RFA Number #1612280202/Grants Gateway #DOH01-ASTHM1-2017

New York State Department of Health
Center for Community Health/ Division of Chronic Disease Prevention

Bureau of Community Chronic Disease Prevention

Comprehensive Services and Health Systems Approaches to Improve Asthma Control in New York State

Questions and Answers

8/16/2017

Letter of Intent

QUESTION 1: Will a list of organizations that submitted a Letter of Intent be included in the Questions and Answers document?
ANSWER 1: Yes, the list is provided below:

Organization	Service Area
Healthy Capital District Initiative (HCDI)	1
Ellis Hospital	1
American Lung Association	2
Westchester County Health Department	2
American Lung Association	3
University of Buffalo	3
American Lung Association	4
University of Buffalo	4
Extraordinary Home Care	5
American Lung Association	5
NYU Winthrop Hospital	5
a.i.r. nyc	6
Extraordinary Home Care	6
St. Barnabas Hospital	6
NYC Health + Hospital Lincoln	6
Bronx Lebanon Hospital Center	6
Urban Health Plan	6
Fund of Public Health NYC	6
Fund for City of NY	6
a.i.r. nyc	7
Extraordinary Home Care	7
NewYork-Presbyterian Hospital	7
American Lung Association	7
NYC Health + Hospital Woodhull	7
Fund of Public Health NYC	7
Fund for City of NY	7

Application Content:

QUESTION 2: Please clarify if BOTH Asthma Services AND Health Systems must be included in the application. Since the annual funding is limited to $180,000, is it possible to select one broad area to address? Either Asthma Services OR Health Systems? (RFP page 5)
ANSWER 2: It is not acceptable to select only one broad area of focus. Both Asthma Services and Health Systems should be included in the application.

QUESTION 3a: One point of clarification with this RFA. Are the projects required to deliver services to children, or would a program that targets adults be allowed?
QUESTION 3b: Page 4: Part C, identifies both children & adults as audiences, but later states 0-17 years as the primary focus. Can you please clarify?
QUESTION 3c: Are applicants required to serve both adults and children?
ANSWER 3a-c: Page 27 of the RFA states, "Priority focus should be on reducing asthma burden among children (required) but adults may be included."

QUESTION 4: Page 10 – Preferred Eligibility: Preference will be given to applicants that secure a range of strategic partners to support the delivery of evidence based interventions. In areas where a Coalition has existed, but the Service Area has expanded, what are the expectations of the expanded areas where partnerships may not have had an opportunity to be formed?
ANSWER 4: This RFA is a new competitive procurement to provide funding from March 1, 2018 to February 28, 2023 for the outlined deliverables. Applications should detail plans and partnerships as described in the RFA and letters of commitment should be included as appropriate.

Key Deliverables/Work Plan Outcomes

QUESTION 5a: Page 11-12: Short Term/ Intermediate Expected Outcomes. What skills under the audiences of people with asthma, caregivers, and primary care providers should be measured and is there a required method of assessment?
QUESTION 5b: Page 12. Short Term/Intermediate Outcomes. Are the measures like: "Increased utilization and adherence of long-term control medications among people whose asthma is not well controlled" defined by the applicant or will NYSDOH be requiring how these are measured?
ANSWER 5a-b: Performance measures can be found on pages 31-32. The NYSDOH will operationalize performance measures with awarded contractors.

QUESTION 6: Pages 12 - 13. Key Deliverables. The first paragraph states that Partners/sub-contractors MAY INCLUDE Local Health Departments (and continues with a long list). Are other types of entities (health foundations, consultants) also allowed to be partners/subcontractors, or only those listed?
ANSWER 6: The list of strategic partners provided in the RFA is not exhaustive and is meant to provide examples.

Asthma Services

QUESTION 7: Page 13 – Asthma Services: Can you pleases define the differences between a MOU or MOA and a letter of commitment? And who/ what organizations require each?
ANSWER 7: For the purpose of this RFA, these terms are interchangeable. Please see Glossary of Terms (Attachment 13) for definition.

QUESTION 8: Page 13– Asthma Services: What are the requirements of the MOU or MOA?
ANSWER 8: As stated on page 13 of the RFA, applicants are to "Ensure the delivery of asthma self-management education (ASME) services in multiple settings. Engage key strategic partners through a Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA) or other formal agreement."

QUESTION 9a: Page 13– Asthma Services: demonstration of medication skills (teach-back): is a licensure required of the person conducting the teach-back in order for the session to count? If yes, what licensure? Is an AE-C sufficient?
QUESTION 9b: Page 30 – AS1 Asthma Self-Management Education: What are the credentials required for ASME and return demonstration? Please clarify by setting.
QUESTION 9c: Page 30 – AS3 –Training of Caregivers: List credentials/licensure of staff conducting trainings? What is the minimum requirements for credentials? Is a health educator or AE-C acceptable, or are licensures required? If so, which licensures are acceptable?
QUESTION 9d: Page 13- Training of Caregivers: Are patients and parents/caregivers of patients included in this category, along with the other examples of caregivers? Are these to be any non-clinically licensed individuals such as Health Educators?
QUESTION 9e: Page 30 – AS1 Asthma Self-Management Education: What are the NYS licensure and scope of practice considerations in each setting?
QUESTION 9f: Page 30 – AS3 –Training of Caregivers: List credentials/licensure of staff conducting trainings? Is an AE-C sufficient, or are credentials/licensure required? Are you expecting SPECIFIC staff or the type of credentials we will recruit in those individuals?
ANSWER 9a-f: Applicants are expected to describe how asthma services will be implemented in each setting indicated, including the type of instructor and anticipated credentials/licensure of staff delivering the program. On page 29, the RFA asks applicants to "Specify how a return demonstration of medication administration will be completed (required) according to NYS licensure and scope of practice considerations in each setting for which services are being provided." Questions related to credentials/licensure should be directed to the New York State Education Department Office of the Professions, the entity that oversees the Education Law regarding licensure.

QUESTION 10: Page 13- Asthma Services: Two face-to-face program sessions and one follow up: Is this requirement only for home-based services? Or are three sessions needed for clinical site education as well? Please provide further clarification.
ANSWER 10: Asthma services program requirements include a minimum of: a) two face-to-face sessions, b) one follow-up session occurring one month or more after the face-to-face program sessions are completed, and c) a twelve-month follow-up. Requirements are applicable to all settings.

QUESTION 11: Page 13- Asthma Self-Management Education (ASME) programs: Schools/ School-Based Health Centers (SBHC) are mentioned as coordinated by another contractor: what would be an example of the applicant's responsibility to Schools/SBHCs?
ANSWER 11: SBHCs are an eligible clinical setting for ASME programs through this RFA. ASME programs delivered in the school setting, other than in SBHCs, are excluded from the scope of this RFA. Awardees will support linkages to care and community-clinical linkages, in partnership with the NYSDOH funded school-based services contractor, as noted in the RFA. Examples may include, but are not limited to, facilitating communication between the clinical and school settings, supporting bidirectional referrals, etc.

QUESTION 12: Page 13 - Linkages to Care. The second bullet says "…the NYS of Health for health care coverage." Is there a specific linkage that is expected?
ANSWER 12: As stated on page 13 of the RFA applicants are expected to, "Assure that individuals with asthma without a primary care provider, including those initiating ASME programs, are referred to quality asthma care and if needed, the NYS of Health for health care coverage." Applicants are expected to describe plans for how individuals with asthma who do not have current health care coverage would be connected to the NYS of Health to obtain coverage.

QUESTION 13: Page 14: Policies Supportive of Asthma Control: Does the state have policy priorities you would like grantees to focus on?
ANSWER 13: As noted in the RFA on page 16, policies should be "supportive of asthma control including air quality and trigger reduction" and include policies to "improve care and improve quality of life for people with asthma." Relevant support could relate to any phase of a policy initiative and at any level (local, state, national, etc.).

QUESTION 14a: Page 14- Training of Caregivers: Measure the increase in knowledge and skills? What skills/ how specifically or will that be identified at a later time?
QUESTION 14b: Page 14 – Training of Caregivers: Measure the increase in knowledge and skills of trained caregivers… What method of measurement is required?
ANSWER 14a-b: Performance measures are stated on pages 31-32. The NYSDOH will operationalize performance measures with awarded contractors.

QUESTION 15: Page 14 - Policies of Asthma Control - 2nd Bullet - with the state contracting separately for school-based services, should the efforts on policies exclude those related to schools? Will that be the responsibility of the school-based contractors?
ANSWER 15: Policies supportive of asthma control in the school setting are not excluded though not the primary focus of this RFA.

QUESTION 16a: Can remote patient monitoring via Interactive Voice Response be counted as one of the follow up visits. If videoconferencing is used as a "virtual visit" - can that be counted as one of the face-to-face visits?
QUESTION 16b: Can remote patient monitoring be used as one of the two minimum visits? Does it need video or is IVR alone okay?
QUESTION 16c: What other types of settings would virtual visits qualify for?
ANSWER 16a-c: Remote patient monitoring would not be allowable as one of the minimum required visits or follow-up visits. Videoconferencing may be used as a "virtual visit" for asthma services, for settings other than home-based asthma services (e.g. clinical, community).

Health Systems

QUESTION 17: On Page 14 under Health Systems, Quality Improvement, it states: "Recruit a minimum of three high asthma burden primary care practice sites or other clinical settings such as emergency department, urgent care, and school-based health center sites to engage in quality improvement activities in year 1. Letters of commitment from practices demonstrating their understanding that work will begin immediately upon contract start should be included with the application." Can this include a spread or scaling up to other sites of an organization that has already participated in asthma improvement work with us?

ANSWER 17: This RFA is a competitive procurement to provide funding from March 1, 2018 to February 28, 2023 for the outlined deliverables. Applications should detail plans and partnerships for Quality Improvement activities as described in the RFA and letters of support should be included as appropriate. If an applicant is applying to continue asthma quality improvement initiatives with currently engaged partner organizations, proposed work should expand existing activities or create new activities.

QUESTION 18a: Also, it states: "Engage an additional minimum of three practice sites annually in years 2 through 5. Letters of commitment from additional practices indicating their willingness to participate in future quality improvement activities to be implemented in years 2 through 5 should be included with the application." Just to clarify, you are requiring three letters of commitment for each of three sites per year to include Years 1, 2, 3, 4, and 5 years from now, so 15 letters of commitment from health care organizations alone? As that might be unattainable in reality, is it possible to have a letter of commitment from, let's say, an organization that might state that they are willing to spread the asthma improvement to a different site each year in the targeted areas? What should we do if we cannot obtain commitments from organizations for 4 or 5 years from now?
QUESTION 18b: Slide 24 can you please repeat the requirements and criteria to clarify the # of Year 1 letters of commitments from partners and those and what is required for Years 2-5.
ANSWER 18a-b: The minimum number of letters of commitment should include the three health care practice sites that will engage in Year 1. A letter of commitment for currently identified additional partnerships anticipated in Years 2-5 should also be included with the application to demonstrate existing and potential plans for partnerships. In total, a **minimum** of 5 Letters of Commitment should be submitted in the application which includes:3 letters of commitment from practice sites as described above to engage in Year 1; and, 2 letters of commitment from primary care practices serving a high volume of pediatric patients in the priority population that will engage in the first cohort of the AQIC.

QUESTION 19: If partners for later years are not identified will points be deducted?
ANSWER 19: Applications should clearly outline plans for engaging strategic partners and describe their current working relationships with identified partners, including those partners an applicant plans to engage during years 2-5, as this will be considered during application scoring.

QUESTION 20a: Can you please clarify the following found at bottom of page 14 and top of page 15—I don't quite understand the cohort part—see underline. "Recruit a minimum of two primary care practices serving a high volume of pediatric patients in the priority population to be part of an intensive, 12 to 18-month quality improvement initiative, the NYS Asthma Quality Improvement Collaborative (AQIC) <u>for each cohort (one or more cohorts over five years)</u>. Letters of commitment from two practices indicating their agreement to be part of the initial AQIC that will begin during year one of the contract should be included and will be required prior to contract approval."
QUESTION 20b: Page 15. You reference "each cohort" (one or more cohorts over five years)? Please define cohorts in this context.
ANSWER 20a-b: The contract period will include a minimum of one cohort and may include additional cohorts for the NYS AQIC over the five-year contract period.

QUESTION 21: Page 15- Team Based Care: Can you please define further?
ANSWER 21: Team Based Care is defined in the Glossary of Terms (Attachment 13).

QUESTION 22: Page 15- Coverage and Reimbursement: Are Managed Care Organizations/ 3rd party insurance payers required?

ANSWER 22: Performance Measures include health plans (including Managed Care Organizations) as a targeted point of intervention.

QUESTION 23: Page 15- …asthma stakeholder such as elected officials/ Increase awareness of the burden through legislative office visits etc.: Is there specific requirements on strategies to employ for this bullet? And frequency need? If so, please clarify.
ANSWER 23: The RFA does not outline additional specific requirements.

QUESTION 24: Page 30-31- HS1- Quality Improvement: Identifying a min of 3 health care organizations: Please define or expand on the definition of what consists of a health care organization (ex: hospital, health system, clinical practice level etc.)
ANSWER 24: This is defined in the Glossary of Terms (Attachment 13) of the RFA.

QUESTION 25: Will the Asthma Quality Improvement Collaborative (AQIC) be focused solely on primary health care practices? Is there a difference between the health care organizations and primary health care practices? Will hospitals, emergency departments, urgent care facilities etc. be eligible/ appropriate partners? Please clarify how they will fit together. Can the practices/Health Care Organizations (HCO) be under the same organization umbrella with multiple locations/ settings, or do they need to be unique?
ANSWER 25: The NYS Asthma Quality Improvement Collaborative (AQIC) will engage project teams in primary care practices serving a high volume of pediatric patients in the priority population. Hospitals, Emergency Departments (ED), Urgent Care facilities, etc. may be included as project team partners. Multi provider practice sites under the same health system may be considered as unique project teams.

QUESTION 26: Page 14 - Quality Improvement bullet 2. Is there an expectation that ALL health care organizations within the target area are assessed?
ANSWER 26: Focus should be on health care organizations serving the priority population in the highest asthma burden zip codes.

QUESTION 27: Page 14 - Quality Improvement: The first 3 bullets seem to be suggesting activities to accomplish upon receipt of the grant. But, you are requiring a letter of commitment from three health care organizations to begin immediately upon start of the grant. What are the expectations around the first three bullets once grant is received since it seems that needs to be accomplished during the grant writing submission timeline?
ANSWER 27: The Key Deliverables section outlines required strategies to be implemented by awardees throughout the contract period. Letters of commitment are intended to indicate partner sites prepared to engage during year 1. A comprehensive analysis of health care organizations in the applicant Service Area will inform identification and prioritization of all partner organizations throughout the five-year contract. Work with partners engaging during year 1 should commence at the start of the contract.

QUESTION 28a: Page 14 - Quality Improvement - the last bullet on the page talks about recruiting two primary care practices to be part of an intensive 12 – 18-month quality improvement initiative. Are these two practices in addition to the three that we are already required to have letters of commitment from for what is also described as a QI initiative? We need a total of five health care organizations, at least two being high volume pediatric practices, ready to go in year one, all with letters of commitment? Can the two referenced in the last bullet be two of the health care organizations recruited from the three already identified?
QUESTION 28b: Page 14 - Quality Improvement - Letters of commitment. Is it accurate that 15 different health care organizations have to be lined up by submission date of September 18th? The language

seems to be requiring 15 different organizations lined up, three new ones per year over five years, all with letters of commitment. If that is accurate, can we change the plan if it is determined that a yet identified site would be more appropriate?
QUESTION 28c: On the bottom of page 14/top of 15 - Are the two letters of commitment from providers who agree to be included in the AQIC inclusive of the minimum three letters from clinical sites or is it in addition to those three letters?
QUESTION 28d: Page 30-31: HS1 – Quality improvement: b. states that we are to identify a minimum of three health care organizations; h.ii. states, identify a minimum of two primary health care practices to engage in NYS AQIC. Is that a total of 5? Or are we looking to get 2 of the 3 identified involved in the NYS AQIC? Is there a difference between the health care organizations and primary health care practices? Can the identified practices/HCOs be the same entity with multiple locations, or do they need to be unique practices?
QUESTION 28e: To confirm, for health systems, the grantee will engage a minimum of five practices - including two in the AQIC.
ANSWER 28a-e: Applicants are expected to identify a minimum of three clinical sites to implement proven quality improvement strategies to translate NAEPP Guidelines into practice and improve health outcomes for patients with asthma and include letters of commitment from each site. Letters of commitment from two additional primary care sites serving a high volume of pediatric patients committed to engaging in the Asthma Quality Improvement Collaborative (AQIC) are also required. In total, five letters of commitment from targeted health care organizations prepared to engage during year 1 quality improvement activities are required. Additional letters of commitment may be included from currently identified health care organization sites targeted for quality improvement strategies during Years 2-5. Identified clinical settings may include multiple clinical sites within the same health system.

QUESTION 29: Engaging Federally Qualified Health Centers (FQHC) with School-Based Health Centers (SBHC) in three locations counts as how many practices, if you plan to do Quality Improvement (QI) with all three?
ANSWER 29: Three.

QUESTION 30: Page 15 - Team-Based Care – Is the audience for the team-based care those health care organizations that we will be working with?
ANSWER 30: Yes, identified health care organization sites will be the targeted audience to engage in team-based care strategies. Additional broad-reaching strategies targeted across the Service Area (e.g. recruitment and training of certified asthma educators or community health workers) are also encouraged.

QUESTION 31: Page 15 - last bullet under Health Services. When you say "Support the design and implementation of…." do you really mean support, or are we accountable to make these things happen by initiating and managing?
ANSWER 31: Awardees will be accountable for monitoring and reporting on progress in meeting workplan deliverables and performance measurements as outlined in the RFA.

QUESTION 32: Page 16 – Contractor Activities: Earned media: Can you please define?
ANSWER 32: Earned media, or free media, refers to publicity gained through promotional efforts excluding paid media advertising and owned media (branding).

QUESTION 33: Page 31 - HS3 - here you mention only engaging with health plans. On page 15 - Coverage and Reimbursement you list payers and health care providers. What is the expectation?
ANSWER 33: The measures listed under Health Systems (measures J- O, pages 31-32) refer to both health care organizations (which include health care providers) as well as health plans (synonymous with payers).

QUESTION 34: P. 31: HS4-Community-Clinical Linkages. Can you give some examples of "bidirectional referral systems?"
ANSWER 34: A bi-directional referral system involves a clinical setting that designs and implements an established method for referring patients to a partner organization for services and results of those services are communicated back to the referring provider for ongoing communication/care coordination as appropriate.

QUESTION 35: If agency is a separate entity functioning as part of a health system, is home care agency expected to meet key deliverables for "Health System"?
ANSWER 35: All applicant organizations will be required to work across both Asthma Services and Health Systems to implement all strategies outlined in the RFA, even if the applicant is a separate entity functioning as part of a health system.

Staffing Requirements

QUESTION 36: Page 16 – Staffing Requirements: 1.5 FTE: Is it required the person be hired in advance of the grant award, or can they be hired after? Are they required to have a clinical license?
ANSWER 36: It is not required that staff be hired in advance of the grant award. As noted in the RFA on page 16, "The overall staffing pattern should reflect an adequate distribution of oversight to support implementation of all strategies. Staff should have the appropriate educational and professional background and be at a level within the organization to effectively carry out the responsibilities." The program manager position is not required to hold a clinical license; however, it is strongly recommended that they are a certified asthma educator (AE-C).

QUESTION 37: If the applicant organization submits multiple proposals, is it required to budget for one FTE program manager per proposal/Service Area or can one program manager oversee all the grant work (page 16 under Staffing Requirements)?
ANSWER 37: One FTE is required per application to serve as the full-time program manager for the identified Service Area.

Letter of Commitment & Subcontracting

QUESTION 38: Can you define "subcontract"?
ANSWER 38: A subcontract is used when the primary contractor (recipient of the award resulting from this RFA) seeks another entity to perform a portion of the scope of work of the primary contract. Subcontractors often work off-site and under the direction of a third party. The subcontractor has its performance measured against the objectives of its portion of the score of work of the contract by the primary contractor. Subcontractors receiving $100,000 over the life of the contract are required to complete a Vendor Responsibility Questionnaire (VRQ). Applicants should refer to the Terms and Conditions of the Master Grant Contract (Section IV, page 16, sub-section "B. Subcontractors") for more information. The Master Grant Contract is available in the Forms Menu of the Grants Gateway application under Contract Document Properties, sample master contract for grants. The primary

contractor is responsible for all work of the subcontractor. All subcontracts are subject to approval by the NYSDOH and may be subject to approval by the Office of the State Comptroller.

QUESTION 39a: Do letters of commitment need to be secured for the application that include all partners across the five-year timeframe or just year 1 and across all of the county regions? Even if that area will not be a focus for year 1?
QUESTION 39b: Are all three health care organizations identified for year 1 only? Do we need to secure other health care organizations that will be engaged in future years and spread initiatives? Do existing health care organizations that are spreading work qualify as one of the three required?
ANSWER 39a-b: Applicants are expected to identify a minimum of three clinical sites during Year 1 to implement proven quality improvement strategies to translate NAEPP Guidelines into practice and improve health outcomes for patients with asthma and include letters of commitment from each site. Letters of commitment from two additional primary care sites serving a high volume of pediatric patients committed to engaging in the first cohort of the Asthma Quality Improvement Collaborative (AQIC) are also required. In total, five letters of commitment from targeted health care organizations prepared to engage during year 1 quality improvement activities are required. Additional letters of commitment may be included from currently identified health care organization sites targeted for quality improvement strategies during Years 2-5 to demonstrate existing and potential plans for partnerships. Identified clinical settings may include multiple clinical sites within the same health system.

QUESTION 40: Pages 12 - 13 Key Deliverables. The first paragraph states that Partners/subcontractors MAY INCLUDE Local Health Departments (and continues with a long list). Are other types of entities (health foundations, consultants) also allowed to be partners/subcontractors, or only those listed?
ANSWER 40: Yes, other types of entities may be identified as partners/subcontractors. While not an exhaustive list, instructions for letters of commitment are outlined in the RFA as follows:
"Preference will be given to applicants that secure a range of strategic partners to support the delivery of evidence-based comprehensive asthma control services in identified communities as demonstrated through letters of commitment. Strategic partners should include people with asthma, families of children with asthma, primary care physicians and specialists, hospitals, pharmacists, health care insurers and payers, certified asthma educators, local public health and environmental health agencies and organizations, school districts and school-based health clinics, and other community-based organizations."

QUESTION 41: If we are not using a consultant/subcontractor do we need a letter of commitment?
ANSWER 41: Yes, letters of commitment are requested for identified health systems partners. As noted on page 12 of the RFA, "Letters of Commitment from identified partners/subcontractors should be provided. Letters of Commitment from proposed subcontractors should also include a statement of scope of work." See additional instructions regarding letters of commitment under "Infrastructure and Staffing Qualifications" on page 33.

QUESTION 42: Are other partner letters of support recommended? By whom- please provide examples.
ANSWER 42: See above RFA recommendations regarding strategic partners. Letters of commitment in addition to those required and recommended in the RFA may be included at the applicant's discretion.

QUESTION 43a: Page 33: b) Do all letters of commitment (even for non-subcontractors) require all of the Who/Why/What/ When components? Do all subcontractors need to be finalized at the time of the application?

QUESTION 43b: What should be included in the Letters of commitment?
ANSWER 43a-b: As noted on page 33 of the RFA, "each letter should describe in two double-spaced pages or less (additional pages per letter will not be reviewed):

- Who the partnering organization is;
- Why the collaboration is necessary to achieve the outcomes;
- What strategies the partnering organization proposes to contribute to by performing what activities; and
- When the activities will take place"

QUESTION 44: P. 10-11 Preferred Eligibility Requirements (and throughout RFA references are made to "letters of commitment") Is there value in collecting letters of "support" from coalition members who support our projects in ancillary ways, i.e., serve as faculty for guidelines trainings, serve as experts in creating educational materials, provide data evaluation expertise, etc.? And are these called "letters of commitment?"
ANSWER 44: Instructions for letters of commitment are outlined in the RFA. This RFA does not request "letters of support" and therefore letters of support submitted will not be scored. "Preference will be given to applicants that secure a range of strategic partners to support the delivery of evidence-based comprehensive asthma control services in identified communities as demonstrated through letters of commitment. Strategic partners should include people with asthma, families of children with asthma, primary care physicians and specialists, hospitals, pharmacists, health care insurers and payers, certified asthma educators, local public health and environmental health agencies and organizations, school districts and school-based health clinics, and other community-based organizations."

Region/Service Area

QUESTION 45: Page 10- Who May Apply: Any single application that includes more than one proposed Service Area will be disqualified. Should we write separate grants for each proposed Service Area?
ANSWER 45: Yes, a separate application must be submitted for each service area. Applications that propose to serve more than one service area will be disqualified.

QUESTION 46a: If one lead organization chooses to apply for 2 Service Areas within ONE Region… (with separate applications) – does this disqualify the organization for that Region's consideration?
QUESTION 46b: Page 9- Applicants must select and apply to serve a single eligible service area. If one fiscal agency would like to apply for multiple services areas- will they be disqualified if individual separate applications are submitted?
ANSWER 46a-b: No. Submission of separate applications to serve two service areas within one award region will not disqualify the applicant. However, per page 10 of the RFA, "Up to one (1) contract will be awarded to the highest scoring applicant with a passing score in each Award Region as outlined in Table 1."

QUESTION 47: Page 9- Can one organization apply within a specific region if you submit 2 separate applications (1 per service area)?
ANSWER 47: Yes. Applicants can apply for more than one service area within an award region but must submit a separate application for each service area. However, per page 10 of the RFA, "Up to one (1) contract will be awarded to the highest scoring applicant with a passing score in each Award Region as outlined in Table 1."

QUESTION 48a: Page 9 – Distribution of Funds: Serve a single eligible Service Area – and expected to target highest asthma burden zip codes in selected service area: are the zip codes all expected to be addressed? And if so can that plan be a staggered or strategic approach (not all in year 1)?
QUESTION 48b: Page 9 – Distribution of Funds: Serve a single eligible Service Area – and expected to target highest asthma burden zip codes in selected service area: Are there a specific number of zip codes that are required to focus on? Should the priority zip codes over multiple counties be inclusive or should the list have x number of zip codes per county?
QUESTION 48c: Page 29 b- Target Service Area zip codes: Are there a specific # of zip codes that are required to be chosen?
ANSWER 48a-c: Based on burden, applicants are required to select targeted zip codes and provide the rationale for zip code selections. As noted on page 28 of the RFA "List selected targeted zip codes and explain reasons for selection. Specify population of reach for each targeted zip code. It is not required to target all selected high-burden zip codes simultaneously but all selected zip codes should be served over the five-year contract.

QUESTION 49: On page 9 of the RFA, it states that it is not required to target all selected high-burden zip codes. Is there a recommended number of zip codes that should be selected? Are applicants required to select all the high burden zip codes identified by the State?
ANSWER 49: All contractors will be expected to target the highest asthma burden zip codes in their selected Service Area and should demonstrate sufficient reach to high-risk patients with asthma. It is not required to target all selected high-burden zip codes simultaneously, but all selected zip codes should be served over the course of the five-year contract period.

QUESTION 50: Similarly, on page 9, it states that Service Area 7 is exempt from the requirement of serving all counties. Could the applicant choose to focus on only high burden zip codes in one county in the service area for the grant period?
ANSWER 50: Yes, however the selected Targeted Service Area zip codes should demonstrate sufficient reach to high risk patients with asthma. As noted on page 29 of the RFA, "Reach of individuals with asthma is an RFA priority and will be considered in application scoring."

QUESTION 51: Is it required that the applicant only target the highest burden zip codes or can we also incorporate other moderate zip codes where we have strong support to expand asthma services?
ANSWER 51: As noted on page 29 of the RFA, "Targeted Service Area zip codes should be among the third and fourth quartiles (Q3 and Q4) on county-level asthma burden maps at http://www.health.ny.gov/statistics/ny_asthma/ed/zipcode/map.htm and http://www.health.ny.gov/statistics/ny_asthma/hosp/zipcode/map.htm."

Eligibility

QUESTION 52: Are Delivery System Reform Incentive Payment (DSRIP) Performing Provider Systems (PPS)eligible to apply? (RFP page 10)
ANSWER 52: Yes.

QUESTION 53: Our organization has been providing home-based asthma care in high prevalence communities for 16 years. We are fiscally sponsored by a 501c3, which raises a question about being both the fiscal agent and the lead. Our fiscal sponsor provides our back-office help and is our link to the Grants Gateway, but they don't perform any direct asthma services. All of the direct, mission-driven

activities are carried out by our organization. I would imagine we are eligible given our track record and dedication to alleviating asthma in the communities that most need it, but I'd like to confirm.
ANSWER 53: Per the RFA, Section II. Who May Apply, A. Minimum Eligibility Requirements noted on page 10: "The applicant needs to be both the fiscal agency and the lead agency responsible for implementing the work described in this RFA. The applicant should perform a substantial role in carrying out the project and note merely serve as a conduit for an award to another organization that is ineligible." Therefore, an application submitted by your fiscal sponsor would not meet minimum eligibility. There is not enough information provided in this question for NYSDOH to determine if your organization is eligible to apply directly. Please refer to the above referenced section of the RFA for more information.

Minority/Women-owned Business Entity (MWBE)

QUESTION 54: Is it possible to request a Minority/Women-owned Business Entity (M/WBE) waiver if no subcontracts are used?
ANSWER 54: Even if your organization does not plan to utilize subcontractors, there may be other expenses in the budget that could be provided by certified M/WBEs. You should determine, by searching the M/WBE Directory, if any certified firms can provide any of these goods or services. If your organization has determined through good faith efforts that there are no M/WBEs to provide the services, then yes please complete the Form 2 M/WBE Waiver Request with evidence of good faith effort to utilize M/WBEs. Submit completed Form 2 with the Form 1 Utilization Plan.

Budget

QUESTION 55: What is the base for calculating indirect costs? On page 34 of the RFP, it states 10% of Total Direct Cost. In Attachment 11 (p. 48), it states Modified Total Direct Costs.
ANSWER 55: The base for calculating indirect costs is 10% of Modified Total Direct Costs as stated in Attachment 11. Please note that the Modified Total Direct Costs have exclusions.

Review and Award Process

QUESTION 56a: The total number of possible points is listed as 180. Please confirm, as the total I arrive at is 170.
QUESTION 56b: While the RFA says that the grant is based on a score of 180, when you add up the sections it only adds up to 170 points. Please let us know if there are points not accounted for or if it is out of 170.
ANSWER 56a-b: The RFA includes a possible 180 points up to 10 points of which can be awarded for Preferred Eligibility.

General

QUESTION 57: Are you able to confirm if this is a new round of funding or if it is something that has been awarded in the past. If awarded in past, can you tell me who received it?
ANSWER 57: The previous procurement for this funding was titled, *A Systems Approach to Reducing the Burden of Asthma in New York State*. The contracts (listed below and listed on the NYS DOH website available at https://www.health.ny.gov/diseases/asthma/coalitions.htm) resulting from that Request for Applications are ending 2/28/2018. That initiative will be replaced with this new funding opportunity,

Comprehensive Services and Health System Approaches to Improve Asthma Control in New York State with contracts anticipated to begin 3/1/2018.

A Systems Approach to Reducing the Burden of Asthma in New York State

Contractor	Contract #
New York City Health & Hospitals Corp./Lincoln Medical Center	C026788
Whitney M. Young, Jr. Health Center, Inc.	C026789
New York City Health & Hospitals Corp./Woodhull Medical Center	C026791B
New York Presbyterian Hospital	C026792
American Lung Association of the Northeast, Inc.	C026793A
American Lung Association of the Northeast, Inc.	C026794A
American Lung Association of the Northeast, Inc.	C026795A
American Lung Association of the Northeast, Inc.	C028779

QUESTION 58a: Is there a page guidance on the minimum or maximum for the total application and/or the specific sections?
QUESTION 58b: Is there a page minimum or maximum for the grant?
ANSWER 58a-b: Application word and character limits are established in Grants Gateway. Grants Gateway will indicate applicable limits for each response.

QUESTION 59: Is there guidance on the format, font etc. that is needed for the application?
ANSWER 59: Format and font are pre-established in Grants Gateway.

QUESTION 60: Page 18-19, 25: If an organization is Grants Gateway pre-qualified currently and has updates to the organization structure, does this require a new Grants Gateway account and/or RE: Pre-Qualification process OR can updates be made directly to the current account? Is this process able to then also accept Letters of Interest and draft application materials prior to the Pre-Qualification completion?
ANSWER 60: If a currently Prequalified organization undergoes updates to the organization structure, this information can simply be updated in the Prequalified Grants Gateway Document Vault. Specific forms must be completed if changes are being made to an organization's name or address as well as updates to Certificate of Incorporation, Secretary of State filing, Vendor Responsibility System, and NYS Charities Bureau. An organization can still submit Letters of Interest and draft applications without having a current Prequalified status, yet the Prequalified status must be obtained by the due date and time of the application due date.

QUESTION 61: Page 10 - 11, Section B states Strategic Partners "should" include people with asthma, families of children with asthma, primary care physicians and specialists, etc. Does "should" suggest that <u>all</u> the categories listed need to be included as strategic partners with a letter of commitment provided for each? Can you please expand on who should have a letter of commitment vs. a general letter of support from partners?
ANSWER 61: Instructions for letters of commitment are outlined in the RFA (pages 12, 14, 32 and 42). Letters of support are not requested.

Page 10 of the RFA states, "Preference will be given to applicants that secure a range of strategic partners to support the delivery of evidence-based comprehensive asthma control services in identified

communities as demonstrated through letters of commitment. Strategic partners should include people with asthma, families of children with asthma, primary care physicians and specialists, hospitals, pharmacists, health care insurers and payers, certified asthma educators, local public health and environmental health agencies and organizations, school districts and school-based health clinics, and other community-based organizations."

The above is a list of suggested, not required, strategic partners that may be considered, although the list is not intended to be exhaustive.

QUESTION 62: Is in-school asthma management allowed or NOT allowed?
ANSWER 62: The delivery of asthma self-management education (ASME) in schools is excluded from the scope of this RFA. For the purposes of this RFA, a school-based health center would be considered a health care clinical setting and so could be targeted for implementation of an ASME program as noted in Asthma Services on page 13 of the RFA. Asthma Services strategies under "Linkages to Care" could involve, in partnership with the NYSDOH school-based services contractor, school systems to establish or expand bi-directional referral systems to support asthma management of individuals with asthma.

QUESTION 63a: Are there any details you can provide on the separate contract NYSDOH will have for school-based services, mentioned in the RAC RFA?
QUESTION 63b: When will the school based services contractors be identified?
ANSWER 63a-b: The Department is requesting approval to proceed with a sole source contract for the term 3/1/18-2/28/2023 to provide the school-based services referenced in the RFA. The school-based services contractor will be identified once approval is obtained.

QUESTION 64: Is the applicant required to submit a logic model?
ANSWER 64: No.

QUESTION 65: On Attachment 5 (Application Cover Page), it has an area for geographic area and towns/cities/neighborhoods. Is this organization specific or should we be identifying the targeted zip codes here?
ANSWER 65: Applicants should list the counties they are proposing to serve within the Service Area.

QUESTION 66: How do we account for duplication of services with the DSRIP asthma program which also makes home visits? Seems like we are targeting the same patients.
ANSWER 66: As noted on page 3 and 15 of this RFA, this initiative aligns with the goals of Delivery System Reform Incentive Payment (DSRIP) Program and multiple NYSDOH initiatives, and partnerships with these initiatives are encouraged and expected. However, resources associated with this RFA are **not** intended to fund implementation of DSRIP asthma project 3.d.ii *Expansion of Asthma Home-Based Self-Management Program.* Provision of home-based asthma services through this initiative should cover additional individuals with asthma and their families and support new or expanded services. Contractors are strongly encouraged to partner with area Performing Provider Systems (PPSs) to assure appropriate coordination of asthma services in the geographic area of coverage.

QUESTION 67: Will a link to the applicant conference slides be provided?
ANSWER 67: The recording of the applicant conference is available at:
https://meetny.webex.com/meetny/lsr.php?RCID=aad78de6ad814e8cac99f977c64e066a