RFA #1306271049

New York State Department of Health
Division of Chronic Disease Prevention
Buerau of Tobacco Control

Health Systems for a Tobacco-Free NY

Modifications, Questions and Answers

All questions are stated as received in the Tobacco Control Program Bureau Mail Log by the deadline. The Bureau of Tobacco Control (BTC) is not responsible for any errors or misinterpretation of any questions received.

*The responses to questions included herein are the official responses by the Department to questions posted by potential applicants and are hereby incorporated into the RFA #*1306271049 issued *on October 9, 2013. In the event of any conflict between the RFA and these responses, the requirements or information contained in these responses will prevail.*

RFA UPDATES

The following has been updated/modified in the RFA. Strike-through indicates deleted text; underlined text is new.

Page 23, Section IV, L.

Please be advised that prequalification status will be verified through an initial compliance check for all non-exempt applicants. Applicants who have been prequalified will move on to the application review phase. The BTC will contact organizations that are not prequalified via phone and follow-up email using the contact information provided in the Application Coversheet. The applicant will have 10 days to prequalify with the Grants Gateway. If applications meet the deadline, they will move on to the application review phase. Applications not able to meet this deadline will be at risk of their applications not being reviewed thereby making them ineligible for award.

Although a letter of interest is optional, it is strongly encouraged if you anticipate submitting an application so that the Department may assist applicants with the vendor prequalification process.

Page 12, Section III, Component A, 1. g.

"Funded contractors ~~may~~ will dedicate ~~up to~~ 5% of the Deliverable 1 budget to a health communications campaign (paid media) for the purpose of targeting health care providers and increasing use of guideline-concordant care."

Page 12, Section III, Component A, 1. h.

"Funded contractors ~~may~~ will dedicate ~~up to~~ 1% of the Deliverable 1 budget to statewide collaborative conference calls, webinars, trainings, and supporting materials for the purpose of educating health care providers and increasing use of guideline-concordant care."

Page 26, V., A., Section 6: Budget

Guidance for completing the budget template has been posted along with this Modifications, , Questions and Answers document.

Page 9, Section II,

The catchment area to be served is to be clearly defined on the cover page of the ~~RFA~~ application.

RFA QUESTIONS AND ANSWERS

Introduction Section:

Q1a. Page 3, paragraph 2 "…related to tobacco dependence treatment provided in hospital settings, is not a focus of this RFA." Does this mean contractor should make no efforts in implementing the Opt to Quit in the hospital (even those that are located in and serve the targeted population) setting?

Q1b. Page 3, Section 1, paragraph 2: System Strategy 4, related to tobacco treatment provided in hospital settings, is not a focus of this RFA. Are hospital systems that operate primary care practices that serve low SES population a focus of this RFA?

Answer (Q1a, Q1b):
Promoting systems change related to tobacco dependence treatment provided in inpatient hospital settings is not a focus of the RFA. However, hospital systems with outpatient services that broadly serve the disparate populations outlined in the RFA can be included in an applicant's proposal. System level policies and procedures such as an Opt to Quit type of referral system is allowable when part of an outpatient-focused systems intervention to support disparate populations as defined in this RFA. Opt-to-Quit™ is a branded program of the NYS Smokers' Quitline and one option to facilitate Quitline referrals.

Q2. Page 4 - Paragraph 2 - under Component A - "...incorporating "clinician extender" strategies such as Quitline referrals into tobacco dependence treatment system." Does the phrase "Quitline referrals" refer to what is also known as "Opt to Quit"?

Answer (Q2): Opt-to-Quit™ is a branded program of the NYS Smokers' Quitline and one option to facilitate Quitline referrals, hence employing a clinician extender. Other examples of clinician extenders can include assisting tobacco users with finding free or reduced cost cessation medication, or providing web links or materials for the tobacco user to learn more tips and strategies for a successful quit attempt.

Q3. In Section I pages 4 and 7, Section II page 9, and Section III page 10 and 11: The newly funded contractors will have more counties, but less funding. What assumptions/expectations does the State have in mind for how work will be substantially different from current Cessation Center work?

Answer (Q3): This RFA represents a greater emphasis on change at the system level, rather than the practice level, as is the case under current funding. For the medical health care systems and policy change deliverable, the greatest percentage of effort of Health Systems Component A contractors' work will focus on assisting health care organizations with establishing/adopting system-level policies and procedures that improve tobacco dependence treatment as recommended in the Public Health Service Guideline. For the mental health care systems and policy change deliverable, contractors' work will focus on assisting health care organizations that serve the seriously mentally ill with establishing/adopting tobacco dependence treatment systems as recommended in the PHS Guidelines and considering the unique needs of individuals with serious mental illness.

Q4. In Section II pages 4-6 and page 9: Will the funded Option B "Center of Excellence" contractor assist Option A contractors with top-down recruitment and engagement, so that Option A contractors can cost-control some amount of planned travel for initial relationship-building, administrative commitment meetings, policy development meetings, trainings, etc.?

Answer (Q4): The Component B statewide contractor will serve as a "Center of Excellence" for the adoption of tobacco dependence treatment health systems and will focus its efforts on two sets of consumers. First, the Component B contractor will serve as a resource to all Component A contractors by developing materials, manuals, protocols and other products designed to assist Component A contractors in promoting the adoption of the tobacco dependence treatment health system change with disparately affected groups. Second, the Component B contractor will work with statewide entities to promote large scale systems and policy change and improve health systems delivery of tobacco dependence treatment through efforts with statewide health systems and other statewide stakeholders.

Component A applicants should submit budgets that support Component A work plan activities, which can include recruitment and engagement, and not assume that the entity funded as a result of Component B of this RFA will pay those costs.

Q5. For practices trained in previous contracts and/or previously deemed to be in systems adoption, can we re-engage them as new partners?

Answer (Q5): Applicants funded as a result of this RFA that were contractors for a previous health system change initiative can re-engage previous partners **if and only if** the previous partners meet the definition of a health system as defined on page 10 of the RFA – that is "community health centers, FQHCs, mental health and behavioral health service organizations and similar organizations that serve disproportionately affected populations (low education, low

income, and seriously mentally ill)," AND, to clarify, this partner has not fully implemented a system change consistent with PHS Guidelines.

Q6a. Page 7, under *Health Systems for a Tobacco-Free NY*, paragraph 2, compared with the end of paragraph 3. "health care systems" are defined by Health Care Provider Organizations (HCPO's) vs. "health systems" defined as Medicaid Managed Care Providers? Or are they both referring to HCPO's. Please define further.

Q6b. What level of flexibility can we have in working with HCPO's that may be independent (i.e., not part of larger system) targets? Small Docs' offices? Medical Specialty offices? Dentists? (Sections I, III: Pages 4,11).

Answer (Q6a, Q6b): See page 10. For purposes of this RFA, the phrases health system and health care system are interchangeable. Component A contractors will facilitate health systems change with community health centers, FQHCs, mental health and behavioral health service organizations and similar organizations that serve disproportionately affected populations (low education, low income, and seriously mentally ill) within the contractor's catchment area. This RFA prioritizes change at the system level versus change at the individual practice level such as doctors' offices and dental offices. The strongest applications will be those that propose a robust approach to systems-level changes.

Section II Who May Apply:
Q7. Are organizations allowed to apply for both Component A and Component B?

Answer (Q7): No. Organizations may apply for **either** Component A **or** Component B, **but not both.** For the purposes of this procurement, organizations are distinguished by their NYS Vendor ID#.

Q8. Upon reviewing the RFA our organization would like to clarify whether or not we would be able to apply for multiple catchment areas for RFA #1306271049.

Answer (Q8): See RFA page 9. Agencies may apply to serve more than one catchment area in Component A. However, a separate application must be submitted for each catchment area. A single application for more than one catchment area, as defined in the RFA, **will be rejected**.

Q9. Will applications from Health Care Facilities such as hospitals be given preference over community organizations?

Answer (Q9): No. All applications will be evaluated based on their individual merit using the specifications set forth in the RFA.

Q10a. In order to efficiently and effectively reach multiple counties/boroughs it makes sense to partner with other cessation centers on these proposals. However we would want to provide subcontracts to them for staffing so that the staff are in closer proximity to those communities they serve. Are we allowed to fund a full-time Program Coordinator through subcontracts?

Q10b. Section II, Page 9, states that "All core (required) personnel must be employed by the applicant and cannot be subcontracted." Given that the RFA combines areas but does not allow

subcontracting, how can current Tobacco Cessation providers in the same region partner to provide services?

Q10c. Subcontracts - the RFA says that substantive work cannot be subcontracted out. Currently we have a full-time Academic Detailer subcontract (who works on grant deliverables as related to systems change) with ACS...could this relationship continue under the new guidelines in a less than 1.0 FTE capacity?

Q10d Page 9, Paragraph 3: Regarding subcontracting, the examples provided in the RFA do not include direct delivery of service from the work plan by a subcontractor. It further states major components of the work plan cannot be subcontracted. Is this restriction measured by the dollar value of the contract (less than 50%)? Can subcontractors work directly with organizations on system and organizational changes?

Q10e. My question is regarding the role of subcontractors. On Page 9 of the Project Narrative and Page 16 of the Master Contract for Grants there is information regarding subcontractors. Can a subcontractor be utilized to work on the required deliverables such as the Medical Health System Change or Mental Health System change for a portion of the catchment area?

Q10f. What are considered the major components of the work plan that cannot be subcontracted?

Q10g. In Section II, paragraph 4 (pg. 9), the RFA states: "All core (required) personnel must be employed by the applicant and cannot be subcontracted." How does the Department define "core (required) personnel"? Is there a professional level that is considered "core"?

Q10h. In Section III: Pages- 10,14: The RFA has wording related to limits on sub-contracting and on staff being employed directly by the funded contractor. Is there an approved way that a current Cessation Center could subcontract with the other Cessation Center in the newly defined region for a specific aspect of the proposed work?

Answer (Q10a-h): See RFA page 9. The applicant is responsible for implementing the work described in the RFA. All core (required) personnel must be employed by the applicant and cannot be subcontracted. The only required (core) position for this grant is a full time Project Coordinator. The contractor will use grant funds to employ a minimum of one full-time Project Coordinator position responsible for building, coordinating and guiding the project in meeting the deliverables of the grant. Applicants may subcontract components of the scope of work (e.g., evaluation, media, and information technology), but it is required that the applicant retain a majority of the work in dollar value (more than 50%) of the contract within the applicant organization. This means that the total value of the subcontract section of the budget should not exceed 49% of the budget for the grant funds. Subcontractors are not specifically prohibited from working directly with organizations on system and organizational changes. See also page 16.

Q11a. Are Consultants permitted on the contract?

Q11b. On page 9, it mentions major components cannot be subcontracted. Would consultants to perform trainings be allowed?

Q11c. In the RFA, it states that major components of the contract cannot be subcontracted out. Within an organization where there are affiliate staff who are directly supervised by the

contracting organization, would this be considered a subcontract?

Q11d. Are we allowed to include consultants on the budget?

Answer (Q11a-d): The RFA does not prohibit the use of consultants, subcontracts, or affiliate personnel. Staff not funded directly by the applicant should be clearly represented in the work plan and the subcontract portion of the budget.

Q12a. If an organization is submitting an application as a contractor for Component A, can they function as a subcontractor (10-30%) in a Component B application?

Q12b. While the RFA states that organizations cannot lead proposals to both Component A and B, is it allowable to lead a proposal to one component and be a sub-contractor for the other component. **Refer to page 9, paragraph 2.**

Q12c. Can a current Cessation Center Coordinator be written into two grants? As solo and in partnership?

Answer (Q12a-c): Organizations may apply for Component A and serve as a proposed subcontractor to another entity applying for Component B. Applicants may include a proposed staff person for positions that are not required to be 100% FTE in multiple applications, but no one person can exceed 100% FTE in aggregate when funded through one or more Department contracts.

Q13a. The Defined Regional Catchment Areas can be rather large. Will contracts be expected to reach all counties or can there be focus areas?

Q13b. There are 10 catchment areas listed. E.g. Metro North is listed as New York, Bronx, Queens. Are responses expected to cover the full catchment area - so all 3 boroughs? If not, are responses that cover all 3 areas more attractive to reviewers?

Answer (Q13a,Q13b): Applicants are expected to cover the full catchment area. Component A catchment areas are listed on pages nine and ten of the RFA. Catchment areas define the geographic area in which health systems change activities will occur.

Section III Component A Project Narrative/Workplan Outcomes Medical Health Care Systems and Policy Change:

Q14a. In the RFA, it appears that hospital systems are not to be included in workplans. If there are hospital systems that serve 80% or more of the target population described in this grant (those groups disproportionately impacted by tobacco- disparate populations), could outpatient clinics of hospitals that serve the population described in the RFA at this high proportion be considered as potential partners in the workplan?

Q14b. If hospital ambulatory clinic serves populations mentioned in RFA, can we target these clinic's MDs?

Answer (Q14a,Q14b): It is not the intent of this RFA to focus on hospital inpatient systems of care, but outpatient clinics serving the target population can be an important part of a catchment

area's health care delivery system. Hospital systems with outpatient services that broadly serve disparate communities can be a component of this RFA. The focus on the RFA is not individual clinic practitioners, but systems within which physicians and other providers work. The focus of the workplan activities is on system level changes that can result in improving tobacco dependence service delivery on a broad scale.

Q15a. Funds for Paid Media and for collaborative conference calls are optional in this contract. If a contractor decides not to include these items in their budget, will points be deducted?

Q15b. Page 12 letters g: "…health communications campaign (paid media)"…and letter h: "…statewide collaborative calls…" Since the word "statewide" is included in the collaborative conference call section, but not the paid media section, is it correct to conclude that each center will be in charge of placing their own media, but the conference calls will continue to be a statewide collaborative?

Q15c. In the past, the "optional" budgeting for Media, at 6% of the overall budget was a required amount that was requested to be set aside for the State Media strategies. Should we plan for this 6% for this submission? If we include in this submission, would it be part of the 40-45% Medical Health Care Systems and Policy Change budget? Or from the 10% Sustainability?

Answer (Q15a-c): The intent of the health communications campaign is to contribute to a statewide effort. Some applicants may also choose to budget for local media as described on page 12. Therefore, applicants should plan to contribute to the health systems change statewide media and collaborative conference call initiatives. The specific plans for media and conference calls will be determined, but the budget allocation for media is 5% of the Medical Health Care Systems Change budget and 1% for collaborative calls. There is no point allocation specific to media budgeting in the review tool used to evaluate applications. **SEE RFA MODIFICATIONS SECTION (PAGES 1-2) OF THIS Q AND A DOCUMENT FOR AN IMPORTANT CORRECTION REGARDING FUNDING FOR MEDIA.**

Q16. Page 11, letter a. "For example, working with FQHCs would be appropriate but working directly with its satellite clinics would not." Once policy is signed, can contractor than go into satellite clinics to do the initial trainings, at least until a system of ongoing trainings has been developed?

Answer (Q16): [page 11 d] Yes, but time working with a specific clinic should be minimal. Contractors will work with health care organizations to adopt the PHS Guideline health system initiatives including tobacco use screening systems, a formal tobacco dependence treatment provider training plan, provision of cessation resource materials, and methods for implementing a quality control feedback system that makes providers aware of their performance on a regular basis. Contractors will provide technical assistance on how such systems should be incorporated into current practices and how the new practices can best be disseminated to clinics and providers.

Q17a. Item b concerning the Memorandums of Understanding (MOUs) attachments. Do you have a template of what is expected from the MOUs? Also as a current grantee, we have many existing partnerships with HCPOs and PCPs in our community. Should we include MOUs for these partners as well?

Q17b. Do we develop / propose our own format for MOU's, or is that an example of what the Center for Excellence would do, since they will be asked to provide guidance, facilitate, coordinate protocols, etc. for enhancement of delivery of strategies?

Answer (Q17a,Q17b): There is no RFA attachment of an MOU. MOUs are not required for the application. Templates are not provided. An MOU is the preferred evidence of a contractor's relationship with a health care organization.

Q18. Page 10, Section 3, Paragraph 1: Contractors will facilitate health system changes with community health centers, FQHCs, mental health and behavioral health service organizations. What definition of community health centers is the BTC using in this instance?

Answer (Q18): According to Health Resources and Services Administration (HRSA), health centers are community-based and patient-directed organizations that serve populations with limited access to health care.

Section III Component A Project Narrative/Workplan Outcomes. Mental Health Care Systems and Policy Change:

Q19. Page 13, part e. "Contractors will provide guidance on the content of electronic screening systems noting the recent movement toward ensuring **"meaningful use."** Question - Do Mental Health providers have to attain meaningful use standards in the same way as FQHC's?

Answer (Q19): The Medicare and Medicaid EHR Incentive Programs provide financial incentives for the "meaningful use" of certified EHR technology to improve patient care. Meaningful use is not specific to any category of health care provider organization.

Q20. Section III: Pages-12, 13: How will the OMH be involved under the Mental Health Care Systems and Policy Change component?

Answer (Q20): [page 15] The Component B contractor will participate in a collaborative workgroup consisting of the New York State Office of Mental Health (OMH), Department of Health, and other stakeholders to promote a tobacco-free environment in OMH facilities. This group's goal is to address tobacco use and dependence and promote sustainable tobacco-free norms within treatment settings serving the serious mentally ill. The specifics of involvement with this group will be determined in discussion with the group but the role of the contractor will be consistent with the systems approach described in this RFA and the work will be directed by the Department.

Section III Component A Project Narrative/Workplan Outcomes Local Level Disparity Project:

Q21. Page 13, Section 3, Paragraph 1: The Local Level Disparity Project outlines the same health system changes and target populations as in the medical and mental health care systems. Could this distinction be clarified further? What would be an example of a special project?

Answer (Q21): The local level disparity project can address health systems change for a unique subpopulation or organization that serves the needs of individuals with low income, low

educational attainment, or serious mental illness. Local level disparity projects will require Department approval before work begins.

Q22. Page 13, 3. Local Level Disparity Project: Can this project be in collaboration with a specific County Department of Health?

Answer (Q22): Yes, a county health department could be a potential collaborator. Local level disparity projects will require Department approval before work begins.

Section III Component B Project Narrative/Workplan Outcomes:

Q23. Regarding the statewide support of Health Systems Change, is the Component B contractor expected to perform a lead role in fostering relationships, such as convening webinars and conference calls? What, if any percentage of the role involves travel? **Refer to page 15, paragraph 3.**

Answer (Q23): Yes, convening webinars and conference calls could be a strategy for working with statewide stakeholders. The project coordinators for Component B will be required to attend and participate in all regional and statewide meetings, and attend required trainings as determined by the Department. Successful applicants should plan on approximately six trips to the Albany area for meetings and trainings annually.

Q24. Can you describe the potential overlap for the work to be done under Component B, particularly work on 'statewide support of health systems change', with other state funded efforts such as work done through the New York State Smokers' Quitline? **Refer to pages. 14-15, Component B.**

Answer (Q24): The Component B contractor will foster relationships with statewide stakeholders and organizations with an intent of coordinating any existing efforts at reaching common goals such as those listed in this section (for example promoting and increasing use of cessation related health plan benefits). NYS Smokers' Quitline could be a stakeholder and partner to promote large scale systems and policy change and improve health systems delivery of tobacco dependence treatment.

Section III Additional Requirements Components A and B:

Q25. In Section III, Additional Requirements, number 3. Staff Orientation, Training…etc. (pg. 17), the RFA states: "Contractors are required to support contract staff by providing the following:…current computer system with access to an individual e-mail account and internet connection…"; are computers and other technology equipment still allowed to be purchased?

Answer (Q25): Contract staff should have access to a current computer system with access to an individual e-mail account and internet connection. Equipment, such as computers, can only be purchased for staff on the grant, and the expense should be proportionate to the percentage of FTE.

Section IV Administrative Requirements:

Q26. Question Re Section IV: K and L; Our applicant may be a corporation that has not yet completed a Vendor Responsibility Questionnaire or a Grants Gateway Pre - Qualification / Registration. With the Grants Gateway in place, is it necessary to also do the Vendor Responsibility Questionnaire?

Answer (Q26): The Grants Gateway prequalification process and the Vendor Responsibility Questionnaire process are separate. The questionnaire gathers a large amount of data about the organizational structure, business characteristics, and primarily issues related to integrity; for bidding, for contracts, licenses, and leadership as well as current/recent legal proceedings and financial/organizational capacity. While the Grants Gateway includes some similar information about the organization's structure and business characteristics, it includes only a few questions that are similar about integrity. The Vendor Responsibility Questionnaire (VRQ) is a requirement for non-exempt organizations prior to the Department entering into a contract. The Vendor Responsibility Attestation (Attachment 7) should be submitted with the application (see RFA, pg 23). Applicants recommended for award will be required to complete a VRQ prior to the Department approving the resulting contract. Please note, that there are organizations, such as municipalities, that are exempt from the Vendor Responsibility process. For more information please visit the Office of the State Comptroller website http://www.osc.state.ny.us/vendrep/. Grants Gateway registration and prequalification (if applicable) is required for an application to be evaluated for an award. For more information on the Grants Gateway registration and prequalification, please visit www.grantsreform.ny.gov . Please also refer to the modifications above regarding L. Vendor Prequalification for Not-for-Profits.

Section V Completing the Application General:

Q27. Is there any specified format for the requested Table of Contents?

Answer (Q27): No, there is no specified format for the requested Table of Contents.

Section V Completing the Application Statement of Need:

Q28. Clarify what should be included in the Statement of Need (e.g. are we addressing the populations' need or just the level of adherence to system changes and guideline recommendations across health systems in the region?)

Answer (Q28): See RFA page 25. For Component A applicants, describe **local health system policies** in the catchment area using the best information available, the current status of compliance with these policies, and opportunities for tobacco control action in the catchment area.

For Component B applicants, describe statewide health systems and policies that would be the focus of the applicant's work using the best information available, current challenges to successfully completing this work, and opportunities for statewide health systems tobacco control action.

Section V Completing the Application Program Plan:

Q29. Page 25, Section 3, Program Plan: There is a 10 page limit on the Program Plan section. There is a request for a written narrative and then two work plan templates that need to be included for program planning. Is the narrative different from the templates? If they are different, do the templates contribute to the 10 page limit? Does the work plan template contribute to the 10 limit? Is there a document available on work plan definitions and guidance to completing the template? For example, how do you define goals, outcomes, objectives and performance measures?

Answer (Q29): Budget pages, workplan and other attachments do not count in page total. Goals, Objectives, and Outcomes are stated within the workplan. See attachment 6.

Q30. Do you have to identify the names and/or titles of the Administrators targeting?

Answer (Q30): If known, all personnel, including administrators, names and titles should be provided.

Section V Completing the Application Staffing Pattern and Qualifications:

Q31. Are a job description and resume required for the Fiscal Agents finance department? I am referring only to those persons who would be directly involved with the vouchering of this grant.

Answer (Q31): Yes.

Q32. The grant states that there must be at least one full time position, is there a maximum number of staff, for example no more than three full time staff?

Answer (Q32): No.

Section V Completing the Application Budget:

Q33. Should we submit a budget for the first 9 months AND each of the subsequent four years?

Answer (Q33): See page 26. Applicants should submit two budgets. Budget 1 is a nine-month budget (July 1, 2014 – March 31, 2015) and Budget 2 is an annualized 12-month budget that will represent the remaining four years.

Q34. Page 26, Section 6, Paragraph 1: Budget 2 is an annualized budget that represents the remaining four years of the contract. How are annual salary increases considered for the last three years of the contract? Is it expected that a budget modification be submitted to address this issue each year?

Answer (Q34): Any modifications to the budget for any year of the resulting contract(s) would be addressed annually and are subject to prior approval of the Department.

Q35. Please provide further explanation of "This funding may only be used to expand existing activities or create new activities pursuant to this RFA. These funds may not be used to supplant funds for currently existing staff activities."

Answer (Q35): If staff/activities are already being funded via another source, funding from this grant cannot now be used to fund those staff/activities. If the applicant is currently funded under a contract with the Department and is selected for funding as a result of this RFA, the resulting new contract will begin when the current Department contract expires (June 30, 2014). Supplanting will not apply.

Q36. Our PI is technically an employee of NYU, which is the affiliate of HHC/Woodhull. Last year, the State made us list this line under OTPS. The PI contributes 10% of his time. Would this still be allowed? If not, could his contributions be in-kind or do the rules about subcontracts prohibit his involvement?

Answer (Q36). Only employees of the applicant organization should be listed in the personnel section of the budget. Other consultants, affiliates, or subcontractors should be listed in the subcontract section.

Section V Completing the Application Optional Program Components:

Q37. If our agency is not planning a local level disparity project or direct cessation, can we omit this section or would you like a sentence in the proposal to state that we are not planning a project or offering cessation services?

Answer (Q37): This section may be omitted. It is not necessary for applicants to stipulate why they are not planning a local level disparity project or providing direct cessation services.

Section V Application Format:

Q38a. What are the margin limits for formatting the application? Can we use 0.5?

Q38b. The RFA does not specify margin size for the proposal. Could you please provide guidance on this?

Q38c. The RFA does not mention headers and footers. Are they allowed, and if so, is there a specific format, such as page numbers, name of applicant, etc.?

Answer (Q38a-c): The RFA did not describe a margin requirement, but a 1 inch margin is preferred. Similarly, there is no specified format for headers and footers, but all pages should be numbered.

Q39. For the submission of the original plus 5 copies of the application, should the 5 copies include the full application - e.g. all of the counted pages (cover sheet, check list, TOC, tobacco-free policies) and attachments (budget, workplan and other attachments)?

Answer (Q39): Yes.

Section VI Attachments General:

Q40. Will the RFA be made available in Word format so our organization may electronically fill in all necessary forms?

Answer (Q40): No, the RFA will not be released in Word format. However, many of the forms in the Attachment section are posted on the Department website in Excel and Word format here: http://www.health.ny.gov/funding/rfa/1306271049/index.htm.

Section VI Attachment #5 Budget:

Q41. What is the allowable budget (per year and for how many years?)

Answer (Q41): Pages 9-10 of the RFA lists the catchment areas and estimated annual funding amounts. As stated on page 21 of the RFA, the contract is a single multi-year contract with a term of four years and nine months.

Q42. For indirect costs, may we include a percentage of time for the organization's accounting/finance office to assist with bookkeeping? May the program's administrative supervisor (who will oversee the director) have a line under personnel or just under indirect? May an independent auditor have its own line or must that come out for the 10% for indirect costs?

Answer (Q42): Staff who have a significant role in the administration of this grant may be included in the personnel services category showing the percentage of FTE. A cost such as independent auditor should be included in the indirect services, or as a contractual service. The administrative costs included in the indirect line are ultimately determined by the applicant organization.

Q43a. Are there guidelines for staff salary rates?

Q43b. Is there a salary cap?

Q43c. What is the dollar value of the executive compensation level?

Answer (Q43a-c): This RFA does not dictate staff salaries, however e*ffective July 1, 2013, limitations on administrative expenses and executive compensation contained within Governor Cuomo's Executive Order #38 and related regulations published by the Department (Part 1002 to 10 NYCRR – Limits on Administrative Expenses and Executive Compensation) went into effect*. Please see RFA Section IV.I, Limits on Administrative Expenses and Executive Compensation for more details.

Q44. Is there a limit on the number of new computers that can be purchased?

Answer (Q44): Yes, equipment, such as computers, can only be purchased for staff on the grant, and the expense should be proportionate to the individual's percentage of FTE on the grant.

Q45. An identified barrier to Health Systems making system-wide changes to their EMR systems is that some EMR vendors will charge for this. Can some of the Option A or Option B funding be used to purchase IT programming?

Answer (Q45): Use of grant funds to purchase IT programming is not prohibited. Any proposal for this will be evaluated during the application review process for its cost benefit to the initiative. The potential contribution to achieving the goals of this RFA will be balanced against

the cost.

Q46. Attachment 5 budget template – tab: personal service salary detail = when this information is filled in, only row 17 "fringe" is populated on tab: expenditure based budget. Can a revised spreadsheet be requested, or may applicants make changes to the existing spreadsheet to adjust?

Answer (Q46): When the columns (Annualized Salary per Position, Percent of Effort Funded, and Number of Months Funded) on the personal service detail tab are filled in for each position, the total column will auto-calculate. The subtotal cell's data will then be transferred into the expenditure based budget tab (row 16). A revised spreadsheet is not available. If changes are made to the existing spreadsheet, the auto-populate formulas will not work. Guidance for completing the budget template has been posted along with this Q&A document.

Q47. How can per diem employees be added to attachment 5 budget template without their salary being included in fringe?

Answer (Q47): In the narrative tab, include detail about fringe being excluded for per diem employees.

Q48a. What are the limits on administrative expenses? What are the administrative expenses? Is there a difference between administrative costs (presumably indirects at 10%) and administrative expenses?

Q48b. In Section V, page 27, paragraph 3, there is a formula for determining Administrative costs. Assuming the Total Budget = $300,000 for Component A in Years 2-4, the direct costs allowable would be 300,000/1.1 = $272,727, and the Administrative allowance would be $27,273. Is this correct?

Answer (Q48a,Q48b): There is not a difference between administrative/indirect costs and administrative expenses. In accordance with page 27 of the RFA, Administrative costs are limited to a maximum of 10% of the total budget using the following calculation:
Total budget / (1 + .10) = Remaining budget. The difference is reserved for administrative costs. Administrative costs are expenses that are indirectly related to the implementation of program services. They may also be referred to as indirect costs or overhead costs. These are the costs of doing business and typically include items such as insurance, salary of staff not directly implementing program activities, payroll processing, IT support, utilities, rent/space, bookkeeping, bank and audit fees.

The calculation in Q48b is correct.

Q49. Should the budget be the same for all years? For example, salaries increase every year, so we are wondering how much flexibility we will have each year to address such changes. Additionally, is a revised fiscal handbook available at this time to guide us through this process? For example, we would like to be able to answer questions such as, "Is overhead remaining at 5%," or "Are the allowable budget lines staying the same?"

Answer (Q49): Salary adjustments should be included in the applicant's budget. A fiscal handbook is not available for reference. Applicants should follow the specifications set forth in

the RFA. In accordance with page 27 of the RFA, Administrative costs are limited to a maximum of 10% of the total budget using the following calculation:
Total budget / (1 + .10) = Remaining budget. The difference is reserved for administrative costs.

Section VI Attachment #6 Workplan:

Q50a. Do we use attachment C or appendix 6 as the format for the workplan.

Q50b. There seems to be a difference in the workplan format included in the RFA and the workplan format that is listed at http://www.health.ny.gov/funding/rfa/1306271049/index.htm http://www.nyhealth.gov/funding
The Workplan template provided on the website http://www.health.ny.gov/funding/rfa/1306271049/index.htmhttp://www.nyhealth.gov/funding is referred to as "Attachment 6a – Health Systems for a Tobacco Free NY – Component A – Workplan Template" The Workplan included in the RFA is called "Attachment C – Workplan – Detail" Are we to complete both of these workplans or are we to use only the format posted on the http://www.health.ny.gov/funding/rfa/1306271049/index.htmhttp://www.nyhealth.gov/funding ?

Q50c. There seems to be two workplans in the application posted. One embedded in the RFA description and a word document downloadable (Attachment C and 6a). Would we be expected to fill out our workplan in both of these? If not, which one should we submit?

Q50d. Could you please provide guidelines for completing the "Budget Category / Deliverable (if applicable)" column in Attachment C - Work Plan?

Answer (Q50a-d): The Attachment C Work plan is part of the Master Grant Template (RFA Attachment 1) which is provided as a reference document only for purposes of this RFA. Attachment C of the template is not a required document to be completed as part of the application process. Applicants are to complete Attachment 6 as stated on page 25 of the RFA. Complete Attachment 6a (Component A Work Plan Template) or 6b (Component B Work Plan Template) for this application.

Q51. Attachment 6a (Workplan), Medical Health Care Systems and Policy Change Initiative Outcome: Hospital systems have various sub-systems, defined in complicated ways, mergers, etc. As a target outcome, what is meant by "at least 50%". Does this mean 50% of all health service parent organizations (FQHC's, Hospital Systems), or of all units underneath those organizations (individual clinics, points-of-care for services)?

Answer (Q51): The outcome refers to health care parent organization administrators.

Section VI Attachment #7 Vendor Responsibility Attestation:

Q52. Do we need to submit Attachment 7, Vendor Responsibility Attestation with the grant?

Q53. If we have a Vendor Responsibility Questionnaire currently on file and valid within the period of submission in the "vault" on the Grants Gateway, would we need to submit it separately via the New York State VendRep System?

Answer (Q52, Q53): See RFA page 23. Yes, you would need to separately submit via the NYS VendRep System. These are two separate databases, maintained by different State Agencies. Please note the Vendor Responsibility Questionnaire is not a requirement to submit with an application but rather, a requirement prior to entering into a contract with the Department. The Vendor Responsibility Attestation, Attachment 7 of the RFA, should be submitted with the application.

Section VI Attachment #9 Tobacco-Free Policies Attestation:

Q54. Regarding Attachment 9, Tobacco-Free Policies Attestation: In the past, the sponsor has considered our Department (Public Health Sciences) as the "funded unit" within our University. Our previous Tobacco-Free assurances have been signed by the Department Chair and an Institutional Business Official. We are assuming that it is acceptable for us to complete the new Tobacco-Free Policies Attestation in a similar fashion, identifying our Department of Public Health Sciences as the organizational unit meeting the policy requirements and the financial relationship restrictions in this year's RFA. Is this acceptable and will the Department Chair's signature be sufficient on this form, since there is only one signature block provided?

Answer (Q54):. Applicants are asked to complete the form attesting, to the best of their knowledge, that the applicant organization, its subcontractors and subgrantees do not have any affiliation or contractual relationship with any tobacco company or tobacco product manufacturer, its affiliates, its subsidiaries or its parent company.

Q55. Who can sign the attestation page?

Answer (Q55): The Tobacco-Free Policies Attestation should be signed by the same Applicant Authorized Representative who signed the Cover Sheet.

Miscellaneous:

Q56. Will "cessation resources and materials" to accompany technical assistance be provided to the contractors by the Department or will the contractors produce and fund their own resources and materials? P. 3, second paragraph

Answer (Q56): Cessation resources and materials will be developed by the Component A contractors, the Component B contractors and the Department. Applicants should budget resources to develop and produce such materials.

Q57. Will SCC meetings continue to be in person in Albany, requiring travel and travel dollars for members of the SCC?

Answer (Q57): If a successful applicant has an employee who becomes a member of the Statewide Coordinating Council (through the regional nomination process), the applicant organization will be responsible for travel costs for that staff person. The meetings will continue to be in-person in Albany four times per year.

Q58. Could a car be leased or purchased for this program?

Answer (Q58): No

Q59a. Is this RFA #1306271049 the reissuance of the current Cessation Centers RFA?

Q59b. We have a Community Partnerships grant that will commence 6/30/14. Your e-mail announcement is in reference to another RFA, not the Community Partnerships, correct?

Answer (Q59a,Q59b): With RFA # 1306271049, the New York State Department of Health Bureau of Tobacco Control (BTC) seeks applications from organizations that will work to engage health care systems to improve the delivery of guideline concordant care for tobacco dependence through systems and policy change at the organizational level.

Q60. I am working on our Community Health Improvement Plan with area hospitals, the Federally Accredited Health Center and the cessation center in our region. One of our goals addresses increasing the number of adults who access smoking cessation services. I plan to read the RFP but I wondered if there was any quick feedback/information I should know on how the new RFP may affect the development of our CHIP.

Answer (Q60): Community Health Improvement Plans are critical to public health improvement, and the Department applauds the inclusion of your local cessation center. However, the Department is not able to comment on your specific local plan at this time.

Q61a. Will Letters of Support be recognized? The RFA does not mention them. We would like to know if they will be read or if we will be penalized for including additional pages.

Q61b. In previous RFAs, letters of support were required as part of the application process. There is no mention of letters of support in this RFA. Should letters of support be included in the completed application? If so, do they count towards page limits?

Q61c. Letters of support – where should they be placed in the grant? Are they considered appendixes?

Q61d. Can we get letters of support from state agencies?

Q61e. Can we submit letters of support with the application?

Q61f. Are additional appendices allowable, such as Letters of Support, References/Bibliography, etc.?

Q61g. How much supporting documents and evidence do you request with the application?

Answer (Q61a-g): Letters of Support are not required for this RFA and are not considered when scoring the applications. There are no restrictions on who can supply a Letter of Support. If an applicant chooses to include any, then an appendix could be created. Applications should not exceed *29* single-spaced typed pages for Component A or *26* single spaced typed pages for Component B (page count includes the Application Cover Sheet, Check List, Table of Contents, Tobacco-Free Policies Attestation form; (budget pages, workplan and other attachments do not

count in page total), using a Times New Roman 12-point font. Applications should adhere to page limits within each section. Any pages exceeding the limit will not be reviewed.

Q62. When will grantees be announced?

Answer (Q62): This is yet to be determined. It is anticipated that award recipients will be announced in time for contracts to begin on July 1, 2014.

Q63. What is the reason for the change of strategy? Like conglomerating large metropolis areas?

Answer (Q63): The RFA describes the evidence base for the chosen strategies. Catchment areas were designed based on currently existing health care systems and health care system related collaborations and consideration of expected program funding.

Q64. Keeping a contractor name that has been in use for 10 years has strong "name recognition" that would be useful in maintaining collaborations, working relationships, policy development, training, etc. Will (or can) the new Health Systems contractors funded by this new contract still be referred to as a Cessation Center if it was part of their name? (Section I, pages 3, 4 and 7, Section II page 9, and Section III page 10 and 11).

Answer (Q64): The initiative is entitled Health Systems for a Tobacco-Free NY. Appropriate individual names meant to identify a specific contractor will be discussed during the contract development process. It is acceptable for a current Cessation Center project contractor who is applying to this RFA to reference the current name it is known by in the application.

Q65. Are there any other staffing requirements?

Answer (Q65): Yes. The RFA clearly states the minimal staffing requirements (Section II Who May Apply; page 16). Additional staff needed to achieve required deliverables should be part of the application.