

**RFA # 1405230955
Grants Gateway # DOH01-AIHCV-2015
Grants Gateway # DOH01-AIHCVB-2015**

**New York State Department of Health and Health Research, Inc.
AIDS Institute**

**Division of HIV and Hepatitis Health Care
Viral Hepatitis Section
Internal Program # 14-0003**

Improving Linkage and Access to Hepatitis C Virus (HCV) Care and Treatment

**Component A: Improving Linkage and Access to HCV Care and Treatment for HCV C
Mono-infected Persons**

**Component B: Improving Linkage and Access to HCV Care and Treatment for HIV/HCV
Co-infected Persons**

**This is a procurement which encompasses 2 components.
In order to apply for either component, eligible applicants must submit separate
applications for each Component via the New York State Grants Gateway.**

KEY DATES

Release Date:	August 21, 2014
Deadline to Submit Questions:	September 4, 2014, by 4:00 p.m.
RFA Updates, Questions and Answers Posted (on or about):	September 18, 2014
Letter of Intent Due:	September 25, 2014
Applications Due:	October 8, 2014, by 4:00 p.m.
DOH Contact Name & Address:	Colleen Flanigan, RN, MS Director, Viral Hepatitis Section New York State Department of Health AIDS Institute Email: hepatabc@health.state.ny.us

**Division of HIV and Hepatitis Health Care
Viral Hepatitis Section
Request for Applications (RFA)
RFA #: 1405230955
Internal Program # 14-0003**

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I. Introduction

The New York State Department of Health (NYSDOH), AIDS Institute (AI) and Health Research, Inc. (HRI) announce the availability of state and federal funds for:

Component A: Improving Linkage and Access to HCV Care and Treatment for HCV Mono-infected Persons.

Component B: Improving Linkage and Access to HCV Care and Treatment for Individuals Co-infected with HIV and HCV.

The 2010-2015 NYS Viral Hepatitis Strategic Plan specifically identifies integrating HCV care and treatment into primary care settings as a priority and strategy for improving access to care and treatment. Since 2010, the NYSDOH AI has provided funding to a limited number of programs across the state to integrate HCV care and treatment services into existing primary care models. These programs have been critical in ensuring timely access to HCV care and treatment and increasing the number of persons treated for HCV. This successful model utilizes a multidisciplinary team approach to offering comprehensive HCV care and treatment. Key to the success is the availability of a mental health provider, nutritionist, peer support and other supportive services (e.g., support groups, counseling and education, etc.) in a primary care setting. Since the initiative began, over 2,167 individuals have received HCV care and treatment services, 430 initiated treatment, and 85 have been cured of HCV disease.

Since the release of the original solicitation in 2010, new and more effective HCV therapies have been approved and even more therapies are awaiting FDA approval, including interferon-free treatments. New HCV rapid screening technologies are also available, making it easier for people to know their HCV status. The Centers for Disease Control and Prevention (CDC) has expanded its HCV screening recommendations to include a one-time only test for those persons born between 1945 and 1965. Three quarters of those infected with HCV fall within this birth cohort. In October 2013, a law was signed in NYS requiring the one time offer of an HCV screening test (with additional offers required when indicated) to all persons born within this birth cohort who receive services in a hospital or in outpatient settings providing primary care services. In addition, the Affordable Care Act (ACA) has improved access to care for more people with chronic HCV. All of these changes should result in more people seeking HCV care and treatment. Despite these advances in screening, treatment and access to care, many barriers still exist to linking people to care and treatment for HCV.

Programs funded under Components A and B of this RFA will ensure linkage to HCV care and treatment and improve access to comprehensive HCV care, treatment and supportive services for persons identified with HCV and HIV/HCV.

Applicants for Components A and B must meet minimum eligibility requirements noted in Section III – Who May Apply.

NOTE: Applicants may apply for Components A and B. If applying for both components, separate applications must be submitted for each component via the New York State Grants Gateway. If both components are included in one application, the application will be rejected.

A. Background

Hepatitis C Virus

Hepatitis C virus (HCV) is a major public health problem in the United States (US) and in New York State (NYS). In the US, an estimated 3.2 million people are living with HCV infection ^[1]. In NYS, for persons ≥ 20 years of age, an estimated 195,000 are currently living with chronic HCV infection ^[2]. It is estimated that 45-85% of adults with chronic HCV are unaware of their infection. Infection is most prevalent among those born during 1945–1965, and people who inject drugs are most at risk for becoming infected ^[3]. Left untreated, HCV can cause serious liver damage, including liver cancer. HCV-associated disease is also the leading indication for liver transplants in the US. A recent study by Centers for Disease Control and Prevention (CDC) found the deaths associated with HCV now exceed the deaths related to HIV ^[4].

Nationally, researchers have estimated that HCV-related morbidity and mortality are expected to rise for at least the next decade and that medical costs for persons living with HCV could more than double over the next 20 years to \$85 billion per year ^[5,6]. In NYS, total estimated costs associated with hepatitis C in 2009 were between \$1.36 billion and \$2.43 billion. Direct costs were between \$0.39 billion and \$1.42 billion, and productivity costs totaled over \$0.97 billion. Three-quarters and 80% of HCV-related health care utilization and productivity costs, respectively, were attributed to persons born between 1945 and 1965 ^[7].

HCV is common among persons infected with HIV because of shared routes of transmission. On average, 15%–30% of HIV-infected patients are also infected with HCV, although the prevalence of co-infection varies significantly by mode of transmission ^[8]. Prevalence of HCV among HIV-infected injection drug users (IDU) is high (>80%) ^[9]. There is also evidence of

1 Armstrong GL, Wasley A, Simard EP, McQuillan GM, Kuhert WL, Alter MJ. The prevalence of hepatitis C virus in the United States, 1999 through 2002. *Ann Intern Med* 2006;144:705-714.

2 Hart-Malloy R, Carrascal A, DiReienzo G, Flanigan C, McClamroch K, Smith L. Estimating prevalence at the state level: A call to strengthen current surveillance systems. *Am J Public Health* 2013;103:1402-1405

3 Centers for Disease Control and Prevention. Recommendations for the identification of chronic hepatitis C virus among persons born during 1945-1965. *MMWR* 2012;61(No.RR-4):1-32

4 Ly K, Xing J, Klevens M, Jiles R, Ward J, Holmberg S. The growing burden of mortality from viral hepatitis in the US, 1999-2007. *Ann Intern Med* 2012;156:271-278.

5 Rein D, Smith BD, Wittenborn JS, Lesesne SB. The cost-effectiveness of birth cohort hepatitis C antibody screening in US primary care settings. *Ann Intern Med* 2011;155:263-270.

6 Wong J, McQuillan GM, McHutchison JG, Poynard T. Estimating future hepatitis C morbidity, mortality and costs in the United States. *Am J Public Health* 2000;90:1562-1569.

7 Hart-Malloy R, Flanigan C, Laufer F. (2013) Costs associated with hepatitis C: A model for estimating cost burden at the state level. Unpublished manuscript.

8 Sherman KE, Rouster SD, Chung RT, et al. Hepatitis C virus prevalence among patients infected with human immunodeficiency virus: a cross-sectional analysis of the US Adult AIDS Clinical Trials Group. *Clin Infect Dis*. 2002; 34:831–837.

9 Strader DB. Co-infection with HIV and hepatitis C virus in injection drug users and minority populations. *Clin Infect Dis*. 2005;41(suppl 1):S17-13.

outbreaks of HCV in HIV-infected men who have sex with men (MSM)^[10]. Liver disease has emerged as a leading cause of morbidity and mortality in HIV-infected persons. HIV infection exacerbates the progression of HCV infection. Although HCV treatment success rates are not as high in the HIV/HCV co-infected population compared to the HCV mono-infected, persons with HIV/HCV should be considered and evaluated for HCV treatment. Newer therapies are showing better efficacy.

Linkage to Care

The first step in getting HCV-infected individuals on treatment is to confirm their HCV infection. As previously stated, it is estimated that 45-85% of adults with chronic HCV are unaware of their infection. Many persons identified as HCV-infected do not receive recommended medical evaluation and care after the diagnosis of HCV infection^[11]. This gap in linkage to care can be attributed to several factors, including being uninsured or underinsured, failure of providers to provide a referral, failure of patients to follow up on a referral, drug or alcohol use, and other barriers. The lack of such care or substantial delays before care is received, negatively impacts the health outcomes of infected persons. The availability of HCV rapid testing, along with routine testing of persons born during 1945–1965, will lead to more HCV-infected persons identified earlier in the course of disease. However, to improve health outcomes, persons testing positive for HCV must be provided with appropriate care and treatment. Linking patients to care and treatment is a critical component of the strategy to reduce the burden of disease^[13].

Strategies are needed to improve linkage and retention in care for HCV-infected persons who are experiencing barriers to care. These persons might benefit from effective linkage to care models. Active linkage to care programs provided in a patient centered model (e.g., the use of case managers to schedule appointments, bring infected patients to medical appointments and follow-up with patients) have been found to be more effective than passive referral methods (e.g., providing patients with information about the disease and a list of resources or referrals to medical care)^[12,13,14]. Such linkage creates opportunities for patients to receive information, vaccinations and prevention counseling messages, and to more fully engage in care^[15]. Results from the NYC Check Hep C Project show patient navigation activities used to assist participants in obtaining test results and completing follow-up diagnostic testing and medical appointments led to the majority of HCV infected patients attending medical appointments. The rate of

10 Wandeler G, Gsponer T, Bregenzer A, et al. Hepatitis C virus infections in the Swiss HIV cohort study: a rapidly evolving epidemic. *Clin Infect Dis* 2012;55:1408-1416.

11 Shehab TM, Sonnad SS, Lok AS. Management of hepatitis C patients by primary care physicians in the USA: results of a national survey. *J Viral Hepatitis* 2001;8:377-383.

12 Gardner LI, Metsch LR, Anderson-Mahoney P, Loughlin AM, del Rio C, Strathdee S, Sansom SL, Siegel HA, Greenberg AE, Holmberg SD, ARTAS Study Group. *AIDS* 2005;19:423-431.

13 Horstmann E, Brown J, Islam F, Buck J, Agins BD. Retaining HIV-infected patients in care: Where are we? Where do we go from here? *Clin Infect Dis* 2010;50:752-761.

14 Molitor F, Waltermeyer J, Mendoza M, Kuenneth C, Aguirre A, Brockmann K, Crump C. Locating and linking to medical care HIV-positive persons without a history of care: Findings from the California Bridge Project. *AIDS Care* 2006;18:456-459.

15 Mayer KH. Introduction: Linkage, engagement and retention in HIV care- essential for optimal individual and community-level outcomes in the era of highly active antiretroviral therapy. *Clin Infect Dis* 2011;52 (Suppl 2):S205-207.

attendance at medical appointments for diagnosis and assessment of treatment eligibility was quite high compared to that reported in observational studies of similar populations^[16].

With the availability of HCV rapid antibody testing as a point of care test, access to HCV screening is more widely available throughout NYS. Many community based organizations (CBOs) serving persons at risk for HCV have implemented HCV screening using the rapid test. However, because of limited funding and resources, only passive referrals are provided, resulting in few people getting linked to care.

Hepatitis C Care and Treatment

The HCV treatment landscape has changed dramatically over the past few years and will likely continue to do so. The goal of HCV treatment is to prevent complications and death from HCV infection. Sustained virologic response (SVR) to treatment decreases progression to cirrhosis and incidence of hepatocellular carcinoma and improves survival^[17]. New direct acting anti-viral (DAA) therapies approved in 2011, when used in combination with pegylated interferon and ribavirin in clinical trials, increase SVR rates from 44% to 75% in persons infected with genotype 1^[18]. Additional therapies, including interferon-free regimens, are proving to be even more effective than the DAAs in clinical trials. Therefore, as less complex treatments with more manageable side effects and shorter durations become available, management of HCV infection will move from being a disease managed by specialists to a disease managed by primary care providers (PCPs).

It has been widely reported that few people with HCV get treated. In the US, only 21% of infected individuals had received HCV therapy by the end of 2007 and treatment rates appear to be declining^[19]. The availability of more effective, less complex treatments with more manageable side effects and shorter durations offer a tremendous opportunity to increase the number of people on treatment and potentially cured of HCV. As previously stated, despite advances in HCV therapies, barriers to accessing and initiating HCV treatment still exist. The barriers exist at three levels: 1) patient, 2) provider and 3) health care system. Patient level barriers most often cited are lack of knowledge, low priority, stigma, lack of financial resources and fear of side effects. In addition, many individuals with HCV present with co-occurring disorders such as HIV, mental health and/or substance use disorders further impacting their decision to initiate HCV treatment and engage in care, which impacts treatment outcomes. Provider related barriers include insufficient training, lack of infrastructure to support the needs of the HCV patient, reluctance to treat former or current drug users and insufficient reimbursement. The health care system level barriers include lack of capacity to support the number of persons in need of treatment^[20,21].

16 Hagan H. Evaluation of the implementation of evidence based practices as part of Check Hep C – New York City. Unpublished manuscript.

17 Clark BT, Garcia-Tsao G, Fraenkel L. Patterns and predictors of treatment initiation and completion in patients with chronic hepatitis C virus infection. *Patient Preference and Adherence* 2012;6:285-295.

18 Jacobson I, McHutchison J., Dusheiko G, et al. Telaprevir for previously untreated chronic hepatitis C virus infection. *New Engl J Med* 2011;364:2405-2416.

19 Volk ML, Tocco R, Saini S, Lok AS. Public health impact of antiviral therapy for hepatitis C in the United States. *Hepatology* 2009;50:1750-1755.

20 Bruggmann P. Hepatitis C patients who are difficult to reach: It is time to overcome the barriers. *J Viral*

To overcome many of the patient barriers identified above, support groups, chronic disease management approaches and integrated multidisciplinary care approaches can help improve care^[22,23]. These approaches emphasize engagement and trust-building and include using peers to provide comprehensive and culturally appropriate care. Peer support coupled with multidisciplinary care has been shown to be an effective strategy for engaging drug users in HCV care^[24]. HCV support groups can help empower IDUs so that they have a voice in their HCV care and treatment plan and can motivate them to believe that positive treatment outcomes are attainable^[25].

Integrating HCV care and treatment into primary care settings will also alleviate some of the provider and systems barriers. It is generally recognized that the number of gastroenterology, hepatology and infectious disease specialists who are available to treat HCV is insufficient to provide care for the millions of people with chronic hepatitis C^[26]. This is particularly true in rural areas. PCPs can successfully treat HCV with mentoring from a specialist. This is illustrated by the currently funded programs and through an innovative telemedicine project in New Mexico - Project ECHO^[27]. In addition, primary-care settings are well suited to provide care for people with chronic HCV because primary care is much more widely available than specialty care, can create and sustain a long-term relationship between patients and care providers, and provides comprehensive care that addresses a patient's physical, behavioral, and family/community needs^[28,29,30].

Despite tremendous advances in HCV screening and treatment, challenges remain for getting people into care, as well as on treatment and through treatment completion. With better access to care as a result of the ACA, and the advent of new HCV therapies that can halt disease

Hepatitis 2012;19:829-835.

21 Grebely J, Oser M, Taylor L, Dore GL. Breaking down the barriers to hepatitis C treatment among individuals with HCV/HIV co-infection: Action required at the system, provider and patient level. *J Infect Dis* 2013;207(S1):S19-25.

22 Schiff GD, Kim S. Case management/multidisciplinary care models. In: King TE, Wheeler MB, Fernandez A, Schillinger D, Bindman A, Grumbach K, et al., editors. *Medical management of vulnerable and underserved patients: principles, practice and populations*. New York: McGraw-Hill; 2007. p. 151-8.

23 Sylvestre DL, Loftis JM, Hauser P, Genser S, Cesari H, Borek N, et al. Co-occurring hepatitis C, substance use and psychiatric illness: treatment issues and developing integrated models of care. *J Urban Health* 2004;81:719-734.

24 Grebely J, Knight E, Genoway KA, Viljoen M, Khara M, et al. Optimizing assessment and treatment for hepatitis C virus in illicit drug users: a novel model incorporating multidisciplinary care and peer support. *Euro J Gastroenterol and Hepatology* 2010;22:270-277.

25 Litwin AH, Soloway I, Gourveitch. Integrating services for injection drug users infected with hepatitis C virus with methadone maintenance treatment: Challenges and opportunities. *Clin Infect Dis* 2005;40(Suppl 5):S339-345.

26 Zevin B. Managing chronic hepatitis C in primary care settings: More than anti-viral therapy. *Public Health reports* 2007;122:78-82.

27 Arora S, Kalishman S, Thorton K, Dion D, Murata G, et al. Expanding access to hepatitis C virus treatment – extension for community healthcare outcomes (ECHO) project: Disruptive innovation in specialty care. *Hepatology* 2010;52:1124-1133.

28 McGinn TG, Gardnier D, McGinn LK, Alfandre D, Oconnor-Moore N, Strum TM, et al. Treating chronic hepatitis C in the primary care setting. *Simin Liver Dis* 2005;25:65-71.

29 Shehab TM, Orrego M, Chunduri R, Lok AS. Identification and management of hepatitis C patients in primary care clinics. *Am J Gastroenterol* 2003;98:639-644.

30 Clark EC, Yawn BP, Galliher JM, Temte JL, Hickner J. Hepatitis C identification and management by family physicians. *Family Medicine* 2005;37:644-649.

progression and cure most persons, there is a critical need to develop innovative, integrated models of care to reduce the significant morbidity and mortality associated with HCV infection.

Intent of RFA

The intent of this RFA is to create an innovative HCV care and treatment model that will diminish patient, provider and health care system barriers. The funded HCV care and treatment model will: 1) increase the number of people infected with HCV who get linked to care and 2) improve HCV treatment initiation and completion rates. This will be accomplished by implementing evidence-based strategies for linkage to care, treatment adherence and supportive services and by providing HCV care and treatment utilizing a multidisciplinary care team approach in a primary care setting.

II. Funding

It is expected that \$2,110,000 in State and HRI funding will be awarded under this RFA. NYSDOH AI and HRI reserve the right to revise this amount as necessary due to changes in the availability of funding.

Should additional funding become available, the AIDS Institute may select a program from the pool of applicants deemed approved, but not funded. If it is determined that the needed expertise/services are not available among these organizations, the NYSDOH AI and HRI reserve the right to establish additional competitive solicitations.

Sources of support for this RFA are subject to change, but at this time include:

- \$1,840,000 in funds appropriated from New York State
- \$270,000 in HRI funds

Individual award amounts will vary depending on component.

NYSDOH AI and HRI reserve the right to revise the award amounts and component amounts as necessary due to changes in the availability of funding. The Affordable Care Act and NYS Medicaid Reform are redefining allowable grant reimbursement. The expansion of covered services under health care reform on the federal and local level is rapidly changing the landscape of grant fundable activities and services. It is possible that the continued changes may affect the current grant funded model during the award period. Applicants must anticipate work plan and work scope changes that will be responsive to health care reform. Grant funds are dollars of “last resort” and can only be used when there are no options for other reimbursement. Funds awarded through this RFA may NOT be used to supplant funding from other local, state or federal sources or existing programs.

A. Component A: Improving Linkage and Access to HCV Care and Treatment for HCV Mono-infected Persons

A total of \$1,570,000 in State funding is available to provide linkage to care services and HCV

care and treatment to HCV mono-infected persons. A complete list of the services included under this component is provided in Section IV – Project Narrative. **Up to a total of six (6) awards will be made under Component A.**

Area	Maximum Funding Available Annually Per Award	# of Awards*
Area: Rest of State		
<u>Western Region:</u> Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming. <u>Finger Lakes Region:</u> Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates. <u>Central Region:</u> Broome, Cayuga, Cortland, Chenango, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins. <u>Northeast Region:</u> Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington. <u>Hudson Valley Region:</u> Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester. <u>Long Island Region:</u> Nassau, Suffolk.	\$260,000	4-6*
Area: New York City		
Counties of : Bronx Kings New York Queens Richmond	\$265,000	2-6*
TOTAL	\$1,570,000	6

Funding for Component A is expected to be allocated as follows:

Rest of State: Within the Rest of State area, several regions have been listed in the chart above. The highest scoring application from each of these regions will be considered for funding. From these applications, the three highest scoring applications will be funded with no more than one application funded in each region. However, in the event acceptable applications (scoring 70 or above) are not received from at least three regions, multiple awards to one region may be considered. Additional awards would be made to the next highest scoring applications (scoring 70 or above).

New York City: Awards will be made to the two highest scoring applications (scoring 70 or above).

*In the event that acceptable applications (scoring 70 or above) are not received in one of the defined areas (i.e., Rest of State or New York City), NYSDOH/HRI reserves the right to fund the

next highest scoring application(s) in the other area. In addition, if a sufficient number of acceptable applications (scoring 70 or above) are not received in one of the components (i.e., Component A or Component B), NYSDOH/HRI reserves the right to fund the next highest scoring application(s) in the other component (scoring 70 or above).

B. Component B: Improving Linkage and Access to HCV Care and Treatment for HIV/HCV Co-infected Persons

A total of \$540,000 in State and HRI funding is available to provide linkage to care services and HCV care and treatment to HIV/HCV co-infected persons. A complete list of the services included under this component is provided in Section IV- Project Narrative. Funding is expected to be allocated as stated in the chart below. **Up to a total of four (4) awards will be made under Component B.**

Area	Maximum Funding Available Annually Per Award	# of Awards*
Area: Rest of State		
<u>Western Region:</u> Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming. <u>Finger Lakes Region:</u> Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates. <u>Central Region:</u> Broome, Cayuga, Cortland, Chenango, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins. <u>Northeast Region:</u> Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington. <u>Hudson Valley Region:</u> Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester. <u>Long Island Region:</u> Nassau, Suffolk.	\$135,000	2-4*
Area: New York City		
Counties of: Bronx Kings New York Queens Richmond	\$135,000	2-4*
TOTAL	\$540,000	4

Funding for Component B is expected to be allocated as follows:

Rest of State: Within the Rest of State area, several regions have been listed in the chart above. The highest scoring application from each of these regions will be considered for funding. From these applications, the four highest scoring applications will be funded with no more than one

application funded in each region. However, in the event acceptable applications (scoring 70 or above) are not received from at least four regions, multiple awards to one region may be considered. Additional awards would be made to the next highest scoring applications (scoring 70 or above).

New York City: Awards will be made to the two highest scoring applications (scoring 70 or above).

*In the event that acceptable applications (scoring 70 or above) are not received in one of the defined areas (i.e., Rest of State or New York City), NYSDOH/HRI reserves the right to fund the next highest scoring application(s) in the other area. In addition, if a sufficient number of acceptable applications (scoring 70 or above) are not received in one of the components (i.e., Component A or Component B), NYSDOH/HRI reserves the right to fund the next highest scoring application(s) in the other component (score 70 or above).

III. Who May Apply

A. Minimum Eligibility Requirements- Components A and B

- Applicant must be a not-for-profit health care organization licensed by the NYSDOH under Article 28 of the NYS Public Health Law.
- Applicant must be prequalified in the New York State Grants Gateway on the date applications are due.
- Applicant must maintain an active registration in the System for Award Management (SAM) at SAM.gov, have no exclusions or delinquent federal debt.

B. Preferred Eligibility Requirements- Components A and B

Preference will be given to applicants that:

- Have established HCV service delivery models that are responsive to the complex needs of those chronically infected with HCV.
- Demonstrate that all HCV care, treatment and supportive services listed in Section. IV, Project Narrative, will be offered onsite.
- Are community health centers, hospitals and substance use treatment programs that offer HCV medical care, treatment and supportive services within a primary care setting.
- Demonstrate well established written linkage agreements with other agencies and a method to actively track all referral outcomes made for off-site services (other than core).
- Prescribe opioid replacement therapies such as buprenorphine/suboxone or methadone within a primary care environment or have an MMTP located onsite.

- Have a fully implemented electronic medical record system.
- Demonstrate the administrative and programmatic capacity to carry out the scope of activities delineated in this RFA.
- Have at least two years of experience in the effective oversight of administrative, fiscal, and programmatic aspects of government contracts, including timely and accurate submission of fiscal and program reports.

C. General Program Requirements - Components A and B

Funded applicants are required to:

- Have program staff with the skills, knowledge, experience and success in providing quality medical care, treatment and supportive services for those chronically infected with HCV.
- Provide on-going consultation and clinical decision making support from a liver specialist(s) or gastroenterologist(s) with expertise in providing HCV care and treatment.
- Collaborate with more than one community-based organization providing services, such as HCV screening, to persons at risk for or infected with HCV, to facilitate timely linkage to HCV care and treatment.
- Have clearly defined linkage agreements for non-core services needed by the target population, which are not provided onsite by the funded program. Such agreements must be in writing and should include a system for tracking and documenting outcomes of the referral process.
- Demonstrate linkage to HCV care by assisting new HCV positive patients with scheduling and attending their first HCV primary care visit within 30 days of the date of their reactive HCV antibody test result or detectable HCV RNA test result OR for those known to be infected, within 30 days of their first encounter with the linkage to care specialist. Funded programs must track and report the percentage of new HCV positive patients that attend their first HCV primary care visit within 30 days of the date of their reactive HCV antibody test result or detectable HCV RNA test result or within 30 days of their first encounter with the linkage to care specialist.
- Accept referrals from individuals released from the criminal justice system (i.e., county jails and NYS correctional facilities).
- Participate in data collection and evaluation of services and routinely: 1) provide quarterly narrative reports describing the progress of the program with respect to its implementation; achievement in meeting program objectives, performance measures and service projections; reasons for any difficulties in staying within timelines; any barriers encountered; and plans to address noted barriers; 2) participate in the HCV Quality Improvement Program; 3) participate in program development activities coordinated by

the AIDS Institute, such as annual best practices seminars; and 4) conduct patient satisfaction assessments.

- Submit monthly vouchers and the appropriate supporting documentation for reimbursement of the costs incurred; submit annual audited financial statements and proof of insurance coverage; and maintain all required/specified documentation in accordance with contractual guidelines.
- Use the AIDS Institute Reporting System (AIRS-NY) for the maintenance and reporting of unduplicated patient level data, including demographics and service encounters, in accordance with applicable federal and/or state report content requirements. The AIDS Institute provides and supports the AIRS software to enable providers to meet these requirements. Details on this software product may be obtained on the internet at www.airsny.org, or by calling the AIDS Institute at (518) 402-6790 and requesting a user's manual. Applicants should include the costs associated with AIRS-NY (both personnel and hardware-related) in their proposed budget.

Health Literacy

Health literacy impacts all levels of the health care delivery system. Improving health literacy is critical to achieving the objectives set forth in Healthy People 2020 and, more broadly, key to the success of our national health agenda^[31].

Limited health literacy affects people of all ages, races, incomes, and educational levels. Even people who have adequate health literacy may experience difficulty processing and using information when they are sick, frightened or otherwise impaired. Evidence shows that health information and the complexity of the health care system can overwhelm people regardless of their literacy or health literacy skill level. With this realization has come the recognition that health care professionals have a responsibility to improve patients' understanding of what they have been told and what they need to do to care for themselves. Health care professionals need to assume that all patients are at risk for not understanding information relevant to maintaining or improving their health. As such, a universal precautions approach to health literacy is essential to improve health outcomes, reduce disparities and reduce costs. Health literacy universal precautions is defined as an approach that: 1) assumes everyone could use help with health information; 2) considers it the responsibility of the health care system to make sure patients understand; 3) focuses on making health care environments more literacy friendly and training providers to always communicate effectively. For more information on health literacy universal precautions, see the following journal articles:

1. ["Ten Attributes of Health Literate Health Care Organizations"](http://iom.edu/~media/Files/Perspectives-Files/2012/Discussion-Papers/BPH_Ten_HLit_Attributes.pdf)
(http://iom.edu/~media/Files/Perspectives-Files/2012/Discussion-Papers/BPH_Ten_HLit_Attributes.pdf)

31 US Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). National Action Plan to Improve Health Literacy.

2. [“A Proposed ‘Health Literate Care Model’ Would Constitute A Systems Approach To Improving Patients’ Engagement In Care”](http://www.health.ny.gov/diseases/aids/health_literacy/index.htm). The full journal article is available on the AIDS Institute website: http://www.health.ny.gov/diseases/aids/health_literacy/index.htm

The AIDS Institute recognizes the importance of health literacy universal precautions to improve quality, reduce costs and reduce health disparities. Funded providers will integrate health literacy universal precautions into their funded program policies, staff training requirements, care models and quality improvement activities to ensure patient understanding at all points of contact. Best practice recommendations for health literacy universal precautions include the expansion of these guiding principles agency wide.

Hepatitis C Assistance Program (HepCAP)

Applicants funded under Component A of this RFA will be required to participate in the Hepatitis C Assistance Program (HepCAP). HepCAP was established by the NYSDOH AIDS Institute to assist uninsured persons with HCV in obtaining necessary medical care and treatment. Programs would be reimbursed through this program for services provided to uninsured HCV mono-infected persons.

IV. Project Narrative

A. Component A: Improving Linkage and Access to HCV Care and Treatment for HCV Mono-infected Persons

1. Description

The purpose of this component is to provide support to effectively and actively link individuals infected with HCV to HCV care and treatment and ensure timely access to comprehensive HCV care and treatment. This will be accomplished through close collaborations between community based organizations serving persons at risk for and/or infected with HCV and the funded program that is providing comprehensive HCV medical care, treatment and other support services within a primary care setting. The model is designed to: 1) increase the number of people infected with HCV that get linked to care; and 2) improve HCV treatment initiation and completion rates.

2. Target Population

The target population for this component is **HCV mono-infected persons**. This includes uninsured persons.

3. Scope of Services

Each funded program will perform active linkage to care activities, in addition to providing comprehensive HCV medical care, treatment and support services in a primary care setting.

Funded programs will collaborate with at least one CBO providing services to those at risk for or infected with HCV, such as HCV screening, and effectively link patients back to the HCV care and treatment program.

Funded programs will provide HCV care and treatment services onsite within a primary care setting. Funded programs need to be responsive to the rapidly changing health care and HCV care and treatment environments.

In instances where non-core services are not available onsite at the funded program, services must be accessible through closely linked referrals that are coordinated and tracked by program staff.

An applicant with an established program funded by a source other than the AIDS Institute may apply for funding to supplement/expand the existing program. In these cases, the applicant is expected to demonstrate that, with the addition of the requested service(s), the program will be comprehensive.

4. Core Services

Programs funded through this RFA must provide these core services as described below and in accordance with the attached workplan (Attachment 1): a) linkage to care; b) HCV care and treatment; and c) HCV supportive services. All HCV care, treatment and supportive services must be provided onsite within a primary care setting. For services, other than the core services, that are provided by referral, written linkage agreements must be established with the service provider.

a. Linkage to Care

Linkage to care services will actively and effectively connect individuals infected with HCV to comprehensive HCV medical care and treatment. Each linkage to care service will ensure timely initiation to HCV care and treatment. Patient care will be facilitated and coordinated, resulting in successful navigation of the patient across the care continuum: HCV screening to HCV treatment. Funded programs are required to provide the following linkage to care services:

- Connect new and known HCV infected patients to comprehensive HCV medical care and treatment. This includes known HCV infected patients who have not previously been engaged in HCV care and treatment.
- Establish linkage(s) with at least one CBO providing HCV services to persons at risk for and/or infected with HCV.
- Employ dedicated staff to perform linkage to care services (Linkage to Care Specialist).
 - The Linkage to Care Specialist (LCS) must be:
 - Knowledgeable about HCV and HCV counseling messages and have a basic understanding of HCV treatment.
 - Trained in motivational interviewing.
 - Aware of the resources available in the community that will assist in overcoming the barriers to linking the patient to care and treatment.

- Experienced in the process of acquiring health benefits, including an understanding of the changes in accessing health benefits as a result of the Affordable Care Act (i.e., Health Insurance Exchange).
- Linkage to Care Specialist's (LCS) roles and responsibilities (or services) include:
 - Assessing barriers to linking the patient to care.
 - Developing, implementing and monitoring strategies for overcoming any barriers to linkage and retention in care.
 - Educating, coaching and empowering patients.
 - Providing assistance to the patient with scheduling and keeping medical appointments. This may include providing or arranging for escort to appointments, transportation, reminders and coordinating medical appointments with the members of the HCV care and treatment team.
 - Working collaboratively with other programs and staff supporting the patient, including the HCV peers.
 - Dedicating time onsite at the community based organization(s) that are providing HCV screening services and acting as the liaison between the CBO and HCV care and treatment program
 - Serving as part of the HCV care and treatment team and assisting with care coordination activities for patients enrolled in the HCV care and treatment program.

b. Hepatitis C Virus Care and Treatment

Funded programs are expected to provide quality HCV care, treatment and supportive services within a primary care setting. Funded programs must be responsive to the rapidly changing HCV care and treatment landscape. HCV medical care and treatment must be provided in accordance with nationally recognized standards of care.

Funded programs are expected to provide the following set of core HCV care and treatment services onsite in a primary care setting. In instances where non-core services are offered off site, written linkage agreements must be in place for provision of off-site care. HCV care and treatment services include the following:

- **HCV care and treatment services are provided to patients utilizing a comprehensive, multidisciplinary approach by staff knowledgeable in HCV and HCV treatment. Core services include:**
 - Comprehensive primary care services.
 - Comprehensive HCV medical care including: 1) Pre-treatment evaluation; 2) HCV anti-viral therapy and monitoring, including HCV treatment readiness assessment; and 3) Post-treatment evaluation and management. Comprehensive HCV medical care includes the provision of mental health, nutrition, substance use and HCV counseling and education services.
 - Provision of HCV treatment by a provider with demonstrated experience and knowledge of HCV anti-viral therapy or in consultation with a gastroenterologist or hepatologist. The HCV provider must be current and knowledgeable of the

- new HCV therapies given the rapidly expanding treatment options pending FDA approval.
- Provision of HCV medical care and treatment by a multi-disciplinary health care team focused on and committed to providing quality HCV care and treatment. The team may include, but is not limited to: medical providers including physicians, physician assistants and nurse practitioners; nurses; treatment adherence counselors; mental health and substance use providers; linkage to care specialist, nutritionists; peers and other staff as deemed necessary.
- Coordinating and tracking of referrals for off-site services.
- Conducting routine and formal case conferences with the patient's multi-disciplinary health care team and, if a non-HCV specialist, with the collaborating HCV specialist, and documenting these case conferences in the patient medical record.
- Developing HCV care and treatment services and HCV clinical protocols, reviewing them at least annually, and revising as needed.
- **HCV treatment adherence services are provided to ensure adherence to and completion of HCV treatment.**
 - Evidence based interventions and tools that support treatment adherence (pill boxes, timers, texting, adherence coaches, peer support, etc.) are provided.
 - Information on HCV treatment, treatment side effects and the demands of treatment are clearly communicated to the patient and his/her support system prior to initiation of therapy.
 - Strategies are in place to assess and monitor treatment adherence beginning in the HCV pre-treatment evaluation phase through treatment completion.
 - Treatment adherence issues are communicated to and addressed by the multidisciplinary health care team and documented in the patient medical record.
- **Strategies are used to assess and improve retention in care.**
 - An assessment to identify any barriers to retention in care is conducted with the patient. Reassessments are conducted as needed to address new or recurring obstacles to retention.
 - Retention in care issues are communicated to and addressed by the multidisciplinary team.
 - Systems are in place to alert and remind patients of upcoming appointments.
 - Follow-up procedures are in place for those patients who miss appointments.
 - Data on missed appointments and retention in care are collected and analyzed.

c. HCV Supportive Services

Funded programs are expected to provide supportive services onsite, including peer delivered services, to educate patients about HCV disease and treatment options, assist patients in making decisions about their HCV care and treatment, provide support throughout the course of treatment, and lend support to the HCV care and treatment team as needed.

- **Peer-delivered services should be a formalized program in which peers function as part of the HCV care and treatment team.**
 - Peers must be trained on the role of the peer and motivational interviewing.

- Peers must be knowledgeable about HCV, including a basic understanding of HCV treatment and its side effects.
- Peers must be currently or previously infected with HCV and have current or former experience with HCV treatment.
- Peer services may be delivered one-on-one or in group settings.
- **Other supportive services must also be available onsite.**
 - Supportive services may be provided individually or in a group setting.

B. Component B: Improving Linkage and Access to HCV Care and Treatment in HIV/HCV Co-Infected Persons

1. Description

The purpose of this component is to provide support to actively and effectively link HIV/HCV co-infected individuals to HCV care and treatment and ensure timely access to comprehensive HCV care and treatment. This will be accomplished by: 1) maximizing existing resources for engaging/re-engaging and linking HIV/HCV co-infected patients to care; and 2) collaborating with community-based organizations serving persons at-risk for or living with HIV/HCV. The model is designed to: 1) increase the number of people co-infected with HIV/HCV who are linked to care; and 2) improve HCV treatment initiation and completion rates.

2. Target Population

The target population for this component is **HIV/HCV co-infected persons**. This includes uninsured persons.

3. Scope of Services

Each funded program will perform active linkage to care activities by maximizing and enhancing existing HIV linkage to care resources, in addition to providing comprehensive HCV medical care, treatment and supportive services in an HIV primary care setting.

Funded programs must demonstrate collaboration with at least one CBO providing services, such as HIV and HCV screening, to persons living with or at risk for HIV and HCV and effectively link the co-infected patients back to the HIV/HCV care and treatment program.

Funded programs must provide HCV care and treatment services onsite within an HIV primary care setting. Funded programs must be responsive to the rapidly changing health care and HCV and HIV care and treatment environments.

In instances where non-core services are not available onsite at the funded program, services are required to be accessible through closely linked referrals that are coordinated and tracked by program staff.

An applicant with an established program funded by a source other than the AIDS Institute may apply for funding to supplement/expand the existing program. In these cases, the applicant is

expected to demonstrate that, with the addition of the requested service(s), the program will be comprehensive.

4. Core Services

Programs funded through this RFA must provide these core services as described below and in accordance with the attached workplan (Attachment 1): a) linkage to care; b) HCV care and treatment; and c) HCV supportive services. All HCV care, treatment and supportive services must be provided onsite within a primary care setting. For services other than the core services and that are provided by referral, written linkage agreements must be established with the service provider.

a. Linkage to Care

Linkage to care services will actively and effectively link individuals co-infected with HIV/HCV to comprehensive HIV/HCV medical care and treatment. Each linkage to care service will ensure timely linkage to HCV care and treatment and help to facilitate and coordinate patient movement across the care continuum: HIV and HCV screening to HIV and HCV treatment. Funded programs are expected to provide the following active linkage to care services:

- Funded programs must link new and existing HIV/HCV co-infected patients to comprehensive HIV/HCV medical care and treatment. This includes previously known HIV/HCV co-infected patients who have been lost to care.
- Establish linkage(s) with community-based organizations providing services to those living with and/or at risk for HIV and HCV to recruit and engage (or re-engage) co-infected patients in care and treatment.
- Employ dedicated staff to perform linkage to care services (Linkage to Care Specialist)
 - The Linkage to Care Specialist (LCS) must be:
 - Knowledgeable about HIV/HCV co-infection including a basic understanding of HIV and HCV treatment.
 - Trained in motivational interviewing.
 - Aware of the resources available in the community that will assist in overcoming the barriers to linking the patient to care and treatment.
 - Experienced in the process of acquiring health benefits, including an understanding of the changes in accessing health benefits as a result of the Affordable Care Act (i.e., Health Insurance Exchange).
 - Linkage to Care Specialist (LCS) roles, responsibilities and services include:
 - Assessing barriers to linking the patient to care.
 - Developing, implementing and monitoring strategies for overcoming any barriers to linkage and retention in care.
 - Educating, coaching and empowering patients.
 - Providing assistance to the patient with scheduling and keeping medical appointments. This may include providing or arranging for escort to appointments, transportation, reminders and coordinating medical appointments with the members of the HIV/HCV care and treatment team.

- Working collaboratively with other programs and staff supporting the patient, including the HCV peers.
- Dedicating time onsite at CBO(s) that are providing HIV and HCV screening services and acting as the liaison between CBOs and the HIV/HCV care and treatment program.
- Serving as part of the HIV/HCV care and treatment team and assisting with care coordination activities for the patients enrolled in the HIV/HCV co-infection care and treatment program.

b. Hepatitis C Virus Care and Treatment

Funded programs are expected to provide quality HCV care, treatment and supportive services within an HIV primary care setting. Funded programs must be responsive to the rapidly changing HCV care and treatment landscape. HCV medical care and treatment must be provided in accordance with nationally recognized standards of care.

Funded programs are expected to provide the following set of core HCV care and treatment services onsite in an HIV primary care setting. In instances, where non-core services are offered offsite, written linkage agreements must be in place for provision of offsite care. HCV care and treatment services include the following:

- **HCV care and treatment services are provided to patients utilizing a comprehensive, multidisciplinary approach by staff knowledgeable in HIV/HCV and HIV/HCV treatment. Core services include:**
 - Comprehensive HIV primary care services.
 - Comprehensive HCV medical care including: 1) Pre-treatment evaluation; 2) HCV anti-viral therapy and monitoring, including HCV treatment readiness assessment; and 3) Post-treatment evaluation and management. Comprehensive HCV medical care includes the provision of mental health, nutrition, substance use and HCV counseling and education services.
 - HCV anti-viral therapy and monitoring, including HCV treatment readiness assessment.
 - Provision of HCV treatment by a provider with demonstrated experience and knowledge of HCV anti-viral therapy or in consultation with a gastroenterologist or hepatologist. The HCV provider must be current and knowledgeable of the new HCV therapies given the rapidly expanding treatment options pending FDA approval.
 - Provision of HCV medical care and treatment by a multi-disciplinary health care team focused on and committed to providing quality HIV/HCV care and treatment. The team may include, but is not limited to: medical providers including physicians, physician assistants and nurse practitioners; nurses; treatment adherence counselors; mental health and substance use providers; linkage to care specialist; nutritionists; peers and other staff as deemed necessary.
 - Coordinating and tracking of referrals for off-site services.
 - Conducting routine and formal case conferences with the patient's multi-disciplinary health care team and, if a non-HCV specialist, with the collaborating

- HCV specialist, and documenting these case conferences in the patient medical record.
- Developing HCV care and treatment services and HCV clinical protocols, reviewing them at least annually, and revising as needed.
- **HCV treatment adherence services are provided to ensure adherence to and completion of HCV treatment.**
 - Evidence based interventions and tools that support treatment adherence (pill boxes, timers, texting, adherence coaches, peer support, etc.) are provided.
 - Information on HCV treatment, treatment side effects and the demands of treatment are clearly communicated to the patient and his/her support system prior to initiation of therapy.
 - Strategies are in place to assess and monitor treatment adherence beginning in the HCV pre-treatment evaluation phase through treatment completion.
 - Treatment adherence issues are communicated to and addressed by the multidisciplinary health care team and documented in the patient medical record.
- **Strategies are used to assess and improve retention in care.**
 - An assessment to identify any barriers to retention in care is conducted with the patient. Reassessments are conducted as needed to address new or recurring obstacles to retention.
 - Retention in care issues are communicated to and addressed by the multidisciplinary team.
 - Systems are in place to alert and remind patients of upcoming appointments.
 - Follow-up procedures are in place for those patients who miss appointments.
 - Data on missed appointments and retention in care are collected and analyzed.

c. **HCV Supportive Services**

Funded programs are expected to provide supportive services onsite. Peer delivered services to educate patients about HCV disease and treatment options, assist patients in making decisions about their HCV care and treatment, provide support throughout the course of treatment, and lend support to the HCV care and treatment team as needed.

- **Peer-delivered services should be a formalized program in which peers function as part of the HCV care and treatment team.**
 - Peers must be trained on the role of the peer and motivational interviewing.
 - Peers must be knowledgeable about HIV/HCV, including a basic understanding of HIV/HCV treatment and its side effects.
 - Peers must be currently or previously infected with HCV and have current or former experience with HCV treatment.
 - Peer services may be delivered one-on-one or in group settings.
- **Other supportive services must also be available onsite.**
 - Supportive services may be provided individually or in a group setting.

V. **Administrative Requirements**

A. **Issuing Agency**

This RFA is issued by the New York State Department of Health AIDS Institute, Division of HIV and Hepatitis Health Care and Health Research, Inc. (HRI). The Department and HRI are responsible for the requirements specified herein and for the evaluation of all applications.

B. Question and Answer Phase:

All questions must be submitted in writing to Colleen Flanigan, Director, Viral Hepatitis Section, New York State Department of Health at the following Bureau Mail Log:
hepatabc@health.state.ny.us

To the degree possible, each inquiry should cite the RFA section and paragraph to which it refers. Questions related to formatting or other minor details related to preparation of the application may also be addressed in writing at the email address noted above.

All questions must be received by the date referenced on the cover page of this RFA.

All questions submitted by email should state “HCV RFA” in the subject line.

Some helpful links for questions of a technical nature are below. Questions regarding specific opportunities or applications should be directed to the DOH contact listed on the cover of this RFA.

- www.grantsreform.ny.gov/grantees
- Grants Reform Videos (includes a document vault tutorial and an application tutorial) on YouTube: <http://www.youtube.com/channel/UCYnWskVc7B3ajjOVfOHL6UA>
- Agate Technical Support Help Desk
Phone: 1-800-820-1890
Hours: Monday thru Friday 8am to 8pm
Email: helpdesk@agatesoftware.com
(Technical questions)
- Grants Team Email: Grantsreform@budget.ny.gov
(Application Completion, Policy, and Registration questions)
- www.grantsgateway.ny.gov

Prospective applicants should note that all clarifications and exceptions, including those relating to the terms and conditions of the contract, are to be raised prior to the submission of an application.

This RFA has been posted on the Department's public website at: <http://www.health.ny.gov/funding/> and the NYS Grants Gateway website at: https://www.grantsgateway.ny.gov/IntelliGrants_NYSGG/module/nysgg/goportal.aspx. The RFA is also posted on HRI's public website at <http://www.healthresearch.org/funding->

[opportunities](#).

Questions and answers, as well as any updates and/or modifications, will also be posted on these websites. All such updates will be posted on or about the date identified on the cover sheet of this RFA.

C. Letter of Interest

Submission of a letter of interest is strongly encouraged but not mandatory. The letter of interest should be received by the date posted on the cover page of the RFA. Applications may be submitted without first having submitted a letter of interest. A sample Letter of Interest is included as Attachment 2 of this RFA.

D. An applicant conference will not be held for this project.

E. How to file an application

Applications must be submitted online via the Grants Gateway by the date and time posted on the cover of this RFA. Tutorials (training videos) for use of the Grants Gateway are available at the following web address (and upon user log in):

https://www.grantsgateway.ny.gov/IntelliGrants_NYSGG/module/nysgg/goportal.aspx .

To apply, log into the Grants Gateway and click on the View Opportunities button under View Available Opportunities. To get started, in the Search Criteria, enter the Grant Opportunity name listed above and select the Department of Health as the Funding Agency and hit the Search button. Click on the name of the Grant Opportunity from the search results grid and then click on the APPLY FOR GRANT OPPORTUNITY button located bottom left of the Main page of the Grant Opportunity.

In order to access the online application and other required documents such as the attachments, you MUST be registered and logged into the NYS Grants Gateway system in the user role of either a “Grantee” or a “Grantee Contract Signatory”.

For further information on how to apply, please access the Grantee Quick Start Guide under the Pre-Submission Upload Properties for this opportunity.

Reference materials and videos are available for Grantees applying to funding opportunities on the NYS Grants Gateway. Please visit the Grants Reform website at the following web address: <http://grantsreform.ny.gov/Grantees> and select the “Grantee Quick Start Guide” from the menu. There is also a more detailed “Grantee User Guide” available on this page as well.

Late applications will not be accepted. **Applications will not be accepted via fax, e-mail, hard copy or hand delivery.**

F. Department of Health and Health Research, Inc. reserve the right to:

1. Reject any or all applications received in response to this RFA.

2. Withdraw the RFA at any time, at the Department's /HRI's sole discretion.
3. Make an award under the RFA in whole or in part.
4. Disqualify any applicant whose conduct and/or proposal fails to conform to the requirements of the RFA.
5. Seek clarifications and revisions of applications.
6. Use application information obtained through site visits, management interviews and the state's investigation of an applicant's qualifications, experience, ability or financial standing, and any material or information submitted by the applicant in response to the agency's request for clarifying information in the course of evaluation and/or selection under the RFA.
7. Prior to application opening, amend the RFA specifications to correct errors or oversights, or to supply additional information, as it becomes available.
8. Prior to application opening, direct applicants to submit proposal modifications addressing subsequent RFA amendments.
9. Change any of the scheduled dates.
10. Waive any requirements that are not material.
11. Award more than one contract resulting from this RFA.
12. Conduct contract negotiations with the next responsible applicant, should the Department or HRI be unsuccessful in negotiating with the selected applicant.
13. Utilize any and all ideas submitted with the applications received.
14. Unless otherwise specified in the RFA, every offer is firm and not revocable for a period of 60 days from the bid opening.
15. Waive or modify minor irregularities in applications received after prior notification to the applicant.
16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an offerer's application and/or to determine an offerer's compliance with the requirements of the RFA.
17. Negotiate with successful applicants within the scope of the RFA in the best interests of the State or HRI.
18. Eliminate any mandatory, non-material specifications that cannot be complied with by all applicants.
19. Award contracts based on geographic or regional considerations to serve the best interests of the State or HRI.

G. Terms of Contract

Any State contract resulting from this RFA will be effective only upon approval by the New York State Office of the Comptroller. Any HRI contract resulting from this RFA will be effective only upon approval by HRI.

Contract periods may vary based on the source of funding.

It is expected that NYS DOH contracts resulting from this RFA will have the following time period: April 1, 2015 – March 31, 2020. Continued funding throughout this period is contingent upon satisfactory contract performance and availability of funding and state

budget appropriations. DOH reserves the right to revise the award amounts as necessary due to changes in the availability of funding.

HRI funded contracts resulting from this RFA will be for 12 month terms. The anticipated start date of HRI contracts is April 1, 2015. HRI awards may be renewed for up to four (4) additional annual contract periods based on satisfactory performance and availability of funds.

State Health Improvement Plan/Prevention Agenda

In keeping with the Department's efforts to improve the health of all New Yorkers, we are requesting your collaboration and participation in implementing the state's new health improvement plan, the *Prevention Agenda 2013-2017*.

Developed by a diverse group of stakeholders, the *Prevention Agenda 2013-2017* is a comprehensive plan which identifies goals, measurable objectives and a range of evidence based and promising practices in five priority areas that can be implemented by public health, health care and community partners. The Agenda focuses on the social determinants of health and on health disparities along racial, ethnic, and socioeconomic lines.

The Prevention Agenda 2013 is a blueprint for state and local community action to improve the health of New Yorkers. In 2013, local health departments and hospitals are working with their community partners including community based organizations, businesses, schools, and other organizations to conduct local community health assessments, identify local priorities and develop and implement community health improvement plans. Each health department and hospital has been asked to identify at least two priorities from the Prevention Agenda including one that addresses a health disparity.

The Department cannot achieve the ambitious goals of the *Prevention Agenda 2013-2017* without the full participation of our public health and health care partners in these local community health improvement efforts. We are encouraging you to reach out to your local health department's state health improvement plan contact person to learn more about how you can participate in Prevention Agenda planning and implementation. Your local health department contact is available here:

http://www.health.ny.gov/prevention/prevention_agenda/contact_list.htm

It is our expectation that each funded recipient will join with their local health departments and other Prevention Agenda partners to participate in the development and implementation of a plan toward achieving the *Prevention Agenda 2013 -2017* goals which are related to this RFA.

H. Payment & Reporting Requirements of Awardees

1. The Department may, at its discretion, make an advance payment to not for profit contractors in an amount not to exceed twenty-five (25) percent. Due to requirements of the federal funder, HRI will not make advance payments.
2. The HRI funded grant contractor will be required to submit *monthly* invoices and required

reports of expenditures to the State's designated payment office listed below. The State funded grant contractor will be required to submit *monthly* invoices and required reports of expenditures through the Grants Gateway to the State's designated payment office:

Viral Hepatitis Section
AIDS Institute
New York State Department of Health
P.O. Box 2112
Corning Tower Station
Albany, New York 12220

For State contracts, contractors must provide complete and accurate billing invoices in order to receive payment. Billing invoices submitted to the Department must contain all information and supporting documentation required by the Contract, the Department and the Office of the State Comptroller (OSC). Payment for invoices submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with OSC's procedures and practices to authorize electronic payments. Authorization forms are available at OSC's website at: <http://www.osc.state.ny.us/epay/index.htm>, by email at: epayments@osc.state.ny.us or by telephone at 855-233-8363. CONTRACTOR acknowledges that it will not receive payment on any claims for reimbursement submitted under this contract if it does not comply with OSC's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

Payment of such claims for reimbursement by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be: Contractor will be reimbursed for actual expenses incurred as allowed in the Contract Budget and Workplan.

For HRI contracts, contractors will be expected to submit voucher claims and reports of expenditures in the manner that HRI requires. Required forms will be provided with the contract package.

3. The State funded grant contractor will be required to submit through the Grants Gateway the following periodic reports:
 - A monthly narrative addressing program implementation, barriers, and accomplishments.
 - Monthly client service and outcome data through the AIDS Institute Reporting System (AIRS). See Attachment 10, "Considerations for Approval of Computer Systems Purchased with AIDS Institute Funds".

The HRI funded grant contractor will be required to submit the following periodic reports:

- A monthly narrative addressing program implementation, barriers, and accomplishments.

- Monthly client service and outcome data through the AIDS Institute Reporting System (AIRS). See Attachment 10, “Considerations for Approval of Computer Systems Purchased with AIDS Institute Funds”.

All payment and reporting requirements will be detailed in Attachment D of the final NYS Master Grant Contract. For HRI Contracts, payments and reporting requirements will be detailed in Exhibit “C” of the final contract.

I. Minority & Woman-Owned Business Enterprise Requirements

Pursuant to New York State Executive Law Article 15-A, the New York State Department of Health (“DOH”) recognizes its obligation to promote opportunities for maximum feasible participation of certified minority- and women-owned business enterprises and the employment of minority group members and women in the performance of DOH contracts.

In 2006, the State of New York commissioned a disparity study to evaluate whether minority and women-owned business enterprises had a full and fair opportunity to participate in state contracting. The findings of the study were published on April 29, 2010, under the title “The State of Minority and Women-Owned Business Enterprises: Evidence from New York” (“Disparity Study”). The report found evidence of statistically significant disparities between the level of participation of minority- and women-owned business enterprises in state procurement contracting versus the number of minority- and women-owned business enterprises that were ready, willing and able to participate in state procurements. As a result of these findings, the Disparity Study made recommendations concerning the implementation and operation of the statewide certified minority- and women-owned business enterprises program. The recommendations from the Disparity Study culminated in the enactment and the implementation of New York State Executive Law Article 15-A, which requires, among other things, that DOH establish goals for maximum feasible participation of New York State Certified minority- and women-owned business enterprises (“MWBE”) and the employment of minority groups members and women in the performance of New York State contracts.

Business Participation Opportunities for MWBEs

For purposes of this solicitation, the New York State Department of Health hereby establishes a goal of 0% on any subcontracted labor or services, equipment, materials, or any combined purchase of the foregoing greater than \$25,000 under a contract awarded from this solicitation. The goal on the eligible portion of this contract will be 0% for Minority-Owned Business Enterprises (“MBE”) participation and 0% for Women-Owned Business Enterprises (“WBE”) participation (based on the current availability of qualified MBEs and WBEs and outreach efforts to certified MWBE firms). A contractor (“Contractor”) on the subject contract (“Contract”) must document good faith efforts to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract and Contractor agrees that DOH may withhold payment pending receipt of the required MWBE documentation. For guidance on how DOH will determine “good faith efforts,” refer to 5 NYCRR §142.8.

The directory of New York State Certified MWBEs can be viewed at:

<https://ny.newnycontracts.com>. The directory is found in the upper right hand side of the webpage under “Search for Certified Firms” and accessed by clicking on the link entitled “MWBE Directory”. Engaging with firms found in the directory with like product(s) and/or service(s) is strongly encouraged and all communication efforts and responses should be well documented.

In addition, successful awardees will be required to certify they have an acceptable Equal Employment Opportunity policy statement.

This RFA does not establish minimum goals for participation of minority or women-owned business. Therefore, completion of the Minority & Women Business-Owned Business Enterprise Requirement Forms are optional (Attachment 3). Funded applicants are encouraged to engage with firms found in the directory for the acquisition of required product(s) and/or service(s) associated with this grant.

J. Limits on Administrative Expenses and Executive Compensation

Effective July 1, 2013, limitations on administrative expenses and executive compensation contained within Governor Cuomo’s Executive Order #38 and related regulations published by the Department (Part 1002 to 10 NYCRR – Limits on Administrative Expenses and Executive Compensation) went into effect. Applicants agree that all state funds dispersed under this procurement will, if applicable to them, be bound by the terms, conditions, obligations and regulations promulgated by the Department. To provide assistance with compliance regarding Executive Order #38 and the related regulations, please refer to the Executive Order #38 website at: <http://executiveorder38.ny.gov>.

K. Vendor Identification Number

Effective January 1, 2012, in order to do business with New York State, you must have a vendor identification number. As part of the Statewide Financial System (SFS), the Office of the State Comptroller's Bureau of State Expenditures has created a centralized vendor repository called the New York State Vendor File. In the event of an award and in order to initiate a contract with the New York State Department of Health, vendors must be registered in the New York State Vendor File and have a valid New York State Vendor ID.

If already enrolled in the Vendor File, please include the Vendor Identification number on the application cover sheet. If not enrolled, to request assignment of a Vendor Identification number, please submit a New York State Office of the State Comptroller Substitute Form W-9, which can be found on-line at:

http://www.osc.state.ny.us/vendor_management/issues_guidance.htm.

Additional information concerning the New York State Vendor File can be obtained on-line at: http://www.osc.state.ny.us/vendor_management/index.htm, by contacting the SFS Help Desk at 855-233-8363 or by emailing at helpdesk@sfs.ny.gov.

L. Vendor Responsibility Questionnaire

The New York State Department of Health recommends that vendors file the required

Vendor Responsibility Questionnaire online via the New York State VendRep System. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at http://www.osc.state.ny.us/vendrep/vendor_index.htm or go directly to the VendRep system online at <https://portal.osc.state.ny.us>.

Vendors must provide their New York State Vendor Identification Number when enrolling. To request assignment of a Vendor ID or for VendRep System assistance, contact the Office of the State Comptroller's Help Desk at 866-370-4672 or 518-408-4672. Vendors may also email the Vendor Responsibility Unit directly through their website at http://www.osc.state.ny.us/vendrep/contact_us_email.htm.

Vendors opting to complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website at: http://www.osc.state.ny.us/vendrep/forms_vendor.htm or may contact the Office of the State Comptroller's Help Desk for a copy of the paper form.

Applicants should complete and submit the Vendor Responsibility Attestation (Attachment 4).

M. Vendor Prequalification for Not-for-Profits

All not-for-profit vendors subject to prequalification are required to prequalify prior to grant application and execution of contracts.

Pursuant to the New York State Division of Budget Bulletin H-1032, dated June 7, 2013, New York State has instituted key reform initiatives to the grant contract process which requires not-for-profits to register in the Grants Gateway and complete the Vendor Prequalification process in order for applications to be evaluated. Information on these initiatives can be found on the [Grants Reform Website](#).

Applications received from not-for-profit applicants that have not Registered and are not Prequalified in the Grants Gateway on the application due date listed on the cover of this RFA cannot be evaluated. Such applications will be disqualified from further consideration.

Below is a summary of the steps that must be completed to meet registration and prequalification requirements. The [Vendor Prequalification Manual](#) on the Grants Reform Website details the requirements and an [online tutorial](#) are available to walk users through the process.

1) Register for the Grants Gateway

- On the Grants Reform Website, download a copy of the [Registration Form for Administrator](#). A signed, notarized original form must be sent to the Division of Budget at the address provided in the instructions. You will be provided with a Username and Password allowing you to access the Grants Gateway.

If you have previously registered and do not know your Username, please email grantsreform@budget.ny.gov . If you do not know your Password, please click the [Forgot Password](#) link from the main log in page and follow the prompts.

2) Complete your Prequalification Application

- Log in to the [Grants Gateway](#). **If this is your first time logging in**, you will be prompted to change your password at the bottom of your Profile page. Enter a new password and click SAVE.
- Click the *Organization(s)* link at the top of the page and complete the required fields including selecting the State agency you have the most grants with. This page should be completed in its entirety before you SAVE. A *Document Vault* link will become available near the top of the page. Click this link to access the main Document Vault page.
- Answer the questions in the *Required Forms* and upload *Required Documents*. This constitutes your Prequalification Application. Optional Documents are not required unless specified in this Request for Application.
- Specific questions about the prequalification process should be referred to your agency representative or to the Grants Reform Team at grantsreform@budget.ny.gov.

3) Submit Your Prequalification Application

- After completing your Prequalification Application, click the **Submit Document Vault Link** located below the Required Documents section to submit your Prequalification Application for State agency review. Once submitted the status of the Document Vault will change to *In Review*.
- If your Prequalification reviewer has questions or requests changes you will receive email notification from the Gateway system.
- Once your Prequalification Application has been approved, you will receive a Gateway notification that you are now prequalified to do business with New York State.

Vendors are strongly encouraged to begin the process as soon as possible in order to participate in this opportunity.

N. General Specifications

1. By signing the Application Cover Sheet (Attachment 5) each applicant attests to its express authority to sign on behalf of the applicant.
2. Contractors will possess, at no cost to the State/HRI, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction

where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

3. Submission of an application indicates the applicant's acceptance of all conditions and terms contained in this RFA, including the terms and conditions of the contract. Any exceptions allowed by the Department/HRI during the Question and Answer Phase (Section V.B.) must be clearly noted in a cover letter attached to the application.
4. An applicant may be disqualified from receiving awards if such applicant or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.
5. Provisions Upon Default:
 - a. The services to be performed by the Applicant shall be at all times subject to the direction and control of the Department/HRI as to all matters arising in connection with or relating to the contract resulting from this RFA.
 - b. In the event that the Applicant, through any cause, fails to perform any of the terms, covenants or promises of any contract resulting from this RFA, the Department/HRI shall thereupon have the right to terminate the contract by giving notice in writing of the fact and date of such termination to the Applicant.
 - c. If, in the judgment of the Department/HRI, the Applicant acts in such a way which is likely to or does impair or prejudice the interests of the State/HRI, the State/HRI shall thereupon have the right to terminate any contract resulting from this RFA by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgment of the State Comptroller/HRI, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was engaged in at the time of such termination, subject to audit by the State Comptroller/HRI.

O. HRI General Terms and Conditions

Health Research, Inc.'s General Terms and Conditions (Attachment 6) will be incorporated as an attachment into HRI contract(s) resulting from this Request for Applications.

VI. Completing the Application

A. Application Content

Please refer to the Quick Start Guide for assistance in applying for this procurement through the NYS Grants Gateway. This guide is available on the Grants Reform website at: www.grantsreform.ny.gov/Grantees.

Applicants should provide a response to all questions and statements in each section listed

below. Include a budget that is reflective of the workplan. An Application Checklist (Attachment 7) has been included to help ensure that submission requirements have been met. Applicants should review this attachment before and after writing the application.

B. Application Format

It is the applicant's responsibility to ensure that all materials to be included in the application have been properly prepared and submitted. Applications must be submitted via the Grants Gateway by the date and time posted on the cover of this RFA. The value assigned to each section is an indication of the relative weight that will be given when scoring your application.

1. Program Summary: Not Scored

Summarize your proposed program. Describe the purpose of your program, the target population(s), proposed services and anticipated outcomes.

2. Statement of Need: Maximum Score: 10 points

- a) Describe the target population(s) to be served by this funding. Include information such as demographics, HCV **or** HIV/HCV statistics, risk behaviors and any other information that demonstrate the impact of the HCV epidemic on the target population(s).
- b) Describe how you have determined the need for the services proposed in your application, including any pertinent HCV or HIV/HCV statistics, including the number of HCV or HIV/HCV co-infected patients currently served by your agency, to describe the burden of HCV disease in your catchment area and to substantiate your rationale.
- c) Describe the major barriers in accessing medical care and treatment for the population(s) you plan to serve.
- d) Estimate the number of individuals you expect to serve under your proposed program and how this has been determined.
- e) Indicate the geographical area to be served and how your organization is well-placed within this geographic area to serve the target population(s).
- f) Describe how consumers were involved in identifying the needs and interventions during the application process.

3. Organizational Capacity: Maximum Score: 15 points

- a) Briefly describe your agency, its overall mission, services and location of services.
- b) Describe the population(s) currently being served by the agency including age, gender, race, ethnicity, socioeconomic status, insurance status, risk behaviors and other significant characteristics.
- c) Describe the number and characteristics of HCV-infected **or** HIV/HCV co-infected and at-risk individuals currently served.
- d) Describe your agency's experience in providing primary care.
- e) Describe all existing HCV **or** HIV/HCV co-infection related activities/services, including length of time these services have been provided and all outcomes. Indicate whether or not the services are being provided onsite.

- f) Describe your agency's capacity and experience for providing onsite the HCV core services outlined in Section. IV- Project Narrative. *Preference will be given to applicants that have established models of HCV service delivery that are responsive to the complex needs of those chronically infected with HCV. Preference will also be given to applicants that have the administrative and programmatic capacity to carry out the scope of activities delineated in this RFA.*
- g) Describe your agency's capacity for prescribing opioid replacement therapies such as buprenorphine/suboxone or methadone within a primary care environment. *Preference will be given to applicants that prescribe opioid replacement therapies such as buprenorphine/suboxone or methadone.*
- h) Describe your agency's Electronic Medical Record (EMR) system, including the name of the system. Include whether or not HCV specific templates have been created in the EMR and if so, describe the HCV templates. If your organization has multiple systems in place to maintain various components of care (i.e., labs, medications, pharmacy), please list accordingly. If your organization is in the process of implementing an EMR, please include the name of the system, the status of implementation and projected completion date. Also, indicate if the EMR offers HL7 interfacing capabilities and if so, the version being used. *Preference will be given to applicants that have a fully implemented electronic medical record system.*
- i) Describe your agency's experience in working collaboratively with other agencies and CBOs providing services (e.g., HCV and HIV screening, etc.) to those at-risk for or infected with HCV or HIV/HCV. Indicate and include any relevant Memorandums of Understanding (MOUs) with such agencies and CBOs.
- j) Describe your agency's participation in HCV and/or HIV networks, task forces, coalitions and other planning bodies.
- k) Describe the racial/ethnic composition of the board and staff (management and program) in relation to the population served.
- l) Describe your agency's capacity to provide administrative and executive support for program implementation, fiscal management, grants management, and information systems (Attachment 8).
- m) Describe your experience in the effective oversight of administrative, fiscal, and programmatic aspects of government contracts. *Preference will be given to applicants who have at least two years of experience in the effective oversight of administrative, fiscal and programmatic aspects of government contracts, including timely and accurate submission of fiscal and program reports.*

4. Program Design and Activities:

Maximum Score: 40 points

- a) Describe the goal(s), specific objectives, performance measures and anticipated outcomes of your proposed program. Complete Attachment 9 – Hepatitis C Projections of Services form, projecting the number of patients to be served and services to be provided during the 5 year funding cycle. Include the anticipated number of patients to be served and anticipated number of patients to initiate HCV treatment each year.
- b) Describe how your agency will effectively link individuals infected with HCV to comprehensive HCV medical care and treatment. Describe the linkage to care model, including staff performing linkage to care activities and the types of services to be provided.

- c) Describe how the agency will work with CBOs to recruit and link HCV and HIV/HCV infected patients back to the funded HCV or HIV/HCV care and treatment program.
- d) Describe how the agency will provide quality HCV care, treatment and supportive services within a primary care setting. This care must include mental health, nutrition, substance use and HCV counseling and education services. *Preference will be given to programs that offer HCV medical care, treatment and supportive services within a primary care environment.*
- e) Describe how the agency will be responsive to the rapidly changing HCV care and treatment landscape.
- f) Describe how HCV clinical protocols are developed, reviewed and revised.
- g) Describe how the agency will provide HCV anti-viral therapy and monitoring, including treatment readiness assessments.
- h) Describe who will provide HCV treatment including their experience and credentials.
- i) Describe the role of the consulting gastroenterologist or hepatologist and how this person(s) will be utilized by the agency.
- j) For any service(s) not being offered onsite, describe how the service(s) will be provided and how the agency will make and track outcomes of these referrals to ensure services have been received in a timely fashion. *Preference will be given to organizations that demonstrate well established linkages and have written linkage agreements with other agencies.*
- k) Describe how HCV treatment adherence services are provided to ensure adherence to, and completion of HCV treatment.
- l) Describe the strategies to assess and improve retention in care.
- m) Describe how HCV supportive services will be provided, including the type of services and the staff providing them.
- n) Describe how peer services will be provided, including, how peers will be selected and trained for your program; type of peer services that will be provided and how peers will improve outcomes and the relationship of the peers to the health care team.
- o) Describe the proposed staffing for the program, including qualifications, roles and responsibilities of each position by completing and submitting Attachment 8.
- p) Describe activities to ensure all providers and staff have accurate and current knowledge of hepatitis C and hepatitis C care and treatment.
- q) Describe how consumers were involved in developing the program design.
- r) Describe how the agency will ensure that the services provided are culturally competent and how language, age and developmentally appropriate services will be provided for all populations identified as priorities.
- s) In the Work Plan Properties section of the Grants Gateway on line application, please include the required performance measures for each workplan objective listed in Attachment 1A.

5. Evaluation:

Maximum Score: 15 points

- a) Describe how the agency will provide ongoing monitoring and evaluation of the proposed program activities to ensure that patients are receiving the services they need and that services are having their desired outcomes. Describe how this information will be shared with HCV program staff and agency leadership.
- b) Describe your agency's process for Continuous Quality Improvement.

- c) Explain how your agency will monitor its progress in meeting workplan objectives and performance measures.
- d) Describe the method the agency will use to determine patient satisfaction; how it will be administered, including frequency and with whom the results will be shared.
- e) Describe your agency's capacity and existing systems for collecting and reporting unduplicated, patient-specific data.
- f) Describe how consumers will be involved in the program evaluation.
- g) Describe how your agency is currently using or plans to implement or use AIRS. (Attachment 10)

6. Budget:

Maximum Score: 20 points

- a) **The budget for year one (April 1, 2015 – March 31, 2016) must be entered into the Grants Gateway. Budgets for Years two through five must be uploaded as Attachment 12.** A guide has been provided to assist applicants in completing the budget forms (Attachment 11). For years two through five budgets, please be sure to complete all required Budget Pages included in Attachment 12. The budgets for Years two through five should be labeled as listed below and combined into one .pdf document, then uploaded to the Grants Gateway as Attachment 12.

Years two through five budgets should be labeled as follows:

- Budget Year 2 – April 1, 2016 – March 31, 2017
- Budget Year 3 – April 1, 2017 – March 31, 2018
- Budget Year 4 – April 1, 2018 – March 31, 2019
- Budget Year 5 – April 1, 2019 – March 31, 2020

- b) The amount requested each year should be reasonable and cost effective, relate directly to the activities described in the application, and be consistent with the scope of services outlined in the RFA. **For each budget year, do not exceed the maximum annual funding amount for the component for which you are applying.**
- c) All budgeted positions should be consistent with the proposed services. The Budget Justifications should delineate how the percentage of staff time devoted to this initiative has been determined. **The percent of effort allowed for billable staff must not exceed 20% cumulative, meaning the combined percent of effort for all billable staff positions cannot exceed 20%.**
- d) The budgets should include all subcontracts/consultants with contractual amounts and methodologies.
- e) The annual budgets should include travel for at least one HCV care and treatment clinician to attend a national conference on topics related to HCV care and treatment.
- f) Budgeted items should be justified and fundable under state and federal guidelines. Ineligible budget items will be removed prior to contracting. Ineligible items are those determined by NYSDOH/HRI personnel to be inadequately justified in relation to the proposed workplan or not fundable under state and federal guidelines (OMB circulars). The budget amount requested will be reduced to reflect the removal of the ineligible item(s).
- g) Funding for administrative and management costs may be requested to support a fair portion of the overall organizational structure to an extent that it allows the funded

applicant to implement program activities and must adhere to the following guidelines:

- Indirect overhead costs are limited to a maximum of 10% of total direct costs.
- Funds may NOT be used to supplant resources supporting existing services or activities.

C. Freedom of Information Law

All applications may be disclosed or used by DOH to the extent permitted by law. DOH may disclose an application to any person for the purpose of assisting in evaluating the application or for any other lawful purpose. All applications will become State agency records, which will be available to the public in accordance with the Freedom of Information Law. **Any portion of the application that an applicant believes constitutes proprietary information entitled to confidential handling, as an exception to the Freedom of Information Law, must be clearly and specifically designated in the application.** If DOH agrees with the proprietary claim, the designated portion of the application will be withheld from public disclosure. Blanket assertions of proprietary material will not be accepted, and failure to specifically designate proprietary material may be deemed a waiver of any right to confidential handling of such material.

D. Review & Award Process

Applications meeting the guidelines set forth above will be reviewed and evaluated competitively by the New York State Department of Health AIDS Institute and Health Research, Inc. using an objective rating system reflective of the required items specified for each component. The AIDS Institute anticipates that there will be more worthy applications than can be funded with available resources. Applications will be deemed to fall into one of three categories: 1) approved and funded, 2) approved but not funded, and 3) not approved.

In addition to applicant responses to the above statements and questions, reviewers will also consider the following factors:

- Overall merit of the application;
- Demonstration of need for proposed services;
- Availability of similar services/resources in the applicant's service area;
- Geographic coverage;
- Agency capacity and experience to provide the proposed services;
- The agency's access to the target population;
- The appropriateness of the evaluation strategy;
- Relevance and justification for costs included in the budget;
- The applicant's experience in the effective oversight of the administrative, fiscal and programmatic aspects of government contracts;
- The funding and performance history of the agency or program with the AIDS Institute and other funding sources.

Applicants are requested to select their primary region of service on the Cover Sheet of the Application (Attachment 5). The primary region of service for the application should be based on the location where the largest number of patients is to be served.

In cases where two or more applicants for funding are judged on the basis of their written applications to be equal in quality, the applicant with the highest score in Section 4 – Program Design and Activities will receive the award.

If changes in funding amounts are necessary for this initiative, funding will be modified and awarded in the same manner as outlined in the award process described above.

Once an award has been made, applicants not funded under this RFA may request a debriefing of their application. Please note the debriefing will be limited to only the strengths and weaknesses of the subject application and will not include any discussion of other applications. Requests must be received no later than ten (10) business days from the date of non-award announcement.

In the event unsuccessful applicants wish to protest the award resulting from this RFA, applicants should follow the protest procedures established by the Office of the State Comptroller (OSC). These procedures can be found on the OSC website at <http://www.osc.state.ny.us/agencies/guide/MyWebHelp>.

VII. ATTACHMENTS

Please note that the attachments can be accessed in the “Pre-Submission Uploads” section of an online application. In order to access the online application and other required documents such as the attachments, prospective applicants must be registered and logged into the NYS Grants Gateway in the user role of either a “Grantee” or a “Grantee Contract Signatory”.

- Attachment 1: Workplan
- Attachment 1A: Required Workplan Performance Measures
- Attachment 2: Sample Letter of Interest to Apply*
- Attachment 3: Minority & Women-Owned Business Enterprise Requirement Forms*
- Attachment 4: Vendor Responsibility Attestation*
- Attachment 5: Application Cover Sheet*
- Attachment 6: General Terms and Conditions – Health Research Incorporated Contracts**
- Attachment 6A: Additional General Terms and Conditions HRI Contracts**
- Attachment 7: Application Checklist*
- Attachment 8: Agency Capacity and Staffing Information*
- Attachment 9: HCV Projection of Services*
- Attachment 10: AIDS Institute Reporting System*
- Attachment 11: Instructions for Completion of Budget Forms for Solicitations
- Attachment 12: Expenditure Based Budget*

*These attachments are located / included in the Pre-Submission Upload section of the Grants Gateway on line application.

** These attachments are located in the Contract Document Properties section of the Grants Gateway on line application.

**ATTACHMENT 1 – WORK PLAN
DETAIL**

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
Objective 1: Establish and maintain an active linkage to care program.		<ol style="list-style-type: none"> 1. Hire and maintain position of Linkage to Care Specialist. 2. Collaborate with community based organizations providing services to individuals at risk for or infected with HCV. 	A linkage to care specialist will be hired and maintained throughout the contract period.
			Written linkage agreements are in place with at least one CBO providing services to individuals at risk for or infected with HCV.

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
<p>Objective 2: Develop strategies to effectively link clients to care.</p>		<ol style="list-style-type: none"> 1. Assess barriers to linking clients to care. 2. Develop, implement and monitor strategies to overcome barriers. 3. Educate, coach and empower clients. 4. Assist clients in scheduling and keeping HCV appointments. 5. Collaborate with other programs and staff to support HCV clients. 6. Document all linkage to care activities in the patient medical record and in AIRS. 	<p>At least 50% of newly identified HCV positive clients will attend their first HCV primary care visit within 30 days of their first encounter with the linkage to care specialist.</p>

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
Objective 3: Establish and maintain a comprehensive hepatitis C care and treatment program within a primary care setting.		1. Provide HCV care and treatment in accordance to state and/or national guidelines.	One provider will attend the AASLD conference each year of the contract period.
		2. Provide comprehensive primary care services.	At least 40% of all clients enrolled in the program and eligible for HCV treatment will initiate treatment.
		3. Provide comprehensive HCV medical care including: 1) Pre-treatment evaluation, 2) HCV anti-viral therapy and monitoring and 3) Post-treatment evaluation and management. This includes mental health, nutrition and substance use services and HCV counseling and education.	At least 80% of patients with a diagnosis of chronic HCV and are receiving antiviral treatment will receive a quantitative HCV RNA test within 12 months prior to initiation of antiviral treatment.
		4. Provide HCV care and treatment services utilizing a comprehensive multidisciplinary approach.	At least 80% of patients with a diagnosis of chronic HCV, have completed antiviral treatment and had an end-of-treatment response will receive a quantitative HCV RNA test after the completion of antiviral treatment.
		5. Ensure and maintain HCV providers and staff knowledge and understanding of the new	A subcontract or MOU is established and maintained with a gastroenterologist or hepatologist.

		<p>HCV therapies given the rapidly expanding treatment options pending FDA approval.</p> <ol style="list-style-type: none"> 6. Establish and maintain collaboration with a gastroenterologist or hepatologist. 7. Establish and maintain written linkage agreements for all services provided offsite by referral. 8. Establish a system to coordinate and track referrals for off-site services. 9. Conduct routine and formal case conferences with the patient's multi-disciplinary health care team. 10. Review HCV clinical protocols at least annually, and revise as needed. 11. Document all HCV care and treatment services in the patient's medical record and in AIRS. 	<p>Written linkage agreements are available for all offsite services.</p> <p>At least 80% patients with a diagnosis of chronic hepatitis C are counseled regarding the risk of alcohol consumption at least once while enrolled in the program.</p> <p>At least 80% of patients with a diagnosis of chronic HCV will have documentation of a formal screening for depression <u>or</u> a recommendation for or documentation of a <u>HCV related consultation</u> with a mental health provider prior to the initiation of antiviral treatment.</p> <p>At least one case conference will be held and documented for each client enrolled the program.</p>
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OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
Objective 4: Implement HCV treatment adherence services to ensure adherence to and completion of HCV treatment.		1. Employ evidence based interventions and tools that support treatment adherence (pill boxes, timers, texting, adherence coaches, peer support etc.). 2. Provide information to clients on HCV treatment, treatment side effects and the demands of treatment.	At least 80 % of all clients enrolled in the HCV program will have documentation in the medical record that medication adherence was addressed during the pre-treatment evaluation phase.
		3. Assess and monitor treatment adherence beginning in the HCV pre-treatment evaluation phase through treatment completion. 4. Communicate treatment adherence issues with the multidisciplinary health care team. 5. Document all treatment adherence services in the patient medical record and in AIRS.	At least 80% of patients receiving HCV treatment will have evidence of at least two assessments of medication adherence while on treatment.

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
<p>Objective 5: Ensure the delivery of effective strategies to improve retention in care.</p>		<p>1. Conduct assessments to identify any obstacles with retention in care. Perform reassessments when certain situations arise that may impact retention.</p>	<p>At least one intervention to remind and/or alert patients of upcoming appointments is developed and implemented by the program.</p>
		<p>2. Communicate retention in care issues with the multidisciplinary team.</p>	<p>At least 80% of patient medical records indicate retention in care assessment has been conducted.</p>
		<p>3. Establish and employ systems to alert and remind patients of upcoming appointments.</p>	<p>A system has been established to follow-up on patients' missed appointments.</p>
		<p>4. Establish mechanisms to follow-up on patients that miss appointments.</p> <p>5. Collect and analyze data on missed appointments and retention in care.</p> <p>6. Document retention in care activities in the patient medical record and in AIRS.</p>	<p>At least 80% of clients initiating HCV treatment will be retained in care through treatment completion, including final post treatment HCV RNA.</p>

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
<p>Objective 6: Ensure the availability of comprehensive HCV supportive services to assist clients throughout the various stages of HCV treatment.</p>		<ol style="list-style-type: none"> 1. Develop, implement and monitor a formal HCV Peer Program. 2. Ensure the availability of supportive services either one-on-one or within a group setting. 3. Educate the clients about HCV disease, treatment options and side effects. 4. Assist clients in making decisions about their HCV care and treatment. 5. Assist the clients in managing treatment side effects. 6. Document any supportive services in the patient medical record and in AIRS. 	<p>At least one HCV peer will be maintained by the program during the contract period.</p>
			<p>HCV supportive services will be available either one-on-one <u>or</u> HCV support groups will be held onsite periodically.</p>
			<p>Culturally and linguistically appropriate HCV educational materials are easily available to patients.</p>

Attachment 1A

REQUIRED WORKPLAN PERFORMANCE MEASURES

Instructions:

In the Work Plan Properties section of the Grants Gateway on line application, please include the required performance measures for each workplan objective as listed below. Please note: The performance measures may not necessarily match each task. However, due to system limitations this is the preferred option for entering the required performance measures.

OBJECTIVE	PERFORMANCE MEASURE
Objective 1: Establish and maintain an active linkage to care program.	A linkage to care specialist will be hired and maintained throughout the contract period.
	Written linkage agreements are in place with at least one CBO providing services to individuals at risk for or infected with HCV.
Objective 2: Develop strategies to effectively link clients to care.	At least 50% of newly identified HCV positive clients will attend their first HCV primary care visit within 30 days of their first encounter with the linkage to care specialist.
Objective 3: Establish and maintain a comprehensive hepatitis C care and treatment program within a primary care setting.	One provider will attend the AASLD conference each year of the contract period.
	At least 40% of all clients enrolled in the program and eligible for HCV treatment will initiate treatment.
	At least 80% of patients with a diagnosis of chronic HCV who are receiving antiviral treatment for whom a quantitative HCV RNA test was performed within 12 months prior to initiation of antiviral treatment.
	At least 80% of patients with a diagnosis of chronic HCV, have completed antiviral treatment and had an end-of-treatment response will receive a quantitative HCV RNA test after the completion of antiviral treatment.
	A subcontract or MOU is established and maintained with a gastroenterologist or hepatologist.
	Written linkage agreements are available for all offsite services.
	At least 80% patients with a diagnosis of chronic hepatitis C are counseled regarding the risk of alcohol consumption

	at least once while enrolled in the program.
	At least 80% of patients with a diagnosis of chronic HCV will have documentation of a formal screening for depression <u>or</u> a recommendation for or documentation of a <u>HCV related consultation</u> with a mental health provider prior to the initiation of antiviral treatment.
	At least one case conference will be held and documented for each client enrolled the program.
Objective 4: Implement HCV treatment adherence services to ensure adherence to and completion of HCV treatment.	At least 80 % of all clients enrolled in the HCV program will have documentation in the medical record that medication adherence was addressed during the pre-treatment evaluation phase.
	At least 80% of patients receiving HCV treatment will have evidence of at least two assessments of medication adherence while on treatment.
Objective 5: Ensure the delivery of effective strategies to improve retention in care.	At least one intervention to remind and/or alert patients of upcoming appointments is developed and implemented by the program.
	At least 80% of patient medical records indicate retention in care assessment has been conducted.
	A system has been established to follow-up on patients' missed appointments.
	At least 80% of patients initiating HCV treatment will be retained in care through treatment completion, including final post treatment HCV RNA.
Objective 6: Ensure the availability of comprehensive HCV supportive services to assist clients throughout the various stages of HCV treatment.	At least one HCV peer will be maintained by the program during the contract period.
	HCV supportive services will be available either one-on-one <u>or</u> HCV support groups will be held onsite periodically.
	Culturally and linguistically appropriate HCV educational materials are easily available to patients.

Attachment 11

INSTRUCTIONS FOR COMPLETION OF BUDGET FORMS FOR SOLICITATIONS

Budgets for Years two through five are to be completed using the excel budget forms in Attachment 12. Please be sure to complete all required budget pages for years two through five. The budgets for years two through five should be labeled as instructed in the RFA and combined into one .pdf document, then uploaded to the Grants Gateway as Attachment 12.

Tab 1 - Summary Budget

- A. **Project Name** – Enter the Component for which you are applying
- B. **Contractor SFS Payee Name** - Enter official contractor name listed on Statewide Financial System (SFS). If you do not have an SFS Contractor name, please enter the official name of agency.
- C. **Contract Period** – “From” is the Start date of the budget and “To” is the end date of the budget. A separate budget must be completed for each 12 month budget period and labeled for each contract period.
- D. The **GRANT FUNDS** column is automatically populated based on the information entered in the major budget categories on Tabs 2 through 5 of the excel spreadsheet. These categories include:
 - Salaries
 - Fringe Benefits
 - Contractual Services
 - Travel
 - Equipment
 - Space, Property & Utilities
 - Operating Expenses
 - Other

Tab 2- Salaries

Please include all positions for which you are requesting reimbursement on this page. If you wish to show in-kind positions, they may also be included on this page. *Please include a written justification on Tab 6.*

Position Title: For each position, indicate the title along with the incumbent’s name. If a position is vacant, please indicate “TBD” (to be determined).

Annualized Salary Per Position: For each position, indicate the total annual salary regardless of funding source.

Standard Work Week (Hours): For each position, indicate the number of hours worked per week regardless of funding source.

Percent of Effort Funded: For each position, indicate the percent effort devoted to the

proposed program/project.

Number of Months Funded: For each position, indicate the number of months funded on the proposed project.

Total: This column automatically calculates the total funding requested from the AIDS Institute based on annualized salary, hours worked, percent effort and months funded for each position. If the amount requested for a position is less than what is automatically calculated, please manually enter the requested amount in the total column.

Tab 2 - Fringe Benefits

On the bottom of Tab 2, please fill in the requested information on fringe benefits based on your latest audited financial statements. Also, please indicate the amount and rate requested for fringe benefits in this proposed budget. If the rate requested in this proposal exceeds the rate in the financial statements, a brief justification must be attached. *Please include a written justification on Tab 6.*

Tab 3 – Contractual Services

Please indicate any services for which a subcontract or consultant will be used. Include an estimated cost for these services. *Please include a written justification on Tab 6.*

Tab 3 – Travel

Please indicate estimated travel costs for the contract period. *Please include a written justification on Tab 6.*

Tab 4 – Equipment and Space

Please indicate estimated equipment or space costs for the contract period. *Please include a written justification on Tab 6.*

Tab 5 – Operating Expenses / Other

Please indicate any operating expenses for the contract period. (*Operating costs include may include Supplies and any other miscellaneous costs for the contract period*). *Please include a written justification on Tab 6.*

Please indicate the estimated other costs requested for the contract period. (*Other costs include indirect costs*) Please note indirect costs are limited to 10% of direct costs. *Please include a written justification on Tab 6. The justification for indirect costs needs to include the requested rate.*

Tab 6 - Narrative Budget Justification

Please provide a brief narrative justification in the **JUSTIFICATION** column in Tab 6 for each budgeted item. Requested amounts entered on Tabs 2 through 5 will automatically populate the **BUDGETED** column on Tab 6. The justification should describe the requested item, the rationale for requesting the item, and how the item will benefit the proposed program/project.

Those agencies selected for funding will be required to provide a more detailed budget as part of the contract process.