REQUEST FOR APPLICATIONS

LEVERAGING RETAIL HEALTH CLINICS FOR STI/HIV SERVICES AND CARE FOR UNDERSERVED MINORITIES

National Association of County and City Health Officials (NACCHO)

Release Date: March 31, 2022

Due Date: May 31, 2022*

***If this due date poses a problem for your jurisdiction, please reach out in advance of the deadline to discuss options.

For questions about the Request for Applications (RFA), contact Rebekah Horowitz, Senior Program Analyst, HIV, STI, & Viral Hepatitis, at rhorowitz@naccho.org.

SUMMARY INFORMATION

Project Title: LEVERAGING RETAIL HEALTH CLINICS FOR STI/HIV SERVICES AND CARE FOR UNDERSERVED MINORITIES
Proposal Due Date and Time: May 27, 2022, at 11:59pm
Selection Announcement Date: June 10, 2022
Source of Funding: Centers for Disease Control and Prevention, Division of STD Prevention
NOA Award No.: 6NU38OT000306-02-01
CFDA No.: 93.421—Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health
Maximum Funding Amount: $300,000 per site
Estimated Period of Performance: July 2022-July 2023

I. Overview

The National Association of County and City Health Officials (NACCHO) represents the nation's nearly 3,000 local health departments (LHDs), which work to protect and improve the health of all people and all communities. NACCHO's HIV, STI, and Viral Hepatitis program aims to strengthen the capacity of LHDs to prevent, control, and manage HIV, STIs, and hepatitis in their communities. NACCHO supports these efforts by providing technical and capacity building assistance, developing, and disseminating tools and resources, facilitating peer information exchange, and providing learning opportunities.

In the last 20 years, large retailers (drugstores, supermarkets) have capitalized on the consumerization of healthcare by placing walk-in clinics within their stores. Retail health clinics (also known as convenient care clinics; herein after RHCs) are defined as clinics located within a retail setting, primarily staffed by a nurse practitioner or physician's assistant (e.g., MinuteClinic), and provide affordable, accessible episodic care. In general, RHCs provide a limited range of diagnostic tests, vaccines, and treatments for minor illnesses and injuries. RHCs generally do not have on-site labs and lack capacity to provide long-term care. However, retail health clinics provide valued conveniences to consumers, with reduced costs, extended hours, walk-in service, and broad geographic reach. Many of these RHCs currently provide STI/HIV testing and diagnosis, and treatment for uncomplicated STI/HIV cases, and the pharmacies where many of these clinics are co-located dispense the medications used to treat common STIs, treat HIV, and provide PrEP.

This project will offer essential information about the development of expanded STI/HIV patient care provided in retail health clinic settings. The goal of this project is to explore the extent to which it is feasible for local health departments (LHDs) in Ending the HIV Epidemic (EHE) jurisdictions to leverage RHCs to expand the reach of their STI/HIV diagnosis and prevention services, especially for underserved racial/ethnic and sexual minorities, including young people. To establish models of practice, NACCHO, with support from the Centers for Disease Control and Prevention (CDC) Division of STD Prevention (DSTDP) will fund 3-4 health departments up to $300,000 (per site) to develop, design, and implement a collaborative partnership with these entities to expand STI/HIV services and care. Findings will be shared broadly with STD and HIV programs across the country.

II. Problem Statement

CDC estimates that 1 in 5 people in the U.S. have a STI on any given day in 2018 and an estimated 34,800 new HIV infections occurred in the United States in 2019. Nearly half of newly acquired infections are among individuals aged 15-25 years. Frequently reported barriers to accessing timely STI/HIV care and treatment include inconvenient hours, long wait times, distance to clinic, and confidentiality/privacy concerns. New strategies are needed to increase access and improve convenience to quality sexual

healthcare. The STI National Strategic Plan (2021-2025) includes both RHCs and pharmacies among its strategies for STI prevention and control. The Plan highlights their role as non-traditional settings for scale-up of innovative STI service delivery models and in increasing screening and linkage to STI care. The HIV National Strategic Plan: A Roadmap to End the Epidemic for the United States (2021-2025) focuses on four key strategies that include: Diagnose, Treat, Prevent, and Respond to reduce new HIV infections in the United States. Partnerships with RHCs can provide new access points for STI/HIV services.

Retail Health Clinics

Today, there are an estimated 3,000 RHCs throughout the United States, located in 44 states and the District of Columbia, with more than 50% of the US population within a 10-minute drive of an RHC. RHC operators are commonly found in convenient locations such as drugstores, food stores, and other retail settings. RHCs record approximately 50 million patients, annually. Clinics are generally open seven days a week, with extended weekday hours, appointments are not necessary, and visits take 15-20 minutes with usual wait times less than 10-minutes. Most RHC visits are walk-ins with two-thirds of patients reporting not having a primary care provider (PCP). Young and middle-aged adults are among the most seen (ages 18-44). Some research suggests that patients choose retail clinics over traditional PCPs because of difficulty accessing PCPs and the appeal of lower costs. Clinics generally see patients within a 15–20-minute window.

RHCs are primarily staffed by highly qualified advanced practice nurses, including nurse practitioners, as well as by physician assistants. Many STI conditions can be fully evaluated and treated within the retail health setting and those that cannot are referred to another provider for treatment. Large clinic chains have reported that the number of patients with STI conditions utilizing RHCs has more than doubled since 2012. Clinics provide comprehensive STI evaluation for patients and/or the partners of patients for conditions including bacterial vaginosis, chlamydia, gonorrhea, hepatitis, herpes, HIV/AIDS, human papillomavirus (HPV), pelvic inflammatory disease (PID), syphilis, trichomoniasis, and other STIs. Urine and swab tests are available, but STI testing via self-collection is not offered. The availability of 3-site testing is expanding, but not available everywhere due to limited capabilities. Some clinics can conduct a blood draw for HIV, syphilis, and Hepatitis B, but all blood testing is sent to a lab. Treatment capacity varies across clinics, but not all RHC can provide onsite treatment for gonorrhea, and fewer yet can do so for syphilis. For more complex cases, patients are referred out. Partner therapy is encouraged, but expedited partner therapy is not practiced – partners are physically required to come into the clinic. Some RHCs do have age restrictions that impact their ability to offer care to minors; many states require parental oversight to seek care.

RHCs are well-positioned with significant capacity to support and respond to the nation's STI epidemic, and EHE efforts. RHC leaders have expressed potential and desire to collaborate more closely with health departments on increased demand for STI services, referrals, and data information and sharing. There is also strong interest in the billing, cost-sharing, and expansion of 340B pricing to RHCs so their patients (especially those referred by health departments) can afford the treatment they need.

Need for Collaborative and Innovative STI Care Models

A variety of models for partnership are needed to examine these considerations and expand STI/HIV services and care in retail health clinic settings—looking at the variety of ways that LHDs and RHCs can partner to address communities' growing needs and their changes to healthcare consumption. Several scenarios/examples are set forth below, although these are not exhaustive.

Potential applicants are encouraged to think beyond these examples and submit innovative ideas for models that can be beneficial to STI programs, industry partners, and their communities. Applicants are also encouraged to pilot models in which they can continue to add services, evaluate outcomes, and adjust as needed over the course of the project.

Scenario 1: Health department A partners with RHC B to refer asymptomatic patients for STI services. The RHC could also consider piloting express services with self-collected specimens and/or 3-site testing. Deliverables/outcomes could include MOUs, standard operating procedures, protocols for delivery of result, cost-sharing, etc.

Scenario 2: RHC B is designated as a location for the community to go to start PrEP as part of the "Ready, Set, PrEP" program including express testing services with self-collected specimens and/or 3-site testing for on-going STI/HIV testing. Deliverables/outcomes could include data-sharing and MOUs with the LHD, standard operating procedures, protocols for delivery of results, cost-sharing, etc.

Scenario 3: RHC C wants to pilot the introduction of injectable STI antibiotics and explore training of NPs/PAs and partners with Health Department A for technical assistance, training, and to take on referrals. Deliverables/outcomes could include standard operating procedures and protocols for medication storage and administration and NP/PA education and training.

Scenario 4: A model focusing on coverage of costs and transference of 340B pricing or cost-sharing among RHCs. LHDs interested in partnering with a RHC, would need to establish a separate agreement between the LHD and the RHC(s)[1] and develop protocols for order receiving, record keeping, test result delivery, and reporting.

Scenario 5: RHC D pilots privacy-conserving telehealth approaches such as electronic assessments and Q&A, provision of results, and facilitated referrals for HIV patients in partnership with LHD—allowing patient to go to RHC for testing/treatment but having a telehealth appointment with PCP or LHD provider at the same time.

Scenario 6: Patient can do LHD's risk assessment and Q&A via computer/phone/tablet while waiting for testing/treatment in the RHC so that both entities are aware of patient needs and LHD can follow-up with partners, etc. without having to contact patient again. Partners with demonstrable proof of exposure (e.g., electronic, or hard copy notification document from the LHD) can receive testing and treatment services at the RHC, with disposition information provided to the LHD.

Scenario 7: LHD develops referral protocols for RHCs to initiate STI/HIV testing and treatment and expedite linkage/re-engagement to care for newly diagnosed and previously diagnosed patients with HIV. Protocols can include training on motivational interviewing, partner services, and community-based assistance programs referrals (ADAP) (if applicable).

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[1] As it stands, patients who have health insurance or Medicaid can seek services directly at a RHC but are not eligible for 340B drugs. However, if the patients are referred by a STD clinic provider and there is an auditable record of the referral in the STD clinic, this patient may be eligible for 340B drugs. For uninsured patients, cost sharing would need to be negotiated locally between the STD program and the clinic.

Other possibilities could include expansion of: STI and sexual health care training, STI services for patients under the age of 18 years, 3-site testing approaches, and EHRs and data sharing for enhanced continuity of care. Additionally, any scenario could, and likely should, include communications/marketing plans and materials as deliverables to increase demand for sexual health services at RHCs and reduction of stigma around accessing these services.

III. Objectives

Integration of sexual health services for underserved, and under-diagnosed, populations across RHC, health department, primary care, and other healthcare settings is the primary goal of this project. **This funding is only available to partnerships in Ending the HIV Epidemic (EHE) priority jurisdictions**. RHCs will serve as the access point for clients, providing them with rapid/self-collected HIV and STI tests, injectable antibiotics for STIs, and access to ART, nPEP, and PrEP. Further, RHCs may pilot privacy-conserving telehealth approaches such as electronic assessments and Q&A, provision of results, and facilitated referrals. LHDs and RHCs will work together to assure appropriate record-keeping and patient care as well as for outreach and marketing (including social marketing activities to facilitate service uptake by target population), and to establish/modify referral systems to easily link clients to resources for primary health care, insurance (e.g., ADAP), behavioral counseling, and treatment adherence, and to assure STI/HIV related data reporting.

At minimum, one of the following objectives must be a key objective in the development and implementation of the partnership models. The objectives of this project include, but are not limited to:

- Design and pilot a model for health departments and RHCs to collaborate to engage or re-engage people living with HIV into HIV care.
- Design and pilot a model for health departments and RHCs to collaborate to serve the community's needs for HIV and STI testing and treatment jointly. Examples would be the definition and piloting of referral systems for testing, treatment, or disease intervention/partner notification services in the RHC setting;
- Assess the feasibility of cross-organizational cost coverage and transference of 340B pricing as well as coordination of order receiving, record keeping, tracking system of 340B drugs, test result delivery, and reporting;
- Determine protocols and procedures necessary for stocking Penicillin G benzathine on site to treat syphilis patients and ceftriaxone to treat gonorrhea, including adequate refrigeration space for these injectables and training of staff on drug administration;
- Assess the ability to implement an STI express testing model with self-collected specimens (including extragenital testing) in the RHC setting;
- Assess ability of RHCs to provide STI care to those under 18 years old;
- Participation and collaboration on partner services approaches.

This is a demonstration and evaluation effort to identify replicable models and best practices for local health departments and RHCs/pharmacies to work together.

IV. Scope of Work and Requirements

This funding is open to local health departments (LHDs) that have at least one RHC with a committed interest in partnering to expand STI/HIV services in their jurisdiction.

The local health department must have the organizational and project management capacity over the project period to design and implement a model that creates a network between the RHC/pharmacy and the health department.

RHCs and LHDs will collaboratively plan for and implement some, or all, the following services:

- Onsite testing for HIV.
- Onsite testing and treatment for STI via rapid tests. Treatment must be concordant with CDC STD treatment guidelines published in the MMWR.
- Onsite treatment for HIV (i.e., ART) and/or facilitated referrals to treatment at a collaborating facility.
- Onsite or remote access to sexual health assessments to include assessment for PrEP, PEP, nPEP, and hepatitis vaccine eligibility, as well as provide each of these services.
- Onsite or remote access to substance use quick screen and provision of referral information for harm reduction/substance use services.
- Electronic patient follow-up and brief monitoring processes, such as phone/video follow-up appointments (as part of collaboration with primary care organizations) for those who are high-risk for falling out of care and/or newly engaged in care.

LHDs and RHCs will work collaboratively for the development/implementation of systems to:

- Provide referrals to cooperating healthcare partners for care not available in RHCs
- Support referral uptake (including training on motivational interviewing, etc.)
- Link persons with newly diagnosed HIV to HIV medical care and ART initiation within 30 days of diagnosis including connecting them to patient assistance programs/ADAP.
- Re-engage persons with previously diagnosed HIV into HIV medical care and ART when it is determined that the individuals are not currently in HIV medical care, within 30 days of the encounter.
- Establish online appointment scheduling for onsite services (if possible).

A letter of agreement between the LHD and the RHC detailing mutual roles and responsibilities under this partnership is required.

Applicants must demonstrate need by providing chlamydia, gonorrhea, and syphilis case counts and positivity rates among important populations in the jurisdiction (e.g., adolescents, racial/ethnic minorities, and sexual and/or gender minorities). Applicants must also note that they are in an Ending the HIV Epidemic (EHE) jurisdiction.

Expansion of STI services into retail health and pharmacies should reflect elements laid out in the CDC's *Recommendations for Providing Quality Sexually Transmitted Diseases Clinical Services, 2020 (STD QCS)*. Screening and treatment protocols should reflect guidelines/recommendations from the CDC STD Treatment Guidelines and/or USPSTF. RHCs can be designated as "Ready, Set, PrEP" locations and/or those offering HIV treatment should refer to the Learn About PrEP | Preventing New HIV Infections | Clinicians | HIV | CDC and Recommendations for HIV prevention with adults and adolescents with HIV in the United States, 2014 (amended December 2016) guidelines.

Applicants will have flexibility in how project approaches are designed and are encouraged to propose and apply approaches that are sustainable and can be expanded (scalable). Applicants may also consider innovative approaches to challenging issues, such as logistics or third-party/healthcare insurance reimbursement.

During the project period, awardees will:

- Ensure that relevant local stakeholders are aware of the project, engaged, and informed appropriately throughout the duration of the funding period.
- Finalize a partnership and implementation model and plan to leverage RHC/pharmacies for STD services and care.
- Finalize a plan to evaluate implementation of the project with process and outcome measures to answer the primary evaluation questions stated in Section V
- Implement the RHC/Pharmacy project and assess short-term outcomes proposed in implementation plan.
- Collaborate with NACCHO to collect, analyze, interpret, and synthesize findings.
- Collaborate with NACCHO during and post-project period to share ongoing lessons learned and findings through reports, conference abstracts, webinars, and limited 1:1 technical assistance with other areas interested in learning more about the approach and lessons learned.
- Participate in project conference calls as well as site visit(s) (virtual or in person) and any project dissemination meetings, as appropriate.
- Submit final project deliverables.

Summary of required project deliverables

- Final project model and implementation plan
- Final evaluation plan
- Clean summaries of all data collected based on evaluation plan
- A minimum of 3 progress reports summarizing project status, completed deliverables, and next steps
- Electronic copies of any materials developed to implement the model, including standard operating and reporting procedures, a referring patient and treatment algorithm, sample lab requisition forms, educational material for patients, promotional materials, training modules, sample MOUs, data sharing, cost sharing, and other legal agreements between the entities.
- Final report documenting methods, results, conclusions, and lessons learned. This also should include documentation of the partnership development process with a partnership logic model.

V. Evaluation Guidance and Requirements

The awardees will be expected to answer the following evaluation questions using scientific methods:

- How operationally feasible was it to improve or expand HIV and STI services/referrals in the RHC?
- What barriers and facilitators affected implementation?
- How feasible and successful was the partnership itself?
- To what extent will the partnership be sustained beyond the funding period?

Applicants should propose a basic evaluation design in their application. Applicants are encouraged to provide as much detail as possible in their applications to facilitate project timelines upon funding. Various types of data are needed to create a multi-dimensional description of feasibility, replicability, facilitators, and barriers. NACCHO and CDC are committed to working with funded jurisdictions to develop process and short-term outcomes with both quantitative and qualitative methods for the evaluation and provide support as otherwise needed.

Project measures could include, but are not limited to:

- Systems-level data – documentation of the partnership process:
    - Number of members, roles, and responsibilities
    - Partner participation rate
    - Proportion of partners engaged
    - Meetings and trainings held
    - Objectives met
    - Resources leveraged
    - Adopted or refined policies
- Intervention-level:
    - Number of referrals
    - Number screened
    - number of online appointments scheduled for onsite services/baseline comparison of online appointments scheduled
    - Number of sexual health assessments for PrEP, PEP, nPEP and hepatitis vaccine eligibility conducted/all eligible patients
    - Number of positive STI cases
    - Number of positive HIV cases
    - Number of self-collected swabs collected/all swabs collected
    - Number of 3 site tests conducted/all eligible patients
    - Number of STI positive individuals treated appropriately (including with injectable antibiotics)/positive STI tests
    - Number of positive STI tests/rapid STI tests completed
    - Number of STI cases successfully treated
    - Number of new HIV positive individuals identified/tests administered
    - Number of new HIV positive individuals initiating ART/new HIV positive individuals identified
    - Number of new PrEP starts
    - Duration between diagnosis and treatment
    - Number of trainings conducted
    - Staff experience with implementing the intervention
    - Lessons learned and opportunities for scalability
    - Number of electronic patient follow-up and brief monitoring processes as part of collaboration with primary care organizations for those who are high-risk for falling out of care/individuals with or newly diagnosed with HIV
    - Number of referrals to cooperating health care partners for care not available in RHCs/all eligible patients
    - Number of new HIV positive individuals linked to HIV care provider/new HIV positive individuals identified
    - Number of individuals with newly diagnosed HIV to HIV medical care and ART initiation within 30 days of diagnosis/new HIV positive individuals identified
    - Number of individuals previously diagnosed with HIV who are not engaged with HIV care who are re-engaged into HIV medical care and ART within 30 days of the encounter/all previously diagnosed individuals with HIV who are identified as having fallen out of care
    - Number of out-of-care HIV positive individuals linked to care/out-of-care HIV positive individuals identified
- Patient-level data:
    - Patient demographics
    - Patient sexual behavior

- HIV/STI history
- Reason for choosing RHC
- Assessment of patient satisfaction with the experience and likelihood of returning

Project deliverables/outcomes must include documentation and evaluation of the partnership process, including a partnership logic model as part of the final report. Any tools and materials developed to implement the project will also be required project deliverables. These may also include but are not limited to toolkits that describe standard operating and reporting procedures, a referring patient and treatment algorithm, sample lab requisition forms, educational material for patients, training modules, sample MOUs, data sharing, cost sharing, and other legal agreements between the entities.

VI. Support and Technical Assistance

NACCHO will provide ongoing support to awardees in the form of:

- Technical assistance via conference call and/or webinar to facilitate project planning, implementation, data collection and analysis, and reporting
- In-person and/or virtual site visits to observe the program model, review and discuss implementation plans and evaluation data, and provide technical assistance, as applicable
- Work with a training partner to develop appropriate trainings for RHC staff to enhance existing services and support new services. Training to include self-collection and 3-site testing for STI testing, access to ART/nPEP/PrEP, delivery of injectable antibiotics for STI (as indicated), and cultural competence training for working with underserved minorities
- Provide input and feedback on intervention protocols, workflows, work plan, and evaluation plan
- Analysis of reported data
- Provision of templates for interim and final reports and dissemination/summary products
- Coordination of dissemination back to recipients and to the broader community of STD programs

Additionally, NACCHO will develop resources and materials based on project findings to disseminate broadly to LHDs and other STI and retail health/pharmacy stakeholders across the country.

VII. Funding and Timeframe

Selected sites will be awarded up to $300,000 per site (depending on project budgets and the number of sites awarded funding) to design, pilot, and evaluate a collaborative model for providing STI and HIV services (testing, treatment, partner notification services) between a RHC and a health department. The selection of sites will be determined through demonstrated background need, location in an EHE jurisdiction, site capacity as described in their application, and feasibility of the proposed approach.

Funding should be used to support costs for personnel, training, educational materials, HIV/STI test kits, HIV/STI treatment, IT equipment, and contractual support for surveillance or public health information systems enhancements. Funds may be used to support a full-time employee with the organizational capacity to conduct and oversee program activities. Funding may not be used for research or clinical care (except as allowed by law) and generally, funding should not be used to purchase furniture and equipment. Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.

KEY DATES

EVENT	DATE
RFA RELEASE	MARCH 31, 2022
INFORMATIONAL WEBINAR FOR POTENTIAL APPLICANTS	APRIL 19, 2022
APPLICATION SUBMISSION DEADLINE	MAY 31, 2022
ANTICIPATED AWARD NOTIFICATION	JUNE 10, 2022
IMPLEMENTATION AND EVALUATION PERIOD	JULY 1, 2022-JULY 31, 2023
DISSEMINATION OF LESSONS LEARNED	YEAR FOLLOWING PROJECT PERIOD

VIII. Eligibility and Contract Terms

Eligible applications are the health department but must include a connection to at least one retail health clinic (including a memorandum of understanding or other formal agreement to work together) in addition to meeting criteria specified below in the selection criteria. The health department and retail health clinics must be in an EHE jurisdiction. See the Requirements section for additional information about eligibility.

Applicants should plan for approximately 12 months of project implementation. Projects will begin on the date of contract execution. NACCHO will pay the selected project areas upon receipt of deliverables per the payment schedule identified in the scope of work. Please note that NACCHO reserves the right to make changes to the project timeline and payment schedule if necessary. ***All projects must be completed by July 31, 2023.***

IX. Proposal Format

The application should be single-spaced and use Times New Roman 12-point font, not to exceed eight (8) pages in length, and should include the following sections in this order:

A. Cover page

B. Background and Need (~2 pages)

a. Describe your site population including an overview of your service area and community, number and socio-demographic description of clients seen/tested annually by the health department and any already seen in the RHC(s), and sociodemographic description of STI and HIV positivity and rates.
   i. Provide the chlamydia, gonorrhea, and syphilis case counts and positivity rates overall and among important populations (e.g., adolescents, racial/ethnic minorities, and sexual and/or gender minorities) for the past two years (pre-COVID and currently).
   ii. Note your EHE priority jurisdiction.

b. Describe the current STI and HIV services offered by the RHC and HD in the jurisdiction.

c. Describe the STI testing, treatment, and referral gaps and needs in your community that could be addressed by this joint initiative.

d. Describe the HIV testing, treatment, and referral gaps and needs in your community that could be addressed by this joint initiative.

e. Describe how will this project help eliminate health disparities in your community.

C. Project Design and Potential for Impact (~2 pages)

a. Scope of work with project goals, objectives, and proposed outcomes, including estimated timeline for deliverables and completion.

b. Describe how you propose to accomplish project objectives and any specific determinations about what patient population(s) you will reach may be included.
c. Describe how the current LHD-RHC relationship will change/expand because of this joint initiative.
d. Describe how your project aligns with recommendations set forth the in the CDC's STD QCS recommendations, PrEP Guidelines, and/or STD Treatment Guidelines.
e. Describe the potential for substantial positive impact on the need described in the RFA and whether the impact is likely to be long-term.

D. Capacity to Implement Project and Plans for Long-term sustainability (~1 pages)
a. Describe your experience with, and capacity for, managing and implementing this sort of project.
b. Describe plan to sustain these services after the project is completed.

E. Monitoring and Evaluation (~1 pages)
a. Describe plan to measure progress against stated project goals, objectives, and outcomes.

F. Key Staff and Partners (~1 pages)
a. Proposed key staff to manage the project overall, their role, and relevant experience
b. Proposed key staff to implement the project, their role, and relevant experience
c. Proposed key staff to evaluate the project, their role, and relevant experience
d. Description and relationship to any partners critical to implementing the innovation or improvement
    i. Include letter(s) of agreement between the LHD and the RHC(s) detailing mutual roles and responsibilities under this partnership (as an attachment)
e. Description and relationship to any partners critical to evaluating the innovation or improvement

G. Attachments - Required
a. Proposed budget with a separate budget narrative document (funding going to collaborating retail health clinic(s) must be highlighted)
b. Letters of support from any key partners critical to the project
c. Vendor Information Form
d. Certification of Non-Debarment
e. W-9
f. FFATA data collection form
g. Proof of an active registration with SAM.gov

H. Attachments – Optional
a. Resumes/CVs of Key Staff

The cover page, budget with justification, resumes/CVs, and other optional attachments do not count against the total page limit. All pages, charts, figures, tables, and any additional information/attachments should be numbered.

Before a contract can be entered, proof of active registration with SAM.gov in accordance with an active DUNS number must be obtained. Registration can be done here.

X. Selection Criteria

Applications will be reviewed and scored in accordance with the following criteria (out of 100 points):

- Evidence of need/burden – (10 points) [including what EHE jurisdiction the sites are in]

- Project design (ingenuity and feasibility of concept) – (30 points)
- Potential for impact (potential for substantial positive impact on the need described in the RFA and whether the impact is likely to be long-term) – (20 points)
- Jurisdictional capacity to implement the project (prior experience with, and capacity for, managing and implementing this sort of project) – (20 points)
- Monitoring and Evaluation – (10 points)
- Relevant experience of key staff/partners responsible for carrying out project activities – (10 points)

NACCHO reserves the right to award jurisdictions that do not have the highest raw score to account for factors such as geography or population size.

XI. Submission Instructions

The deadline to submit applications is **May 31, 2022,** by 11:59 PM Pacific Time (PT). If this deadline poses an issue, please reach out to discuss options. Proposals should be submitted as a single PDF in an email to rhorowitz@naccho.org with subject line: "LHD/RHC Partnership RFA." Budget and contracting documents may be separate attachments.

An informational webinar will be hosted for potential applicants on April 19th, 2-3PM ET. Please note that **advanced registration is required**. Click here to register. Questions may be submitted in advance to rhorowitz@naccho.org.

XII. Additional Information and Resources

- Convenient Care Association
- Retail Health Clinics and Sexual Health (NCSH and CCA Report)
- American Pharmacists Association
- National Community Pharmacists Association
- Methods and Resources for Engaging Pharmacy Partners
- Partnering with Pharmacies in the Prevention and Control of Chronic Diseases
- Pharmacist Authority to Administer Medications
- COVID-19 information – compilation of state actions affecting pharmacy
- Nurse Practitioner Scope of Practice Laws
- State-by-State Guide to Laws Regulating Physician Assistant Authority

XIII. Appendices

- Sample Contract Language
- Budget Template
- Contract Coversheet

For questions, contact:
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