RFP Number: QPS-2016-03

HEALTH RESEARCH, INC.

New York State
Department of Health

Office of Quality and Patient Safety
State Health Innovation Plan / State Innovation Model Initiative

Request for Applications

L.I.F.T Population Health
*(**L**inking **I**nterventions **F**or **T**otal Population Health)*
Questions and Answers

QUESTION 1:
Can an applicant propose to simultaneously address more than one priority area, should they limit a proposal to one of these Priority Areas?

ANSWER 1: Applicants should select only one of the five issues listed on page 3 of the RFA. However, HRI/NYSDOH recognizes that there are overlapping risk factors for the development of many chronic diseases and thus some proposed prevention activities may cross issue areas. For example, applicants selecting the "Prevent Cardiovascular Disease and Control High Blood Pressure" issue may be proposing activities (e.g., addressing tobacco use, nutrition or physical activity) that also address one of the other issues on page 3.

QUESTION 2:
a. When we are defining the population area and focus, can we target a sub-set of the population within a population area (pre- and post-natal women, children, etc.) or is the expectation that the initiative/intervention(s) proposed would target the whole community or a majority of the population.
b. If we are permitted to target a sub-set of a population within a population area, does that sub-population have to be 50,000-250,000+ or do they have to reside in the population area with those parameters? In other words, is there a requirement for the sub-population size?

ANSWER 2:
a. The goal of the LIFT Population Health initiative is to implement a set of coordinated interventions across all three buckets (categories) of prevention to improve health for all individuals in the population area. While some of the interventions can target population subgroups experiencing health disparities, the goal is that some interventions (especially in Bucket 3) will benefit the entire population area and achieve area-wide health improvements.

b. The population size requirements apply to the geographical area selected (i.e., a county or group of contiguous counties). There is no requirement for subpopulation size; however, an analysis and estimate of targeted subpopulation sizes may be necessary to prove need.

QUESTION 3:
The LIFT RFA explains that the smallest geographical unit is to be a county. Can we propose to target a geographic area smaller than (or defined differently than) an entire county/borough if we are able to meet the other criteria for a defined geographic area?

ANSWER 3: For the purposes of determining which type of award applies to an applicant (i.e., small population area or medium/large population area), applicants must use the population size of their entire selected county or group of contiguous counties. However, applicants should include in their narratives a description of subpopulations that they are targeting within their population area and estimates of the sizes of those subpopulations. See Answer #2.

QUESTION 4:
When deciding on which type of award applies to us (i.e. Small Population Area or Medium/Large Population Area), should we only consider the population size of our entire county which is > 250,000 or can we identify a smaller population within our county that has the highest need (population size approximately 150,000)?

ANSWER 4: See Answers #2 and #3.

QUESTION 5:
If we must apply based on population size of our county, must we implement our strategies county-wide or can we focus our strategies within the high need communities?

ANSWER 5: See Answer #2.

QUESTION 6:
Can some of our strategies be county-wide and others focus on high need communities or must all strategies be county-wide?

ANSWER 6: See Answer #2.

QUESTION 7:
In Section III, distribution of funding, first paragraph on page 9, the RFA instructs applicants to identify a service area as a county or group of counties. It then goes on to say that applicants should select a defined geographic area with certain characteristics.

The question is: is it recommended that the intervention focus on a subset of the service area (i.e., the defined geographic area) rather than the entire service area? If so, are there any requirements for interventions to reach beyond the defined geographic area, that is, to serve the entire county?

ANSWER 7: The overall reach must be area-wide, but some interventions may target specific subpopulations. See Answer #2.

QUESTION 8:
While the larger funds are meant for large population areas, we have a very dense population area. Can we base our population on a target audience, more in the line of 100,000-200,000 and apply for the smaller award?

ANSWER 8: Applicants must use the population size of their entire selected county or group of contiguous counties to determine if they are applying for a small population area award or a medium/large population area award. See Answer #2.

QUESTION 9:
Would a potential grantee have to select an entire county (e.g., all of Queens) as listed in Attachment 5 of the RFA; or could we define a number of neighborhoods (e.g. community districts) that, combined (or even one alone) have more than 250,000 residents?

ANSWER 9: See Answer #8.

QUESTION 10:
The RFA states that SIM funds cannot be used to pay for service delivery. What is the definition of service delivery in this context?

ANSWER 10: While funding cannot be used for actual health care service delivery (e.g., cannot pay for a health care provider's services), it can be used to increase the use of evidence-based services. This would be considered a Bucket One intervention. An example could be developing an electronic health record alert or an appointment reminder process.

QUESTION 11:
Prevention Framework: Does each activity have to include interventions in all 3 buckets? (e.g. if we choose complete streets activities do we need to demonstrate involvement in buckets 1 and 2?)

ANSWER 11: This RFA requires applicants to provide a range of strategies and activities across all three buckets to address the issue selected in a coordinated manner. However, each activity does not need to involve all three buckets. The overall portfolio of work must be in all three buckets and at the level of effort outlined for each bucket on page 7 of the RFA.

QUESTION 12:
Bucket One: Traditional Clinical Prevention: Can you define what "clinical intervention" means? (e.g. Does Traditional Clinical Prevention interventions require the involvement of a licensed professional or physician diagnosis?)

ANSWER 12: Traditional Clinical Prevention interventions involve the care provided most often by physicians and nurses in a doctor's office setting in a routine one-to-one encounter. They have a strong evidence base for efficacy in health and/or cost impact. Examples include seasonal flu vaccines, colonoscopies, and screening for obesity and tobacco use. But for the purposes of this RFA, it is not required that the intervention involve a licensed health care professional.

While funds associated with this RFA cannot be used for actual health care service delivery (e.g., cannot pay for a health care provider's services), it can be used to increase the use of evidence-based clinical services. Please see examples on Pages 6 and 11 of RFA.

QUESTION 13:
Summary: How restrictive is our area of focus? (e.g. If we choose obesity as a topic can we focus on a) breastfeeding for a mother and child b) children in schools c) additionally work on increasing activity in general population? Does it need to be highly focused or can it be diverse?)

ANSWER 13: Applicants must choose one of the five issues on page 3 of the RFA, but the different interventions and activities can target various subpopulations and subcomponents of that issue. For example, if an applicant chooses "Prevent and Control Obesity and Diabetes," they may choose various interventions and different targets for those interventions, such as breastfeeding (targeting new mothers) and exercise/healthy eating (targeting school age children). The overall portfolio of work must be in all three buckets and at the level of effort outlined for each bucket as outlined in the RFA on page 7. While some of the interventions should target population subgroups experiencing health disparities, the overall goal is that some interventions (especially in Bucket 3) will benefit the entire population area and achieve area-wide health improvements. See Answer #2.

QUESTION 14:
In section VI, Completing the Application, under the section on Statement of Need on page 27:

a. For number 1: For the description of the burden disease, condition or risk factor, should the county level data be used or should we use data for the subset of the county that we intend to focus on, namely the defined geographic area.

b. For Number 2. You ask for data for the proposed geographic area in the first sentence and then go on to say that applicants are encouraged to use data to describe the county or group of counties. If we are intending to focus on a geographic area that is a subset of the county, could you please clarify what data is requested: are you requesting data about the health issue for the county, for the proposed defined geographic area, or for both?

ANSWER 14:

a. Applicants should provide sufficient information that helps justify the selection of the issue for the applicant's selected county or group of contiguous counties and also any subpopulations that the applicant may be targeting.
b. See Answer # 14 a.

QUESTION 15:
Section I and Section IV both refer to the buckets of prevention, and in the example in Section I, Bucket Two indicates that assessing individual homes and limited remediation would be an example of an intervention for persons with asthma. Bucket Three also raises the issue of limiting indoor pollutants. In Attachment 4, Budget Instructions, however, items 1.a. and 2.f. refer to funds not being able to be used for capital improvement and construction. Does this mean that none of the funding can be used to make physical improvements to improve air quality? Must other funds be used for such improvements, or are these improvements not considered to be construction?

ANSWER 15: Bucket Three refers to total population or community-wide prevention interventions, including policy and systems changes to improve the overall health of the community. Funds may be used for making those policy and systems changes, but not actual capital improvement and construction.

QUESTION 16:
Due to the quick turnaround time and time to begin work, will there be any opportunity to carryover any funds from year 1 (11/1/16-1/31/17) to year 2?

ANSWER 16: Unexpended funds cannot be carried forward to the next project year.

QUESTION 17:
If we create videos to be placed on the internet (our website and social media) is it mandated that it be closed captioned?

ANSWER 17: NYSDOH follows the federal government's Section 508 *Standards for Electronic and Information Technology, Web-based Intranet and Internet Information and Applications* to ensure that people with disabilities have access to information and data. This includes the use of captioning, when appropriate. NYSDOH/HRI will work with contractors to ensure that section 508 requirements are followed.

QUESTION 18:
When is the decision made on who is awarded the funds?

ANSWER 18: We expect that applicants will be notified regarding the results of this RFA in Fall 2016.

QUESTION 19:
Can we put money into stipends for focus groups?

ANSWER 19: Yes, applicants may propose this as part of their application.

QUESTION 20:
If we have samples is there money for messenger service and to store them?

ANSWER 20: This question is not clear. Funds are not available for health care service delivery, including the transportation and storage of clinical specimens.

QUESTION 21:
Is there money to run meetings?

ANSWER 21: Funding to support meetings to manage this project are allowable expenses and should be included in the application budget.

QUESTION 22:
Would it be permissible for the funded organization to use LIFT funding to make small grants to community partners to promote engagement in the project?

ANSWER 22: The applicant must be the contractor, but applicants may propose subcontractors as part of the application.

QUESTION 23:
What scope of activities can be included in the Prevent and Detect Cancer Category? (pg3 and throughout document) – To what extent can activities overlap with the other prevention categories? For example, does the "Prevent and Detect Cancer" category include or exclude interventions to achieve: a) tobacco use prevention and cessation; b) improved nutrition and physical activity; c) Prevention of infectious diseases (in addition to HPV) such as HIV, HCV? Also, can we address cancers that effect specific segments of the population even if they are not high prevalence in the general population (such as gastric cancer)?

ANSWER 23: Applicants should select an issue that pertains to their proposed geographic area in order to achieve area-wide health improvements. The Prevention Agenda's Prevent Chronic Disease Action plan specifically addresses breast, cervical and colorectal cancers. HRI/NYSDOH recognizes that there are overlapping risk factors for the development of many chronic diseases and thus some proposed prevention activities may cross issue areas.

QUESTION 24:
Given disagreements concerning cancer screening guidelines among major organizations, are we required/recommended to use any specific set of standards? For example, American Cancer Society versus U.S. Prevention Services Task Force differ in the initial age and frequency of mammography screening. Last year, members of our PPS adopted standards that included earlier and/or more frequent screening than either of these bodies. Is there any guidance about what standard to promote?

ANSWER 24: The NYSDOH recommends clinical preventive service recommendations issued by the United States Preventive Services Task Force (USPSTF) and also recognizes a variety of evidence-based guidelines around cancer screening published by other reputable organizations. Some of these organizations include the National Comprehensive Cancer Network (NCCN), National Cancer Institute (NCI), American Cancer Society (ACS), American College of Obstetricians and Gynecologists (ACOG), and the American Society for Colposcopy and Cervical Pathology (ASCCP). NYSDOH does not endorse the use of population-based cancer screening guidelines that do not align with an existing national standard, and does not endorse earlier, more frequent cancer screenings in asymptomatic men and women at average risk for specific cancer types. Regarding breast cancer screening, there are many organizations and professional societies that have developed guidelines. While differences exist in what age to start screening and how frequent screening should occur, all guidelines recommend that women should talk with their doctor or health care provider about the potential benefits and harms of screening as well as their own personal risk for breast cancer in order to make an informed choice about their health care.

QUESTION 25:
Does the RFA envision the inclusion of secondary prevention for individuals at high risk, or should we focus on more universal and primary prevention approaches? For example, lung cancer screening targeting former smokers is secondary prevention as is genetic testing of individuals at high familial risk. Should these be considered within LIFT?

ANSWER 25: While some activities in Buckets 1 and 2 may involve secondary prevention, the main focus of the LIFT Population Health RFA is on primary prevention and achieving area-wide health improvements.

QUESTION 26:
Is our DSRIP PPS qualified to serve as the lead organization for this effort? Although many member organizations within our PPS have served our selected county and identified cancer "hot spots" for many years, we did not come together as the Montefiore Hudson Valley Collaborative until preparation of our DSRIP application April 2014? Are we qualified to serve as the lead organization? Would it be more responsive to this RFA to respond as Montefiore, which is the parent organization of MHVC but which is a separate corporate entity? More generally, do you agree that pre-existing coalitions like a PPS are well-situated to serve as lead organizations for LIFT, or do you expect lead organizations to form new coalitions specifically for this effort?

ANSWER 26: Pre-existing coalitions may be well situated to serve as lead agencies for LIFT Population Health if they are inclusive of the partners outlined in the RFA (see Minimum Eligibility Requirement on page 7). However, the membership must be able to effectively implement a set of interventions across all three buckets with the level of effort per bucket that are outlined on page 7 of the RFA. This initiative includes a major emphasis on Bucket 3 work, which may be different than the focus of work of many other existing health care reform projects.

QUESTION 27:
Are we limited to assessing "behavioral change" for ONLY two interventions? Given the kinds of process evaluation we will propose, we will have behavioral change data of the type described in the RFA (pg 13) for more than two of our programs. Do you mean "at least two", or should we view this language as limiting what we should measure and/or report?

ANSWER 27: Applicants should propose at least two interventions for behavior change.

QUESTION 28:
Can you clarify the nature of Interventions that would fall into bucket 3?
We are considering interventions in the following categories:

- Forming Community Action Councils of stakeholders to help us plan, oversee and at times, conduct LIFT interventions, particularly those in Buckets 2 and 3
- Identifying and addressing gaps in providers to perform cancer screening and follow-up care by mobilizing support and creating linkages to several local hospitals
- Improving transportation and reducing other barriers that globally interfere with cancer screening and prevention information countywide or in targeted communities
- Implementing Mass media and social media to raise awareness and build recognition of LIFT activities
- Empowering patients/clients who seek screening to carry information back to their communities
- Conducting relevant programs to raise cancer awareness and promote referrals through local public libraries and potentially other popular cultural venues in the community
- Increasing PCP participation in the Advanced Primary Care Model (APC mentioned in page 4)
- Dissemination of information about HPV vaccination to children and parents in public schools
- Engagement of community-based organizations and local businesses such as grocers or pharmacies that reach large segments of the at-risk and underserved population, to conduct on-site health programs

ANSWER 28: Bucket 3 refers to total population or community-wide prevention interventions, including policy and systems changes to improve the overall health of the community. Bucket 3 activities target community settings (including neighborhoods, schools, workplaces, childcare facilities) rather than individual patients or patients covered by a certain health care provider or insurer. Examples of Bucket 3 interventions include activities to increase the availability and access to healthy and affordable foods, or activities to increase access to opportunities to exercise. Interventions that help connect individuals to health services are considered Bucket 2 activities.

Examples of evidence-based community-wide interventions can be found in the links provided on Page 11 of the RFA. In addition, please see the Centers for Disease Control and Prevention's Community Health Improvement Navigator at: http://www.cdc.gov/chinav/index.html

QUESTION 29:
Are we permitted to use New York State administrative data for our outcomes evaluation? Language in the RFA on page 12 states that awardees are not expected to gather and report measures from the Prevention Agenda or APC Measures sets. Will NYS provide these data back to our program?

ANSWER 29: Applicants may propose to use New York State administrative data for the purpose of measuring outcomes associated with a specific intervention or program. New York State is not planning to provide contractors with Prevention Agenda or Advanced Primary Care (APC) Measure set data to use for the purpose of outcome evaluations. Contractors will receive notification of relevant data releases, and updates on Prevention Agenda indicators and APC Measure sets on the NYSDOH public website.