

FAQs from the AFC Case Management Bidders' Conferences
March 19, 2008

LOI / PROPOSAL FORMAT

- Q. **Will there be a confirmation that the Intent to Apply that I faxed in was received?**
- No. AFC will not send a confirmation. However, agencies are encouraged to contact us at casemanagementrfp@aidschicago.org to check on confirmation. In addition, agencies are encouraged to keep a copy of the send receipt from a fax machine or email address.
- Q. **Do potential applicants need to be exact in the "estimated amount of their requests" on the letter of intent forms?**
- No. This is designed to give AFC a ballpark figure of how much total will be requested. Applicants will be allowed to change the amounts of request between the submission of the LOIs and overall budget request within the proposals.
- Q. **Do the attachments count towards the 35 page limit of the proposal? What attachments need to be included on the CD?**
- No, the attachments do not count towards the 35 page limit. The attachments and budget forms are in addition to the narrative (the narrative is not to exceed 35 pages.) The CD must include the following:
 - Program Narrative
 - Line Item Program Budget
 - Budget Narrative
 - Board of Director's List
 - Program Work Plan
 - Quality Management Plan
 - Memoranda of Agreement (both the Matrix and agreements)
- Q. **According to the "Format Instructions" on p.13, the narrative should be on paper and applicants are NOT to submit CDs. However, on p.3 and p.22, it is stated that an electronic copy of the proposal and all attachments must be submitted on CD. Should an electronic copy on CD be submitted or not?**
- We do not want applicants to submit marketing materials (such as videos, DVDs, etc.). We do, however, want applicants to submit their proposal on a CD Rom or DVD (in addition to the multiple hard copies as specified in the RFP).
- Q. **In what sequence should the proposal be organized? According to the "Proposal Check List" on p.22, or as listed under "IX. Instructions for Completing the Program Narrative" on p.14-18?**
- Please follow the order of the proposed check-list on page 22.
- Q. **Does the Work Plan template take the place of narrative, or is it a complement?**
- The template is a good tool to shorten the proposal. While you do not need to repeat what you list on the template, you still might want to use both narrative and the template.
- Q. **With regard to the Work Plan template, who is the lead?**
- The lead will be the person responsible for achieving a particular goal.

CASE MANAGEMENT

- Q. What is the rationale behind not allowing stand-alone FTEs and prioritizing multiple levels of case management at one agency?**
- AFC conducted a pilot project to test the implementation of the levels of case management services. Among the many findings that influenced the new program design, two significant findings emerged:
 1. Agencies that have only one stand-alone case manager lacked an infrastructure to support and invest in case management. The most successful programs were comprised of teams of case managers who had ongoing, consistent supervision.
 2. Client feedback, focus groups, and surveys identified a strong continuity of services for agencies that provide at least two levels of services. When clients have to be transferred to a new agency because of their level of need changed, they experienced frustration, confusion, and a disruption in services. In addition, the trust and familiarity that was built up with the original agency was lost.
- Q. Do case managers have to be trained prior to the proposal being submitted? Will priority be given to the agencies that have trained staff that have passed the competencies?**
- Case managers do not need to be trained prior to proposal submission. Case managers must be trained within 3 months of hire and (for medical case managers) must pass the competencies training within 6 months of hire. There will be no priority given through the review process towards agencies that have case managers who have passed the competencies.
- Q. Can clients move between levels of case management? Are there time limits on each level?**
- There are no time limits on RW or DRS case management services. While the overall goal is to move clients towards stability and eventually out of case management, this is determined by client need and not time parameters. Clients can move between different levels of case management as their needs change. The purpose of the system of case management is to ensure smooth continuity of services through this transition.
- Q. What intensive case management programs are being rebid?**
- DRS is the only intensive case management program being rebid. PACPI, Corrections, and Supportive Housing case management programs are not being rebid through this RFP.
- Q. Will AFC continue to provide referrals for DRS?**
- AFC will continue to provide the referrals for DRS.
- Q. Do agencies have to apply for DRS case management?**
- Due to program continuity and fiscal reasons, AFC strongly recommends that agencies consider carrying a DRS caseload, even if it is a small one. However, agencies are not required to apply for DRS case management services.
- Q. What if the case manager only has an associate's degree?**
- Then they cannot be a DRS case manager, as the state requires a BA. They can be a medical or supportive case manager.
- Q. What is the expectation regarding how large a caseload will be and how often case managers will contact clients? Will agencies have to address this in the proposal?**

- AFC is in the process of finalizing the case management policies and procedures which will clearly define the caseload size and the required levels of client contact. Agencies will not have to address this in their proposals.

Q. Is the AAU Nurse Liaison considered the RN for the team or do we have to hire our own?

- The AAU Nurse Liaison works for the AAU and is assigned to the agency for quality assurance purposes. In other words, the Nurse liaison takes the place of the nurse on the “team” doing QA work, so the case management agencies don’t have to have a nurse on staff.

Q. Are case managers that were grandfathered in 2006 eligible to continue providing DRS home service case management for the RFP?

- The "grandfather clause" applies to those who have and continue to serve as DRS case managers; there can be no disruption. In other words, if somebody leaves for two years or more and then returns, the grandfather clause does not apply to him/her.

Q. Regarding the qualifications for the Home Service Case Management (CM) Team, can a case management team of 3 DRS case managers have one BA and the other two be non-degreed but AAU certified?

- No. All DRS case managers must have degrees unless previously “grandfathered” in by AAU.

Q. When does the case management competencies occur?

- The case management competencies training is a five-day training that occurs four times per year. There will be a competencies training held in August 2008.

Q. Can a case manager’s position be split between different levels of case management? Can a supervisor be a part time case manager and a part time supervisor?

- Case managers’ positions can be split between levels of case management. Also, supervisors can be paid as a part time case manager and provide relevant services.

Q. Can a supervisor supervise all three levels of case management?

- As long as the supervisor meets the DRS requirement and passes the case management competencies training, he/she will be eligible to supervise all three levels of case management.

Q. Will AFC provide technical assistance to use the case management client-level database? Will agencies be able to input data and run reports between AFC’s database and the agency’s other databases?

- AFC will conduct training for case managers and provide technical assistance for the set up of the client-level database. AFC staff will also provide ongoing technical assistance for data input and report running. Agencies that wish to put data between an agency’s database and AFC’s database must talk to Roman Buenrostro at AFC.

Q. Will AFC continue to provide referrals to agencies?

- Yes, however agencies are expected to describe other points of entry where clients may be identified.

Q. If you are a social service agency do you have to be a Medicaid provider?

- No, however if you are a Medicaid provider please provide an explanation of what services your agency can bill for.

- Q. **Can we get information on which clinics serve our clients?**
- AFC collects limited data on where clients receive their medical care. Given that AFC has the information on an agency's clients and given appropriate releases of information are up to date, AFC can provide reports to applicant agencies upon request.
- Q. **Is there a template for the Quality Improvement Plan?**
- No. Quality Improvement plans will vary by agency. Agencies might use client satisfaction surveys or quality checks with data. Describe the means are used by your agency to monitor and evaluate the level of service provided. In the future, AFC will provide technical assistance with Quality Improvement plans.
- Q. **How are agencies expected to describe their program start up by August 1, 2008?**
- Describe how your case managers will be hired and scheduled for competencies training, and how your program will conform to the updated policies and procedures of the Northeastern Illinois HIV/AIDS Case Management Program.

TREATMENT COORDINATORS

- Q. **What is the rationale behind implementing the Treatment Coordinators? Why will they not provide direct services? Will they be expected to interact with all case managers?**
- AFC conducted a pilot project back in 2006 that resulted in many lessons learned and significant findings related to medical case management. One in particular was that the biggest barrier to case managers tracking clinical indicators and creating service plans to assist clinically-vulnerable populations was the lack of communication between case manager and clinician. An exorbitant amount of time was spent by case managers attempting to gain access to this information and to coordinate services with clinicians, oftentimes to no avail. In lieu of creating RN-level case managers based at clinics to provide medical case management (which is not realistically affordable and able to serve all the clients who need it), AFC and its advisory groups created the Treatment Coordinator component to enhance medical case management.

Given the activities associated with Treatment Coordinators (please see the RFP for more detail), there realistically isn't any time for this person to provide direct services to clients. Instead, the Treatment Coordinators will interact with case managers and give them information regarding their medical case managed clients (in particular) and complete the Medical Assessment forms for all clients. In addition, the Treatment Coordinator will be responsible for inputting data regarding the HRSA clinical indicators into the client-level database.

The Treatment Coordinator component is, at this time, a pilot project. AFC recognizes that services will not be comprehensive and that there will not be enough positions to serve the entire EMA. At this time, we are working to build a model that reaches most of the case managed clients, identifies the needs of those medical case management clients, complete the program design, and secure ongoing funding.

- Q. **Are Treatment Coordinators funded out of Ryan White?**
- No. The Treatment Coordinator positions are a pilot project funded by other funds that AFC has raised.

MEMORANDA OF AGREEMENT

- Q. **Is there any template we can use in terms of the MOAs? We understand this is emphasized.**
- We list the elements that you should include as part of your MOA. These MOAs should not be generic. As such, we did not provide a template. If you address all of the areas included in the RFP, which serves as a road map, you will address this in a comprehensive way.
- Q. **Are we required to have an MOA with all agencies with whom we collaborate? What about outreach outside of Chicago?**
- You might have a referral mechanism that doesn't require a MOA. If, however, you are ensuring that agency x provides y services, then a more formal MOA will make sense – especially for core services. You should address the main priority areas outlined in the RFP (see page 28). We particularly want to see MOAs for core services if your agency doesn't already provide the services. If you have relationships with providers outside the city of Chicago we would also like to understand what those relationships are and how you coordinate services.
- Q. **What are the expectations for the structure of the Memoranda of Agreement? Are agencies expected to develop MOAs with Treatment Coordinator sites, even if they have not been funded yet? Can we use our old linkage agreements?**
- The Memoranda of Agreement will be critical in determining the level of clinical and other service coordination case managers are going to be able to provide within the newly re-designed system. Agencies are encouraged to create a few (4-5) targeted, specific MOAs that will be the basis for ongoing relationships that will provide information regarding a client's clinical care.

The structure of these are much more specific than generic linkage agreements. Agencies are required to provide an individualized agreement or a plan for developing agreements for each of the principle partners in service provision. Agreements should address identified service priorities that are based on core clinical services, defined by HRSA, and number of clients seen by agency. Agreements should address the following factors that include but are not limited to:

- The services(s) to be provided, the number of participants to be served, the period in which the services(s) will be provided, and, if known, the monetary value of the services;
- Priority areas addressed;
- Relationship between agencies and services provided between the two;
- Specific, identified contact staff for both agencies, including the extent of the authority and responsibility both will take in the collaboration;
- Mechanisms for referral and referral tracking; and
- Mechanisms for treatment and service coordination (i.e. case conferencing) and expectations of data sharing.

Although Treatment Coordinator providers have not yet been identified, agencies are encouraged to begin discussion with potential Treatment Coordinator applicants to determine MOAs. At the very least, if a medical provider is not anticipating becoming a Treatment Coordinator provider, an MOA can still be developed that addresses how case managers will get clinical data from the

clinician and how service plans will be created in conjunction with both the clinician and case manager.

Q. What is the timeframe for the MOAs?

- MOAs can be established for as long as three years, however they should be updated yearly to address service needs and program developments. The MOAs submitted with this proposal will run from August 1, 2008 through July 31, 2009.

Q. Do we need supporting documentation from the other agency with which we are doing a MOA?

- Ideally the MOA will be signed by both agencies. You will not need additional supporting documentation.

Q. Regarding the MOA, since there might be some overlap among agencies in terms of having the same memorandum with one agency, does that impact the priority status of the organization?

- It is likely that certain agencies will have lots of MOAs (because they provide an enormous volume of services), but each MOA must be specific with that agency (not carbon copy), and should be signed by both parties.

Q. Are electronic signatures acceptable on the Memoranda?

- Yes. Electronic signatures are acceptable.

Q. How do we estimate the number of clients to be served by an MOA?

- You can estimate the number of clients to be served based on your agency's past experience.

BUDGET RELATED

Q. What specifically are you requesting in regards to the agency fiscal structure?

- This is listed in more detail in the RFP – we are looking for agencies to describe their fiscal, administrative and information system structure and experience. They should describe how accounting and payroll processes are organized and who is responsible, as well as the agency's ability to operate on a reimbursement basis – and to begin services before reimbursement is provided (e.g. line of credit, cash flow, etc.).

Q. Do agencies have to delineate the Programmatic Operating Costs in the budget? What are the allowable Programmatic Operating Costs?

- Agencies do not have to delineate the Programmatic Operating Costs for the purposes of the budget; instead agencies may list a flat 5%. However, agencies will be required to delineate the costs when submitting reimbursement requests (if funded.) AFC utilizes the HRSA Part A list of allowable Programmatic Operating Costs (available upon request.)

Q. Given that DRS is a fee-for-service contract and not a flat salary/program cost grant, how are agencies to draft a budget?

- Agencies are requested to estimate, to the best of their abilities, the costs associated with the DRS programs. Agencies should provide an estimate of the salary/fringe, travel, and keep the 5% programmatic operating cost rate. AFC respects that this may not accurately reflect what

will be billed during the course of the contract year and will not impose any caps based on this budget.

- Q. **If an agency is combining two levels of funding to create one FTE (i.e. .5 medical case management and .5 supportive service case management) should the budget delineate those two or combine it into one position?**
- Because the three levels of case management are funded out of separate and distinct funding sources, the positions will need to be delineated by type of case management and not particular to a person. For example, if Joe Smith has a salary of \$40,000 a year to be a .5 DRS case manager and a .5 medical case manager, the budget should list two line items for his salary: \$20,000 for DRS and \$20,000 for medical case management.
- Q. **Is the award is for a 3-year contract period?**
- Yes, but it is dependent on annual appropriations and agency performance. And while we are asking agencies to submit a budget for a 12 month period, the first year will be for 7 or 8 months, depending on whether the funding comes from RW Part A or Part B.
- Q. **If we are applying for more than 2 FTE case managers (e.g. 3 or more), can we apply for more than .25 of a supervisor's position?**
- If you are applying for 3 or more FTE case managers, you may apply for up to .5 of a supervisor, but no more.
- Q. **Is travel reimbursed for supervisors?**
- Travel is reimbursed at the same rate for supervisors that it is for RW DRS case managers.
- Q. **Are social service agencies required to be a certified Medicaid provider?**
- No, however if your agency is a Medicaid provider, please let us know what services you bill Medicaid for. If you are not a Medicaid provider, please let us know how you screen to ensure that Ryan White funds are the funds of last resort.
- Q. **Can the 5% cap for programmatic operating expenses be used to cover administrative expenses?**
- No. Administrative costs are not covered through the 5% programmatic/operating cap for Ryan White funding. DRS funding, on the other hand can be used towards salary, programmatic, and administrative costs.

MISCELLANEOUS

- Q. **What are the measurable indicators for cultural competence that can be addressed in the proposal?**
- There are two ways an agency can discuss indicators for cultural competence, both qualitatively and quantitatively:
 - The Quantifiable indicators can be summarized as how many of an agency's clients that need translation services are able to receive translation services.
 - The Qualitative indicators include the areas addressed in the RFP questions: composition of board/staff, ongoing training, integration of client input in program development and improvement.

- Q. You indicated that it is estimated that we may see up to 8,000 new cases of HIV in the next three years. Where did that number come from?**
- The number provided in the presentation are based on very rough estimates that there are currently 10,000 undiagnosed individuals in the state of Illinois. Given CDC guidelines regarding routine testing, it is estimated that many of these individuals will be identified over the next few years. Based on current epidemiology, around 80 percent of all reported cases of HIV/AIDS are in the Chicago EMA.
- Q. Are agencies required to have community advisory boards for consumers?**
- Agencies don't have to have a consumer advisory board, but we do want to see that you have some mechanism to ensure that feedback comes in from clients and people living with HIV/AIDS. We also want to see how that feedback is influencing agency decisions.
- Q. Issues around technology have always been a thorn for us; people without real training do it by default. Are you doing anything to address this?**
- AFC will provide funding for client-level database licenses, provide start-up and ongoing technical assistance, and provide training for all case managers and treatment coordinators required to enter client-level data. AFC also provide technical assistance on a case-by-case basis for agencies that request it. In addition, AFC is beginning a grant initiative that looks to build the technology capacity on the south side of Chicago; individuals are encouraged to contact Cynthia Tucker at AFC for more information.
- Q. What is AFC's plan to continue funding for case management services that ended last Friday?**
- Agencies that are currently funded through Part A or Part B will receive continued level funding for services through July 31, 2008. AFC is in the process of preparing contracts for the period ending July 31.