

**CITY OF HOUSTON
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF HIV/STD PREVENTION**

**REQUEST FOR PROPOSALS
HIV/STD PREVENTION SERVICES**



**RELEASE DATE: October 25, 2006
PROPOSAL DUE DATE: 2:00 P.M., December 8, 2006**

**8000 N. Stadium Drive, 5th Floor
Houston, Texas 77054
Tel (713) 794-9092 Fax (713) 798-0830
www.houstonhealth.org**

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Intent to Apply

Please submit this form by **5:00 p.m., Wednesday, November 22, 2006.**

**TO: Beau J. Mitts, MPH
Program Manager, HIV/STD Prevention
Bureau of HIV/STD Prevention
Disease Prevention and Control Division**

FAX: (713) 798-0830

This is to inform you that our organization is interested in applying for funding under the RFP for HIV/STD PREVENTION SERVICES. We understand that this is not a commitment, but is provided to the HDHHS only for the purposes of identifying interest in the RFP and to adequately plan for the proposal review process.

AGENCY NAME:					
AGENCY ADDRESS:					
CONTACT PERSON:					
PHONE:			FAX:		
E-MAIL:					
EXPECTED NUMBER OF PROPOSALS TO BE SUBMITTED UNDER THIS RFP:					
Category 1:	Category 2:	Category 3:	Category 4:	Category 5:	Category 6:

Signature of Executive Director, CEO, or designated Board Member **Date**

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Tentative Schedule of Events

<u>Event</u>	<u>Date</u>
Release of RFP	October 25, 2006
Proposers' Conference	9:00 AM, Wednesday, November 8, 2006
Mandatory Intent to Apply Form Due to HDHHS.....	5:00 PM, Wednesday, November 22, 2006
<u>PROPOSAL SUBMISSION DEADLINE</u>.....	2:00 PM, Friday, December 8, 2006
Funding Recommendations Given to Applicants	November 2006
Contract Approval by the City Council	December 2006
Contract Start Date.....	January 1, 2007

I. Purpose

The Houston Department of Health and Human Services (HDHHS) Bureau of HIV/STD announces the availability of funds to support the delivery of comprehensive HIV/STD Prevention Services in the Houston/Harris County, including HIV health education and risk reduction services (HE/RR), HIV/STD counseling, testing and referral services (CTR), and comprehensive risk counseling services (CRCS), targeted to or intended to benefit persons at high risk for HIV/STD infection or persons at risk for HIV/STD transmission in Houston/Harris County.

This Request For Proposals (RFP) will solicit HIV/STD Prevention Services that target and serve those Behavioral Risk Groups (BRGs) identified and recommended for funding in 2006 by the Houston HIV Prevention Community Planning Group (CPG) and considered critical to the development of a comprehensive and effective local HIV prevention program. These services are also recognized as integral to a continuum of HIV care within Houston/Harris County. This RFP seeks to identify organizations that 1) have the expertise, demonstrated success and desire to implement evidence-based, culturally-sensitive, linguistically- and developmentally-appropriate HIV/STD Prevention Services to persons at greatest risk for HIV infection or greatest risk for HIV transmission in Houston/Harris County, 2) are willing to aggressively contribute to reducing incident HIV infections in Houston/Harris County, and 3) demonstrate financial stability. HIV/STD Prevention Services funded under this RFP will be distributed throughout Harris County based on the geographic indicators of need including, but not limited to, new HIV diagnoses.

The Bureau of HIV/STD Prevention will accept proposals for HIV/STD Prevention Services in the following categories:

Category 1: **Health Education/Risk Reduction (HE/RR)**, including outreach, individual-level interventions (ILI), group-level interventions (GLI), community-level interventions (CLI) and health communication/public information (HC/PI) targeted to high-risk HIV-negative persons and HIV-positive persons. This category is intended to increase knowledge, awareness and skills to decrease the prevalence of HIV risk behaviors, to maintain and reinforce risk reduction behaviors and create community norms and values that support HIV risk reduction efforts, learning of one's HIV status and disclosure of HIV serostatus, when appropriate. This category will secondarily serve as a vehicle to refer HIV at-risk persons of unknown HIV serostatus to available HIV counseling, testing and referral services.

Category 2: **HIV/STD Counseling, Testing and Referral (CTR) including Syphilis Elimination**, includes the following: risk assessment, rapid and conventional HIV-antibody testing, disclosure counseling, post-disclosure counseling, partner counseling, referral services and social networks targeted to persons of unknown HIV status. Two interventions will be funded, Targeted HIV Screening and Protocol-Based Counseling. Funding under this category will emphasize confidential HIV testing services and will support traditional settings (clinic-based) for HIV testing as well as non-traditional settings such as community-based venues, outreach settings, and mass testing days. All HIV CTR programs

will also receive Syphilis Elimination funding and be required to concurrently test for Syphilis when testing for HIV.

Category 3: **Comprehensive Risk Counseling Services (CRCS)**, targeted to HIV-negative persons at high risk for HIV infection and HIV-positive persons at high risk for HIV transmission. The goal of this category is promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. CRCS is intended for persons having, or likely to have, difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission, or re-infection. CRCS is essentially a hybrid of HIV risk-reduction counseling and traditional case management. Funded agencies must establish a referral network to assist clients in meeting specific needs.

Category 4: **Social Marketing**, designed to alter HIV testing and risk reduction behaviors, correct misperceptions and misinformation, and create a supportive environment for communication about what it means to be HIV-positive or HIV-negative. This intervention addresses the community norms and other barriers preventing individuals from testing or accessing needed services, including: 1) fear of the impact of an HIV diagnosis, 2) lack of knowledge about testing sites and procedures, and 3) lack of knowledge about the health care system.

Category 5: **School-Based Programs** including the development and provision of an innovative HIV/AIDS training program that increases broad school-based support for HIV/AIDS education among school administration, teachers and medical staff, school boards, parent-teacher organizations and parents for comprehensive HIV education and prevention activities for students.

Category 6: **HIV Prevention Program Evaluation, Technical Assistance and Capacity Building**, including Behavioral Scientists, to assist local HIV prevention providers in the development of evidenced-based, behavior theory-based and behavioral risk group-specific interventions, to ensure collection of relevant program evaluation markers and to assist with program assessment and refinement efforts.

II. Background

One purpose of the Bureau of HIV/STD Prevention is to develop an effective response to the HIV/AIDS epidemic in Houston/Harris County by improving our response to HIV infection and associated risk factors, preventing the spread of HIV, maximizing health and social outcomes and coordinating effective and efficiently targeted comprehensive services for those at risk for, living with or affected by HIV.

To accomplish this mission, the HDHHS partners with a broad array of public and private service providers to deliver HIV prevention programs that include a range of tailored interventions designed to help persons learn their HIV status, develop skills to prevent HIV infection or HIV transmission, reinforce behaviors that help mitigate HIV infection and transmission, and provide linkage to HIV and other systems of care. The HDHHS maintains partnerships to create prevention service delivery networks, to implement multiple morbidity

programming, to implement structural interventions and to implement site-specific (e.g. County jails) or community-specific (e.g. faith community) interventions.

HIV prevention partnerships most often are in the form of contracted services with community-based organizations (CBOs), local hospitals and clinics, and programs within the HDHHS. These contracts are primarily supported with funds from the Centers for Disease Control and Prevention (CDC), the Texas Department of State Health Services (DSHS), and the City of Houston.

Houston/Harris County and the HIV/AIDS Epidemic

Spanning more than 1,700 square miles with nearly 3.7 million residents, Harris County is the most populous county in Texas and the third most populous county in the United States. Harris County remains the eighth most HIV/AIDS impacted local jurisdiction in the United States with approximately 19,000 to 21,000 people living with HIV or AIDS. In 2004, the jurisdiction's AIDS case rate of 23.9 (per 100,000 residents) was higher than the national AIDS case rate of 15.0. Within Harris County, the City of Houston covers more than 600 square miles with over 2 million residents, making it the fourth most populous city in the United States. The City of Houston accounts for more than 95% of HIV and AIDS cases within Harris County.

There are approximately 16,000 persons diagnosed and reported living with HIV or AIDS (PLWH/A) in Harris County, many of whom routinely access HIV care and prevention services and some who do not. There are an estimated additional 4,000 to 6,000 people who are HIV infected and who do not know their HIV status. These persons are not accessing HIV specific medical care, can benefit from such care and may be unknowingly transmitting HIV to sexual and drug using partners.

By comparison, at the end of 2003, the CDC estimated that there were approximately 1,039,000 to 1,185,000 persons in the United States living with HIV/AIDS, with 24-27% (249,360 to 319,950) undiagnosed and unaware of their HIV infection. The CDC estimates that two-thirds of all new HIV infections each year are transmitted by persons who are unaware of their HIV infection – hence our emphasis on diagnosing as many undiagnosed persons as possible. By comparison, the CDC also estimates that one-third of all new HIV infections each year are transmitted by persons who are aware of their status, many of whom lack the tools and skills to remain transmission free – hence our emphasis on prevention interventions for persons living with HIV.

In addition and conversely, many new HIV infections involve persons without the appropriate level of knowledge, skills, resiliency or support to avoid or reduce risk behavior – hence our emphasis on broad sets of interventions for high-risk HIV-negative persons. Finally, some infections involve persons who face multiple and complex life challenges, including substance abuse, childhood abuse and mental illness, among others, that demand intensive and ongoing interventions (e.g. comprehensive risk counseling services) to keep persons either HIV infection risk free or HIV transmission risk free.

A closer look at HIV/AIDS prevalence in Harris County shows that as of January 2006, the epidemic continues to be predominantly among males (74%), specifically among men who have sex with men (43%) and among people of color (70%). The most striking change in the local epidemic over the last few years has been a shift to communities of color. However, the proportion of HIV-infected Latinos in Harris County is slightly higher than in the United States

as a whole, and the new HIV diagnosis rate among African-Americans in Harris County remains much higher than in other racial/ethnic groups.

In Harris County, HIV/STD Prevention Services are planned jointly by the Bureau of HIV/STD Prevention and the Houston HIV Prevention Community Planning Group (CPG), consistent with the requirements of the HDHHS' HIV Prevention Cooperative Agreement with the Centers for Disease Control and Prevention (CDC). This Request for Proposals is based on the past and recent recommendations of the CPG to the HDHHS.

Prioritized Risk Groups

In 2004, based on a comprehensive review of local HIV epidemiology, the CPG developed and recommended for adoption the use of a behavioral risk group (BRG) model to allocate HIV prevention resources. This recommendation was a departure from the previous target population model that did not significantly factor in the behavioral HIV risk of targeted groups.

Over the past year (2005-2006), the CPG reviewed numerous secondary data sources to assess met and unmet HIV prevention needs and evaluate the appropriateness of the current BRG model. Recently, the CPG re-affirmed the existing BRG model for the purposes of priority setting, resource allocation and prevention program planning with some minor adjustments. The CPG recommended that transgenders, incarcerated individuals, and individuals recently released from incarceration be considered populations of special need. Additionally, the CPG recognized the continued importance of placing the highest priority for prevention resources on people of color, youth and persons living with HIV within each BRG and special population and forwarded recommendations accordingly.

The six prioritized BRGs include:

- Males who have sex with males (MSM);
- Females who have sex with males (FSM);
- Males who have sex with females (MSF);
- Male injection drug users (M/IDU);
- Female injection drug users (F/IDU), and;
- Males who have sex with males and use injection drugs (MSM/IDU).

Additional priority populations include:

- Persons living with HIV/AIDS, and;
- Youth (persons ages 13 – 24).

Additional populations of special need include:

- Transgenders;
- Incarcerated individuals, and;
- Individuals recently released from incarceration.

BRG categories are mutually exclusive and persons at risk for HIV are counted in only one BRG category. HIV-positive individuals are a high priority in every behavioral risk group, in addition to high-risk HIV-negative individuals and those who do not know their serostatus. In order to bring about a reduction in new infections, it is of primary importance that programs reach HIV-positive individuals. Interventions for HIV-positive individuals (both those who know their serostatus and those who are unaware that they are positive) should be designed to address their risk behavior as well as meet their specific needs.

Also, the CPG recommends that interventions be targeted to prioritized behavioral risk groups and subpopulations in accordance to the definition of persons at very high risk for HIV included in Program Announcement #04064 from the CDC. In summary, persons at very high risk for HIV are defined as someone who, within the past 6 months, has had 1) unprotected sex with a person who is living with HIV; 2) unprotected sex in exchange for money or drugs; 3) multiple (greater than 5) or anonymous unprotected sex or needle-sharing partners; or 4) has been diagnosed with a sexually transmitted disease.

Advancing HIV Prevention Initiative and Other Complementary HIV Prevention Programs and Funding

On April 17, 2003, the CDC announced a new HIV prevention initiative, “Advancing HIV Prevention (AHP): New Strategies for a Changing Epidemic.” The aim of the AHP Initiative is to reduce barriers to early diagnosis of HIV infection and increase access to quality medical care, treatment, and ongoing prevention services for HIV-positive persons and their partners. The initiative is intended to complement, expand or strengthen existing HIV prevention efforts in local jurisdictions, including Houston/Harris County, and consists of four strategies for HIV prevention:

- 1) Make HIV testing a routine part of medical care;
- 2) Implement new models for diagnosing HIV infections outside medical settings;
- 3) Prevent new infections by working with persons diagnosed with HIV and their partners, and
- 4) Further decrease perinatal HIV transmission.

The CDC further defined the implementation of these strategies through seven activities:

- 1) Routinely recommend voluntary HIV testing as part of regular medical care services;
- 2) Offer rapid HIV testing in non-traditional settings;
- 3) Routinely and voluntarily test inmates in correctional facilities for HIV;
- 4) Offer HIV partner counseling and referral services (PCRS);
- 5) Offer comprehensive risk counseling services (CRCS);
- 6) Offer HIV prevention services in medical care settings, and;
- 7) Achieve universal HIV testing of pregnant women.

III. Availability of Funds

The HDHHS Bureau of HIV/STD Prevention plans to purchase HIV/STD Prevention Services totaling approximately \$3.2 million under this RFP. The amount of funding available to support these services is subject to variance depending upon changes in available local, state and federal resources. The HDHHS will review various factors in making funding recommendations including, but not limited to, overall cost effectiveness, technical expertise, experience in providing proposed program activities and meeting past program goals, organizational financial stability, and demonstrated responsibility in delivering contracted services.

For purposes of this RFP, HIV/STD Prevention Services will be purchased under the following four categories at the identified total available amounts. Consistent with recommendations by the CPG, under some funding categories and for specific behavioral risk groups, a minimum

subportion (not additional portion) of the total amount available will be earmarked for programs and services serving either persons living with HIV/AIDS and/or persons who are 13 – 24 years of age under that program category or BRG category. Geographic need will also be considered.

CATEGORY 1: HIV Health Education/Risk Reduction Counseling (\$1,488,000)

The HDHHS Bureau of HIV/STD Prevention will fund between five (5) and nine (9) programs between \$100,000 and \$300,000 annually to provide HIV health education and risk reduction services to identified behavioral risk group and priority populations in Houston/Harris County. Under this category, the HDHHS will fund a broad cross-section of outreach, individual-level, group-level, community level, and health promotion interventions targeted to HIV-positive and HIV-negative persons of the identified behavioral risk groups under a cost-reimbursement fee structure. All programs proposing to serve persons living with HIV must develop and integrate a partner elicitation strategy into their respective program designs.

Also under this category, the HDHHS will fund one (1) to two (2) HE/RR programs up to a total of \$100,000 to serve incarcerated individuals and/or individuals recently-released from a correctional institution. Services should be delivered in proportion to the distribution of incarcerated individuals across correctional facilities and/or recently-released individuals across geographic areas. These services must also be targeted to a BRG and/or priority population.

Table 1: HE/RR Funding Allocations

Behavioral Risk Group	Total Amount Available	Minimum Amount Targeting HIV+	Minimum Amount Targeting Youth
Males Who Have Sex With Males	\$714,240.00	\$92,851.20	\$142,848.00
Females Who Have Sex With Males	\$416,640.00	\$20,832.00	\$104,160.00
Males Who Have Sex With Females	\$208,320.00	\$10,416.00	\$12,499.20
Male Injection Drug Users	\$59,520.00	\$10,118.40	\$0.00
Males Who Have Sex With Males and Use Injection Drugs	\$44,640.00	\$6,696.00	\$0.00
Female Injection Drug Users	\$44,640.00	\$5,803.20	\$0.00
TOTAL	\$1,488,000.00	\$146,716.80	\$259,507.20

Furthermore, **please note** that in accordance with the resource allocations setting of the CPG, two (2) percent of the HE/RR funding and two (2) percent of the CTR funding has been set aside to serve Transgenders. Through this RFP, the HDHHS is expecting to fund one combined HE/RR and CTR proposal targeting this population at a minimum of \$50,000.

CATEGORY 2: HIV Counseling, Testing and Referral Services including Syphilis Elimination (\$1,088,000)

Under this category, the HDHHS Bureau of HIV/STD Prevention will fund HIV counseling, testing and referral services targeted to persons of unknown HIV status in a broad cross-section of venues throughout Houston/Harris County under a cost-reimbursement fee structure. All HIV CTR programs will also receive Syphilis Elimination funding and be required to concurrently test for Syphilis when testing for HIV. The HDHHS will support testing in the following areas of emphasis and funding ranges:

- Up to three (3) HIV testing programs in clinic-based (traditional) settings between \$100,000 and \$150,000 each.

- Up to five (5) HIV testing programs in community-based venues (non-traditional settings) between \$100,000 and \$150,000 each.
- Up to five (5) HIV testing programs in outreach settings including mass testing day events (non-traditional settings) between \$100,000 and \$150,000 each.

Table 2: HIV CTR Funding Allocations – Traditional Settings Only

Behavioral Risk Group	Total Amount Available	Minimum Amount Targeting Youth
Males Who Have Sex With Males	\$130,560.00	\$26,112.00
Females Who Have Sex With Males	\$76,160.00	\$19,040.00
Males Who Have Sex With Females	\$38,080.00	\$2,284.80
Male Injection Drug Users	\$10,880.00	\$0.00
Males Who Have Sex With Males and Use Injection Drugs	\$8,160.00	\$0.00
Female Injection Drug Users	\$8,160.00	\$0.00
TOTAL	\$272,000.00	\$47,436.80

Table 3: HIV CTR Funding Allocations – Non Traditional Settings Only

Behavioral Risk Group	Total Amount Available	Minimum Amount Targeting Youth
Males Who Have Sex With Males	\$391,680.00	\$78,336.00
Females Who Have Sex With Males	\$228,480.00	\$57,120.00
Males Who Have Sex With Females	\$114,240.00	\$6,854.40
Male Injection Drug Users	\$32,640.00	\$0.00
Males Who Have Sex With Males and Use Injection Drugs	\$24,480.00	\$0.00
Female Injection Drug Users	\$24,480.00	\$0.00
TOTAL	\$816,000.00	\$142,310.40

Furthermore, **please note** that in accordance with the resource allocations setting of the CPG, two (2) percent of the HE/RR funding and two (2) percent of the CTR funding has been set aside to serve Transgenderers. Through this RFP, the HDHHS is expecting to fund one combined HE/RR and CTR proposal targeting this population at a minimum of \$50,000.

CATEGORY 3: Comprehensive Risk Counseling Services (\$100,000)

Under this category, the HDHHS will fund up to two (2) comprehensive risk counseling programs at a combined level not to exceed \$100,000 annually, to support the delivery of comprehensive risk counseling services to high-risk HIV-negative and HIV-positive persons throughout Houston/Harris County under a cost-reimbursement fee structure. The majority of the CRCS funding, if not all, will be targeted to HIV-positive individuals.

Table 4: Comprehensive Risk Counseling Services Funding Allocations

Behavioral Risk Group	Total Amount Available	Minimum Amount Targeting HIV+	Minimum Amount Targeting Youth
Males Who Have Sex With Males	\$48,000.00	\$36,000.00	\$9,600.00
Females Who Have Sex With Males	\$28,000.00	\$21,000.00	\$7,000.00
Males Who Have Sex With Females	\$14,000.00	\$10,500.00	\$840.00
Male Injection Drug Users	\$4,000.00	\$3,000.00	\$0.00

Behavioral Risk Group	Total Amount Available	Minimum Amount Targeting HIV+	Minimum Amount Targeting Youth
Males Who Have Sex With Males and Use Injection Drugs	\$3,000.00	\$2,250.00	\$0.00
Female Injection Drug Users	\$3,000.00	\$2,250.00	\$0.00
TOTAL	\$100,000.00	\$75,000.00	\$17,440.00

CATEGORY 4: Social Marketing (\$296,000)

Under this category, the HDHHS will fund up to two (2) social marketing projects at a combined level not to exceed \$296,000 annually to support the delivery of HIV prevention messages to high-risk HIV-negative and HIV-positive persons throughout Houston/Harris County under a cost-reimbursement fee structure.

Table 5: Social Marketing Funding Allocations

Behavioral Risk Group	Total Amount Available	Minimum Amount Targeting HIV+	Minimum Amount Targeting Youth
Males Who Have Sex With Males	\$142,080.00	\$18,470.40	\$28,416.00
Females Who Have Sex With Males	\$82,880.00	\$4,144.00	\$20,720.00
Males Who Have Sex With Females	\$41,440.00	\$2,072.00	\$2,486.40
Male Injection Drug Users	\$11,840.00	\$2,012.80	\$0.00
Males Who Have Sex With Males and Use Injection Drugs	\$8,880.00	\$1,332.00	\$0.00
Female Injection Drug Users	\$8,880.00	\$1,154.40	\$0.00
TOTAL	\$296,000.00	\$29,185.60	\$51,622.40

CATEGORY 5: School-Based Programs (\$200,000)

Under this category, the HDHHS will fund up to two (2) school-based structural intervention prevention programs at a combined level not to exceed \$200,000 annually, to support the delivery of a school-based structural intervention targeted to teachers, school administrators and parent/teacher associations in the Houston Independent School District (HISD) throughout Harris County under a cost-reimbursement fee structure.

CATEGORY 6: HIV Prevention Program Evaluation, Technical Assistance and Capacity Building (\$128,000)

Under this category, the HDHHS will fund one project at up to \$128,000 annually, to support the delivery of HIV prevention program development technical assistance, capacity building and evaluation by a research or academic entity which will employ a team of high-level behavioral scientists with expertise in program design, behavior change theory and program evaluation and knowledge of national HIV prevention program indicators and areas of evaluation focus under a cost-reimbursement fee structure.

Table 6: Overall Funding Summary

Funding Category	Amount	Funding Range	Estimated Number of Funded Programs (Not Agencies)
1 – HE/RR	\$1,488,000	\$100,000 - \$300,000	5 – 9
2 – CTR	\$1,088,000	\$100,000 - \$150,000	6 – 13

Funding Category	Amount	Funding Range	Estimated Number of Funded Programs (Not Agencies)
3 – CRCS	\$100,000	Up to \$100,000	1 – 2
4 – Social Marketing	\$296,000	Up to \$296,000	1 – 2
5 – School-Based	\$200,000	Up to \$200,000	1 – 2
6 – Evaluation/TA	\$128,000	Up to \$128,000	1
TOTAL	\$3,200,000	\$100,000 - \$300,000	15-28

LIMITATIONS OF FUNDING

The City of Houston shall not in any way be liable or responsible to a Proposer or any third party for any costs incurred in connection with the preparation or submission of any proposal, in connection with the modification of any of the Proposer’s operations in response to this RFP, in connection with a Proposer’s protest of the contract award process, or in connection with the contract negotiation process.

IV. Contract Term

The HDHHS Bureau of HIV/STD Prevention plans to have an overall contract period (including initial term and renewal option) of two (2) years, subject to changes in local, state and federal resources, from January 1, 2007 through December 31, 2008, consistent with the CPG update to the Houston HIV Prevention Plan which ends December 31, 2008.

The contract term shall include an initial one-year term and one one-year renewal option. The renewal option will be at the sole discretion of the Director of the Houston Department of Health and Human Services or his/her designee. The contract shall commence after approval by the City Council, but not prior to January 1, 2007.

When responding to this RFP, Proposers should submit a budget reflective of a twelve (12) month contract term from January 1 through December 31, 2007. Depending on the funding source of the funded proposals (CDC, Texas Department of State Health Services, Department of Housing and Community Development, or City of Houston General Fund), the annual contract periods may vary and need to be adjusted (January 1 through December 31 or July 1 through June 30). Please refer to the Forms section of this RFP for additional budget instructions (page 62). Continued funding beyond the first and subsequent terms will be dependent upon contractor performance and the availability of funding.

V. Minimum Mandatory Eligibility Requirements and Funding Preferences

Interested and qualified Proposers under any funding categories (1, 2, 3, 4 and 5) that can demonstrate their ability to successfully provide the required services outlined in the Statement of Work section of this RFP are invited to submit proposal(s) for any of the funding categories, provided they meet the following requirements.

- Proposer is a public entity, or a university or research institution, or a 501(c)(3) private non-profit provider. One of the following documents must be included among the proposal attachments as acceptable evidence of non-profit status:

- 1) **A copy of** a currently valid IRS tax exemption certificate;
 - 2) A reference to the applicant organization's listing in the Internal Revenue Service's most recent list of tax-exempt organizations described in Section 501(c)(3) of the IRS Code; or
 - 3) **A statement from** a state taxing body, State Attorney General, or other appropriate state official certifying that the applicant organization has a non-profit status and that none of the net earnings accrue to any private shareholders or individuals.
- Proposer must certify intent to comply with all applicable local, State and federal client-level reporting requirements, including, but not limited to, intent to use the Program Evaluation and Monitoring System (PEMS).

The Program Evaluation and Monitoring System (PEMS) is data collection software designed for health departments and community-based organizations (CBO's) funded by the Centers for Disease Control and Prevention to deliver HIV prevention services. All funding grantees will be required to comply with all HDHHS program monitoring and evaluation systems to include technology infrastructure requirements relating to PEMS.

PEMS is an electronic/browser-based prevention tool to facilitate the collection, reporting, analysis, and interpretation of standardized data on HIV prevention service activities as required in the health department and CBO program announcements. Data collection and reporting must be consistent with CDC's requirements to ensure data quality, security and client confidentiality.

The following are minimal agency computer system requirements for HDHHS supported PEMS data collection:

- 1) High Speed Internet Access
 - 2) Windows 98 Operating System or higher
 - 3) Windows 2000 or XP Professional
 - 4) Pentium III 1.0 GHz processor
 - 5) 256 MB RAM
 - 6) 20 GB hard drive
 - 7) Microsoft Internet Explorer 6.0
- Proposer must certify intent to deliver HIV/STD Prevention Services at hours that maximize service delivery and are consistent with client need. Evening service delivery hours will be necessary as will be a departure from the traditional 9:00 am to 5:00 pm Monday through Friday service delivery schedule;
 - Proposer must comply with the proposal format and requirements set forth in the Proposal Submission Requirements section of this RFP.

Additional minimum eligibility requirements for each funding category are as follows:

CATEGORY 1: HIV Health Education and Risk Reduction Counseling

- Proposer must demonstrate at least three years targeting and successfully engaging the intended behavioral risk group;

- Proposer must comply with all applicable outreach, individual-level, group-level, and community-level program indicator data collection and reporting requirements.

CATEGORY 2: HIV Counseling, Testing, and Referral Services including Syphilis Elimination

- Proposer must understand and promote the benefits of confidential HIV-antibody testing services;
- Proposer must comply with all Texas HIV/AIDS and STD names reporting requirements under a timeline defined by the HDHHS in partnership with the Texas DSHS;
- Proposer must demonstrate at least three years experience providing CTR services consistent with State and local guidelines;
- Proposer must demonstrate past compliance with CTR behavioral risk group and return rate standards or articulate a plan to reach these goals if past standards were not met;
- Proposer must demonstrate strong counselor retention history or develop a counselor retention plan if counselor retention has been poor or counselor turnover has been high;
- If rapid HIV-antibody testing services are proposed, Proposer must provide: 1) documentation that testing staff have appropriate training to conduct the rapid test, 2) evidence of a Certificate of Waiver in accordance with the Clinical Laboratory Improvement Act (CLIA) to perform the rapid test, and 3) complete Agency rapid testing protocols and procedures.
- Proposer must provide documentation that appropriate CTR staff members have successfully completed phlebotomy training, including a preceptorship, or a plan to ensure this training is received by appropriate CTR staff members upon award.

CATEGORY 3: Comprehensive Risk Counseling Services

- Proposer must demonstrate ability and experience recruiting and retaining clients into this and/or similar interventions.
- Proposer must demonstrate experience providing comprehensive risk counseling services (formerly prevention case management) to persons at risk for HIV infection or living with HIV, and evidence of positive client risk reduction outcomes.

CATEGORY 4: Social Marketing

- Proposer must demonstrate at least two years experience working with all proposed media outlets including but not limited to radio, television, print, and transit. Proposer must also demonstrate at least two years targeting and successfully engaging the intended behavioral risk group as well as two years experience in conducting focus groups.

CATEGORY 5: School-Based Programs

- Proposer must demonstrate at least two years experience working with school boards, parent/teacher associations, teachers or school administrators on a health related structural intervention designed to meaningfully impact teaching to and learning of students, improve student health awareness or demonstrate positive health outcomes.

CATEGORY 6: HIV Prevention Evaluation, Technical Assistance and Capacity Building

- Proposer must be a research or academic institution with specialization in a field of behavioral, social science or epidemiology, and demonstrate experience with the design,

evaluation and implementation of research projects in a behavioral or social science field.

- Proposer must have at least three year's experience monitoring, auditing and/or evaluating HIV/STD Prevention Services provided by contractors to governmental agencies.

VI. Evidence- and Theory-based Interventions, Program Descriptions, Definitions, Standards and Indicators

Evidence- and Theory-Based Interventions

The benefits and impact of evidence- or behavior change theory-based HIV prevention interventions is increasingly clear. In recent years, an increased emphasis on the development and implementation of rigorously evaluated prevention programming has taken place. Our federal partners have strongly encouraged the adaptation and tailoring of evidence-based interventions and have provided a range of reference documents and source materials (e.g. CDC Program Announcement 04064 Application Guidance, Diffusion of Effective Behavioral Interventions documents) for use by local health departments and community-based providers. Local health departments are charged with ensuring that HIV prevention programs recommended for funding are supported by sufficient scientific evidence or theory.

The HDHHS recognizes that a select number of group-, individual-, and community-level interventions that have demonstrated some level of efficacy have been identified by our federal partners for **adaptation or tailoring** throughout the country. These include Street Smart, SISTA, Safety Counts, Popular Opinion Leader, and Community PROMISE, among others. The HDHHS encourages providers to review the basis for which these interventions have been endorsed by the CDC, but does not obligate you to adapt or tailor any one of these interventions for purposes of this RFP. The HDHHS does however expect that sufficient programmatic evidence (i.e. outcome evaluation) be provided to support your program design.

The HDHHS understands and maintains that multiple types of evidence can be used to support an intervention. For purposes of this RFP, the HDHHS will consider the following four types of evidence and offers this synopsis of evidence- or theory-based interventions to guide the development of select interventions including group-level interventions, individual-level interventions, community-level interventions, structural interventions and comprehensive risk counseling services.

- 1) Evaluation of the same intervention,
- 2) Evaluation of a similar intervention,
- 3) Theory from the scientific literature, and
- 4) Informal theory.

Evaluation of the Same Intervention

With this type of evidence, the proposed intervention is identical to one that has already been evaluated and shown to be effective. Congruence must exist between the proposed intervention and the evaluated intervention with regard to the population served, intervention setting, and core elements of the intervention. Though core elements may vary, for two interventions to be considered the same, contractors are encouraged to use the same content, format, and method of delivering the intervention and to deliver the same number and length of intervention sessions.

Example: A contractor proposes to conduct a GLI for African American MSM who are in an urban setting. The intervention was previously conducted and evaluated in a different city, but with the same population. Core elements of the intervention will be replicated including using the same curriculum and materials, focusing on the same content, conducting the same number of group sessions, and utilizing peer educators who have been trained to deliver the intervention.

The financial resources available may challenge the feasibility of replicating exactly a previously evaluated intervention (e.g., the same level of funding is not available with a jurisdiction). If this occurs, "evaluation of a similar intervention" may be the best choice.

Evaluation of a Similar Intervention

With this type of evidence, the proposed intervention is similar, though not identical, to an intervention that has already been evaluated. Although modifying a previously evaluated intervention may compromise its effectiveness, it may be necessary if available resources cannot support full implementation of the evaluated intervention or if the intervention needs to be adapted to be culturally appropriate for a different population and setting.

Generally, "evaluation of a similar intervention" means that there are differences between the proposed intervention and the previously evaluated intervention in one or more of the following areas: population served; intervention setting, content, and format; method of delivering the intervention; and the number and length of interventions session. If differences are too significant between the proposed and the previously evaluated intervention, the prior evaluation may no longer provide sufficient evidence to support using the proposed intervention.

Example: A contractor proposes to conduct an ILI for rural heterosexual Latinas. A similar intervention has been evaluated with heterosexual African American women in a rural setting. The intervention plan explains how the risk assessment protocol and educational materials used in the evaluated intervention have been adapted to be culturally and linguistically appropriate for Latinas. The number and length of intervention sessions and the risk reduction skills addressed in each session remain the same.

Theory from the Scientific Literature

With this type of evidence, the proposed intervention is based on formal behavioral science theory, social science theory, or some other theory that is published in the scientific literature. The theory is divided into component parts (e.g., skills, self-efficacy) and corresponding intervention elements are then developed (e.g., intervention activities to develop condom use skills and increase self-efficacy to use condoms). When using this approach, the intervention plan cannot simply mention a theory. It must explain how the theory is integrated into the content, format, and delivery of the intervention.

Example: A contractor proposes to conduct a comprehensive risk counseling services (CRCS) intervention based on the Stages of Change theory. The intervention plan summarizes the theory, explains how it will be used to assess client readiness for behavior change, and describes how counseling strategies will be targeted to the client's stage. The plan includes an example of a risk assessment tool based on the Stages of Change theory.

A brief summary of behavioral science theories is included below. Another resource that describes behavioral science theories and their application to health programs is "Theory at a

Glance, A Guide for Health Promotion Practice,' National Institutes of Health (NIH), September 1997 (NIH publication number 97-3896).

Table 7: Summary of Behavioral Science Theories

Behavioral Theory	Brief Description
<i>Health Belief Model</i>	Proposes that an individual's actions are based on four (4) key beliefs. This model identifies key elements of decision-making such as the client's perception of susceptibility, perceived severity of the illness, perceived benefits of performing a behavior, and the perceived barriers to prevention.
<i>Theory of Reasoned Action</i>	Intention is the main influence on behavior. Intention is defined as the combination of personal attitudes toward the behavior as well as the opinions of peers, both heavily influenced by the social milieu.
<i>Social Cognitive Theory</i>	Describes learning as a social process influenced by interactions with other people. In the Social Cognitive Theory, physical and social environments are influential in reinforcing and shaping the beliefs that determine behavior (reciprocal determinism). A change in any one of the three (3) components behavior, physical, or social environments will influence the remaining two. Self-efficacy is also an essential component of the theory. It is the client's belief that he or she is capable of performing the new behavior in the proposed situation.
<i>AIDS Risk Reduction Model</i>	To change behavior the client must first identify and "label" the behavior as risky. Then the client must make a commitment to reduce the risky behavior and change his or her behavior. Factors influencing movement between these stages include fear/anxiety and social norms.
<i>Diffusion of Innovation</i>	Describes how new ideas or behaviors are introduced and become accepted by a community. People in the same community adopt new behaviors at different rates and respond to different methods of intervention.
<i>Transtheoretical Model (Stages of Change)</i>	Explains the process of behavior change from not being aware of the negative effects of a behavior, to maintaining safer behaviors. The five (5) stages are pre-contemplation, contemplation, preparation, action, and maintenance. Different stages exist in the same population. Clients do not necessarily pass through stages sequentially and may repeat stages.
<i>Harm Reduction</i>	Accepts that while harmful behaviors exist, the main goal is to reduce their negative effects. Harm Reduction examines behaviors and attitudes of the client to offer ways to decrease the negative consequences of the targeted behavior.
<i>Popular Education</i>	The belief that teachers and students both have strengths and should learn reciprocally from each other. Group discussions examine problems and develop solutions to personally empower people to change their environment, thereby influencing their subsequent actions.
<i>Empowerment Theory</i>	Explains how groups of people change through a process of coming together to share experiences, understand social influences and collectively develop solutions to problems.

Informal Theory

With this type of evidence, the proposed intervention is based on a theory that is not described in conventional theoretical language and is not published in the scientific literature. The distinction between an informal and formal theory is subtle. Informal theory usually describes a contractor's "practice wisdom" (i.e., knowledge that comes from working with or being a member of a population) and is explained in lay terms. For example, the concept of "self-efficacy" from the behavioral science literature on Social Learning Theory may be stated as "confidence to use condoms" by someone not familiar with the formal language of behavioral science. Health departments are encouraged to work with their contractors to ensure that informal theory provides a logical explanation of why the population is at risk and to help them describe how the theory is integrated into the content, format, and delivery of an intervention that will address that risk.

Example: A contractor describes an informal theory by stating that some people are at risk for HIV because they lack confidence in their ability to use condoms, because they don't know how to talk about condom use with their sex partners, and because there are not enough positive role models in the community promoting condom use. The intervention plan describes a peer-led, individual-level counseling intervention focusing on condom use attitudes and skills, emphasizing the role of peer counselors as positive role models to promote the use of condoms.

Summary

The HDHHS will use any of the four types of evidence to determine whether intervention plans are supported by sufficient evidence. Two examples are provided below to further illustrate the difference between interventions that do and do not have sufficient evidence.

Sufficient Scientific Evidence: A contractor proposes to conduct an outreach intervention with MSM in public sex environments. This intervention replicates a previously evaluated outreach intervention conducted in public sex environments with the same population in a similar city.

Insufficient Scientific Evidence: A contractor proposes to conduct an outreach intervention with MSM. The intervention has not been evaluated and it does not appear to be adapted from an intervention that has been evaluated. Although the intervention plan mentions the Health Belief Model, there is no explanation of how the theory was used to develop the intervention. No other theory, formal or informal, is mentioned in the intervention plan.

Applying Behavioral Theory to Prevention

Interventions developed by local providers are often the result of multiple sources of information. Professional and community experience is a critical source of important, practical information. In addition to practical experience, it is important that interventions have a basis in evidence or theory. Care must be taken in making this assessment to determine the extent to which the evidence has actually been used and not just referred to in the proposal. It is important that program components or elements are based on behavioral theory.

Theories can give HIV program planners a framework for the goals of the intervention, or help explain aspects of risk-taking behavior when working with a new population. Using theories to design HIV prevention interventions can help improve programs saving valuable time and resources. The previously referenced theories are not mutually exclusive and can work together to guide effective programs.

Program Descriptions, Definitions, Standards and Indicators

The development of the intervention and sub-intervention definitions, standards and indicators provided below were formed by a review of the Centers for Disease Control and Prevention's (CDC), Guidelines for Health Education and Risk Reduction Activities, US Department of Health and Human Services, 1995, the CDC's Evaluating CDC-Funded Health Department HIV Prevention Programs: Volume 1 - Guidance & Volume 2 - Supplemental Handbook, and the CDC's HIV Prevention Health Department Program Guidance, 2003. In addition, some definitions or terms have been added or enhanced to reflect the HDHHS Bureau of HIV/STD Prevention's position on HIV prevention activities based on their implementation locally and historically. In addition, the Bureau of HIV/STD Prevention continues to strengthen its quality management activities, and all funded agencies will be required to work with the HDHHS to meet prevention standards if they are changed or amended during the contract year.

In 2003, the CDC released a number of **Core Indicators** for HIV prevention programs across the country. The specific core indicators are listed under each intervention description below. Funded programs are required to collect core indicator data to measure program outcomes.

CATEGORY 1: HIV Health Education/Risk Reduction Counseling (\$1,488,000)

This category includes outreach, individual-level interventions, group-level interventions and community-level interventions consistent with the definitions and descriptions provided below. This category is intended to increase knowledge, awareness and skills to decrease the prevalence of HIV risk behaviors, to maintain and reinforce risk reduction behaviors and create community norms and values that support HIV risk reduction efforts, learning of one's HIV status and disclosure of HIV status, when appropriate. This category will secondarily serve as a vehicle to refer HIV at risk persons of unknown HIV status to available HIV counseling and testing services.

Under this category, the HDHHS will fund one program targeted exclusively to Transgenders at a minimum funding level of \$50,000. This funding is a subportion of the Males Who Have Sex with Males (MSM) behavioral risk group (BRG) available funding. The proposed program should include a Health Education/Risk Reduction component designed consistent with the guidelines provided in this RFP and should also include an HIV counseling, testing, and referral component designed to diagnose Transgenders with HIV.

Proposed HE/RR programs may focus on a singular behavioral risk group, or may target a primary and secondary behavioral risk group. The HDHHS will consider prevention program designs that include any variation of the HE/RR interventions mentioned below, provided the program design is sound and consistent with a continuum of HIV service delivery. The HDHHS will also consider proposals that effectively integrate HE/RR and CTR program services targeted to the same behavioral risk group. Proposer may submit a single proposal for Category 1 and Category 2, but must submit two separate program budgets.

Tailoring Services Based on HIV Status

HE/RR services must be tailored for targeted behavioral risk groups and populations. Because of the specificity of the services, curricula, and programs, the HDHHS requests that you include, in your proposal, a plan that demonstrates how your health education/risk reduction intervention will incorporate HIV counseling, testing and referral (CTR) strategies. For effective service provision, clients must know their HIV status in order to align them with the best-matched

services. Strategies can include a proposal to fully integrate HIV counseling, testing and referral services through the development of a continuum of care model, so that CTR is an integral and consistent component of HE/RR services. Additional strategies can include a formal plan to offer CTR through a partnership with other community-based CTR providers who target the particular populations that you intend to serve. Lastly, to substantiate and strengthen your proposal, you can also include a protocol that provides the details you intend to implement as a part of your HE/RR services to make available testing services. Proposer's scopes of work should also include objectives and implementation activities that support this integration and partnership.

All proposed programs must measure the prevention program indicators identified below as a condition of award. The HDHHS will not support versions of outreach, individual-level interventions (ILI's), group-level interventions (GLI's), and community-level interventions (CLI's) that are not consistent or are incongruent with the definitions provided.

RECRUITMENT¹ DEFINITION

Recruitment is the means by which an organization brings members of a population into HIV prevention interventions, programs, and services. Populations recruited (target populations) can be persons living with HIV or persons whose HIV serostatus is negative or unknown and who are at high risk for HIV. Recruitment can take different forms (outreach, internal referrals, external referrals, etc.) depending on the target population and on the needs and abilities of the CBO doing the recruiting. Recruitment takes place where the target population congregates; this may or may not be where services are provided. Both places must ensure privacy and confidentiality for clients. Recruitment must link clients whose HIV serostatus is unknown to counseling, testing, and referral services and must link persons living with HIV to care and prevention services. CBOs must develop ways to assess whether and how frequently the referrals made by their staff members were completed.

¹For more information regarding Recruitment, go to:

http://www.cdc.gov/hiv/topics/prev_prog/ahp/resources/guidelines/print/pro_guidance.htm

Core Elements of Recruitment

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.** Recruitment has the following 5 core elements:

- Use information from multiple sources to describe common characteristics of the target population.
- Develop and deliver health messages (to be delivered by an outreach worker or by a referral source) that are appropriate for the setting.
- Recruit for specific services (e.g., counseling, testing, and referral services; CRCS; other prevention interventions).
- Link persons living with HIV to care and prevention services.
- Track whether clients complete their referrals (to monitor the effectiveness of the referral strategy).

Quality Assurance

The following quality assurance activities should be in place when implementing Recruitment:

- Method for collecting information to select the target population
- Records of formal or informal agreements with other CBOs
- Training for outreach and referral staff
- Procedures for tracking referrals, including the number completed and barriers for those not completed
- Staff supervision to include having key staff observe and review outreach workers and their interactions with clients. This review should focus on adherence to referral protocols and service to clients (accessibility and responsiveness to expressed client needs)
- Documentation of contact
- Follow-up on referrals
- When appropriate, clients' satisfaction should be assessed upon completion of referrals.

Recruitment through Outreach

HIV/AIDS educational interventions are generally conducted by peer or paraprofessional educators either face-to-face or via the internet with high-risk individuals in neighborhoods or other areas where the agency's target population gathers. Examples of sites might include streets, bars, parks, bathhouses, shooting galleries, specific websites, etc. **The primary purpose of outreach is recruitment of individuals of behavioral risk groups into more intensive prevention and/or treatment services.** These interventions are conducted by program staff in person or via the internet with high-risk/hard-to-reach individuals. Condoms, bleach, safer sex kits (e.g., condoms/latex barriers with instructions, lubricants), promotional and educational materials and information may be distributed.

Key characteristics of outreach include:

- Go to places where potential clients congregate, and go at times when they are likely to be there.
- Conduct outreach in teams (for safety).
- Screen clients to determine their needs for specific prevention services such as counseling, testing, and referral services; comprehensive risk counseling services; or other prevention interventions.
- Develop and deliver tailored and appropriate messages (health promotion and prevention).
- Provide tailored and appropriate materials (describing programs and services for potential clients).
- Use peers as outreach workers, when possible.

Other aspects of outreach include that the outreach worker discusses the agency's or other HIV/AIDS programs and how the individual can benefit from these services. The outreach worker may also ask a few questions to assess risk behavior(s). If individuals are interested in the program, the outreach worker will collect the client's name, address, and phone number to set

up an appointment for intake or a linked referral. A referral mechanism for measuring the use of referral services is required.

Minimum Outreach Indicator

The mean number of outreach encounters required to get one person to access any of the following services: HIV counseling, testing and referral services, sexually transmitted disease screening or testing services, individual-level intervention services, group-level intervention services, or comprehensive risk counseling services.

Recruitment through Internal Referrals

Often a CBO will refer clients to other services within the same organization. This strategy takes advantage of the client's existing trust in the organization. When a referral is made to another service within that organization, the client may be more likely to accept and access the services.

Key characteristics of Internal Referrals include:

- Develop criteria that will help providers of other services within the CBO know who or when to refer.
- Assess all clients to find out whether they would benefit from prevention services
- Deliver within the organization, and refer them as needed.
- Develop targeted and appropriate messages to be delivered by individual members of the CBO or by mass-messaging strategies (e.g., on posters hung throughout the organization).

Recruitment through External Referrals

Another source for recruitment is referrals from outside organizations. Because persons at risk for transmission or acquisition of HIV often have competing needs that make HIV prevention a lower priority, they may seek services other than HIV prevention. They can be referred from these other services to HIV prevention interventions. To reach clients in need of prevention services, it is important to obtain a commitment from other service providers to assess their clients for risk of transmitting or acquiring HIV and to make referrals as needed.

Key characteristics of External Referrals include:

- Establish linkages with those service providers that members of the target population are most likely to access, and provide them training related to prevention services.
- Develop formal agreements with appropriate service providers for ongoing screening and referrals to and from these providers.
- Give referral agents tailored and appropriate materials that advertise programs and services.
- Give potential clients tailored and appropriate materials that describe programs and services.

INDIVIDUAL-LEVEL INTERVENTIONS (ILI) DEFINITIONS

Health education and risk-reduction counseling is provided to one individual at a time and either face-to-face or via the Internet. Individual-level interventions assist clients in making plans for individual behavior change, provide ongoing appraisals of the client's own behavior, and include skills-building activities. These interventions also facilitate linkages to services in both clinic

and community-based settings (e.g., substance abuse treatment settings, HIV counseling, testing and referral services) and are intended to support behaviors and practices that prevent transmission of HIV.

Note: According to a strict categorization, outreach and comprehensive risk counseling services are also individual-level interventions. However, under this definition, ILI's exclude outreach, comprehensive risk counseling services, and HIV counseling, testing and referral services which each constitutes their own intervention.

Risk-Reduction Counseling: One-on-one counseling sessions should focus on the understanding of human behavior (why people do what they do), identifying the personal factors that affect actions (self-efficacy, social situations, and cultural norms), knowledge, skills building, and behavior change activities (safer sex practices, proper condom/latex barrier use and demonstration, needle cleaning techniques). The counseling sessions will be conducted by trained program staff. Internet activities such as chat rooms or internet counseling also fall under this category. **One-on-one risk reduction counseling must include a thirty (30), sixty (60) and ninety (90) day follow-up component to assess risk reduction behaviors over a period of time or an alternative follow-up schedule approved by the HDHHS.**

One-on-One Internet Risk Reduction Counseling: Risk Reduction Counseling activities conducted on the internet are generally targeted to gay, bisexual and/or MSM populations. This type of intervention should have a clear engagement and screening process to determine client eligibility (e.g., BRG, zip code etc.), client identifier, and document client-level data. The agency should develop an evaluation plan designed to document outcomes and measures of success. Agencies must document an existing relationship with an Internet service provider or website in the RFP to show evidence of necessary capacity for successful implementation of the project. Internet activities must have a protocol describing how clients will be recruited, topics to be discussed, and the method of documenting Internet sessions.

Minimum Individual-Level Intervention Indicators
<ul style="list-style-type: none">• Proportion of persons that completed the intended number of individual level intervention sessions.
<ul style="list-style-type: none">• Proportion of the intended number of the target population to be reached with the individual level intervention who were actually reached.

GROUP LEVEL INTERVENTIONS (GLI) DEFINITIONS

Health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. Group-level interventions include peer and non-peer models involving a wide range of skills, information, education, and support. Group level interventions must have a multiple session component thereby including at least three (3) sessions in its design with a follow-up component.

Note: Many providers may consider general education activities to be group-level interventions. However, for the purposes of this RFP, GLI does not include “one-shot” educational presentations or lectures, particularly if they lack a skill development component. These types of activities should be included in the Health Communication/Public Information category.

Group Risk Reduction Counseling: Small group counseling sessions focus on behavior change activities, such as safer sex practices, proper condom/latex barrier use and demonstration, and needle cleaning techniques, and are conducted by trained program staff. Any group level intervention that lacks a skills component (e.g., “HIV 101” only workshops) is excluded from this category. “One shot” educational sessions are considered Health Communication/Public Information interventions. Group risk reduction counseling interventions should range from a series of three (3) sessions (or modules) to six (6) sessions.

Group risk reduction counseling sessions follow the close-ended group model (as opposed to the open-ended model). Close-ended groups are structured, have a defined lifespan, and are also likely to set membership limits. The closed group allows for important continuity and facilitating the development of trust among members, as they get to know each other over time. The closed group model is more suitable to the establishment of client-specific outcome objectives that can be monitored over time (e.g. self-reported increased condom use with sexual partners at the end of four (4) weeks of group attendance). This differs from open-ended support group sessions that are less structured, informal and are geared to risk reduction behavior maintenance. Note: Closed-ended groups are usually finite and open-ended groups are usually ongoing.

Peer Health Educator (PHE): Peer education implies a role-model method of education in which trained, self-identified members of the client population provide HIV/AIDS education to their behavioral peers. This method provides an opportunity for individuals to perceive themselves as empowered by helping persons in their communities and social networks, thus supporting their own health enhancing practices. At the same time, the use of peer educators sustains intervention efforts in the community long after the professional service providers are gone. Peer Health Educators will not replace an agency’s professional health educators, but they can complement the intervention team and enhance intervention efforts. Peer Health Educators must complete and pass a certification course developed by an agency that provides the Peer Educator with the skills and knowledge to assist in health education activities.

Remember, Peer Health Educators must have defined roles and responsibilities after they are successfully trained. Peer Health Educator trainings cannot be a stand-alone intervention.

Minimum Group-Level Intervention Indicators
<ul style="list-style-type: none"> • Proportion of persons that completed the intended number of group level intervention sessions.
<ul style="list-style-type: none"> • Proportion of the intended number of the target population to be reached with the group level intervention who were actually reached.

COMMUNITY-LEVEL INTERVENTIONS (CLI) DEFINITIONS

These are interventions that seek to reduce risk conditions and promote healthy behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilization efforts, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

Community Mobilization: This is a process by which community citizens take an active role in defining, prioritizing, and addressing issues in their community. This process focuses on identifying and activating the skills and resources of residents and organizations while developing linkages and relationships within and beyond the community for the purpose of expanding the current scope and effectiveness of HIV/STD prevention.

Community Forum: A community-level intervention in which information is provided to and elicited from a community.

Health Fairs/Community Events: Special events such as street fairs, job fairs, health fairs, World AIDS Day activities, and local celebrations in communities that deliver public information to large numbers of people.

Structural Interventions: This is an intervention designed to remove barriers and incorporate facilitators of an individual's HIV prevention behaviors. These barriers or facilitators include physical, social, cultural, organizational, community, economic, legal, or policy circumstances or actions that directly or indirectly affect an individual's ability to avoid exposure to HIV.

Social Marketing: A community-level intervention that uses modern marketing principles to affect knowledge, attitudes, beliefs, and/or practices regarding HIV/AIDS risk, and associated behavior change and risk reduction, access to services and treatment education, eventually leading to a change in social norms. Social marketing must go beyond advertising a particular service or hotline number and include an action statement. Social marketing activities must include a planning, development, and distribution phase.

HEALTH COMMUNICATIONS/PUBLIC INFORMATION (HC/PI) DEFINITIONS

HC/PI is the delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safer behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection or transmission how to obtain specific services. HC/PI interventions exclude group interventions with a skills building component, which constitutes a separate intervention category.

Group Presentations: These are information-only activities conducted in-group settings; often called "one-shot" education interventions (e.g., "HIV 101" classes). Group presentations differ from risk reduction counseling in that presentations lack a skills-building component. Group presentations cannot be a stand-alone intervention and must be complemented by at least one other HE/RR intervention.

CATEGORY 2: HIV Counseling, Testing and Referral Services including Syphilis Elimination (\$1,088,000)

This category includes the following: risk assessment, rapid and conventional HIV-antibody testing, disclosure counseling, post-disclosure counseling, partner counseling, referral services and social networks targeted to persons of unknown HIV status. Two interventions will be funded; 1) Targeted HIV Screening and 2) Protocol-Based Counseling. Funding under this category will emphasize confidential HIV testing services and will support traditional settings (clinic-based) for HIV testing as well as non-traditional settings such as community-based venues, outreach settings, and mass testing days. All HIV CTR programs will also receive Syphilis Elimination funding and be required to concurrently test for Syphilis when testing for HIV.

Proposed CTR programs in each of the subcategories may target more than one behavioral risk group, but must clearly identify the percentage of each BRG to be served.

Consistent with a continuum of HIV service delivery, the HDHHS encourages proposals that effectively integrate CTR and HE/RR program services targeted to the same behavioral risk group. In these instances, the HDHHS will implement a cost reimbursement structure for HE/RR services and for CTR services under one program contract with two distinct program budgets.

All proposed CTR programs must implement the steps associated with counseling, testing and referral services consistent with the definition below, and, at a minimum, all funded programs must measure the prevention program indicators identified below as a condition of award.

HIV COUNSELING, TESTING AND REFERRAL (CTR) DEFINITIONS

HIV counseling, testing and referral services constitute an individual-level intervention designed to inform persons of their HIV status. It is the voluntary process of client-centered, interactive information sharing in which an individual is made aware of the basic information about HIV/AIDS, an explanation of testing procedures and test results, an assessment of the individual's risk for HIV transmission, a review of strategies to prevent HIV infection or transmission, a review and offering of partner counseling and referral services and the delivery of client-centered referrals.

Diagnostic testing is performing an HIV test based on the presence of clinical signs or symptoms.

Screening is performing an HIV test for all persons in a defined population.

Targeted testing is performing HIV screening on subgroups of persons at higher risk, generally defined on the basis of behavioral, clinical, or demographic characteristics.

Opt-out screening is performance of an HIV test after explaining the test and notifying the patient that the test will be done; consent is inferred unless the patient declines.

Informed consent is a process of communication between patient and provider through which an informed patient can participate in choosing whether to undergo HIV testing. It may include providing information about HIV and the implications of HIV test results.

HIV prevention counseling is an interactive process to assess risk, recognize specific behaviors that increase the risk for acquiring or transmitting HIV, and develop a plan to take specific steps that will reduce risks.

Background

Over the past two years, the technology for HIV counseling, testing and referral services (CTR) has improved so that community-based providers (where available) now have a choice to offer individuals two different HIV testing technologies: Conventional and Rapid. Both Conventional and Rapid Testing can be provided either confidentially or anonymously; however, Rapid Testing allows the individual being tested to receive his or her HIV test results within a half hour of being tested.

HIV counseling, testing and referral services (CTR) are a voluntary, client-centered interactive process through which an individual seeks to learn his or her HIV status. During this process,

the individual receives basic HIV/AIDS information, an explanation of testing procedures and test results, an assessment of the individual's risk for HIV transmission, a review of strategies to prevent HIV infection or transmission, information and offering of partner counseling and referral services, and the delivery of client-centered, linked referrals. Referrals are made as appropriate to the needs of the individual whether that person is newly diagnosed HIV positive or HIV negative. The components of CTR, regardless of testing technology, are as follows:

Components of CTR

- 1) Risk Assessment utilizes a standardized tool to determine the client's risk behavior and whether the client is in need of a high-level or low-level intervention. During Targeted HIV Screening, a brief one-on-one discussion and information sharing session with the client is included in the Risk Assessment session.
- 2) Prevention Counseling (Initial) Session is a one-on-one, client-centered interactive process that assists and encourages the client to identify the specific behaviors that place him or her at risk for getting or passing on HIV/STD/HCV. The process of counseling also helps the client identify and commit to a specific step designed to reduce the risk for HIV transmission or acquisition and gives a chance to practice skills that go along with that step.
- 3) HIV Test must be a Food and Drug Administration-approved HIV-antibody test to determine and confirm the presence of HIV antibodies.
- 4) Disclosure Counseling (Follow-Up) Session occurs after the test results have been processed and returned. Within the context of a client-centered discussion, the CTR Risk Reduction Specialist (RRS) informs the client of his or her HIV-antibody test results. The CTR RRS integrates the test result in a meaningful discussion based on the individual's reported risk factors and consistent with his or her risk reduction efforts. This session reinforces the issues and topics discussed in a prevention counseling session. Also at this time, the CTR RRS provides the opportunity for partner elicitation and for clients to receive additional counseling, information, and linked referrals
- 5) Post-Disclosure Counseling Session (Optional) occurs after the disclosure session and provides an additional opportunity for partner elicitation and for clients to receive counseling, information, and linked referrals.
- 6) Partner Elicitation occurs during the Disclosure Counseling (Follow-Up) Session and/or the Optional Post-Disclosure Counseling Session once an individual has tested positive for HIV. This is an interaction in which the names, locating information and identifying information of the HIV-positive client's sex partners and/or needle-sharing partners are elicited. Partner Elicitation should be followed by a discussion of the best method of partner notification: by health department or by contract referral with the client. See also: Partner Counseling and Referral Services below.
- 7) Utilizing Social Networks² (Optional) is a strategy for reaching and providing CTR to persons with undiagnosed HIV infection. Enlisting HIV-positive or high-risk HIV-negative persons (i.e., recruiters) to encourage people in their network (i.e., network associates) to be tested for HIV may provide an efficient and effective route to

accessing individuals who are infected, or at very high risk for becoming infected, with HIV and linking them to services.

- 8) Linked Referrals direct individuals being tested for HIV to a specific service of immediate need as assessed and prioritized during his or her individual assessment (e.g., group-level HE/RR program, CRCS, substance abuse treatment, medical care). The CTR counselor provides written information regarding the referral, which may include but not be limited to: date, client's name, agency referred to, reason for referral, and the name of the individual making the referral. The distinguishing characteristic of a linked referral is that verification is obtained regarding the client's access to the referred service(s). **In the context of prevention counseling, referral does not include ongoing support or management of the referral.**

²For more information regarding Social Networks, go to:
<http://www.cdc.gov/hiv/resources/guidelines/snt/pdf/SocialNetworks.pdf>

CTR Interventions

- 1) HIV screening has been recommended in traditional, health-care settings; however, it may be beneficial in non-traditional settings when targeted in high-prevalence venues and geographic areas. Targeted HIV Screening includes the following CTR components: 1) Risk Assessment, 2) HIV Test, 3) Disclosure Counseling Session, 4) Partner Elicitation, 5) Social Networks (Optional), and 6) Linked Referrals, which may include referral to Protocol-Based Counseling.
- 2) Protocol-Based Counseling (PBC)³ is an individual-level intervention involving a pre-defined set of standards for multiple interventions delivered as a set and includes the following CTR components: 1) Risk Assessment, 2) Prevention Counseling (Initial) Session, 3) HIV test (Optional), 4) Disclosure Counseling (Follow-Up) Session, 5) Post-Disclosure Counseling Session (Optional), 6) Partner Elicitation, 7) Social Networks (Optional), and 8) Linked Referrals. Counseling, partner elicitation, and/or referral may be provided without testing.

³For more information regarding Protocol-Based Counseling in Texas, including Quality Assurance Standards, go to:
<http://www.dshs.state.tx.us/hivstd/training/pctools.shtm>

De-Linking Counseling and Testing

In certain situations, it may be appropriate and beneficial to de-link HIV counseling from HIV testing, i.e. not require counseling prior to administering an HIV test. With this Request for Proposals (RFP), the HDHHS is making this distinction using the CTR interventions listed above: 1) Targeted HIV Screening and 2) Protocol-Based Counseling (PBC). Targeted HIV Screening can be done without a counseling session while PBC requires counseling and may or may not include an HIV test. Please refer to Table 8: CTR Matrix to determine the appropriateness of these interventions in conjunction with testing technologies and settings. Proposers should understand and clearly define the benefits to the target behavioral risk group (BRG) in relation to the proposed CTR intervention(s).

HIV Testing Technologies

- 1) Conventional HIV Testing requires a specimen (usually blood or oral fluid) to be collected from the client and sent to a laboratory for processing. A screening test for HIV antibodies (e.g. EIA, ELISA) must be performed. If HIV antibodies are detected

with the screening test, a highly specific, confirmatory test (e.g. Western Blot, IFA) must be performed. Test results are then returned to the requesting provider within a two-week period of time.

- 2) Rapid HIV Testing requires a specimen (usually blood or oral fluid) to be collected from the client and processed within a short interval of time, approximately 10 – 60 minutes. Rapid HIV testing is only a screening test for HIV antibodies, and positive results are considered “presumptive” until confirmatory results can be obtained through a conventional HIV testing technology. All “presumptive” HIV-positive test results are required to have a specimen collected by a conventional HIV testing technology at the time the “presumptive” result is given in order to confirm the HIV-positive result.

Settings for CTR Services

Traditional Settings include:

- 1) Clinic-Based CTR services offered in a clinic setting where clients may access other health services if needed.

Non-Traditional Settings include:

- 2) Community-Based CTR services offered in community-based venues to effectively reach high-risk target populations. Examples of community-based venues include bars, clubs, commercial sex venues, etc.
- 3) Outreach CTR services offered in outreach settings in high-prevalence geographic areas. Examples of outreach settings include parks, street corners, outdoor events, etc.
- 4) Mass Testing Day CTR services offered either in community-based venues or outreach settings in high-prevalence geographic areas usually in conjunction with a National day of recognition. These events typically require coordination among several different providers to provide a high volume of HIV tests on a given day.

Partner Counseling and Referral Services (PCRS)

PCRS is a systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can learn their HIV status, avoid infection or, if infected, prevent HIV transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services. See also: Partner Elicitation above.

- 1) Partner Elicitation is the process of eliciting or obtaining names, locating information and identifying information of the client’s sex and/or needle-sharing partners as well as social networks of an HIV-positive individual. Due to the very sensitive nature of PCRS, CBO staff must be well trained in order to conduct partner elicitation. In Texas, this activity may be conducted by health department staff and/or CBO staff.
- 2) Partner Notification is the process of informing an HIV-positive individual’s sexual or needle sharing partner of his or her possible exposure to HIV. Partner notification is traditionally a function of the health department and, in Texas, may only be conducted by health department staff or through contract referral with the client.

HIV COUNSELING, TESTING AND REFERRAL (CTR) CONSIDERATIONS

Matrix for Appropriate Use of CTR Interventions and HIV Testing Technologies

Below is a matrix that outlines the appropriate settings to be utilized in conjunction with appropriate CTR interventions and HIV testing technologies. For example, appropriate settings for the use of Protocol-Based Counseling in conjunction with the conventional HIV testing technology include clinic-based and community-based settings only.

Table 8: CTR Matrix

CTR INTERVENTIONS	HIV TESTING TECHNOLOGIES	
	Conventional HIV Testing	Rapid HIV Testing
Targeted HIV Screening	Appropriate Settings Include: <ul style="list-style-type: none"> • Clinic-Based • Community-Based • Outreach • Mass Testing Day 	Appropriate Settings Include: <ul style="list-style-type: none"> • Community-Based • Outreach • Mass Testing Day
Protocol-Based Counseling	Appropriate Settings Include: <ul style="list-style-type: none"> • Clinic-Based • Community-Based 	Appropriate Settings Include: <ul style="list-style-type: none"> • Clinic-Based • Community-Based • Outreach

Considerations for Non-Traditional Settings for CTR Services⁴

- 1) Privacy and Confidentiality – Ensuring clients’ privacy and confidentiality during CTR is essential, but could present unique challenges in some non-traditional settings. Confidentiality can more easily be breached in settings where clients and providers can be seen or heard by others. Suggested strategies for maintaining privacy and confidentiality in non-traditional settings include the following:
 - a) Use privacy screens to create a separated area in a mobile van.
 - b) Use private offices or rooms at the location, preferably with locking doors.
 - c) Mark a specific room with a “do not disturb” or “occupied” sign.
 - d) Designate an area in the setting that provides physical privacy.
 - e) In parks and similar locations, seek areas with as much privacy as possible.
 - f) Provide counseling and testing services in the client’s home or other secure setting.
 - g) Have clients return to the setting to receive test results and counseling and referral.

- 2) Informed Consent – Staff members providing CTR services should be sensitive to barriers that can interfere with obtaining true informed consent, including alcohol and drug use, mental illness, and peer pressure in venues where persons congregate or socialize. Suggested strategies for obtaining informed consent in non-traditional settings include the following:
 - a) Use of a Sobriety Standard. *In conjunction with the HDHHS and community mental health providers, establish clear and easy guidelines and sobriety standards to help counselors determine when clients are not competent to provide consent. Although it is important to assess sobriety level, every person who has been drinking or using other substances should not be*

excluded from testing. Some persons will be active substance abusers who use substances on a daily basis; these persons are generally at high risk for infection and should not be excluded from testing if they are still capable of providing informed consent.

- b) Schedule an appointment to test at a later date/time.
 - c) Follow up at a later time with the client if contact information is available.
 - d) Read the informed consent form to the client.
 - e) Use verbal prompts to ensure that the client understands information in the informed consent form.
- 3) **Counseling** – Staff members working in community-based and other non-traditional settings should know and use risk-screening strategies to determine whether HIV prevention counseling should be recommended. Staff members should be trained in HIV prevention counseling or other approaches aimed at personal HIV risk reduction. When appropriate (e.g., among IDUs), information regarding other STDs and blood borne diseases should be incorporated into the counseling sessions.
- 4) **Testing** – The decision to offer HIV testing in non-traditional settings should be based on several factors, including availability of resources and feasibility of providing test results and follow-up. In some cases, referral to other providers is appropriate. The selection of a specific HIV test technology should be based on quality control and logistical issues (e.g., field conditions related to collection, transport, and storage of specimens; worker safety; and the likelihood that clients will receive HIV test results). Providers must understand the extent to which field conditions can affect specimens (e.g., extreme temperatures or time lapse from collection to processing). Test specimens should be collected, stored, and transported according to manufacturer instructions.
- 5) **Provision of Test Results** – Clear protocols for provision of test results and prevention counseling should be developed. The following strategies might be useful in ensuring the provision of results in non-traditional settings:
- a) Provide a telephone number that clients can call to schedule an appointment to receive test results.
 - b) Make an appointment with the client at the time of testing to receive results.
 - c) Provide incentives (e.g., food certificates, hygiene kits, food).
 - d) Return to a site on a regularly scheduled basis.
 - e) Provide reminders when contact information is available.
- 6) **Referral** – Staff members working in community-based and outreach settings should be trained to implement and manage referrals. Providers should establish appropriate collaborative relationships for referrals. Arranging for PCRS staff members or case managers to be available to clients at the time test results are provided might help promote referral.
- 7) **Record Keeping** – Maintaining the confidentiality of client records is critical. Providers should develop written protocols for record keeping that address transport of client records to and from outreach venues. Strategies to maintain confidentiality of client records in non-traditional settings include the following:
- a) Return all client records to the office immediately after the CTR session.

- b) Transport ALL client records in a locked briefcase or backpack. Store all records in a secured area (e.g., locked file drawers) in compliance with all HIPAA guidelines.
- c) Provide option of anonymous counseling and testing as well as confidential counseling and testing.
- d) Verify identity of client (e.g., match client signature with that provided for informed consent or check identification card) when providing test results.
- e) Store paperwork in a lockbox while in outreach settings.
- f) Password protect and encrypt electronically stored client records.

For anonymous HIV testing, procedures to ensure client anonymity (i.e., no indication of testing in the client’s record and no recording of personal identifying information on laboratory requests) should be developed. Even when staff members providing CTR services know the client (including name and locating information) from other activities, the client’s right to be tested anonymously should be protected.

- 8) Staff Safety – Providing services in outreach settings (e.g., bars, parks) might compromise staff safety, which must be considered in development of outreach protocols. Appropriate training and precautions (e.g., working in teams) should be developed in planning services in non-traditional settings.

⁴Information regarding the CDC’s Revised Guidelines for HIV Counseling, Testing, and Referral at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm>

Development of Non-Traditional CTR Settings

The CPG recommends that the HDHHS work with community partners and Commercial Sex Venue (CSV) owners to support the delivery of rapid HIV testing in CSVs. Rapid HIV testing must be implemented in high prevalence geographic areas and/or high-risk populations, ensuring that resources and efforts are directed appropriately. The expansion of rapid HIV testing services into non-traditional CTR settings (including community-based venues and outreach settings) will be guided by the following steps:

- 1. Site identified as high volume, high prevalence setting
- 2. Site and/or community express interest in implementing Rapid HIV Testing
- 3. Resources are identified to support Rapid HIV Testing in new site
- 4. Site is inspected to ensure that requirements for providing Rapid HIV testing are in place and that the Quality Assurance plan can be met
- 5. The HDHHS provides implementation guidelines and technical assistance
- 6. Rapid HIV Testing staff is identified, trained and certified
- 7. Rapid HIV Testing services begin

Minimum HIV Counseling, Testing and Referral Indicators
<ul style="list-style-type: none"> ● Percent of newly identified, confirmed HIV-positive test results among all tests reported by CDC-funded HIV counseling, testing and referral sites.
<ul style="list-style-type: none"> ● Percent of newly identified, confirmed HIV-positive test results returned to clients.
<ul style="list-style-type: none"> ● Percent of facilities reporting a prevalence of new HIV-positive tests equal to or greater than the jurisdiction’s target as specified in the first indicator immediately above.

Minimum Partner Counseling and Referral Services Indicators
<ul style="list-style-type: none"> • Percent of contacts with unknown or negative serostatus who receive an HIV test after PCRS notification.
<ul style="list-style-type: none"> • Percent of contacts with a newly identified, confirmed HIV-positive test among contacts who are tested.
<ul style="list-style-type: none"> • Percent of all contacts with a known, confirmed HIV-positive test among all contacts.
<p>NOTE: Although PCRS indicators apply to the health department regarding partner notification, they are included here as a reference as to why partner elicitation is important.</p>

NOTE: New HDHHS Counseling, Testing and Referral Guidelines

Full-time (1.0 FTE) certified HIV Risk Reduction Specialists must conduct a minimum of twenty-four (24) HIV counseling, testing and referral sessions per month. Furthermore, each site (testing site, not agency) conducting HIV counseling, testing and referral services is required to administer a minimum of 60 tests monthly, must realize an HIV-positivity rate of 1.00% or greater, and must serve a client population where a minimum of 85% of the clients are classified as being part of a behavioral risk group.

CATEGORY 3: Comprehensive Risk Counseling Services (\$100,000)

The HDHHS will fund up to two comprehensive risk counseling programs in Houston/Harris County at a combined level not to exceed \$100,000 annually and targeted to HIV-negative persons at high risk for HIV infection and HIV-positive persons at high risk for HIV transmission. Programs may be developed as stand-alone programs or as an adjunct component to a separately funded HE/RR or CTR program. These programs are being solicited separately given their intensity, unique recruitment designs and selective staffing patterns. Programs should consider the number of clients to be served, the needs of those clients and the services available in their area when determining the staffing levels needed. However, a typical caseload will include approximately fifteen to twenty clients for each CRCS case manager. The funded CRCS program must be implemented consistent with the definition provided below, as well as the CDC CRCS guidance⁵, and comply with all HDHHS reporting requirements.

⁵For more information regarding the CDC’s guidance on Comprehensive Risk Counseling Services (CRCS), go to: http://www.cdc.gov/hiv/topics/prev_prog/CRCS/resources.htm

COMPREHENSIVE RISK COUNSELING SERVICES DEFINITION

Comprehensive Risk Counseling Services (CRCS) are a client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk reduction needs. It is a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage. It excludes any one-on-one counseling that lacks ongoing and individualized prevention counseling, support, and service brokerage.

The core elements of CRCS require the assessment of HIV risk behaviors and other psychosocial and health service needs in order to provide risk reduction counseling and to assure psychosocial and medical referrals, such as housing, drug treatment, and other health and social services for HIV positive and high-risk negative persons. CRCS provides intensive, individualized support

and prevention counseling to assist persons in remaining HIV-negative, or to reduce the risk of HIV transmission by those persons who are HIV-positive. CRCS should not duplicate services funded by psychosocial case management services (funded by the Ryan White CARE Act, Texas Department of State Health Services or other care-specific funding streams) that support case management for HIV-positive persons.

Comprehensive Risk Counseling Services must follow CDC guidelines and ensure that all characteristics and components are conducted (e.g., develop a client recruitment and engagement strategy, screen and assess clients for appropriateness for CRCS, develop a client-centered prevention plan, establish protocols to classify clients as “active”, “inactive”, or “discharged”). CRCS sessions technically begin once the client consents to the service and is successfully engaged. **Please note that recruitment and screening activities occur before the engagement process.** It is expected that a CRCS case manager will meet at least once with the client before the client is considered a true “CRCS client.” CRCS clients must complete a minimum of four (4) sessions. Agencies must hire CRCS case managers with the appropriate training and skills to complete the CRCS activities consistent with this intervention description.

Minimum Comprehensive Risk Counseling Services Indicators
<ul style="list-style-type: none">• Proportion of persons that completed the intended number of CRCS sessions.
<ul style="list-style-type: none">• Proportion of the intended number of the target population to be reached with CRCS who were actually reached.

CATEGORY 4: Social Marketing (\$296,000)

The HDHHS will fund up to two (2) social marketing projects at a combined level not to exceed \$160,000 annually to support the delivery of HIV prevention messages to high-risk HIV-negative and HIV-positive persons throughout Houston/Harris County under a cost-reimbursement fee structure. These projects will be designed to alter HIV testing and risk reduction behaviors; correct misperceptions and misinformation, and create a supportive environment for communication about what it means to be HIV-positive or HIV-negative. This intervention addresses the community norms and other barriers preventing individuals from testing or accessing needed services, including: 1) fear of the impact of an HIV diagnosis, 2) lack of knowledge about testing sites and procedures, and 3) lack of knowledge about the health care system. These projects are being solicited separately given their intensity and unique design requirements.

SOCIAL MARKETING⁶ DEFINITIONS

The HDHHS defines “social marketing” as the use of modern marketing principles and methodologies to affect in some way knowledge, attitudes, beliefs and/or practices regarding HIV/AIDS risk, associated behavior change and risk reduction and access to services and treatment education. Social marketing materials are distinct from other educational materials in that social marketing materials are for relatively broad use, are frequently used independently of other services and are generally more public in their use and exposure.

Primary social marketing materials include advertising in newspapers, billboards and other out-of-doors media. Collateral materials include flyers, brochures, palm cards and other materials.

Generally, social marketing campaigns are designed to coordinate messages, images and design elements among primary and collateral social marketing materials. Effective coordination of social marketing materials synergistically increases the impact of each element. The following social marketing techniques help service providers develop, target, deliver and evaluate prevention messages:

Audience segmentation and profiling is done through formative research. The goal is to find audience segments whose members have certain things in common – they pay attention to the same communication channels (e.g., certain television talk show hosts) and are likely to respond positively to the same messages. Demographic (e.g., age, income, race, gender), psychographic (e.g., readiness for change), and lifestyle (e.g., leisure time pursuits) categories are used to draw the boundaries of a target audience segment.

A **4 “P’s” analysis** includes product, price, place, and promotion. Whether you are selling a physical product or something intangible like safer behavior, the first three “p’s” suggest taking steps to make your “product” seem attractive, affordable (in terms of money and emotional costs like embarrassment), and convenient to access. Promotional/advertising considerations are brought to bear in trying to get clear, effective, memorable messages to the largest proportion of your target audience while you stay within your budget constraints.

Emphasize product benefits from the consumer’s point of view. Some people already buy or do what you are trying to promote to other people much like them. What do the “doers” think they stand to gain by behaving that way? These are the beneficial aspects of your “product” that you should promote to those who don’t yet meet your behavioral objective.

Get **constant consumer feedback** and refine your marketing strategy on the basis of this input. You may not be able to afford formal consumer surveys, but focus groups and other quick means of polling your audience should drive continuous improvements in your marketing approach.

⁶For more information about social marketing, see:
Andreasen, A.R. (1995). *Marketing social change: Changing behavior to promote health, social development, and the environment*. San Francisco, CA: Jossey-Bass.

Social Marketing Guidelines

Proposers should be aware of and consider these guidelines as they prepare their proposals. These guidelines will be used by the Materials Review Panel to review and approve all social marketing materials.

Simplicity is the fundamental guideline for creating good media products. The assessment by the HDHHS of social marketing materials will include reference to the following generally accepted principles of social marketing.

- a. Design elements should be unified to create a clear and succinct message. Viewing time for most out-of-doors messages is only a few seconds.
- b. Visual elements are just as important as words. Each element should be well defined within the context of a design, and contribute to the call to action.
- c. Minimize the number of words. The most effective out-of-doors designs contain six or fewer words.
- d. Use color thoughtfully. Well-balanced and coordinated color selection can enhance the impact of a message.

- e. Type fonts and sizes should be appropriate for the medium. Fonts that work well in a print ad may not be effective on a billboard. Out-of-doors displays are often seen from far distances, which may cause some typefaces to bleed together while others may lose resolution.

Evaluate the combined elements of a design in a simulated out-of-door environment for viewing. Headline sub-heads and phone number type should be readable from 200 feet. Attribution text may be smaller, not smaller than 60 points, or 30 points when set at 1" = 1' format.

Notes on legibility of typefaces:

Kerning, or space between letters – Sufficient kerning assures the legibility of text from distances. Tight kerning reduces legibility causing adjacent letters to attach visually. Without proper kerning “clear morning” could be interpreted as “dear mom.”

Crowding letters into a restricted space will reduce legibility.

Several contrasting letter strokes will lose definition when viewed from a far distance.

Script typefaces are difficult to read at any distance.

Bulky typefaces lose distinction between letters

Advisory Panel. It is the responsibility of the contractor to ensure that a current list of members for their social marketing advisory panel is on file with the Program Manager.

Narrative. A narrative description of the process used to develop the social marketing materials is required. The narrative should discuss the following:

- The intended effect of the social marketing campaign, including the specific call to action.
- The population(s) targeted by the campaign identified by behavior risk group and/or other characteristics consistent with the contracted program’s scope of work.
- The population(s) likely to consume the materials, irrespective of program target.
- Copy of field tests or focus groups report conducted to develop and/or review the materials. The report should describe recruitment methods and demographic information of the participants. A summary of feedback should be included, as well as a narrative description of the response of the contractor to the results. Contractors should keep on file, but not include in the submission unless requested, drafts of materials viewed by participants of any field test or focus group. The field test or focus group should include consideration of the extent to which participants discerned the message intended, considered it effective, relevant, memorable, credible and generally acceptable to the target population and communities intended.
- A detailed implementation and distribution plan. The plan should be specific in terms of the kind and number of media planned.
- Specific information on the placement, duration and target population for out-of-doors media is required. The location should include the identifying street location, geographic area (neighborhood), and zip code.

- For broadcast media, including public service announcements, specific information on the stations, programs, days and time should be provided. In addition, the demographic characteristics of the likely audience should be described.
- For print ads, provide the publications targeted, and the demographic characteristics of the likely readership.
- An evaluation plan that describes how the social marketing campaign will be evaluated for effectiveness.

CATEGORY 5: School-Based Prevention Programs (\$200,000)

The HDHHS will fund up to two (2) school-based structural intervention prevention programs each at a level not to exceed \$200,000 annually to develop and provide an innovative, comprehensive HIV/AIDS training program that increases broad school-based support for HIV/AIDS education among school administration, teachers, school boards, parent-teacher organizations, parents, and school medical staff for HIV education and prevention activities. Funds are limited to programs who are not receiving support directly from the CDC for this or a similar school-based program. Funds can be used to increase the capacity of schools to deliver high-quality, up-to-date school-based HIV education programs. Funded providers are expected to coordinate with HISD programs to maximize teaching opportunities.

The proposed structural intervention must be consistent with the CDC's definition of structural interventions and must include program components and benchmarks that can be evaluated.

STRUCTURAL INTERVENTION DEFINITION

Structural interventions aim to modify the social, environmental and political structures and systems that influence the delivery of HIV/STD Prevention Services. Structural interventions may impact legislation, technology and health care standards, among others to improve the delivery and/or effectiveness of HIV prevention efforts.

A critical step in the development of structural interventions is to assess the feasibility to accomplish the intended task and to gauge what impact the intervention may have. Samples of structural interventions include, but are not limited to integrating HIV/AIDS ministries into the faith-based activities, mandating HIV-antibody testing for specific offenders, modifying a standard of care to include mandatory offering of HIV-antibody testing to pregnant women or establishing standards and regulations for the operation of commercial sex venues.

CATEGORY 6: HIV Prevention Evaluation, Technical Assistance and Capacity Building (\$128,000)

The HDHHS will fund one (1) Evaluation/Technical Assistance Team to assist providers in the development of population specific interventions and program evaluation. Up to \$128,000 will be available for one project that will employ two (2) minimum Masters-level behavioral scientists/evaluation specialists to work with prevention services providers and HDHHS staff to coordinate prevention activities, identify measurable prevention intervention outcomes, to provide training and technical assistance on evaluation science and behavioral science theory, to assist in the development of evidence-based evaluation plans for interventions, and to assist in the evaluation of intervention programs and activities. The goal is to identify programs that are either effective at achieving measurable outcomes related to prevention interventions, or to

identify those programs with limited effectiveness, and to create an environment for continuous improvement at the program level. Proposers will be responsible for completing the following activities:

- Conduct a minimum of four (4) formal training opportunities annually for prevention providers on behavior change theory.
- Coordinate a minimum of one (1) symposium annually featuring leading national HIV prevention behavioral scientists.
- Evaluate contractor responsibility and/or contractor performance, and to direct, plan and coordinate the work of several HDHHS-funded agencies and organizations working on a variety of contracts.
- Communicate effectively in writing, and prepare technical assistance and progress reports.
- Monitor, review and provide technical assistance in program evaluation.
- Conduct on-site technical assistance to HDHHS-funded HIV prevention contractors.
- Investigate any potential problem areas and recommend resolutions.
- Ensure that required monthly reports and evaluation activities are completed correctly and in a timely manner.
- Design and implement processing systems for process monitoring and outcome monitoring data.
- Develop and recommend standards for evaluating programs and for preparing research reports.
- Consult and advise on both existing and proposed research projects and incorporate methods of evaluation necessary for measures of effectiveness.
- Review and approve documents prior to technical review and formal implementation.
- Assist in the development of guidelines, standards, and procedures for the evaluation of HIV prevention contracts in terms of quantity and quality of services provided.
- Perform other work-related duties, as assigned.
- Work collaboratively with and report to HDHHS Project Manager(s).

The Proposer must develop an annual work plan, which at minimum includes the following elements: orientation training for the evaluation specialists; monitored technical assistance sessions; provision of at least three technical assistance sessions for all HDHHS-funded prevention agencies, with one being specifically focused on drafting the agencies' evaluation plans; assistance with review and approval of the agency evaluation plans; participation in an assessment meeting; and continual assistance to their assigned agencies in meeting reporting and evaluation requirements.

All Behavioral Science Evaluation Specialists are required to attend all required meetings and follow HDHHS customer service policies and procedures when working with HDHHS contracted agencies.

VII. Reporting and Other Program Requirements

All funded providers will also be expected to provide or conduct the following activities:

Client-level Tracking and Data Collection – Two of the main objectives of Houston/Harris County's HIV/AIDS prevention services delivery system are 1) to improve the integration and coordination, and 2) to employ technological and other advances to bring efficiency to the

delivery system. This will be accomplished through automated client-level tracking and data management systems where providers have common intake forms, eligibility criteria, service protocols (including linked referrals) and outcome measures. Currently, there are several initiatives underway that will enhance current client reporting, and the HDHHS is in the process of creating a local client-level data system. Agency staff will enter client-level data either directly into the HDHHS system or into the CDC's Program Evaluation and Monitoring System (PEMS) directly.

Other types of technological advances will be implemented over the course of future years for referral mechanisms, continuous client feedback and satisfaction measurements, outcome evaluation, and for other purposes. Providers will be expected to accommodate those innovations, and use them, as they become available on-line. The HDHHS will provide the necessary assistance to integrate these improvements into the service delivery system, provide adequate training, a backup paper-based system, and enhance the capacity of the system to adapt appropriately.

Progress Reports – Please refer to page 54 for additional information and requirements related to routine (quarterly and annual) progress reports.

Evaluation Process and Outcome Measurements – Almost all data collected in the quarterly and annual progress reports are process data. Other program performance indicators, such as those listed below, are required. These program performance indicators may be modified and additional program indicators may be developed at the discretion of the Bureau Chief of the Bureau of HIV/STD Prevention:

- Proportion of newly identified, confirmed HIV-positive test results among all tests reported by HIV counseling, testing, and referral sites
- Proportion of newly identified, confirmed HIV-positive test results disclosed to clients
- Number of HIV-positive tests
- Number of persons who complete the intended number of sessions for each of the following interventions: individual-level interventions (ILI), group-level interventions (GLI), and comprehensive risk counseling services (CRCS).
- Proportion of the intended number of the target populations to be reached with any of the following specific interventions: ILI, GLI, or CRCS who were actually reached.
- Average number of outreach contacts required to get one person to access any of the following services: Counseling, Testing & Referral Services, Sexually-Transmitted Disease Screenings and Testing, ILI, GLI, or CRCS.
- Percent of contacts with unknown or negative serostatus receiving an HIV test after PCRS notification.
- Percent of partners with a newly identified, confirmed HIV-positive test among partners who are tested.
- Percent of partners with a known, confirmed HIV positive test among all partners.
- Number of newly diagnosed HIV infections (incidence)
- Distribution of HIV-positive tests by Behavioral Risk Group (BRG) category.
- Distribution of HIV-positive tests by racial/ethnic, gender and age characteristics.
- Proportion of HIV tests by targeted BRG category.

- Number of newly diagnosed HIV infections, 13-24 years of age.
- Proportion of HIV-positive persons that complete the intended number of sessions for comprehensive risk counseling services (CRCS).
- Percent of HIV infected persons who, after a specified period of participation in CRCS, report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with seronegative partners and with partners of unknown status.

Additional outcome indicators based on the program curriculum are required for inclusion in the contract Scope of Work. Routine reporting of data will be included in, but not limited to, quarterly reports and annual evaluation progress reports. HDHHS staff and HDHHS-contracted Evaluation and Technical Assistance staff will work with each of the funded programs on specific evaluation issues and provide technical assistance as indicated. Because the HDHHS is developing a consistent and cohesive evaluation effort across all programs, proposers should not budget for evaluation staff and consultants through their individual budgets.

Curricula and Educational Materials – Any materials or curriculum developed for, or used by any of the funded programs are subject to review and approval by the HDHHS.

Hours of Service – The proposed services, particularly outreach activities, must take place at hours that are consistent with the highest accessibility of clients. Prevention activities must be scheduled during evening or night hours and on weekends as appropriate.

Geographic Access – It is the intention of this RFP to make HIV/STD Prevention Services available to as many Houston/Harris County residents who fall into a BRG category as possible. Contracts will be awarded based on the geographic need, and providers are required to identify the geographic areas (zip codes, super neighborhoods, council districts, etc.) in which they propose to provide services.

Culturally and Linguistically Appropriate – Services must be culturally and linguistically appropriate for the target population(s). Providers must describe how they will use other services to reduce/eliminate language and cultural barriers.

Community Needs and Provider Expertise – Providers must design models of HIV/STD Prevention Services that are based in behavioral science, and that address and are reflective of the community being served. Providers are expected to include the target population in the development of HIV prevention and education materials. Examples of this inclusion are: community advisory boards, consumer review of documents, focus groups, etc.

Linked Referrals – A principle goal of these services is linking clients to needed services, and particularly linking clients who test positive for HIV with the care services system.

When appropriate, provider will be expected to make “linked referrals” for clients. “Linked referrals” are not only meant to show that the client has been referred for other services, but they require that the provider takes the steps necessary to ensure that the client has accessed those services once referred.

Providers will be required to use a data management system designated by the HDHHS to help facilitate, connect and access referrals from providers to one another, and services to one another.

Quality Management Plans – Providers are expected to develop a Quality Management plan within 90 days of contract execution that includes a mechanism for client feedback and a “Quality Management Committee.” The Committee shall consist of persons representative of the program and agency such as clients, volunteers, program staff, management, consultants and others (e.g. staff from other community-based organizations). Please refer to page 52 for more details regarding the Quality Management Committee and Plan requirements.

Evaluation Plans (Categories 1-4) – Providers are expected to develop a program evaluation plan **outline/framework** within 90 days of contract execution, by working with HDHHS staff and designated behavioral scientists pertaining to all service categories funded under this RFP. Final evaluation plans for 2007-2008 will be developed and implemented throughout 2007 and 2008 with the assistance of designated behavioral scientists and HDHHS staff, and are to be submitted for HDHHS approval. In addition, an evaluation progress report is required for each year. Outcome monitoring and reporting is required and should commence no later than 120 days after contract start date. Time specific and measurable outcome indicators must be included in the Scope of Work and be based on the program curriculum.

Countywide Needs Assessments – Providers are expected to participate in CPG-approved activities or any needs assessment-related activity as indicated by the Bureau Chief of the Bureau of HIV/STD Prevention.

Unit(s) of Service – The units of service that providers must use to track services provided include the number of prevention interventions (e.g. outreach, individual-level interventions, HIV Counseling, Testing and Referrals) actually provided. Applicants should use these *Units of Service* when completing the *Scope of Work (Form 6)*.

Program Requirements

- Proposal must describe how and what staff will be hired or how the necessary expertise will be obtained for the successful provision of the defined services. Proposer must describe how they will ensure that HIV prevention staff stays current on required training and certifications.
- Programs must describe how they will maintain documentation of all service provision.

DISCLAIMER RELATIVE TO PERFORMANCE AND SPENDING INCONGRUENCE

All programs funded under this RFP may be subjected to further program requirements as set forth by the HDHHS. Those requirements include, but are not limited to: comparison of monthly and annual expenditures and program performance, comparison of BRG served versus non-BRG served, etc. The HDHHS may modify payment for services based on the above-mentioned criteria. Any such requirements will also be stipulated in the contract agreement or further correspondence from the Bureau of HIV/STD Prevention.

VIII. Submission Deadlines and Critical Dates

Proposal Submission Deadline

The City of Houston must receive all proposals and financial stability documents absolutely no later than: **Friday, December 8, 2006, 2:00 P.M. (Central Standard Time).** **No late proposals**

will be accepted, and no proposals will be received at the Houston Department of Health and Human Services. If hand delivered, proposals should be delivered to: City Secretary's Office, City Hall Annex, Public Level, 900 Bagby, Houston, Texas 77002, Attn: Beau J. Mitts, MPH, Program Manager, HIV/STD Prevention.

Mandatory Intent to Apply Form

****Proposers must submit an "Intent to Apply" form on or before 5:00 p.m. (Central Standard Time), Wednesday, November 22, 2006.****

The Intent to Apply form must be signed by the Executive Director, CEO or designated Board Member of the proposing agency. Intent to Apply forms may be faxed to the attention of Beau J. Mitts, Program Manager at (713) 798-0830 or e-mailed to beau.mitts@cityofhouston.net. Submitting agencies are responsible for verifying that the fax and/or email is received. The submitting agency assumes the risk of non-receipt of its Intent to Apply form for any cause outside the reasonable control of the HDHHS including, but not limited to, failure or unavailability of any electronic circuit or item of equipment necessary for the transmission or receipt of information by fax.

Proposers' Conference

A Proposers' Conference will be held to discuss the RFP and requirements. City staff will respond to questions from potential Proposers. Proposals are generally strengthened by the attendance of key staff contributing to the proposal's development at the Proposers' Conference. The Proposers' Conference is scheduled as follows:

Date: Wednesday, November 8, 2006
Time: 9:00 AM – 1:00 PM
Location: Houston Department of Health and Human Services
Media Center (1st Floor) at Medical Center Clinic
1115 S. Braeswood Blvd.
Houston, TX 77030

If proposers are unable to attend the Proposers' Conference, audiocassette tapes of the conference will be available for review at the Bureau of HIV/STD Prevention. To arrange for a time to listen to the tape recording, please contact Beau J. Mitts at (713) 794-9079 or by e-mail at beau.mitts@cityofhouston.net.

Questions and Correspondence

Only written inquiries will be accepted regarding the RFP and must be submitted to the Program Manager identified below. **No telephone inquiries will be accepted.** Proposers may submit questions via email, fax, or mail. All questions must be received by **5:00 P.M. Thursday, November 16, 2006.** Questions must be addressed to:

Beau J. Mitts, MPH, Program Manager
Houston Department of Health and Human Services
Bureau of HIV/STD Prevention
8000 N. Stadium Drive, 5th Floor
Houston, TX 77054
Fax number: (713) 798-0830
Email address: beau.mitts@cityofhouston.net

All inquiries must include:

- Contact Person's Name
- Address
- Area code and Phone number
- Area code and Fax number
- E-mail address, and
- Question(s) with reference to related section in the RFP.

Questions will be compiled with the appropriate answers and issued as an addendum to the RFP. The addendum will be mailed to all Proposers that attend the Proposers' Conference, in addition to being posted on the Houston Department of Health and Human Services' web site. To ensure receipt of any addendums, Proposers should include correct mailing address, fax number and e-mail address.

Contract Start Date

Services resulting from this RFP are intended to start **January 1, 2007**.

Proposal Withdrawals

All proposals shall be firm offers and may not be withdrawn for a period of one hundred eighty (180) days following the last day to submit proposals.

Distribution of Request for Proposals

This RFP is available and posted on the City of Houston Department of Health and Human Services website at <http://www.houstontx.gov/health/HIV-STD/index.html>.

Copies of this RFP may also be obtained in person through **5:00 PM Wednesday, November 22, 2006** at the HDHHS, Bureau of HIV/STD Prevention, 8000 N. Stadium Drive, 5th Floor, Houston, Texas, 77054, or by faxing a request with contact person's name, agency, and address to Beau J. Mitts, MPH at fax number (713) 798-0830. Copies will be mailed as a courtesy and will not be faxed. Copies will be sent to the City mailroom no later than the close of the first business day after the day the request is received. The deadline for requesting mailed copies is **5:00 PM Monday, November 20, 2006**. Copies will be available via the web for downloading during the entire open period of this RFP. The release of the RFP will be advertised in the classified sections of several local newspapers. The City assumes no responsibility for mail delays or any failure to send the RFP to all interested parties, although every reasonable effort will be made to do so.

This RFP may be obtained from the Houston Department of Health and Human Services website at <http://www.houstonhealth.org>. The required forms attached to this RFP may also be downloaded in MSWord and/or MSEXcel format from the HDHHS website. Proposers are responsible for ensuring that the forms submitted are complete and identical to the forms in the printed version of the RFP. The City may, at its sole discretion, disqualify any proposal that includes forms that are incomplete or modified.

IX. Submission Requirements

Agencies intending to submit an application are expected to thoroughly examine the entire contents of this Request for Proposals and become fully aware of all the deliverables outlined herein.

Truth and Accuracy of Representations

False, misleading, incomplete, or deceptively unresponsive statements in connection with a proposal shall be sufficient cause for rejection of the proposal. The evaluation and determination in this area shall be at the HDHHS Director's sole judgment and his/her judgment shall be final.

Notice To Proposers Regarding The Public Records Act

Responses to this RFP shall become the exclusive property of the City. At such time as the HDHHS makes funding recommendation(s) to the City Council and such recommendation(s) appears on the Council agenda, all such proposals submitted in response to this RFP become a matter of public record, with the exception of those parts of each proposal which are defined by the Contractor as business or trade secrets, and plainly marked as "Trade Secret," "Confidential," or "Proprietary".

The City shall not, in any way, be liable or responsible for the disclosure of any such record or any parts thereof, if disclosure is required or permitted under the Texas Freedom of Information Act or otherwise by law. **A blanket statement of confidentiality or the marking of each page of the proposal as confidential shall not be deemed sufficient notice of exception. The Proposer(s) must specifically label only those provisions of the proposal which are "Trade Secrets," "Confidential," or "Proprietary" in nature.**

Proposal Format

All proposals must be written in English and assembled into one volume in the format and order described below. **The City may reject any proposal submitted that fails to adhere to this format.**

Cover Letter and Formatting

1. Submit **one original cover letter** signed in blue ink with the proposal on agency letterhead. Address the cover letter to:

Marlene McNeese-Ward, Bureau Chief
Bureau of HIV/STD Prevention
Houston Department of Health and Human Services
8000 N. Stadium Drive, 5th Floor
Houston, TX 77054

The cover letter should include:

- (a) A statement that the proposal is submitted in response to the **"RFP for HIV/STD Prevention Services"**
- (b) The Category that the proposal is responding to and the amount of funding requested.
- (c) The geographic area where the applicant's headquarters are located and a listing of the geographic areas where services proposed herein will be provided.
- (d) The name, telephone number and FAX number of the agency's **contact person** for the RFP.
- (e) The signature of the agency's Executive Director, Chief Executive Officer, or other designee. (Note: The cover letter must be signed in blue ink.)

Do not include any additional information in the cover letter.

2. Complete the Proposals Information Form (page 61) and include it immediately after your cover letter. This form can be found in the forms section of the RFP.
3. Submit a complete application, **one single-sided original** and **seven (7) double-sided copies** of the original (including attachments), so that there are a **total of eight (8) copies** of the proposal available for review. Include a copy of the cover letter and Proposal Information form with each copy.
4. All material must be typewritten, single-spaced, with a font size of 12 points or 10 pitch on 8½” by 11” paper, with the 8½” ends of the paper as the top and bottom of the page (portrait orientation), and 1” margins, excluding headers and footers. The budget and the scope of work are the only exceptions, which can be printed in landscape orientation.
5. The narrative must be **no more** than 9 pages (excluding executive summary, budget, scope of work and attachments). Suggested page limits for each section are provided under the “Narrative Format” below. These are intended solely as guidelines for the development of the proposal. **Narrative beyond the 9-page limit will not be read.**
6. Number each page sequentially following the cover letter, including appendices and attachments, and provide a complete Table of Contents to the application and its attachments. Label each section clearly.
7. Do not bind the original proposal. Use a rubber band or binder clip to keep the pages of the original proposal together. Staple the seven (7) copies. If the thickness of the copies prohibits stapling, please use an appropriately sized binder clip. **Do not professionally bind** (e.g., spiral binding) the original or copies of the proposal.
8. If this proposal is a collaborative response from more than one agency/organization, answers to the following questions should address all agencies.

Executive Summary (1 - 2 pages)

The Executive Summary shall condense and highlight the contents of the Proposal to provide the HDHHS with a broad understanding of the agency, qualifications, proposed activities and funding requested.

Narrative Format

Applicants must complete all sections of the proposal as outlined below. Be complete and specific in your responses. Number the narrative to correspond to each of the required elements in the same order as presented below. Do not leave any element blank.

Section 1: Organizational Information (2 pages).....Maximum Score: 150 points

1. Describe the history of your organization including your mission and/or purpose statement. Include prior history or work with the City or other public agencies. What are the services you currently provide? How do the proposed services promote your organization’s mission? How do the proposed services relate to the services currently provided by your organization?
2. Describe your capacity to deliver HIV/STD Prevention Services consistent with the HDHHS and CPG priorities. Specifically, describe your experience with developing science-based and behavior theory-based prevention interventions and related curricula.

What collaborations/relationships with other organizations will you establish to address any gaps in experience?

3. Describe your agency's involvement and participation in the HIV prevention community planning process.

Section 2: Statement of Need (1 page).....Maximum Score: 150 points

CATEGORY 1 – 5 ONLY:

1. Describe the behavioral risk group targeted for these services or the population that will benefit from the implementation of the proposed service. What are the specific HIV prevention needs of the targeted behavioral risk group as it relates to the proposed service? What process did you use to assess these needs?
2. What similar or related services are currently in place to address the prevention needs you have identified and intend to address? Describe your relationship with other organizations who are working to address these prevention needs? How will you collaborate with these organizations to maximize the availability of services for the target population while avoiding the duplication of services? Attach forms documenting these collaborations or coordination strategies.
3. How will your proposed services contribute to facilitating access and retention in prevention services for the behavioral risk group? How will your proposed program result in greater access to prevention services, including HIV counseling, testing and referral services?
4. What are the barriers or factors that contribute to the needs described in your answer to question 1? What other barriers or issues exist that may prevent the behavioral risk group from accessing HIV/STD Prevention Services? How will your proposed program reduce these barriers? How will you coordinate activities with other providers to overcome these barriers?

CATEGORY 6 ONLY:

1. Describe the program design, program evaluation and capacity building needs of City of Houston HIV prevention providers. How have you assessed these needs?
2. Describe your experience developing and evaluating behavior-change theory based HIV prevention interventions.
3. Describe the benefits of program evaluation including its impact on ongoing HIV prevention programming and how you will contribute to countywide HIV prevention evaluation efforts.

Section 3: Program Design (4 pages).....Maximum Score: 400 points

CATEGORY 1 – 5 ONLY:

1. Describe the behavior(s) you intend to modify or impact and list and describe the intervention(s) you plan to implement. Describe your follow-up plan. Describe why the proposed intervention was chosen for the population you intend to serve.

2. Describe the proposed program activities and describe the specific outcomes and outcome measures for each intervention. Describe your plan to measure the CDC program indicators.

Complete the SOW Form to specify the program objectives, implementation activities, timelines, and the evaluation activities necessary to achieve the stated goals and objectives of the program (the SOW Form will not count towards the specified page limit). Include the number of **unduplicated** individuals you plan to reach for each intervention and outcome. (Please note that the scope of work should reflect all the significant activities described in your narrative and only the interventions described in this RFP will be considered.)

3. Describe the type of evidence you used to support your proposed program.
4. Describe which behavioral theory you will use in the design of your program.
5. Describe the staffing pattern of the proposed program. Indicate how many full time equivalent (FTE) employees will implement each intervention and the staff qualifications for these positions. Describe your employee recruitment and retention strategy.
6. How will you ensure that HIV/STD Prevention Services are available to those persons who most need the service? Describe how your organization will promote the availability of the proposed services.

CATEGORY 6 ONLY:

1. Describe your plan to assess the effectiveness of HDHHS-funded HIV prevention interventions.
2. Describe the proposed program technical assistance, evaluation and capacity building activities and describe the specific outcomes and outcome measures for each intervention. Describe your plan to ensure measurement of the CDC program indicators.
3. Complete the SOW Form to specify the program objectives, implementation activities, timelines, and the evaluation activities necessary to achieve the stated goals and objectives of the technical assistance and evaluation program (the SOW Form will not count towards the specified page limit).
4. Describe the staffing pattern of the proposed program. Describe your plan to hire two (2) full time equivalent (FTE) behavioral scientists/evaluation specialists (Masters-level and above) and the qualifications for these positions. Describe your employee recruitment and retention strategy.
5. How will you ensure that HIV prevention technical assistance, evaluation and capacity building services are available to those programs who most need the service? Describe how your organization will promote the availability of the proposed services.

Section 4: Evaluation/Quality Management Section (2 pages).....Maximum Score: 150 points

CATEGORY 1 – 5 ONLY:

1. Write a brief narrative on the evaluation of a similar or identical intervention you have previously implemented. Include both quantitative and qualitative data to support successes and challenges of process and outcome monitoring.

2. How will you use evaluation information and client feedback, including through the use of a “consumer advisory committee,” to modify and/or improve your services?
3. How will you communicate and disseminate information on “lessons learned” to the behavioral risk group, the HDHHS, the HIV Prevention Community Planning Group and your local provider network?
4. Describe your organization’s capacity to use HDHHS’ data management systems and your staffing plan to meet data management requirements.
5. How will you ensure that the data submitted to the HDHHS are accurate, complete and submitted in a timely manner?
6. Who will be designated to work with HDHHS-identified behavioral scientists/evaluation specialists? How are you planning to structure this collaborative relationship within your organization to ensure maximization of behavioral science and evaluation expertise?

CATEGORY 6 ONLY:

1. Write a brief narrative on how you have evaluated the delivery of technical assistance in the past. Include both quantitative and qualitative data to support successes and challenges of process and outcome monitoring.
2. How will you use evaluation information and provider feedback, including through the use of a “provider advisory committee,” to modify and/or improve your services?
3. How will you communicate and disseminate information on “lessons learned” to the providers, the HDHHS, and the HIV Prevention Community Planning Group?
4. How will you ensure that the data submitted to the HDHHS are uniform or common across programs, accurate, complete and submitted in a timely manner?
5. Describe how you plan to work with HDHHS monitoring and evaluation staff, and how will your relationships with providers be structured to ensure maximization of behavioral science and evaluation expertise?

Section 5: Budget (no page limit).....Maximum Score: 150 points

Complete the attached Budget Forms, **as applicable**, and include a narrative justification. Prepare a 12-month budget. Budget must not exceed funding availability as described in this RFP. The budget and budget justification submitted with this proposal should reflect all the significant activities described in the narrative and scope of work for a twelve-month period.

Budget form attachments are as follows:

- **Budget Form B-1 (Proposed Service Category Funding) (Form 2)**
 - **Budget Form B-2 (Proposed Personnel Schedule) (Form 3)**
 - **Budget Form B-3 (Proposed Service Description) (Form 4)**
- Note: Except Proposers in Service Categories 5 and 6*
- **Budget Form B-4 (Proposed Budget Justification (Form 5)**

**Information included in proposals beyond the page limits will not be reviewed.
Review panels may reject any proposal deemed too difficult to read.**

Attachments/Required Documents (no page limit)

Please submit the following documents with your proposal in the following order. These documents should follow the budget and budget justification forms in the order listed below.

- **Scope of Work (Form 6)**
The scope of work must reflect all program components described in the application narrative and be consistent with the Statement of Work included in this RFP. Agencies must ensure that the scope of work includes all activities necessary for the successful implementation of the proposed services if awarded funding.
- **Authorized Signatures (Form 7)**
- **Lobbyist Certification for Non-Profit Organizations (Form 8)**
- **Indemnification and Release Statement (Form 9)**
- **Minority, Women, Disadvantaged Business Enterprise Program Requirements (Form 10)**
- **Drug Detection and Deterrence Policy (Form 11)**
- **Campaign Finance Ordinance Submission List (Form 12)**
- **Affidavit of Ownership or Control (Form 13)**
- **Equal Employment Opportunity (EEO) Certification (Form 14)**
Proposer must comply with EEO laws, regulations and policies.
- **Performance Standards and Sanctions (Form 15)**
- **Documentation, Reporting and Evaluation Acknowledgement (Form 16)**
- **Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion for Covered Contracts and Grants (Form 17)**
- **Conflict of Interest Questionnaire (Form 18)**
- **Identification of Consultants and/or Volunteers (Form 19)**
- **Intent to Enter into Memorandum(a) of Agreement, Bilateral Service Agreements and Letters of Support/Reference (Forms 20 and 21)**
- **Services Funding (Form 22)**
- **Prospective Contractor References (Form 23)**
Proposer must complete and submit with Proposal. References listed here should be able to verify proposers minimum requirements for this RFP.
- **Prospective Contractor Public Entity Reference List (Form 24)**
Proposer must complete and submit with Proposal. References listed here should be able to verify proposers past performance.

Financial Stability Documentation

In addition to the above-mentioned documents, please submit two (2) sets of Financial Stability Documentation along with the proposal. **NOTE:** Governmental agencies (County facilities and programs, a department or agency of a City, a School District, or a State supported college or university) are **NOT** required to submit this documentation.

Each private (not-for-profit) proposing agency must provide documentation that it can carry the costs of its proposed program without reimbursement from the resulting contract for at least 90

days at any point during the term of the contract. Such documentation includes the following items:

1. Most current independent audited financial statements completed by a CPA, and
2. Current Financial Statements, and
3. Current Operating Budget, and
4. Prior Year Line-Item Operating Actual Cost Report, and
5. Signed statement from the agency's financial institution (bank) stating that the agency can carry the costs of the proposed program for at least 90 days at any point during the term of the contract, with the name and phone number of an individual who may be contacted for verification.

Submission Instructions

In a sealed package plainly marked in the upper left-hand corner with the name and return address of the Proposer, submit one (1) single-sided, unbound original and seven (7) complete (including all attachments and a copy of the cover letter and financial documentation), stapled, double-sided copies of the proposal (for a total of eight (8) copies). Note the contents on the outside of the envelope as:

**RFP for HIV/STD PREVENTION SERVICES
Houston Department of Health and Human Services**

The City Secretary's Office must receive all proposals and all required supporting documentation absolutely no later than: **Friday, December 8, 2006, 2:00 P.M. (Central Standard Time)**.
Late proposals will not be accepted.

Proposals should be hand-delivered or mailed to:

**City Secretary's Office
City Hall Annex, Public Level
900 Bagby
Houston, TX 77002
ATTN: Beau J. Mitts, MPH
Program Manager, HIV/STD Prevention**

It is the sole responsibility of the submitting Proposer to ensure that its proposal is received before the submission deadline. Submitting Proposers shall bear all risks associated with delays in delivery by any person or entity, including the U.S Mail. Any proposals received after the scheduled closing time for receipt of proposals will be returned to the sender unopened. Timely hand-delivered proposals are acceptable. No faxed or e-mailed copies will be accepted.

****FAXED OR EMAILED PROPOSALS
WILL NOT BE ACCEPTED****

Please be advised that the City Hall Annex Building, where the City Secretary's Office is located, has security screening that may cause delays when submitting proposals. No proposals, amendments, and/or addenda will be accepted after this deadline, and no extensions will be granted for any reason.

PLEASE ALLOW ADEQUATE TIME FOR DELIVERY.

X. General Provisions

Use of Funds

Funds provided under this announcement must support activities directly related to primary HIV/STD prevention; however, intervention activities, which involve preventing other STDs or substance abuse as a means of reducing or eliminating the risk of HIV transmission, may also be supported. No funds will be provided for direct patient medical care (including substance abuse treatment, medical treatment, or medications) or research.

Applicants may contract with other organizations under this cooperative agreement; however, applicants must perform a substantial portion of the activities (including program management and operations and delivery of prevention services) for which funds are requested. Applications requesting funds to support only administrative and managerial functions will not be accepted.

The contractual agreement will be with the City of Houston, therefore, all city requirements related to each contractual agreement will be applicable during each contract period.

Funds are awarded for a specifically defined purpose and may not be used for any other project.

1. Allowable Use of Funds

Grant funds may be used for personnel, fringe benefits, staff travel, equipment, supplies, contractual services, other direct costs, and indirect costs. Equipment purchases are allowed if justified and approved in advance.

2. Program Income

Funds are provided to allow provision of services to clients free of charge. Proposers must ensure that fees are not collected for any funded activity.

3. Disallowances

Funds received under this RFP may not be used to:

- Supplant local or state funds;
- Make cash payments to intended recipients of services;
- Acquire real property, building construction, alterations, renovations, or other capital improvements;
- Duplicate services already available or funded by other sources.

Notice of Grant Award

Issuing this RFP does not commit the City of Houston to award a contract in response to this request, or to procure, contract, or reimburse for expenses related to this proposal, nor does it guarantee a contract to any proposer. The Houston Department of Health and Human Services reserves the right to accept or reject any or all proposals received as a result of this RFP process; to negotiate with all qualified applicants; to cancel in part or in its entirety, the RFP, if this cancellation is in the best interest of the Houston Department of Health and Human Services.

Contract Negotiations

Successful applicants will receive a notice to negotiate for provisions of service. The applicant may then negotiate with the Houston Department of Health and Human Services for provision of services. Only a fully executed contract is binding. In the event that services are initiated prior to the processing of a fully executed contract (one signed by all parties), such services will be deemed to be gratuitously provided without guarantee of compensation.

Award Letter

Accompanying the Award Letter will be the proposed contract document, including programmatic, administrative and compliance requirements for review and signature by officials of the proposing agency. Once the contract is approved by City Council, it may be circulated to secure remaining signatures. After all necessary signatures are obtained, a copy is returned to the grantee by the Bureau of HIV/STD Prevention. **Only after the contract is fully executed (properly signed by all parties) may services be eligible for reimbursement.**

Monitoring and Evaluation

The contractor's efficient and effective performance under the contract will be monitored both qualitatively and quantitatively based on program reports submitted, quarterly site visits and program evaluations. Monthly service unit utilization will be monitored along with the corresponding monthly supporting documentation, which must be attached to the monthly invoice to the HDHHS. Program reports documenting the number of programs evaluated, persons served, locations of activities, age, sex, and ethnic backgrounds of program participants must be submitted to the Bureau of HIV/STD Prevention as required. The HDHHS maintains the rights to change, alter, modify or otherwise replace forms during the contract period if it is deemed appropriate to maintain the proper reporting and data collection.

Applicable Laws

Any contract executed from this RFP is subject to all laws of the State of Texas, the charter and ordinances of the City of Houston, the laws of the federal government of the United States of America and all rules and regulations of any regulatory body or officer having jurisdiction over these funds.

Publications/Confidentiality

As applicable, the applicant shall protect the confidentiality of the data as required by grant award, state law, and HDHHS project procedures. Confidentiality of individual information, records, and files shall be maintained and only aggregate data released, without personal identifying information. The HDHHS shall be the depository of all documents, files, and records collected (including electronically stored information) as a result of any contracts and shall conduct and coordinate the release, presentation, and publication of all such information and data.

Importance of Proposal Content

The contents of successful proposals may be contractual obligations. The proposer must be prepared to accept those obligations for any activities described within the proposal.

Contractor Responsibilities

The contractor will be required to assume full responsibility for all services specified in the contract. The contractor will be required to note on all printed material and state in each educational presentation the source of program funding.

XI. HDHHS Bureau of HIV/STD Prevention Requirements

Program Materials

All surveys, assessment tools, reports, brochures, pamphlets, videotapes, curricula, newsletters and other materials to be developed with these funds must be submitted to the HDHHS for review and approval thirty (30) days prior to utilization and before costs will be reimbursed.

Intervention Documentation

Outreach

A client and/or session file is expected on every outreach session performed, and at a minimum, should include the information listed below. This information is expected only on clients that have been engaged and have been referred for services.

1. Date of Encounter
2. Location, including address or cross street and zip code
3. Client Name, identification number, or unique identifier
4. Age
5. Race/Ethnicity
6. Sex and Gender
7. Behavior Risk Group
8. Contact Information (Phone number at minimum, also includes address, email address, etc.)
9. Contact (Follow-Up) Method Preferred
10. Type and number of referrals given (enough information to be able to follow-up and determine whether a linkage was made, i.e. did client show up for service?)
11. Documentation of linkage, if available
12. Documentation of individual educational materials distributed, if any
13. Documentation of individual incentives distributed, if any

Individual-Level Interventions (ILI)

A client file is expected on every ILI performed, and at a minimum, should include the following:

1. Date of Encounter
2. Location, including address or cross street and zip code
3. Client Name
4. Date of Birth and Age
5. Race/Ethnicity
6. Sex and Gender
7. Behavior Risk Group
8. Contact Information (Phone number at minimum, also includes address, email address, etc.)
9. Contact (Follow-Up) Method Preferred
10. Type and number of referrals given (enough information to be able to follow-up and determine whether a linkage was made, i.e. did client show up for service?)
11. Documentation of linkage, if available
12. Documentation of individual educational materials distributed, if any
13. Documentation of individual incentives distributed, if any
14. Case notes, such as:
 - a. Risk Reduction Step(s)
 - b. What could deter you from getting to follow-up or referral? (Need baby sitter, no food, no clothing, need money to buy meds, drug use/abuse issues...)

Group-Level Interventions (GLI)

A client and/or session file is expected on every GLI performed, and at a minimum, should include the following:

1. Date of Encounter and Session Number
2. Required Number of Sessions
3. Location, including address or cross street and zip code
4. Sign-in Sheet or individual registration forms including the following:
 - a. Client Name, identification number, or unique identifier
 - b. Age
 - c. Race/Ethnicity
 - d. Sex and Gender
 - e. Behavior Risk Group
 - f. Contact Information (Phone number at minimum, also includes address, email address, etc.)
 - g. Contact (Follow-Up) Method Preferred
5. Written Pre-test
6. Written Post-Test
7. Documentation of Curriculum Used
8. Documentation of individual educational materials distributed, if any
9. Documentation of individual incentives distributed, if any

At the end of all GLI sessions, agencies are encouraged to allow time for ILIs. These ILIs can be used for further in-depth discussion as well as a referral mechanism. It will be important to have more than one person available for these ILI sessions. Ensure that clients have appropriate and correct agency contact information for later follow-up.

Counseling, Testing and Referral Services

A client file is expected on each individual receiving CTR services (repeat testers are expected to be in one file), and at a minimum, should include the following:

1. Date of Encounter
2. Location, including address or cross street and zip code
3. Client Name, identification number, or unique identifier
4. Date of Birth and Age
5. Race/Ethnicity
6. Sex and Gender
7. Behavior Risk Group
8. Contact Information (Phone number at minimum, also includes address, email address, etc.)
9. Contact (Follow-Up) Method Preferred
10. Type and number of referrals given (enough information to be able to follow-up and determine whether a linkage was made, i.e. did client show up for service?)
11. Documentation of linkage, if available
12. Documentation of individual educational materials distributed, if any
13. Documentation of individual incentives distributed, if any

With the inception of Protocol Based Counseling (PBC), agencies are encouraged to use the tools (forms) included in the PBC manual to capture all the data/information required for CTR. These tools can be downloaded at <http://www.dshs.state.tx.us/hivstd/training/pctools.shtm>.

Comprehensive Risk Counseling Services

A client file is expected on each individual receiving CRCS, and at a minimum, should include the following:

1. Name of Client
2. Copy of Valid Identification
3. Date of Birth and Age
4. Sex and Gender
5. Race/Ethnicity
6. Contact Information (Phone number at minimum, also includes address, email address, etc.)
7. Contact (Follow-Up) Method Preferred
8. Case notes, including:
 - a. Dates of Service Enrollment, Encounters and Discharge
 - b. Clients Behavioral Risk Group
 - c. Completed Client Needs Assessment
 - d. Completed Risk Reduction Plan
 - e. Type and number of referrals given (enough information to be able to follow-up and determine whether a linkage was made, i.e. did client show up for service?)
 - f. Documentation of linkage, if available
 - g. Contacts Attempted
 - h. Documentation of individual educational materials distributed, if any
 - i. Documentation of individual incentives distributed, if any
9. Signed/Dated CRCS Agreement and Grievance Forms
10. Evidence of Supervisory Chart Reviews

Quality Management Plan

If awarded funding as a result of this RFP, contractors shall be required to develop and submit to the HDHHS within ninety (90) days of the execution of this Agreement a written Quality Management (QM) plan. The QM plan shall describe the process for continually assessing the Contractor's program effectiveness in accomplishing contractor mission, goals, and objectives. The plan shall describe the process for the following components: QM Committee, Written Policies and Procedures, Client Feedback, Program Staff, Measurable Program/Service Quality Indicators, QM Plan Implementation, and Quality Assessment and Management Reports.

- A. Quality Management Committee: The QM Committee shall develop, review, and revise the agency's QM plan on an annual basis. In addition, the QM Committee shall continually assess and make recommendations regarding the improvement of program services. It shall, at a minimum, be responsible for developing plans of corrective action for identified program deficiencies, discussing and acting upon process and outcome data results, and results from client feedback. The Committee shall consist of persons representative of the program and agency such as clients, volunteers, program staff, management, consultants and others (e.g., staff from other community-based organizations). The project coordinator(s) under this contract must be included as a Committee member. Committee membership shall be described, at a minimum, by title and role, and the constituency represented (i.e., staff, management, client). The Contractor shall review the Committee recommendations and ensure recommendations are appropriately implemented.

A separate Committee need not be created if the contracted program has established an advisory committee or the like, so long as its composition and activities conform to the criteria described in this Agreement.

The QM Committee activities shall be documented. Required documentation shall include but not be limited to agendas, sign-in sheets, QM Committee meeting minutes (including date, time, topics discussed, recommendations, and corrective actions).

- B. Written Policies and Procedures: The QM plan shall describe the process for reviewing and modifying written policies and procedures. In addition, the plan shall specify that policies be reviewed at a minimum of once a year, approved and signed by the Executive Director or designee. Policies and procedures shall be based on essential program activities and scopes of work specific to this contract. Written policies and procedures shall be maintained in a manual and available for review at the time of a monitoring review.
- C. Client Feedback: The QM plan shall include a mechanism for obtaining ongoing feedback from program participants regarding program effectiveness, accessibility, and client satisfaction. Describe the method(s) to be used for client feedback (e.g., satisfaction surveys, focus groups, interviews, etc.). Client feedback shall be collected on an ongoing basis or at a minimum of semi-annually. Describe how client feedback data will be managed by the QM Committee and used to make improvements to the program.
- D. Program Staff: The QM plan shall describe the process for developing, training and monitoring staff performance. The QM plan shall specify that staff are evaluated annually.
- E. Measurable Program/Service Quality Indicators: Indicators are intended to measure: 1) Process – How well the services are being provided, and 2) Outcome – The benefits or other results for clients that may occur during or after program participation. By developing a set of indicators specific to each program, establishing a measurable minimum standard for each indicator, and conducting an assessment on the extent to which the indicator is met, the Contractor shall assess the quality of service delivery on an ongoing basis.

The QM Committee is responsible for developing and shall describe in its minutes, a plan of corrective action to address indicators that are marginally met and describe how the results of the measurable data will be used to improve services. Process and outcome indicators shall be developed based on key activities described in the SERVICES TO BE PROVIDED Paragraph of this Exhibit. The QM plan shall require measurement of and include at a minimum the following measurable program indicators/outcomes listed in the “Program Description” section of this RFP.

- F. QM Plan Implementation: Contractor shall implement its QM plan to ensure the quality of the services provided are assessed and improved on a continuous basis.
- G. QM Summary Reports: The QM plan shall include the requirement for two (2) brief and concise QM Summary Reports: Mid-Year and Year-End. These reports shall be developed by the QM Committee and signed by the Executive Director. The following reports shall be made available to the HDHHS Program Manager at the time of monitoring review or upon request by the HDHHS:
 - 1) Mid-Year QM Summary Report shall, at a minimum, document:
 - Areas of concern identified by the QM Committee;
 - Program performance;
 - Results of process and outcome measures;
 - Data collected from client feedback; and
 - Results of plans of corrective action.

- 2) Year-End QM Summary Report shall, at minimum, document:
- Outcomes of implementing plans of corrective action for the previous six months; and
 - Overall QM program performance.

Progress Reports

Contractors are required to submit quarterly progress reports that include a summary of the agency's information and services provided; demographic information about clients receiving services; detailed information about performance towards program goals and objectives; and a narrative description of performance accomplishments, challenges, strategies for addressing challenges and progress on outcome data collection.

Quarterly Reports: The Contractor shall submit a signed quarterly progress report for services provided within **fifteen (15) business days** after the end of each quarter. The reports shall clearly reflect all required information as specified on the quarterly report form and be transmitted, mailed, or delivered to Houston Department of Health and Human Services, Bureau of HIV/STD Prevention, 8000 N. Stadium Drive, 5th Floor, Houston, Texas 77054.

Annual Reports: As directed by the HDHHS, the contractor shall submit to the Bureau of HIV/STD Prevention an annual report within **thirty-days (30)** of term end.

Financial Reports

Contractors are required to submit invoices on a monthly basis and an annual cost report. In addition, a copy of the monthly supporting documentation must accompany all monthly invoices, clearly stating or identifying the HDHHS HIV/STD Prevention Program. Payment will not be considered without timely submission of required Progress Reports or any other required documents.

XII. Proposal Review

Review Process and Evaluation Criteria

The City reserves the sole right to judge the contents of the proposals submitted pursuant to this RFP and to review, evaluate and select the successful proposal(s). The selection process will begin with receipt of proposals on December 8, 2006.

Evaluation of the proposals will be made by an Evaluation Committee/Review Panel (Committee) selected by the HDHHS. The Committee will evaluate the proposals and will use the evaluation approach described herein to make recommendations for selecting a prospective Contractor(s).

After the prospective Contractor(s) has been recommended for the awarding of a contract, the HDHHS and the prospective Contractor(s) will negotiate a Contract for submission to the City Council for its consideration and possible approval. If a satisfactory Contract cannot be negotiated, the City may, at its sole discretion, begin contract negotiations with the next qualified Proposer who submitted a proposal, as determined by the City.

Phase I: Evaluation of Required Components (Internal Review)

The purpose of this phase of the review process is to determine if the Proposal contains all of the information requested in the RFP and to determine if the Proposer meets the Minimum Eligibility Requirements outlined in the RFP. The Proposal must pass this review phase prior to

being evaluated by the Review Panel. Failure to include required components is grounds to disqualify the proposal from further review, which shall be at the sole discretion of the City.

GROUND FOR DISQUALIFICATION

- a. The application is received after the deadline set forth in this RFP.
- b. Failure of the applicant to complete, sign, and return all required forms, documents, and attachments, as instructed in this RFP.
- c. Failure to meet format or procedural submission requirements.
- d. Applicant provides inaccurate, false, or misleading information or statements. (The evaluation and determination of this requirement will be in the City’s sole judgment and its judgment shall be final. Applicants acknowledge with the submission of this proposal that all the information in the proposal is true and accurate.)
- e. Applicant supplies cost information that is conditional, incomplete, or contains any unsigned material alterations or irregularities.
- f. Applicant does not meet the minimum eligibility requirements set forth in this RFP.
- g. Proposer is debarred from doing business with the City of Houston or any public entity within the last ten years.

Phase II: External Review Committee

Proposals that met the “Internal” review will be submitted to an external review committee. To avoid conflicts of interest in the review process, all committee members are required to sign a “No Conflict of Interest Certification by Evaluation Member” form. Prospective committee members must confirm that they do not, and will not, acquire any direct or indirect financial interest, rights, or benefits pursuant to any resultant agreement between the City of Houston and any of the proposers which respond to this RFP.

Committee members will independently rate and rank each Proposal according to the criteria described in the RFP. Each Proposal will be reviewed and scored based upon the adequacy and thoroughness of its response to the City’s needs and the RFP requirements. Five weighted evaluation criteria and their respective weights are shown below, including the maximum number of points possible. The final External Review Committee score will be the average of each committee member’s scores. Proposal scores may range from 0-1000 points. Only proposals receiving a score of 700 points or more will be reviewed in the next phase of the review process.

Category Maximum

Organizational Information.....	150 points
Statement of Need.....	150 points
Program Design	400 points
Evaluation/Quality Management	150 points
<u>Budget</u>	<u>150 points</u>
Total	1,000 points

Proposal Evaluation Criteria

The specific evaluation criteria used to score each responsive proposal will be as follows:

Organizational Information (Maximum Score: 150 points)

- Does the applicant describe their organizational history, structure (e.g., mission, purpose, infrastructure, and current services)? Do the proposed services promote the organization's mission and relate to the services currently provided by the organization?
- Does the applicant describe its capacity to deliver HIV/STD Prevention Services? Are these described services consistent with the HDHHS and CPG priorities? Does the applicant describe collaborations/relationships with other organizations to address any gaps in experience?
- Does the applicant describe the agency's involvement and participation in the HIV prevention community planning process?

Statement of Need (Maximum Score: 150 points)

CATEGORIES 1 – 5:

- Does the applicant describe the behavioral risk group(s) targeted for proposed services or the population that will benefit from the implementation of the proposed services? Does the applicant describe the specific HIV prevention needs of the targeted behavioral risk group as it relates to the proposed service? Does the applicant describe the process it used to assess these needs?
- Does the applicant describe similar or related services that are currently in place to address the prevention needs it identified and intends to address? Does the applicant describe its relationship with other organizations that are working to address these prevention needs? Does the applicant describe its plans to collaborate with these organizations to maximize the availability of services for the target population while avoiding the duplication of services? Did the applicant attach forms documenting these collaborations or coordination strategies?
- Did the applicant describe how proposed services will contribute to facilitating access and retention in prevention services for the targeted behavioral risk group? Did the applicant describe how the proposed program will result in greater access to prevention services, including HIV counseling, testing and referral services?
- Did the applicant describe the barriers or factors that contribute to the needs described in its answer to question one? What other barriers or issues exist that may prevent the behavioral risk group from accessing HIV/STD Prevention Services? Did the applicant describe how the proposed program will reduce these barriers and how it will coordinate activities with other providers to overcome these barriers?

CATEGORY 6 ONLY:

- Did the applicant describe the program design, program evaluation and capacity building needs of Houston/Harris County HIV prevention providers? Did the applicant describe how it has assessed these needs?
- Did the applicant describe its experience in developing and evaluating behavior-change theory-based HIV prevention interventions?

- Did the applicant describe the benefits of program evaluation including its impact on ongoing HIV prevention programming and how it will contribute to countywide HIV prevention evaluation efforts?

Program Design (Maximum Score: 400 points)

CATEGORIES 1 – 5:

- Did the applicant describe the behavior(s) it intends to modify or impact and list and describe the intervention(s) it plans to implement? Did the applicant describe its follow-up plan? Did the applicant describe why the proposed intervention was chosen for the population it intends to serve?
- Did the applicant describe the proposed program activities and describe the specific outcomes and outcome measures for each intervention? Did the applicant describe its plan to measure the CDC program indicators?
- Did the applicant complete the SOW Form to specify the program objectives, implementation activities, timelines, and the evaluation activities necessary to achieve the stated goals and objectives of the program? Did the SOW include the number of **unduplicated** individuals the applicant plans to reach for each intervention and outcome? Did the scope of work reflect all the significant activities described in the applicant’s narrative? Did the scope of work only reflect the interventions described in this RFP?
- Did the applicant describe the type of evidence it used to support the proposed program?
- Did the applicant describe the behavioral theory it plans to use in the design of its program?
- Did the applicant adequately describe the sites and/or locations at which services will be provided?
- Did the applicant describe the staffing pattern for the proposed program? Did the applicant indicate how many full time equivalent (FTE) employees will implement each intervention and the staff qualifications for these positions? Did the applicant describe its employee recruitment and retention strategy?
- Did the applicant describe how it will ensure that HIV/STD Prevention Services are available to those persons who most need the service? Did the applicant describe how its organization will promote the availability of the proposed services?

CATEGORY 6 ONLY:

- Did the applicant describe a plan to assess the effectiveness of HDHHS-funded HIV prevention interventions?
- Did the applicant describe the proposed program technical assistance and evaluation activities and the specific outcomes and outcome measures for each intervention? Did the applicant describe its plan to ensure measurement of the CDC program indicators?
- Did the applicant complete the SOW form to specify the program objectives, implementation activities, timelines, and the evaluation activities necessary to achieve the stated goals and objectives of the technical assistance and evaluation program?

- Did the applicant describe the staffing pattern for the proposed program? Did the applicant describe its plan to hire two (2) full-time equivalent (FTE) Masters-level or higher behavioral scientists/evaluation specialists and the qualifications for these positions? Did the applicant describe its employee recruitment and retention strategy?
- Did the applicant describe how it will ensure that HIV prevention technical assistance and evaluation services are available to those programs who most need the service? Did the applicant describe how its organization will promote the availability of the proposed services?

Evaluation and Quality Management (Maximum Score: 150 points)

CATEGORIES 1 – 5:

- Did the applicant provide a brief narrative on the evaluation of a similar or identical intervention it has previously implemented? Did the applicant include both quantitative and qualitative data to support successes and challenges of process and outcome monitoring?
- Did the applicant describe how it will use evaluation information and client feedback, including “consumer advisory committees,” to modify and/or improve its services?
- Did the applicant describe how it will communicate and disseminate information on “lessons learned” to the behavioral risk group, the HDHHS, and the HIV Prevention Community Planning Group?
- Did the applicant describe its organization’s capacity to use HDHHS’ data management systems and its staffing plan to meet data management requirements?
- Did the applicant describe how it will ensure that the data submitted to the HDHHS are accurate, complete and submitted in a timely manner?
- Did the applicant describe whom it will designate to work with HDHHS-identified behavioral scientists/evaluation specialists? Did the applicant describe how it is planning to structure this collaborative relationship within its organization to ensure maximization of behavioral science and evaluation expertise?

CATEGORY 6 ONLY:

- Did the applicant provide a brief narrative on how it has evaluated the delivery of technical assistance in the past? Did the applicant include both quantitative and qualitative data to support successes and challenges of process and outcome monitoring?
- Did the applicant describe how it will use evaluation information and provider feedback, including a “provider advisory committee,” to modify and/or improve its services?
- Did the applicant describe how it will communicate and disseminate information on “lessons learned” to the providers, the HDHHS, and the HIV Prevention Community Planning Group?
- Did the applicant describe how it will ensure that the data submitted to the HDHHS are uniform or common across programs, accurate, complete and submitted in a timely manner?

- Did the applicant describe how it plans to work with HDHHS monitoring and evaluation staff, and how it will structure its relationships with providers to ensure maximization of behavioral science and evaluation expertise?

Budget (Maximum Score: 150 points)

- Did the applicant complete all necessary Budget Forms?
- Did the applicant include a narrative justification for cost reimbursement budgets?
- Did the applicant prepare a 12-month budget? Did the budget not exceed funding availability as described in this RFP?
- Did the budget and budget justification submitted with the proposal reflect all the significant activities described in the narrative and scope of work for a twelve-month period?

Phase III: HDHHS Review and Ranking

The HDHHS will review proposals that pass the Review Committee phase and independently score each proposal based on:

- 1) each agency’s fiscal and administrative performance* (250 pts);
- 2) programmatic performance with City or other public agencies* (250 pts);
- 3) demonstrated capacity to implement proposed services based on past evaluations and reviews* (250 pts.); and
- 4) appropriate and valid collaborations necessary to implement the proposed services and create multiple access points within the proposed geographic areas (evaluated by verifying Letters of Intent to Enter into MOAs and Bilateral Service Agreements submitted with the proposal.) (250 pts).

The HDHHS will adapt and tailor for its use the United States Department of Health and Human Services - Centers for Disease Control and Prevention’s Health Department Review Form to facilitate this level of review and to ensure uniform assessment of bidders.

NOTE: The HDHHS will contact the references provided in **Form 23** to obtain this information. Agencies that have recent HDHHS contracts (contracted with the HDHHS within the last 3 years) should list the HDHHS as the first reference.

Scores from Phase 3 will be averaged with scores from Phase 2 resulting in the final proposal score. Only proposals receiving a score of 700 points or more will be considered for funding. Applications receiving a score of less than 700 points after this phase of the review will be considered technically deficient and will not be considered for funding. There is no guarantee that scoring above 700 will result in funding at the level requested or any funding level.

The HDHHS will place proposals in rank order of priority based upon the final review score, comments and funding recommendations made by the review committee.

XIII. Proposal Checklist

- One original cover letter on agency letterhead signed in blue ink plus seven (7) photocopies of the cover letter addressed to:

Marlene McNeese-Ward, Bureau Chief
Bureau of HIV/STD Prevention
Houston Department of Health and Human Services
8000 N. Stadium Drive, 5th Floor
Houston, TX 77054

- Specifies the name of the RFP as well as the service category
 - Specifies the amount of funding requested and geographic area to be served
 - Identifies agency contact person, telephone, and FAX numbers
 - Signed by Executive Director, CEO, or designated Board member
- Completed "Proposals Information Form." (Form 1)
 - Proof of Non-Profit Status
 - The original proposal, with appropriate signatures in blue ink, must be complete, held together with a rubber band or binder clip (not stapled), and single-sided. In addition, seven (7) photocopies of the original that are complete, stapled and double-sided, so that there are a total of eight (8) copies of the proposal available for review (include the cover letter with each copy). Proposal must include table of contents and page numbers on all pages following the cover letter.

Required Forms (submit in this order after the proposal narrative)

- Table of Contents
 - Budget Form B-1 (Proposed Service Category Funding) covering a 12-month period (Form 2)
 - Budget Form B-2 (Proposed Personnel Schedule) covering a 12-month period (Form 3)
 - Budget Form B-3 (Proposed Service Description) covering a 12-month period (Form 4) (*Except Proposers in Service Categories 5 and 6*)
 - Budget Form B-4 (Proposed Budget Justification) covering a 12-month period (Form 5)
 - Scope of Work (Form 6)
 - Authorized Signatures (Form 7)
 - Lobbying Certification for Non-Profit Organizations (Form 8)
 - Indemnification and Release Statement (Form 9)
 - Minority, Women, Disadvantaged Business Enterprise Program Requirements (Form 10)
 - Drug Detection and Deterrence (Form 11)
 - Campaign Finance Ordinance Submission List (Form 12)
 - Affidavit of Ownership or Control (Form 13)
 - Equal Employment Opportunity (Form 14)
 - Performance Standards and Sanctions (Form 15)
 - Documentation, Reporting and Evaluation Acknowledgement (Form 16)
 - Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion for Covered Contracts and Grants (Form 17)
 - Conflict of Interest Questionnaire (Form 18)
 - Identification of Consultants and/or Volunteers (Form 19)
 - Memorandum(a) of Agreement, Letters of Intent, Letters of Verification and/or Letters of Support (Forms 20 and 21)
 - Services Funding (Form 22)
 - Prospective Contractor References (Form 23)
 - Prospective Contractor Public Entity Reference List (Form 24)
- Proposers are required to submit Financial Stability Documentation attesting that the agency can carry the cost of the proposed program for 90 days (two (2) copies separately packaged).
 - Agency name and return address on envelope, addressed to City Secretary's Office, City Hall Annex, Public Level, ATTN:Beau J. Mitts, MPH, Program Manager, HIV/STD Prevention.
 - "RFP for HIV/STD Prevention Services – Houston Department of Health and Human Services" marked on envelopes.
 - Submitted to the City Secretary's Office before **2:00 PM Friday, December 8, 2006.**

NOTE: Please submit neat, readable, and error-free documents. Be sure that budget items add up to the total and are discussed in the accompanying Budget Justification narrative.

***** Faxed or Emailed proposals will not be accepted. *****