

**Rhode Island Department of Health
Office of HIV/AIDS & Viral Hepatitis**

**Comprehensive HIV CARE Act funded
Health Care and Support Services for
Rhode Islanders living with HIV/AIDS**

Request for Proposals

Please note: All applicants submitting a proposal are strongly encouraged to attend a technical assistance workshop to be held on December 27, 2006 from 2:00 to 3:00 pm at the Department of in the Health Policy Forum (lower level).

Applications are due at the Office of HIV/AIDS & Viral Hepatitis no later than 1:00 pm on January 22, 2007. Applications after 1:00 pm will not be accepted.

**REQUEST FOR PROPOSALS
RYAN WHITE COMPREHENSIVE AIDS RESOURCE EMERGENCY (CARE)
ACT**

**HIV Care Grant Program Title II
Service for Rhode Islanders Living with HIV/AIDS**

This request for proposals (RFP) provides interested applicants with information to assist them in preparing and submitting proposals. The Office of HIV/AIDS & Viral Hepatitis of the Rhode Island Department of Health will make awards to qualified agencies for direct services to Rhode Islanders living with HIV/AIDS. Continued funding will be based on the quality of service provided and the availability of funding.

Part A. Background

Brief history of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (also called the HIV CARE Act) (Public Law 101-381) was signed on August 18, 1990. This legislation was reauthorized in May 1996 as the Ryan White CARE Act Amendments of 1996 (Public Law 104-146). CARE Act funding has supported services for persons infected with the Human Immunodeficiency Virus (HIV) including those who have clinically defined Acquired Immune Deficiency Syndrome (AIDS). The Health Resources and Services Administration (HRSA) is the federal agency that is the grants management unit for the HIV CARE Act. The CARE Act is intended to help communities and States to increase the availability of primary health care and support services, in order to reduce utilization of more costly inpatient care, increase access to care for underserved populations and improve the quality of life of those affected by the epidemic.

The CARE Act directs assistance through the following channels:

Title I. Eligible Metropolitan Areas (EMAs) with the largest numbers of reported cases of AIDS, to meet emergency service needs of people living with HIV disease.

Title II. All States, the District of Columbia, Puerto Rico, and eligible U.S. Territories to improve the quality, availability and organization of health care and support services for individuals living with HIV disease and their families

Title III. Public and private nonprofit entities to support outpatient early intervention HIV services for persons living with HIV disease (PLWH)

Title IV. Public and private nonprofit entities for projects to coordinate services to, and provide enhanced access to research for, children, youth, women, and families with HIV/AIDS.

Part F. Special Projects of National Significance to support the development of innovative models of HIV/AIDS care that are designed to be replicable and have a strong evaluation component; AIDS Education and Training Centers (AETC) to conduct education and training for health care providers; and the HIV/AIDS Dental Reimbursement Program to assist accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral health treatment to

HIV-positive individuals.

This RFP addresses Title II services only.

FY 2007 HIV Care Grant Program Title II Program Guidance

Purpose of Title II Programs

Title II funding is used to assist States and Territories in developing and/or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals and families living with HIV. A comprehensive HIV/AIDS continuum of care includes primary medical care, HIV-related medications, mental health treatment, substance abuse treatment, oral health, and case management services that assist PLWH in accessing treatment of HIV infection that is consistent with Public Health Service (PHS) Treatment Guidelines. (Current treatment guidelines are available at www.aidsinfo.nih.gov.) This includes ensuring access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections as well as combination antiretroviral therapies. Comprehensive HIV/AIDS care beyond these core services also includes access to other health services (e.g., home health care, nutritional, and rehabilitation services). In addition, this continuum of care may include only supportive services that enable individuals to access and remain in primary medical care.

Rhode Island HIV/AIDS Demographic Profile

AIDS Cases in Rhode Island

As of December 31, 2005, 2712 adult/adolescent (age >13 years) Rhode Islanders have been diagnosed as having AIDS. Approximately 51% (n=1377) of these persons with AIDS are known to have died. Males continue to be more likely than females to have AIDS (2,054 vs. 658), although the gender gap has gradually decreased throughout the 1990's. Women accounted for 27% of all new estimated AIDS cases across the entire United States in 2004. In Rhode Island, women accounted for 32% of all new AIDS cases during 2004 and 36% in 2005.

Among Rhode Islanders reported with AIDS, the two largest risk-exposure categories are injecting drug users (IDU) (35% of AIDS cases) and men having sex with men (MSM) (35% of AIDS cases). Combining all adult/adolescent IDU-associated risk factors (IDU, MSM & IDU, and heterosexual sex with an IDU) accounts for 48% of all AIDS cases reported in Rhode Island. Of the 2,712 adult AIDS cases in Rhode Island, 1201 (44%) have occurred in persons whose racial/ethnic background is non-white. 678 AIDS cases have occurred among African Americans (25% of all AIDS cases in the state), even though African Americans comprise 5% of the general population in Rhode Island. Hispanics also endure a disproportionate burden of the disease, accounting for 488 cases of AIDS (18% of all cases) while representing 9% of the state's population. In terms of age, 44% of all AIDS cases in Rhode Island have been diagnosed in individuals aged 30-39. Persons aged 40-49 (30%) and aged 20-29 (15%) represent the next two largest age groups diagnosed with the disease. It is noteworthy that while the age group 13-19 represents a very small proportion of all Rhode Island AIDS cases, many in the age group 20-29 may have been infected in their teens.

There have been a total of 27 pediatric AIDS cases in Rhode Island. Of these 27 cases, 76% have been males and 56% have been African Americans, 25% white and 19% Hispanic. The most common risk factor identified in these pediatric AIDS cases was a mother with HIV/AIDS (87%). A transfusion or transplant as the source of transmission was cited in 13% of the cases.

HIV Cases in Rhode Island

From January 1, 2000 through December 31, 2005, 858 HIV cases among adults and adolescents (age >13) were reported to the Department of Health. Of these positive HIV cases, 607 (71%) have been in males and 251 (29%) have been in females. Among these case reports, the most common risk factor identified was MSM (32%), followed by Heterosexual Contact (19%). However, for 267 (31%) of the positive cases no risk factor was identified. The age group with the largest number of HIV cases is aged 30-39, whose 344 positive tests account for 40% of all HIV cases reported in Rhode Island. The age groups 40-49 (28%) and 20-29 (21%) account for the second and third highest groups of HIV cases in the state. Whites in Rhode Island, comprise the highest number of HIV cases (40% of all HIV cases). Similar to AIDS cases, the proportion of HIV cases among African Americans (31%) and Hispanics (27%) far exceeds the proportion of these races in the general population.

For the complete HIV/AIDS Epidemiological Profile link to the Department of Health Office of HIV/AIDS & Viral Hepatitis web site at <http://www.health.ri.gov/hiv/data.php>

Rhode Island Healthy People 2010 Objectives

The provision of these services for PLWH would contribute to the achievement of the Rhode Island Healthy People 2010 Objective 13, "Prevent HIV infection and its related illness and death" For more information about the Rhode Island Healthy People 2010 objectives link to the Department of Health web site at <http://www.health.ri.gov/hri2010/index.php>

Part B. General Purpose

The Rhode Island Department of Health Office of HIV/AIDS & Viral Hepatitis of is requesting proposals for the provision of direct services to Rhode Islanders living with HIV/AIDS (PLWH) for a twelve (12) month period and up to two (2) additional twelve (12) month periods depending on performance and availability of funding. The source of funding for these services include state funding and the HIV Care Grant Program Title II funding to states and territories by Health Resources and Services Administration (HRSA).

The specific service categories for which proposals are being sought are listed in the Scope of Services Section. The HRSA listing and definition of all allowable service categories are located at <http://hab.hrsa.gov/law/dsspolicies.htm>

The HIV CARE Act specifies that allowable services may be provided to Rhode Islanders living with HIV/AIDS who have no other source of payment for these services. The Department of Health (RIDH) based recommendations for services and awards on the highest priority specified by HRSA; the RIDH-sponsored HIV Provision of Care Committee;

the analysis of Unmet Needs; the State Wide Statement of Need; and the availability of funding.

The Office of HIV/AIDS & Viral Hepatitis is soliciting proposals for a twelve (12) month period, with a contract start date of approximately April 1, 2007. RIDH reserves the right to renew awards on an annual basis for up to two (2) additional twelve (12) month periods depending on performance and availability of funding.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care

The collective set of CLAS mandates, guidelines, and recommendations issued by the HHS Office of Minority Health intended to inform, guide and facilitate required and recommended practices related to culturally and linguistic appropriate health services. All Title II funded program activities and services must meet the Office of Minority Health mandated Standards as follows:

Standard 4 – Qualified language assistance services (mandate)

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5 – Notices to patients/consumers of the right to language assistance services (mandate)

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6 – Qualifications for bilingual and interpreter services (mandate)

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7 – Translated materials (mandate)

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

For more information about the Office of Minority Health standards link to <http://www.omhrc.gov/>

A single agency must be the lead applicant. However, HEALTH strongly encourages collaboration and cooperation among agencies that are proposing to provide services. The lead applicant's proposal must describe and document such collaborative efforts with written agreements in the attachment section of the proposal. The collaborative plan must be specific and detailed with roles and responsibilities associated with the deliverables of the contract. It is expected that these collaborations will be arranged to provide services of the highest

possible quality. Collaboration should also be designed to improve or maintain easy access to these services for PLWH. RIDH encourages the design of proposals which aim to achieve "100% access and 0% disparity" with respect to all services for Rhode Islanders living with HIV/AIDS. Subcontracting for some program services is allowed, and the applicant agency is responsible for administrative oversight of all work performed by the subcontractor.

Reimbursement for Services

Reimbursement for all services must be consistent with the Medicare Program fee structure for clinical and diagnostic services. This includes inpatient and outpatient hospital care, preventive services, durable medical equipment, diagnostic, mental health and many more services and benefits. Only clients who are ineligible for third party reimbursement of services are eligible for HIV Care Act services.

In addition, all proposals should include collaborative agreements that describe and document how the applicant will accomplish the following:

- ❑ Formalize, document, and implement referral networks to assure access to comprehensive care for people living with HIV/AIDS.
- ❑ Conduct interagency linkage, confidentiality agreements and client level information sharing so that that duplication of services is minimized.
- ❑ Explore all other avenues of third party reimbursement services with the client so that HIV Care Act funds will only be used as "payor of last resort" as mandated by HRSA.

Continuing Quality Management

The Rhode Island Department of Health contracted with John Snow, Inc, a public health consulting company in Boston, Massachusetts in 2004 to implement a quality management program in conjunction with HEALTH and HIV Care Act funded services staff . This initiative reflects HEALTH'S commitment to enhancing the quality of HIV care services provided for those affected by HIV and its response to requirements embedded in the Ryan White Care Act Reauthorization in 2000 regarding implementation of HIV quality management activities. The purpose of the RI quality management program is to build the capacity of the state's HIV/AIDS service network to assess "the degree to which a health or social service meets or exceeds established professional standards and user expectations" [HAB quality definition] and to implement quality improvement activities as needed. The Office of HIV/AIDS & Viral Hepatitis is committed to a quality management program that reflects the needs and expertise of consumers and providers.

Quality Management activities should accomplish the following goals:

- Increase access to primary care and ancillary services. Inclusion of supportive services facilitates access to primary medical care and supports adherence to life-saving HIV treatment regimens. Quality management activities contribute to minimizing the proportion of people living with HIV/AIDS (PLWHA) who fall out of care.
- Help providers improve the quality of care and services they deliver to their clients.
- Enhance continuity and coordination of care.
- Make it possible to monitor HIV-related illnesses and trends in the local epidemic through use of demographic, clinical and service utilization information.

To accomplish these goals, providers from HIV Care Act services funded through HEALTH and consumers have been working together with JSI to:

- Develop standards of care that define the minimal level of quality of care provided across the continuum of services in RI.
- Identify and collect data that will be used to inform continuous quality improvement.
- Strengthen communication, coordination and collaboration across the HIV/AIDS services network.
- Integrate quality management activities into ongoing service delivery.
- Create opportunities for AIDS services providers in RI to learn from one another. Fostering a collaborative climate will lend itself to sharing best practices as well as lessons learned.

Standards of care (SOC) have been developed for primary care, targeted HIV case management and the ADAP program. They include measures consistent with PHS guidelines, and specific indicators with associated goals that will be monitored to assess and track implementation of the standards. The standards, developed in RI for the first time, will serve as the framework for assessment of the quality of care provided to consumers across the services network. (See Appendix 1: Standards of Care)

Training and technical assistance will be offered to providers as needed to support their ongoing QM activities. This will focus on assistance with documentation of implementation of the standards, sampling and data extraction, utilization of a QM database, enhancement of existing data collection systems, and analysis of findings to identify Continuous Quality Improvement (CQI) priority areas. Consultation on the CQI process will also be provided. Technical assistance is designed to support providers as they gradually take on the responsibility for collecting, analyzing and using QM data on a regular basis. Successful applicants must demonstrate that they have the capacity to participate in all quality management activities and trainings.

The applicant should demonstrate an understanding of the new HRSA requirements for the establishment of “quality management programs “ as described by HRSA (for the complete document visit sites: <http://hab.hrsa.gov/tools/QM> and <http://hab.hrsa.gov/tools/TACR2003jul.htm>). Also, the applicant should indicate that it has the intent and capacity to cooperate with the grantee and/or the grantee’s consultant to implement this requirement.

Part C. Scope of Services

Determining the scope for services for this RFP was a multidimensional process involving consumer, providers and the HIV community. In addition, policies and recommendation from the Health Resources and Service Administration (HRSA) were

also taken into consideration. Based on this process CORE services were identified from the list of services available for funding under HRSA guidelines. (See Appendix 2: HRSA listing and definition of all allowable service categories.)

The following CORE SERVICES will be considered for awards under this request for proposal:

CORE SERVICES

Targeted HIV Case Management. A range of client-centered services that links clients with primary medical care, psychosocial and other services to insure timely, coordinated access to medically-appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and inpatient case-management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include initial comprehensive assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; periodic reevaluation and revision of the plan as necessary over the life of the client; and client-specific advocacy. The review of utilization of services and the implementation and the monitoring of the quality management standards of care are required by HEALTH. This service is for clients **not** eligible for any other case management services (i.e. Medicaid, HOPWA). Every effort by the agency must be take to prevent duplication of billing and services such as: client release forms; screening and intake; interagency collaboration and referral mechanisms; and cooperative agreements with other HIV target case management agencies, etc.

The following services are options for agencies applying for HIV targeted case management funds only. If the applicant applies for these funds, include written procedures and protocols; estimate of clients to be service; and examples of tools and forms to be used etc.:

- ***Emergency Financial Assistance.*** Provision of short-term payments for essential utilities, heat, rent and/or non-ADAP medication assistance. These short-term payments must be carefully monitored to assure limited amounts of funding are reaching clients who have exhausted other avenues of emergency financial assistance. Applicants are strongly recommended to limit the allocation to no more than \$50/client/year. Expenditures must be reported under the relevant service category. Agencies must have signed releases from clients to verify that the client has not received Emergency Financial Assistance from any other HIV CARE Act agency in the same grant year.
- ***Nutritional Supplements.*** Provision of nutritional supplements based on medical need is available to clients. Applicants must have a plan for collecting a signed verification from the client's medical provider stating that the patient is in medical need of nutritional supplements.
- ***Oral Health.*** Diagnostic, prophylactic, and therapeutic services rendered by a Rhode Island licensed dentists, dental hygienists, and similar professional practitioners in. Dental services are limited to \$850/year/client after the clients has exhausted all

other payers for this services. Agencies must have signed releases from clients to verify that the client has not received Oral Health benefits from any other HIV CARE Act agency that year. Reimbursement for all oral health services must be consistent with the Medicare Program fee structure for clinical and diagnostic services.

- ❑ **Transportation.** Conveyance services provided to a client in order to access primary medical care or mental health services. May be provided routinely or on an emergency basis.
- ❑ **Psychosocial Support Services.** Individual and/or group counseling, other than mental-health counseling, provided to clients by non-licensed counselors. May include psychosocial providers, peer counseling and support group services. Applicants are encouraged to document how this service will enhance drug adherence, reduce risk behavior and/or improve health outcomes for people living with HIV.
- ❑ **Mental Health Services.** Psychological and psychiatric treatment and counseling services, including individual and group counseling, provided by a mental-health professional who is licensed or authorized within the State, including psychiatrists, psychologists, clinical-nurse specialists, social workers, and counselors. Mental health services are provided by referral from case management for people living with HIV/AIDS who have no other means of receiving mental health services. HIV targeted case managers servicing the chronically mental ill client with HIV should make every effort to refer the client to existing state funded services for the chronically mentally ill. Reimbursement for all mental health services must be consistent with the Medicare Program fee structure for clinical and diagnostic services.
- ❑ **Health Insurance.** Provide financial assistance for individuals with HIV to maintain a continuity of their health insurance through COBRA.

Primary Medical Care for the Treatment of HIV Infection includes the provision of care that is consistent with Public Health Service guidelines and HEALTH quality management standards of care. Such care must include access to anti-retrovirals and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

The following services are options for agencies applying for Primary medical care funds only. If the applicant applies for these funds, include written procedures and protocols; estimate of clients to be service; and examples of tools and forms to be used etc. in the attachments:

- ❑ **Nutritional Counseling.** Provision of nutrition education and/or counseling provided by a licensed/registered dietitian with a referral from the health care provider. Reimbursement for all services must be consistent with the Medicare Program fee structure for clinical and diagnostic services.
- ❑ **Treatment Adherence Services.** Provide services to enhance patient adherence to drug therapy regimens.
- ❑ **Risk Reduction in clinical settings.** Provide proven effective risk reduction

interventions in clinical settings. Applicants are expected to base their initiative on guidance and recommendations made by the Centers for Disease Prevention and Control, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medical Association of the Infectious Diseases Society of America in the *MMWR*, July 2003 (available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm>).

Community Based Health Care. Therapeutic, nursing, supportive and/or compensatory health services provided by a **licensed/certified** health care agency in a residential setting in accordance with a written, individualized plan of care established by a case-management team that includes appropriate health-care professionals. Component community based health care also includes durable medical equipment, intravenous and aerosolized drug therapy, and routine diagnostic testing. Community-based care does not include inpatient hospital services or nursing home and other long-term care facilities. Reimbursement for all community based health care services must be consistent with the Medicare Program fee structure for clinical and diagnostic services.

Minority AIDS Initiative

HRSA has set aside funding to effectively assist the state in overcoming the barriers of providing care to minority populations (e.g., providing linguistically/culturally appropriate information, providing specialty care oriented services exclusively developed to meet the needs of this group, strategies to keep people in care, strategies that overcome barriers to access and availability of care, etc.). Available funding for this category is \$13,823 and will be designed to an agency that can successfully target HIV positive individuals of color that are not able to access care and/or have dropped out of care.

Successful bidders in this category must be able to 1) track these funds separately and state how that will be done, 2) prove that their agency has direct access to the population of HIV positive individuals of color that are not in care and/or have dropped out of care, and, 3) present data that accounts for a thorough assessment of the issues at hand, 4) describe the population the agency shall target including demographics, need, barriers to care, and quantifiable client projections, and, 5) provide a clear and definitive strategy complete with specific, measurable, accurate and timely goals and objectives.

Transitional Social Support and Primary Care Services for Incarcerated Persons

The purpose of this funding is to provide transitional primary care and social support services to incarcerated persons in the custody of a local, State, or Federal correctional system who are either nearing release or whose incarceration is of short duration. This initiative is based on a the HIV/AIDS Bureau policy released by HRSA in 2001. Reimbursement for all transitional services must be consistent with the Medicare Program fee structure for clinical and diagnostic services.

Part D. Proposal Preparation and Content

Introduction

Eligible applicants include only community-based, public or nonprofit (501c3) agencies that will provide the direct services listed in the Scope of Services Section of this RFP. Include a copy of the agency's 501c3 status as Attachment 1. Applicants must be in good standing with the federal government and in compliance with all pertinent federal mandates. These services will be provided to Rhode Islanders living with HIV/AIDS who have no other source of payment for these services.

Instructions for preparation of a proposal

Proposals must be typed, 12 CPI or an equivalent font, in English, double spaced, on one side of the page, and completely paginated with a one-inch minimum margin on all sides.

Proposal Outline

Proposal Checklist

Applicants are strongly urged to use the Proposal Checklist located in Appendix 3. This same checklist will be used for a technical review of all proposals. Proposals that fail to include all the required components of the proposal outlined below will be deemed ineligible for review by the proposal review team.

The proposal should strictly adhere to the following outline:

1. Title Page

Include the name of the agency, FEIN number, full address with zip code, phone and fax numbers, e-mail address; a contact person who can answer questions about the proposal; and the name, title and address of the person authorized to sign contracts for the agency.

2. Cover Letter

Include a cover letter from the Board of Directors of the agency submitting the proposal. The letter needs to include how this proposal is consistent with the agencies missions and goals.

3. Table of Contents

Number all pages in all sections of the proposal including attachments.

4. Project Summary (Limited to one page.)

Provide a summary of the project outlined in the proposal. List brief but **very specific** information about the goals and objectives of the project. Lead agencies must propose a comprehensive delivery system of programs. The project summary must specifically detail a continuum of services and the manner by which clients will receive these services. **Indicate the total number and demographic makeup of the population of clients to be assisted by the program. Also, include a summary of the plan for the evaluation of program**

process and outcome monitoring.

5. Agency Narrative (Limited to two pages.)

Provide a brief description of the agency. Include the type of agency, nonprofit status, (include a copy of the 501c3 statement as Attachment 1), an explanation of the governing structure of the agency (including the composition of the Board of Directors and staff with respect to membership from minority communities), a brief history and general goals of the agency, the current activities/services of the agency (include all projects related to AIDS/HIV), a description of the agency's prior experience, if any, with providing Title II funded services, and reasons why the agency would be an appropriate choice to receive Title II funding through this RFP. Describe all funding and awards the agency receives to provide services to people living with HIV/AIDS.

6. Project Proposal (Limited to ten pages, not including collaborative agreements/plans. These will not be counted in the page limit, but each collaborative agreement/plan will not exceed one page.)

The information requested in this section constitutes the bulk of the project proposal. In this section, describe, in detail, the proposed project. Submit the information according to the following format:

a. Needs Statement (Limited to one page.)

Describe the demographics of the target population you have identified. Why does this population need the **specific** services you propose to provide? How do you plan to reach out to individuals currently not in care, that is, people who know they are HIV infected but are currently not receiving care services? How will your agency program fulfill an unmet need for services to Rhode Islanders living with HIV/AIDS, i.e., needs for services which cannot be obtained through private or public insurance or entitlements or funded in any other way? (Note; the HIV Care Act requires that Title II funding be used as a "payer of last resort".) Please note, also, that this needs statement will be used to ensure that the Title II grantee complies with the HIV Care Act requirement to allocate a minimum of 27% of Title II funding for health and support services to infants, children and women with HIV disease.

b. Goals and Objectives (Limited to four pages.)

List overall project goals and objectives. "Goals" should describe the general overall purpose of the program for which the applicant is seeking Title II funding support. "Objectives" should relate to one specific goal and should quantify the expected program achievements with respect to specific outcomes. Objectives must be **specific as to time and number of people being served, measurable, and realistic.**

c. Strategies and Activities (Limited to four pages.)

This section describes how the project will actually function on a day-to-day basis. Cost-effective use of project staff and community resources are especially encouraged and should be described. Please detail the entire scope of program activities, including but not limited to the following elements:

- outreach to prospective clients;
- demonstration that the agency can effectively access the identified target population and that people living with HIV/AIDSs would likely be willing and able to accept the services offered;
- intake and enrollment procedures;
- facilitation of access/intake;
- precise description of the agency staff members providing services; and interface with and/or referral to appropriate medical and/or other social services (and the agencies which are providers of these services), especially other HIV Care Act funded services/program;
- outline strategies within the context of a high standard associated with the delivery of services and
- specify as to what the standards of delivery are.

- d. Statement of Consultant and Subcontract Agreements and Collaborations. (One page for each consultant agreement and/or subcontract. This will not be added to the total page limit. Include the signed consultant and subcontract agreement(s) as Attachment 2 in the proposal.)**

Collaborations

Describe the agency's plan for collaboration with other entities. Include how the agency will be able to refer and track clients appropriately within a *comprehensive continuum of care and services and minimize the duplication of services*. Collaborations are formal agreements between the agency and other entities to assure that people living with HIV can access services with as seamless a care system as possible and not duplicate services. The proposal needs to include referral-tracking tools and signed collaborative agreements in the attachments. Collaborative agreements are not a mechanism for the applicant to provide funding to other entities as in a subcontract or a consultant agreement as outlined below.

Consultant

Describe the nature of all consultant services including how it will enhance client services and the relevance to the project. The proposal must document consultant services with a written, signed agreement between the applicant agency and the consultant. A signed copy of an agreement outlining the components between the lead agency and consultant must be included in the proposal as Attachment 2.

All consultant agreements must include statements that describe and document the following components:

- name and title of the consultant,
- relevance of service to the project,
- nature of services to be rendered,
- number of hours/days of consultation,
- expected rate of compensation, and
- method of accountability.

Subcontracts

Describe the nature of all subcontracts including how they will enhance client services and the relevance to the project. The proposal must document subcontracts with a written, signed agreement between the applicant agency and subcontracting agency(ies). A signed copy of an agreement outlining the components between the lead agency and subcontractor must be included in the proposal as Attachment 2.

All subcontract agreements must include statements that describe and document the following components:

- name of the subcontracting agency,
- name and/or title of the staff assigned to the subcontract;
- objectives and activities to be performed by the subcontract;
- standards for training, supervising and maintaining staff in the subcontracting agency;
- description of the subcontracting agency's role in evaluation and quality management;
- subcontracting agency's budget including line items and budget justification; and
- inter-agency linkage and sharing of information so that client access to services is facilitated and so that duplication of services is minimized.

Letters of Support

Letters of support for the agency's proposal are not considered adequate documentation of consultant and/or sub-contractor services. However the applicant may include support letter as an attachment to the proposal.

e. Evaluation (Limited to two page.)

Describe the evaluation strategies for measuring the accomplishment of the goals and objectives listed above. How will you know that the goals and objectives have been achieved? Examples of existing or proposed process and outcome monitoring evaluation tools should be included as an attachment to the proposal.

f. Quality Management (Limited to two pages)

Describe the steps that the agency will take to insure implementation of a quality management program for services funded by HEALTH. Include in this quality management section descriptions of the following:

- How the program will increase access to primary care, HIV Care Act services and other support services to assure that clients needs are met and the burden of costs are directed to the most appropriate provider so that HIV Care Act services are payor of last resort.
- How the agency will ensure implementation of the standards of care for targeted HIV case management, primary care and relevant ADAP measures to improve the quality of care and services delivered to their clients.
- How the agency will implement the following requirement: collection and reporting to HEALTH every six months of three standards of care measures; two chosen by the agency and one by HEALTH. Of the two chosen by the agency, they must be either a process or outcome measure, and reflect an area the agency has prioritized for improvement. Rationale for measures chosen will be submitted to HEALTH along with

the QM data when submitted.

- How the agency will support staff with training, professional development opportunities and participate in HEALTH sponsored quality management efforts.
- How the quality management program will enhance continuity and coordination of care.

7. Project Administration (Limited to two pages)

Provide a narrative description with information on all applicant staff involved in the project.

Indicate the specific training and experience of staff whose activities will be funded by the proposal and, where appropriate, provide information about academic credentials and professional certifications. Indicate the amount of their time (1 FTE, .5 FTE, etc) that they will spend on the project. Describe the staffing in terms of FTEs and indicate very specifically how the applicant agency defines an FTE (40 hours/week or 35 hours/week, etc).

Include as a proposal attachment a detailed job description, including required credentials, on all staff positions (current and vacant). Include the job descriptions, credentials and resumes, etc as Attachment 3 of the proposal.

Describe methods for recruiting and hiring culturally competent personnel who are knowledgeable and experienced with HIV/AIDS and, also, trained and experienced in the provision of the proposed services. For current staff, who will be involved in the proposed project. Provide resumes as a proposal attachment.

Describe measures to supervise staff, provide professional development, new staff orientation and training. Include a brief description of content areas and number of hours.

8. Budget and Budget Justification

Use the attached budget forms (Appendix 3: Budget and Budget Justification) to prepare a budget that indicates an estimate of total program costs. Only program specific costs should be listed under budget categories 1 through 12. Include in the budget narrative a full description of the activities, services and/or cost items. Request for reimbursement will be made on the bases of the described activities only. Describe the specific payments to health insurers, dental providers, emergency financial assistance, and "fee for service" payments, include the amount/client. Reimbursement for all services must be consistent with the Medicare Program fee structure for clinical and diagnostic services. This includes inpatient and outpatient hospital care, preventive services, durable medical equipment, diagnostic, mental health and many more services and benefits. Only clients who are ineligible for third party reimbursement of services are eligible for HIV Care Act services.

The agency administrative cost line item is limited to 10% of overall program cost and may include reasonable agency expenses related to the administration of the program and/or the agency expense usually referred to as "indirect cost". The Budget Justification must list all staff involved with program services including the amount of time devoted to the funded activities in this proposal. Subcontracts and consultants must be described in the budget narrative as outlined in the part d. section of this outline.

For a program that uses a "fee for service" structure, the Budget Justification should also include the unit(s) reimbursement rate, the definition of each unit of service and the proposed

number of units of service to be provided within the twelve (12) month contract period.

A verifiable in-kind match of at least 10% is required from the applicant and must be shown on the Budget and described in the Budget Justification.

9. Description of services for racial and ethnic minority populations (Limited to one page.)

Include a description of how the agency staff will deliver culturally and linguistically appropriate services to racial and ethnic minority populations using the mandated standards in **National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care** (See the CLAS mandated standards under the General Purpose section of this RFP).

In addition provide information on the following:

1. The projected number of racial and ethnic minority clients to be reached by the project.
2. A demonstration or an example of the agency's access and/or proposed outreach to the population described in number one above.
3. A description of how the racial and ethnic composition of the target population will be given consideration in the selection and recruitment of administrative and service delivery staff.

If these groups are not identified as a target population for service delivery by your program, please provide a paragraph explaining the reasons why these populations are not an appropriate target group for your program.

10. Describe how your proposal will contribute to the achievement of *Healthy People 2010* Objectives (Limited to one page)

Describe how your proposal will contribute to the achievement of *Healthy People 2010* objectives. For more information about the Rhode Island Healthy People 2010 objectives link to the Department of Health web site at <http://www.health.ri.gov/hri2010/index.php>

Part E. Proposal Submission

Proposal Deadline

The closing date and time for receipt of all proposals is **Monday, January 22, 2007 at 1:00 p.m.** All proposals must be received and date stamped in the Office of HIV/AIDS & Viral Hepatitis, Room 106, Rhode Island Department of Health, 3 Capitol Hill, Providence **on or before** this deadline. All applicants should consider the difficulty parking at the Department of Health and are encouraged to submit proposals early. Applicants must hand deliver or send proposals by certified mail. Absolutely no faxed or email proposals will be accepted.

Any Proposals "received" after this date and time will be ineligible for consideration.

Pre-Proposal Technical Assistance Workshop

All applicants for funding through this RFP announcement are strongly urged to attend a Technical Assistance Workshop on **Wednesday, December 27, 2007 from 2:00 – 3:00 p.m.** at the following location:

Rhode Island Department of Health/Cannon Building
Health Policy forum, lower level
3 Capitol Hill
Providence, RI

Applicants should call 222-2320 to pre-register all Workshop participants. The workshop will provide an overview of the RFP and will answer questions about this RFP.

Receipt, Protection, and Opening of Proposals:

Proposals will be stored in a safe or locked file cabinet as they are received and will be protected from disclosure until they are opened.

Proposal Submission

An original plus seven (7) copies of the completed proposal must be submitted and formatted according to the outline described in this RFP. Applicants are strongly urged to use the Proposal Checklist (Appendix 3: Proposal Checklist).

To apply for funding under this RFP, please submit the proposal package to:

Rhode Island Department Of Health
Office of HIV/AIDS & Viral Hepatitis
3 Capitol Hill, Room 106
Providence, RI 02908-5097
Attention: Paul Loberti, MPH

For technical information only about this RFP, contact:

Paul Loberti, MPH, Chief Administrator
Office of HIV/AIDS & Viral Hepatitis, Room 106
3 Capitol Hill Providence, RI 02908-5097
Telephone: (401) 222-2320

No other contact with HEALTH employees regarding the content of this RFP is permitted.

Part F. Requirements, Tasks, Data

The applicant will:

- Participate in the quality management, central processing/intake and client centered data correction work groups and activities such as trainings. HEALTH will incorporate a central processing/intake system for all Ryan White CARE Act Title II support services and client data collection within the contract period.
- Participate in the planning process for HIV Care Services (Ryan White CARE Act Title II) including participation in the Provision of Care Committee, needs assessment and planning activities, and supporting participation of people living with HIV/AIDS in consumer activities organized by the Office of HIV/AIDS & Viral Hepatitis. Funded agencies will be expected to have a representative at all meetings associated with these activities.
- Provide quarterly narrative and monthly data program reports to the Ryan White CARE Act Title II Programs Manager. The data will include demographic, clinical and service utilization information as designated by HEALTH. Successful applicants will be trained and prepared on HEALTH's client level data collection requirements. Data will include units of services provided, number of clients serviced, their racial and ethnic background, their HIV disease status (i.e., whether or not they have an AIDS diagnosis), their age and gender.
- Maintain data on clients and services that are sufficient for HEALTH to prepare the HRSA required conditions of award report. The agency will collect demographic, clinical and service utilization information so that HEALTH can better monitor HIV-related illnesses and trends in the local epidemic.
- Make available to HEALTH during site visit, information on services rendered, client record keeping and administrative oversight.
- Make available to HEALTH during site visit request information on quality management measurers.
- Make available all records and reports pertinent to a funded project accessible to the Rhode Island Department of Health upon request.

Part G. Contract Information

The initial HIV CARE Act service awards will be for a twelve (12) month period and the awards may be renewed at the sole discretion of the State for two (2) subsequent periods of twelve (12) months each, based on contractor performance and availability of funding.

Contract Period

Contracts will be issued for a twelve (12) month period and up to two (2) additional twelve (12) month periods depending on performance and availability of funding. Continuation awards after the initial period will be based on the availability of funds and the extent to which the recipient has successfully met program objectives during the preceding budget period.

Contract Award

Approximately \$1,500,000 of federal funding is available for a twelve (12) month period in the state fiscal year July 1, 2007- June 30, 2008. If additional funding should become available for a specific contracted service, there could be a potential to increase the grant awards. However based on current trends both nationally and locally in the increased cost and enrollment in ADAP, agencies will more likely experience a decrease in available funding for support services. While the Office of HIV/AIDS & Viral Hepatitis is committed to support services for people living with HIV, the AIDS Drug Assistance Program is a priority. Issues such as waiting list, formulary restrictions and utilization caps in ADAP will be avoid as much as possible. The Office of HIV/AIDS & Viral Hepatitis will make every attempt to keep the community informed and involved with information on anticipated budgetary restrains, re-prioritization of services and other cost cutting measures.

Part H. Contract Awards

The Office of HIV/AIDS & Viral Hepatitis' Right to Award, Reject, or Negotiate

The Office of HIV/AIDS & Viral Hepatitis reserves the right to:

Award a contract with or without further discussions of the proposals submitted. (Therefore, proposals should be submitted initially with the most favorable cost and technical performance terms the agency can propose).

Reject any and all proposals as a result of this RFP.

Request an oral presentation of the proposal to the selection committee to clarify the proposal and to ensure mutual understanding.

Arrange a pre-award site-visit by the Office of HIV/AIDS & Viral Hepatitis staff to determine the agency's ability to meet the terms and conditions of the RFP.

Establish a later effective date in the contract if circumstances are such that it is in the Office of HIV/AIDS & Viral Hepatitis best interest to delay it, or if funding availability is undetermined.

Review and Selection

The Rhode Island Department of Health expects to award contracts to applicants whose proposals demonstrate conformity to this RFP's specifications with respect to the scope of services and the project budget. Applicants must possess the fiscal resources required to implement the proposed project.

The review process consists of the following steps:

- Each proposal will undergo a preliminary review by the Office of HIV/AIDS & Viral Hepatitis using the Proposal Checklist. The initial review will determine if the minimum proposal submission requirements are met. Proposals may be disqualified at this point if

they do not meet the criteria set forth in this RFP.

- Qualified proposals will be sent to a Proposal Review Team, comprised of representatives from the Office of HIV/AIDS & Viral Hepatitis and other state agencies.
- The Proposal Review Team will meet to review and discuss each proposal according to established evaluation criteria and guidelines. The attached Proposal Evaluation Form (Appendix 4: Proposal Evaluation Form) lists the relevant evaluation items and their maximum scores.
- A zero rating on any item may exclude the proposal from further consideration. A minimum score of seventy (70) points out of 100 points will be required for a proposal to be considered for funding.
- Based upon the individual ratings assigned to each proposal by the Proposal Review Team members, the proposals will be ranked in order of priority for funding by the entire team. The applicants with the highest total scores will be offered contracts.

The Review Team will submit the rank-ordered recommendations, comments and score to David Gifford MD, MPH, the Director of Health, for final approval.

Appendices

Appendix 1: Standards of Care

Appendix 2: HRSA listing and definition of all allowable service categories.

Appendix 3: Budget and Budget Justification

Appendix 4: Proposal Checklist

Appendix 5: Proposal Evaluation Form

Appendix 1: Standards of Care

<i>Case Management Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal</i>	<i>Comments</i>
I Structural/Organizational						
A. Professional Development	1) Newly Hired Case Managers (less than one year with agency) will have completed training in the following			1) Personnel Records with documentation of completed trainings. Acceptable documents include:		
	a) Within 3 months of hire: (i) HIV/AIDS – including Living with Chronic Illness and the Ryan White Care Act, Treatment, Adherence, etc (ii) Record Keeping (iii) Confidentiality (iv) Ethics and Liability (v) Entitlement Programs	a) Number of newly hired case managers with completed training during first 3 months in HIV/AIDS, Record Keeping, Confidentiality, Ethics and Liability and Entitlement Programs	a) Number of newly hired case managers	a) supervisory checklist and supervisor’s notes of date, time and content/topic		
	b) Within 1 year of hire: (vi) Certificate program (see standard C outcome measure i.) (vii) Co-Occurring disorders (viii) Cross Cultural Competence, including LGBT, sexuality, recovery, etc (ix) Behavior Change/Risk Reduction including sexuality, trauma, motivational interviewing (x) Permanency Planning (xi) Interpersonal Boundaries	b) (vi) Number of newly hired case managers with certificate from Case Management program within one year of hire date (vii) – (xi) Number of newly hired case managers with completed training within one year of hire date in Co-Occurring disorders, Cross Cultural Competence, Behavior Change/Risk Reduction, Permanency Planning, Interpersonal Boundaries	b) Number of newly hired case managers with one year at agency	b) certificate of training attendance and completion		

1 Measuring What Matters: Allocation, Planning and Quality Assessment for the Ryan White CARE Act (2004), copyright 2004, 2001. National Academy of Sciences

A. Professional Development (continued)	2) Case Managers at agency for more than one year will have completed a minimum of twelve hours training annually.	2) Number of active case managers during reporting period with one or more year's tenure who have completed twelve hours of training during the reporting period.	2) Number of active case managers during reporting period with one or more year's tenure			
B. Staff Qualifications	<p>All Case Managers hired after 10/1/05 will have:</p> <p>1) At least a high school diploma or GED. Those having only a GED or high school diploma will complete a Case Management certification program within one year from date of hire.</p> <p>2) Minimum of two years experience in social services arena</p> <p>4) Strong interpersonal and communication skills, at minimum literate and conversant in English</p>			<p>Staff Records:</p> <p>1) Resume, diploma and certificate of completion</p> <p>2) Resume, reference check, agency specific application</p> <p>4) Brief writing sample, conversant during interview, letter of application</p>		<p>GED = General Equivalency Diploma</p> <p>BCI = Bureau of Criminal Investigation</p> <p>CANTS = Child Abuse Neglect Tracking System</p>

B. Staff Qualifications (continued)	5) Completed criminal background check through BCI and CANTS if CM has any contact with children			5) BCI and CANTS printouts.		
C. Waiting List(s) for care/service	<p>Policy exists delineating maintenance and timing of contacts with clients seeking service(s) but not yet assigned to Case Manager. Policy should include:</p> <p>a) Mechanism for tracking waiting list b) Estimated time of wait (for assignment to Case Manager) c) Frequency of status updates and contact with client d) Specify mechanism for access to emergent service</p>			Updated/Current policy and procedure		

<i>Case Management Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal</i>	<i>Comments</i>
II. Process						
D. Needs Assessment and care plan will be completed within 45 days from case manager assignment	A) Client assessed for need of care/service: 1. Mental Health 2. Substance Abuse 3. Medical Care a. Primary Care/Infectious Disease b. Oral Health c. Medication Use/Adherence 4. Financial Issues, including Medication Access (ADAP, etc.) 5. Legal History and Legal Needs 6. Housing 7. Risk Reduction 8. Education/Employment 9. Transportation	Number of clients with documented need or no need within 45 days of assignment in: 1. Mental Health 2. Substance Abuse 3. Medical Care a. Primary Care/Infectious Disease b. Oral Health c. Medication Use/Adherence 4. Financial Issues, including Medication Access (e.g., ADAP, etc.) 5. Legal History and Legal Needs 6. Housing 7. Risk Reduction 8. Education/Employment 9. Transportation	Number of new clients and Number of re-established clients	Client chart	A) 75%	HEALTH checking to see if goes against Medicaid requirement
	B) Comprehensive Care Plan addressing all mutually agreed upon needs drafted and signed by case manager, client, and case manager supervisor	B) (i) Number of clients with care plans signed and dated by client within 45 days of assignment to case manager. (ii) Number of clients whose care plan has been signed by the client, case manager, and case management supervisor.	B) Number of new clients and Number of re-established clients			B) 60%

E. Clients will be assigned to case manager within 14 calendar days of intake	A) Timely assignment to case management	A) Number of clients assigned to case manager within 14 calendar days of intake	A) Number of new clients completing intake process	A) Client chart	A) 65%	B) <i>The waiting list is an important documentation of existing capacity issues and potential unmet need</i>
	B) Average wait time spent on waiting list	B) Aggregate number of days on waiting list	B) Number of potential clients who are 'unassigned'	B) Agency waiting list		
F. Clients will have needs assessed and care plan monitored on an on-going basis	Updated and signed care plan every six months	Number of clients with care plan updated, dated and signed by case management supervisor, within six months from the date of the prior needs assessment and care plan, respectively	Number of active clients	Client chart	75%	Use HEALTH definition of Active Client (per combination of CADR and Case Management Workgroup instructions*)
G. Case managers will maintain contact with all active clients	Clients remain engaged in case management	Number of clients with a documented face to face visit every three months	Number of active clients during review period	Daily log, Client chart	75% of active clients will have at least one face to face contact during three month period	
H. Client files will be appropriately closed/inactivated	Outreach is completed and unresponsive clients' files are closed			Client chart		NOTE: Use combination of CADR and Case Management Workgroup instructions*

A) Client files will not be closed/inactivated without appropriate outreach		A) Number of clients with documentation of at least three contact attempts of any combination of the following: 1. letter sent 2. phone call made 3. home visit 4. Collateral contacted	A) Number of clients with closed/inactivated files due to inactivity and/or unresponsiveness in past six months		A) 85%	A) Reason for termination/closure of client file should be documented. Note site will need to review all closed files but calculation will be done using only subset (those closed for inactivity or unresponsiveness).
B) Clients will have contact with a case manager by the end of six months or the file will be closed/inactivated		B) Number of clients with 3 client contacts within past six months	B) Number of active clients in past six months		B) 85% will be truly active as defined by minimum of 3 client contacts within 6 months.	B) Numerator and Denominator for B capture the clients whose files should be active. The complement (i.e., subtract B from 1 or, (1-B)) of this measure represents files that should be closed but which are still counted as active (artificially inflating the number of active clients). This measure can be reviewed in conjunction with Process SOC G.

*Combination of CADR and Case Management Workgroup Instructions for Definition of Status:

Active Client, new to the program: is an individual whose first point of contact with the program occurred during this reporting period. If a client's file had been closed and then the client is re-engaged, the re-engagement would be considered the first point of contact. If the client's file had not been closed, use definition for Active Client, continuing in program.

Active Client, continuing in program: is an individual who was a client when the period started and continued in the program

Deceased: clients have died sometime during this reporting period

Inactive: includes, for example, clients who have moved or were lost to follow-up

Unknown/Unreported: Indicates that the vital/enrollment status is unknown or not reported.

<i>Case Management Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal</i>	<i>Comments</i>
III. Outcome						
I. Clients' agreed upon needs are addressed	Clients are: Linked to care/services	Referrals completed and outcomes documented as needed for: 1. Mental Health 2. Substance Abuse 3. Medical Care a. Primary Care/ID b. Oral Health c. Medication Use/Adherence 4. Financial Issues a. Emergency Financial Assistance b. Medication Access i. ADAP ii. Other Medicine Payment Assistance 5. Legal History and Legal Needs 6. Housing 7. Transportation	Total number of referrals for: 1. Mental Health 2. Substance Abuse 3. Medical Care a. Primary Care/ID b. Oral Health c. Medication Use /Adherence 4. Financial Issues a. Emergency Financial Assistance b. Medication Access i. ADAP ii. Other Medicine Payment Assistance 5. Legal History/Needs 6. Housing 7. Transportation	Database, client chart, referral tracking system, referral forms	85%	Reasons/Explanation for Outcomes should be documented

<p>J. All case management clients have access to primary care</p>	<p>Completed primary care visits</p>	<p>(i) Number of clients with at least one primary care visits in six months</p> <p>And</p> <p>(ii) Number of clients with less than one primary care visit/6 month period</p>	<p>(i) Number of case management clients seen during six month period</p> <p>And</p> <p>(ii) Number of case management clients seen during 6 month period</p>	<p>Client self-report, Case Management progress notes, Medical Evaluations, Direct Contact with Physician</p>	<p>85%</p>	<p>Measure (i) captures those meeting HRSA standard – include all case management clients’ status. Measure (ii) is the complement of (i) (i.e., 1-(i)) Measure (ii) is rate of individual who NEED to be re-engaged or are not meeting HRSA Primary Care standard of being in care</p>
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<i>Primary Care Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal/Benchmark</i>
I. Organizational Standard (required)					
A. Regular Quality Improvement (QI) activities focus on HIV care process measures	Clinic meets or exceeds its performance goals on at least 2 “process of care” measures annually	Number of care process measures in which goal is met or exceeded	Not applicable	Chart audit or database report for QI measures selected (based on sample of or all HIV clients, not restricted to RWCA-funded subgroup)	2 or more measures where performance meets or exceeds target

II. Process Standards (required)					
A. RWCA client’s ongoing participation in primary medical care for HIV infection	RWCA clients have a visit with HIV medical care provider at least every 6 months	Number of RWCA clients reporting primary care visits every 6 months	Number of RWCA clients receiving primary medical care for HIV/AIDS at site during last year	Chart audit of sample, patient-level database, or other source of utilization/visit information (e.g., billing records)	Achieved by 80% of all HIV/AIDS clients
B. RWCA client’s ongoing laboratory monitoring of immune function	RWCA clients have CD4 count and HIV viral load monitored at least every 6 months	Number of active RWCA clients having CD4 counts and/or viral load tests performed every 6 months	Number of RWCA clients receiving primary medical care for HIV/AIDS	Chart audit or patient-level database (if available)	Achieved by 70% of all HIV/AIDS clients receiving primary care at the site
C. Recommendation of HAART	RWCA clients meeting eligibility requirements have been offered or are on HAART	Number of RWCA clients who are on HAART or have had HAART discussed in the last 12 months	Number of RWCA clients who meet HAART eligibility criteria in current USPHS guidelines or are already on HAART	Chart audit of sample of patients or patient-level database (if available)	Achieved by 70% of all HIV/AIDS clients
D. Assessment of substance abuse and mental health	RWCA clients have at least annual assessment of	Number of RWCA clients who have	Number of RWCA clients receiving primary medical	Chart audit or patient-level database (if available)	Achieved by 80% of all HIV/AIDS clients

treatment needs	substance abuse and mental health treatment needs	evidence in medical record of assessment	care for HIV/AIDS		
E. Prevention of PCP	RWCA clients at risk for PCP are on appropriate prophylaxis	Number of RWCA clients with absolute CD4 count <200 or <14% in last 6 months who are on PCP prophylaxis ¹	Number of RWCA clients with absolute CD4 count <200 or <14% in last 6 months	Chart audit or patient-level database (if available)	Achieved by 80% of all HIV/AIDS clients

¹ Exclude patients who have CD4 count recovery in last 3 months and have PCP prophylaxis discontinued

<i>Primary Care Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal/Benchmark</i>
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F. Risk reduction counseling (prevention for positives)	RWCA clients have risk reduction counseling at least annually	Number of RWCA clients who have evidence in medical record of prevention for positives counseling	Number of RWCA clients receiving primary medical care for HIV/AIDS	Chart audit or patient-level database (if available)	Achieved by 70% of all HIV/AIDS clients
Optional Standards:					
HIV resistance testing for first HAART regimen failure					
Adherence to medications for patients on HAART (assessment and offering interventions to address problems)					

III. Outcome Standards (required)

A. Disease progression is arrested or slowed for RWCA clients participating in primary medical care	Sustained CD4 count ≥ 200 or $\geq 14\%$ during year	Number of RWCA clients with CD4 count ≥ 200 or $\geq 14\%$ during year	Number of RWCA clients receiving primary medical care	Medical record or database: Lowest absolute CD4 count or percentage from previous 12 months	Achieved by 60% of all HIV/AIDS clients
B. Disease progression is arrested or slowed for RWCA clients participating in primary medical care	Viral load (HIV RNA) is < 5000 copies/ml <u>if on HAART or eligible for antiretroviral therapy according to current national treatment guidelines</u>	Number of RWCA clients who meet criteria for antiretroviral (ARV) therapy or are on HAART AND maintain VL below 5000 copies/ml during	Number of RWCA clients who meet criteria for HAART or are taking HAART during year and have a VL measured	Medical record: Highest viral load measurement from previous 12 months and HAART status (eligible or on)	Achieved by 50% of all HIV/AIDS clients who were eligible for antiretroviral therapy by national guidelines

		year			
Optional Standards					
Disease progression is arrested or slowed for RWCA clients participating in primary medical care	No additional new AIDS-defining condition (OI or CD4 < 200)	Number of RWCA clients who do <u>not</u> have a new AIDS-defining condition	Number of RWCA clients receiving primary medical care	Chart audit	None selected

Appendix 2: HRSA listing and definition of all allowable service categories.

Ryan White Health Care and Support Services

Rhode Island has adapted this list from the services available through Title II. Case Management services are not available through this RFP. Case Management services were awarded in August 2003 under a different. Since the Drug Reimbursement Program is administrated directed under HEALTH, it is also not available through this RFP.

Ambulatory/Outpatient Medical Care. Provision of professional, diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient, community-based, and/or office-based setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health and nutritional issues, minor surgery and assisting at surgery, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care.

Primary Medical Care for the Treatment of HIV Infection includes the provision of care that is consistent with Public Health Service guidelines. Such care must include access to antiretrovirals and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Drug Reimbursement Program. Ongoing service/program to pay for approved pharmaceuticals and or medications for persons with no other payment source. Subcategories include:

- State-Administered AIDS Drug Assistance Program (ADAP). Title II CARE Act-funded and administered program or other state-funded Drug Reimbursement Program.
- Local/Consortium Drug Reimbursement Program. A program established, operated, and funded locally by a Title I EMA or a consortium to expand the number of covered medications available to low-income patients and/or to broaden eligibility beyond that established by a State-operated Title II or other State-funded Drug Reimbursement Program.

Medications include prescription drugs provided through ADAP to prolong life or prevent the deterioration of health. The definition *does not include* medications that are dispensed or administered during the course of a regular medical visit or that are considered part of the services provided during that visit. If medications are paid for and dispensed as part of an *Emergency Financial Assistance Program*, they should be reported as such.

Health Insurance. A program of financial assistance for eligible individuals with HIV disease to maintain a continuity of health insurance or to receive medical benefits under a health-insurance program, including risk pools.

Home Health Care. Therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home-health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case-management team that includes appropriate health-care professionals.

Component services include:

- Durable medical equipment
- Homemaker or home-health aide services and personal care services
- Day treatment or other partial hospitalization services
- Intravenous and aerosolized drug therapy, including related prescription drugs
- Routine diagnostic testing administered in the home of the individual
- Appropriate mental health, developmental, and rehabilitation services
- Home- and community-based care does not include inpatient hospital services or nursing home and other long-term care facilities.

Oral Health. Diagnostic, prophylactic, and therapeutic services rendered by dentists, dental hygienists, and similar professional practitioners.

Hospice Services.

Home-Based Hospice Care. Nursing care, counseling, physician services, and palliative therapeutics provided by a hospice program to patients in the terminal stages of illness in their home setting.

Residential Hospice Care. Room, board, nursing care, counseling, physician services, and palliative therapeutics provided to patients in the terminal stages of illness in a residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services for terminal patients.

In-Patient Personnel Costs. Within the limitations of the legislation, up to ten percent of the total award is allowable for such costs, if it has been determined by the planning council that a shortage of inpatient personnel exists which has in turn resulted in inappropriate utilization of inpatient services.

Mental Health Services. Psychological and psychiatric treatment and counseling services, including individual and group counseling, provided by a mental-health professional who is licensed or authorized within the State, including psychiatrists, psychologists, clinical-nurse specialists, social workers, and counselors.

Nutritional Counseling. Provision of nutrition education and/or counseling provided by a licensed/registered dietitian outside of a primary care visit. Nutritional Counseling provided by other than a licensed/registered dietitian should be provided under *Psychosocial support services*. Provision of food, meals, or nutritional supplements should be reported as a part of the subcategory, *Food and/Home-Delivered Meals/Nutritional Supplements*, under Support Services.

Rehabilitation Services. Services provided by a licensed or authorized professional in accordance with an individualized plan of care, which is intended to improve or maintain a client's quality of life and optimal capacity for self-care. This definition includes physical therapy, speech pathology, and low-vision training services.

Substance Abuse Services. Provision of treatment and/or counseling to address substance-abuse issues (including alcohol, legal and illegal drugs), provided in an outpatient or residential health service setting.

Treatment Adherence Services. Provision of counseling or special programs to ensure readiness for and adherence to complex HIV/AIDS treatments.

Support Services

Child Care Services. The provision of care for the children of HIV positive clients while the clients are attending medical or other appointments. This does not include daycare while the client is at work.

Child Welfare Services. Assistance in placing children younger than 20 in temporary (foster care) or permanent (adoption) homes because their parents have died or are unable to care for them due to HIV-related illness.

Buddy/Companion Services. Activities provided by peers or volunteers to assist a client in performing household or personal tasks. Buddies also provide mental and social support to combat loneliness and isolation.

Case Management. A range of client-centered services that links clients with primary medical care, psychosocial and other services to insure timely, coordinated access to medically-appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and inpatient case-management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include initial comprehensive assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic reevaluation and revision of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services.

Client Advocacy. Assessment of individual need, provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up on medical treatments.

Day or Respite Care. Home- or community-based non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of client or client's child.

Early Intervention Services (EIS). Counseling, testing, and referral services to PLWH

who know their status but are not in primary medical care or who are recently diagnosed and are not in primary medical care for the purpose of facilitating access to HIV-related health services.

Emergency Financial Assistance. Provision of short-term payments for transportation, food, essential utilities, or medication assistance, which planning councils, Title II grantees, and consortia may allocate. These short-term payments must be carefully monitored to assure limited amounts, limited use, and for limited periods of time. Expenditures must be reported under the relevant service category.

Food Bank/Home Delivered Meals/Nutritional Supplements. Provision of food, meals, or nutritional supplements.

Health Education/Risk Reduction. (1) Provision of information, including the dissemination about medical and psychosocial support services and counseling or (2) preparation/distribution of materials in the context of medical and psychosocial support services to educate clients with HIV about methods to reduce the spread of HIV.

Housing Assistance. This assistance is limited to short-term or emergency financial assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Use of Titles I, II and IV funds for short-term or emergency housing must be linked to medical and/or health-care services or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.

Housing Related Services. Includes assessment, search, placement, and advocacy services provided by professionals who possess an extensive knowledge of local, State and Federal housing programs and how they can be accessed.

Legal Services. Legal services directly necessitated by a person's HIV status including: preparation of Powers of Attorney, Do Not Resuscitate Orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act. See also, Permanency Planning and Child Welfare Services.

Outreach Services. Programs which have as their principal purpose identifying people with HIV disease, particularly those who know their HIV status so that they may become aware of and may be enrolled in ongoing HIV primary care and treatment. Outreach activities must be planned and delivered in coordination with State and local HIV-prevention outreach activities to avoid duplication of effort and to address a specific service need category identified through State and local needs assessment processes. Activities must be conducted in such a manner as to reach those known to have delayed seeking care. Outreach services should be continually reviewed and evaluated in order to maximize the probability of reaching individuals who do not know their HIV status or know their HIV status but are not actively in treatment. Broad activities that market the availability of health-care services for PLWH are not considered appropriate Title I

outreach services.

Permanency Planning. The provision of social service counseling or legal counsel regarding:

- The drafting of wills or delegating powers of attorney
- The preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption

Psychosocial Support Services. Individual and/or group counseling, other than mental-health counseling, provided to clients, family, and/or friends by non-licensed counselors. May include psychosocial providers, peer counseling/support group services, caregiver support/bereavement counseling, drop-in counseling, benefits counseling, and/or nutritional counseling, or education.

Referral. The act of directing a person to a service in-person or through telephone, written, or other forms of communication. Referral may be made formally from one clinical provider to another, within a case-management system by professional case managers, informally through support staff or as part of an outreach services program.

Transportation. Conveyance services provided to a client in order to access primary medical care or psychosocial support services. May be provided routinely or on an emergency basis.

Other Support Services. Direct support services not listed above, such as translation/interpretation services.

Appendix 3: Budget and Budget Justification

**Proposal Budget
(12-month budget)**

The agency estimates that its budget for work to be performed for a twelve (12) month period under this Proposal is as follows:

<u>Expense Category</u>	<u>Estimated Expenditures</u>
1. Personnel.....	\$
2. Fringe Benefits.....	\$
3. Consultants.....	\$
4. In-State Travel	\$
5. Printing.....	\$
6. Program Supplies	\$
7. Educational Material.....	\$
8. Postage	\$
9. Telephone.....	\$
10. Direct Services Fees	\$
11. Other	\$
12. Agency Administrative Cost (Indirect Cost)	\$
(Suggested maximum -10%)	
13. TOTAL	\$
Required match of at least 10%	\$

Budget Justification Descriptions

Include a full description of the line item as outlined below in the budget justification.

Personnel: \$

- Must be the actual hourly rate paid to the staff named on the project
- Include the Percent of FTE for each staff on the project
- Name and title of all program administrator & staff

Fringe Benefits: \$

- Fringe may be calculated as a percent of salary, but must be the actual Rate of fringe paid to the staff

Consultant/Subcontracts: \$

- Include the hourly rate paid to the consultant
- Include the budget and signed agreements for consultant and Subcontracts
- Complete the attached budget page for each consultant(s) and subcontract(s)

In-State Travel: \$

- Number of miles/staff at no higher than the state rate of .445/mile
- Copies of travel logs must be include with request for reimbursement

Printing: \$

- Cost of materials associated with client care such as client record forms
- Copies of invoices must be include with request for reimbursement

Program Supplies: \$

- Costs associated with staff needs and client activities such as support group expenses.
- Copies of invoices must be include with request for reimbursement

Education Supplies: \$

- Cost of curriculum copies, videos, and training aids associated with client education such as risk reduction and drug adherence.
- Educational activities must be included in the objectives.
- Copies of invoices must be include with request for reimbursement

Postage: \$

- Specific about the amount of anticipated mailings, other than routine client contact must be included in the objectives.

Telephone: \$

- Cost associated with telephone needs other than the usual

administrative cost.

- Copies of telephone billing must be included with request for reimbursement.

Direct Services Fees: \$

- Describe the specific payments to health insurers, dental providers, emergency financial assistance, and "fee for service" payments, include the amount/client.
- Reimbursement for all services must be consistent with the Medicare Program fee structure for clinical and diagnostic services. This includes inpatient and outpatient hospital care, preventive services, durable medical equipment, diagnostic, mental health and many more services and benefits.
- Only clients who are ineligible for third party reimbursement of services are eligible for HIV Care Act services.

Other (Explain briefly) \$

Agency Administrative Cost (Indirect Cost)
(Maximum -10%)

TOTAL AWARD: \$

In Kind Match: \$

Describe the in-kind agency match offered with this proposal. In-kind matches should be consistent and/or of similar value as the resources being requested in the proposal budget line items.

Appendix 4: Proposal Checklist

Proposal Checklist
Attach this checklist as page 1 of the proposal.

- Name and telephone number the agency representative whom the Review team may contact with questions:

Name: _____

Telephone number: _____

- Proposal was delivered to HEALTH on or before January 22, 2007 at 1:00 pm**
- Original proposal and seven (7) copies are included in submission package.**
- Proposal is typed, 12 point or equivalent, in English, double-spaced.
- The proposal has pages numbered.

Proposal is written according to RFP Proposal Preparation requirement, submitted in the proper sequence and adhering the page limits as follows:

- Proposal Checklist- (this page)**
- Title Page**
- Cover Letter**
- Table of Contents**
- Project Summary (1 page)**
- Agency Narrative (2 pages)**

Project Narrative

- Needs Statement (1 page)
 - Goals and Objectives (4 pages)
 - Strategies and Activities (4 pages)
 - Statement of Consultant/Subcontract Collaborations
 - Evaluation (2 pages)
 - Quality Management (2 pages)
- Project Administration (2 pages)**
 - Budget and Budget Justification**
 - Description of Services for Racial and Ethnic minorities (1 page)**

Attachments:

- Attachment 1 - Copy of 501c3 documentation
- Attachment 2 – Signed Consultant/Subcontract Agreement(s)
- Attachment 3 – Job descriptions, staff credentials, etc.
- Other Attachments, if any

Appendix 5: Proposal Evaluation Form

Proposal Evaluation Form

Total Score _____ Out of 100

Agency

Reviewer Number

Please score the proposal using the criteria below.

POINTS	DESCRIPTION OF SCORING CRITERIA
____ Points (0-5)	The proposal describes agency history, governing structure, a Board of Directors, which is racially/ethnically diverse, general goals/mission, prior HIV/AIDS services provision and explains why the agency is an appropriate choice for Title II services. The applicant demonstrates present and past expertise and/or experience in the provision of services to people living with HIV/AIDS. Agency has other sources for funded services to people living with HIV/AIDS. The documentation for the 501c3 is included as Attachment 1.
____ Points (0-10)	The proposal describes the demographic characteristics and projected numbers of the targeted population to be reached based on the agency’s needs assessment and local data. The agency's describes its access to and/or proposed outreach to the targeted population. The target population is fully described in terms of age, race, ethnicity, HIV risks and service needs.
__ Points (0-10)	The proposal describes the unmet gaps and needs for the HIV/AIDS services to be provided is detailed and the applicant describes how the proposal will address the gaps and needs. The unmet needs are based on the agency’s needs assessment and local data.
_ Points (0-10)	The proposal lists realistic program goals and objectives are specific as to time lines and the number of people to be served. The objectives can be quantified and measured. The objectives are responsive to the needs identified in the needs statement and are within the HRSA defined scope of services outlined in the RFP.
____ Points (0-10)	The proposal describes, in detail, strategies and activities that can accomplish program goals and objectives. The activities associated with the objectives are fully described with time line, staffing, protocols and procedures. Examples of documentation such as client assessments are included as attachments.
____ Points (0-10)	The applicant has described a collaboration to enhance service delivery to people living with HIV/AIDS. The collaboration, consultant and subcontract plans with other entities are consistent with the objectives and needs statement. The agency’s plan to refer and track clients is appropriate and within a <i>comprehensive continuum of care and services and will minimize the duplication of services.</i> Signed agreements for collaborations, consultant services and/or subcontracts, as outlined in the RFP, are included in Attachment 2. Tracking tools for referrals to other agencies are included in the attachments.

POINTS	DESCRIPTION OF SCORING CRITERIA
____ Points (0-5)	The proposal includes an evaluation plan that will be able to document/measure the achievement of goals and objectives. There are process and outcome measures in place and examples of evaluation tools are included as attachments to the proposal.
____ Points (0-5)	The proposal describes the quality management measures that the agency will undertake during the life of the funding period. Agencies providing targeted case management and primary care included standard of care targets.
____ Points (0-5)	The proposal describes the direct service and administrative/supervisory staff. The staff are qualified and experienced in the provision of HIV specific services and the duties and work time devoted to the specific services to be provided are described in detail. The proposal includes a description for recruiting and hiring culturally competent personnel and staff development measures. Copies of job descriptions, resumes, credentials are included as Attachment 3.
____ Points (0-15)	The budget pages include realistic, appropriate estimates of the cost of both program-specific and administrative (indirect cost) expenses and a 10% agency match. The budget narrative describes in detail each line item as outlined in the RFP. The fee for service structure includes unit costs, reimbursements rates, definition of unit of services and the number of service units proposal for a 12 month period. The reimbursement for all services is consistent with the Medicare Program fee structure for clinical and diagnostic services.
____ Points (0-5)	The proposal provides a description of services for racial and ethnic minority populations, which includes: the projected number of clients to be served, a demonstration of the agency's access/outreach to these populations and a description of how the racial and ethnic composition of the target population will be given consideration in the selection and recruitment of administrative and service delivery staff. There is a description of how the staff will deliver culturally and linguistically appropriate services to racial and ethnic minorities using the mandated standards in CLAS. Proposal program/services will advance the HRSA/HAB goal of "100% access and 0% disparity".
____ Points (0-5)	The proposal describes how the agency will contribute to the achievement of the Healthy people 2010 objectives.
For current vendors only ____ Points (0-5)	Current Title II-funded vendors currently Demonstrates successful administration of Title II services including adherence to goals and objectives, work specifications, client numbers, etc.