5. SECTION B - SCOPE OF SERVICES:

5.1. Background

A. One of the most serious and persistent public health problems is the disparity in health status of ethnic and racial minority populations. African Americans/Blacks have been identified by Montgomery County, Maryland (County), Department of Health and Human Services (DHHS) as one of the groups directly affected by health disparities. The County's African American Health Program (AAHP) was created by the Montgomery County Department of Health and Human Services in 1999 to improve health access and health awareness in order to eliminate health disparities in African Americans/Blacks and individuals from African and Caribbean descent (the "Target Populations").

The African American Health Program is supported by a community advisory committee, known as the "Executive Committee". The Executive Committee reorganized the existing coalition and created additional subcommittees to bring together community organizations and community members to address specific health disparities within the Target Populations. The current subcommittees are Diabetes/Cardiovascular Health, Maternal and Child Health, Men's Health, Cancer, and HIV/AIDS/STIs. Mental Health and Aging crosscut all subcommittees.

B. DHHS has established three essential community outcome goals. All County residents should live healthy, safe, and self-sufficient. To that end, the AAHP is committed to addressing these goals with a particular focus on eliminating health disparities and improving the number of years and quality of life for the Target Populations in Montgomery County by improving the community's health and increasing its access to quality health care and social services.

Using the health indicators from Healthy Montgomery, the AAHP will work to eliminate preventable deaths and poor health outcomes of Target Populations. The focus of the AAHP is to:

- Provide culturally competent services for Target Populations who are expectant mothers or who are living with chronic diseases.
- Raise awareness of individual behavior changes that can prevent chronic diseases or mitigate their negative effects.
- Advocate for changes in policy and practice that will increase Target Populations' access to high-quality health services.
- Raise awareness of the need for, and availability of, behavioral health services.
- Improve outcomes and reduce racial inequities in infant mortality, as well as, maternal morbidity and mortality.
- Provide referrals and resources to the Target Populations surrounding minority primary care practitioners, obstetrics, and mental health care.

5.2. Intent

A. County seeks qualified organizations to deliver culturally appropriate services and interventions to the Target Populations, through the AAHP. The AAHP is committed to eliminating health disparities and improving the number of years and quality of life for the Target Populations.

B. When new contract(s) are awarded as a result of this Request for Proposals (RFP), the County requires a smooth transition between the present provider of these services and the new provider(s) ("Contractor(s)") that will be awarded a contract resulting from this RFP. The intent of the County is for the Contractor to continue to focus on health disparities, specifically focusing on disease prevention, health promotion and wellness. Disease categories and health disparities will include, but are not limited to, infant mortality/low birth weight, maternal health, STI education/support services, an integrated approach to chronic disease management and prevention for health conditions including cancer,

diabetes, cardiovascular disease, diabetes, mental health, opioid awareness/abuse/education, and oral health. Services to be provided must include outreach activities, health education, disease prevention, wellness education, support groups, dissemination of information, testing and referrals, and nurse case management. These services must be provided within the framework of the AAHP and DHHS strategic plans and in collaboration with the DHHS, the AAHP Executive Committee, AAHP subcommittees, and other possible entities.

The Contractor(s) may subcontract for components required under the Scope of Services. In a subcontracting arrangement, the prime contractor has complete responsibility for and is fully accountable for the performance of the Scope of Services proposed to be provided under any contract awarded as a result of this RFP.

C. Any funding information is an estimate and is not guaranteed, final funding for these programs is contingent upon the appropriation and encumbrance of funding for the services to be provided as described in this RFP.

D. This RFP solicits two scopes of services.

   a. Scope 1 will focus on maternal and child health, and
   b. Scope 2 will focus on chronic disease and wellness.

E. Up to two (2) contracts may be awarded as a result of this RFP. An offeror may submit a proposal for one or both scopes. If applying for both scopes, the offeror must submit two separate proposals and detailed budgets.

F. Scope 1's annual budget for Maternal and Child Health is estimated to be $1,456,004.08. Scope 2's annual budget for Chronic Disease and Wellness' is estimated to be $1,943,811.04.

5.3. Scope of Services

1. General – this section is applicable to both Scope 1 and Scope 2

A. The Contractor must demonstrate sensitivity, knowledge in and have a proven track record of working with the Target Populations, as well as the managerial experience and the collaborative abilities necessary to provide the services described in this RFP. The Contractor must provide these services within the framework of the AAHP and DHHS. While the AAHP's offerings are available to all interested residents of Montgomery County, the focus for the services provided by the AAHP are the Target Populations as defined in this RFP under Section 5.1.A. In addition, specific activities and/or initiatives should be directed at areas of greatest need, i.e., greatest concentration of the Target Populations, greatest prevalence of health disparities, etc., either through specific zip codes or neighborhoods identified in the AAHP Health Disparities Hot Spot Report. These approaches should incorporate population health strategies with the intent to improve health outcomes. It is the goal of the County, and responsibility of the Contractor, to ensure that the Contractor's work prioritizes disadvantaged communities to address disparities for the Target Populations and uses existing and current data effectively.

B. The Contractor must work with DHHS in the implementation of various elements of the AAHP components relevant to the scope of work under this RFP and the resulting contract.

C. The Contractor must provide qualified staff and/or subcontractors who are sensitive to the cultural, linguistic, and ethnic diversity of the Target Populations. The Contractor must provide responsible fiscal and budget management, oversight of all expenditures, accounting, personnel management, and record keeping services for the AAHP.

D. Contractor and County's Program Manager will hold contract monitoring meetings monthly, or more frequently as needed. The Contractor must have staff available, during the evenings and weekends to respond to unexpected emergencies and to provide and participate in programmatic meetings and activities, as needed, or as requested by the County's Program Manager. This could include administrative staff, nurses, social workers, Community Health Workers (CHW) and consultants.

E. The Contractor must provide information to the County Program Manager to update the County's AAHP's website: https://aahpmontgomerycounty.org/. The Contractor must also produce a monthly electronic newsletter relative to the program being managed. The Contractor must adhere to the Montgomery County ADA compliance guidelines for the management of all printed, electronic and web-based materials (this includes electronic newsletters, websites, etc.). The Contractor must develop an annual plan outlining health topics for the website and newsletter in coordination with the County's Program Manager. The Contractor is prohibited from using AAHP contractual staff/consultants, newsletters, emails, telephones, business cards, collection tools or social media platforms for any financial gain or marketing.

F. Within 30 days upon the contract's effective date, the Contractor must present a plan for the management, collection, analysis and reporting on data and program measures of all program elements and provide training to all hired Contractor's staff on any collection tool used. Upon approval of the plan by the County, the Contractor must execute the plan. All data collected by the Contractor for the AAHP, is the property of the County .

G. The Contractor must report on and work towards meeting established goals and performance measures designed to reduce health disparities for each program as outlined in this RFP and the resulting contract. The Contractor must collect and report monthly, as appropriate, the output measures and data described for each scope. A template will be provided by the County for data collection.

H. The Contractor must set a baseline performance measure for each health area that is addressed in this solicitation and the resulting contract based on data collected. The baseline performance measures must be established based on Specific Measurable Attainable Realistic Time (SMART) objectives and logic models to ensure outcomes have improved as a result of program activities. Proposed measures of achievement/outcomes expected for each focus area of work will be decided by the County's Program Manager.

I. The Contractor is responsible for the daily operations of the AAHP activities, which can include the use of flex time for weekend activities. Flex time is work hours scheduled outside of the Contractor's regularly assigned hours that is balanced to make sure Contractor's staffs do not work over their assigned number of hours While the working hours of the Contractor's staff is expected to include evenings and weekends, the Contractor must provide administrative and telephone coverage for the AAHP Monday through Friday, from 9:00 a.m. to 5:30 p.m.

J. The Contractor must coordinate and work directly with the County Program Manager and DHHS grants management staff to assist in applying for grants to seek additional funding for program activities. The Contractor must coordinate and work directly with the County's Program Manager and DHHS grants management staff to develop materials and submit all required documents for all grant applications on behalf of the AAHP. The Contractor must provide a brief explanation of their ability to leverage additional funding sources to expand program services for each grant application.

K. Contractor, once identifying a participant is without a Primary Care Medical Home (PCMH), will refer participants to a PCMH. This includes ensuring participants are being linked to a maternal health provider (OB, midwife, family physician) for routine prenatal care.

L. Contractor must host a minimum of 12 events per year focused on chronic diseases, breast health, prostate health, or related men's health topics.

M. The Contractor must support and continue the County's established Diabetes Self Management Education (DSME) classes in congruence with the accreditation from the Association of Diabetes Care and Education Specialists(ADCES formally AADE) as well as the CDC Prediabetes Diabetes Prevention Program (DPP) classes and accreditation.

N. All accreditations will be overseen by the County designee and any updates, modifications or changes required of the accreditation entity will be approved and administered by County staff in collaboration with the Contractor.

O. In the event the County receives additional funding for the services described in this solicitation, the County reserves the right to expand the existing scope of services for any resulting contracts. Such additional services are not guaranteed and will only be requested if funds for additional services are appropriated and encumbered by the County.

2. Scope 1: Maternal and Child Health Program

A. The Contractor must continue the AAHP's established nurse case management services for the AAHP "Start More Infants Living Equally healthy" (SMILE) program, by retaining 5 full time Registered Nurses (RN) who will serve as nurse case managers, three (3) certified doulas/perinatal CHWs, and one full time RN supervisor. The RN supervisor must participate in pertinent committees, coalitions, and meetings (State or local) which address infant and maternal mortality or prenatal health, including but not limited to the AAHP Infant Mortality Subcommittee, Interagency Coalition on Adolescent Pregnancy Group (ICAPP), Fetal Infant Mortality Review/Community Action Team (FIMR/CAT), Babies Born Healthy and Home Visiting Meetings.

Each nurse must maintain a current license in the State of Maryland to practice nursing. At least one of the nurse case managers must be a certified lactation consultant. The nurse supervisor, must have a bachelor's degree, previous maternal health experience, be licensed in the State of Maryland for nursing, and must be available to work between 9:00 a.m. and 5:30 p.m. Monday through Friday; and nights and weekends as necessary. The Contractor must maintain current copies of the licenses of all personnel providing services under the contract resulting from this solicitation whether the personnel be employees of the contractor or consultants/subcontractors. The five nurse case managers and three doulas/perinatal CHW must be supervised by the RN supervisor. Through the SMILE program, the Contractor's nurse case managers must conduct case management for women in the Target Populations, including those identified as high-risk pregnant women (experienced a previous loss, multiples, etc.) and new mothers and their infants, who are ineligible and not receiving case management services from other DHHS prenatal/postpartum programs.

The duties of each RN nurse case manager include, but are not limited to, the following:

1. Conduct case management for a minimum of 25 unduplicated medically at-risk or high-risk pregnant women in the Target Populations each fiscal year with 75% of the enrolled women at 36 weeks pregnant or less and babies continuing into the SMILE program for up to one-year post-partum. The case load is determined by evidence-based criteria and previous participation rates.
2. Maintain a minimum case load of 10 perinatal mothers and 15 postpartum mothers. Doulas/perinatal CHW will support nurses in case management when necessary and/or when requested.

3. Screen each enrolled woman with the Edinburgh Perinatal/Postpartum Depression and Post-Partum Depression Scale screening tool at 6-8 weeks post-partum, and as needed.
4. Must submit a copy of the Standard Operating Procedures for the SMILE Program. The Standard Operating Procedures must align and adhere to the requirements as outlined in the AAHP Standard Operating Procedures and must be submitted to the County for approval within 3 months of the effective date of the contract resulting from this solicitation.
5. Conduct outreach to the Target Populations, including uninsured and insured women, regardless of income.
6. Coordinate, organize, and facilitate multiple multi-session Childbirth/Breastfeeding classes, focusing on prenatal health, childbirth/breastfeeding and well-baby care for women of the Target Populations. Location of activities and classes must be determined in consultation with DHHS.
7. Provide referrals to other public and private services in the community, as needed, for women and their families. This includes mental health, housing, food assistance and domestic violence referrals to meet the needs of the Target Populations.
8. The Contractor must have sufficient electronic medical record database and each nurse case manager must record the Subjective, Objective, Assessment, and Plan (SOAP) notes for all participants in the database. The database must be approved by the County. Access to the database must be given to the County.
9. Must ensure participants are being linked to a maternal health provider (OB, midwife, family physician) for routine prenatal care.
10. Must track number of participants doctor visits to Obstetrician, Family practice, etc. during pregnancy and postpartum and provide education on importance of:
    i. 1st trimester prenatal visit completed
    ii. Attendance at routine prenatal visits (visits will vary based on the pregnancy and increase closer to delivery, but at minimum should be seen monthly). It is important to know if moms are going to these visits or not
    iii. 3rd trimester TDAP vaccine given
    iv. 1-2 week newborn infant visit completed
    v. 6 week post partum visit completed
    vi. Postpartum family planning method

3. Scope 2: Chronic Disease and Wellness Program (CDWP)

A. The CDWP must consist of the following:

1. Director of CDWP- Must be a supervisory nurse, pharmacist, dietician or other health professionals with special certifications that demonstrate mastery of diabetes knowledge and training, such as Board Certified in Advanced Diabetes Management (BC-ADM) or Certified Diabetes Care and Education Specialist (CDCES). The Director must:
    i. Develop protocols for integrated program activities.
    ii. Provide support, education, and follow-up to all patients with hypertension and diabetes who are enrolled in AAHP's chronic disease management classes.
    iii. Work with participants to provide education on goal setting and increase knowledge of skills needed to manage hypertension and diabetes and prevent complications and follow up of behavioral and outcome changes
    iv. Register themselves in the ADCES Accreditation Program web portal, commonly known as DEAP, as a program coordinator for the AAHP and maintain AAHP's accreditation through DEAP's annual reports.
2. At least two Diabetes Community Care Coordinators (DCCC)- One must serve as Program Coordinator for the DPP accreditation and one must serve as Quality Coordinator for AAHP's ADCES accreditation. DCCCs may be Certified Health Education Specialists (CHES), Master Certified Health Education Specialists (MCHES), Exercise Physiologists, or other para health professionals such as CHWs, health promotors, dietetic technicians, medical assistants, pharmacy technicians, peer educators, and trained peer leaders. The DCCCs must:

i. Provide basic instruction, reinforce self-management skills, behavior change support, facilitate group discussion, provide psychosocial support, and provide ongoing self-management support.
ii. Provide support, education, and follow-up to all patients with hypertension and diabetes who are enrolled in AAHP's chronic disease management classes.
iii. Provide individual education and support to referred participants who are diagnosed pre-diabetic, diabetic, pre-hypertensive, or hypertensive, as well as for participants referred from other AAHP programs, including SMILE, HIV and Health Promotion.
iv. Work with participants to provide education on goal setting and increase knowledge of skills needed to manage hypertension and diabetes and prevent complications and follow up of behavioral and outcome changes
v. Register in the ADCES Accreditation Program web portal, commonly known as DEAP, as the program coordinator for the AAHP and maintain AAHP's accreditation through DEAP's annual reports, as applicable.
vi. Register in the CDC DPP Portal as Quality Coordinator for AAHP's DPP Organizational Code, as applicable.

3. At least five CHWs to develop and coordinate Health Promotion and Wellness Program activities for the Target Populations. One of the five CHWs must be a HIV/AIDS certified educator. CHW's must perform the following duties but not limited to:
    a. Provide support, education, and follow-up to all patients with hypertension and diabetes who are enrolled in AAHP's chronic disease management classes.
    b. Provide individual education and support to referred participants who are diagnosed pre-diabetic, diabetic, pre-hypertensive, or hypertensive, as well as for participants referred from other AAHP programs, including SMILE, HIV and Health Promotion.
    c. Work with participants to provide education on goal setting and increase knowledge of skills needed to manage hypertension and diabetes and prevent complications and follow up of behavioral and outcome changes
    d. HIV/AIDS certified CHW must provide education surrounding the use and distribution of Pre-exposure prophylaxis (PreP) at screening locations.
    e. Provide health education, promotion, and prevention messages to communities at events and activities.
    f. Assist in the planning and staffing of events and/or health education forums and health screenings. Examples include weekly health education classes health fairs, AAHP Community Day, AAHP Walk, Homeless Resource Day, Martin Luther King, Jr. Day of Service, Heart Health, World AIDS Day and community events and forums.
    g. Provide outreach, participant assistance and referrals to resources and services within Montgomery County.
    h. Contact participants in person, over the telephone and by utilizing on-line tools to share health prevention and wellness activities, including the importance of utilizing health care and other services appropriately, as well as providing resources and follow-up for participants with high-risk health behaviors. Examples include referrals to health services and follow-up from health screenings.
    i. Assist with health screenings for CDWP outreach activities.
    j. Assist in assuring all CDWP participants have a PCMH and if found not to have one via screening or initial assessment to refer the participant to a PCMH.
4. A licensed mental health specialist and two substance abuse outreach workers. The mental health specialist, which could be a psychologist or social worker, must perform duties including, but not limited to, the following:

a. Manage and update the utilization of AAHP's on-line mental health approved screening tool.
b. Must use the Patient Health Questionnaire (PHQ-9) as the baseline mental health screening tool if no other is identified and approved by Program Management.
c. Serve as the liaison for mental health workgroups/committees within Montgomery County.
d. Serve as the primary point of contact for mental health presentation and liaison services to the AAHP Mental Health Subcommittee and other AAHP subcommittees.
e. Provide participant assistance for referrals and navigation to community resources as necessary.
f. Develop or secure mental health tools such as webinars, PowerPoints, flyers, brochures, infographics, or other material.
g. Track and closeout mental health referrals to community providers
h. Provide mental health resources across all AAHP programs.
i. Provide mental health support, presentations, and other functions to SMILE and CDWP participants.

5. A certified substance abuse counselor and two CHWs to assist in the fentanyl/opioid outreach. These positions must:
    a. Address the increase in fentanyl abuse by conducting increase collaboration on health issues with parents, youth, Black community organizations, non-profits, faith-based organizations, businesses, schools, and venues to understand the harmful effect of fentanyl, awareness of fentanyl, detecting fentanyl, and living a healthier lifestyle free of drug, opioid and fentanyl use.
    b. Keep track of and lead the use and distribution of Narcan supplies.
    c. Must reach at least 60 participants per month as part of the Fentanyl/Opioid Awareness
6. A cancer coordinator with at least 5 years of cancer outreach experience and a cancer community outreach worker. These positions must:
    a. Work directly with AAHP Program Managers, AAHP staff, and Montgomery County cancer community partners to increase screenings through site-specific evidence-based interventions to increase colorectal cancer and breast screening and completion rates in Montgomery County.
    b. Collaborate in developing a curriculum for The Breast and Colorectal Cancer Education Series.
    c. Coordinate, participate, and engage in all meetings and events related to cancer awareness, screening, and education in Montgomery County.
    d. Utilize the AAHP's web-based portal for data collection, tracking, and reporting purposes.
    e. Build and maintain partnerships with local health departments, community-based organizations, and other health providers.
    f. Maintain detailed meeting notes from meetings.
    g. Maintain documentation of colorectal cancer programs to support outcomes identified in the work plan.
    h. Assist with preparation of reports; progress updates; data reporting; development of timely materials for dissemination to relevant stakeholders (including the local public health departments; local, regional, and national advocacy orgs; and academic research institutions).
    i. Ensure necessary reports/documentation are submitted on time and in appropriate formats to all stakeholders when needed.
    j. Conduct data collection, needs assessments, and analysis to support program planning and evaluation.
    k. Interact with faculty, researchers and staff for committee work or information, as needed.
    l. Performs other related work as needed.

7. An administrative assistant and/or a CHW with data entry experience to input all of the data collected from screenings, classes, and events with special consideration for data collected to fulfill ADCES and DPP accreditations.

A CHW cannot be assigned to more than one duty. For example, any one of the two CHWs that perform the duties as stated in #5 above cannot be performing the CHW duties as stated in #7 above. The contractor must assign individual CHWs for each task.

B. The Contractor must implement the Real Conversation Series to inspire conversations around tough health topics affecting the Black community and connect participants to the AAHP as listed below:
    a. Contractor must develop a preventative health education program to increase awareness and access to health services and provide health education prevention awareness to improve Black health outcomes or reduce health disparities gaps in areas such, Men's Well-being, Clinical Trials, COVID-19 Long Haulers, Sickle Cell Disease, Complementary and Alternative Medicine practices, Mindfulness Meditation and more.
    b. Establish annual event to involve Black males with emphasis on ages 18-45 which are currently under-represented in current programs.
    c. Create annual AAHP Integrative Health Event bringing Montgomery County minority healthcare providers together from both conventional medical practices as well as Complimentary Alternative Medicine Practitioners (Naturopathic, Chiropractic, Acupuncture) and the community, to engage, share resources, and facilitate increased access and integrative wholistic care for the Black family unit.
    d. The Contractor must provide mentorship/internship framework and opportunities to build the next generation of minority health professionals.
        1. Select middle or high schools in highly Black concentrated areas.
        2. Recruit retired health professionals to serve as mentors to dedicate no less than 4 hours per month to offer professional development enrichment activities.
        3. Strategize with community-based organizations who are or have a history of working with student populations to combine resources aimed to encourage public health careers.
    e. Workforce Navigation Programs
        1. The Contractor will incorporate navigation programs to help Black men and women be more aware of the County and State's safety net programs, help them apply, and provide follow-up support.

C. Health Promotion and Wellness

1. The Contractor must design and execute strategies to integrate health and wellness for chronic disease prevention. The Contractor must support and continue the established DSME and DPP classes in conjunction with education classes on cardiovascular disease, cancer, and other diseases that impact the target population disproportionately including health behavior change classes such as exercise and healthy nutrition activities. Appropriate health screening activities, education, and follow-up with participants about abnormal/elevated blood pressure, glucose and cholesterol findings should be standard and must include education to participants regarding disease prevention (primary and secondary), and promotion of healthy behaviors. The Contractor must provide pre-diabetes, diabetes, pre-hypertension and hypertension self-management classes throughout the different parts of Montgomery County.

2. The Contractor must develop and execute a plan for blood pressure, glucose, HbA1c, and total cholesterol screenings across all the AAHP programs and areas within Montgomery County identified as having a higher incidence of chronic diseases amongst the Target Populations with referral and follow-up for participants with elevated blood pressure values to the cardiovascular

program and referral and follow-up of those with elevated glucose values to the DSME or DPP respectively.

3. The Contractor must facilitate and ensure participants who are found not to have a PCMH during screenings be referred to a primary care provider/PCMH.

4. The Contractor must use the most up to date Montgomery County population health data to identify locations that have higher incidence of chronic disease, infant and child mortality, STI's, mental illness, and opioid abuse. The Contractor must outline and implement a plan of outreach and promotion that includes monthly education sessions, screenings and information on resources available related to health and wellness. These activities must be aligned with the AAHP focus areas of maternal and child health, diabetes, cardiovascular health, mental health, oral health, cancer, and HIV/AIDS/STIs. Actives must include behavioral change strategies for disease prevention and health promotion. The Contractor must describe and provide effective strategies for hard-to-reach at risk populations in their outreach and promotion plan.

5. The Contractor must develop training modules to increase CHWs knowledge of AAHP focus areas. The training of the CHWs must include a standard curriculum supported by DHHS. A copy of the CHW training will be part of the deliverables to the County. The Contractor must test for knowledge of the CHWs by conducting pre and post training testing.

5.4. Contractor's Qualifications

A. The Contractor must be registered to do business in the State of Maryland and must be in good standing.
B. The Contractor must demonstrate experience using a team or collaborative approach to provide services, especially working with other public and private programs to achieve stated goals and objectives.
C. The Contractor must demonstrate knowledge, experience, familiarity, and capacity to implement culturally appropriate services to the Target Populations and achieve performance measures described in the RFP.
D. The Contractor must demonstrate capacity to execute the program according to the Scope of Service listed in this RFP.
E. Demonstrate the ability to hire and retain qualified staff and/or subcontractors, with current licensure and certification, who can deliver culturally and linguistically appropriate health information, health education, and case management services as applicable,
F. Demonstrate the capacity to provide responsible fiscal and budget management, oversight of all expenditures, accounting, personnel management, and record keeping services for the AAHP.

5.5. Contractor's Responsibility

A. The Contractor must follow all local, State, and federal laws and regulations, policies, and procedures to protect patient confidentiality and privacy rights.

B. The Contractor must ensure that its staff members providing services under the contract resulting from this solicitation are available to meet with the County as needed. The Contractor must accommodate scheduled and/or unscheduled monitoring visits by the County to evaluate program effectiveness and accept recommendations from the County. This may include program record, chart or data reviews, direct observation of programs and services provided (if appropriate) and consultations with participants receiving services. The Contractor must adhere to the County's request for documentation regarding all participant, employee, fiscal and programmatic aspects for

evaluation and quality assurance review. The Contractor must execute a Business Associate Agreement with the DHHS to facilitate this information sharing of participant information (Attachment E).

C. The Contractor must provide, to the County, copies of employee, consultant, and intern resumes including the credentials of all staff providing services through the contract resulting from this solicitation upon hire or field placement. The Contractor must maintain credentials, current licenses, background checks and other personnel records such as timesheets, contract agreements, and mileage records in accordance with general business and accounting practices and principles. Volunteer resumes may be required based upon interaction with AAHP's participants.

D. The Contractor must include the County seal and the following phrase on all printed and other media materials: **"The African American Health Program is funded and administered by the Montgomery County Department of Health and Human Services."**

E. All health education and public relations materials produced, acquired, or reprinted by the Contractor are the property of the County.

F. The Contractor must comply with Maryland Occupational Safety and Health Administration (MOSHA) standards for environmental safety, infection control and hazardous waste materials.

G. The Contractor must adhere to the Montgomery County ADA compliance guidelines for the management of all electronic and web-based materials, as stated in CLAS STANDARD #5-8 Attachment G.

H. The Contractor must collect and report all data to be in accordance with requirements, listed in the link below, to submit an annual report and maintain accreditation as a Diabetes Self-Management Program. (https://www.adces.org/docs/default-source/default-document-library/click-hereedf6f336a05f68739c53ff0000b8561d.pdf?sfvrsn=b2a99b58_0)

I. The contractor must collect and report all data in accordance with required bimonthly report submissions to maintain CDC's DPP recognition.

5.6. Reports

A. The Contractor must provide a monthly report to the County, in a format approved by the County, no later than 15 days following the end of each month, that must accompany the monthly invoice. The Contractor must report on each program activity, including provision of data on the County's performance measures as described in Section 5.7 and other program statistics as requested by the County. The report should include data on the current month, 2 months prior, and the national average according to CDC Data and Statistics. The report must include a narrative summary regarding program activities, collaborative efforts, challenges, and successes. The approved monthly reports will be shared with the Executive Committee during Executive Committee meetings. The report must include the following information, at a minimum:

Scope 1: Maternal and Child Health Program

Maternal and Child Health Data Collection

1. Number of referrals broken down by prenatal, post-partum, and infants.
2. Number of participants broken down by prenatal, post-partum and infants.
3. Total number of cases managed broken down by prenatal, postpartum and infants.
4. Number of deliveries to mothers enrolled prenatally including number and percentage of pre-term deliveries.

5. Number and percentage of low-birth-weight deliveries.
6. Number of infant deaths and reason for deaths.
7. Number of home visits and number of contacts.
8. Number of participants that breastfeed.
9. Length of time of participants breastfeeding (from initiation of breastfeeding).
10. Number of participants with insurance;
11. Breakdown of participants by government and private insurance.
12. Number of participants uninsured.
13. Participants referred to Maryland Health Benefit Exchange or Medicaid, and WIC during the enrollment period.
14. Number of participants with prenatal (3, 6, and 9 month) and postpartum pediatrician/obstetrician doctor visits.

Scope 2: CDWP

HIV/AIDS/STIs

1. Number of participants in HIV/AIDS/STI prevention programs.
2. Number of participants (breakdown by race/ethnicity/gender) receiving HIV testing.
3. Number of participants who received counseling services and educated on use of PrEP by the AAHP certified HIV Health Educator.
4. Number of participants who tested positive and number of participants who tested negative.
5. Number of referrals for participants to be tested for HIV and/or STI.

Chronic Disease

1. Number of participants identified as hypertensive and/or diabetic.
2. Number of participants enrolled in diabetes and hypertension self-management classes as well as DPP.
3. Number of participants screened using PHQ9 mental health wellness tool.
4. Participants' baseline, three, six, and nine-month clinical data-weight, BMI, blood pressure (pre-hypertension, hypertension), glucose and A1C levels and percentage of improvement over time.
5. Participants' pre and post testing knowledge and behavior change and follow up outcomes of baseline data at specific intervals- baseline, three, six- and nine-months post intervention.
6. Number and percentage of participants connected to primary care physicians via referrals to doctors, clinics, and/or hospitals; and details of follow up with participants to determine if referrals were completed.
7. Number of participants educated for cancer prevention, to include breast and prostate cancer.
8. Number of participants referred for breast and prostate screenings, including participant and outcome of referral (i.e. attended or did not attend) and participant data.

Oral Health

1. Number of participants educated and screened on oral health.
2. Number of participants referred for oral health services in Montgomery County, including outcome of referral (i.e. attended or did not attend) and participant data (such as demographics and pregnancy status).

Community Health & Wellness

1. Number of participants educated through community health promotion

activities, including health fairs and community outreach events.
2. Number of participants attending Real Conversation Series events.
3. Number of Black men between ages 18-45 attending events.
4. Number of schools and students at respective school engaged in Minority Youth Development Program.
5. Number of participants served as part of the Fentanyl/Opioid Awareness.
6. Number of participants taught to use Narcan supplies.
7. Number of Narcan supplies disseminated to the Target Populations.

Mental Health

1. Number of participants educated on mental health issues.
2. Number of women within the SMILE program screened using the Edinburgh screening tool and postpartum screening tool.
3. Number of participants screened using an approved mental health screening tool.
4. Number of participants referred for mental health services and follow-up with participants to determine if referrals are completed.

B. The Contractor must provide a quarterly report, in a format approved by the County, no later than 20 days following the end of the quarter. The report must include outcome data, staffing information, and achievement towards goals. This report must also include provision of data as requested by the County. The reports will be shared with the Executive Committee during the meeting months of February, May, August, and November.

C. The Contractor must provide a final annual report that highlights the outcome data for all AAHP activities for the County's fiscal year, significant accomplishments and achievements, challenges faced, and steps taken to address them. The report must include annual customer satisfaction survey (Attachment F) results for all participant case management and education classes and services. This report is due on September 1, following the end of the fiscal year on June 30. The approved report will be shared with the Executive Committee upon completion. The Contractor must provide an electronic formal annual report to be used on the AAHP website or the County's website or within electronic publications.

5.7. Performance Measures

A. The Contractor must work to achieve, and report annual benchmark performance measures as outlined below:

Scope 1: Maternal and Child Health Program

1. The rate of African American/Black infant mortality in AAHP participants will be reduced to 6.0 or below per 1000 live births.
2. The Contractor must educate and support 100% of the mothers in the SMILE program, and their families, in the effort to reduce infant and maternal mortality.
3. The Contractor must increase the percentage of post-partum breastfeeding among AAHP participants to above the national average at the time.
4. The Contractor must educate and connect 100% of the mothers, in the SMILE program, on importance of high quality maternal and infant health care providers and medical visits, which could include an obstetrician, family physician, nurse and/or midwife. For infants/children it could be a pediatrician, family physician, nurse practitioner/physician's assistant.

5. 85% of births in the SMILE program will be at a healthy birth weight (equal to or greater than 5 lbs., 9 oz.).
6. SMILE will reduce the number of pre-term births of participants to below the national average at the time.
7. 80% of all participants in the SMILE program will have medical insurance.
8. Increase the number of SMILE participants who breastfeed for up to three consecutive months postpartum by 5% each year.
9. Increase the number of SMILE participants by 25% in the second contract term from baseline (baseline being the first contract term) and increase by 5% each year thereafter for the remainder of the contract.
10. 85% of mothers will have a documented family planning method (even if the method is 'no plan'

Scope 2: CDWP

1. Increase the percentage of African American/Black AAHP adult participants that are at a healthy weight by 5%.
2. Screen at least 25% of AAHP participants at each event for HIV infection.
3. Educate all AAHP participants screened on the use of PrEP.
4. Increase the percentage of Target Population AAHP participants who are willing to seek treatment to above the national average at the time.

5. 65% of participants in a multi-session group health promotion and wellness program of diabetes, and/or cardiovascular health will have a positive health and/or behavior change.

6. 60% of participants in the diabetes/cardiovascular program in the first term of the contract will have improved A1C levels at 3 months follow up with yearly increases to reach 75% as the goal.

7. 75% of all participants that meet with the Diabetes Educator will reach one goal to improve their management of their diabetes.

8. 100% of participants in the diabetes/cardiovascular program will learn to read food labels.

9. 100% of participants in the diabetes/cardiovascular program will learn to inspect their feet daily.

10. 100% of participants in the diabetes/cardiovascular program will learn to take, record, and monitor their own blood pressure.

11. 20% of the participants with elevated blood pressure will show improvement over 3-6 months.

12. 40% of all participants in the diabetes/cardiovascular program will have improvement in nutrition and fitness behaviors over 3-6 months.

13. Number of participants tested for HIV and number of participants referred for STI testing will increase by 5% each year.

14. The number of participants, between the age of 40 to 69 years, who participated in the breast cancer outreach program that receive appropriate mammography will increase by 10% each year for the duration of the contract.

15. 100% of Target Populations participating in SMILE and chronic disease program Management will receive information on how to perform a breast self-exam.

16. Increase the number of AAHP participants in the Target Populations getting their baseline prostate cancer screening at age 40 or younger for those considered high risk by 5% each year.

17. At least 1,500 members of the Target Populations will be educated through the health education and promotion activities implemented by CHW.

18. 60% of the Target Populations reached through health education and promotion activities will be screened using an approved mental health screening tool.

19. 90% of participants in diabetes/cardiovascular health, SMILE, and HIV/STI

programs will be screened for mental health utilizing an approved mental health screening tool.

6. SECTION C - PERFORMANCE PERIOD

6.1. TERM

The anticipated effective date of any Contract resulting from this RFP begins on July 1, 2025, upon signature by the Director, Office of Procurement, and continues through June 30, 2026. Contractor must also perform all work in accordance with time periods stated in the Scope of Work. Before this term for performance ends, the Director at his/her sole option may (but is not required to) renew the term. Contractor's satisfactory performance does not guarantee a renewal of the term. The Director may exercise this option to renew this term 4 time(s) for 1 year(s) each.

6.2 PRICE ADJUSTMENTS

Prices are fixed for the first term of this Contract. For any renewal term of this Contract, a price increase may be allowed as follows:

a. If the County Council provides for an Inflationary Adjustment that applies to this Contract, the Contractor will receive the Inflationary Adjustment in the amount set forth by Council for the subject Fiscal Year. In this event, the Contractor may not seek any additional price increase(s) during the renewal term.
b. If there is no Council-approved Inflationary Adjustment applicable to this Contract, the Contractor may request a price increase, subject to the following:
    - Approval or rejection by the Director, Office of Procurement, or designee
    - Must be submitted in writing to the Director, Office of Procurement and accompanied by supporting documentation justifying the Contractor's request. A request for any price adjustment may not be approved unless the Contractor submits to the County sufficient justification to support that the Contractor's request is based on its net increase in costs in delivering the goods/services under the contract.
    - Must be submitted sixty (60) days prior to contract expiration date, if the contract is being amended.
    - Must not be approved in an amount that exceeds the amount of the annual percentage change of the Consumer Price Index (CPI) for the twelve-month period immediately prior to the date of the request. The request shall be based upon the CPI for all urban consumers issued for the Washington-Arlington-Alexandria, DC-VA-MD-WV, Metropolitan area by the United States Department of Labor, Bureau of Labor Statistics for ALL ITEMS.
    - The County will approve only one price adjustment for each contract term, if a price adjustment is approved.
    - Should be effective sixty (60) days from the date of receipt of the Contractor's request.
    - Effective only if executed by written contract amendment.

7 SECTION D - METHOD OF AWARD/EVALUATION CRITERIA

7.1 PROCEDURES

7.1.1. Upon receipt of proposals, the Qualification and Selection Committee (QSC) will review and evaluate all proposals in accordance with the evaluation criteria listed below under Section D.7.1.9.a. Offerors must indicate the scope of work for which they are applying and must submit a separate proposal for each scope of work.

7.1.2. **Vendor interviews will be conducted with the three highest scoring offerors for each scope of work that achieve at least a score of 60 points based on the QSC's score for each written proposal.** The interview criteria that will then be utilized are listed below under Section D.7.1.9.b.

7.1.3. The QSC will make its award recommendation of the highest ranked offeror based on the QSC's combined written and interview scores, and its responsibility determination.