Request for Applications (RFA) No. 22-10150

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California Department of Public Health (CDPH)
Office of AIDS (OA)
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PART I. FUNDING OPPORTUNITY DESCRIPTION

A. TENTATIVE RFA TIME SCHEDULE

Table 1. Tentative RFA Time Schedule

Event	Date
Project Cornerstone release **RFA available on CDPH/OA website:** Request for Application	3/4/22 by 5PM PST
Project Cornerstone Pre-Application webinar	3/15/22 at 1PM PST
Deadline for submitting written questions	3/17/22
Answers to written questions **Answers available on CDPH/OA website:** Request for Application	3/21/22
Deadline to submit mandatory Letter of Intent (LOI)	3/23/22 by 12PM PST
Application submission deadline	4/22/22 by 5PM PST
Notice of intent to award released **Award available on CDPH/OA website:** Request for Application	~~**5/11/22**~~ **5/17/22 by 5PM PST**
Appeal deadline	~~**5/13/22**~~ **5/19/22 by 5PM PST**
Anticipated contract start date	Upon execution

B. INTRODUCTION

California Health and Safety Code (HSC) 121295 requires the CDPH/OA, in consultation with the California Department of Aging (CDA), to establish demonstration projects allowing for innovative, evidence-informed approaches to improve the health and well-being of older people living with HIV (PLWH). For the purposes of this RFA, CDPH/OA defines these individuals as PLWH age 50 and above (PLWH50+). Recognizing both the increasing population of these individuals and the complexity of needs as PLWH age, the legislature has put forth one-time funding to develop demonstration projects that will address the comprehensive needs of PLWH50+. CDPH/OA will provide $4.5 million over the course of three fiscal years (FY) for four demonstration projects. These projects will be selected through a competitive RFA process. The resulting awards from this RFA will be part of CDPH/OA's funding initiative, titled Project Cornerstone.

Today, the number of older PLWH is increasing and predicted to grow over the next decade. People with diagnosed HIV can live long, full, happy, healthy lives thanks to early detection of HIV infection and highly effective antiretroviral therapies (ART). This diverse community includes long-term survivors (LTS) as well as those who were diagnosed later in life.

LTS of HIV lived through the early years and darkest periods of the AIDS epidemic, when there were few, if any, treatment options available. Individuals lost their loved

ones and were looked down upon by society. Communities most affected by HIV/AIDS were ignored, disregarded, stigmatized, villainized, and unacknowledged. Prior to ART, many people from these communities succumbed to AIDS. Those still living continue to be marginalized while often experiencing the trauma and guilt that comes with surviving friends, romantic partners, and peers. Furthermore, early medications had higher toxicity and significant side effects and the long-term consequences of those medications on LTS are still being identified. HIV has impacted LTS medically, socially and financially. Before effective ART, most PLWH were told to prepare to die and had to leave the workforce, often relying on government assistance. Without retirement savings, individuals that survived have been left with fewer financial resources.

Both LTS and those diagnosed later in life face complex health and social needs. As people age, they are more likely to have increasing health challenges, which, as they accumulate, may erode the individual's ability to do high-order functions which affect overall health. For PLWH, HIV infection can increase the risk of aging-related conditions such as heart disease, osteoporosis, cognitive/neurological disorders, and cancer. The onset of these health conditions is seen earlier in PLWH than in their HIV-negative peers (Francisco; Premaor & Compston, 2020). Services and programs must therefore respond to comorbidities in PLWH50+ at an earlier age than in HIV-negative individuals. In addition, PLWH50+ must navigate complicated healthcare systems and key healthcare access support programs. While some services and programs to support PLWH50+ may be established in a community, coordination of those services and ensuring that services are sensitive to the needs of PLWH50+ is lacking. PLWH50+ tend to have less access to social support networks because of the loss of friends, romantic partners, and peers; agism in the gay community; and lack of acknowledgement. Individuals are therefore prone to isolation, lacking supportive social networks that promote health and well-being. As life expectancy increases, more individuals will come to rely on the availability of robust clinical and non-clinical services and programs within their communities.

Engagement of older PLWH in the design and evaluation of services for people aging with HIV is a cornerstone to high-quality service delivery. Public conversation on both aging and HIV/AIDS generally does not include what it means to live and age with HIV. Few aging and health professionals are equipped to address the unique and diverse needs of PLWH50+. HIV and aging interventions are minimal, scattered and rarely coordinated in a systemic way that link services. Additionally, public policies rarely consider PLWH50+, or provide sufficient funding for programs and other interventions that could improve their quality of life . Over the coming decades, more support will be needed to address the complex health and social needs of a growing population of PLWH50+. To meet that need, it is vital that older PLWH be heard, respected, and treasured for their experiences, insight, and knowledge of the needs that exist within their communities.

Project Cornerstone appreciates the strength, knowledge, and lived experience of LTS and those diagnosed with HIV later in life. Demonstration projects are intended to uplift and empower this unique group of individuals in the development, implementation, and

evaluation of services designed to meet the unique needs of older PLWH. By partnering with older PLWH and those who care for them (service providers, caregivers, friends, and family), Project Cornerstone seeks to ensure that PLWH50+ receive the vital, high-quality services necessary to improve their overall health and well-being.

C. Purpose

Project Cornerstone will fund clinical and non-clinical services for the growing population of PLWH50+. "Cornerstone" demonstration projects will help build a foundation of understanding and knowledge on how to meet the specific needs of these individuals, while also helping them build community. All projects must include an evaluation component and a plan for sharing lessons learned that will help develop new programs and strengthen existing programs.

Applications will be evaluated on several components including, but not limited to:

- Entity competency, capacity, and experience serving PLWH50+
- Demonstrated need in the geographic region
- Innovative program design
- Clearly defined priority population and subpopulations

Entity Competency and Capacity

Any entity in any California county shall be eligible to apply if it demonstrates (1) experience and expertise in providing culturally appropriate services to the most vulnerable and underserved PLWH50+, and (2) has the capacity to ensure that the multidisciplinary clinical and non-clinical needs of PLWH50+ are assessed and addressed. CDPH/OA encourages projects to use existing service providers with established clinical or non-clinical services in addressing the needs of PLWH50+ through referrals or partnerships with other entities.

Demonstration projects and implementation strategies must address the complex needs of PLWH50+ through the integration of clinical, behavioral, and social services in the same physical space, when possible, or through coordination of care for off-site services. Applicants should discuss how they plan to leverage the existing continuum of providers in their areas to reduce access barriers, increase the health and well-being of PLWH50+, and ensure that multi-disciplinary clinical and non-clinical needs of individuals in the applicant's community are addressed. Interventions may involve various social networks (peers, romantic partners, family members, caregivers, community members, community and/or faith-based organizations, health systems, community clinics, and clinical providers, etc.) to provide intensive support and quality care that is culturally competent and non-stigmatizing.

Demonstrated Need in the Geographic Region

PLWH50+ in California have unique and diverse needs that vary across geographic regions. Smaller towns and rural areas may have different needs and resources than larger urban areas. CDPH/OA acknowledges that communities have varying ability to provide specific services through public or private organizations.

Program Design

CDPH/OA defines “innovative” as the application of new ideas or promising practices that use the required approaches within this RFA to address the needs of PLWH50+, as demonstrated by both qualitative and quantitative data. This also includes the advancement of existing programs or approaches that have been deemed successful in serving PLWH50+. Funded projects must include innovative, evidence-informed approaches to improve the health and well-being of PLWH50+.

CDPH/OA defines social determinants as “the conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes” (CDC, 2019). These include conditions for early childhood development, education, employment/work, food security, health services, housing, income, social exclusion, xenophobia/immigration status, homelessness, homophobia/transphobia, and others that can exacerbate vulnerability to poor health outcomes (CDC, 2021). Health disparities in HIV are linked to social determinants that influence an individual’s ability to access services and address health and wellness. Well-documented racial and ethnic disparities in HIV among communities of color due to racism often result in inequitable living conditions and chronic stress (Russell et al., 2012). Effective projects will address the social determinants of health and promote health equity in populations that carry disproportionate rates of HIV in their communities. Although applicants will propose their own ideas, projects must include interventions that address both clinical and non-clinical needs, as well as the social determinants of health and disparities for PLWH50+.

Projects that use holistic approaches to meet the needs of PLWH50+ may be well-positioned to increase the health and well-being of these individuals. The California Planning Group (CPG) Committee on HIV and Aging has made recommendations on ways the community can bolster programs serving these individuals including, but not limited to:

- Robust case management, including coordination of appointments, transportation, assistance with understanding insurance and medical bills, and benefits navigation to assist individuals enrolling in programs available to support them as they age with HIV
- Coordinated program and service delivery efforts between multiple, preferably co-located organizations
- Local and regional surveys/assessments to ensure the needs of PLWH50+ are met

- Targeted funding to providers that already have a demonstrated client base of PLWH50+
- Caregiver support

Priority Populations

Priority populations include PLWH50+ who are Black/African American (AA), Latinx, American Indian/Alaskan Native (AIAN), Asian, Native Hawaiian and other Pacific Islander (NHOPI). However, projects must aim to serve all PLWH50+ while also demonstrating how services will be tailored to meet the unique needs of at least one of the communities who are disproportionately affected by HIV.

D. Background

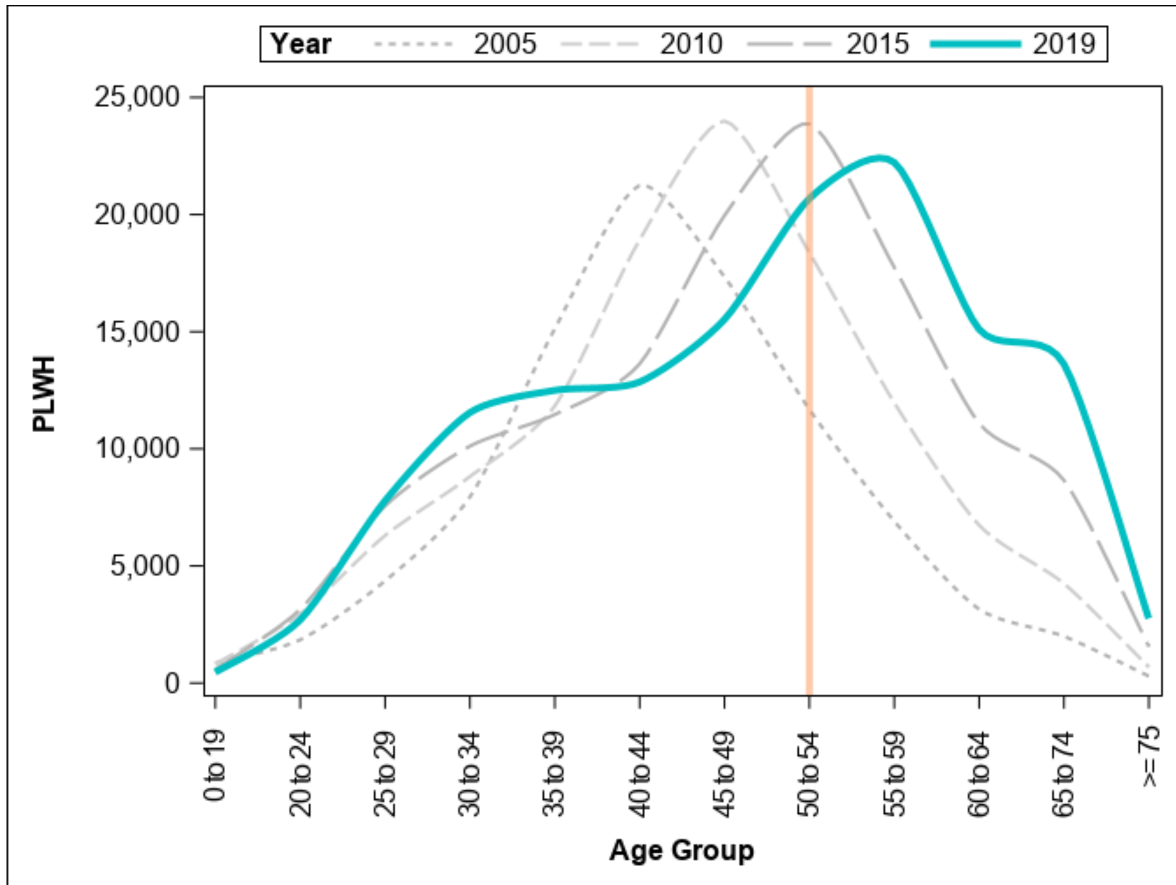
While the early identification of individuals with HIV and ART allow individuals to live lifespans almost equivalent to HIV-negative individuals, managing one’s healthcare when there are multiple conditions being addressed by multiple providers can be complicated and overwhelming (Erlandson & Karris, 2019). It is important to recognize that assistance in managing healthcare appointments and benefits can positively impact the quality of life, viral suppression, and longevity (McManus et al., 2020).

Research finds that retaining PLWH in care to achieve viral suppression and to maintain optimal health is the most effective strategy for reducing HIV incidence (Allison Perry, 2018). Retention in care requires addressing the cultural, social, economic, and other factors such as stigma and intimate partner violence, which directly influence HIV prevention and transmission, and sustaining viral suppression. Funding from Project Cornerstone will support programs that aim to increase access to HIV care and viral suppression for PLWH50+, with the goal to improve the health and well-being of PLWH50+, including identifying and treating comorbidities associated with aging.

The population of PLWH50+ is increasing, both in absolute numbers and as a proportion of all those living with HIV. The increase is a result of significant strides in the detection and treatment of the disease, as well as new diagnoses in persons 50+.

Figure 1 shows how the age distribution of PLWH has shifted over the past 15 years. In 2005, PLWH50+ accounted for 24,074 (26%) of the 92,793 of PLWH in California. In 2019, PLWH50+ accounted for 74,418 (54%) of the 137,785 PLWH in California.

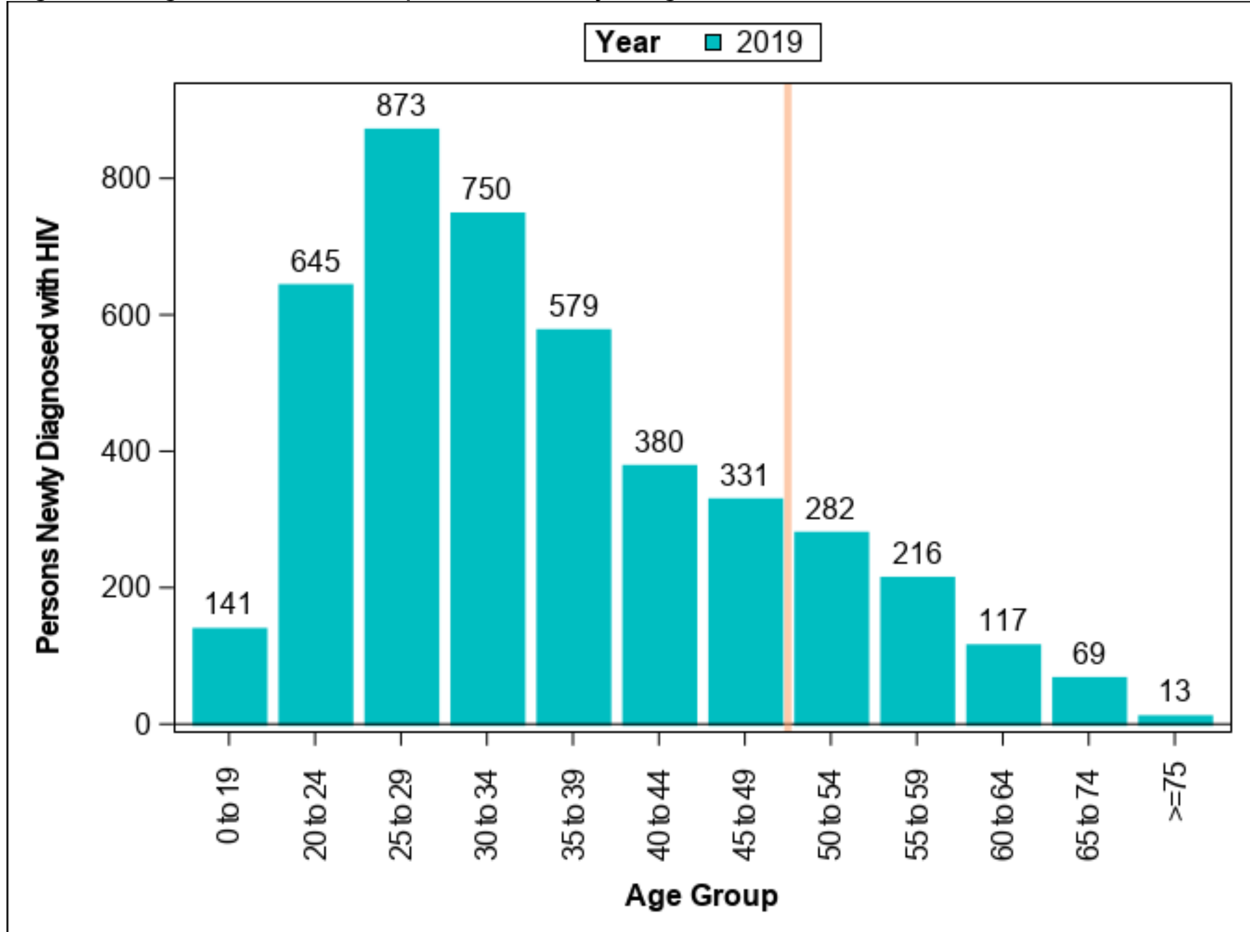
Figure 1. Age distribution of Persons Living with HIV in California as of 2005, 2010, 2015, 2019



Data Source: California Department of Public Health, Office of AIDS, Surveillance Section. Age group is based on the age at the end of the specified calendar year. Counts include all cases diagnosed with HIV infection whose last known residence was in California.

Individuals 50 years of age and older continue to represent a significant percentage of new diagnoses. In 2019, those over 50 accounted for 16 percent (n=697) of the 4,396 persons newly diagnosed with HIV infection in 2019, as shown in Figure two.

Figure 2. Age distribution of persons newly diagnosed with HIV in California in 2019



Data Source: California Department of Public Health, Office of AIDS, Surveillance Section. Age group is based on the age at the end of the specified calendar year. Counts include all cases diagnosed with HIV infection whose last known residence was in California.

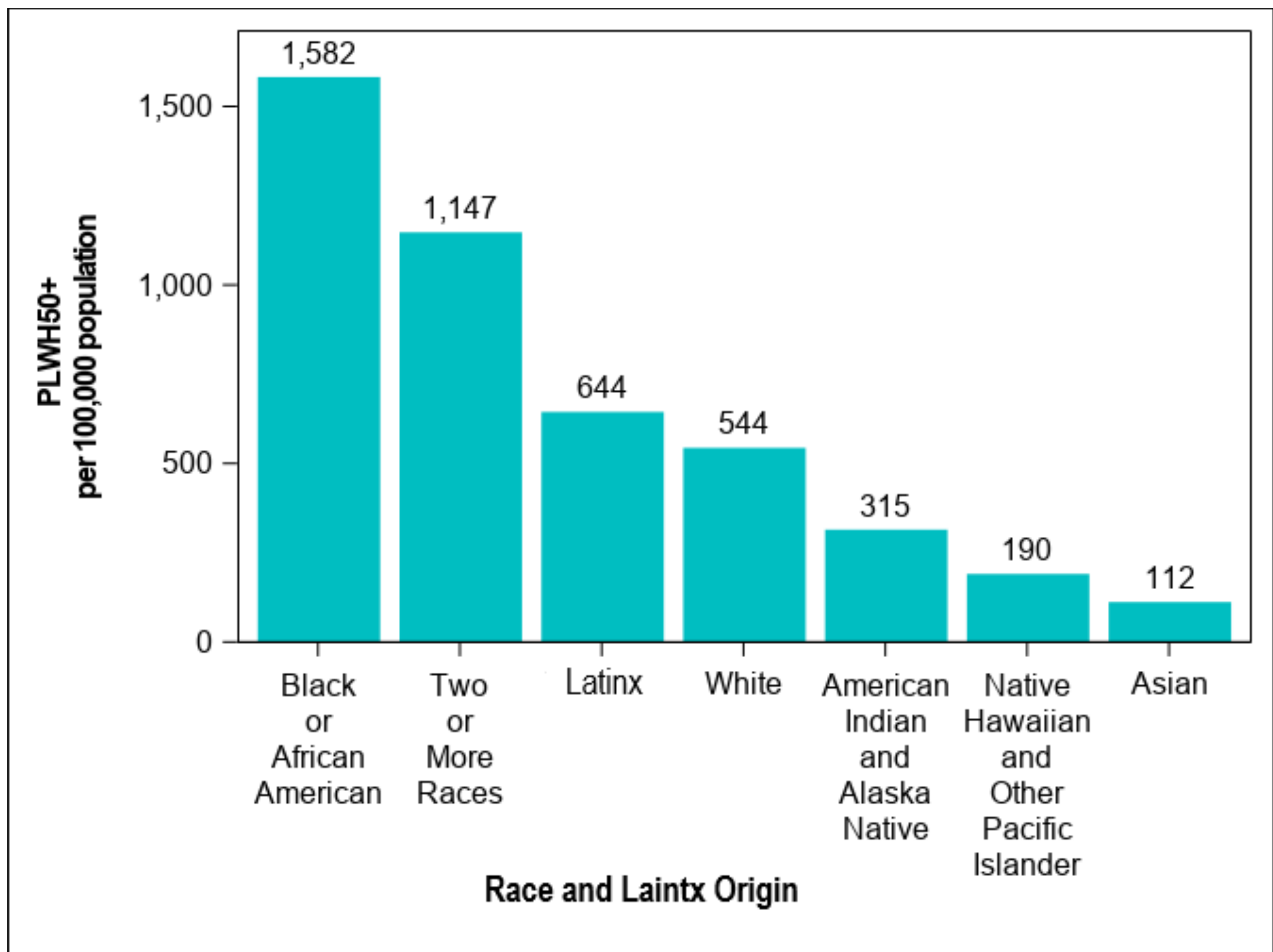
Project Cornerstone awardees must serve all PLWH50+, regardless of race/ethnicity; however, projects should focus on communities who are disproportionately affected by HIV. Based on surveillance outcomes and population size, CDPH/OA has determined that Black/AA and Latinx individuals/communities are the most underserved. Data demonstrates (California Surveillance, 2019):

- viral suppression is low among Black/AAs
- viral suppression is low among Latinxs
- a disproportionate number of Black/AAs are diagnosed with HIV as compared to other race/ethnic groups, among both men and women
- young Black/AAs and Latinxs are less likely to know their HIV status, and less likely to be virally suppressed than young Whites
- Latinxs make up the largest percentage of new diagnoses
- Black/AA and Latinx cisgender women are diagnosed at higher rates than White cisgender women

- Latinx trans women make up the largest percentage of new HIV diagnoses among trans women
- Latinxs have the highest percentage of AIDS diagnoses within 12 months of their HIV diagnosis

Black/AA have the greatest burden of HIV among persons age 50+ in California (Figure 3). At 1,582 living with HIV per 100,000, the estimated prevalence of HIV was substantially higher for Black/AA than for all other race/ethnicity groups. Among those age 50 years and older in California, the estimated HIV prevalence in 2019 was nearly three times higher for Black/AAs than it was for Whites.

Figure 3. Estimated prevalence of PLWH50+ per 100,000 population by Race and Latinx Origin in California, 2019

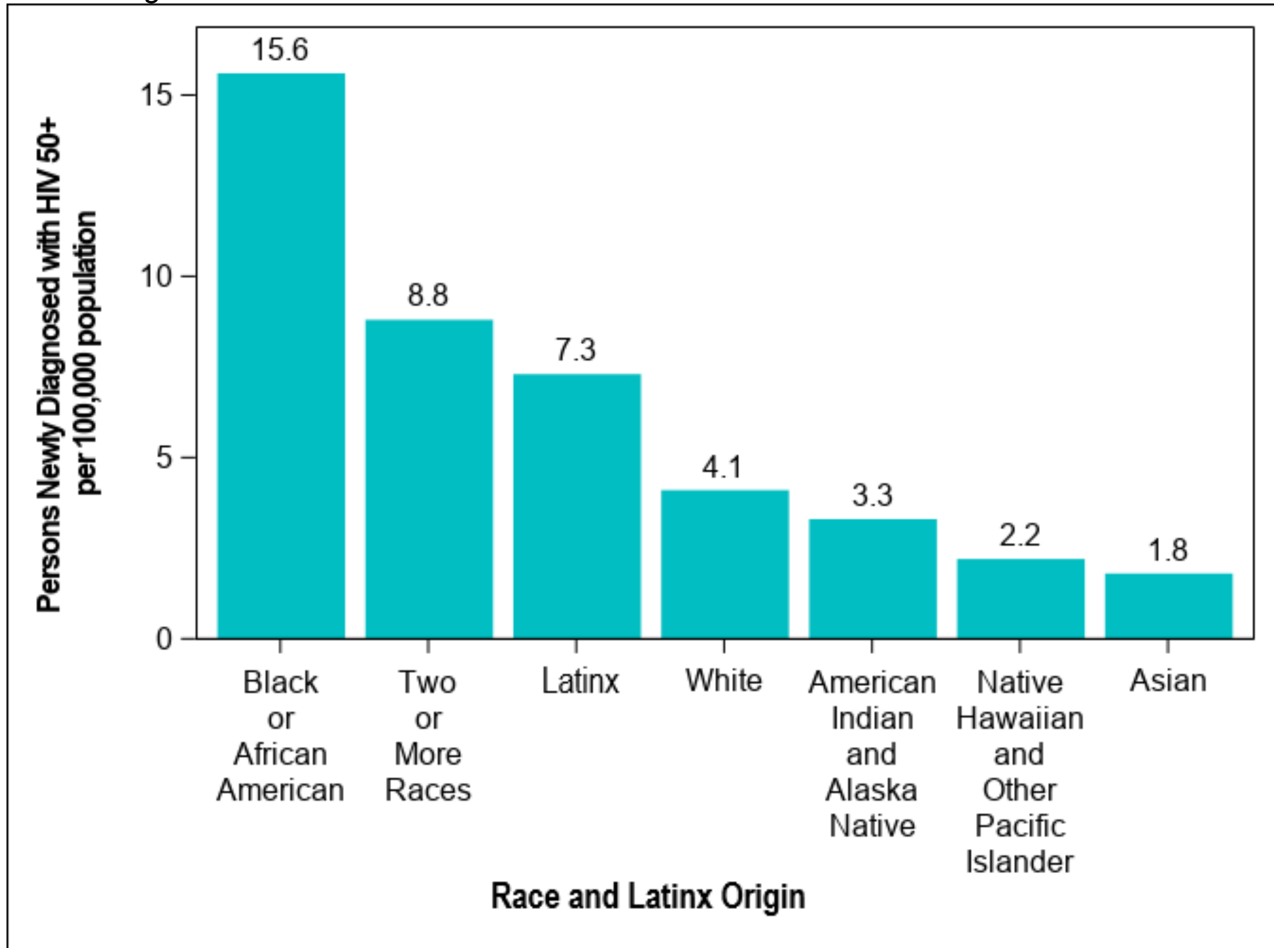


Data Source: California Department of Public Health, Office of AIDS, Surveillance Section

As seen in figure four, Black/AA Californians age 50 and older also have the greatest rate of new HIV diagnoses, at 15.6 new diagnoses per 100,000. The disparity gap between Black/AAs age 50+ and Whites age 50 + was 3.8. The disparity gap between

Black/AA age 50+ and the racial/ethnic group with lowest new diagnosis rate, Asians, was 8.6.

Figure 4. New HIV Diagnoses in persons 50+ per 100,000 population by Race and Latinx Origin in California as of 2019

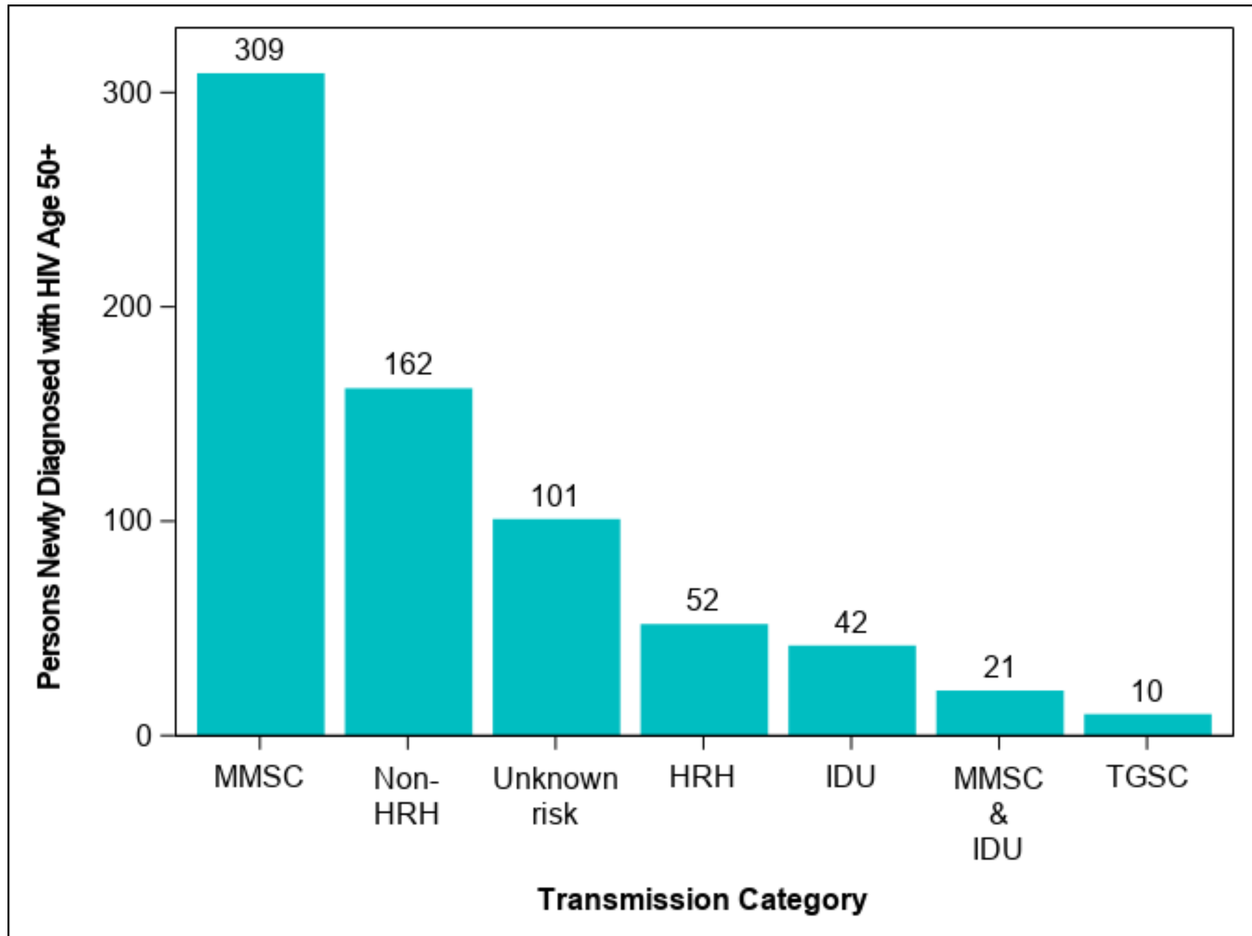


Data Source: California Department of Public Health, Office of AIDS, Surveillance Section

Early in the epidemic, most HIV cases were diagnosed among gay men, of which a significant number are still living and will be served by Project Cornerstone. Over time, transmission by other means has increased.

Figure five shows new diagnoses in 2019 among persons age 50+ in California by transmission category. While male-to-male sexual contact (MMSC) continues to make up most new diagnoses, increasingly higher rates of other modes of transmission such as injection drug use (IDU) and both high-risk heterosexual contact (HRH), non-high risk heterosexual (Non-HRH), and Transgender sexual contact (TGSC) has been occurring each year.

Figure 5. New Diagnoses of PLWH50+ by Transmission Category in California as of 2019



Data Source: California Department of Public Health, Office of AIDS, Surveillance Section

E. Eligible Applicants

Applicants located in any California county are eligible to apply for funding. An applicant shall be eligible to operate a demonstration project if it meets both of the following requirements:

1) Demonstrated experience and expertise in providing culturally appropriate services to the most vulnerable and underserved older people living with HIV, including, but not limited to, PLWH50+ who are Black, Indigenous, and people of color (BIPOC).
2) Demonstrated the capacity to ensure that the multidisciplinary clinical and non-clinical needs of PLWH50+ are assessed and addressed. Services may be co-located or coordinated across different locations, including through referrals or partnerships with other entities.

Upon an appropriation in the annual Budget Act, CDPH/OA willl award funding, on a competitive basis, to four eligible applicants. Agencies that provide health care and/or linkage services to PLWH50+ may apply and include, but are not limited to:

- area agencies on Aging (AAAs)
- community-based organizations (CBOs)
- local health jurisdictions (LHJs)
- federally qualified health centers (FQHCs)
- community clinics
- tribal health centers
- hospital emergency departments
- veteran's services
- other facilities where medical care is provided
- and other government bodies.

CDPH/OA encourages collaborations between AAAs, CBOs, LHJs and other organizations within your geographic region to ensure that the clinical and non-clinical needs of PLWH50+ are met. Applicants that intend to partner with another agency to provide medical care or any of the other required activities must include a detailed explanation of how services will be delivered. All referrals or hand-offs of clients for service provision must be warm hand-offs followed by confirmation of service delivery. In addition, for reporting and evaluation purposes, agencies must have an existing relationship, or include a detailed plan to develop a strong working relationship with the local county health department. Subcontractors may be located in any California jurisdiction, and regional multi-jurisdictional applications are permitted.

F. Award Period

State general fund local assistance funding in the amount of $4.5 million for four HIV demonstration projects will be awarded through this RFA to strengthen and support strategic program planning, service initiatives and capacity building among California's PLWH50+ population. Funds must be spent over three FY.

The terms of the resulting contracts will be three FY in duration. The anticipated project start date referenced in the RFA Time Schedule may vary due to the time required to finalize the contracts, obtain signatures, and process the contracts between awardees and CDPH/OA. Awardees are not authorized to begin work until the contract is finalized. Work conducted outside the effective start and end date of the contract will not be eligible for reimbursement. All funding is contingent on the availability and continuation of state general funds allocated for this purpose, as stated in California HSC 121295.

The three FY are defined as:

FY1: July 1, 2022 to June 30, 2023
FY2: July 1, 2023 to June 30, 2024
FY3: July 1, 2024 to June 30, 2025

G. Scoring

Applications will be scored using a defined scoring tool. Applicants must demonstrate that they have the experience, expertise, credibility, and organizational capacity to fulfill Project Cornerstone program and administrative requirements, including the ability to work successfully in providing culturally appropriate services to the most vulnerable and underserved PLWH50+ and HIV-negative partners of PLWH50+ who may be vulnerable to HIV infection. Eligible applicants include any organization that meets the requirements outlined above.

PART II. PROJECT REQUIREMENTS

A. TIERS AND AWARD ALLOCATIONS

CDPH/OA will award four awards: one $1.5M award, one $1.2M award, and two $900,000 awards. Eligible entities may only apply for one of the following award tiers and amounts:

Table 2. Tiers and Award Allocations

Tier	Number of Awards	Total Award Amount (over 3 FY)	Estimated Annual Amount
Tier 1	One	$1,500,000	$500,000
Tier 2	One	$1,200,000	$400,000
Tier 3	Two	$900,000	$300,000

Awardees may choose to budget:

- The total award accordingly over the course of FY1 - FY3, and will be required to indicate their chosen yearly budgeted amounts in the budget template (Attachment 5) for each year (e.g., a Tier 3 awardee may decide to budget $400K in FY1, $300K in FY2 and $200K in FY3); or
- The estimated annual award listed, with equal amounts for FY1 - FY3.

As required by California law, business entities must be in good standing and qualified to do business in California, including applicants that have concurrent or prior contract/grant relationships with CDPH/OA. CDPH/OA will consider any prior letter of correction, written notice of breach, or inadequate performance sent to the applicant in its scoring.

B. PROJECT ACTIVITIES

Table 3 lists clinical and non-clinical service activities identified as most valuable to PLWH50+ based on feedback provided to CDPH/OA via stakeholder listening sessions and/or current literature. Table 4 lists service activities to support PLWH50+ and those at risk of HIV infection.

Applicants are not restricted to these service listings. Applicants can propose services and scale services based on their specific circumstances. Note that some services may be delivered within either clinical and/or non-clinical settings.

Table 3. Clinical and Non-Clinical Service Activities with High Value Among Potential Project Cornerstone Participants

Service Listing		
Service Type Level I	**Service Type Level II**	**Service Type Level III**
Clinical	Allied care	Mental health counselor, family therapist, psychologist
Clinical	Allied care	Nutritionist/dietician
Clinical	Allied care	Physical therapist
Clinical	Allied care	Other:
Clinical	Primary care	Screening/assessment/evaluation for age-related health conditions including but not limited to: • Neurologic assessment • Functional ability assessment • Mental health screening • Bone health assessment • Cardiovascular assessment • Cancer screening • Hearing, dental, or vision screening • Polypharmacy assessment • Diabetes • Renal disease
Clinical	Primary care	Monitoring common health issues and comorbidities of aging
Clinical	Primary care	*Other:*
Clinical	Specialty care	Cardiovascular (Heart, lungs, and blood vessels)
Clinical	Specialty care	Dentist (Teeth)
Clinical	Specialty care	Geriatric (Medical and psychosocial issues associated with aging)
Clinical	Specialty care	Gynecologist (Female reproductive system)
Clinical	Specialty care	Hepatologist (Liver)
Clinical	Specialty care	Nephrologists (Kidney)
Clinical	Specialty care	Neurologist (Brain and nervous system)
Clinical	Specialty care	Ophthalmology/optometry (Eye)
Clinical	Specialty care	Orthopedic (Musculoskeletal system including the bones, muscles, and joints)
Clinical	Specialty care	Otolaryngologist (Eye, nose, and throat)
Clinical	Specialty care	Pharmacist (Medications)
Clinical	Specialty care	Psychiatrist (Mental health)
Clinical	Specialty care	Urologist (Urinary tract and make reproductive system)
Clinical	Specialty care	*Other:*

Non-clinical	Benefit navigation	Enrolled/facilitated enrollment in AIDS Drug Assistance Program (ADAP)
Non-clinical	Benefit navigation	Enrolled/facilitated enrollment in Covered CA
Non-clinical	Benefit navigation	Enrolled/facilitated enrollment in Medi-Cal
Non-clinical	Benefit navigation	Enrolled/facilitated enrollment in OA Health Insurance Premium Payment (OA-HIPP) Assistance Program
Non-clinical	Benefit navigation	Enrolled/facilitated enrollment in Ryan White housing program
Non-clinical	Benefit navigation	Enrolled/facilitated enrollment in linkage to care (LTC) assistance
Non-clinical	Benefit navigation	Enrolled/facilitated enrollment in-home support servicesnka
Non-clinical	Benefit navigation	Enrolled/facilitated enrollment in food assistance
Non-clinical	Benefit navigation	*Other:*
Non-clinical	Group class	Brain health
Non-clinical	Group class	Cooking
Non-clinical	Group class	Exercise
Non-clinical	Group class	Financial literacy
Non-clinical	Group class	Technology coaching/assistance
Non-clinical	Group class	Meditation
Non-clinical	Group class	Nutrition
Non-clinical	Group class	Planning for disability/death
Non-clinical	Group class	Sexual Health
Non-clinical	Group class	Strength/weight training
Non-clinical	Group class	Technology literacy
Non-clinical	Group class	Yoga
Non-clinical	Group class	*Other:*
Non-clinical	Group social event	
Non-clinical	Medical good	Facilitated contacts/glasses
Non-clinical	Medical good	Facilitated dentures
Non-clinical	Medical good	Facilitated durable medical good
Non-clinical	Medical good	Facilitated hearing aids
Non-clinical	Medical good	*Other:*
Non-clinical	Provider education	
Non-clinical	Social support	Informal caregiver support
Non-clinical	Social support	Partner services
Non-clinical	Social support	Peer to peer support
Non-clinical	Social support	Aging/enrichment services
Non-clinical	Social support	Transportation
Non-clinical	Social support	*Other:*

Applicants should also ensure that testing, LTC, PrEP, PEP, and harm reduction services are available either via Project Cornerstone funds or by collaborations with existing agencies and services readily available within their specific geographic region. Applicants are expected to describe how these services will be delivered either by the demonstration project itself or by already existing services located within their communities.

Table 4.Recommended Service Activities to be Coordinated with Project Cornerstone Services

Categories	Activities
Testing	HIV and/or Sexually Transmitted Infection (STI) testing, rapid testing, routine opt-out testing (ROOT), self-testing, outreach testing, etc.
LTC	Rapid linkage to ART, retention, adherence, etc.
PrEP and PEP	Assessment and linkage to PrEP, PEP, adherence, ongoing evaluation, etc.

This RFA allows for maximum flexibility to ensure that PLWH50+ have access to and receive services within the applicant's specified region. While funded demonstration projects are not required to fund all the activities listed within this section, they should ensure that these services are available to PLWH50+ and their partners in some capacity within their specific region. As such, successful applicants will demonstrate that they have the capacity to partner with, subcontract and/or develop agreements with other organizations within the community to ensure that these needs are met. The overall goals of these recommended service activities to be coordinated with Project Cornerstone are to:

- Increase the number of PLWH50+ who know their serostatus
- Increase the number of newly diagnosed PLWH50+ who are who are rapidly linked to HIV medical care (within seven calendar days of HIV diagnoses)
- Increase the number of newly HIV diagnosed PLWH50+ who are virally suppressed within six months of diagnosis
- Increase the number of people who are vulnerable to HIV on PrEP

Note: Awardees who subcontract services will be required to monitor consultant and/or subcontractor performance to ensure program fidelity and fiscal responsibility and compliance. If a consultant and/or subcontractor is an affiliate of the applicant, the applicant must disclose in writing to OA any affiliate relationships and any potential, actual or perceived conflicts of interest supported by this award.

C. Required Programmatic Approaches

Successful applicants will apply the following ten programmatic service delivery approaches in their program planning strategies:

1) Benefits counseling and navigation
2) Telehealth
3) Involvement of the priority population in service delivery
4) Safe and secure program environment
5) Trauma-informed approach
6) Comprehensive sexual health and sex-positive education
7) Harm reduction
8) Health and wellness approach
9) Social networks
10) Caregiver support

The following section includes complete descriptions of the required programmatic approaches required for Project Cornerstone. Applicants must describe project goals and proposed activities to implement projects designed to provide innovative approaches and direct services to all PLWH50+ as identified in the priority populations section. Use the Application Narrative template (Attachment 6) to address all program requirements as described in the following:

1. Benefits Counseling and Navigation

Applicants must incorporate a benefits counseling and navigation approach in their projects using client-centered culturally and linguistically appropriate practices that empower individuals to make informed decisions and exercise control over their long-term care needs to assist PLWH50+ in assessing their eligibility for different types of health insurance, premium payment assistance and essential preventative, support, and emergency services.

Access to healthcare and treatment through public safety net programs as well as private insurance are an essential need and a fundamental right for all PLWH. Programs such as Medicare, Medi-Cal, Medi-Cal Waiver, ADAP, OA-HIPP, Social Security Disability Insurance (SSDI), as well as private insurance plans, provide PLWH50+ the preventative and emergency services necessary to maintain and improve health, and curb new infections. Applicants must ensure equitable access for PLWH50+ to programs that already exist in their communities such as healthcare navigation services, benefits counseling and advocacy, and medical case management.

Benefit counselors and navigators must be responsive to client's changing needs and circumstances, guide clients to health care systems, assist with health insurance, identify and reduce barriers to care, and tailor health information to the client to support their full engagement in care. These individuals also assist by lowering the barriers that PLWH50+, their caregivers, and families face in accessing the information they need and navigating a fragmented and complicated system. Getting timely, accurate information is critical to avoiding costly institutional care, and preventing health and safety emergencies.

Benefits counseling and navigation can help PLWH50+ access critical insurance to pay for medical care and medication by providing counseling and guidance to help people navigate complex enrollment and benefits decisions in Medicare and other health insurance programs. For example, many PLWH50+ who become eligible for Medicare due to age or disability are also eligible for the Ryan White Program, which provides health care and supportive services to moderate-income PLWH50+. Coordination of benefits issues can arise when someone receiving Ryan White services becomes eligible for Medicare or other insurance programs and participates in multiple programs simultaneously. Navigators assist people in obtaining coverage through options such as Original Medicare (Parts A & B), Medicare Advantage (Part C), Medicare Prescription Drug Coverage (Part D), and Medicare Supplement (Medigap). They also assist beneficiaries with limited income to apply for programs, such as Medi-Cal, Medi-Cal Waiver , In-Home Support Services (IHSS) and Extra Help/Low Income Subsidy, which help pay for or reduce healthcare costs and provide in-home care services.

2. Telehealth

Telehealth programs have become increasingly utilized by providers as an approach to overcome access barriers and deliver much needed, high-quality health services including diagnosis, consultation, treatment, education, and care management. Telehealth has the potential to increase client engagement and retention, because patients will be less likely to encounter access barriers such as lack of transportation, busy schedules, and appointment availability. Additionally, telehealth can decrease the time to ART initiation and improve adherence and retention outcomes.

Applicants must demonstrate the ability to provide services, and achieve the goals of this funding, through a combination of in-person and telehealth and/or telemedicine methods. From a health equity perspective, projects must take into consideration the varying levels of technology available to PLWH50+. Some individuals may not have access to smartphones, computers and/or may be in areas of California with limited internet reception, such as in internet deserts, mountains or remote regions of the state. Funded projects must be able to provide services to clients with internet, smartphone, and telephone access, but must also be able to accommodate clients who do not have access to or an understanding of how to use these technologies. Many PLWH50+ experience a learning curve in accessing telehealth services. This can become overwhelming for some which may prohibit them from taking full advantage of telehealth services available to them. Applicants may propose providing a component that supports training and capacity building to assist clients in learning technologies and increasing skills to be able to access service remotely.

3. Involvement of the Priority Population in Service Delivery

Applicants are expected to involve PLWH50+, HIV negative partners who are disproportionately impacted by HIV, and/or caregivers in the planning, design, and implementation of the proposed program. Funded projects are expected to maintain the ongoing involvement of these populations in an advisory capacity. Applicants will be asked to describe how the priority population has been involved in the application development process and how they will be involved in the delivery of services.

4. Safe and Secure Program Environment

CDPH/OA recognizes that Black/AA, Latinx and other people of color are often hesitant and/or unable to access services due to HIV related stigma, medical mistrust, and systemic/institutional oppression and racism. Community input and recommendations regarding best practices emphasize the need for programs serving PLWH50+ to create environments where clients feel safe and supported, both physically and psychologically, and where both their differences and life experiences are respected and appreciated. A key component to creating a safe program environment is hiring staff and peers who are welcoming, represent the PLWH50+ community, who work with clients in a respectful manner, and have experience serving PLWH50+.

Applicants will be expected to develop and maintain an easily accessible, safe space where clients can discuss health, social and emotional issues, as well as receive services (e.g., housing, mental health, legal services).

Applicants must have front-line staff in place who have strong, clear communication skills, and who are respectful and patient with clients, whether in person or by phone, to mitigate adverse interactions between front-line staff and PLWH50+, which often creates a barrier for clients when attempting to access services.

Applicants must use cultural competence and cultural humility in their service delivery. Cultural competence is the ability of an organization to effectively deliver services that meet the social, cultural, and linguistic needs of its constituents. Cultural humility is a respect for the unique cultural experience of the individual, or an openness to what an individual has determined is his, her or their personal expression of heritage and culture.

5. Trauma-Informed Approach

Effective projects must ensure that medical providers, frontline staff and navigators and other service providers use an intersectional approach to understand trauma. Applicants must demonstrate an understanding of the challenges these populations face and should effectively engage individuals with past and current experiences of trauma and violence so that they are not further stigmatized but instead are linked to appropriate care, treatment, and support services.

Applicants are expected to apply the principles and practices of a trauma-informed approach to care with respect to the delivery of services. CDPH/OA defines “trauma-informed” as an approach to administering services in care and prevention that acknowledge that traumas may have occurred or may be active in clients' lives, and that those traumas can manifest physically, mentally, and/or behaviorally. A trauma-informed approach is expected to be understood and applied by agency staff at multiple points of service delivery (NASTAD, 2018). By applying this approach, applicants understand the importance of recognizing and addressing an individual’s underlying mental health issues/needs that may influence their coping skills and self-protective behaviors. Furthermore, this approach recognizes historical and communal trauma, which can be a key factor in clients’ decision-making process.

PLWH50+ experience many different traumas related to their age and time of HIV diagnosis. For individuals diagnosed after age 50, there can be shame and guilt associated with their positive diagnosis, and their social peer network may not provide needed support and affirmation. Their primary healthcare providers may not be familiar with treating HIV, nor anticipate older patients to be vulnerable to HIV infection. As such, funded demonstration projects and staff providing services must be educated about these traumas and must be able to provide services respectfully while recognizing and appreciating the variety of traumas that PLWH50+ have experienced. They should effectively engage individuals with past and current experiences of trauma and violence so that they are not further stigmatized but instead are linked to appropriate care, treatment, and support services.

Traumatic experiences early in life are also referred to as Adverse Childhood Experiences (ACE) (Boroughs et al., 2015; Dale et al., 2015; Friedman et al., 2011; Golin et al., 2016; Khan et al., 2015; Nuttbrock et al., 2013). ACE studies have shown that the number of adverse childhood events is associated with adulthood high-risk health behaviors such as smoking, alcohol and drug abuse, promiscuity, and severe obesity (Campbell et al. 2016). ACE are also correlated with depression, heart disease, cancer, chronic lung disease and shortened lifespan (Felitti et al., 1998; Prevention; Weiss & Wagner, 1998).

PLWH have higher rates of most mental health disorders than the general public (Do et al., 2014; Hobkirk et al., 2015; Mathers et al., 2013; Rosenberg et al., 2001). Additionally, men who have sex with men (MSM) have been shown to have more than three times the rate seen in non-MSM males. CDPH/OA recognizes that Black/AA and Latinx communities are disproportionately impacted by trauma and successful applicants will take this into account in their service approaches.

The 2016 National Survey of Children's Health found that 61% of Black/AA children and 51% of Latinx children have experienced at least one ACE. Black/AA and Latinx persons are disproportionately vulnerable to acquiring HIV or are PLWH who are victims of violence and/or may have a history of childhood sexual abuse, rape, and/or incest. These same populations have experienced physical or emotional abuse and stigma when disclosing their HIV status to partners or family members. Communities of color have experienced overt discrimination and chronic microaggressions. Individuals from these communities may become estranged from their families and support networks and experience loss of important support systems. Cofactors such as substance use and mental health issues may also be present, further emphasizing the importance of providing comprehensive and integrated services with a trauma-informed lens. For more information on trauma-informed care, please see the NASTAD's Trauma-Informed Approaches Toolkit.

An important consideration in providing trauma-informed services is recognizing the intersectionality of PLWH50+. CDPH/OA defines intersectionality as the overlap of various social identities, such as age, race, gender, sexual identity/orientation, disability,

class, and immigration status, which all contribute to systemic oppression and discrimination experienced by an individual. Successful applicants will consider an individual's intersectional identities when providing services, including, but not limited to those listed. As HIV and health inequities continue to disproportionally impact PLWH50+ with intersectional identities, using an intersectionality lens is critical in recognizing that everyone has unique experiences of discrimination and oppression, and how these experiences intersect and influence each other. Through an intersectional lens we consider the multiple factors that can marginalize PLWH50+.

6. Comprehensive Sexual Health and Sex-Positive Education

Comprehensive sexual health and sex-positive education acknowledges and affirms PLWH50+ may continue to be sexually active, and that sexual activity may not cease with age. Effective programs address the sexual health, self-image, and sexual lives of PLWH50+, empowering sexually active PLWH50+ to make informed decisions to keep themselves safe, healthy, and happy. Many PLWH50+ experience increased vulnerability when perusing new sexual and emotional connections and partners. Insulting behavior on the internet, ageism, and negative attitudes toward PLWH being sexually active can create barriers to PLWH50+ from seeking intimacy and sexual experiences or needing to cope with the offensive experiences. As such, applicants should ensure safe spaces and opportunities for clients to share their experiences and to ask for assistance if/when needed.

Comprehensive sexual health and sex-positive education includes medically accurate information on a broad set of topics related to sexuality, including human development, healthy relationships, decision making, abstinence, contraception, and disease prevention. Age specific issues such as menopause, testosterone levels, sexual libido, and the impact of medications on sexual desire and functioning must be addressed; this affords opportunities for developing skills as well as learning. Projects should provide education on the importance of viral suppression not only for sustained health but to eliminate the potential of HIV transmission. The concept and meaning of Undetectable = Untransmissible (U=U) should be addressed. Talking about sexuality and sexual health with both their healthcare providers and their sexual partners is encouraged. Projects should use a holistic approach to provide clients with accurate sexual health education that helps them reduce their vulnerability to HIV/STI, and support positive, affirming, sexual experiences.

7. Harm Reduction

CDPH/OA promotes a harm reduction framework to support the health and safety of people who use drugs. Harm reduction accepts, without judgement, that people use drugs for many reasons. Risk and behaviors related to drug use occur across a spectrum, and everyone has the capacity to make positive changes without requiring abstinence. Harm reduction also seeks to challenge the circumstances by which people's experiences of drug use and its relationship to HIV risk or other health outcomes are deeply shaped by stigma and discrimination – including within the health care system – and by policies that target and exclude people from care related to drug use based on race, ethnicity, gender, housing status, poverty, and other factors.

Applicants may incorporate harm reduction strategies in their projects using a variety of tools depending on the needs of the people they intend to serve. This includes syringe services for people who inject drugs, counseling and health education designed to promote safer drug use (including for opioids, stimulants, alcohol, or polydrug use), safety for people who use drugs during sex, integration of mental health and substance use disorder care, overdose prevention services, and/or other strategies as appropriate.

It is important to acknowledge that methamphetamine or "meth" use is a significant driver of both HIV and congenital syphilis in gay male culture and associated communities of lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals, including MSM and trans individuals. Meth use dovetails with opioid injection drug use in an array of associated effects such as mental health issues, overdose, death and is prevalent in many regions within California including rural, suburban, and urban areas. Using a harm reduction approach, meth use should be discussed and addressed accordingly with clients in a non-judgmental fashion by creating opportunities for dialogue and contingency management with clients, if possible.

8. Health and Wellness Approach

CDPH/OA requires projects serving PLWH50+ to integrate the concepts of health and wellness into their HIV/STI services. Comprehensive health and wellness approaches address the physical, psychological, and environmental impacts on an individual's overall health. PLWH50+ have common and vital needs that should be addressed to ensure that they have the best health and wellness outcomes. To achieve this, applicants should ensure that the hearing, vision, and dental needs of PLWH50+ are addressed appropriately. Monitoring common health issues and comorbidities of aging, (e.g., heart disease, hypertension, stroke, diabetes, etc.) which may be complicated due to their HIV diagnosis ensures optimal health and wellness. As such, successful applicants will recognize and ensure that PLWH50+ are routinely screened and, for those experiencing comorbidities that require intermittent check-ups and medical evaluations, have access to the necessary healthcare to achieve the highest possible health outcomes.

Applicants should incorporate wraparound services that address the social determinants of health (social, economic, and environmental factors that determine the health status of individuals or populations such as housing and food security, mobility, stigma, social isolation, and depression that impact overall health and quality of life) which play a role in HIV infection and the ability of people vulnerable to, or living with HIV to seek treatment, care and support.

9. Social Networks

CDPH/OA defines social networks as members or peers that are a part of the same social, sexual, or alcohol/ drug using network that act as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CDPH/OA expects applicants to use social network strategies to enlist persons who are HIV/STI positive,

or vulnerable to HIV/STI, to recruit peers in their social, sexual, and drug/alcohol using networks to seek HIV/STI testing. Members of the applicant's program can be recruited and trained to work with members of their networks to:

- Provide education and connections to supportive services
- Distribute safer sex supplies and information on obtaining sterile syringes
- Locate HIV/STI testing sites, help link those who test positive to care and services

CDPH/OA recognizes that some PLWH50+ may be a minority to the programs which serve them. As such, it is important to create spaces for these individuals to connect with others. In the context of HIV and aging, social networks may also refer to creating spaces and linking PLWH50+ with other individuals and/or forums that aim to reduce social isolation, providing a sense of community to individuals who may have shared experiences, traumas, and needs.

10. Caregiver Support

Caregivers are both family (born of relation and of choice) and friends of those living with a chronic illness. Many PLWH face stigma and discrimination from their families due to their HIV status, sexual orientation, or gender identity, for which caregivers and families of choice are their family, and an integral part of a client's core team of care providers.

CDPH/OA recognizes the invaluable and unique role of caregivers who provide support, caring and contributing to the health and well-being of their loved ones. Caregivers' responsibilities change based on varying needs of their loved ones and may change along with their loved one's condition. However, one thing remains the same - these tasks can be time consuming and potentially exhausting. Caregivers take on daily roles beyond medical care, providing in-home support services such as at-home care, providing meals and transportation, caring for the daily personal needs, all the while being social and emotional support systems. Often, caregivers also serve as benefit navigators and linkage to care coordinators; are responsible for locating resources, making appointments, navigating insurance, HIV benefits and government services; and are involved in financial and healthcare decisions. Caregiving in the best of circumstances is demanding, and when circumstances are less than ideal, caregiving can be overwhelming and isolating and can negatively impact the physical, mental, and emotional health of those providing care for loved ones.

Applicants must include culturally competent caregiver support services as part of a patient-centered approach to integrated care that supports the range of care needs for PLWH50+.

D. Project Objectives

Applicants must describe their capacity to accomplish the following required programmatic objectives, by providing responses to the components in the Application Narrative Template (Attachment 6).

a) Provide PLWH50+ screening/assessment/evaluation for age-related health conditions including, but not limited to:
    i) Neurologic assessment
    ii) Functional ability assessment
    iii) Mental health screening
    iv) Bone health assessment
    v) Cardiovascular assessment
    vi) Hearing, dental, or vision screening
    vii) Polypharmacy assessment
b) Provide PLWH50+ primary and specialty medical care for age-related health conditions
c) Provide social and/or education opportunities for PLWH50+
d) Provide benefits navigation for PLWH50+
e) Provide caregivers of PLWH50+ support and/or resources
f) Increase the number of PLWH50+ who are virally suppressed

E. Program Monitoring and Evaluation

1. Evaluation Strategy

CDPH/OA will use a systems-oriented evaluation framework that is sensitive to context and adaptable to proposals at varying stages of development. The evaluation strategy, summarized in Table 5, is designed to evaluate new interventions that may change in response to emerging conditions. The design and approach will be highly collaborative, and CDPH/OA expects a high level of participation from awardees.

Table 5. Evaluation Strategy Summary

	Description	Major goals
Purpose	Organizational learning	Explore relevance, fit, effectiveness, efficiency, sustainability, and equity
	Ensure accountability	Determine the level of support needed by CDPH/OA for the program; Assess the local and statewide evaluability of demonstration projects
Approach	Developmental	Apply a flexible learning approach to capture unexpected, context-specific outcomes and needed adaptations

Design	Theory-informed Dissemination and Implementation Science (DIS)	Understand how new approaches are shared and adopted; Find opportunities to integrate Quality Improvement into early implementation efforts; Collect and share information from quantitative and qualitative data captured throughout the implementation period
Focus	Utility-focused	Identify and engage primary intended evaluation users in identifying evaluation goals; Ensure evaluation findings have practical application; Ensure project partners can share and facilitate use of evaluation findings

2. Evaluation Information Sources

Evaluation data and information, summarized in the following table (Table 6), will be generated at the participant, local organization, and state levels. The data collection strategy is designed to minimize data collection burden by maximizing the use of routinely collected or transactional data before adding to data requirements.

Table 6. Summary of Key Evaluation Information Sources

Source	Level	Information type	Main use
RFA applicants	Site	Organizational characteristics, description of the proposed intervention and theory of change	Capture institutional factors (e.g., size, maturity), assess evaluability of proposed intervention
Contract artifacts, budgets, and invoicing	Site	RFA application details, project staff lists, project invoices	Measure resource needs by site and over time
Site progress updates	Site	Teleconferences and reports, as needed, describing operational lessons learned and adaptations needed	Understand and monitor adaptations needed, changes to programmatic assumptions
Site surveys	Site	Operational process descriptions; levels of satisfaction, perceived importance or value,	Monitor perceptions of feasibility and fit as projects mature

		suggestions for improvement, endorsements, or concerns	
Site status updates/ virtual site visits	Site	Operational process descriptions; descriptions of environment (e.g., space(s) used)	Identify implementation challenges and adaptations
Web-based encounter data (Local Evaluation Online (LEO))	Participant	Project enrollment and exit date(s), services delivered, duration of services from enrollment to exit	Measure outreach, enrollment, service utilization, and retention
Client surveys, potential focus groups	Participant	Levels of satisfaction, perceived importance or value, suggestions for improvement, endorsements, or concerns	Measure satisfaction with services received, perceived value, challenges/barriers; low burden data collection on outcomes (e.g., Health-related Quality of Life, Adherence Barriers)

F. Project Components

Using the Application Narrative Template (Attachment 6) respond to all statements and questions within each of the following sections listed. When responding to the statements and questions, be mindful that application reviewers may not be familiar with the applicant and proposed services. Therefore, answers should be specific, succinct, and responsive to the statements and questions as outlined. Review teams will base their scoring on the maximum points indicated for each section. Breakdown of total points for each section is as follows:

Table 7. Project Components

Program Component	Maximum Points
1. Demonstrated Need	**60**
2. Priority Populations	**50**
3. Entity Competency	**60**
4. Clinical Services	**130**
5. Nonclinical Services	**130**
6. Testing	**9**
7. Linkage to and Retention in Care	**18**
8. PEP and PrEP	**12**
9. Harm Reduction	**15**
10. Programmatic Approaches	**81**
11. Innovation	**70**
12. Community Engagement	**45**

13. Staffing and Staff Training	**50**
14. Applicant Capacity	**60**
15. Program Monitoring and Evaluation Activities	**70**
Total Possible Points	**860**

1. Demonstrated Need in Applicant's Geographic Area

a) Describe your geographic area (county, specific neighborhoods, or zip codes; urban, rural, other, etc.).
b) Describe the specific clinical gaps and/or needs of PLWH50+ in your geographic area.
c) Describe the specific non-clinical gaps and/or needs of PLWH50+ in your geographic area.
d) How will you be responsive to the unique needs of PLWH50+ in your geographic area?

2. Priority Populations

a) Provide an estimated number of PLWH50+ in your jurisdiction, and the number intended to be served by the project.
b) Identify the subpopulations that will be served.
c) Provide a narrative explanation of the disparities that exist within the affected population and subpopulations, and how the project will reduce those disparities.
d) Provide local epidemiological data, a local care continuum of PLWH50+, HIV testing data, Ryan White Services data, and/or other data that demonstrate high HIV incidence, high rate of new HIV diagnoses, late-stage diagnosis and/or low rates of viral suppression for PLWH50+.
    i. For LHJs: use local surveillance data, HIV prevention program data (if available), and/or Ryan White Services data (if available).
    ii. For other organizations: use agency data, and applicable/available local, State, or national data.

3. Entity Competency

a) Describe your current and previous experience working with PLWH50+, including the skills of staff who will be serving PLWH50+.
    i. Include a description of staff trainings that specifically address both the experiences and needs of PLWH50+, cultural humility, etc.
b) Describe your current relationships with other providers who address the needs of PLWH50+.
c) Describe your experience and expertise in providing culturally appropriate services to the most vulnerable and underserved PLWH50+, including, but not limited to, PLWH50+ who are Black/AA, Latinx, AI/AN, Asian, and NHOPI.
d) Describe the cultural and linguistic competency of your organization and staff who will provide services to PWLH50+.

e) Describe collaborations with other organizations or entities addressing the same or similar issues, which includes how collaboration partners and/or subcontractors will contribute to the success and effectiveness of the project.

4. Clinical Needs Met

a) Describe how you will leverage the existing continuum of clinical services in your geographic region to meet the needs of PLWH50+.
   i. How will these services fit into your program to create robust clinical services for PLWH50+ in your area?
b) Describe how clinical services will be provided.
   i. If services will be located and/or provided via multiple organizations through agreements, referrals, etc., please describe.
c) Describe how you will ensure that clinical services are flexible to meet the unique needs of clients from priority populations.

5. Non-Clinical Needs Met

a) Describe how you will leverage the existing continuum of non-clinical services in your geographic region to meet the needs of PLWH50+.
   i. How will these services fit into your program to create robust non-clinical services for PLWH50+ in your area?
b) Describe-how non-clinical services will be provided.
   i. If services will be located and/or provided via multiple organizations through agreements, referrals, etc., please describe.
c) Describe how you will ensure that non-clinical services are flexible to meet the unique needs of clients from priority populations.

6. HIV Testing

a) Will your organization provide HIV testing to PLWH50+ who are unaware of their status, and if so, please describe (outreach testing, rapid HIV testing, routine opt-out HIV testing, etc.)? If your organization does not provide HIV testing, how will the identification of undiagnosed PLWH50+ occur in your geographic region?
b) If your organization performs HIV testing, describe outcomes of testing of PLWH50+ for HIV in the last calendar year (number tested, number identified positive, number of new infections identified, number newly diagnosed provided partner services, number referred to PrEP).
c) Identify venues that currently perform HIV testing and describe how PLWH50+ who are diagnosed at these venues may refer individuals to your project and/or services.

7. Linkage to and Retention in Care

a) Describe your engagement strategies for providing and ensuring linkage to HIV care within seven calendar days for PLWH50+ who receive a preliminary positive HIV test result.

b) Describe your process for screening, service provision and/or referrals for comorbidities, geriatric conditions, behavioral health, and social services that support the specific needs of PLWH50+.
c) Describe your strategies for ensuring that PLWH50+ are retained in continuous care and are adherent to both clinical and non-clinical appointments and prescribed medications.
d) Describe the clinical care services that your agency will provide to PLWH50+.
e) Describe referral services to other clinical and non-clinical services not provided at your agency. Identify how you will determine outcomes of referrals.
f) Describe how you identify and address individual, systemic, and/or structural barriers to linkage, medical adherence, and retention for priority populations.

8. PrEP and PEP

a) Describe how and where PLWH50+ and their partners will be screened, assessed, and referred to PrEP and PEP services.
b) Describe the ways PrEP is being discussed and recommended to clients (i.e., PrEP 2-1-1, intermittent, daily, etc.). What are the most successful methods of PrEP uptake among clients and how is your agency measuring the success of these methods?
c) Describe the challenges and barriers among PEP and/or PrEP uptake among Black/AA or Latinx clients age 50 and older. What strategies will be deployed to avoid or overcome those barriers within this project?
d) Describe the procedures to transition clients from PEP to PrEP.

9. Harm Reduction

a) Describe your harm reduction philosophy and core services related to substance use. What innovative practices will you implement to serve your priority population?
b) Describe key characteristics and needs of the population of the PLWH50+ who use and/or inject drugs you will serve (e.g., gay men and other MSM, trans individuals, unhoused individuals, etc.).
c) Describe how staff members are trained to provide education and treatment referral for significant drug user health issues, including safer injection education, overdose risk, viral hepatitis, abscess prevention, and wound care.

10. Programmatic Approaches

a) Describe how your agency will incorporate a benefits counseling and navigation approach in your project to ensure that PLWH50+ have maximal opportunities for healthcare assessment, access to services, and different types of insurance and/or premium payment assistance, including but not limited to, ADAP, OA-HIPP, Medicare, Medi-Cal, Medi-Cal Waiver, and private insurance.
b) Describe services that will be provided via telehealth methods.

i. Describe how your agency will utilize telehealth and/or telemedicine to reduce barriers and increase access to services for PLWH50+.
ii. Describe how you will provide capacity building assistance and training to PLWH50+ to fully understand and utilize telehealth methods available to them (i.e., smartphone access, facetime, Zoom, phone calls, etc.).
iii. Describe how your agency will accommodate clients who do not have access to technologies to provide telehealth.

c) How will you involve PLWH50+ HIV negative partners and/or caregivers, who are disproportionately impacted by HIV, in the planning, design, and implementation of your project?
   i. How will you ensure that PLWH50+ will be heard, respected, and treasured for their experiences, insight and knowledge of the needs that exist within their communities?

d) Describe how you will create and maintain a safe and secure space for PLWH50+ to discuss sexual health, social and emotional issues, as well as receive services free from judgment and fear.
   i. Describe how you will ensure that frontline staff are competent in serving PLWH50+, and prepared to greet, serve, and assist individuals in a respectful and patient manner, limiting adverse interactions.
   ii. Describe how you will address cultural competence and cultural humility through your service delivery.

e) When providing direct services, discuss your trauma-informed model and describe your agency's policies and procedures related to providing trauma-informed services.
   i. Describe how you will provide services to both LTS, newly diagnosed PLWH50+, and/or individuals diagnosed after age 50. Describe your understanding of how these individuals may differ in their own personal experience and journey with a positive HIV diagnosis.
   ii. How will your approaches to service provision differ in understanding the nuances of time and/or age of HIV diagnosis (i.e., LTS vs. diagnosed after 50, new diagnoses, etc.)?
   iii. How will you ensure that staff providing services are educated about these traumas and able to provide services respectfully while recognizing and appreciating the variety of traumas that PLWH50+ have experienced?
   iv. Describe how your agency incorporates the theory of intersectionality to understand and address trauma among persons vulnerable to or living with HIV. If you are not currently incorporating intersectionality into client services, what is your agency's plan to do so?
   v. Describe how your agency will address HIV related stigma, medical mistrust, and systemic/institutional oppression among the populations you will be serving.

f) Describe how your agency will incorporate a comprehensive sexual health and sex-positive education approach in program planning and delivery.

i. How will you support PLWH50+ to make informed decisions to keep themselves safe, healthy, and happy while maintaining a positive sexual health outlook, self-image, and sexual life?
ii. How will you use a holistic approach to provide clients with accurate sexual health education that helps them reduce their vulnerability to HIV/STI, and support positive, affirming, sexual experiences?
iii. Describe how you provide education on the importance of viral suppression (including U=U), not only for sustained health, but to eliminate the potential of HIV transmission.

g) Describe your harm reduction philosophy and core services. What innovative practices will you implement to serve your priority population?
h) Describe how your agency will incorporate a health and wellness approach in program planning and delivery.
   i. Describe what structural approaches or interventions you have implemented or will implement for HIV prevention to improve outcomes, including ensuring that clients receive wraparound services that address social determinates of health for PLWH50+.
   ii. Describe how you will ensure that PLWH50+ are routinely screened and for those experiencing comorbidities that require intermittent check-ups and medical evaluations have access to the necessary healthcare to ensure the highest possible health outcomes are achieved.
   iii. Discuss your approach to benefits navigation.
i) How will you build and maintain social networks to help reduce social isolation and provide a sense of community to individuals who may have shared cultures, languages, experiences, traumas, and/or needs.
j) Describe how you will provide and/or ensure caregiver support to clients who are PLWH50+.

11. Innovation

a) Describe innovative strategies to reach/engage your agency's identified population and sub-population.
   i. Describe how the strategies used by the applicant will be responsive to effectively reach all PLWH50+.
   ii. Describe how the strategies used by the applicant will be culturally responsive to effectively reach BIPOC PLWH50+.
   iii. Describe how your proposed activities and strategies are evidence-informed.
b) Describe how the proposed program will be distinct without duplicating services.

12. Community Engagement

a) Describe your experience with community engagement and history with reaching the priority population(s). How will you gain or maintain trust within these communities?

b) How will you maintain ongoing involvement of the population in the delivery of services and in an advisory capacity, including assessing satisfaction with services?
c) Describe how the priority population has been involved in the application development process.
d) Describe any community assessment tools and activities that have been used to determine priority population needs. What were the outcomes of these assessments and activities? If no assessment has been conducted, describe how your agency will determine the needs of the population.
e) Describe how your agency will utilize social networks to identify PLWH50+ who may be eligible for services, and how social networks will assist in the delivery and strengthening of services to PLWH50+.
f) Describe what client engagement strategies will be used to engage clients in the proposed services/interventions. If media will be utilized for client recruitment/engagement activities, indicate the media tools (websites, social platforms such as Facebook, Instagram, Twitter, etc.; posters, palm cards, point of sale media, etc.; news articles, advertisements in local media, radio promotions, etc.) that will be used and how they will be utilized and deemed successful in the proposed program.

Note: Funded agencies must adhere to CDPH/OA's guidelines around media. Preauthorization is required by CDPH/OA prior to the development of new media campaigns. Awardees may spend up to 5 percent of the total award on new media. However, new media campaigns must be approved in advance by CDPH/OA. Approved new media must be fully developed and implemented before the end of the project period. Any materials created must be approved by a community review panel, and available to CDPH/OA for distribution throughout the State of California or as needed outside of the state. Media developed and available from the CDC's Let's Stop HIV Together Campaign is a good source for free, pre-approved media.

13. Staffing and Staff Trainings

a) Describe your agency's planned staffing for the project. Identify the number and type of positions needed and full-time equivalent (FTE) per position; how they will be recruited and maintained; Include any peer related staffing; Indicate if any staff providing services will be bilingual; Indicate who will be responsible for development and management of the program.
b) If staff hiring or reassignment will occur for this project, discuss applicant's capacity to hire/reassign staff within the first period (July 1, 2022, to August 31, 2022).
c) If any personnel positions are listed as "to be determined" in the project budget, provide applicant's plan for hiring the open position(s).

    Note: if awarded funding, failure to fill positions within the first quarter of FY1 without receiving an extension from CDPH/OA may result in the termination of funding.

d) Describe staff personal and professional experience working with PLWH50+ populations, including trainings they have received that specifically address the experiences and needs of PLWH50+.
e) Describe staff personal and professional experience working with BIPOC populations, including trainings they have received that specifically address the experiences and needs of BIPOC.
f) Describe how staff development and training practices will continue in an ongoing basis throughout the cycle of the award.
g) Describe how you will assess staff competency and address deficiencies in staff skills and service provision.
h) Discuss your capacity to maintain project integrity in the event of staff turnover.
i) If consultants will be hired to meet program requirements, identify the consultants. Explain the need for hiring a consultant and specify the consultant's role and responsibilities in the project.
j) If applicant will be working with subcontractor(s), describe how you will assess cultural and linguistic competency, and specifically how your agency will plan for monitoring subcontractor performance.

Note: Applicants awarded through this RFA must monitor consultant and/or subcontractor performance to ensure program fidelity and fiscal responsibility and compliance. If a consultant and/or subcontractor is an affiliate of the Contractor, the Contractor must disclose in writing to OA any affiliate relationships and any potential, actual or perceived conflicts of interest supported by this award. Additionally, awardees must ensure consultant and/or subcontractor adheres to all data requirements and submits accurate and complete data on time. The awardee is responsible to ensure that all required program services are met in the event of consultant/subcontractor withdrawal or non-performance.

Note: CDPH/OA caps allowable administrative costs at 10% for personnel. All staff funded through this project, or working in-kind, should be listed in the budget table.

14. Applicant Capacity

a) List any concurrent or prior contract/grant relationships with CDPH/OA over the last five years. If the applicant has received any letters of correction, written notices of breach, or inadequate performance from CDPH/OA related to any concurrent or prior contract/grant relationships, please describe them.
b) If your agency intends to conduct any activities via referrals or collaboration with partner agency(ies) specify the partner agency(ies) and identify what clinical and/or non-clinical services will be provided at the agency(ies).
    i. Describe the partnering agency(ies) expertise, history, and credibility working successfully in engaging PLWH50+, and describe how you will ensure that services are delivered.
    ii. Attach Letters of Support if collaborations are planned.
    iii. Describe the process for warm hand-offs of clients to partner agencies.

iv. How will your agency ensure that clients have been referred to prevention, care, treatment, and support services?

c) If clients will be referred to agencies other than those you partner with, describe their successful history and experience serving PLWH50+. If they do not have history and experience serving PLWH50+, describe how you will ensure that services are delivered in a culturally competent and respectful manner.
d) Describe your agency's administrative systems and accountability mechanisms for contract management.

Note: If during the course of the project, collaboration with partner agency(ies) is not successful, and activities of the contract are not successfully implemented, the contract may be terminated by CDPH/OA.

15. Program Monitoring and Evaluation Activities

a) Describe how your agency will manage changes to the project design or protocol to ensure (1) design changes or adaptations to funded activities are approved by CDPH/OA in advance, and (2) impacts can be measured.
b) Describe how stakeholders will be involved in project planning, quality improvement, and identifying lessons learned.
c) Describe how client service delivery data for proposed activities will be collected. Identify any required inter-agency agreements, as needed.
d) Identify staff who will be responsible for entering client-level service delivery data into CDPH/OA's prevention database, LEO within two weeks of service receipt.
e) Describe data collection and entry procedures to ensure client confidentiality.
f) Identify staff responsible for ensuring data quality in terms of timeliness, completeness, and accuracy.
g) Identify staff responsible for providing progress report summaries at appropriate intervals and at the end of the contract period.
h) Describe how you will support CDPH/OA's administration of confidential client and staff surveys.
i) Identify staff responsible for coordinating evaluation activities and ensure adherence to requirements listed above.
j) Describe your contingency plans to address anticipated delays in implementation of evaluation activities (e.g., gaining access for data entry, hiring of staff, etc.).
k) Describe your plan for disseminating lessons learned to develop new programs and strengthen existing programs.
l) Describe additional resources you anticipate will be needed to successfully manage project data (project budget can include funding for hiring of data management staff).
m) Describe your agency's administrative systems and accountability mechanisms for contract management.

Note: At least 10% of your agency's budget must be allocated to evaluation activities, which include stakeholder engagement, data collection, entry, management, monitoring,

and quality control. Applicants must demonstrate capacity to actively participate in CDPH/OA evaluation activities throughout the project period. CDPH/OA will provide the necessary data collection forms and training regarding system use.

Note: Awardees must ensure consultants and/or subcontractors adhere to all data requirements and submit accurate and complete data on time. In the event of consultant/subcontractor withdrawal or non-performance, the awardee must perform all required program.

G. Budget

Applicants must review the budget guidance (Attachment 4) and complete the budget template (Attachment 5) accordingly. The budget template must detail all expenses included as instructed in the budget guidance. Do not submit the budget guidance attachment as part of your application package.

Applicants are responsible for ensuring the calculations in the budget template are accurate. There will be no reimbursement of pre-award costs. CDPH/OA reserves the right to deny requests for any item listed in the budget that is deemed unnecessary for the implementation of the project.

PART III. ADDITIONAL REQUIREMENTS AND SUBMISSION

A. QUESTIONS AND APPLICATION EVALUATION PROCESS

If upon reviewing this RFA, a potential applicant has any questions regarding the RFA, discovers any problems, including any ambiguity, conflict, discrepancy, omission, or any other error, the applicant shall immediately notify CDPH/OA in writing via e-mail, to request clarification or modification of this RFA.

All such inquires shall identify the author, applicant name, address, telephone number, and e-mail address, and shall identify the subject in question, specific discrepancy, section and page number, or other information relative to describing the discrepancy or specific question.

Questions/inquiries must be received by the time and date referenced in the Tentative RFA Time Schedule. Questions will be accepted via e-mail at the following address.

E-mail Address: ProjectCornerstone@cdph.ca.gov

All questions and CDPH/OA's responses will be posted and available on the CDPH/OA website referenced in the Tentative RFA Time Schedule. Specific inquiries determined to be unique to an applicant will be responded to via e-mail to the requestor only.

If a prospective applicant fails to notify CDPH/OA of any problem or question known to an applicant by the date indicated in this section, the applicant shall apply at their own risk.

Prospective applicants are reminded that applications are to be developed based solely upon the information contained in this document and any written addenda issued by CDPH/OA.

1. Application Evaluation Process

Following the closing date for application submissions, CDPH/OA will evaluate each application to determine responsiveness to the RFA requirements.

Applications found to be non-responsive at any stage of the evaluation, for any reason, will be rejected from further consideration. Late applications will not be reviewed.

CDPH/OA may reject any or all applications and may waive any immaterial defect in any application. CDPH/OA's waiver of any immaterial defect shall in no way excuse the applicant from full compliance with the contract terms if the applicant is awarded the contract. Although personnel budgets may be submitted with unfilled positions noted as "to be determined," no changes in subcontractors or changes in staffing are allowed after a contract is awarded without CDPH/OA approval of a formal contract amendment.

Please note that submitting budgets with "to be determined" positions will not exempt the applicant from providing detail on specific services to be provided by the positions listed.

2. Grounds for Rejection

CDPH/OA may, at its sole discretion, correct any obvious mathematical or clerical errors. CDPH/OA reserves the right to reject any or all applications without remedy to the applicants. There is no guarantee that a contract will be awarded after the evaluation of all applications if, in the opinion of CDPH/OA, none of the applications meet California's needs.

Circumstances that will cause an application package to be deemed non-responsive include:

a) Applicant failed to submit the LOI by the deadline required by this RFA.
b) The application is received after the deadline set forth in this RFA.
c) Applicant failed to complete required forms and attachments as instructed in this RFA or as instructed in the attachments.
d) Applicant failed to meet format or procedural submission requirements.
e) Applicant provides inaccurate, false, or misleading information or statements.
f) Applicant is unwilling or unable to fully comply with proposed contract terms.
g) Applicant supplies cost information that is conditional, incomplete, or contains any unsigned material, alterations, or irregularities.
h) Applicant does not meet applicant qualifications set forth in this RFA.
i) Applicant does not use and/or modifies the Application Narrative Template (Attachment 6) or other provided attachments.

3. Application Review

Applications that meet the format requirements and contain all the required forms and documentation will be submitted to an evaluation committee convened by CDPH/OA. The committee will assign numeric scores to each responsive application. The applications will be evaluated in each category based upon the quality and completeness of its response to California's needs, including but not limited to, the likelihood of maximally improving the health and well-being of PLWH50+, and RFA requirements.

The evaluation will constitute recommendations to CDPH/OA management. Final approval of awardees will be made by the CDPH/OA Division Chief.

B. Instructions for RFA Submission

1. LOI – MANDATORY – date and time as referenced in the Tentative RFA Time Schedule

Prospective applicants are required to submit the LOI to CDPH/OA indicating their intent to apply in response to this RFA. **The LOI must include the award Tier (1, 2 or 3) and chosen yearly budgeted amounts for which the prospective applicant will be applying. Each applicant may only choose one award Tier.** The LOI must be electronically signed by an official authorized to enter into a contractual agreement on behalf of the applicant. A typed signature will suffice. An example of the language for the LOI may be:

"This letter confirms that [name of applying agency] intends to apply for Project Cornerstone Demonstration Projects, Tier [1, 2 or 3]."

Upon submitting the LOI, CDPH/OA will send the applicant all required application attachments. The LOI must be sent via e-mail to the following address. Applicants that fail to submit the LOI by the specified deadline are precluded from applying.

E-mail Address: ProjectCornerstone@cdph.ca.gov

2. Application Submission Requirements

The provided application templates must be used when responding to the RFA. Do not reformat any of the templates. The size of the lettering must be at minimum 11-point, Arial font. Do not send application as one single Portable Document Format (PDF). All attachments should be sent back in the same file format they were provided. Applicants intending to apply are expected to thoroughly examine the entire contents of this RFA and become fully aware of all the requirements outlined in this RFA.

Applications are to be developed solely on the material contained in this RFA and any written addendum issued by CDPH/OA. The following is the order in which sections in the application must be submitted. A complete application package (Attachments 1, 2, 3, 5, 6, 7, 8, 9, and 10 - excluding Attachment 4) must be submitted. A brief description of each attachment is as follows:

a) Attachment 1: Application Certification Checklist: Complete the checklist. This sheet will serve as the guide to ensure the application package is complete, and the required documents are organized in the correct order.

    Note: There may be additional documentation needed outside of this checklist, including letters of support and evidence of HIV prevalence among specific populations.

b) Attachment 2: Application Cover Sheet: Complete the application cover sheet. This sheet must be signed by an official authorized to enter into a contractual agreement on behalf of the applicant.

c) Attachment 3: Executive Summary (one page limit): Include a one-page Executive Summary of the proposed program and how it will be integrated with the applicant's current activities.

d) Attachment 4: Budget Guidance: Full budget guidance, instructions, and complete descriptions of what each line item must include on completing the budget template (Attachment 5). **Do not submit the budget guidance as part of your application**.

e) Attachment 5: Budget Template (Excel workbook): Complete the Budget Template for each funding period. The terms of the resulting contracts will be three FY in duration as noted in Part II: Section A – Tiers and Award Allocations. Funding is contingent on the availability and continuation of state general funds allocated for this purpose, as stated in California HSC 121295.
The budget descriptions of services, duties, etc. found in the Budget Template (Attachment 5) must explain and justify both program services funded by other funding and those, if awarded, funded by this contract. The salaries line item must list each position that is associated with this program. Include a brief explanation of each position's major responsibilities, and the time allocation to be funded by the contract, resulting from this RFA. For the operating expenses category, provide a general description of expenses included in the budget line item. Proposed consultants must indicate the number of contracted hours and costs associated with hiring a consultant for the project. All subcontractor(s) shall be listed by name and address in the application.

Note: These funds may not be used to pay for clinical care or other services that can be billed to third-party payers.

f) Attachment 6: Application Narrative Template: Complete the Application Narrative Template covering funding period July 1, 2022, through June 30, 2025. The Application Narrative Template must include complete descriptions of your plan to carry out Part II: Section F – Project Components of this RFA.

g) Required Forms/Documentation: The following is a list of required forms/documentation to accompany all applications as attachments. Please note that all forms must have the same exact naming convention throughout, or they will not be accepted by the Contracts Management Unit. For example, if the licensed name of an agency is "Trinity Community Healthcare Center Inc.", all documents must include that full name and not a shorten version such as "Trinity Health".

i. Attachment 7: Taxpayer ID Form – (CDPH 9083)
ii. Attachment 8: Payee Data Record – (STD 204)
iii. Attachment 9: Payee Data Record Supplement – (STD 205)
iv. Attachment 10: Local Health Department (LHD) Letter of Support: All applicants must complete the LHD Letter of Support form to be eligible to apply. Please reach out to your LHD for signature and acknowledgement of your application. Applicants who are LHDs may complete the form themselves and submit. If the applicant will provide services across multiple jurisdictions, the applicant must provide a letter of support from each jurisdiction where services will be provided.

Applications that fail to follow any of the requirements will be rejected from further consideration.

Availability of other funding will not affect the scoring of this RFA.

The cost of developing the application for this RFA is entirely the responsibility of the applicant and shall not be chargeable to the State of California or included in any cost elements of the application.

3. Application Submission Instructions

Applications must be submitted via e-mail to the following address as referenced in the Tentative RFA Time Schedule.

E-mail Address: ProjectCornerstone@cdph.ca.gov

4. Notification of Intent to Award

Notification of the State's intent to award contracts for these demonstration projects will be posted on the CDPH/OA website. Additionally, a letter will be emailed to all applicants notifying them of the status of their application.

5. Disposition and Ownership of the Application

All materials submitted in response to this RFA will become the property of CDPH/OA, and subject to the Public Records Act (Government Code Section 6250, et. seq.). CDPH/OA shall have the right to use all ideas or adaptations of the ideas contained in any application received. The selection or rejection of an application will not affect this right. Within the constraints of applicable law, CDPH/OA shall use its best efforts not to publicly release any information contained in the applications which may be privileged under Evidence Code 1040 (Privileged Official Record) and 1060 (Privileged Trade Secret) and which is clearly marked "Confidential" or information that is protected under the Information Practices Act.

6. Contracts Award Appeal Procedures

Any applicant who applied and was not awarded a contract for funding may file an appeal with CDPH/OA. Appeals must state the reason, law, rule, regulation, or practice that the applicant believes has been improperly applied regarding the evaluation or selection process. There is no appeal process for applications submitted late or incomplete. Appeals shall be limited to the following grounds:

- CDPH/OA failed to correctly apply the application review process, format requirements, or evaluating the applications as specified in the RFA.
- CDPH/OA failed to follow the methods for evaluating and scoring the applications as specified in the RFA.

Appeals must be sent via e-mail to ProjectCornerstone@cdph.ca.gov and must be received as referenced in the Tentative RFA Time Schedule. The CDPH/OA Division Chief, or their designee, will then come to a decision based on the written appeal letter. The decision of the CDPH/OA Division Chief, or their designee, shall be the final

remedy. Applicants will be notified via e-mail within 15 business days of the consideration of the written appeal letter.

CDPH/OA reserves the right to award the contract when it believes that all appeals have been resolved, withdrawn, or responded to the satisfaction of CDPH/OA.

7. Miscellaneous RFA Information

The issuance of this RFA does not constitute a commitment by CDPH/OA to award contracts. CDPH/OA reserves the right to reject any and all applications, or to cancel this RFA if it is in the best interest of CDPH/OA to do so.

The award of a contract by CDPH/OA to an entity that proposes to use subcontractors for the performance of work under the resulting contract shall not be interpreted as CDPH/OA approval of the selected subcontractors. Subcontractors can only be added or changed after a contract is awarded with CDPH/OA approval of a formal contract amendment.

In the event a contract is entered into, but later terminated, CDPH/OA has the option to enter into a contract with the entity or organization that had the next highest ranking in the evaluation process for completion of the remaining contract work.

In the case of any inconsistency or conflict between the provisions of the resulting contract, this RFA, addenda to this RFA, and an applicant's response, such inconsistencies or conflicts will be resolved by giving precedence in the following order: (1) the contract, (2) the RFA, (3) any addenda, and (4) the applicant's response.

CDPH/OA reserves the right, after contract award, to amend the resulting contract as needed throughout the term of the contract to best meet the needs of all parties.

A full list of citations used in the development of this RFA is available upon request by request via email to: ProjectCornerstone@cdph.ca.gov

8. Contract Obligations

The successful applicant must enter into a contract that may incorporate this RFA by reference, as well as the application submitted in response to this RFA. It is suggested that applicants carefully review the awardee provisions for any impact to the application, and/or to determine if the applicant will be able to comply with the stated terms and conditions, as little or no deviation from their contents will be allowed.

Individual meetings with CDPH/OA and each selected awardee shall take place within 60 calendar days after release of the Notice of Intent to Award. The purpose of the meetings will be to assure a common understanding of contract purposes, terms, budgets, timelines, and related issues.