New York State Department of Health
Maternal and Infant Health Initiative
Request for Applications (RFA)
RFA # 1207271237

Updates to RFA and Questions and Answers
12/20/2012

All updates to the Maternal and Infant Health Initiative (MIH) RFA will be posted to the New York State Department of Health (NYSDOH) website at www.health.ny.gov/funding/.

The answers to questions included herein are the official responses by the NYSDOH from potential applicants and are hereby incorporated into the Maternal and Infant Health Initiative Request for Applications, RFA # 1207271237 issued on October 17, 2012. In the event of any conflict between the RFA and these responses, the requirements or information contained in these responses will prevail.

Modifications to the MIH RFA

1. Section **II.B**, page 35 of the RFA states:
   "For the purpose of this RFA, CHWs are further defined as trained paraprofessionals working under the direction and supervision of a licensed professional (a public health nurse or licensed social worker with clinical experience) in accordance with standards and practices defined by NYSDOH Bureau of Maternal and Child Health (BMCH) (see Attachment 13).

   This statement is modified to read as follows:
   "For the purpose of this RFA, CHWs are further defined as trained paraprofessionals working under the direction and supervision of a licensed professional (a Registered Nurse with a Bachelors Degree in Nursing, or licensed social worker (either a Licensed Master Social Worker (LMSW) or Licensed Clinical Social Worker (LCSW) with clinical experience) in accordance with standards and practices defined by NYSDOH Bureau of Maternal and Child Health (BMCH) (see Attachment 13).

2. Attachment 11 of the RFA, under the Budget and Staffing Plan, Budget Narrative states:
   "At a minimum, the budget should support a full-time MICHC program coordinator, a community health worker supervisor that is a public health nurse or licensed social worker, and a sufficient number of community health workers to serve the estimated number of women and families to be reached through CHW services as described in the improvement plan."

   This statement is modified to read as follows:
   "At a minimum, the budget should support a full-time MICHC program coordinator, a community health worker supervisor that is a Registered Nurse with a Bachelors Degree in Nursing (BSN) or licensed social worker (either a Licensed Master Social Worker (LMSW) or Licensed Clinical Social Worker (LCSW)) with clinical experience, and a sufficient number of community health workers to serve the estimated number of women and families to be reached through CHW services as described in the improvement plan."

3. **Attachment 13**: NYSDOH Bureau of Maternal and Child Health Community Health Worker Standards has been updated to reflect the change made to the qualifications of the Community Health Worker Coordinator/Supervisor in Update Number 1 above.

General Questions:

1. **Question:** Because participation on the Applicant Webinar was affected by Hurricane Sandy, will it be repeated for those unable to attend?

   Answer: Yes, the Applicant Webinar/Conference Call for the MMIHRFA that initially was conducted on October 29, 2012 was repeated on November 14, 2012. An addendum to the RFA was posted on the NYSDOH's website announcing the additional Applicant Webinar, and a notice was sent to all who registered for the initial call.

2. **Question:** Will the slides and audio from the webinar be made available?

   Answer: The slides from the webinar will be posted on the NYSDOH website at **www.health.ny.gov/funding/** concurrent with posting this initial Questions and Answers document. The audio will not be posted.

3. **Question:** When is the earliest date that the Questions and Answers will be posted?

   Answer: As stated in **Addendum 2** to the RFA, posted to the NYSDOH website on November 14, 2012, the deadline for submitting written questions has been extended to February 1, 2013. Answers to questions received will be posted on the NYSDOH website on a continuous basis, with the final Questions and Answers document posted on or about February 11, 2013.

4. **Question:** Will the list of organizations that have sent in Letters of Intent to Apply for Component A: Maternal and Infant Community Health Collaboratives, and Component B: Maternal, Infant and Early Childhood Home Visiting be made available?

5. **Question:** Will the list of organizations that have sent in Letters of Intent to Apply for Component A: MICHC be made available?

   Answer (Questions 4 & 5): Yes, a list of organizations that submitted Letters of Intent to Apply, sorted by Component A or B, and by county, will be posted to the NYSDOH website. A list based on letters received to date has been posted to the NYSDOH website concurrent with posting this initial Questions and Answers document. As stated in **Addendum 2**, the deadline for submitting Letters of Intent to Apply, has been extended to February 1, 2013. Updates to the list will be posted to the NYSDOH website on a continuous basis along with the questions and answers document, with the final list posted on or about February 11, 2013.

6. **Question:** In **Attachment 1c**, Average Number Annual Medicaid Births by Zip Code, there is no data listed for Richmond County. Will the RFA be amended to include the data for Richmond County?

Answer: Yes, a revised **Attachment 1c** which includes Richmond County as well as the other New York City counties was posted to the NYSDOH website on October 30, 2012.

7. **Question:** How can an applicant obtain Zip Code Level Birth Data 2008 – 2010 (cumulative 3 Year Total) by race and ethnicity?

   Answer: The NYSDOH does not report Zip Code level birth data by race and ethnicity.

8. **Question:** What is the distinction between Component A: Maternal and Infant Community Health Collaborative (MICHC) and Component B: Maternal, Infant and Early Childhood Home Visiting (MIECHV)?

   Answer: As stated on page 5 of the RFA, section **I. Introduction**, the NYSDOH, MIH RFA will support community-based programs to improve maternal and infant health outcomes for high-need women and families in targeted communities. The overarching goal of the MIH RFA is to improve maternal and infant health outcomes for high-need women and to reduce racial, ethnic and economic disparities in those outcomes. The RFA consists of two separate but complementary components:

   - Component A: Maternal and Infant Community Health Collaboratives (MICHC); and,
   - Component B: Maternal, Infant and Early Childhood Home Visiting (MIECHV).

   Applicants may apply for one or both components. Each requires a separate application. Programs funded under each component, will work to improve specific maternal and infant health outcomes including preterm birth, low birth weight, infant mortality and maternal mortality rates through implementation of evidence-based and/or best practice strategies across the reproductive life course. Component A will support collaborative development, implementation and coordination of evidence-based and/or best practice strategies designed to achieve a set of performance standards that include: high-need women and infants are enrolled in health insurance; high-need women and infants are engaged in health care and other supportive services appropriate to their needs; the medical, behavioral and psychosocial risk factors of high-need women and infants are identified and addressed through timely and coordinated counseling, management, referral and follow-up; and within the community there are supports and opportunities in place that help high-need women to be engaged in and maintain healthy behaviors and reduce or eliminate risky behaviors. Component B supports the expansion, enhancement and/or establishment of specific evidence-based home visiting programs that have been shown to positively impact maternal health, child health and child maltreatment outcomes, namely Nurse Family Partnership (NFP) and Healthy Families New York (HFNY), and serves to implement NYS' MIECHV State Plan.

Assessment of Community Needs and Strengths Components A and B

9. **Question:** Can the initial Assessment of Community Needs and Strengths submitted with the application include a review of existing data and resources with a plan for focus groups and surveys for the first year assessment?

Answer: Yes. Applicants should include whatever relevant information is currently available to support their applications. Applicants may opt to conduct focus groups, surveys or other assessment activities during the application development period to further inform the initial assessment of community needs and strengths described in their applications. Additional assessment activities to be completed during the contract period also may be described in your application.

10. **Question:** How often will successful applicants be required to update the Assessment of Community Needs and Strengths?

    Answer: As noted on page 11 of the RFA, section **I. Background**, under Community Assessment, assessment is viewed as an ongoing activity, not a stand-alone "planning" phase of funded projects. In addition to the initial assessments described in their applications, awardees will be expected to integrate ongoing community assessment activities in their MIH initiatives to continuously monitor persistent and emerging needs, barriers, resources and opportunities related to maternal and infant health within target communities. An updated community assessment will be an annual grant deliverable for grantees of both Components A and B.

11. **Question:** When should the applicant conduct the initial assessment of community needs and strengths?

12. **Question:** Can the initial assessment of community needs and strengths be conducted in the first year of the grant?

    Answer (Questions 11 & 12): The Assessment of Community Needs and Strengths is a required narrative section of both Component A and B applications, and should be included as part of the complete application (see **Attachments 11** and **22** for the respective Application Templates). The assessment of community needs and strengths is a cornerstone of the application, as it provides a rationale for the proposed improvement plan by describing the problems/needs being addressed and the related resources currently available.

13. **Question:** What should be included in the initial assessment of community needs and strengths?

14. **Question:** Please describe how the assessment of community needs and strengths should be addressed in the Maternal and Infant Community Health Collaborative (MICHC) application and/or the Maternal, Infant and Early Childhood Home Visiting (MIECHV) application.

    Answer: (Questions 13 & 14): As stated on pages 18 and 47 of the RFA, sections **II.B** and **III.B, Assessment of Community Needs and Strengths (Resources)** for Components A and B respectively, both MICHC and MIECHV projects will be based on comprehensive community assessments. Applications for both Components A and B, will include a preliminary community assessment that incorporates:

    - Identification of specific target populations and geographic communities including Zip Codes;

- A critical analysis of community-level data, needs and strengths related to each of the four Performance Standards for Component A, and each of the six benchmark areas for Component B; and
- A description of the availability and capacity of existing programs and services to serve the target community, and identification of key gaps in services.

The assessment of community needs should build upon previous community assessment and planning efforts including the state's MIECHV Needs Assessment available at: http://www.health.ny.gov/community/infants_children/maternal_infant_early_child_home_visit/. Both initial and ongoing/updated community assessments should reflect collaboration with multiple and diverse partners. Please refer to the Application Templates, **Attachments 11 and 22** for Components A and B respectively for additional detail of what should be included in the Assessment of Community Needs and Strengths section of the application.

Component A: Maternal and Infant Community Health Collaboratives (MICHC)

General Questions:

15. Question: Page 13 of the RFA, "Minimum Eligibility Requirements:" states "Each applicant must propose a target area that accounts for an average of 100 or more Medicaid births annually, based on 2008-10 vital statistics data." Can an applicant combine zip codes to reach the 100 Medicaid births?

Answer: Yes. Multiple zip codes may be combined to achieve the required minimum of 100 Medicaid births per year. As noted, applicants are required to define target service areas that include an average of 100 or more Medicaid births per year.

16. Question: Since only one award will be made for Component A (with the exception of Bronx, Kings, New York and Queens – where two awards will be made), and Component A stresses the need for the awardee to work collaboratively with other community partners, including Component B applicants, could applicants connect with organizations that have sent in letters of intent to apply to discuss a collaborative effort?

Answer: Yes, applicants may connect to discuss potential collaborative efforts to strengthen the Component A application and to develop a community effort that will best result in improved outcomes for the target area. As stated in the answer to Questions 4 and 5, a list of organizations that submitted Letters of Intent to Apply sorted by Component A or B, and by county, will be posted to the NYSDOH website to assist applicants in identifying potential partners.

17. Question: The Community Health Worker Program (CHWP) is currently funded until 12/31/12 and the Maternal and Infant Community Health Collaborative (MICHC) is scheduled to begin on 7/1/13. Will the current CHWPs be funded beyond 12/31/12?

Answer. As stated in **Addendum 2** to the RFA, the deadline for applications to the MIH RFA has been extended to March 15, 2013, with a projected start date for successful

applicants of October 1, 2013. The NYSDOH is seeking an extension of current CHWP and Comprehensive Prenatal – Perinatal Services Network (CPPSN) contracts to provide continued funding of current programs until the new MIH initiative contract period begins, at which time the CHWP and CPPSN programs will end. The request for an extension requires approval from the New York State Office of the State Comptroller. The NYSDOH will communicate additional information directly to current contractors when available.

18. **Question:** How will the Maternal and Infant Community Health Collaboratives (MICHC) replace the CHWP, CPPSN and Healthy Mom – Healthy Baby Prenatal and Postpartum Home Visiting (HMHB) programs?

    Answer: As stated on page 5 of the RFA, section **I. Introduction**, the MICHC initiative integrates and replaces the NYSDOH's current community-based perinatal health programs including the CHWP, CPPSN and HMHB to develop multi-dimensional community-wide systems of integrated and coordinated community health programs and services to improve maternal and infant health outcomes. The goal of the MICHC initiative is to improve maternal and infant health outcomes for Medicaid-eligible high-need low-income women and their families while reducing persistent racial, ethnic and economic disparities in those outcomes. To positively impact preterm birth, low birth weight, infant mortality and maternal mortality, MICHC activities will seek to address maternal and infant health behaviors, supports and service systems across three key life course stages: preconception, prenatal/postpartum and interconception. The current CHWP, CPPSN and HMHB programs will end once the new MICHC initiative begins.

19. **Question:** Is the focus of Component A: Maternal and Infant Community Health Collaboratives to be community collaboration and not client home visiting?

    Answer: The focus of Component A: Maternal and Infant Community Health Collaboratives (MICHC) is the collaborative development and implementation of multi-dimensional community-wide systems of integrated and coordinated community health programs and services to improve maternal and infant health. Collaborative strategies will focus on improving: outreach to find and engage high-need women and their families in health insurance, health care and other needed community services; timely identification of needs and risk factors and coordinated follow-up to address risks identified; the integration and coordination of services within larger community systems; and, the development of supports, opportunities and social norms that promote and facilitate healthy behaviors across the lifespan. As stated on page 28 of the RFA, section **II.B.,** under **MICHC Improvement Strategies**, applicants have the flexibility to propose specific strategies that they determine will be most effective in addressing their identified community needs. Strategies are required to address community factors at multiple ecologic levels. At a minimum, for each of the four MICHC performance standards:
    - High-need women and infant are enrolled in health insurance;
    - High-need women and infants are engaged in health care and other supportive services appropriate to their needs;
    - The medical, behavioral and psychosocial risk factors of high-need women and infants are identified and addressed through timely and coordinated counseling, management, referral and follow-up; and

- Within the community, there are supports and opportunities in place that help high-need women to be engaged in and maintain healthy behaviors and reduce or eliminate risky behaviors,

…and, within each of the four performance standards, for each of the three life course stages:

- Preconception,
- Prenatal/postpartum, and,
- Interconception,

…applicants should propose at least one specific strategy to address factors at each of the flowing ecologic levels:

- Community and/or organizational level, and
- Individual/family level.

Improvement strategies will include Offering and Arranging activities to increase awareness, accessibility and utilization of family planning services among Medicaid-eligible preconception and interconception women. Offering and Arranging activities may be incorporated in community, organizational and/or individual/family level strategies.

Home visiting may be a strategy to address a need identified by the assessment of community needs and strengths, but home visiting alone would be unlikely to achieve the multi-dimensional community-wide systems of integrated and coordinated community health programs and services to improve maternal and infant health, and unlikely to address all four performance standards across the 3 life course stages at each required ecologic level. As stated on page 39 of the RFA, section **II.B**., under **Budget and Funding Restrictions**, funds awarded under Component A, are not intended to support the direct delivery of evidence-based home visiting program services. Applicants seeking funding to support direct delivery of evidence-based home visiting services should apply under Component B. Component A funds may be appropriate for community-wide systems-building or coordination work that includes integration of home visiting services.

20. Question: Would the goals of the current Community Health Worker Program satisfy the Performance Standards for Component A: MICHC?

Answer: No. See answers to **Questions 17, 18** and **19** above. The NYSDOH's current Community Health Worker Program will end once contracts for the MICHC initiative begin. The focus of the MICHC initiative is the collaborative development and implementation of multi-dimensional community-wide systems of integrated and coordinated community health programs and services to improve maternal and infant health. Collaborative strategies will focus on achieving a set of four performance standards as outlined in question 18 and in the RFA. As stated on page 28 of the RFA, section **II.B.,** under **MICHC Improvement Strategies**, all MICHC grantees are required to design and implement strategies to address factors at multiple ecologic levels. At a minimum, for each of the four MICHC performance standards, and within each standard for each of the three respective life course stages (preconception, prenatal/postpartum, interconception), applicants should propose at least one specific strategy to address factors at the community and/or organizational level and at least one specific strategy to address factors at the individual/family level. As stated on page 34 of

the RFA, **Section II.B.** under **Individual/Family Level Strategies**, applicants need to propose strategies to find, engage and provide social support to high-need individuals and families within the target communities. The core individual/family level strategy required for the MICHC initiative is the use of community health workers (CHWs). CHWs will perform a combination of community outreach, home visits, group activities / workshops and community-based supportive services to provide a source of enhanced social support and create a bridge between under-served and hard-to-reach populations and formal providers of health, social and other community services. CHWs may be a strategy to address a need identified by the assessment of community needs and strengths. Utilization of CHWs alone would be unlikely to achieve the multi-dimensional community-wide systems of integrated and coordinated community health programs and services to improve maternal and infant health, and unlikely to address all four performance standards across the three life course stages at each required ecologic level.

21. Question: What is meant by the implementation of multi-dimensional community-wide systems of integrated and coordinated community health programs and services to improve maternal and infant health?

Answer: In NYS, significant emphasis has been placed on building and strengthening maternal and infant health systems to assure that risk factors are systematically and routinely identified, documented and addressed. These efforts focus both on improving systems within health care practices and on building reciprocal linkages between health care and other community providers that serve high-need families, including WIC, home visiting, early care and education, mental health and substance abuse, domestic violence, income assistance and many other services. With support from NYSDOH and other sources, several communities have implemented innovative approaches to build community systems for prenatal risk assessment, referral and follow-up, including: standardized prenatal risk screening and communication forms; structured referral processes between clinical practices, health plans, local health departments and other community service providers; Web-based data systems (e.g., PeerPlace®) that support centralized risk assessments, referrals and coordinated follow-up services across multiple participating health and human service providers within a community; and, integration of community health workers/peer health advisors into health care practice teams to provide ongoing reinforcement, follow-up and systems navigation support for high-need patients. As a companion to these efforts, there has been significant work in NYS over the past decade to integrate and expand home visiting as a particularly effective intervention and support for high-need families within larger prenatal, postpartum and early childhood service systems. As stated on page 29 of the RFA, **Section II.B.,** under **MICHC Improvement Strategies, Community and Organizational Level Strategies,** achieving and sustaining changes at higher ecologic levels (i.e., community and organizational levels), requires a focus on **systems**: the organizations, institutions, structures, processes and resources that collectively are intended to support and improve – or may indirectly influence – the health of individuals and populations. Systems that are accessible, effective and functionally coordinated or integrated can enable service providers to deliver quality services and enable consumers to practice healthy behaviors and utilize health-supporting services.

22. Question: Are MICHC strategies required at each ecologic level identified in the RFA?

Answer: See the answers to **Questions 19** and **20**, and the MICHC Application Template, **Attachment 11**. As stated on page 28 of the RFA, Section II.B.MICHC Improvement Strategies, at a minimum, for each of the four MICHC performance standards, and within each standard for each of the three life course stages (preconception, prenatal/postpartum, interconception), applicants should propose at least one specific strategy to address factors at the community and/or organizational level and at least one specific strategy to address factors at the individual/family level.

For example, to address Performance Standard 1, applicants should propose strategies to ensure high-need women and infants are enrolled in health insurance during the preconception, prenatal/postpartum and interconception periods at the organizational and/or community levels and the individual/family level as follows:

Performance Standard 1: *High-need women and infants are enrolled in health insurance.*
Life Course Period: Preconception
Improvement Strategies:

Organizational / Community Level
Conduct social marketing campaign to promote importance of having health insurance including eligibility requirements and what is available in the community.

Individual/Family Level
Community health workers to provide one-on-one and group education in community settings to promote importance of having health insurance including eligibility requirements and what is available in the community.

Life Course Period: Prenatal / Postpartum
Improvement Strategies:

Organizational / Community Level
Conduct social marketing campaign targeting high-risk pregnant women on the availability of and eligibility for Medicaid.

Individual/Family Level
Community health workers inform high-risk pregnant women of availability of Medicaid and assist with enrollment process within first trimester.

Life Course Period: Interconception
Improvement Strategies:

Organizational / Community Level
Conduct public health detailing to educate providers and community-based organizations on the availability of and eligibility for health insurance programs to ensure continued insurance coverage for high-risk woman postpartum.

Individual/Family Level
Community health workers provide one-on-one education on Family Planning Benefit Program or Family Planning Extension Program and assist women with enrollment process.

Note that the strategies listed above are provided as examples only, for the purpose of illustrating the requirement that applicants propose strategies at multiple ecologic levels for each performance standard and each life course period.

23. Question: Our organization is located in a large urban county. We were planning to submit an application by ourselves and plan to provide all the services by our organization. Is this advisable?

Answer: See the following s**ections under II.B** of the RFA: **Preferred Eligibility Requirements** (page 13), **Organizational Capacity and Experience** (page 17) **and MICHC Improvement Strategies** (page 28). Because of the multi-dimensional nature of maternal and infant health and the strategies needed to address it, collaboration is a strong expectation of the MIH RFA. The lead agency needs to have a substantial coordinating role and cannot simply be a pass-through for funding to other organizations. Preference for Component A: MICHC, will be given to applications demonstrating strong collaboration, including subcontracts, with other partner agencies/organizations that provide health, educational and supportive services to high-need preconception, prenatal/postpartum and interconception women, infants and families, particularly those partner agencies/ organizations with demonstrated experience and capacity serving high-need populations in the high-need neighborhoods identified in the community needs assessment. Lead applicants are strongly encouraged to work in close collaboration with other community partners to develop and implement their improvement plans. Lead applicants are encouraged to develop subcontracts or other partnership agreements with other community organizations and agencies to expand collective capacity, experience and expertise for designing and implementing effective improvement strategies. Applicants in counties with multiple high-need neighborhoods and/or communities should include partners that are well positioned to address the needs of the target populations in those areas. In a large county, it would be unlikely that a single organization could reach all high need communities and that a single organization could address all four required performance standards on their own. Collaboration is emphasized in key sections of the Application Template (**Attachment 11)**, including: Organizational Experience and Capacity (20 points), a description of the experience, expertise and capacity of the application in collaboration with subcontractors and other key partners to assess, develop and implement MICHC strategies; Assessment of Community Needs and Strengths (20 points), should reflect collaboration with multiple and diverse partners; Improvement Plan (30 points), describes the specific strategies that MICHC grantees, in collaboration with local partners, will carry out to address the needs and priorities identified through the community assessment, and which build on the strengths, resources and assets of the target community, the lead applicant organization and its collaborative partners. An application that does not reflect collaboration would not receive the maximum possible ratings for these sections, and thus may not be competitive.

24. Question: Are there specific community organizations or agencies that MICHC applicants should partner with?

Answer: While the RFA does not identify specific partners that an MICHC application must include, to help facilitate collaboration the RFA does include as an attachment, a list of current NYSDOH grantees, including current CPPSN, CHWP and HMHB programs (**Attachment 3**) as well as current Healthy Families NY (**Attachment 4**), Nurse Family

Partnership (**Attachment 5**), Healthy Start (**Attachment 6**), Family Planning (**Attachment 7**) Comprehensive Adolescent Pregnancy Prevention **(Attachment 8),** and Rural Health Network **(Attachment 9)** programs in the state. In addition, as stated on page 17 of the RFA, Section II.B., under **Organizational Capacity and Experience**, other key recommended partners include local health departments, health care providers (including prenatal care, pediatric and women's primary care, family planning), mental health and substance abuse services providers, community-based organizations, home visiting programs, WIC programs, faith-based organizations, business, philanthropic and economic development partners, and other key leaders or organizations serving the community. As stated in the response to Question 4 above, a list of organizations that have submitted letters of intent to apply for MIH funding is being posted to the NYSDOH website along with this Questions and Answers document to further help facilitate collaborative applications.

25. Question: Can a Medicaid Managed Care Plan, a Health Maintenance Organization (HMO), be a subcontractor as part of the Maternal and Infant Community Health Collaboratives?

Answer: Yes.

26. Question: Can there be co-lead agencies for the Maternal and Infant Community Health Collaborative (MICHC)?

Answer: No. As stated on page 18 of the RFA, one organization should be designated as the lead organization and is responsible for submitting the application and administering the grant. The lead agency needs to have a substantial coordinating and/or implementation role and cannot simple be a pass-through for funding to other organizations. Please see the responses to Questions 23 and 24 above. Collaboration and partnership are a central focus of the MICHC initiative. The NYSDOH encourages collaborative applications involving multiple community agencies and organizations working together to respond to and implement this initiative, with coordination and leadership from a strong applicant lead agency.

27. Question: Are separate Maternal and Infant Community Health Collaborative (MICHC) applications required for Tier 1 and Tier 2 counties?

Answer: Yes. As stated on page 39 of the RFA, Section II.B under Projected Number of Awards and Funding Range, a separate application must be submitted, and will be reviewed and scored separately, for each Tier 1 county an applicant proposes to serve. A single application may be submitted to serve multiple Tier 2 counties, if the applicant proposes to serve those as part of a coordinated regional/multi-county project. If the same organization proposes to target both Tier 1 and Tier 2 counties, separate applications must be submitted for Tier 1 and Tier 2. The same lead organization may submit multiple applications targeting Tier 1 counties, but may submit no more than one application for Tier 2, regardless of the number of Tier 2 counties targeted for the proposed project.

28. Question: Should a Health Information Technology (HIT) strategy be included in the Maternal and Infant Community Health Collaborative (MICHC) application?

Answer: There is no specific requirement that a Health Information Technology (HIT) strategy be included in the MICHC application. An HIT strategy may be an appropriate Improvement Plan strategy if the sharing of information on health risks among health care and human service providers is found through your Assessment of Community Needs and Strengths to be a need related to meeting one or more of the Performance Standards. As noted on page 6 of the RFA, section **I. Introduction**, MICHC grantees funded through this RFA may be eligible to receive supplemental funding to support the use of HIT to coordinate the delivery of services among health care providers, health plan, and community-based organizations. It is anticipated that funding will be awarded separately from this RFA as a targeted enhancement to Component A of the MIH initiative. Information about this potential opportunity will be provided separately to successful Component A applicants when available.

29. Question: Should the Organizational Chart reflect the structure of the lead applicant, including the corporate structure, or the structure of the MICHC collaborative?

Answer: Both. The organizational chart should show how the proposed program will be integrated within the organizational structure of the lead agency and also should include a detailed chart that reflects the structure for the overall MICHC project.

30. Question: What are the requirements for Maternal and Infant Community Health Collaborative (MICHC) sub-contractors?

Answer: As stated on page 17 of the RFA, section **II.B.**, under **Organizational Capacity and Experience**, lead applicants are encouraged to develop subcontracts or other partnership agreements with other community organizations and agencies to expand collective capacity, experience and expertise for designing and implementing effective improvement strategies. As stated on page 13 of the RFA, section **II.B**., under **Preferred Eligibility Requirements**, preference will be given to: applications demonstrating strong collaboration, including subcontracts, with other partner agencies/organizations that provide health, educational and supportive services to high-need preconception, prenatal/postpartum and interconception women, infants and families, particularly those partner agencies/organizations with demonstrated experience and capacity serving high-need populations in the high-need neighborhoods identified in the community needs assessment; organizations, including lead applicants and/or subcontractors, who have a history of serving and/or are representative of diverse target populations, including those most impacted by racial, ethnic and economic disparities.

Applicants should read Attachment 26a, Standard NYSDOH Grant Contract with Appendices. Appendices A and A-1 of the Standard Contract contain specific information related to responsibilities of contractors and their subcontractors. The contract language states "If the contractor enters into subcontracts for the performance of work pursuant to this agreement, the contractor shall take full responsibility for the acts and omissions of its subcontractors. Nothing in the subcontract shall impair the rights of the STATE under this AGREEMENT. No contractual relationship shall be deemed to exist between the subcontractor and the State."

31. Question: Are undocumented Maternal and Infant Community Health Collaborative (MICHC) clients eligible for Medicaid?

32. Question: Are undocumented Maternal and Infant Community Health Collaborative (MICHC) clients eligible for Medicaid Prenatal Care?

Answer (Questions 31 & 32): It is not clear from the question what is meant by "MICHC clients". The MICHC initiative targets high-need women, infant and their families, with a particular focus on Medicaid-eligible individuals and populations, residing in the highest need communities. Individual client services from community health workers is one component of the larger MICHC initiative. If the question refers to pregnant women, pregnant women can get Medicaid coverage during pregnancy in New York State regardless of citizenship/documentation status. Eligibility requirement for Medicaid can be found at the NYSDOH website at http://www.health.ny.gov/health_care/medicaid/#qualify.

33. Question: Are undocumented Maternal and Infant Community Health Collaborative (MICHC) clients eligible for Family Planning Services?

Answer: It is not clear from the question what is meant by "MICHC clients". As noted in the response to Questions 31 and 32 above, individual client services from community health workers is one component of the larger MICHC initiative. An individual who is **not** a U.S. citizen, national, Native American or has satisfactory immigration status is **not** eligible for the Medicaid Family Planning Benefit Program (FPBP). However, women who were on Medicaid during their pregnancy (which may include undocumented women) and who lost Medicaid coverage when their pregnancy ended, are eligible for the Medicaid Family Planning Extension Program (FPEP). FPEP provides up to 26 months of additional access to family planning services. The NYSDOH funds 52 agencies in approximately 207 sites to provide accessible reproductive health care services to women and men. Programs provide services to men and women, especially low-income individuals and those without health insurance. See **Attachment 7** of the RFA for a list of NYSDOH Comprehensive Family Planning Grantees.

Program Requirements Component A:

34. Question: Does the Maternal and Infant Community Health Collaboratives (MICHC) require the tracking or data collection of clients receiving clinical services?

Answer: It is not clear what is meant by "the tracking or data collection of clients receiving clinical services". If this answer is not responsive to the question, please resubmit your question with further clarification and we will address in a subsequent update to the Questions and Answer document.

As stated on page 39 of the RFA, section **II.B**., under **Budget and Funding Restrictions**, the MICHC initiative will not fund direct clinical/medical/laboratory services. However, MICHC projects may include other strategies that relate to improved utilization, accessibility or quality of clinical care. The level of data collection (i.e., individual, family, organizational, community) will depend on the nature of the strategies selected by grantees. For example, MICHC grantees will collect and report client/family level data on individuals served by

community health workers, including data on client utilization of clinical services such as prenatal care, postpartum care, or general primary/preventive health care. As another example, MICHC grantees may implement organizational or community-level strategies to improve screening, referral or the use of evidence-based clinical practices amongst providers serving high-risk pregnant women, which may involve collection of organizational or community-level data measures. As stated on page 38 of the RFA, all MICHC grantees will be expected to collect, review and report on a set of defined performance measures to monitor and assess the implementation and effectiveness of MICHC improvement strategies. Specific performance measures will be developed as part of Year 1 implementation, in close consultation with the NYSDOH and the new Maternal and Infant Health Center of Excellence (MIH-COE), which will provide guidance and technical support to successful applicants on performance measure development, data collection and reporting systems, and quality improvement methodology.

35. **Question:** How will the success of a Maternal and Infant Community Health Collaboratives (MICHC) grantee's Improvement Strategies be measured?

    Answer: As stated on page 37 of the RFA, each of the four MICHC performance standards will have one or more associated performance measure that captures the degree to which an initiative has accomplished what was intended. All MICHC grantees will be expected to collect, review and report on a set of defined performance measures to monitor and assess the implementation and effectiveness of MICHC improvement strategies. The specific performance measures will be developed as part of Year 1 implementation in close consultation with NYSDOH staff and the new MIH-COE. The MIH-COE will provide additional guidance and technical support to grantees on performance measure development, data collection and reporting systems, and quality improvement methodology. In addition, the MIH-COE will be charged with developing and implementing an evaluation of the MICHC initiative, including assessment of the implementation and effectiveness/ impact of specific required strategies on performance standards and associated performance measures. As a condition of funding, grantees will be required to participate in any evaluation activities directed by the NYSDOH.

Offering and Arranging

36. **Question:** What are the Maternal and Infant Community Health Collaboratives (MICHC) program requirements for Offering and Arranging?

    Answer: As stated on page 17, all MICHC grantees will conduct activities to increase awareness, accessibility and utilization of family planning services among Medicaid-eligible preconception and interconception women, referred to in the RFA as "Offering and Arranging". A minimum of 25% of each grantee's award amount should be used to support the Offering and Arranging of family planning services. Offering and Arranging activities may be incorporated in community, organizational and/or individual/family level strategies. Offering and Arranging for family planning services is defined in **18 NYCRR 505.13** by three broad categories as follows: disseminating written and oral information about available family planning health services, providing for individual and/or group discussions about all methods of family planning and family planning services, and assisting with arranging visits

to a medical family planning provider. **Attachment 10** of the RFA contains additional detailed guidance on Offering and Arranging of family planning services.

37. Question: If an applicant for Component A: MICHC, is partnering with a current Family Planning grantee for offering and arranging activities, can the 25% of grant funding required by the RFA to be used for offering and arranging be used to support the Family Planning grantee partner?

Answer: The lead applicant organization could sub-contract with a family planning provider or another partner organization to implement strategies related to the Offering and Arranging of family planning services. Note that such funding cannot duplicate or supplant any funding that a family planning provider is receiving from other sources for Offering and Arranging of family planning services. It should also be noted that Offering and Arranging of family planning services is distinct from, and complementary to, the provision of family planning services.

While subcontracting is allowable and encouraged as part of MICHC, Offering and Arranging activities should be integrated into strategies to address each of the four performance standards, and are not stand alone discrete activities. Given the various types of Offering and Arranging activities that could be implemented to address each performance standard, it may be difficult to meet the requirements for Offering and Arranging solely through a subcontract.

38. Question: Are Offering and Arranging activities expected for each performance standard?

Answer: Yes. Offering and Arranging activities should be included in the Improvement Plan of the application, for each the four performance standards. For example:

- Strategies to improve outreach to find and engage high-need women and their families in health insurance (Performance Standard 1) should include a specific focus on increasing enrollment of low-income preconception and interconception women and men in Medicaid Family Planning Benefit Program;
- Strategies to improve engagement of high-need woman and their families in health care and other supportive services appropriate to their needs (Performance Standard 2), should include a specific focus on increasing awareness and utilization of family planning services for preconception, postpartum and interconception women;
- Strategies to improve timely identification of medical, behavioral and psychosocial risk factors of high-need women and coordinated follow-up to address risks identified (Performance Standard 3), should include a specific focus on identifying, counseling and referring individuals who may benefit from family planning services for preconception, postpartum and interconception women;
- Strategies to improve the community supports, opportunities and social norms that promote and facilitate healthy behaviors (Performance Standard 4), should include a specific focus on promoting family planning, birth spacing, prevention of unintended pregnancy, and utilization of family planning services for preconception, prenatal, postpartum and interconception women.

39. Question: Can Offering and Arranging activities be provided to individuals or groups who are not registered clients in the Maternal and Infant Community Health Collaborative (MICHC) program?

Answer: The MICHC initiative requires strategies to influence community and/or organizational-level changes, and individual/family level changes. It is not clear from the question what is meant by "registered clients in the MICHC program". Individual clients services from community health workers is one component of the larger MICHC initiative, however Offering and Arranging activities are not specific to the community health worker strategy alone. See answers to Questions 36, 37 and 38 above.

40. Question: If the Maternal and Infant Community Health Collaborative (MICHC) subcontractor for the community health worker (CHW) strategy is unable to fulfill the Offering & Arranging requirement of the grant, can the Offering & Arranging requirement be provided by the lead agency or another subcontractor?

Answer: Offering and Arranging is not specific to the CHW strategy, and is not the responsibility of just one entity. As noted in response to Question 37 above, while subcontracting is allowable and encouraged as part of MICHC, Offering and Arranging activities should be integrated into community, organizational and/or individual/family level strategies for each of the four performance standards strategies, and are not stand alone discrete activities. Given the various types of Offering and Arranging activities that could be implemented to address each performance standard, it may be difficult to meet the requirements for Offering and Arranging solely through a subcontract. Because Offering and Arranging – including promoting prevention of unintended pregnancy, planning desired pregnancies and adequate birth spacing – is an integral component of the MICHC initiative, including individual/family level strategies carried out by community health workers, it may be very difficult to effectively implement this initiative if a CHW contractor is unable to fulfill the Offering and Arranging requirements, and it is anticipated that an application that does not fully integrate Offering and Arranging activities in its Improvement Plan would not receive the maximum possible score for relevant sections of the application.

41. Question: What is the role of the Maternal and Infant Community Health Collaborative (MICHC) as it applies to preconception health?

Answer: As stated in the RFA, to positively impact maternal and child health outcomes, MICHC activities will seek to address maternal and infant health behaviors, supports and service systems across three key life course stages: **preconception, prenatal/postpartum and interconception**. Improvement strategies for the preconception period should be designed to:

- Reach, inform, enroll and retain high-need, hard to reach preconception women in health insurance (Performance Standard 1);
- Engage and retain high-need, hard to reach preconception women in timely and ongoing health and other needed supportive services (Performance Standard 2);
- Improve timely risk identification, follow-up and coordination of interventions and supportive services for preconception women (Performance Standard 3); and,

- Influence the availability of structural, environmental and social supports and opportunities for health-promoting behaviors for preconception women (Performance Standard 4).

As stated on page 28 of the RFA, **Section II.B**., under MICHC Improvement Strategies, all MICHC grantees are required to design and implement strategies to address factors at multiple ecological levels. At a minimum, for the preconception life course period, for each of the four MICHC performance standards, applicants should propose at least one specific strategy to address factors at the community and/or organizational level and at least one specific strategy to address factors at the individual/family level.

42. Question: What is the role of the Community Health Worker (CHW) as it applies to preconception health?

Answer: Please refer also to the response to Question 41 above. As noted on page 35 of the RFA, through the new MIH initiative the scope of CHW work will be broadened to provide support to high-need women during preconception and interconception periods to promote healthy behaviors, including use of health care services. As part of overall MICHC strategies, CHW activities may target preconception women, with a strong focus on high-need women who are not currently engaged in health care or other supportive community services. CHWs will implement a range of strategies to find and engage high-need individuals in health insurance, health care and other supportive services; to identify specific needs and risk factors of clients; and, to improve the practice of health-promoting behaviors among target preconception women. CHW activities targeting preconception specifically should incorporate activities related to Offering and Arranging of family planning services. See response to Questions 36-40 above for more information about Offering and Arranging.

43. Question: The duties and responsibilities of the Community Health Worker (CHW) look like case management. The RFA indicates that NYSDOH will not fund case management. How is case management defined for the Maternal and Infant Community Health Collaborative (MICHC)?

Answer: The MICHC grant will not support case management services that are reimbursable through third party payers including Medicaid. CHW activities such as ensuring timely access to and coordination of needed medical and psychosocial services, are appropriate activities, supportable through the MICHC grant.

Program Staffing:

44. Question: What is the difference between the Community Health Worker (CHW) Supervisor referenced in the Budget and Staffing Plan section of **Attachment 11** and the Community Health Worker Coordinator referenced in **Attachment 13**: Community Health Worker Standards?

Answer: The CHW Supervisor and the CHW Coordinator are one in the same.

45. **Question:** Can the Maternal and Infant Community Health Collaborative (MICHC) Coordinator and the Community Health Worker (CHW) Supervisor work for separate agencies?

46. **Question:** Is the Maternal and Infant Community Health Collaborative (MICHC) Coordinator required to be an employee of the lead applicant?

    Answer: The MICHC Coordinator and the MICHC-CHW Supervisor may work for separate agencies, and may work for agencies other than the lead applicant agency. However, please note, while the NYSDOH encourages collaborative applications from multiple community agencies and organizations working together to respond to and implement this initiative, the applicant lead agency must have a strong coordination and leadership role. The lead agency needs to have a substantial coordinating and/or implementation role and cannot simply be a pass-through for funding to other organizations.

47. **Question:** How should Community Health Worker (CHW) training be included in the Maternal and Infant Health Collaborative (MICHC) application?

    Answer: CHWs will receive training from a variety of venues including the CHW Coordinator/Supervisor, NYSDOH, Maternal and Infant Health – Center of Excellence (MIH-COE), and MICHC partners. The NYSDOH, in conjunction with the MIH - COE will identify and deliver training to CHWs. It is not necessary to include activities or funding in your application Improvement Plan or Budget for these particular trainings, since all MICHC grantees will be expected to participate in these trainings which are anticipated to be delivered through webinars and/or conference calls that will not entail travel costs for grantees.
    As stated in **Attachment 13** of the RFA, the CHW Coordinator/Supervisor will train CHWs on the following maternal and child health topics: female reproduction, the stages of pregnancy, the postpartum period, caring for the newborn, risks for poor birth outcomes, and maintaining healthy behaviors during the preconception and interconception periods; as well as training that addresses special topic areas to assist CHWs in working with high-need clients, including domestic violence, mental health, substance use and clients in crisis. The NYSDOH has developed training curriculum on these topics for use by the CHW Coordinator/Supervisor with the information needed to prepare CHWs to serve the target population.

    If the Assessment of Community Needs and Strengths identifies specific training topics for paraprofessionals as a need or gap, it would be appropriate to include such training in the Improvement Plan and Budget Plan. In this case, the Improvement Plan should describe and explain the need for the training to be delivered, and the Budget Plan should include the cost of and justification for the training. In addition, CHW training on specific topics could be conducted and supported at the community-level by MICHC partners.

48. **Question:** What are the minimum full time equivalent (FTE) staffing requirements for the Maternal and Infant Community Health Collaboratives (MICHC)?

49. Question: What are the full time equivalent (FTE) requirement of the Maternal and Infant Community Health Collaborative (MICHC) Coordinator position, and the Community Health Worker Coordinator position?

50. Question: Does the Maternal and Infant Community Health Collaborative (MICHC) require staffing ratios?

Answer (Questions 48, 49 and 50): As stated in the Budget and Staffing Plan section of **Attachment 11**, Component A Application Template, at a minimum, the MICHC budget should support: a full-time MICHC program coordinator, a CHW coordinator/supervisor and a sufficient number of CHWs to serve the estimated number of women and families to be reached through CHW strategies as described in the Improvement Plan. The full-time equivalency for the CHW supervisor depends on the number of CHWs supervised. One full-time CHW supervisor will supervise 4 to 6 CHWs.

51. Question: Can the Maternal and Infant Community Health Collaborative (MICHC) Coordinator position also serve as the Director of a program on another grant, such as the Family Planning Program?

52. Question: What is the role of the Maternal and Infant Community Health Collaborative (MICHC) Coordinator position?

53. Question: What are the required minimum qualifications for the Maternal and Infant Community Health Collaborative (MICHC) Coordinator?

Answer (Questions 51, 52 and 53): The MICHC Coordinator is a full time position supported through the MICHC grant, responsible for providing leadership to and coordination of the entire MICHC grant initiative and activities. It would not be appropriate or feasible for the MICHC Coordinator to serve as the director or coordinator of another grant while serving as the MICHC Coordinator. The MICHC Coordinator will be responsible for coordinating all aspects of the MICHC initiative including: development of the annual MICHC Assessment of Community Needs and Strengths in collaboration with multiple and diverse community partners; and development and implementation of the MICHC Improvement Plan in collaboration with multiple and diverse community partners, including ensuring strategies and activities are being implemented by the responsible parties/partners within the stated timeframe.

The RFA does not establish minimum educational qualifications for the MICHC Coordinator. However, to effectively coordinate MICHC grant activities, it is expected that the MICHC Coordinator have:

- Education and experience in maternal and child health;
- Experience managing maternal and child health programs;
- Strong leadership and community organization skills;
- Experience with implementation of collaborative strategies with diverse community organizations and stakeholders;
- Experience with coordinating service delivery across public health and social service programs;

- Familiarity with the target community and target population;
- Experience providing outreach to find and engage Medicaid-eligible high-need low-income women and their families in public health programs; and,
- Excellent writing, communication and interpersonal skills.

Expected maternal and child health knowledge and experience includes implementation of programs designed to improve maternal and infant health outcomes including preterm birth, low birth weight, infant mortality and maternal mortality and to reduce racial, ethnic and economic disparities in those outcomes.

54. Question: Is a Health Educator position a required staff position for the Maternal and Infant Community Health Collaborative (MICHC)?

Answer: No.

55. Question: Does the Maternal and Infant Community Health Collaborative (MICHC) address restrictions of staff activities?

Answer: Activities of the MICHC Coordinator, CHW Coordinator/Supervisor and CHWs are defined by the applicant's Improvement Plan. All activities are in support of the proposed MICHC project in compliance with the requirements of the RFA. As stated on page 39 of the RFA, funds awarded through the RFA may be used to support activities of the MICHC grant initiative and their associated costs. All funds requested for the MICHC grant need to be included in the justification and show support for the proposed improvement strategies. A minimum of 25% of each grantee's award amount should be used to support the Offering and Arranging of family planning services for Medicaid-eligible preconception and interconception women. Funds awarded under Component A of the RFA are not intended to support the direct delivery of evidence-based home visiting program services described in Component B of the RFA. Applicants seeking funding to support direct delivery of evidence-based home visiting services should apply under Component B. As stated on page 39 of the RFA, section **II.B** under **Budget and Funding Restrictions**, the MICHC initiative will not fund direct clinical/medical/laboratory services and supplies, case management, mental health counseling, crisis intervention, transportation, educational preparation (such as GED), job placement, child care services or any other services that are available/funded through other resources.

56. Question: What are the minimum qualifications for the Community Health Worker (CHW) Coordinator/Supervisor?

Answer: A**s** stated in RFA Updates 1, 2, and 3 above, the CHW Coordinator/Supervisor is a licensed professional, either a Registered Nurse with a Bachelors Degree in Nursing (BSN), or licensed social worker (either a Licensed Master Social Worker (LMSW) or Licensed Clinical Social Worker (LCSW)) with clinical experience. As stated in **Attachment 13** of the RFA, additional qualifications for this position include experience in public health, community organization, and clinical case management (focused on individual and family); and experience with supervision and program management. The original **Attachment 13** erroneously omits a Licensed Master Social Worker as meeting the qualifications. The

NYSDOH will accept a Licensed Master Social Worker (LMSW) with experience in public health, community organization, and clinical case management as meeting the qualifications for this position. An update to Attachment 13 has been posted to the NYSDOH website.

57. Question: If a current CHW Coordinator/Supervisor is not a Public Health Nurse (PHN), a Registered Nurse with a Bachelors Degree in Nursing (BSN) or a Licensed Clinical Social Worker (LCSW) can the current Community Health Worker Program (CHWP) Coordinator be retained based on experience in the previously funded CHWP?

58. Question: Will waivers of minimum qualifications for the current CHWP Coordinator position be accepted?

Answer (Questions 57, 58): The qualifications of the CHW Coordinator/Supervisor is not a specific criteria or parameter on which the application will be evaluated and scored. As part of implementation of projects selected for funding, requests to approve CHW Coordinators/Supervisors that do not meet the educational qualifications stated in the response to Question 56 above, will be considered on a case-by-case basis.

59. Question: What are the minimum qualifications for the community health worker (CHW) position?

Answer: As stated in **Attachment 13** of the RFA, the CHW qualification include:

- Indigenous community resident of the targeted area;
- Writing ability sufficient to provide adequate documentation in the family record, referral forms and other service coordination forms, and reading ability to the level necessary to comprehend training materials and assist others to fill out forms;
- Bilingual skills, depending on the community and families being served;
- Knowledge of the community, community organizations, and community leaders;
- Ability to work flexible hours, including evening and weekend hours.

General Budget

60. Question: Can funding for the Maternal and Infant Community Health Collaboratives (MICHC) be used to support a position overseeing the MICHC Coordinator?

61. Question: Can funding for the MICHC grant support a position overseeing the Community Health Worker Coordinator/Supervisor?

Answer (Questions 60 and 61): Yes. MICHC funding may be used to support a position to provide oversight to the MICHC coordinator and/or CHW coordinator/supervisor only up to the percent of time allocated to such duties. The application budget should provide the percent of time related to oversight responsibilities and the budget narrative should justify and describe the position's duties. Note that if the supervising position in question falls within the definition of “Administrative”, then funding is subject to the 10% limit on administrative costs charged to this grant. See response to Question 64 and 65 below.

62. Question: Can a portion of administrative expenses (space, insurance, etc.) be allocated to the 25% of budget requirement for offering and arranging activities?

Answer: Yes, 25 percent of the budget must be for offering and arranging. That 25 percent may include administrative expenses, if the expense is incurred in support of the Offering and Arranging activities (i.e. meeting space costs for community education and outreach related to offering and arranging activities).

63. Question: Can MICHC program funds be used for translation of program materials?

Answer: Yes. Translation of program materials would be an appropriate budget expense if it supports a specific strategy and activity stated in the MICHC Improvement Plan.

64. Question: What are allowable administrative expenses?

65. Question: The RFA states that Indirect/Administrative Costs may not exceed 10% of the budget. What are allowable Indirect/Administrative costs?

Answer (Questions 64 and 65): Administrative expenses are identifiable and verifiable expenses for duties performed in support of a grant by persons not directly involved in the provision of deliverables outlined in the work plan for example, administrative expenses such as executive staff, staff that do not work directly on the program, payroll services, or audit services. Indirect costs applied as a rate is not allowed as a single line item. Administrative expenses must be lined out separately.

66. Question: Can the lead agency use Maternal and Infant Community Health Collaboratives (MICHC) funds to contract for direct clinical services if the clinical services specifically address a key health risk or barrier to care?

Answer: No. As stated on page 39 of the RFA, section **II.B** under **Budget and Funding Restrictions**, the MICHC initiative will not fund direct clinical/medical/ laboratory services and supplies.

67. Question: Is there a limit on the percentage that can be charged for fringe benefits?

Answer: There is not a limit on the percentage of fringe benefits that an applicant may request. Applicants should use their approved agency fringe benefit rates. A breakdown of fringe benefit components is required on budget form B-2.

68. Question: The budget form for the RFA indicates that there is a match requirement. However, the RFA narrative does not mention a match. Is there a match? If so, what percentage of NYSDOH funds must be matched?

Answer: There is no match requirement for the MICHC grant. The match requirement referenced in the question relates to the federal Medicaid funding received by the NYSDOH to support this initiative, not to the MICHC application budgets.

69. Question: Are in-kind contributions required?

Answer: There is no in-kind contribution requirement for this grant. However, as stated on page 45 of the RFA, section III.A., under Preferred Eligibility Requirements, preference will be given to applicants that demonstrate strong in-kind project support from both the lead agency and partners, including public-private partnerships. All in-kind contributions to the project should be shown on your budget.

Component B: Maternal, Infant and Early Childhood Home Visiting (MIECHV)

General Questions:

70. Question: The RFA seems to indicate that grantees must serve 50 families within Year 1 and 100 families in Year 2, and then level off. The Nurse Family Partnership – National Services Office, has options for agencies to serve 50-75 families to account for less populous communities. Is this team size configuration not permitted under this RFA? Similarly, if a current program wants to expand, does it need to do so by at least a 100 slots? Or can it increase capacity by 50-75 slots?

Answer: Applicants may propose to serve less populated areas as long as the target area includes at least 100 Medicaid births a year. The MIECHV programs are not expected to serve all the families within the target area. Applicants proposing to expand current programs are also required to define target service areas that include an average of 100 or more Medicaid births per year. There is no requirement for the actual number of families that would be served through the expansion.

71. Question: The federal law establishing the Maternal, Infant and Early Childhood Home Visiting initiative states that 25% of home visiting funding should go towards promising practices and 75% to evidenced based practice. Why is this not the case for New York State?

Answer: The federal legislation states that a State may propose to expend up to 25 percent of its total grant to implement a model that qualifies as a promising approach. This option was not included in New York State's Updated State Plan, which was approved by the Health Resources and Services Administration. New York State's approved plan supports use of funding for Nurse Family Partnership and/or Healthy Families New York. As stated on page 47 of the RFA, applicants may propose to utilize a portion of their MIECHV grant (up to 10% of the amount requested) to support additional HRSA-designated evidence-based programs if they will be implemented in collaboration with a NFP or HFNY program as part of a coordinated community-wide systems approach. Other HRSA-designated evidence-based home visiting programs currently include: Early Head Start, Family Check Up, Healthy Steps, Parents as Teachers, Home Instruction for Parents of Preschool Youngsters (HIPPY), The Public Health Nursing Early Intervention Program for Adolescent Mothers, and Child First.

72. Question: Our program provides home-based primary care services via Medical Doctors, Nurse Practitioners and social workers. We are looking to partner with a Healthy Families New York (HFNY) program. Would this qualify for an "expansion" of an existing program and therefore qualify for this RFA?

Answer: The question appears to be asking if medical services can be supported by Component B: MIECHV grant. As with the MICHC grant initiative, the MIECHV grant initiative will not fund direct clinical/medical/laboratory services. Additionally, what you are describing appears to be an adaptation, rather than an expansion, of the HFNY program. Expansion of a Nurse Family Partnership (NFP) or HFNY program refers to expansion of a program currently approved by the model developer.

As stated on page 50 of the RFA, in accordance with national MIECHV requirements, applicants wishing to adapt the evidence-based model chosen need prior approval by the respective model developer. An acceptable adaptation includes changes to the model that have not been tested with rigorous impact research but are determined by the model developer not to alter the core components related to program impacts. See **Attachment 19** for specific model elements for NFP and **Attachment 20** for specific model elements for HFA.

73. Question: Could the Public Health Nursing Early Intervention Program for Adolescent Mothers (PHNEIPAM) be added to expand Healthy Families New York to include a nursing visit?

Answer: It is not clear from the question what is being asked. As stated on page 47 of the RFA, in addition to proposing to implement NFP or HFNY, applicants may propose to utilize a portion of their MIECHV grant (up to 10% of the amount requested) to support additional HRSA-designated evidence-based programs if they will be implemented in collaboration with a NFP or HFNY program as part of a coordinated community-wide systems approach. The PHNEIPAM model has been designated by HRSA as an evidence-based home visiting program, and thus could be included in an application. The application would need to describe clearly how the PHNEIPAM program model will be implemented in collaboration with a HFNY program as part of a coordinated community-wide systems approach.

This question appears to be describing an adaptation of the HFNY program model and possibly the PHNEIPAM model. As stated on page 50 of the RFA, in accordance with national MIECHV requirements, applicants wishing to adapt the evidence-based model chosen need prior approval by the respective model developer. An acceptable adaptation includes changes to the model that have not been tested with rigorous impact research but are determined by the model developer not to alter the core components related to program impacts. See answer to Question 72 above.

74. Question: The HFNY model has traditionally had a requirement for universal screening, meaning that the program must be able to serve all of the target area. Is this requirement part of this RFA?

Answer: No. Currently one of the requirements of the Healthy Families America national model developer is universal screening. Screening means to get information on each pregnant or newly parenting family in the target area with regards to certain risk factors. The national model promotes a system of organizational relationships that enables the program to screen/identify at least 75% of the families in the target population and the program has

identified strategies to increase the percentage screened/identified. Screening families does not mean enrollment of families in the home visiting services.

75. Question: Would an application to implement both NFP and HFNY programs be considered as long as they met both programs' requirements?

Answer: No. As stated on page 44 of the RFA, applications may request funding through Component B of this RFA to implement Nurse Family Partnership **or** Healthy Families New York. This does not preclude operation of a second home visiting model using other funding.

76. Question: On page 46 of the RFA it says that projects must include one of the two specific programs (Nurse Family Partnership or Healthy Families New York). Does that mean there is a way to apply for funding for a program like Parents as Teachers if we demonstrate a collaboration and continuum of care using NFP?

77. Question: Our organization oversees a Parents as Teachers program. Can we apply for funding for this program? If so, are we limited to one award in Component B?
Answer (Questions 76 and 77): In addition to proposing to implement NFP or HFNY, applicants may propose to utilize a portion of their MIECHV grant (up to 10% of the amount requested) to support additional HRSA-designated evidence-based programs if they will be implemented in collaboration with a NFP or HFNY program as part of a coordinated community-wide systems approach. Parents as Teachers has been designated by HRSA as an evidence-based home visiting program, and thus could be included in your application. Other HRSA-designated evidence-based home visiting programs currently include: Early Head Start, Family Check Up, Healthy Steps, Home Instruction for Parents of Preschool Youngsters (HIPPY), The Public Health Nursing Early Intervention Program for Adolescent Mothers, and Child First. See http://homvee.acf.hhs.gov/ for further information on these models, and **Attachment 18** for a list of NYS contacts for programs currently operating in NYS. In your application, you need to describe clearly how the proposed additional evidence-based program model(s) will be implemented in collaboration with a NFP and HFNY program as part of a coordinated community-wide systems approach.

As noted on page 45 and 53 of the RFA, if applicants propose to serve more than one county, a separate Component B application must be submitted, and will be reviewed and scored separately, for each Tier 1 county that an applicant proposes to serve. A single application may be submitted to serve multiple Tier 2 counties, alone or in combination with up to one Tier 1 county, if the applicant proposes to serve those as part of a coordinated regional/multi-county initiative. If you are proposing to implement multiple home visiting models, such as NFP and Parents as Teachers, within the same county, you should submit a single application that describes a coordinated, community-wide systems approach for that county.

78. Question: Can the initial MIECHV Assessment of Community Needs and Strengths submitted with the application include review of existing data and resources with a plan for focus groups and surveys for the first year assessment?

Answer: Yes. Applicants should include whatever relevant information is currently available to support their applications. Applicants may opt to conduct focus groups, surveys or other

assessment activities during the application development period to further inform the initial assessment of community needs and strengths described in their applications. Additional assessment activities to be completed during the contract period also may be described in your application. As noted on page 11 of the RFA, Section I. Background, under Community Assessment, assessment is viewed as an ongoing activity, not a stand-alone "planning" phase of funded projects. In addition to the initial assessments described in their applications, funded grantees will be expected to integrate ongoing community assessment activities in their MIH initiatives to continuously monitor persistent and emerging needs, barriers, resources and opportunities related to maternal and infant health within target communities. An updated community assessment will be an annual grant deliverable for grantees of both Components A and B.

AWARD SELECTION

79. Question: If an evidence-based program currently exists in a Tier 1 county, can a second be funded under this funding? For example, if a Healthy Families New York program is already funded in our county, could a stand-alone Nurse Family Partnership program be proposed?

Answer: Yes.

80. Question: How will the already awarded grants in Bronx, Monroe, etc. affect additional applicants being awarded in these counties?

Answer: Organizations that currently receive funding through NYSDOH and/or the NYS Office of Children and Family Services (NYSOCFS) for evidence-based home visiting services, including MIECHV funding, are eligible to apply for additional funding through this RFA, as well as organizations that do not currently receive such funding. Initial preference for funding through this RFA will be given to projects that have not already been awarded MIECHV funding outside of this RFA. Projects previously awarded MIECHV funds outside of this RFA include: NFP in the Bronx, NFP in Monroe County, HFNY in the Bronx and HFNY in Erie County. Please refer to the Selection and Funding Methodology for Component B, pages 53-54 of the RFA, for more detail regarding the order in which awards will be made for Component B.

81. Question: Our program is currently funded for evidence based home visiting through the MIECHV funding. Are we eligible to apply for additional Component B funding?

Answer: Yes. However, as stated in response to Question 80 above, initial preference for funding through this RFA will be given to projects that have not already been awarded MIECHV funding outside of this RFA. As described on page 54 of the RFA, awards will be made in the following order, until all funding allocated for Component B has been distributed:

- Within Tier 1, awards will be made in order from highest to lowest score, except that in this initial step, no more than one award will be made within any Tier 1 county and no additional funding will be awarded to the specific projects previously awarded MIECHV funding outside of this RFA (i.e., NFP in the Bronx, NFP in Monroe

County, HFNY in the Bronx, and HFNY in Erie County) pursuant to NYS' MIECHV State Plan.

- All remaining passing applications from both Tiers 1 and 2 (including those that were previously awarded funding through MIECHV) will then be combined, re-sorted into New York City (5 boroughs) vs. Rest of State, and ranked in order of decreasing score within each of these two regional groups.
- Awards will then be made in descending order by score, alternating between Rest of State and New York City, until all available funding has been awarded.
- Any applications that have received a score at or above the minimum passing score of 65, but that are not selected to receive an award through this RFA, will be designated as "approved but not funded". Should additional funding become available to support MIECHV activities, additional awards will be made to fund these applications in accordance with this funding methodology.

82. Question: Our organization currently implements an OCFS funded HFNY program and a MIECHV-funded HFNY program in the Bronx. Would we be eligible for an award for Component B? Could we submit a proposal for a different county in Tier 1 New York City?

Answer: You may submit an application for funding under Component B to support further expansion of your HFNY program in the Bronx. However, as stated in response to Question 80 above, initial preference for funding through this RFA will be given to projects that have not already been awarded MIECHV funding outside of this RFA, and thus that application would not be selected for an award under Component B until viable applications targeting other Tier 1 counties (i.e., counties that have not previously been selected to receive NYS MIECHV funding outside of this RFA) have been funded. You may also submit a separate proposal to establish or expand a HFNY or NFP program in a different county in Tier 1, which would be considered separately. As noted on page 45 and 53 of the RFA, a separate Component B application must be submitted, and will be reviewed and scored separately, for each Tier 1 county that an applicant proposes to serve.

83. Question: The RFA states (on page 54, Step #3a) that first priority will be given to Tier 1 counties not previously awarded MIECHV funding and that only one award will be made per Tier 1 county. If a Tier 1 county applies to develop a new (not previously funded) Healthy Families NY program, could they include an expansion of a currently MIECHV funded NFP program in the same application? If yes, would you still consider this a top priority application or would it negatively impact the likelihood of receiving an award? Or could you determine after reading the proposal to fund one program and not the other within the same application if you so choose?

Answer: No, **s**ee Answer to **Question 75.** Applications may request funding through Component B of this RFA to implement Nurse Family Partnership **or** Healthy Families New York. This does not preclude continued operation or expansion of a second home visiting model using other funding. As stated on page 51 of the RFA, Performance Standard 5 requires that home visiting programs be coordinated and integrated with larger community maternal, infant and early childhood service systems. In your application you should describe a system of services that include outreach and engagement of high-need women and families; assessment of parent, child and family health, mental health, development social, and other service needs; and early intervention and referrals to an array of coordinated

support services including home visiting services. Home visiting is a key component of this system of care. Component B grantees will be expected to work collaboratively with other community partners, including MIH Component A grantees to coordinate outreach, referral, assessment and intake processes with other home visiting programs including current Healthy Families NY and Nurse Family Partnership programs operating in the same community.

84. Question: The RFA states that first priority will be given to new NFP and/or HFNY programs (page 54, Step #3b) but that if there is remaining funding available after those awards are made, you may consider the expansion of a currently funded NFP or HFNY program in a Tier 1 community. The RFA also states that if additional MIECHV funding becomes available those projects that are not funded in this round may again be considered. As a community we are considering submitting two applications for Component B from the same community to meet our agreed upon community needs (different applicants); one to start a new program and one to expand on an existing program so that the expansion could be considered if there is remaining money or if additional funds become available. However, the RFA says that only one award would be given to any Tier 1 County. Would this be viewed as the community lacking coordination, and therefore negatively impact the likelihood of funding for either application? Is there a better way to handle this concept/application as one?

Answer: The approach you are describing is acceptable. Each application will be reviewed on its own merits and rated based on how well it addresses the established review criteria. Note that within the selection and funding methodology on page 54 of the RFA, the statement that no more than one award will be made within any Tier 1 county is specific to Step #3a. Please refer to the RFA page 54 and the response to Question 81 above for additional detail on the selection and funding methodology.

BUDGET

85. Question: We receive funding from our local health department for Nurse Family Partnership. These funds are comprised of a variety of federal, state and city dollars. Can we show them as coming from the city or do we need to identify the specific sources for the funding?

Answer: The specific sources of the funding should be identified.

86. Question: Are in-kind contributions required?

Answer: There is no in-kind match requirement in this grant, but as stated in the MIH RFA Section III. A., page 45, preference will be given to applicants that demonstrate in-kind project support from both the lead agency and partners, including public-private partnerships. All in-kind contributions to the project should be shown on your budget.