New York State Department of Health -AIDS Institute

Division of HIV and Hepatitis Health Care

Bureau of Community Support Services

&

Health Research, Inc. (HRI)

REQUEST FOR APPLICATIONS (RFA) – QUESTION AND ANSWERS DOCUMENT

RFA #13-0003

Ryan White Part B HIV/AIDS

Behavioral Health Education Initiative

Component A: Community Based HIV/AIDS Behavioral Health Education and Engagement Services

Component B: HIV/AIDS Behavioral Health Education Training & Technical Assistance Center

All questions are stated as received by the deadline announced in the RFA. The NYSDOH/HRI is not responsible for any errors or misinterpretation of any questions received.

The responses to questions included herein are the official responses by *NYSDOH/HRI* to questions posted by potential bidders and are hereby incorporated into the RFA #13-0003. In the event of any conflict between the RFA and these responses, the requirements or information contained in these responses will prevail.

Contents for Questions and Answers

1. GENERAL QUESTIONS:

Question 1: Is this funding new funding?

1a: Is this new funding, or renewal funding? If it is new, is this funding replacing a previous funding stream?

1b: If this is not new funding, how is the RFA different from the previously funded program?

Answer 1: No. This is a re-solicitation of existing federal Ryan White Part B dollars previously dedicated to Mental Health Care for Persons with HIV/AIDS. The previous solicitation funded services that included: Mental Health Care Coordination, Medical and Supportive Care Coordination, Psychiatric Treatment Adherence, and Health Education/Risk Reduction. This award will fund services that include behavioral health screenings, behavioral health education sessions to de-stigmatize behavioral health issues and encourage engagement into appropriate treatment, and facilitated referrals for behavioral health care treatment services.

Question 2: If it is not new funding, will you provide us with a list of the organizations that currently have this funding?

2a: Can you tell me which agencies currently have this funding?

Answer 2: Current providers include:

Region	**Mental Health Care for Persons with HIV/AIDS Component A: Direct Services for Persons with HIV/AIDS**
New York City	AIDS Center of Queens County
	Bronx Lebanon Hospital Center
	Harlem United Community AIDS Center, Inc.
	Institute for Family Health (also serving the Hudson Valley)
	Montefiore Medical Center
	NYC Health and Hospital Corporation (NYCHHC) – Bellevue Hospital Center
	NYC Health and Hospital Corporation (NYCHHC) – Harlem Hospital Center
	New York Presbyterian Hospital – Special Needs Clinic
	Mount Sinai Hospital - Mount Sinai Comprehensive Health
	SUNY Downstate Medical Center
	Union Settlement Mental Health Services
Long Island	North Shore University Hospital
	Federation Employment & Guidance System (FEGS)
Western New York	Women & Children's Hospital of Buffalo/Kaleida Health
Northeastern New York	Albany Medical College
Central New York	SUNY Upstate Medical University Hospital
Finger Lakes	Anthony L. Jordan Health Center
Hudson Valley	Institute for Family Health (also serving the Bronx)
	Mount Vernon Neighborhood Health Center
Region	**Mental Health Care for Persons with HIV/AIDS Component B: Training and Technical Assistance**
NYS - statewide	Cicatelli Associates, Inc.
NYS - statewide	Columbia University Mental Health

Question 3: Is the term of the grant awarded one year or 5 years?

Answer 3: Refer to Section IV.G. *Term of Contract*, page 14 of the RFA. Contracts resulting from this RFA will be for 12 month terms. However, the initial contract term could be for a shorter time period based on the timing of the initial contract period. Contracts may be renewed for up to four (4) additional annual contract periods. Renewals are dependent upon satisfactory performance and continued funding. HRI reserves the right to revise the award amount as necessary due to changes in the

availability of funding. The anticipated start date is **July 1, 2014**.

Question 4: In the RFA page 12, it says "Prospective applicants are encouraged to check the BML on a regular basis for pertinent and current information", what is the "BML"?
Answer 4: This was a misprint. Prospective applicants should check http://www.healthresearch.org/funding-opportunities on a regular basis for pertinent and current information.

Question 5: How should applications be delivered? Must they be hand-delivered or can they be mailed? Should Federal Express be used? Is fax or email definitely unacceptable?
5a: If an application is received after 5PM on January 8, 2014, will it be considered?
5b: What is the address that applications should be mailed to?
Answer 5: Applications must be mailed or hand-delivered to:

Valerie J. White
Deputy Director, Administration and Data Systems
New York State Department of Health AIDS Institute
ESP, Corning Tower Room 478
Albany, New York 12237-0658

If mailing, applicants are encouraged, but not required, to use an express service. Applications will not be accepted via fax or email. It is the applicant's responsibility to see that applications are delivered to the address stated in the RFA prior to the date and time specified. Late applications due to a documentable delay by the carrier may be considered at the Department of Health's discretion but there are no guarantees. Applicants should make every effort to ensure that complete applications are received before 5pm on January 8, 2014. Refer to Section IV.E. *How to File Application*, page 12 of the RFA.

Question 6: Are the budget pages provided on the website in an Excel format?
6a: If we are already an AIDS Institute funded program, should we use the forms we already have? They include the information requested in Attachment 8a.
6b: I cannot do a direct entry on the summary page as it is locked**.**
Answer 6: Yes, the budget pages are included on the website in an Excel format. Applicants should complete the information requested on the forms provided as Attachment 8a, regardless of whether or not they are currently funded by the AIDS Institute. **Please see Addendum #2 that was added to the website on 11/22/2013.**

The summary budget forms should be accessed through your internet browser at: http://www.healthresearch.org/funding-opportunities and then saved to the hard drive of your computer. Once saved to your hard drive, open the document without updating the links. Some of the pages are protected so if you are having problems entering information you should unprotect the sheet by clicking on the tools button on your toolbar, click on "protection" and click on "unprotect sheet".

Question 7: Please provide the forms in a Word format.
Answer 7: All the attachments (forms) are in Word except the budget forms which are in Excel.

Question 8: Is there a specific font size required for the narrative?
Answer 8: Refer to Section V.A. *Application Format*, page 16 of the RFA. Applications should use a 12-pitch font with one-inch margins on all sides.

2. COMPONENT A SPECIFIC:

Region and Geographic Questions:

Question 9: Are boroughs considered "regions" as defined in the RFA?

9a: Can I apply for more than one region?

9b: Must the applicant be located in the borough for which they are applying (e.g. Can we also apply for the Bronx if we provide PLWH/A services to a large number in the borough, but are located in Manhattan)?

9c: As we would be applying to serve Long Island, can we just focus on Nassau County or must the population served reside in both Nassau and Suffolk Counties?

9d: Is it permissible to apply to submit one application to serve portions of 3 different regions? Our current Ryan White contract encompasses Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Tioga and Tompkins Counties.

Answer 9: Yes, each borough is considered a region. Refer to Section I.C. *Available Funding and Geographic Distribution*, page 4 of the RFA. Applicants serving comparable numbers of clients in more than one region may submit two separate applications for Component A. **Applicants may submit no more than two applications in response to Component A.** If more than two applications are submitted in response to this component, the first two applications that are opened will be reviewed and considered for funding. All other applications will be rejected. **Please see Addendum #1 that was added to the website on 11/5/2013.**

Applicants are required to select their primary region of service on the cover page of the application. The primary region of service for the application should be based on the location where the largest number of clients is to be served. Funded applicants for Component A will be expected to make services available to all PLWH/A in a geographic region and not limit services to agency clients only. Refer to Section I.B. *Intent*, pages 3-4 of the RFA.

Question 10: Page 18, Section IV, Item 2: Is there a minimum number of clients that should be served annually?

10a: The RFA references specific counties, boroughs and regions, as well as activities and services (e.g., targeted outreach, screening, engagement in care, etc.). Can the AIDS Institute provide a range of the numbers of patients they are looking for that will achieve the outcomes of interest?

Answer 10: Refer to Section I.B. *Intent*, pages 3-4 of the RFA. Funded applicants for Component A will be expected to make services available to all PLWH/A in a geographic region and not limit services to agency clients only. The intent of the RFA is to ensure regional coverage for HIV/AIDS Behavioral Health Education Services.

Question 11: Under Introduction (page 1): Is the purpose of this proposal to (a) reduce stigma regarding accessing HIV/AIDS services; (b) reduce stigma regarding accessing behavioral health services; or (c) both?

Answer 11: The purpose of this program is to educate clients about the benefits of engaging in mental health and substance abuse treatment, and to address stigma or related anxiety that may impact a client's willingness to engage in, adhere to, and be retained in their HIV medical and behavioral health care and treatment.

Provider Eligibility and Services:

Question 12: I am interested in exploring the opportunity to apply for the Ryan White Part B HIV/AIDS Behavioral Health Education and Engagement services grant, as a collaboration between a college and a nonprofit community based organization that serves one of the mentioned HIV at risk populations. Please let me know if this is feasible.

12a: Under II.A) page 6 "eligible applicants" - must the registered not-for-profit be a licensed Article 28 facility?

Answer 12: Refer to Section II.A. - *Minimum Eligibility Requirements*, page 6 of the RFA. Eligible applicants include: Registered not-for-profit 501(c)(3) community based organizations **or** New York State Department of Health licensed Article 28 facilities with a minimum of three years of experience providing services to PLWH/A. Per the RFA, Section III, project narrative, the population to be served is Ryan White eligible persons living with HIV/AIDS who are not engaged in or are resistant to needed behavioral health treatment.

Question 13: Can testing services be utilized as an intervention to identify HIV positive clients?

Answer 13: No. **Ryan White funds cannot be used to support HIV testing.** The population to be served is Ryan White eligible persons living with HIV/AIDS who are not engaged in or are resistant to needed behavioral health treatment.

Question 14: For the Needs section of the proposal, the applicant is asked to describe the process for determining need in the region (p. 17). Does NYSDOH expect this to be primarily a literature review or is the applicant expected to have conducted a needs assessment or survey of some sort?

Answer 14: Describe how the need for services proposed in the application was determined. Include the population to be targeted, the identified service gaps and needs in the region, and indicate how these grant dollars will address the service gaps and needs. Include pertinent statistics to substantiate your rationale; documentation of need may come from a variety of qualitative and quantitative sources.

Question 15: Is it allowable to focus all intended services on one target population? For example, we would propose providing services to only YMSM under the age of 30. Or must proposed services be available to all HIV positive persons?

Answer 15: The purpose of this program is to educate clients about the benefits of engaging in mental health and substance abuse treatment, and to address stigma or related anxiety that may impact a client's willingness to engage in, adhere to, and be retained in their HIV medical and behavioral health care and treatment. The population to be served is Ryan White eligible persons living with HIV/AIDS who are not engaged in or are resistant to needed behavioral health treatment. Refer to Section II.B. *Applicant Preference Factors*, page 7, and Section III.C. *Program Requirements and Guiding Principles*, page 9 of the RFA for more information.

Question 16: Describe what is involved in screening for Medicaid and other funding sources as part of initial assessment of clients.

16a: Can we provide services to clients that have either private insurance, Medicaid or some type of health insurance under the Affordable Care Act? Will a client's income prevent being able to be served under this grant?

Answer 16: Ryan White funding may be used for services that are not reimbursable by Medicaid, ADAP Plus or other third-party payers. Contractors must screen clients for eligibility to receive reimbursable health care services through other programs (e.g., Medicaid, Medicare, VA benefits, HIV Uninsured Program (ADAP), private health insurance), reassess client eligibility for Ryan White services every six months, and document client eligibility. Per Ryan White Guidance: Contractors receiving Ryan White funds must have systems in place to ensure and document client eligibility based on HIV Status, income, and residency. Financial eligibility is based on 435% of the Federal Poverty Level (FPL). Clients

above 435% of FPL are not eligible for services. FPL varies based on household size and is updated semi-annually. New York State residency is required. U.S. citizenship is not required. Please refer to Attachment #1 - Ryan White Guidance for Part B Subcontractors for more information.

Question 17: Because this funding is Ryan White Part B (payer of last resort), will clients who are currently enrolled in a health home and receiving assistance from a health home patient navigator, be eligible for services?

Answer 17: Yes. Refer to Section II. B. *Applicant Preference Factors,* page 7 of the RFA. This program is not intended to fund ongoing care coordination services. Linkages are encouraged to other sources for the ongoing provision of behavioral health and medical care coordination. Preference will be given to those who can **demonstrate** these linkages. Preference will also be given to applicants who show evidence of linkages to licensed behavioral health treatment providers and demonstration of facilitated referrals that expedite linkage to care and result in minimal delays in treatment.

Question 18: Pages 30-31 state that programs will be required to establish sliding fee scales for clients with incomes greater than 100% of the federal poverty level. It appears both a charge and a discount in an equal amount will be applied to services provided to clients with incomes greater than 100% of FPL. In other words, clients served under this program will not be required to pay any out of pocket expenses regardless of income level. Is that correct?

18a: Will there need to be some sort of financial transaction documented for each service visit to comply with this requirement?

18b: Is this a relatively recent (within the last year) requirement for HRI Ryan White grantees?

Answer 18: Clients eligible for services under this program will not be required to pay for services. Contract managers will work with funded providers to ensure documentation requirements are met. For more information, please see Attachment #1 – Ryan White Guidance for Part B Contractors and Answer #16.

Question 19: Clarify eligibility for services funded under this RFA for immigrants: documented and undocumented status.

Answer 19: Refer to Section III.A. *–Project Narrative- Population to be Served*, page 7. The population to be served is Ryan White eligible persons living with HIV/AIDS who are not engaged in or are resistant to needed behavioral health treatment. This could include those who are documented and those who are undocumented. New York State residency is required. U.S. citizenship is not required. Also see answer to question #16.

Question 20: Can we propose to hire an LCSW/LMSW that can provide short term Mental Health counseling for individuals who have ADAP and cannot receive any additional benefits under the Affordable Care Act (ACA) because of immigration status or other issues?

Answer 20: No, this funding cannot be used for mental health treatment. Persons eligible for ADAP may also be eligible for ADAP Plus, which will reimburse for the provision of covered mental health services delivered by an ADAP Plus provider.

Question 21: Excerpt from the RFP, page 8: Section III. B. Description and Overview of Components … Funding will support: A 1.0 Full time HIV/AIDS Behavioral Health educator to: Hereafter the RFP lists seven bullets. The first bullet begins: “conduct targeted outreach ….” Our question is: can outreach activities be targeted to include Health Home organizations?

Answer 21: Yes, targeted outreach may be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached.

Program Related:

Question 22: Under A) Background, page 3: Please confirm that behavior health is defined here as mental health support. Please provide a definition and example of behavior health education, and how that differs from mental health support.

22a: Can this RFA be used to fund services to clients for screening and referral to substance abuse services? In addition to, or in place of screening and referral for mental health services? (Substance use is considered a mental health condition by the DSM, and the term "behavioral health" technically encompasses both.)

22b: It is unclear how substance abuse screening and referral fit into this application. Is education and a referral strictly for substance abuse treatment (along with peer escort, follow-up etc.) acceptable under this funding?

Answer 22: Yes. Refer to Section I.A. *Background*, page 3 of the RFA. Behavioral health education and engagement services are short term mechanisms advocating treatment by [empowering PLWHA] through education regarding HIV and behavioral health that help engage individuals into care and support their adherence. These services are intended to strengthen engagement and retention efforts by focusing on the benefits of early and ongoing behavioral health services**, including mental health and substance use treatment**, that address the various biological, psychological and social factors impacting client willingness and readiness to engage in treatment and care.

Question 23: On page 8 it states that the contract supports a maximum of 3 behavioral health education sessions per client. Does this mean that the peer navigator's contacts with the client are not included in that number?

23a: Can the peer navigator implement group sessions that are on-going?

23b: Is there a maximum length of time that the peer navigator can provide services to a client?

Answer 23: Refer to Section III. B. *Description and Overview of Components A and B,* pages 7-8 of the RFA. Funding will support Peer Navigator(s) to assist with engagement and education activities (i.e., follow-up calls, appointment accompaniment, initial appointment tracking, participation in behavioral health awareness activities, etc.) to ensure successful linkage to behavioral health treatment. These activities are separate from the three visits provided by the Behavioral Health Educator. The Peer Navigator may also assist the Behavioral Health Educator with conducting targeted outreach to PLWH/A through education and awareness activities designed to reduce stigma, but these activities are intended to be single episode events, not ongoing. Patients with more intensive needs would be referred to a case management program designed to address long term care coordination.

Question 24: For Component A: Section III Project Narrative/ B)Description and Overview/ 2nd Paragraph, Is there an expectation regarding the time frame a patient can be enrolled, for example, could the psycho-educational sessions be provided over a period of 6-9 months for patients with high resistance?

Answer 24: No, there are currently no set time frames for patient enrollment, although all interventions should be **short term** mechanisms for identifying clients and promoting treatment readiness for linkage to and engagement in behavioral health treatment.

Question 25: Can the Behavioral Health Educator provide other interventions, not included in the "education" restriction, that will allow for additional contacts?

Answer 25: Refer to Section III. B. - *Description and Overview of Components A and B,* page 7-8 of the RFA and review the list of fundable activities allowed for the Behavioral Health Educator. Ryan White contractors are expected to provide documented, fundable services to eligible clients and to clearly define the scope and nature of such services in the contract work plan. Contract work plans and duties descriptions of staff supported by Ryan White funds will be reviewed to ensure that they include

only those activities that are fundable under the Ryan White Law.

Intake/Screening Tools:

Question 26: In Section III, part B, on the bottom of page 7 of the RFA, is the intake form mentioned the A.I.R.S. form?

26a: For Component A, section III Project Narrative/ B)Description and Overview (Component A)/ 2nd Paragraph (2nd bullet under 1.0 FTE HIV/AIDS Behavioral Health Educator): Please clarify: is the AIDS Institute/HRI providing the intake referred to in the Description and Overview

Answer 26: Refer to Section III. B. - *Description and Overview of Components A and B,* page 7-8 of the RFA. Funding will support completion of an intake form that will be provided to all funded providers. This intake form will be used in conjunction with AIRS.

Question 27: In Section III, part B, at the top of page 8 of the RFA, "standardized tools" to identify PLWH/A are mentioned. Are there particular tools that you have in mind?

27a: Per the list of activities that the funding will support, for the SBIRT (p.8 of RFA), is the Client Diagnostic Questionnaire or something similar acceptable to use?

27b: For Component A, section III Project Narrative/ B) Description and Overview (Component A)/ 2nd Paragraph (3rd bullet under 1.0 FTE HIV/AIDS Behavioral Health Educator): Can you provide examples of the standardized tools referred to in the Description and Overview?

Answer 27: There are several standardized tools that are being used for behavioral health screening nationwide. The AIDS Institute and the HIV/AIDS Behavioral Health Education Training & Technical Assistance Center (Component B) will discuss with contractors awarded funding use of appropriate screening tools.

Behavioral Health Education Sessions:

Question 28: Does DOH have suggested EBIs and DEBIs to use for the behavioral health education component?

28a: Can we incorporate the use of evidenced based interventions such as Healthy Relationships in our proposal or must all interventions be short-term (limited to 3 sessions)?

28b: On page 8 of the RFP it states that the Health Educator is to "provide individual behavioral health education sessions (maximum of three) to de-stigmatize behavioral health related issues and encourage engagement into appropriate treatment." Can you provide us with suggestions for evidence-based or other curricula to use for those three sessions? Or are we permitted to use NYC DOHMH-approved curricula in the proposed program?

Answer 28: Refer to Section II. B. *Applicant Preference Factors,* page 7 and Section III. B. *Description and Overview of Components A and B,* page 8 of the RFA. Preference will be given to component A applicants who have experience in the provision of behavioral health education and engagement services to PLWH/A. They should be able to demonstrate the ability to design and implement effective community based HIV/AIDS behavioral health education and engagement services, and have relevant experience and be able to demonstrate their success in serving the target population(s) in a manner that is client-centered, culturally appropriate, sensitive to the patient's literacy level, and that enhances patient self-management. The AIDS Institute and the HIV/AIDS Behavioral Health Education Training & Technical Assistance Center (Component B) may make specific program related recommendations or suggestions in dialogue with the funded contractors. See also answer to #29.

Question 29: Why are applicants limited to providing a maximum of three individual behavioral health education sessions (p. 8 of RFA)? What evidence is this limit based on? What is an applicant to do if the client is not ready after three sessions?

29a: Regarding the limit of three behavioral health education sessions (p. 8 of RFA), are these limited to in-person sessions? Are there any minimum or maximum time limits for these sessions? What about phone conversations in between in-person sessions?

29b: Given the fact that very often there may be a wait of over 2 weeks or more for a client to actually be seen by a mental health provider, for example, does this funding support additional activities (like additional behavioral health education sessions) to continue engaging clients in order for them to have a successful transition to ongoing behavioral health services? Or is it expected that when clients are referred into primary care services they will receive this support? How about if the medical program is also limited in the services they provide?

29c: Description and overview, page 8, 2nd bullet: Can a patient who completes three sessions with the behavioral health educator, but does not engage in mental health or chemical dependency treatment return to the program some months later and receive an additional three sessions of behavioral health education for a second attempt at engaging in treatment?

Answer 29: The Behavioral Health Educator will provide individual behavioral health education sessions (maximum of three) to de-stigmatize behavioral health related issues and encourage engagement into appropriate treatment. Session time limits and modalities will be determined by the program. These are short term mechanisms for identifying clients and promoting treatment readiness for linkage to and engagement in behavioral health treatment. Experience with support services has suggested that three interventions is best practice and individuals in need of further services should be referred to a long term program. Preference will be given to applicants who show evidence of linkages to licensed behavioral health treatment providers and demonstration of facilitated referrals that expedite linkages to care and result in minimal delays in treatment. Applicants are encouraged to present how they will work with other programs and link clients to other interventions that will foster ongoing assessment for treatment readiness.

Question 30: Section B, page 8: Does the maximum of three behavioral health education sessions include the assessment? Or can the assessment be done in a separate session and followed with up to three behavioral health education sessions?

Answer 30: The behavioral health intake and screening may be provided in a separate visit from the three behavioral health education sessions. Ryan White funding may only be used for services that are not reimbursable by Medicaid, ADAP Plus or other third-party payers. **This funding cannot support the provision of reimbursable behavioral health services, including diagnostic assessments.**

Question 31: How are applicants to handle administrative discharges for patients who do not meet the 3 visits in care that would result in successful discharge (p. 8)? We need something in place for when we cannot have a successful discharge and cannot continue to outreach a patient and must administratively discharge them. Will the AI provide an administrative discharge policy at the start of the project?

Answer 31: The intent of this RFA is to successfully engage and retain clients into behavioral health treatment; this will be measured by three successfully attended behavioral health treatment appointments. Policies and procedures will be discussed during contract negotiations with providers awarded funding. Also see Answer #29.

Successful Engagement in Behavioral Health Treatment/Outcomes:

Question 32: Regarding the goal of having clients successfully attend three behavioral health treatment appointments (p. 8 of RFA), is there a time limit for these appointments taking place? Do they have to be consecutive? For example, what if a client misses an appointment, does the count then re-start from one or is it just a cumulative three appointments? What is your preferred tracking method? Also, what happens after three appointments – does the applicant stop tracking even if the client continues receiving services?

32a: What constitutes a completed behavioral health treatment appointment? That is, what will NYSDOH expect to see in the way of reporting? For example, would reporting be by provider report/confirmation, medical record review, client self-report, or other?

Answer 32: Refer to Section III. B. *Description and Overview of Components A and B,* page 8 of the RFA. Funding will support a full time HIV/AIDS Behavioral Health Educator to track, coordinate, and communicate behavioral health referral activities with other service providers until clients have successfully attended three behavioral health treatment appointments. Appointments will be counted cumulatively. The intent of this funding is to employ short term mechanisms for identifying clients and promoting treatment readiness for linkage to and engagement in behavioral health treatment.

Question 33: If a patient successfully engages in treatment after three sessions, but subsequently stops adhering to treatment for a period of months, can the behavioral health educator re-engage the patient for an additional three sessions to get him/her back into treatment?

Answer 33: Yes, clients may be re-enrolled into the program as a means of further assisting with re-engagement into behavioral health treatment.

Question 34: What are the expected program outcomes? What key indicators/measures will we be expected to track?

Answer 34: Refer to Section III. B. - *Description and Overview of Components A and B,* page 8 of the RFA. Funding will support staff to perform behavioral health screenings using standardized tools and track, coordinate, and communicate behavioral health referral activities with other service providers as applicable until clients have successfully attended three behavioral health treatment appointments. Key indicators/measures will be discussed during contract negotiations with providers awarded funding.

Staffing:

Peer Navigator:

Question 35: Re peer navigator (page 8): Does this need to be a full-time position?

35a: Part III, section B, page 8 mentions a Peer Navigator. Is this a part-time position funded by the contract?

35b: Can you please tell me if the use of Peer Navigator(s) is required (or is it just a suggested model).

35c: The RFA states that funding will support a Peer Navigator. Does that mean a Peer Navigator is a required component of the program, or does it mean that a Peer Navigator is an optional component of the program?

35d: Can Peer Navigators be staff?

35e: For Component A, section III Project Narrative/ B) Description and Overview/ 2nd Paragraph, 2nd dark bullet: Is a peer navigator required? What is the minimum FTE for peer Navigator? What is the maximum FTE for peer navigator?

35f: Are peer navigators full-time (1.0 FTE) employees or paid an hourly stipend?

35g: Can the role of the peer navigator be further explained? It appears that the Health Educator services are short term (meet with an individual up to 3 times). The roles described for the Peer Navigator appear to be longer term and on-going. Please clarify.

35h: Could you please provide a specific definition for a "Peer Navigator?"

35i: Do we have to have an existing Peer Navigator project ongoing, or does our past experience providing these services under a SAMSHA grant qualify us? We still employ that trained staff in other roles?

Answer 35: The peer navigator position is optional and can be a paid full time/ part time position. The intended role of the peer navigator is to assist the Behavioral health Educator with short term engagement and education activities (i.e., follow-up calls, appointment accompaniment, initial appointment tracking, participation in behavioral health awareness activities, etc.) to ensure successful linkage to behavioral health treatment. They can assist with monitoring services until clients are successfully established into behavioral health care. Peer navigation services should be short term and in line with the intent of the RFA – successful linkage to behavioral health care – measured by the completion of three behavioral health treatment appointments. See also answer #23.

Question 36: Is there any specific training required for Peer Navigators?

36a: Per the RFA – "b) provide and arrange for the adequate training and support of staff and peers;" (page 8) – Should this training be for internal staff of the agency or be provided to partner agencies and other community resources?

Answer 36: Peer navigator's training needs will be determined by the program. Training is intended for staff performing functions supported by this grant funding.

Question 37: Does the Peer need to be HIV-positive to qualify as a Peer Navigator? Does s/he need to have behavioral health issues to qualify as a Peer Navigator?

37a: In Section III Part B (page 8 of RFA), you state that funding will support "Peer Navigators". Will you please describe the minimum qualifications of Peer Navigators or any characteristics Peer Navigators should have?

37b: Regarding **Component A** of the RFA, how is "peer navigator" defined (p. 8)? Must the peer navigator be both HIV+ and actively engaged in behavioral health services?

37c: Do peer navigators all have to be HIV positive? Can peers with substance abuse and MH backgrounds be considered for the peer navigator role in this program?

37d: Describe the desired qualifications of the Peer Navigator. Is the expectation that the Navigator will be a PLWH/A peer? A mental health "consumer" peer? Either?

Answer 37: There are no minimum qualifications for this position. It is recommended that peer navigators represent the population they are working with.

Question 38: Should applicants submit resumes for peer navigators or other outreach staff?

Answer 38: Refer to Section V. B. – *Staffing Pattern and Qualification,* page 19. Attach all existing staff and consultant resumes and include both agency and proposed program level organizational charts. Applicants should indicate who will be directly responsible for the supervision provided to the behavioral health educator and peer positions. If submitting resumes for peers, please ensure that HIV and/or behavioral health confidentiality is not compromised.

Behavioral Health Educator:

Question 39: Are any other non-administrative staff positions allowable (e.g., care coordinator)?

Answer 39: Refer to Section III. B. - Description and Overview of Components A and B, page 7-8 of the RFA. The intent of the RFA is to ensure regional coverage for HIV/AIDS Behavioral Health Education Services and staffing needs to focus on the Behavioral Health Educator and the Peer Navigator positions. Other types of positions may be considered if they directly support the provision of HIV/AIDS Behavioral

Health Education. Refer to Section II. B. *Applicant Preference Factors,* page 7. Linkages are encouraged to other sources for the ongoing provision of behavioral health and medical care coordination.

Question 40: Based on the staffing pattern outlined on pp. 7-8 in Section III, Part B of the RFA, might there be some flexibility in reassigning roles between the Behavioral Health Educator and Peer Navigator? Based on some experience we have in similar areas, we might like to propose a slightly different structure that would still cover all of the work outlined in the overview.

40a: The RFA states that funding will support 1 FTE HIV/AIDS Behavioral Health Educator and Peer Navigator(s). Is this an exhaustive list of services this funding will support, or are there other services providers may identify that are fundable?

40b: On page 7 on the subject of staffing you state that the contract will support 1 FTE Behavioral Health Educator. Can we design a program that employs 2 Behavioral Health Educators? And a part-time supervisor to oversee the program?

40c: In the RFP for Category A in the Section titled Project Narrative. B) DESCRIPTION AND OVERVIEW OF COMPONENTS A AND B it lists that funding will support a Behavioral Health Educator and Patient Navigators, are these the only positions the RFP will agree to fund?

40d: What are some alternatives to hiring one new FTE on this grant?

40e: Can the budget support more than 1 FTE Health Educator?

40f: Can this position be shared by more than one staff person?

40g: For Component A section III Project Narrative/ B) Description and Overview/ 2nd Paragraph: Is there a limit to the FTE/number of Behavioral Health Educators per award?

40h: Will only a 1.0 FTE Behavioral Health Educator and peer navigators be allowed or can >1.0 FTE be on the budget (pp. 7-8)?

Answer 40: Refer to Section III. B. *Description and Overview of Components A and B*, pages 7-8. Funding will support a 1.0 Full Time Equivalent (FTE) HIV/AIDS Behavioral Health Educator and optional Peer Navigator(s). This position is required, and splitting the position across multiple funding sources will not be permitted. Additional 1.0 FTE Behavioral Health Educator(s) may be added if the program's caseload can support it. Peer navigators are optional and may be shared across other programs. See also Answers #35 and #39.

Question 41: If the Behavioral Health Educator position will be a new hire, should applicants submit a job description in place of a resume?

Answer 41: A job description is acceptable to submit as part of the application package. Please also see Answer #38.

Question 42: Should applicant submit a resume for staff supervising the behavioral health educator?

Answer 42: Refer to Section V.B. *Section V Staffing Pattern and Qualifications*, page 19. Attach all existing staff and consultant resumes and include both agency and proposed program level organization charts. Applicants should indicate who will be directly responsible for the supervision provided to the behavioral health educator and peer positions.

Question 43: Is it acceptable to propose a 1.0 FTE Behavioral Health Educator who has lesser degrees or certificates in combination with multiple years of experience doing the work described with the target population(s)? Is it acceptable to propose a 0.5 FTE candidate with a Masters degree(s) who will work in concert with a proposed 0.5 FTE candidate who does not have a BS or BA, but who has lesser degrees or certificates, in combination with multiple years of experience doing the work described with the target population(s)?

43a: For Component A section III Project Narrative/ B) Description and Overview/ 3rd Paragraph: Would any exceptions or substitutions be made for the minimum qualifications of the behavioral health educator? For example, would a NYS CASAC without a degree but with many years experience in the other 3 qualifications be permitted in the behavioral health educator role?

Answer 43: No. Refer to Section III. B. *Description and Overview of Components A and B*, page 7. The minimum qualifications for the HIV/AIDS Behavioral Health Educator are:

- B.A. or B.S. with 2 years of experience working in the field of HIV/AIDS, behavioral health, or other chronic illness;
- 1 year of experience providing health education;
- Possess an understanding of community level work and the importance of collaborating and coordinating with other organizations; and
- Effective communication and documentation skills.

Please also see Answer #40.

Question 44: What level of license will staff need to provide diagnostic assessments? LMSW? LCSW? Per the RFA – "This does not include the provision of diagnostic assessments, which can only be provided by licensed behavioral health professionals." (page 8)

44a: For Component A Section III Project Narrative/ B) Description and Overview/ 3rd Paragraph: Are there any higher education exclusions to the qualifications of the behavioral health educator? For example, can the behavioral health educator be an LMSW (not providing reimbursable services)?

44b: For Component A in Section III, Project Narrative/ B) Description and Overview/ 2nd Paragraph: Would an LCSW be precluded from grant funding if the services provided by the LCSW were not reimbursable services? For example, facilitating a psycho educational group focused on stigma related to mental health or HIV, or facilitation of an educational/support group used as outreach to target patients in need of mental health services?

44c: Can we allocate funding for staff (e.g. social workers) in addition to the positions identified in the RFA (pages7-8)?

Answer 44: Refer to Section III. B. - *Description and Overview of Components A and B*, page 7 of the RFA. Ryan White funding may only be used for services that are not reimbursable by Medicaid, ADAP Plus or other third-party payers. **This funding cannot support the provision of reimbursable behavioral health services, including diagnostic assessments.** Funding will support 1.0 Full Time Equivalent (FTE) HIV/AIDS Behavioral Health Educator(s) to perform short-term, non-clinical behavioral health education services. Licensed professionals (e.g. LMSW or CAC) can serve in the capacity of a Behavioral Health Educator as long as they are full time in that role and not performing any clinical interventions. Please also see Answer #40.

Linkages:

Question 45: Section V, B, Part#1, item 4, page 18 - should letters of agreement with behavioral health agencies be included as an attachment?

45a: In Section I, part B, at the top of p.4 (and elsewhere throughout the RFA) collaborating with other regional providers and the use of referral networks are mentioned. Are letters of support and/or partnership agreements from our partner community-based organizations and service providers required with the application?

45b: In addition to Attachment 7 – Behavioral Health Services Linkage Chart, are we expected to include copies of signed linkage agreements with each agency that we list in the chart?

45c: Per the RFA, applicants are expected to identify and leverage other community resources that will enhance the provision of services delivery, assist clients to overcome

personal or cultural barriers that prevent them from accessing care and treatment, and address issues that may compromise their behavioral health needs. If the applicant provides many of these services in-house, is it still expected to seek out community resources and establish referral linkages?

45d: What linkages to health homes are expected? Do they need to be formal MOUs?

Answer 45: Refer to Section II. B. *Applicant Preference Factors,* page 7 of the RFA. Linkages are encouraged to other sources for the ongoing provision of behavioral health and medical care coordination. Preference will be given to those who can **demonstrate** these linkages. Preference will also be given to applicants who show evidence of linkages to licensed behavioral health treatment providers and demonstration of facilitated referrals that expedite linkage to care and result in minimal delays in treatment. Completion of the Behavioral Health Services Linkage Chart (attachment 17) is sufficient evidence of linkages. Applicants who provide services in house should describe the availability of services in their application and should demonstrate linkages to any services that are not available onsite.

Question 46: Excerpt from the RFP, page 8, Section III. B. Description and Overview of Components …Funding will support: A 1.0 Full time HIV/AIDS Behavioral Health Educator to: Hereafter the RFP lists seven bullets. The 4th bullet (i.e., provide individual education sessions (maximum of three) to … The 7th (and final bullet) concludes with "… until clients have successfully attended three behavioral health treatment appointments." We understand grant funds are to be used to support staff to address the 4th bullet. Our question is: can the care management functions to achieve the 7th bullet be carried out by staff other than those supported by grant funds? For example, by care management staff at a HIV medical primary care provider? At a behavioral health provider? At a Health Home organization? At a community based organization?

Answer 46: Yes, provided the applicant is able to collect this data and submit the outcomes through AIRS. Preference will be given to applicants showing evidence of linkages to care management providers for the provision of behavioral health and medical care coordination. When linkages are utilized and care coordination activities performed by other entities yields successful behavioral healthcare outcomes, the activities should not be reported twice.

3. ADMINISTRATIVE

Programmatic Expenses/Budget: **(NOTE: Budget Forms have changed – See Addendum #2)**

Question 47: Are incentives an allowable cost?

Answer 47: Yes. Incentives are allowed with restrictions. Ryan White funding traditionally only allows grant activity related incentives (e.g. gas cards, metro cards, bus passes to assist with client transportation to relevant appointments, etc.). Refer to Attachment 1- Ryan White Guidance for Part B Contractors for a list of the activities and services that cannot be supported by Ryan White funds.

Question 48: For Component A, Attachment I RW Guidance for Part B Subcontractors/ Administration/ (D) Travel : Would travel expenses of staff meeting patients at mental health visits, but not necessarily transporting patients to mental health visits, be considered "programmatic" expenses?

Answer 48: Yes

Question 49: In Attachment 1 RW Guidance for Part B Subcontractors/Administration, first paragraph and (H) Indirect, does the 10% Indirect cap include the 10% Admin cap?

Answer 49: Ryan White providers requesting to budget indirect costs must have a Health and Human Services (HHS) negotiated, federally approved Certificate of Cost Allocation Plan or Certificate of Indirect Costs. However, even with a federally approved rate, indirect costs are capped at 10%. If

requested, all indirect costs must be included within the 10% Ryan White administrative cap. Without a federally approved indirect cost rate, Ryan White providers may not request indirect costs.

Question 50: The budget form that is available on line does not seem to allow the programs to show the administrative costs that are incurred, which are capped at 10%. How are programs supposed to show the administrative costs?

50a: Component A: Can funding be used to provide clerical assistance for scheduling and follow up of ongoing behavioral health sessions as well as psycho educational sessions? If so, would this be considered "programmatic"?

Answer 50b: Please see Addendum #2 that was added to the website on 11/22/2013. Clerical assistance for scheduling and follow up of services associated with this program would be considered programmatic. Refer to Attachment 1 – Ryan White Guidance for Part B Contractors for more information.

Question 51: Is supervision of the staff considered a purely administrative cost or can that be considered a programmatic cost?

Answer 51: Applicants must determine the percentage of a position that is considered administrative in nature based on actual effort worked on the project. With regard to supervision, the percentage of time devoted to supervising programmatic activities and/or providing overall direction to program activities should be considered programmatic. Refer to Attachment 1 – Ryan White Guidance for Part B Contractors for more information. This will be discussed in more detail with funded applicants during contract negotiations.

Question 52: For Component A: Attachment I RW Guidance for Part B Subcontractors/ Administration, table on top of p33. Is funding for staff fulfilling the data requirements considered programmatic, i.e., not restricted to the 10% admin cap?

Answer 52: All staff time related to AIRS data management is administrative.

Question 53: In reviewing the budget forms submitted for the RFA, we noted there is no page for Misc. (for CAB support, phone line, postage, etc.) items nor Program/Office Supplies. In the past it has been page 5 of the budget package and we want to know if it was omitted intentionally or by accident.

Answer 53: Please see Addendum #2 that was added to the website on 11/22/2013 and the updated budget forms.

Question 54: For Component A: Section V Completing the Application/ B) Application Content/ Component A/ Section VII: Budget and Justification, 2nd bullet after #6 (p.20), May funds be used to cover positions/services currently in place that will be defunded prior to start of new RFA grant; as long as the positions/services meet the intent and requirements outlined in the RFA?

Answer 54: Refer to Section III. B. Description and Overview of Components A and B, pages 7-8. The intent of the RFA is to ensure regional coverage for HIV/AIDS Behavioral Health Education Services and staffing is intended for the Behavioral Health Educator and a Peer Navigator. The previous solicitation funded services that included: Mental Health Care Coordination, Medical and Supportive Care Coordination, Psychiatric Treatment Adherence, and Health Education/Risk Reduction. This award will fund services that include behavioral health screenings, behavioral health education sessions to de-stigmatize behavioral health issues and encourage engagement into appropriate treatment, and facilitated referrals for behavioral health care treatment services. Funds may be used to support positions currently in place that will be defunded if the incumbents meet the required qualifications and are capable of performing the duties associated with this program.

Question 55: Do we only complete budget forms for the first year of the program, or do we do one for each additional year? If the latter, is a justification also necessary for each year?

Answer 55: Please complete a budget for the first year only**.**

Population Data Form:

Question 56: We are not currently a grantee of the Mental Health Initiative but we do provide short term mental health services to our HIV+ patients. Can we use the numbers served in our program to fill out the Population Data Form?

Answer 56: Behavioral health education is intended for PLWHAs who are not engaged in or are resistant to needed behavioral health treatment. Most clients already receiving mental health services would not be eligible to receive behavioral health education services. As per Attachment #11, please fill out for ***current*** number of HIV+ individuals receiving behavioral health education services AND the **proposed** number of HIV+ individuals to receive behavioral health education services.

Board of Directors:

Question 57: We would like to clarify what information is required for attachment #10. The guidelines seem to indicate a list of individuals related to the project – however the form's title is Board of Directors. Can we get additional clarification as to who should be listed on this form? We are presuming that the personal information requested at the bottom of attachment 10 is optional. Please let us know if we are incorrect about this.

Answer 57: Refer to Section III.B.III. Question #4 under *Applicant Capability and Experience*, page 22 of the RFA. Provide a description of the role of the applicant's key management staff (i.e. administrative, fiscal, information systems, etc.) related to implementing behavioral health education training and technical assistance. Complete *Attachment 10 (Board of Directors/Task Force)* and *Attachment 15 (Agency Capacity and Staffing Information – Component B).* In addition to responding to the first part of this question in the narrative section of the application, applicants should also complete and submit Attachment 10. If you do not have a Board of Directors, write "N/A or Not Applicable" on the attachment. The information requested at the bottom of attachment 10 is encouraged but optional. It is best practice to have a Board of Directors that is representative of the community receiving services from the program they are governing.

Quality Assurance:

Question 58: Is the evaluation of the proposed program design, including issues pertaining to agency infrastructure, resources, staff development and staffing patterns needed to support the proposed program focused on our agency or the agencies receiving TA/CBA? (Component B, Questions, Section VI: Evaluation and Quality Improvement – Question #1) Describe how the applicant will conduct formal quality improvement projects to evaluate the proposed program design, including issues pertaining to agency infrastructure, resources, staff development and staffing patterns needed to support the proposed program. Indicate all staff, including their credentials and experience, which will be responsible for evaluation and quality management/improvement of the proposed program.

Answer 58: Applicants are required to respond to this question by describing the activities they will engage in to evaluate the proposed Behavioral Health Education Program.

Reporting:

Question 59: What is the definition of a "service visit" within the context of this RFA?

Answer 59: A service visit may include a behavioral health intake/screening session, one of the three behavioral health education sessions, or Peer Navigator engagement/ education activities that include client contact (i.e. appointment accompaniment). Refer to Section III. B. - *Description and Overview of Components A and B*, page 7-8 of the RFA.

Question 60: For Component A: Section III Project Narrative/ C) Program Requirements and Guiding Principles/Additional Requirements to Component A, a, line 4, "…reporting of unduplicated client level data…" Would you please specify the client level data requirements for programs funded by this RFA?

Answer 60: Funded programs will be required to submit client enrollment and closure data, client services data (e.g., intakes, education sessions, peer engagement activities, peer accompaniment services, etc.), and client health indicators. Additional data requirements may be added in the future as required by the funder.

Question 61: For Component A: Section III Project Narrative/ C) Program Requirements and Guiding Principles/Additional Requirements to Component A, a, Are all data requirements of the current RWB MH BCSS, including multiple client level data indicators, going to be required in the Behavioral Health funding?

Answer 61: Data requirements, additions, and/or amendments will be discussed during contract negotiations with providers awarded funding.

4. COMPONENT B SPECIFIC

Question 62: Regarding **Component B** of the RFA, does the intended target audience of "community based HIV/AIDS behavioral health education and engagement services staff funded under Component A" include physicians and other clinicians (pp. 4; 7)?

Answer 62: Refer to Section III. B. - *Description and Overview of Components A and B*, page 9 of the RFA. HIV/AIDS behavioral health education staff (including clinical providers who are not necessarily excluded from being potential staff) funded under Component A of this RFA will be targeted for this training and technical assistance. All services provided under the program, as well as all training needs, would be limited to the provision of behavioral health education services designed to promote client linkage to and engagement in behavioral health treatment. See also answer to #44.

Question 63: Does AI have a formal training evaluation that they use or will we develop our own? Do we need to make specific reference to the curriculum and trainings we have developed around LBGT Cultural Competency, Motivational Interviewing, Retention and Stigma and do these topics constitute behavioral health education for this RFA? We have also developed a documentation training for care management providers to better coordinate services between their behavioral and medical providers. Should these be addressed in the RFA? (Component B, Questions, Section VI: Evaluation and Quality Improvement – Question #4) Describe the processes and mechanisms for reviewing the performance and abilities of the trainers and consultants, including but not limited to: presentation skills, group processing, interpersonal skills, communication, and cultural sensitivity.

Answer 63: Refer to Section III. B. *Description and Overview of Components A and B*, page 9 of the RFA. A successful applicant for Component B will be able to demonstrate that they are able to evaluate training and technical assistance activities including process and outcome measures that examine the impact of training activities on promoting client linkage to and engagement in behavioral health treatment. Preference will be given to Component B applicants that demonstrate experience in the development and delivery of training services in topics related to behavioral health education.