CHILD AND ADOLESCENT HEALTH CENTER PROGRAM
FY 2012 RFP Q AND A

****Revised 12-9-2010****

This question and answer document will be updated as new questions come in through December 17, 2010. Please send any questions to dollt@michigan.gov.

Q: Our current school-linked clinic is applying for a HRSA grant to construct a new site that would be school based at one of our schools. If we are awarded the MDCH grant; when do we have to be operational as the HRSA grant project is a 2 year project that must be operational by June 30, 2013?

A: All centers and school wellness programs funded under this RFP must be fully operational on October 1, 2011.

Q: Can we receive a MDCH award for the five year period, but decline funding for the first one or two years dependent on completion of the site or would we have to submit an alternative plan before the site is ready?

A: You cannot decline funding for a period of time while a center is being constructed. If the center is not going to be operational on October 1, 2011, the center is not eligible for funding.

Q: We have a unique site and I am unsure what focus areas I should select.

A: No matter what the target population, the focus areas should be focused on the needs of the population. This should be determined through a comprehensive needs assessment.

Q: Is this grant for new funding or will continuation funding be eligible as well?

A: This RFP is open to all eligible applicants. New centers and continuation centers may be funded under this RFP. All centers must be fully operational by October 1, 2011.

Q: Will existing sites be competing for continuation funding, or can they only apply for “enhancements” to their present services?

A: Existing state-funded centers are eligible to apply for continuation funding to support their health center through this RFP. If a health center is currently

operating without state funding, the health center is eligible for apply for this funding to enhance current services but funding must not supplant funding.

Q: The RFP states that we need to select either elementary or adolescents populations. We currently serve both populations. How do we need to address this in the grant?

A: See page 18 of the RFP for a detailed explanation. Applicants are strongly encouraged to **choose one** of the age groups (5-10 or 10-21). If both populations are served, focus the application on the age group that encompasses the majority of the population that will be accessing the center. If both populations are proposed to be served equally, the applicant must provide a detailed description of how they will ensure that the teen population will view this clinic as accessible and acceptable. *The applicant must describe in the narrative how serving young children will not pose a barrier to the teen population accessing this center.* Please note that there are separate Minimum Program Requirements (MPRs) for clinical centers serving the 5-10 year old population versus centers serving the 10-21 year old population. If the grantee plans on serving both age groups, they must adhere to both MPRs, which are included in *Attachment E*. If the Adolescent (10-21 year old) population is being served, the applicant **must provide** a teen-friendly clinic atmosphere that is both acceptable and accessible to this population.

Q: Please clarify the construction constraints (p. 76 states "Cost for acquisition and or construction of property are not allowable costs under this RFP"). Is renovation of existing space considered an allowable cost?

A: Renovations *may* be considered an allowable cost. Grant funds cannot be used to pay for permanent structural renovations (e.g., drywall), but can be used for equipment, plumbing, wiring, hardware, temporary structures and flooring (e.g., carpeting).

Q: Are award funds secure? When awards are determined, will the funding be there to make them?

A: Awards are based on availability of funding. The CAHC program, appropriated annually by the Michigan legislature, is funded through State Aid and Federal Medicaid match.

Q: We are submitting for an Alternative School-Linked Clinic model within a large facility. Do we have to provide a separate, dedicated entrance to the clinic?

A: A separate, dedicated entrance is encouraged but not required.

Q: Can an Alternative School-Linked Clinic share waiting/reception space with other providers, or must the adolescent clientele be kept separate from other patient populations?

A: There must be separate waiting rooms for the general population and the CAHC program. Part of the goal of the program is to create a teen friendly environment (for adolescent sites) which includes privacy from other adult patients.

Q: On p.17 of the RFP, applicants are directed to fill out all boxes accurately and provide an original signature. We can't find a form for this anywhere in the RFP. Are we just to copy and paste the "PART A" section from that page and create a signature line in a Word document inserted as page 1 of the application? Or is there a form somewhere that must be used?

A: There is not a form to use. Please develop a cover page on your own and make sure that it includes the required information.

Q: On p. 22 of the RFP, applicants are instructed to describe the case-finding system they'll employ to recruit clients. Please provide an operational definition of Case-Finding System.

A: A case finding system is made up a number of methods or strategies to promote, identify and recruit children and youth to utilize the CAHC.

Q: Could you provide an operational definition of "unduplicated youth"?

A: An unduplicated youth, for purposes of the CAHC program, is a unique individual. Each person is counted only once per year in the unduplicated count. For example, if 600 youth were seen, the unduplicated count would be 600. It would not increase based on the number of times these youth returned to the center.

Q: Does the Table of Content have to be double-spaced?

A: No, it can be single-spaced if desired.

Q: Is the project abstract counted in the 30-page written narrative limit?

A: No. The two-page abstract is NOT part of the 30-page written narrative limit.

Q: On page 23 of the RFP states that applicants must select at least two mandatory focus areas. We are confused as to whether applicants must employ two evidence-based programs for EACH of the focus areas (so 2x2=4 interventions/programs), or just one intervention for each of the two chosen focus areas?

A: CAHCs must implement two evidence-based programs for EACH of the two selected focus areas (four total).

Q: Is the actual organizational chart an attachment or is it part of the narrative under Organizational Structure?

A: The organizational chart should be included as an attachment, not as part of the narrative.

Q: For the new Work Plan format for the focus areas, has intervention replaced Goal?

A: It hasn't replaced the goal, but the new focus area format focuses on interventions.

Q: Since we have two evidence based initiatives for each Focus Area, do we complete two forms for that Focus Area. For example if one intervention is clinical and one is educational, do we submit them under one intervention (aka, broad goal)?

A: Each focus area should have at least TWO workplan pages, one for each intervention. Two focus areas are required, therefore, at least four workplan pages should be submitted for focus areas.

Q: For the Primary Care and Medicaid work plans it appears there is no goal required and again you complete the form for each objective—let say 5 separate objectives for Primary Care, then 5 separate forms are required.

A: The Medicaid Outreach work plan for clinical applicants will consist of five pages (forms) – one for each mandatory Medicaid Outreach area as described in the RFP. Objectives and activities should correspond directly to the Medicaid Outreach area indicated on each page (form). The Primary Care/Clinical Services work plan can be completed in the same manner e.g., with a different objective (and corresponding activities) on separate pages. If the Primary Care/Clinical Services objectives are listed on a single page, the activities and evaluation relevant to each objective should be clearly distinguishable for reviewers.

Q: On page 23 of the grant application it states "Focus areas must include ***evidence based programs and/or clinical strategies*** that go above and beyond comprehensive primary care services". My question is whether or not it is alright to have *two clinical strategies* for one focus area as opposed to one clinical strategy and one program. I would like to implement two evidence based clinical strategies in both of my focus areas.

A: Yes. The requirement is two evidence-based programs or interventions per focus area. If the interventions are both clinical, that is acceptable.

Q: Can you please provide the MDCH's operational definition of "evidence-based intervention"?

A: Research-based or evidence-based programs are those which have been shown through rigorous evaluation design to be effective in significantly impacting specific health outcomes and/or risk behaviors among the population to which the program was delivered. These programs generally have been replicated in multiple populations or locations with similar effects. The results of an empirical evaluation design, demonstrating significant effectiveness, are typically published in the literature (e.g., peer-reviewed journals), reviewed by independent scientific review panels, and are recognized by nationally respected organizations and/or government agencies.

Research-based clinical care can be included as an intervention, but only if this care goes above and beyond what is considered routine primary care for clients. Evidence-based clinical services and guidelines are widely available.

Q: When using the work plan format for the mandated focus areas, where do we list the activities we are going to provide? We have a form to list the intervention, and one to list the objectives, but nowhere to list the activities we are going to do to accomplish the objectives? Is the "intervention" the "activity" for the focus areas? Could you provide a hypothetical example showing the new mandated focus forms filled out?

A: The work plan format is designed to help you describe in detail the evidence-based interventions (activities) that you will be providing to meet the focus areas. You should complete one form for each evidence-based intervention. We regret that we cannot provide an example as this is a competitive RFP.

Q: Should the narrative be referenced? Where would the bibliography go? Is there a format?

A: The narrative does not need to be referenced.

Q: What is the difference between the budget narrative and the financial plan?

A: The budget narrative accompanies and provides a detailed, narrative description of the budget forms (Budget Summary and Budget Cost Detail) including identification and distribution of all sources of revenue; and justification for all expenditures including relevant calculations that justify line item costs. When looking at the budget narrative, it should be clear which expenses are being paid for by which funding source(s).The

financial plan is a section of the application narrative which discusses not only the overall budget in more general terms (e.g., total revenue including amount and sources of local match, all expenditures), but also gives sites that are not currently state-funded the opportunity to explain how the budget will not be used to supplant (replace) existing funds/services that are being, and will continue to be, provided. The financial plan also identifies how revenue is generated and applied back to the health center (e.g., how the fee schedule is developed, how the billing and fee collection processes works without posing a barrier to access of services or breaching confidentiality per the Minimum Program Requirements.)

Q: After review of attachment E-1 relative to Primary Care, is each ***heading*** (i.e., "Primary Care Services, Illness/Injury Care, Chronic Conditions Care), ***the objective*** and ***the bullets*** (i.e, Well Child Care, EPSDT screenings and exams etc.) ***the activities/interventions*** that need to be addressed? See example below:

PRIMARY CARE SERVICES **(Objectives)?**

- Well child care **(activities/interventions)?**
- EPSDT screenings and exams
- Comprehensive physical exams

ILLNESS/INJURY CARE **(Objectives)**

- Minor injury assessment/treatment and follow up **(activities/intervention)?**
- Acute illness assessment/treatment and follow up & /or referral

A: In both your narrative service delivery plan and your work plan, it should be clear that the health center will provide comprehensive primary care in all of the areas listed in Attachment E-1. (Note that this is not an exhaustive list of primary care services that are delivered through clinical health centers, but a list of the minimum services that should be addressed in the application.) Your primary care work plan must include the overall primary care objectives that your center will strive for and will evaluate. The primary care interventions should include major interventions/services that will contribute directly to achieving the stated objectives. You will likely include specific objectives and interventions in the broader areas or even on some individual bullet points; but you do not need a distinct intervention for each separate bullet point listed in the document.

Q: Regarding minimum service requirements, what is required / included in the EPSDT Screenings and exams (we are trying to determine what kinds of vision and hearing equipment are required)?

A: What is required for EPSDT visits is based on age and risk assessment. Hearing and vision screening is universal across the age ranges *periodically.* We would refer you to the document "Revised Standards of Care for EPSDT" (specific to Michigan) at www.hpmich.com/pdf/0578_001.pdf. Within this document you will find the site to access the **Periodicity Schedule.** What type of vision and hearing equipment you need will also be influenced by the age of the proposed target group. We have no specific requirements, other than to have the type of equipment best suited to the needs of your population.

Q: Regarding the Laboratory Requirements, what specimens are required to be collected for outside lab testing? Anything other than STI specimens? Which STI need to be tested for?

A: We require that our Adolescent sites assess and screen for sexually transmitted infections. Most of these tests are not "waived tests" and require full laboratory service. These tests primarily are HIV, Gonorrhea, and Chlamydia. Other STI testing may be needed. Some centers choose to use their own microscopy for diagnosis of some STIs. This is not required. Other specimens that may be typically "sent out" are urine and/or throat cultures, blood chemistry, other non-waived tests, or tests beyond the type of equipment the health center has on site.

Q: Regarding the Laboratory Requirements, what tests are required to be done by microscopy?

A: There are no requirements for testing done by microscopy. This would be a decision made by the health center provider staff, medical director, and the fiduciary.

Q: Can you define what a certified HIV counselor/tester is according to this RFP? Who is the certification through?

A: MDCH provides the certification training for HIV Counselor/Testers. Twice per year, the CAHC program, through MDCH, also provides an accelerated HIV Counselor/Tester training specific to adolescents for state-funded CAHC staff.

Q: On page 53, the minimum requirements require that pregnancy services are required. Can you expand on what these services are? Prenatal care, referral to prenatal care, etc.

A: Pregnancy testing and either pre-natal care or referral for prenatal care is required. The majority of state-funded health centers refer clients for prenatal care. While both school-based and school-linked health centers provide reproductive health counseling (e.g., reproductive health and sexuality education, contraceptive education, referral for family planning/contraceptives) at a minimum, school-based health centers **may not**, under Michigan law, prescribe, dispense or distribute contraceptives. School-linked health centers can, however, prescribe, dispense and distribute contraceptives in accordance with state and federal laws. Abortion counseling, services and referral **may not** be provided by any state-funded health center under Michigan law.

Q: Regarding the focus area programs/interventions, do clinic staff have to deliver these programs, or can other appropriate (trained/certified) personnel deliver these programs in concert with the clinic objectives?

A: Focus are interventions do not have to be provided by clinical staff and may be delivered by other appropriate personnel.

New questions for clinical applications as of 12-9-2010

Q: Is proof of 501c3 incorporation required to be included in attachments for a free standing non-profit?

A: No, proof of 501c3 status is not required.

Q: In the RFP it states that the advisory committee does not need to be fully functioning at the time of grant submission. It is our understanding that the advisory committee makes recommendation to certain policies, such as parental consent. On page 22 of the RFP, there are requirements for the School Board if the clinic takes place on school property, which include written approval for: location of health center, administration of a health survey, parental consent policy, and services rendered. Given the time constraints of school board meetings prior to the grant being due, would it be appropriate for the school board to approve the development of an advisory committee and defer consent/services decisions to the advisory committee with final approval going to the school board should the grant be funded?

A: Yes, that is fine.

Q: What level of organizational chart is required for the RFP--clinic level or organizational level?

A: Both. The organizational chart should show the clinic or program structure as well as how and where the clinic or program fits into the overall organizational system. The RFP states: Submit an organizational chart depicting the program, including the advisory committee, the fiduciary agency, program coordinator, Medical Director, proposed subcontractors (if applicable) and all related program personnel, as an attachment.

School Wellness Program

Q: What is the definition of a "user" for the SWP?

A: An SWP user is an individual who has presented for an individual health service with the Nurse or the mental health provider and for whom a record (chart) has been opened. Once per year, the user is counted to generate the unduplicated count of clients utilizing the center services for that calendar year.

Q: Also, it says the school nurse must be available 30 hours/week. Is this a 4 day/week position?

A: Hours of operation (including days per week) should be based on the needs of your target population. There is no required number of days per week to be open, however your hours of operation should be consistent each week.

Q: Is there any support time or just the 30 hours of "direct service" to the school?

A: The nurse is required to provide direct service 30 hours per week which can include limited clinical care, health education and programming, professional development for school staff and administrative time.

Q: In the application, I believe I read on page 38 of the RFP that SWPs are allowed to close during summer break.

A: Yes, that is correct. While the Clinical and Alternative Clinical centers are required to be open year round, the SWP sites can *choose* to close during the summer months. Note: SWP sites are not required to close during the summer months.

Q: Are we expected to bill for any services at the Wellness Center?

A: Successful SWP grantees should expect to bill for mental health services, to the extent possible, in order to generate additional funds to support the program. The services provided by the SWP nurse are services aimed at the general population of students, which typically cannot be billed to third party payers at this time. However, MDCH and MDE hope that in the future there will be a mechanism to bill and capture reimbursement for at least some SWP nurse services provided to the general population. Therefore, your sponsoring agency may be required to have certain medical supervision and billing infrastructure in place in order to facilitate billing in the future. Should the opportunity become available MDCH will assist grantees in determining the oversight, policies and procedures that need to be in place to bill.

Q: How many School Wellness Centers are currently in operation?

A: Currently three sites are piloting the program.

Q: Is there a mechanism for billing for mental health services for an FQHC?

A: Yes, there is. You should contact your billing services staff to determine steps for billing for mental health services provided through the FQHC.

Q: For the School Wellness Program it states that a school building needs to have 50% of the population on free and reduced meals. It also states that the services may only be provided at no more than 2 buildings and must provide services to at least 350 students (minimal). Is only one of the buildings required to have the 50% free and reduced meals or would both buildings need to be at 50%?

A: Yes, if the SWP covers two schools, each school needs to meet the 50% or greater threshold.

New questions for school wellness program applications as of 12-9-2010

Q: If a School Wellness Program reduces hours for the summer can staff still be doing outreach, administrative work and mental health counseling for those students that need ongoing care, but not offer nursing services?

A: Yes. School Wellness Programs do not have to close during the summer months, it is only an option. Reducing the services offered over the summer months is an acceptable option.

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