) a listing that includes all of our awarded contracts with similar services?

A99. Yes. Proposers must provide a list of all public entity contracts for the last three years where the same or similar scope of services was provided.

Exhibit 11, Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions (45 C.F.R. Part 76)

Q100. Exhibit 11 has no place for a signature. Will Exhibit 13-Declaration act as the signature page?

A100. Refer to Part 1 of this Addendum, Modifications to RFP, Number 15.

Exhibit 12, Prevention Services Proposer Capacity

Q101. Should the baseline data presented in Exhibit 12 be reflective of aggregated data for clinics we are proposing in the RFP or is it agency wide?

A101. Baseline data presented in Exhibit 12 should be reflective of aggregated data for clinics being proposed under the RFP.

Q102. Should Exhibit 12 be completed for each proposed clinic?

A102. Yes. Exhibit 12 Prevention Services Proposers Capacity form should be completed for each proposed clinic.

Q103. On the Checklist, Exhibit 12 - Prevention Services Proposer Capacity is listed under Section 8.4.5. However, it's also listed under Section 8.4.6.1 - Completed tables in Appendix E (Prevention Services Proposer Capacity Form). Where should we place this document?

A103. Refer to Part 1 of this Addendum, Modifications to RFP, Number 13.

Q104. Regarding the Prevention Services Proposer Capacity form, does this include testing visits or should it also include treatment visits during which testing is performed?

A104. Exhibit 12, Prevention Services Proposer Capacity form is specifically limited to information related to testing visits.

Exhibit 13, Declaration

Q105. Should applicants correct the Declaration Form from Exhibit 12 to Exhibit 13?

A105. Refer to Part 1 of this Addendum, Modifications to RFP, Number 15. Revised forms are attached to this Addendum.

Pursuant to Section 5.0 of the RFP, County Rights & Responsibilities, subsection 5.4, County's Right to Amend Request for Proposals, Proposers are reminded that 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. This Addendum Number 2 has been made available on the Department of 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 Addendum Number 1 and this Addendum Number 2, there are no other revisions to the RFP. All other terms and conditions of the RFP remain in full force and effect.