

California Department of Public Health
Center for Infectious Diseases
Office of AIDS
HIV Prevention Branch

Strategic Rapid Antiretroviral Therapy
Fiscal Year 2021-2023
Request for Applications

RFA Release Date: **2/4/2021**

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SCHEDULE OF EVENTS

EVENT	DATE
Request for Application (RFA Release) Available on the California Department of Public Health (CDPH) Office of AIDS (OA) website: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_RFA.aspx	February 4, 2021 By 5:00 P.M. PDT
Strategic Rapid Antiretroviral Therapy Community Zoom Webinar Register in advance for this meeting: https://zoom.us/meeting/register/tJMqf-GurjspHtXot9VcoFvA6TT-HX3kze8z After registering, you will receive a confirmation email containing information about joining the meeting.	February 12, 2021 At 1:00 P.M. to 2:30 P.M. PDT
Deadline for Submitting Written Questions	February 12, 2021 By 5:00 P.M. PDT
Answers to Written Questions Available on OA website: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_RFA.aspx	February 16, 2021 By 5:00 P.M. PDT
Deadline to Submit Letter of Intent (Mandatory)	February 17, 2021 By 12:00 Noon PDT
Application Submission Deadline	March 15, 2021 By 5:00 P.M. PDT
Notice of Intent to Award Released . Available on OA Website: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_RFA.aspx	April 12, 2021 By 5:00 P.M. PDT
Appeal Deadline	April 14, 2021 By 5:00 P.M. PDT
Projected Contract Start Date	July 1, 2021

A. Purpose

The purpose of this RFA is to fund the development of innovative, stigma-free, culturally and linguistically competent, evidence-based demonstration projects that will deliver rapid antiretroviral therapy (ART) to people living with HIV (PLWH). For the purposes of this RFA, “rapid ART” is defined as initiation within 0-5 days. Projects must be strategic in that they intentionally serve individuals from the most underserved populations that are most disproportionately affected by HIV, and must do so by implementing a combination of in-person and telehealth services. As indicated by HIV surveillance data, the populations most vulnerable to HIV are Black/African American (AA) and Latinx populations. California Department of Public Health (CDPH)/Office of AIDS (OA) will also consider other populations for which local and/or national data indicates a disproportionate impact by HIV (e.g. [Native Hawaiian and Other Pacific Islanders \(NHOPI\)](#) or [American Indian/Alaskan Native \(AI/AN\)](#) populations as data indicates that they are disproportionately affected by HIV). For national data on race/ethnicity and HIV in the United States, visit the Centers for Disease Control and Prevention (CDC) [website](#). Projects will include rapid initiation of ART, medication adherence counseling, follow-up and education using telehealth methods to improve retention in care and increase viral suppression rates. Additionally, projects will educate clients, medical providers and clinic/agency staff on the concept and principles of undetectable = untransmittable (U=U). Through these program components, the resulting funded Strategic Rapid ART projects will substantially reduce the time to viral suppression for these individuals, providing clinical benefits to clients and reducing risk of HIV transmission within their communities.

In 2014, the California state legislature established Health & Safety Code (HSC) Section 121287 which allows CDPH/OA to establish, through a competitive process, public health demonstration projects, which must be innovative, use evidence based approaches to provide HIV screening and provide linkage to and retention in care for the most vulnerable and underserved populations in the state. Projects will last two years and must be designed to be replicated statewide. CDPH/OA will award funding up to four selected entities to fund Strategic Rapid ART projects based on responses to this competitive RFA. Funding for these programs is dependent upon appropriation of funding in the Annual Budget Act. This RFA is aligned with California’s Laying a Foundation for Getting to Zero: California’s Integrated HIV Surveillance, Prevention and Care Plan and the National HIV/AIDS Strategy (NHAS), which directs federal HIV prevention funding allocations to the jurisdictions and communities where HIV is most heavily concentrated and prioritizes resource distribution to activities most likely to reduce HIV transmission.

In the winter of 2020, the onset of the COVID-19 pandemic resulted in a massive ripple effect in HIV prevention and care programs statewide. Local health jurisdiction (LHJ) and community based organization (CBO) staffing was greatly affected as individuals were reassigned to COVID-19 response, leaving HIV prevention and care services understaffed and spread thin. As COVID-19 infection rates increased, the resulting shelter-in-place order also reduced staff in the field. LHJ, clinic and CBO closures caused interrupted and limited services, including in-person appointments. Community outreach stopped as services came to a halt and client and staff fear and anxiety around COVID-19 mounted. However, as shown by the resilience of the HIV prevention and care community, organizations quickly responded by transitioning to innovative approaches which allowed them to continue providing services using the principles of telehealth and telemedicine. As such, Strategic Rapid ART projects must be able to demonstrate that they can bolster their services using the methods of telehealth and/or telemedicine in their project proposals.

The goals of this funding are to improve health outcomes for Black/AA, Latinx or data supported underserved PLWH and include several components. The first is to reduce time to linkage and engagement in ART while prioritizing linkage for individuals with suspected acute infection. Next, projects will implement the benefits of medication adherence counseling to promote and increase viral suppression among Black/AA and Latinx PLWH, thereby preventing future HIV acquisition within these communities that are particularly vulnerable to HIV. Projects will conduct follow-up and education shortly after ART initiation to confirm treatment began, identify and address barriers with adherence and retention in care, and provide additional education as appropriate. And finally, projects will educate clients, medical providers and clinic/agency staff on the benefits of U=U for both the client and community at large.

Before initiating ART, clients should be counseled on the importance of daily adherence, possible side effects, adherence strategy options, and the benefits of ART to both the client, their sexual partners, and the community. Time should also be allocated for client follow-up soon after initiation (preferably 2- 4 days) to confirm that ART medications were obtained and treatment started. This session should also be an opportunity to identify and address any challenges to adherence or retention in care, provide or refer to essential support services, and provide additional education if necessary. Assuring clients that PLWH from many different walks of life are living healthy, productive lives with the help of ART may help to normalize treatment and reduce internalized stigma.

Strategic Rapid ART treatment protocols should improve the process for client linkage and initiation of ART by decreasing the number of steps and time from diagnosis of

HIV infection to initiation of treatment. Additional potential benefits of a comprehensive program that achieves rapid linkage to ART and addresses other cultural, social, and economic factors, include increased retention in care, decreased risk behavior, and increased client satisfaction with care. All entities that receive funding for Strategic Rapid ART projects will be required to submit flowcharts, protocols and best practices to OA upon request.

CDPH/OA seeks applications for innovative demonstration projects to implement strategic rapid ART to be offered to all PLWH who are deemed eligible for rapid ART. OA defines “innovative demonstration projects” as newly developed, novel, original or new to your agency and/or community. Applicants are encouraged to replicate existing, evidenced-based programs and modify them for integration into their agency. **Existing Rapid ART programs may apply for this funding provided their proposal demonstrates that funds will be used to develop a new component, focus on a currently unserved priority population (e.g. trans women, recently incarcerated or recently released, homeless, etc.), and/or serve a new geographic location in their community where there are gaps in service for linkage to care for PLWH.** OA defines “rapid ART” as intake, first care appointment, and ART initiation within 0-5 days of diagnosis. Preference will be given to applications that demonstrate capacity to initiate same day ART or reduce initiation to 1-3 days. OA defines “initiation” as giving a written prescription for ART to the client, calling the client’s ART prescription into a pharmacy or providing a same-day starter pack of ART (e.g. Biktarvy) until the client can receive prescribed ART. Projects will be “strategic” in that they will intentionally focus on Black/AA and Latinx PLWH using the principles of telehealth/telemedicine to allow for the provision of services during COVID-19.

Persons **eligible** for rapid ART include:

- Any person with a new, confirmed HIV+ diagnosis, for whom there is no clear contradiction for ART, or
- Any previously diagnosed HIV+ person who has either never initiated ART, or who has an uncomplicated history on ART and concern for acquired resistance is low

Persons **ineligible** for rapid ART include:

- Anyone for whom immediate ART might be medically dangerous
- Clients who state they are not ready to start HIV treatment, or
- Clients likely to have multiple mutations for whom resistance testing is required before prescribing an appropriate ART regimen

Priority Populations

Funded strategic rapid ART projects must demonstrate the capacity to effectively provide services to Black/AA, Latinx or data supported underserved PLWH. Allowable priority sub-populations that fall under Black/AA and Latinx PLWH may include 1) gay, bisexual, or other men who have sex with men (MSM), 2) transgender MSM, 3) transgender women, 4) cisgender women, and/or 5) people who inject drugs. However, CDPH/OA will consider other populations for which local and/or national data indicates a disproportionate impact by HIV (e.g. [Native Hawaiian and Other Pacific Islanders \(NHOPI\)](#) or [American Indian/Alaskan Native \(AI/AN\)](#) populations as data indicates that they are disproportionately affected by HIV). For national data on race/ethnicity and HIV in the United States, visit the Centers for Disease Control and Prevention (CDC) [website](#).

Strategic rapid ART funding is intentionally focused on serving the communities that have been historically underserved by existing HIV prevention and health care systems. Funded projects will support the strategic planning and implementation of innovative and culturally responsive programs that reduce health inequities, HIV-related stigma, medical mistrust, and barriers to HIV care and treatment services. Through trauma informed care approaches, awardees will advance community health and wellness while understanding the current and historical trauma that adversely impacts Black/AA and Latinx health outcomes.

Telehealth Approaches

Over the last several years, telehealth programs have become increasingly utilized by providers as an approach to overcome access barriers and deliver 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 outcomes.

Applicants seeking funding for strategic rapid ART projects must demonstrate the ability to provide services and achieve the goals of this funding through a combination of in-person and telehealth/telemedicine methods. Funded projects must be able to provide strategic rapid ART services to clients with internet access, smartphone or telephone but must also be able to accommodate clients who do not have access to these technologies.

Some examples of services that can be provided and/or improved by telehealth include but are not limited to:

- Rapid ART initiation
- Flexible and/or immediate appointments
- Benefits enrollment assistance
- Medical case management
- Scheduled follow-up
- Adherence counseling, and
- U=U education (e.g. Zoom and/or teleconference w/medical providers)

Applicants should also discuss how they plan to leverage the existing continuum of providers in their areas to reduce access barriers, increase rapid ART initiation and to ensure that the full range of strategic rapid ART project goals are provided.

Required Approaches

CDPH/OA requests that applicants apply the approaches listed below to the activities set forth in their proposals and service delivery. In doing so, applicants must describe how they will address the needs of Black/AA, Latinx or other communities as demonstrated by data. This also includes the advancement of existing programs or approaches that have been deemed successful in serving Black/AA and/or Latinx individuals and/or communities.

CDPH/OA will take into account the applicant's ability to effectively reach these populations through the strategies listed below. Strategic rapid ART projects must apply the following approaches to HIV treatment and prevention in their program planning strategies:

- Involvement of the priority population in service delivery
- Safe and secure program environment
- Trauma-informed approach
- Comprehensive sexual health education
- Harm reduction
- Health and wellness approach
- Social networks

Involvement of the Priority Population in Service Delivery

Applications are expected to involve Black/AA and Latinx PLWH and HIV negative individuals who are disproportionately impacted by HIV, in the planning, design, and implementation of the proposed program. Funded projects are expected to maintain

the priority population's ongoing involvement in an advisory capacity. Eligible entities (EEs) 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.

Safe and Secure Program Environment

Community input and recommendations regarding best practices emphasize the need for projects serving Black/AA, Latinx or data supported underserved populations to create environments where clients feel safe and supported, both physically and psychologically and where their differences are respected and appreciated. 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 or her personal expression of heritage and culture. Successful EEs will use both of these approaches in their service delivery.

CDPH/OA recognizes that Black/AA and Latinx individuals are often hesitant and/or unable to access services due to HIV related stigma, medical mistrust, and systemic/institutional oppression.

Successful EEs will be expected to develop and maintain an easily accessible "safe" and/or "brave" spaces that account for stigma, mistrust and systemic oppression, where clients can discuss health, social and emotional issues, as well as receive services (e.g. housing, mental health, legal services). OA recognizes that in order to truly honor someone's needs, EEs must be brave in addressing and creating safe spaces that can feel inherently unsafe to clients. A key component to creating safe and brave program environments is hiring staff and peers who are not only welcoming and who will work with clients in a respectful manner, but are also representative of Black/AA, Latinx or data supported underserved populations.

Trauma-Informed Approach

Successful EEs are expected to adopt the principles and practices of a trauma-informed approach to care, especially with respect to the delivery of services for the proposed project as well as for in the workplace. OA defines trauma-informed as an approach to administering services in care and prevention that acknowledges 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 adopted by agency staff at multiple points of service delivery. By adopting this approach, entities understand the importance of recognizing and addressing an individual's underlying mental health 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. Ultimately, clients will be supported to become safer emotionally, physically, and socially.

Black/AA and Latinx communities are disproportionately impacted by trauma. 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 adverse childhood experience. 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 when disclosing their HIV status to partners or family members. Co-factors 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. Providers should have an understanding of the challenges these populations face and should effectively engage these populations 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.

Intersectionality recognizes that the more devalued identities an individual has including race, class, disability and gender, increases the risk of adverse outcomes, such as homelessness, assault, depression and drug use. Successful EEs will take into account an individual's intersectional identities when providing services. As HIV and health inequities continue to disproportionately impact Black/AA and Latinx populations, it is essential to ensure that medical providers, frontline staff and navigators use an intersectional approach to understand trauma.

Comprehensive Sexual Health Education

Comprehensive sexual health education addresses the root issues that help young Black/AA and Latinx populations make informed decisions to keep themselves safe and healthy. Projects must use a holistic approach to provide youth with accurate sexual health education that helps them navigate their lives and sexual health as a PLWH while reducing their vulnerability to sexually transmitted infection (STI) and unintended pregnancies.

Comprehensive sexual health education includes age and developmentally appropriate, medically-accurate information on a broad set of topics related to sexuality, including human development, healthy relationships, decision making, abstinence, contraception and disease prevention. It affords opportunities for developing skills as well as learning. Projects that work with youth should provide

youth, particularly, with the tools to make informed decisions, build healthy relationships, and prepare them for when/if they resume sexual activity after receiving a HIV-positive diagnosis. Projects should provide medically accurate information; encourage family communication about sexuality with parents/guardians; and teach youth the skills to make responsible decisions about sexuality. Comprehensive sexual health education should use a “harm reduction” approach in that EEs use the principals applied to harm reduction to sex, thereby managing and understanding sexual risk, and choosing the least harmful sexual options.

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; that risk and behaviors related to drug use occur across a spectrum, and that 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 or ethnicity, gender, housing status, poverty, and other factors.

Entities incorporating harm reduction strategies in their programs may use a variety of tools depending on the needs of the people they intend to serve, including 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) and safety for people who use drugs during sex, integration of mental health and substance use disorder care, or overdose prevention services, and/or other evidence-based strategies as appropriate.

Health and Wellness Approach

CDPH/OA encourages programs serving the priority population to integrate the concepts of health and wellness into their HIV/STI prevention services. The health and wellness model promotes comprehensive approaches that address the physical, psychological, and environmental impacts on an individual’s overall health. In the context of an HIV/STI prevention program, a health and wellness approach would enable a program to recognize and address how various health related factors interact and increase a person’s vulnerability for HIV infections and STI’s.

Projects that incorporate a health and wellness approach into their HIV/STI programs will be better prepared to facilitate access to healthcare services, thus enhancing their

strength-based model of care, and empower their clients to become primary agents of change for themselves.

Successful applicants will also incorporate wraparound services that address the social determinants of health. Wraparound services must include gender affirming care for transgender clients, as well as health navigation services for uninsured, underinsured and/or undocumented clients. CDPH/OA defines social determinants of health as the range of social, economic and environmental factors that determine the health status of individuals or populations. Social determinants of health play a role in HIV infection and the ability of people vulnerable to, or living with HIV to seek treatment, care and support.

Social Networks

When applicable, CDPH/OA requires the use of social network strategies to enlist PLWH or vulnerable to HIV in order to recruit peers in their social, sexual and drug/alcohol using networks to seek HIV testing. When engaging transgender women and men, EEs should recognize the unique needs and challenges in engagement in differing social networks. PLWH who receive strategic rapid ART services can be recruited and trained to work with members of their networks to:

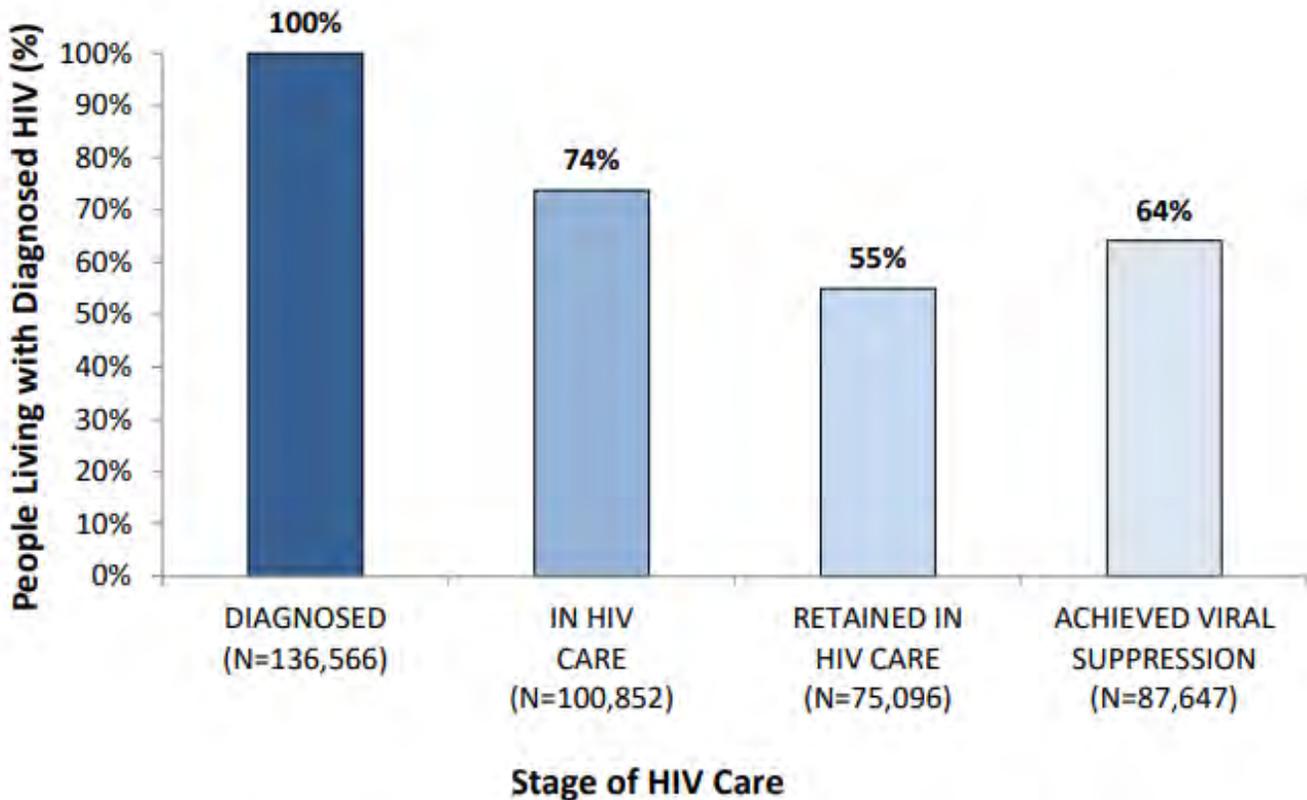
- Provide education and connections to supportive services
- Distribute safer sex supplies and information on obtaining sterile syringes
- Locate HIV/STI testing sites, help link those who test positive to care and services at the primary strategic rapid ART project

B. Background

Over 136,000 persons were living with diagnosed HIV infection in California in 2018. Black/ AA, Latinx, men who have sex with men (MSM), and transgender individuals were all disproportionately impacted, with the greatest impact to MSM and transgender individuals.

The California Continuum of HIV Care for HIV-positive persons (**Figure 1**) identifies from initial diagnosis to viral suppression the points at which accessing and engaging in care and treatment may break down. 64% of persons diagnosed with HIV infection in California had sustained viral suppression in 2018. This falls short of the CDC target of 80% viral suppression for all persons diagnosed with HIV infection.

Figure 1. The Continuum of HIV Care: All Persons Living with Diagnosed HIV Infection — California, 2018



Diagnosed persons met the CDC surveillance case definition for HIV infection, and were presumed to be alive and living in California if no death document was received and they were residing in California as of the last known address. Persons who had at least one CD4, viral load, or HIV-1 genotype test during the calendar year were considered to be engaged in HIV care. Persons who had two or more CD4, viral load, or HIV-1 genotype tests that were performed at least 3 months apart during the calendar year were considered retained in care. Persons whose most recent HIV viral load test result during the calendar year was ≤ 200 copies/ml were considered to be virally suppressed.

Why Strategic Rapid ART?

Advances in ART have dramatically decreased HIV-related morbidity and mortality, and have substantially reduced the risk of HIV transmission through suppression of viral viremia since the release of the National HIV/AIDS Strategy (NHAS) in 2010. As emphasized in the 2015 update, the effectiveness of treatment as prevention has become clear. U=U is a campaign that promotes awareness that persons infected with HIV who take ART daily and have a sustained undetectable viral load for more than six months are unlikely to infect their sexual partners. Despite the compelling evidence, many medical providers, their clients, and the general public are unaware of this effective prevention approach.

The World Health Organization (WHO) and US Department of Health and Human Services (DHHS) recommend that persons testing positive for HIV infection start ART as soon as possible. Furthermore, persons with acute and early HIV infection (the state of disease immediately after infection with virus) are an important group to prioritize for treatment for a number of reasons. First, clients receiving HIV treatment early in the course of infection can gain substantial clinical benefits. Early treatment improves laboratory markers of disease progression and can decrease the severity of acute disease, lower the viral set point, and preserve immune function, which can improve the ability of an individual's immune system to control the virus on its own in certain situations. Second, initiation of ART is shown to be a strong correlate of retention in HIV care among treatment-naïve participants entering care and thus, early treatment might improve retention in life-saving HIV care. Lastly, the high viral load characteristic of early HIV infection contributes disproportionately to HIV transmission; modeling studies have demonstrated that early treatment can reduce the number of new HIV infections by nearly 50%.

Modern ART medications are safe, conveniently dosed (once-daily pills are available), have a high threshold to viral resistance, and can achieve viral suppression in as little as two weeks, making the benefits of acute and early HIV treatment achievable. Unfortunately, with many current standards of care, there are typically lengthy delays in initiating ART. In one study evaluating treatment outcomes among persons diagnosed with acute HIV infection, the median time for 50% of the cohort to achieve viral suppression was 10 months, and these delays occurred during a period when significant immunological damage was occurring in a client and when there was a maximum risk for further transmission.

Research finds that retaining PLWH in care in order to achieve viral suppression is the most efficacious strategy for reducing HIV incidence (Allison Perry, 2018). Meanwhile, with the emergence of various new evidence-informed HIV prevention interventions over

the last several years, researchers and providers have come to recognize that no single approach aimed at increasing viral suppression is sufficient to control HIV, and that even the most efficacious interventions are not likely to succeed if they are delivered in isolation. Rather, they should include a combination of strategic prevention strategies that encompass prevention and care, and include biomedical, behavioral, and structural interventions. Components that address cultural, social, economic, and other factors such as stigma and intimate partner violence, which directly influence HIV prevention and transmission, are also a valuable part of an overall strategy.

Intentional Focus on Priority Populations

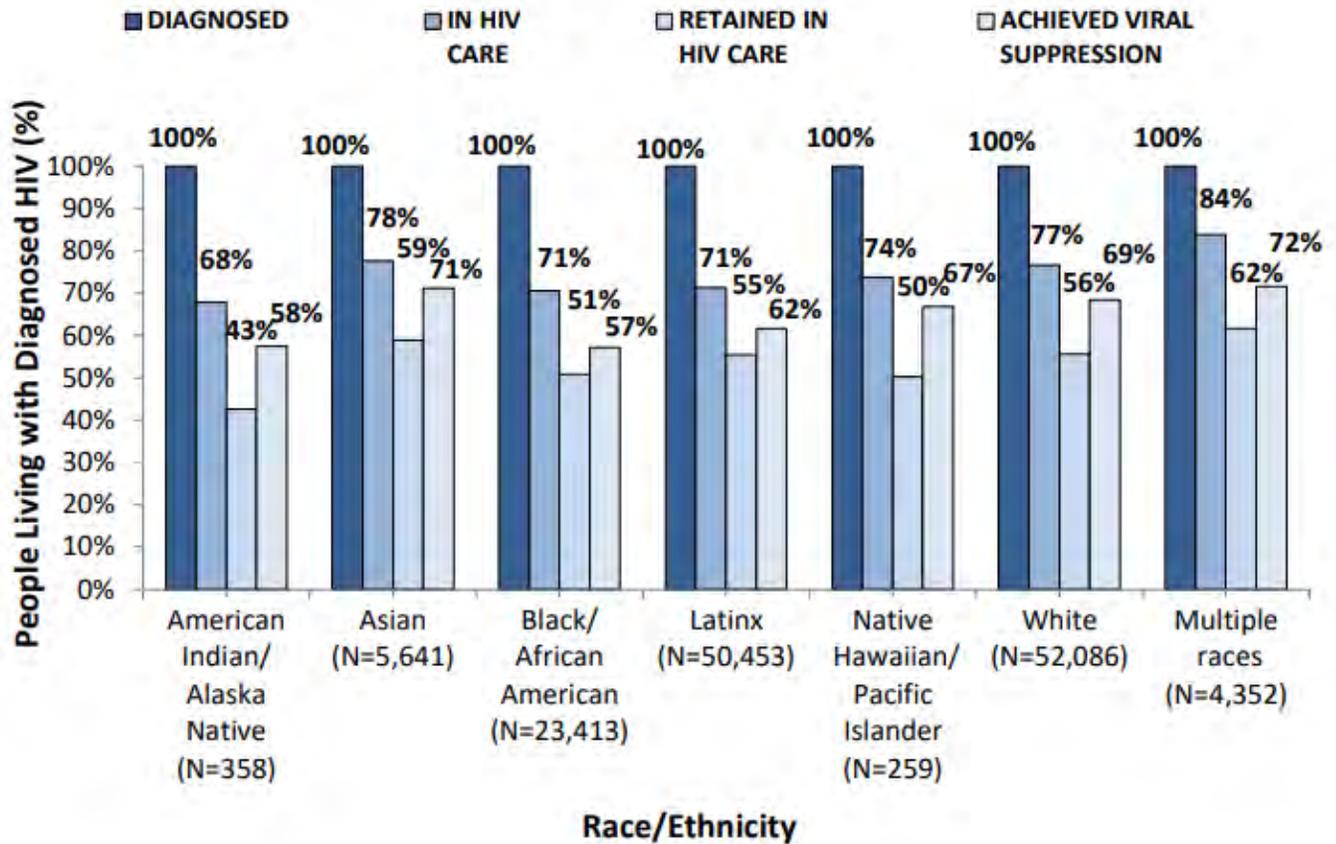
The strategic rapid ART projects will aim to increase access to HIV care, with an ultimate goal of increasing viral suppression rates, and preventing HIV among people underserved by existing HIV care and prevention programs. Based on surveillance data and population size, OA has determined that Black/AA and Latinx individuals and communities are the most underserved. The following data demonstrates that:

- Viral suppression is low among Black/AAs
- Viral suppression is low among Latinx
- Latinx make up the largest percentage of new diagnoses
- A disproportionate number of Black/AAs are diagnosed with HIV as compared to other race/ethnic groups, among both men and women
- Black/AA and Latinx cisgender women are diagnosed at higher rates than White cisgender women
- Latinx transgender women make up the largest percentage of new HIV diagnoses among transgender women
- Young Black/AA and Latinx are less likely to know their HIV status, and less likely to be virally suppressed than young Whites
- Latinx have the highest percentage of AIDS diagnoses within 12 months of their HIV diagnosis

Viral Suppression

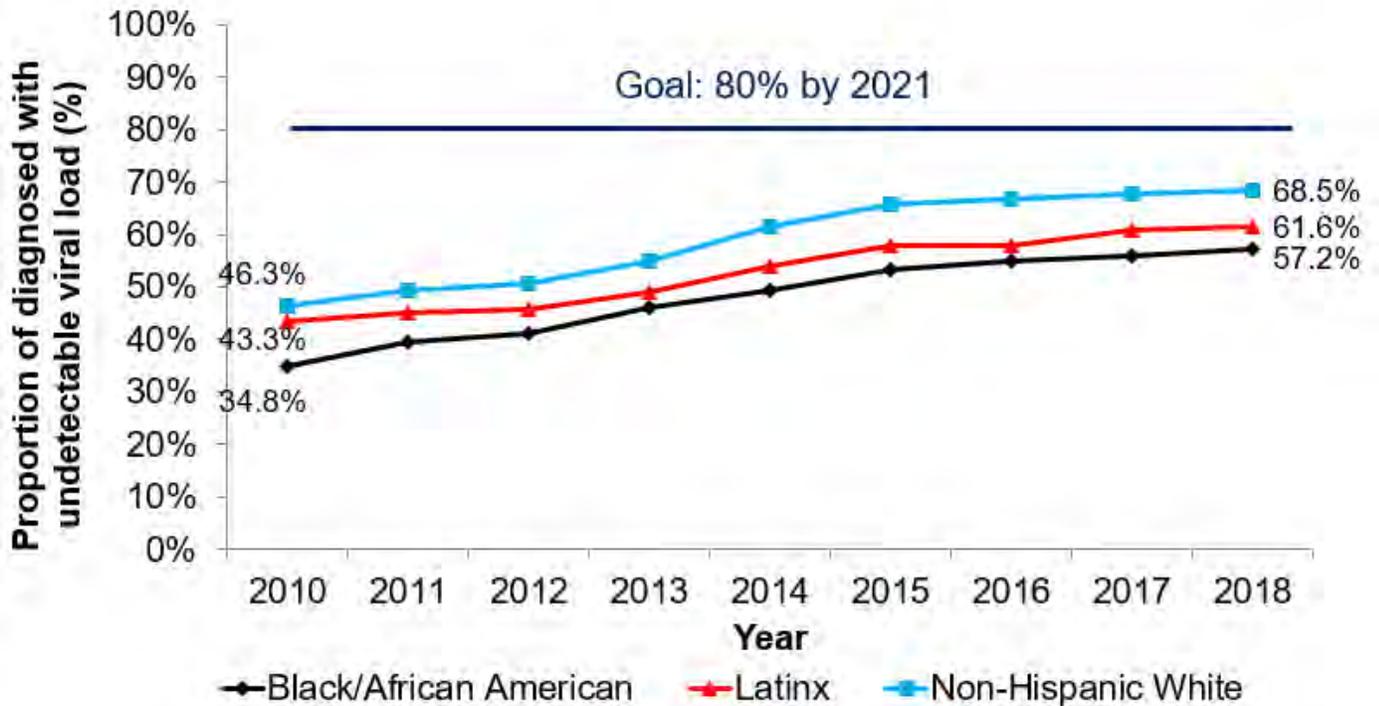
The continuum of HIV care by race/ethnicity (**Figure 1**) shows that Latinx were less likely to be virally suppressed (62%) compared to Whites, Asians, and multiracial persons (69%, 71%, and 72%, respectively). Black/AAs had lower viral suppression (57%) compared to all other groups.

Figure 1. Continuum of HIV Care by Race/Ethnicity — California, 2018



The viral suppression of persons living with diagnosed HIV by race/ethnicity (**Figure 2**) shows that from 2010 to 2018, viral suppression among persons living with diagnosed HIV has increased substantially although notable disparities remain. Black/AA have had the largest increase in viral suppression, a 64% increase from 2010 to 2018, compared to a 48% increase for Whites and a 42% increase for Latinx. However, viral suppression among Black/AAs continues to be low at 57.2%, compared to Whites and Latinx (68.5% and 61.6% respectively).

Figure 2. Viral Suppression of Persons Living with Diagnosed HIV by Race/Ethnicity — California, 2010-2018



New Diagnoses

The race/ethnicity of persons newly diagnosed with HIV (**Figure 3a**) shows Latinx made up the largest racial/ethnic group among new HIV diagnoses in 2018 (47.9%), followed by Whites (25.0%), and Black/AAs (18.1%). The rate of new HIV diagnoses among Latinx (**Figure 3b**) was 1.85 times the rate of Whites. The greatest disparity was among newly diagnosed Black/AAs at a rate 4.8 times that of Whites.

Latinx have the highest number of new diagnoses accounting for almost 48%; however, they also make up the largest racial/ethnic group in California at almost 40%. Black/AAs are among the groups most disproportionately affected by HIV in California, representing about 6% of California’s population but accounting for 18% of new HIV diagnoses.

Figure 3a. Race/Ethnicity of Persons Newly Diagnosed with HIV: California, 2018

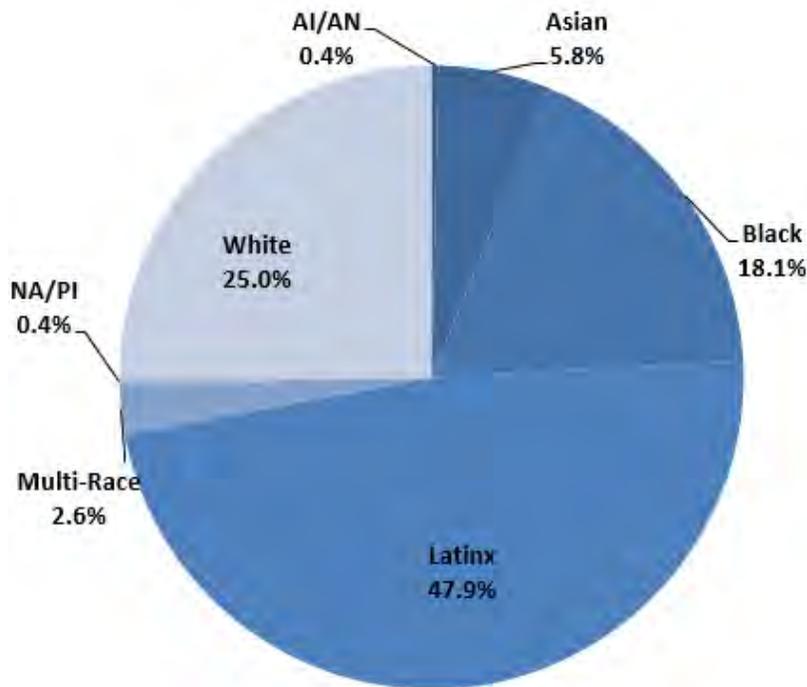
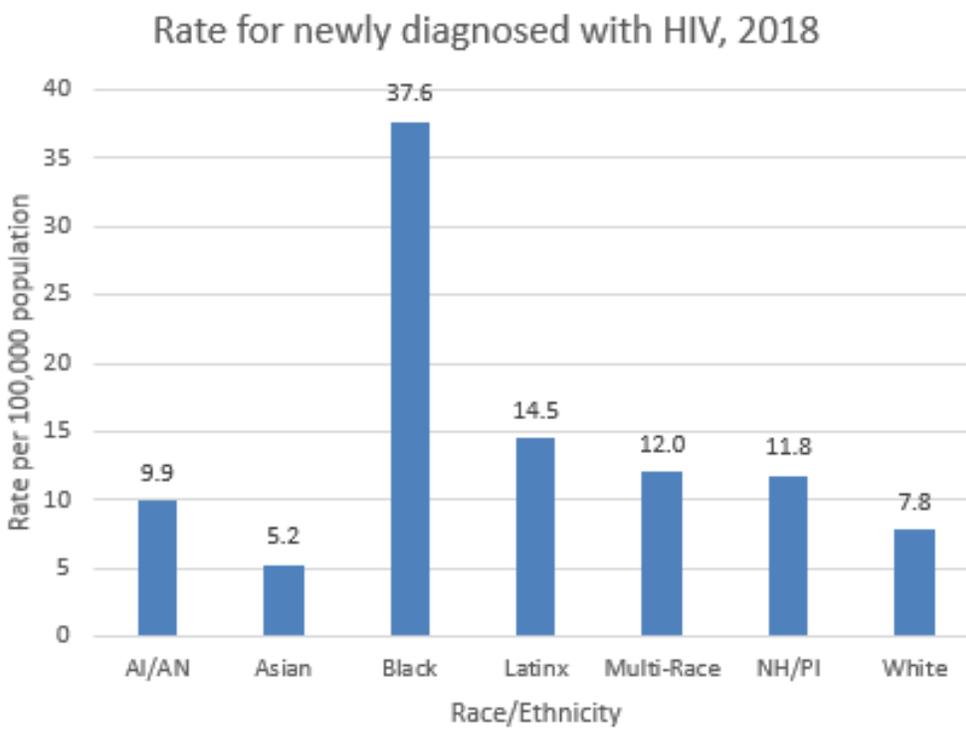
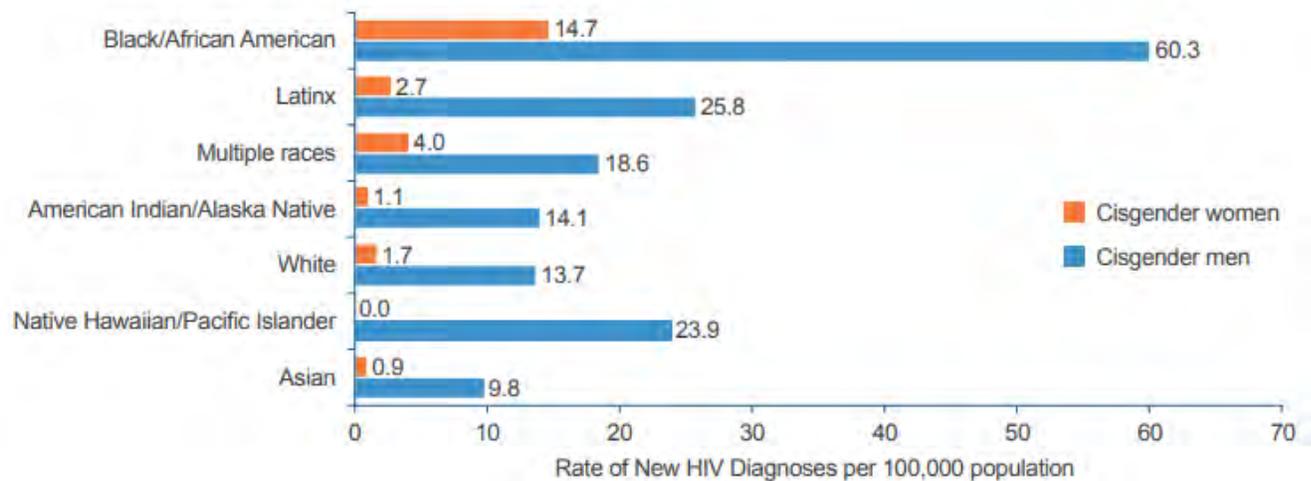


Figure 3b. Rate for Newly Diagnosed with HIV by Race/Ethnicity: California, 2018



The rate of new diagnoses* by race and gender (**Figure 4**) show Black/AAs are disproportionately affected by HIV with rates 4.4 times more than Whites among men and 8.6 times more among women. Latinx are also disproportionately affected by HIV with rates of new HIV diagnoses 1.9 times more than Whites among men and 1.6 times more among women. Although rates for transgender individuals are not available due to a lack of population denominators, it is estimated that both transgender women and men are disproportionately affected by HIV.

Figure 4. Rate* of New Diagnoses by Race and Gender- California, 2018

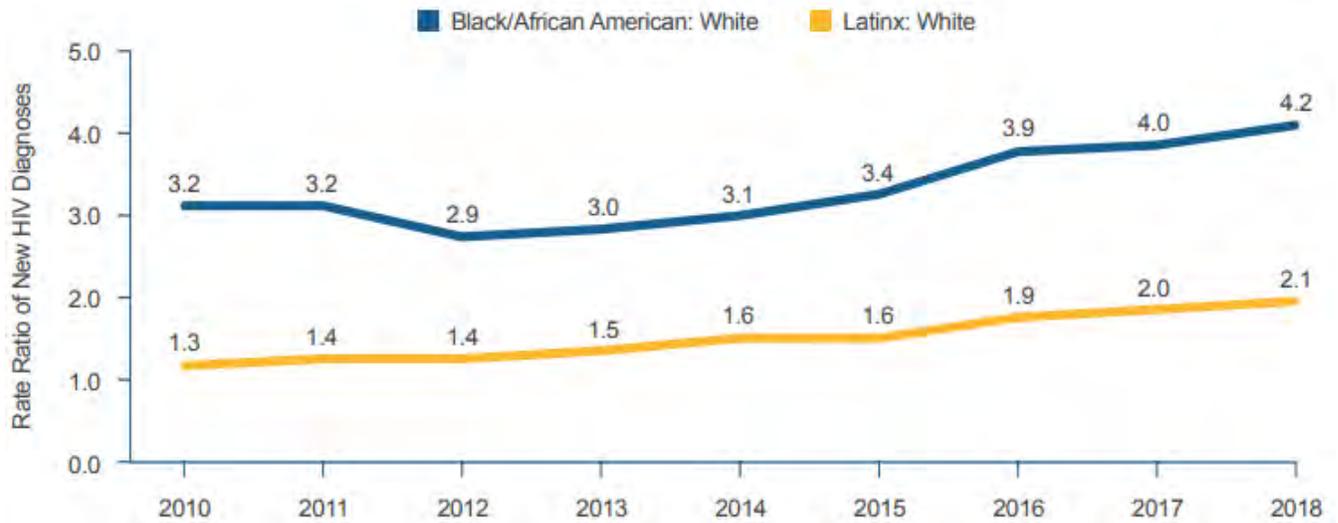


*Rate explanation: Traditionally, disease rates take the form of “X number of cases per 100,000” of the population group specified. However, for some populations, such as male to male sexual contact (MMSC), it can be difficult to accurately estimate population denominators. For that reason, the *rates reported here represent the number of MMSC cases per 100,000 males within the specified race/ethnicity.

The rate ratios of new HIV diagnoses in MMSC by race (**Figure 5**) describe the magnitude of disparities between compared groups. In 2018, the rate of new HIV diagnoses among Black/AA MMSC was 4.2 times higher than White MMSC; Latinx MMSC was 2.1 times higher than White MMSC. From 2010 to 2018, racial/ ethnic disparities for MMSC have increased for Black/AA and Latinx compared to Whites. While new HIV diagnoses rates for both Black/AA and Latinx MMSC have decreased, the rates for White MMSC had greater declines, which contributed to the increasing disparities.

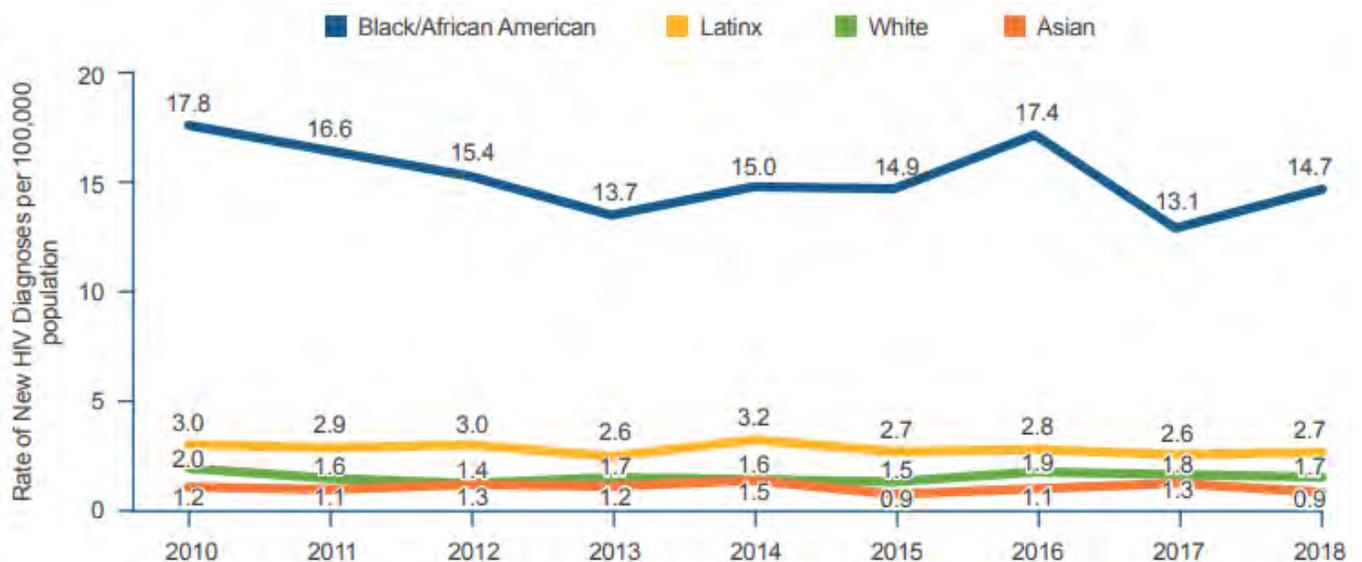
From 2010 to 2018, racial/ethnic disparities among MMSC have increased for Black/AAs and Latinx compared to Whites. The disparity remains higher between Black/AAs and Whites than for Latinx and Whites.

Figure 5. Rate* Ratios of New HIV Diagnoses in MMSC by Race, California 2010-2018



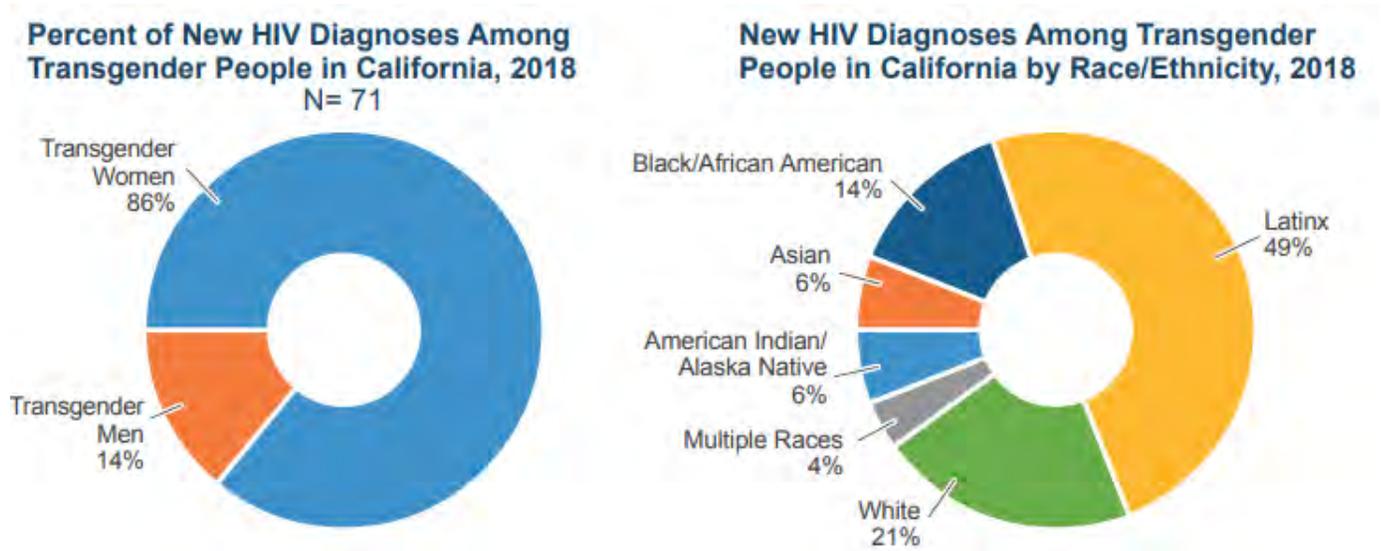
The rate of new HIV diagnoses in cisgender women by race/ethnicity (**Figure 6**) show that among cisgender women, the rate of new HIV diagnoses declined or remained stable since 2010 across all race/ethnicity groups. Black/AA women decreased 17 percent from 17.8 new HIV diagnoses per 100,000 in 2010 to 14.7 in 2018. Yet, the disparity gap between Black/AA and Whites remains large and is higher for women than it is for men.

Figure 6. Rate of New HIV Diagnoses in Cisgender Women by Race/Ethnicity, California 2010-2018



The majority (84%) of new diagnoses among transgender individuals (**Figure 7**) were among Latinx (49%), White (21%) and Black/AAs (14%). In 2018, 86 percent of transgender individuals who received an HIV diagnosis were transgender women. Although rates among transgender individuals are not available, it is estimated that both transgender women and men are disproportionately affected by HIV. According to an analysis conducted by CDC scientists, HIV prevalence among transgender individuals in the US is estimated to be 9.2 percent overall, and higher among transgender women (14.1%) than transgender men (3.2%).

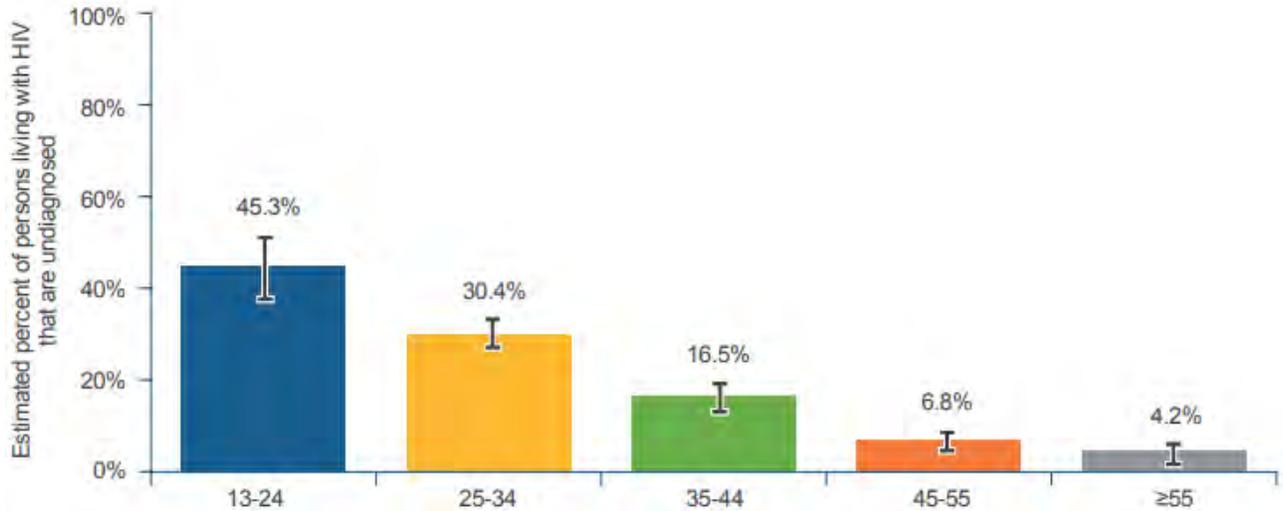
Figure 7. Percent of New HIV Diagnoses Among Transgender People in California and New HIV Diagnoses Among Transgender People in California by Race/Ethnicity, 2018



Youth

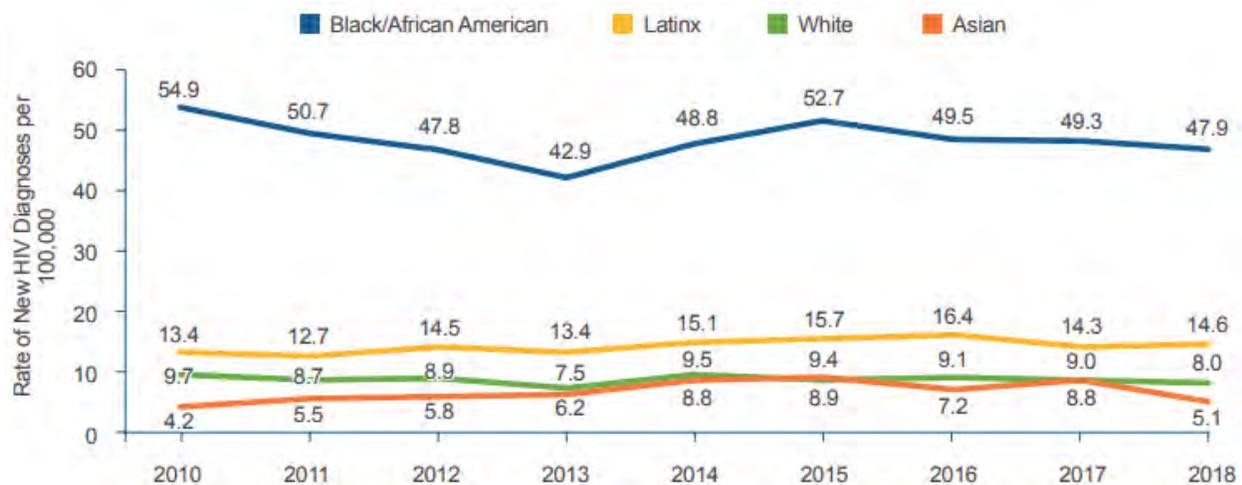
The estimated percentage of persons living with HIV that are undiagnosed by age group (**Figure 8**) shows an estimated 13 percent of people living with HIV in 2018 were unaware of their infection. Youth (aged 13-24) had the highest estimated percentage of individuals living with undiagnosed HIV of any age group. Among people aged 13-24 with HIV, an estimated 45.3% were unaware of their infection.

Figure 8. Estimated Percent of Persons Living With HIV That Are Undiagnosed by Age Group in California, 2018



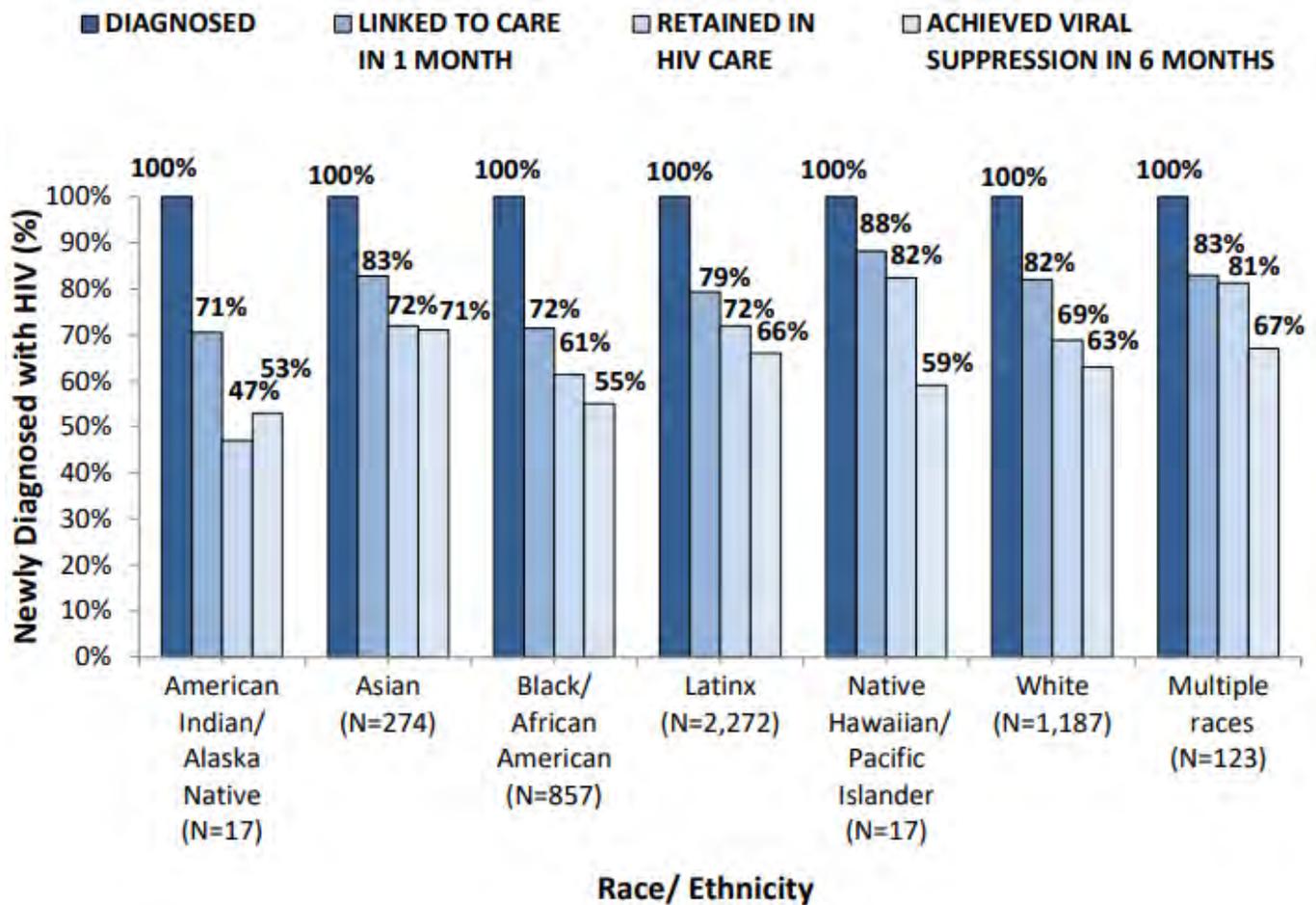
Rate trends of new HIV diagnoses by race/ethnicity among 13-24 year olds (**Figure 9**) show that among 13-24 year olds, Black/AA have significantly higher rates of new HIV diagnoses than any other racial/ethnic group. Although the rate among newly diagnosed Black/AA 13-24 year olds has declined by almost 13% since 2010, the rate in 2018 was 6 times higher than White 13-24 year olds. The rate among 13-24 year old Asians had the highest increase of 21% since 2010.

Figure 9. Rate Trends of New HIV Diagnoses by Race/Ethnicity among 13-24 Year Olds



The continuum of HIV care among youth aged 13 - 24 newly diagnosed with HIV (**Figure 10**) shows that AI/AN, Black/AAs, and NHOPI aged 13 - 24 years had lower viral suppression (53%, 55% and 59%, respectively) compared to all other groups within this age group.

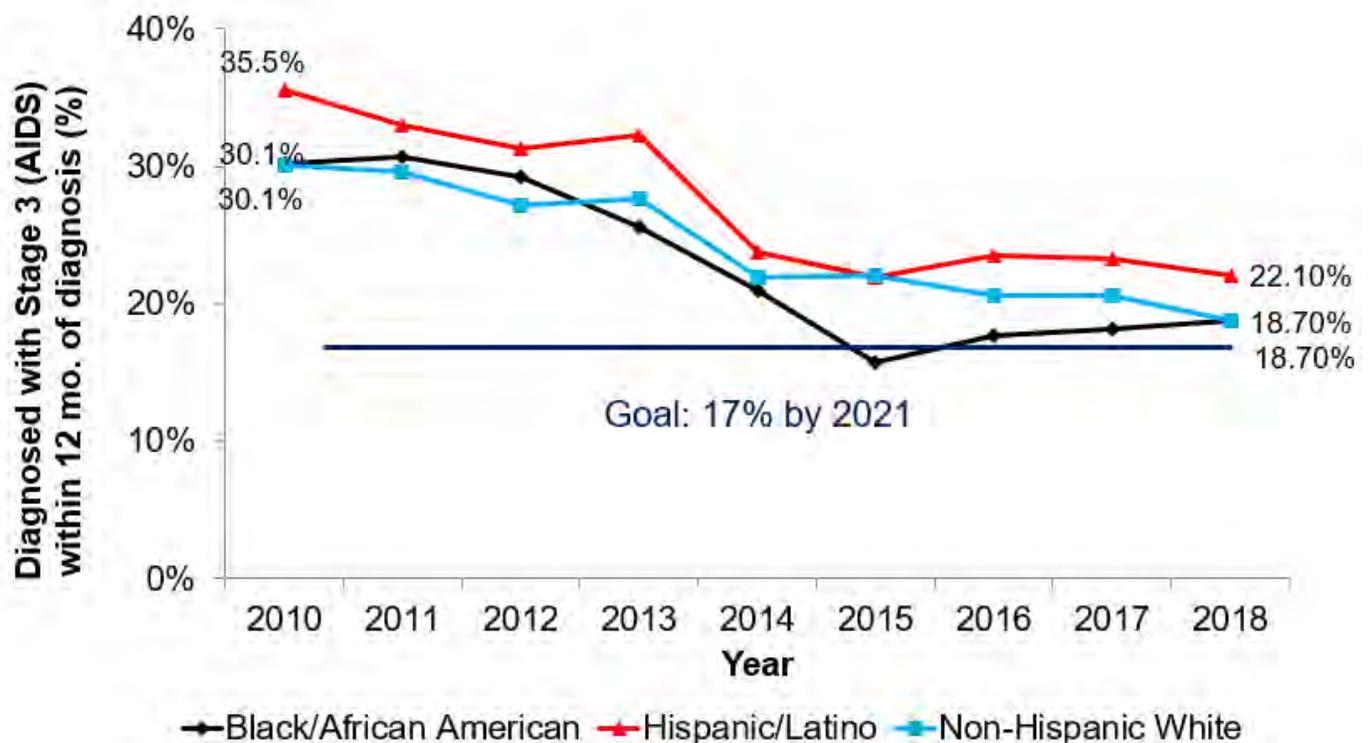
Figure 10. The Continuum of HIV Care by Race/Ethnicity: Persons Newly Diagnosed with HIV Infection — California 2018



Stage 3 (AIDS) Diagnoses

Stage 3 (AIDS) diagnoses by race/ ethnicity (**Figure 11**) show that from 2010 to 2018, the percentage of late diagnoses decreased for Black/AAs, Latinxs and Non-Hispanic Whites. Black/AAs and Whites had the same percentage of late diagnoses in both 2010 and 2018, with a 38% decrease since 2010. Latinxs have also had a 38% decrease since 2010, but still have a higher percentage of late diagnosis than both Black/AA and Whites.

Figure 11. Stage 3 (AIDS) Diagnoses by Race/Ethnicity — California, 2010-2018



C. Award Period

State General Fund local assistance in the amount of \$2 million annually, approved on continuing basis, allows for the establishment of up to four new, innovative HIV prevention demonstration projects. CDPH/OA will award four strategic rapid ART projects in the amount of \$500,000 each based on responses to this RFA and local factors including geographic area and HIV prevalence. EEs must submit proposals and budgets that effectively and efficiently use this award amount in order to be considered for strategic rapid ART funding.

The terms of the resulting awards will be two years in duration. The anticipated project start is July 1, 2021, but may vary due to the time required to finalize 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.

D. Eligible Entities

California State Senate Bill 870 established funding for this RFA. Funding is to be awarded to EEs that have the organizational capacity to fulfill the program and administrative requirements outlined in this RFA, and include: 1) Any LHJ listed below, or 2) any CBO located within any of the LHJs listed below. Agencies that provide health care and/or linkage services are included as eligible CBOs; examples include federally qualified health centers (FQHC), other community clinics, hospital emergency departments, other facilities where medical care is provided, and other government bodies, including county jails.

EEs that intend to partner with another agency to provide medical care or any of the other required activities must include in their narrative response a detailed explanation of how services will be delivered, and attach letters of support or memorandums of understanding (MOU) between the EE and the partner agency(ies). All referrals or handoffs of clients for service provision must be warm handoffs followed by confirmation of service delivery. In addition, for reporting and evaluation purposes, CBOs must have an existing, or include a detailed plan to develop, a strong working relationship with the local county health department.

EEs must be, or be located in, one of the following LHJs. These LHJs represent more than 98% of all Californians living with HIV:

Alameda	Marin	San Bernardino	Santa Barbara	Stanislaus
Contra Costa	Monterey	San Diego	Santa Clara	Ventura
Fresno	Orange	San Francisco	Santa Cruz	City of Long Beach
Kern	Riverside	San Joaquin	Solano	

Los Angeles Sacramento San Mateo Sonoma

Subcontractors may be located outside of these jurisdictions and OA welcomes multi-jurisdictional applications.

E. Program Requirements

EEs must describe program goals and proposed activities to implement a HIV demonstration project designed to provide strategic rapid ART to Californians from one or more of the following communities: Black/AA or Latinx PLWH, including MSM, transgender individuals who have sex with men and Persons Who Inject Drugs (PWID). CDPH/OA will also consider other populations for which local and/or national data indicates a disproportionate impact by HIV (e.g. [Native Hawaiian and Other Pacific Islanders \(NHOPI\)](#) or [American Indian/Alaskan Native \(AI/AN\)](#) populations as data indicates that they are disproportionately affected by HIV). For national data on race/ethnicity and HIV in the United States, visit the Centers for Disease Control and Prevention (CDC) [website](#). Please use the Application Narrative Template (**Attachment 4**) to address all program requirements. Applications that fail to use the Application Narrative Template will be rejected.

EEs are encouraged to develop projects that demonstrate promising program models appropriate to their regions, based on strong local partnerships and tailored to serving Black/AA and/or Latinx PLWH. The activities required to create replicable programs will vary by setting and funding recipient. Proposals should demonstrate the ability to identify, access, and provide evidence-informed, culturally and linguistically competent, stigma-free services to Black/AA and /or Latinx PLWH, and provide assistance to individuals allowing them to access, enroll in, and utilize public or private insurance, AIDS Drug Assistance Program (ADAP), and/or client assistance programs to pay for care services. Ideal proposals will develop a system-wide focus on all components specified above, will address the potential for establishing long-term project sustainability, and will describe strategies for linking clients with any additional health, psychosocial, behavioral, and essential support services in both health and community-based settings.

Funds from these awards may be used for most costs associated with planning, implementing, and evaluating strategic rapid ART projects, including the required approaches and five required activities listed below. Examples include staff time, rent, training, transportation, and some costs related to medical care and treatment. However, as these are demonstration projects, awardees should make every effort to follow the “payer of last resort” model when consuming funds for medical care and treatment.

Medical staff time, blood draws, lab work, and prescription medication starter packs are all allowable expenses.

Project Activities

Successful applications will demonstrate EE's proposal and capacity to accomplish the required programmatic objectives listed below, by providing responses to the components in the Application Narrative Template (**Attachment 4**).

Please note that responses must take into consideration how the EE will implement these objectives using the required approaches and a combination of telehealth/telemedicine and in person services to ensure that clients are served during COVID-19.

Required Programmatic Objectives

1. Promote the initiation of rapid ART for newly HIV diagnosed persons and those previously diagnosed with little or no history of ART, who are among the required priority populations. Include a plan for prioritizing suspected acute cases for immediate ART initiation.
2. Provide adherence counseling and HIV education to promote viral suppression, encourage retention in care, reduce HIV stigma, and normalize ART.
3. Conduct follow-up shortly after ART initiation (preferably 2-4 days) to confirm treatment began, identify and address barriers with adherence and retention in care, and provide additional education as appropriate (additional follow up may be required for certain individuals).
4. Educate clients on the benefits of U=U for both the client and the community at large.
5. Educate medical providers and clinic/agency staff on the benefits of U=U for both the client and the community at large.

Project Components

1. Replicability and Innovation

- a. Projects must be innovative strategic rapid ART demonstration projects. Existing Rapid ART projects may apply for this funding provided their proposal demonstrates that funds will be used to develop a new component, focus on a currently unserved priority population (e.g. trans women, recently incarcerated, homeless, etc.), and/or serve a new geographic location in their community where there are gaps in service for linkage to care for PLWH. Applications must describe how the EE's project provides an innovative approach to providing rapid ART.

- i) 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 priority populations as demonstrated by data.
- b. Describe innovative strategies to reach/engage your agency’s identified population and sub-population.
- c. Describe how your agency will utilize telehealth methods to meet the five required programmatic objectives of this project.
- d. Describe how your agency will accommodate clients who do not have access to technologies to provide telehealth.
- e. Describe how your agency will leverage the existing continuum of services in your area to ensure that the full range of strategic rapid ART objectives are met.
- f. Describe how the approaches used by the EE will be culturally responsive to effectively reach priority populations.
- g. Projects should be structured to be reasonably replicable by other agencies in California with the least amount of barriers to building out a program and which can be reasonably sustained over time. Describe how EE’s project will meet this criterion.

2. Priority Populations

- a. **MUST** serve one or more of the following populations:
Black/AA, Latinx PLWH, including MSM, transgender women who have sex with men, and/or PWID.
- b. May also serve priority sub-populations that fall under Black/AA and Latinx PLWH may include 1) gay, bisexual, or other MMSC, 2) transgender men who have sex with men, 3) and/or other populations for which local data indicate substantial risk for low rates of achieving viral suppression (e.g. [Native Hawaiian and Other Pacific Islanders \(NHOPI\)](#) or [American Indian/Alaskan Native \(AI/AN\)](#) populations as data indicates that they are disproportionately affected by HIV). For national data on race/ethnicity and HIV in the United States, visit the [CDC website](#).
- c. Identify the priority population(s) to be served by the project, and any additional populations in the jurisdiction (if applicable) intended to be served by providing local information on the population(s). Local epidemiologic data, a local care continuum, HIV testing data, Ryan White services data, and/or other data that demonstrate high HIV incidence, high rate of new HIV diagnoses, high testing positivity rate, and/or low rates of viral suppression may be cited to justify the

populations' inclusion.

- d. Provide an estimated size of the priority population(s) to be served by the project.
- e. Provide an estimate of the number of newly diagnosed and previously diagnosed clients to be offered strategic rapid ART.
- f. Based on local priority population data identified above, describe the strategies the EE's strategic rapid ART project will implement to:
 - i) increase rates of engagement and retention in HIV care,
 - ii) promote adherence to treatment, and
 - iii) increase clients', medical providers', and clinic/agency staff knowledge and understanding of U=U.

3. Programmatic Approaches

- a. Describe how the EE will create and maintain a safe and secure space for clients to discuss sexual health, social and emotional issues, as well as receive services free from judgment and fear.
- b. CDPH/OA defines trauma-informed as an approach to administering services in care and prevention that acknowledges that traumas may have occurred or may be active in clients' lives, and that those traumas can manifest physically, mentally, and/or behaviorally. If providing direct services, describe your agencies policy, procedure and practice of being trauma-informed.

If your agency has not implemented this approach, describe your agencies plan to implement trauma-informed approaches in policy, procedures and practices by the end of the project period.

For additional information on trauma informed approaches to HIV care and prevention, access National Alliance of State and Territorial AIDS Directors (NASTAD) toolkit [here](#).

- c. CDPH/OA defines intersectionality as the overlap of various social identities, such as race, gender, sexual identity, disability, and class. Successful EEs will address intersectionality and reduce and/or eliminate the systemic oppression and discrimination experienced by an individual. EEs must describe how their agency incorporates the theory of intersectionality to understand and address trauma among persons vulnerable to or living with HIV. If EEs currently do not incorporate intersectionality into client services, applicants must describe how they plan to do so.
- d. Describe how the EE will address HIV related stigma, medical

mistrust, and systemic/institutional oppression among the populations you will be serving.

- e. Describe how the EE will incorporate a health and wellness approach in program planning and delivery.
- f. CDPH/OA defines social determinants of health as the range of social, economic and environmental factors that determine the health status of individuals or populations. Social determinants of health play a role in HIV infection and the ability of people vulnerable to, or living with HIV to seek treatment, care and support. Describe what structural approaches or interventions EE has implemented or will implement for HIV prevention to improve outcomes of the identified population.
- g. Cultural competence is the ability of an organization to effectively deliver services that meet the social, cultural and linguistic needs of the EEs 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 or her personal expression of heritage and culture. Describe how the EE will address cultural competence and cultural humility through service delivery.
- h. If the EE will provide services to youth, describe EEs plan to provide or enhance a holistic approach to comprehensive sexual education (e.g. sex positive messaging, healthy relationships, safe and consensual sexual activities, etc.).
- i. 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 link between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. Describe how the EE will utilize social networks to deliver and strengthen service delivery to Black/AA and/or Latinx populations.

4. Community Engagement

- a. Describe how the EE will provide services that are culturally, linguistically, developmentally and age appropriate.
- b. How will the identified priority population be involved in the planning and design of the proposed project? Describe how the proposed project will meet the identified needs of the priority population.
- c. Describe what client engagement strategies will be used to engage clients in the proposed services/interventions. Please note that no new media may be funded by this project.
 - i. Media has the potential to deliver HIV/STI and positive sexual

health prevention messages to the priority population in a cost-effective way. New media includes: social media (social networking sites), mobile applications, internet sites, social marketing campaigns/ initiatives, and videos to capture the power of storytelling.

- d. Describe any community assessment tools that have been used to determine priority population needs. What were the outcomes of this assessment? If no assessment has been conducted, describe how your agency will determine the needs of the population.
- e. Describe your experience with community engagement and history with reaching the priority population. How will you gain or maintain trust within these communities?

5. Strategic Rapid ART Initiation and Retention in HIV Care and Treatment

- a. Provide the actual or estimated time it currently takes EE to link a person to ART. How will the services proposed for the innovative demonstration project result in rapid ART (a reduction in time to linkage to ART)?
- b. Describe EE's preparedness to implement strategic rapid ART services within the first quarter of fiscal year one (agency staff should be in place or new positions filled).
- c. Describe the EE's preparedness to implement telehealth services to provide strategic rapid ART.
- d. Describe the types of telehealth services to be implemented that will:
 - i. Promote the initiation of rapid ART for newly HIV diagnosed persons and those previously diagnosed with little or no history of ART, who are among the required priority populations.
 - ii. Provide adherence counseling and HIV education to promote viral suppression, encourage retention in care, reduce HIV stigma, and normalize ART.
 - iii. Conduct follow-up shortly after ART initiation (preferably 2-4 days) to confirm treatment began, identify and address barriers with adherence and retention in care, and provide additional education as appropriate.
- e. Describe the process(es) that will be used to identify new and previously diagnosed HIV positive clients for inclusion in the project.
- f. Describe the initial client interview process, and follow-up and retention activities and procedures.

- g. Describe the process(es) for identifying and addressing individual, systemic, and/or structural barriers to engagement in strategic rapid ART.
- h. Describe the process(es) for identifying and addressing individual, systemic, and/or structural barriers to adherence to ART and retention in care.
- i. Describe how EE will assess and assist those at risk of being lost to care and/or get out-of-care clients back into care and treatment.
- j. Describe EE's plan to address rapid ART for suspected acute cases.

6. U=U Education and Information Sharing

- a. Describe the education and information sharing strategies that will be implemented to educate clients, medical providers, and EE staff on the personal and community benefits of U=U.
- b. Describe how your agency will meet this objective using technology such as Zoom, webinars, teleconferences, etc. to achieve the following:
 - i. Educate clients on the benefits of U=U for both the client and the community at large.
 - ii. Educate medical providers and clinic/agency staff on the benefits of U=U for both the client and the community at large.
- c. Specify any materials to be used or adapted for educating providers, clients, and staff regarding U=U; for example, creating new or adapting existing client brochures, palm cards, or posters for waiting rooms.

7. Staffing and Staff Training

- a. Describe EE's currently available and planned staffing for the project (i.e., existing staff to be reassigned, new staff to be hired), and plans to provide staff education and training for the project components relevant to their position(s).
- b. Describe the personnel policies and procedures that exist within the EE organization to assure that qualified staff are recruited, well trained, and supervised.
- c. Describe how the agency will ensure that projects are staffed by individuals who represent the priority populations for which they serve. (e.g. front line staff who provide direct services to Black/AA and/or Latinx clients should represent the communities they serve).
- d. If staff hiring or reassignment will occur for this project, discuss EE's capacity to hire/reassign staff within the first period (July 1, 2021 to Dec. 31, 2021).

- e. If any personnel positions are listed as “to be determined” in project budget, provide EE’s plan for hiring the open position(s). (Note: if awarded funding, failure to fill positions within the first quarter of fiscal year one without receiving an extension from OA may result in the termination of funding).
- f. Discuss EE’s capacity to maintain project integrity in the event of staff turnover.
- g. 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.
- h. If EE will be working with subcontractor(s), describe specifically EE’s plan for monitoring subcontractor performance.
- i. Notwithstanding the existence of any subcontractors, the selected EE will be ultimately responsible for performance of all terms and conditions.
 - i. Under the resulting contract, if subcontractors have been identified by name and will be used, include a Letter of Support from each proposed subcontractor.
Note: Letters of Support will not be counted towards the page limit.
- j. Staff funded through this demonstration project, or working in-kind, should be listed in the budget table.

8. EE Capacity

- a. Describe EE’s ability to serve the priority population(s) to be included in the project. If a referral model or intra-agency collaborations are planned, describe EE’s relationships with those agencies that demonstrate expertise, history, and credibility working successfully in engaging the priority population(s), and also specify the policies and protocols that will ensure the services are delivered. Attach letters of support if collaborations are planned.
- b. Describe experience implementing a comprehensive health services model (where the client and their environment are considered) for application to a rapid ART protocol for persons diagnosed with acute or early HIV infection, or previously diagnosed persons with HIV who have little or no history on ART.
- c. Describe experience implementing evidence-based programs or generating innovative strategies, or both, with at least preliminary evidence of program effectiveness.
- d. If clients will be referred to outside care providers, specify any relationships with community-based HIV and/or non-HIV health care

providers that have a successful history of working with the priority population(s), and/or providers who can attend to other identified needs of clients who may experience barriers to accessing services. Include letters of support in the attachments.

- e. If EE intends to conduct any activities via referrals or collaboration with partner agencies:
 - i. Specify the partner agencies.
 - ii. Describe the process for warm handoffs of clients to partner(s). If warm handoffs are not planned, explain how you will link the client to ART.

Note: If during the course of the project, collaboration with partner agencies is not successful and activities of the contract are not successfully implemented, the contract may be terminated by OA.

- f. Describe the organization's administrative systems and accountability mechanisms for contract management.

9. Program Monitoring and Evaluation Capacity

At least 10% of the EE's budget must be allocated to evaluation activities, which include data collection, entry, management, monitoring, and quality control.

- a. Quantitative evaluation: EE will enter, collaborate with an LHJ to enter, or collaborate with OA to enter data into two systems: 1) California Reportable Disease Information Exchange (CaREDIE), and 2) Local Evaluation Online (LEO), which is a web-based, OA-provided data application. Data collection forms are available online and must be printed by project awardees themselves.
- b. Qualitative evaluation: EE will collaborate with OA before program implementation, at program end, and as needed during the demonstration to: 1) document current linkage protocols, 2) establish planned protocols and procedures for the rapid ART programs, 3) document and assist with any mid-cycle changes, and 4) provide progress report summaries at appropriate intervals and at end of contract period.
- c. Describe capacity to engage in data collection and entry processes that correspond to the EE's characteristics below (respond to **only one** of the categories: i or ii.):
 - i. LHJ applicants with CaREDIE access: Describe the processes

and/or protocols that will be followed to ensure that staff are available, have access to, and are able to enter project data into both, CalREDIE and LEO.

- ii. CBO applicants without CalREDIE access: Describe the process and/or protocols that will be followed to ensure that the EE's LHJ will assist with entering client data into CalREDIE on EE's behalf. An MOU or letter from the LHJ must be attached to the application. Describe the processes and/or protocols that will be followed to ensure that staff are available, have access to, and are able to enter project data into LEO.
- d. Describe overall capacity to participate in OA program monitoring and evaluation activities, or ability to build capacity to do so. Activities include: data collection, data entry into OA's data systems, data management, project monitoring, development and implementation of quality control measures, progress report submission, and participation in OA program evaluation based on outcome-based activities.
- e. Describe available resources, (e.g., current dedicated staff, or plans to hire or reassign staff) that will facilitate all evaluation activities and requirements listed above to be initiated and implemented continuously throughout project duration.
- f. Describe contingency plans to address anticipated delays in implementation of evaluation activities (e.g., gaining access for data entry, hiring of staff, etc.). Include additional resources EE anticipates will be needed to successfully manage project data (project budget can include funding for hiring of data management staff).

F. Budget

The budget template (**Attachment 6**) must be completed using the budget guidance (**Attachment 5**). The budget template must explain all expenses included as instructed in the budget guidance. Applicants are responsible for ensuring the calculations in the budget 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 to be unnecessary for the implementation of the project.

G. 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 OA in writing via e-mail, to

request clarification or modification of this RFA.

All such inquires must identify the author, applicant entity name, address, telephone number, and e-mail address, and must 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 5:00 p.m. PDT, on **February 12, 2021 at the email address below.**

E-Mail Address
StrategicRapidART@cdph.ca.gov

All questions and OA's responses will be posted and available on the CDPH/OA website at: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_RFA.aspx by 5:00 p.m. PDT on **February 16, 2021**. Specific inquiries determined to be unique to an applicant will be responded to via email 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 will submit an application at the EE's 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, 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.

OA may reject any or all applications and may waive any immaterial defect in any application. OA's waiver of any immaterial defect will 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 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.

a. Grounds for Rejection

OA may, at its sole discretion, correct any obvious mathematical or clerical errors. 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 OA, none of the applications meet California’s needs.

Circumstances that will cause an application package to be deemed non-responsive include, but are not limited to:

- i. Applicant failed to submit a Letter of Intent by the deadline required by this RFA.
- ii. The application is received after the deadline set forth in this RFA.
- iii. Failure of the applicant to complete and submit required forms and attachments as instructed in this RFA or as instructed in the attachments.
- iv. Failure to meet format or procedural submission requirements.
- v. Applicant provides inaccurate, false, or misleading information or statements.
- vi. Applicant is unwilling or unable to fully comply with proposed contract terms.
- vii. Applicant supplies cost information that is conditional, incomplete, or contains any unsigned material, alterations, or irregularities.
- viii. Applicant does not meet EE qualifications set forth in this RFA.
- ix. Applicant does not use and/or modifies the Application Narrative Template or other provided attachments.

b. Application Review

Applications that meet the format requirements and contain all of the required forms and documentation will be submitted to an evaluation committee convened by 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, the likelihood of maximally reducing new HIV infections, and

addresses all RFA requirements.

The evaluation will constitute recommendations to OA management.
Final approval of awardees will be made by the OA division chief.

H. Instructions for RFA Submission

1. **Letter of Intent – MANDATORY** – Due by 12:00 p.m. PDT, **February 17, 2021**.
Prospective EEs are required to submit the Letter of Intent to OA indicating their intent to submit an application in response to this RFA. The Letter of Intent must be digitally signed by an official authorized to enter into a contractual agreement on behalf of the EE. The Letter of Intent must be sent via email to the address below. EEs that fail to submit a Letter of Intent by the specified deadline are precluded from submitting an application for consideration.

Email Address
StrategicRapidART@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. All templates must be submitted to OA in the file format in which they were provided (e.g. do not submit a PDF application). The size of the lettering must be at minimum 12-point, Arial font.

EEs intending to submit an application 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 OA. The following is the order in which sections in the application must be submitted:

- a) Application Cover Sheet
- b) Application Certification Checklist
- c) Executive Summary
- d) Application Narrative Template
- e) Budget Template
- f) Required Forms
 - i. Government Agency Taxpayer ID Form
 - ii. Payee Data Record
 - iii. Letters of support (if applicable)

A complete application package with all attachments listed above must be submitted. Note: applicants need not submit **Attachment 5**, Budget Guidance with their application. A brief description of each section to be included is given below:

- a. Application Certification Checklist
Complete the application certification checklist (**Attachment 1**). This sheet will serve as the guide to make certain that the application package is complete, and to ensure that 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. Application Cover Sheet
Complete the application cover sheet (**Attachment 2**). This sheet must be signed by an official authorized to enter into a contractual agreement on behalf of the EE.
- c. Executive Summary (one page limit)
Include a one-page Executive Summary (**Attachment 3**) of the proposed program and how it will be integrated with the EE's current activities.
- d. Application Narrative Template (20 page limit)
Complete the Application Narrative Template (**Attachment 4**) covering the funding period, from **July 1, 2021** through **June 30, 2023**. This section must include complete descriptions of your plan to carry out Section E – Program Requirements, beginning on page 25 of this RFA.
- e. Budget Template (Excel workbook)
Complete the Budget Template (**Attachment 6**) **for each funding period**. The terms of the resulting contracts will be two fiscal years (FY) in duration as noted below:
FY1: July 1, 2021 to June 30, 2022
FY2: July 1, 2022 to June 30, 2023

See the Budget Guidance (**Attachment 5**) for a description of what each line item must include. Please note that these funds may not be used to pay for clinical care or other services that can be billed to third-party payers.

The budget descriptions of services, duties, etc. found in the Budget Template (**Attachment 6**) must explain and justify both program services funded by other funding and those, if awarded, funded by this contract.

Availability of other funding will not affect the scoring of this RFA. For example, the salary 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 which results 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) must be listed by name and address in the application. Note: The cost of developing the application for this RFA is entirely the responsibility of the applicant and cannot not be chargeable to the State of California or included in any cost elements of the application.

f. Required Forms/Documentation

Below is a list of required forms/documentation to accompany all applications as attachments. Please note that all forms must have the EEs same exact legal business name 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. LHJ's must complete a Government Agency Taxpayer ID, CDPH form 9083. This form is required for payments to entities and will be kept on file at CDPH (**Attachment 7**).
- ii. CBOs must complete a Payee Data Record, STD. 204. This form is required for payments to entities and will be kept on file at CDPH (**Attachment 8**).
- iii. Letters of support: If the EE will provide services across multiple LHJs, the EE must provide a letter support from each jurisdiction where services will be provided.

NOTE: Applications that fail to follow ALL of the requirements may not be considered.

3. Application Submission Instructions

Applications must be submitted via email to the address below by 5:00 p.m. PDT on **March 15, 2021**.

Email Address
StrategicRapidART@cdph.ca.gov

4. Notification of Intent to Award

Notification of the State's intent to award contracts for the HIV Prevention strategic rapid ART projects will be posted on OA's website at: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_RFA.aspx by 5:00p.m. PDT **April 12, 2021**. The award announcement will identify the contractor(s) awarded.

5. Disposition and Ownership of the Application

All materials submitted in response to this RFA will become the property of CDPH/OA and, as such, are subject to the Public Records Act (Government Code Section 6250, et. seq.). 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, 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. Contract Award Appeal Procedures

An EE who has submitted an application and was not funded may file an appeal with OA. Appeals must state the reason, law, rule, regulation, or practice that the EE believes has been improperly applied in regard to the evaluation or selection process. There is no appeal process for applications that are submitted late or are incomplete. Appeals shall be limited to the following:

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

Appeals must be sent by email to StrategicRapidART@cdph.ca.gov and must be received by **April 14, 2021, 5:00 P.M. PDT**. The Division Chief of OA, or a specified designee, will then come to a decision based on the written appeal letter. The decision of the Chief of OA, or the specified designee, will be the final remedy. Applicants will be notified by email within 15 days of the results of the written appeal letter. OA reserves the right to award the contract when all appeals have been resolved, withdrawn, or responded to the satisfaction of OA.

7. Miscellaneous RFA Information

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

The award of a contract by OA to an entity that proposes to use subcontractors for the performance of work under the resulting contract shall not be interpreted to approve the selection of subcontractors. Subcontractors can only be added or changed after a contract is awarded with OA approval of a formal contract amendment. In the event a contract is entered into, but later terminated, 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 EE's response, such inconsistencies or conflicts will be resolved by first giving precedence to the contract, then to this RFA, any addenda, and last to the EE's response. 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.

8. Contract Obligations

The successful EE must enter into a contract that may incorporate, by reference, this RFA as well as the application submitted in response to this RFA. **It is suggested that EEs carefully review these awardee provisions for any impact on your application and/or to determine if the EE 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 OA and each selected awardee shall take place within 60 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.

I. Attachments

1. Application Certification Checklist
2. Application Cover Sheet
3. Executive Summary
4. Application Narrative Template
5. Budget Guidance
6. Budget Template
7. Government Agency Taxpayer ID Form
8. Payee Data Record