GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

Community Health Administration

# Addressing Health Disparities Through Tobacco Control and Food Access

## REQUEST FOR APPLICATIONS

**FO# CHA-PG-00179-10**

**RFA# CHA_AHDTF_07.08.2022**

**SUBMISSION DEADLINE:**

**AUGUST 10, 2022 BY 6:00 PM**

The Department of Health (DC Health) reserves the right without prior notice, to reduce or cancel one or more programs listed in this Request for Applications (RFA). DC Health reserves the right to reject all applications, adjust the total available funds or cancel the RFA in part or whole. Funding levels for the total program and budget amounts of individual awards shall be contingent upon continued receipt of funding by DC Health, as well as any reduction, elimination or reallocation of funds by a federal grantor, the Executive Office of the Mayor (EOM) and/or DC Health. Any adjustments shall be in accordance with authorizing legislation for the use of funds, all DC municipal regulations for grant-making and the applicable federal and DC Health terms of agreement.

**DC DEPARTMENT OF HEALTH**

**Community Health Administration**

# NOTICE OF FUNDING AVAILABILITY (NOFA)

**FO# CHA-PG-00179-010**
**RFA# CHA_AHDTF_07.08.2022**
**Addressing Health Disparities Through Tobacco Control and Food Access**

The District of Columbia, Department of Health (DC Health) is requesting proposals from qualified applicants to provide services in the program and service areas described in this Notice of Funding Availability (NOFA). This announcement is to provide public notice of the DC Health's intent to make funds available for the purpose described herein. The applicable Request for Applications (RFA) will be released under a separate announcement with guidelines for submitting the application, review criteria and DC Health terms and conditions for applying for and receiving funding.

| | |
|---|---|
| Funding Opportunity Title: | Addressing Health Disparities Through Tobacco Control and Healthy Food Access |
| Funding Opportunity Number: | CHA-PG-00179-010 |
| Program RFA ID#: | CHA_AHDTF_07.08.2022 |
| DC Health Administrative Unit: | Community Health Administration |
| DC Health Program Bureau | Cancer and Chronic Disease Prevention Bureau |
| Program Contact: | Carrie Dahlquist<br>Manager, Tobacco Control Programs<br>tobaccocontrol@dc.gov |
| Program Description: | DC Health recognizes tobacco use is a detrimental health behavior influenced by social and environmental factors and disproportionately affects Black/African American DC residents with low socioeconomic risk factors and contributes to health disparities. This funding opportunity will support implementation of sustainable high-reach strategies and activities that integrate tobacco control interventions into healthy food access initiatives and other community settings. |
| Eligible Applicants | Community-based or national nonprofit or for-profit organizations; institutions of higher education, research centers, or healthcare organizations. |
| Anticipated # of Awards: | 1 |

| | |
|---|---|
| Anticipated Amount Available: | $300,000 |
| Annual Floor Award Amount: | $200,000 |
| Annual Ceiling Award Amount: | $300,000 |
| Legislative Authorization | FY23 Budget Support Act of 2022<br><br>301(a) and 317(k)(2) of the Public Health Service Act, [42 U.S.C. Section 241(a) and 247b(k)(2)], as amended |
| Associated CFDA# | 93.387 |
| Associated Federal Award ID# | NU58DP006834 |
| Cost Sharing/Match Required? | No |
| RFA Release Date: | July 8, 2022 |
| Letter of Intent Due Date: | Not applicable |
| Application Deadline Date: | August 10, 2022 |
| Application Deadline Time: | 6:00 p.m. |
| Links to Additional Information about this Funding Opportunity | DC Grants Clearinghouse<br>https://communityaffairs.dc.gov/content/community-grant-program#4<br><br>DC Health EGMS https://dcDC Health.force.com/GO__ApplicantLogin2 |

Notes:

1. DC Health reserves the right to issue addenda and/or amendments subsequent to the issuance of the NOFA or RFA, or to rescind the NOFA or RFA.
2. Awards are contingent upon the availability of funds.
3. Individuals are not eligible for DC Health grant funding.
4. Applicants must have a DUNS #, Tax ID#, and be registered in the federal Systems for Award Management (SAM) with an active UEI# to be registered in DC Health's Enterprise Grants Management System.

# CONTENTS

# RFA TERMS AND CONDITIONS

**The following terms and conditions are applicable to this, and all Requests for Applications issued by the District of Columbia Department of Health (DC Health) and to all awards, if funded under this RFA:**

A. Funding for a DC Health subaward is contingent on DC Health's receipt of funding (local, federal, or private) to support the services and activities to be provided under this RFA.

B. DC Health may suspend or terminate an RFA pursuant to its own grant making rule(s) or any applicable federal regulation or requirement.

C. The RFA does not commit DC Health to make any award.

D. Individual persons are not eligible to apply or receive funding under any DC Health RFA.

E. DC Health reserves the right to accept or deny any or all applications if the DC Health determines it is in the best interest of DC Health to do so. An application will be rejected if it does not comply with eligibility requirements, formatting or submission requirements outlined in the RFA. DC Health shall notify the applicant if it rejects that applicant's proposal for review.

F. DC Health reserves the right to issue addenda and/or amendments subsequent to the issuance of the RFA, or to rescind the RFA. The prospective applicant is responsible for retrieving this information via sources outlined in the RFA (e.g. DC Grants Clearinghouse).

G. DC Health shall not be liable for any costs incurred in the preparation of applications in response to the RFA. The applicant agrees that all costs incurred in developing the application are the applicant's sole responsibility. No funds already awarded the applicant under other instruments or agreements shall be used by the applicant to fund the preparation of the application.

H. DC Health may conduct pre-award site visits (either in-person or virtually) to verify information submitted in the application and to determine if the applicant's facilities are appropriate for the services intended.

I. DC Health shall determine an applicant's eligibility by way of local and federal registries for excluded parties searches and documents and certifications submitted by the applicant.

J. The Applicant Organization must obtain a Data Universal Numbering System (DUNS) number to apply for funding and register for the federal System for Award Management (SAM) at www.sam.gov prior to award.

K. DC Health reserves the right to require registry into local and federal systems for award management at any point prior to or during the Project Period (i.e., the total number of years for which funding has been approved). This includes DC Health Electronic Grants Management System (EGMS), for which the awardee will be required to register and maintain registration of the organization and all users.

L. DC Health may enter into negotiations with an applicant and adopt a firm funding amount or other revision of the applicant's proposal that may result from negotiations.

M. DC Health shall establish terms of agreement for an award funded under this RFA. If funded, the applicant will receive a Notice of Grant Award (NOGA). The NOGA will establish the Project Period and define any segments of the Project Period (e.g. initial partial year, or a 12-month budget period). The NOGA shall outline conditions of award or restrictions.

N. Continuation of funding, if awarded shall be based on availability of funds, documented satisfactory progress in interim and annual reports, continued eligibility and determination that the continued funding and activities is in the best interest of the District of Columbia.

O. DC Health shall provide the citations to the local or federal statute/s and implementing regulations that authorize the award; all applicable District of Columbia and Federal regulations, including 2 CFR 200 and Department of Health and Services (HHS) published 45 CFR Part 75, payment provisions identifying how the awardee will be paid for performing under the award; reporting requirements, including programmatic, financial and any special reports required by the funding agency; and compliance conditions that must be met by the awardee.

P. If there are any conflicts between the terms and conditions of the RFA and any applicable federal or local law or regulation, or any ambiguity related thereto, then the provisions of the applicable law or regulation shall control and it shall be the responsibility of the applicant to ensure compliance.

Additional information about grants management policy and procedures may be obtained at the following site: https://oca.dc.gov/page/division-grants-management or click here: Citywide Grants Manual and Sourcebook.

If your organization would like to obtain a copy of the **DC Health RFA Dispute Resolution Policy,** please visit the DC Health Office of Grants Management webpage, here. Any additional questions regarding the RFA Dispute Resolution Policy may be directed to the Office of Grants Management (OGM) at doh.grants@dc.gov. Your request for this document will not be shared with DC Health program staff or reviewers.

# CHECKLIST FOR APPLICATIONS

- ☐ Applicants must be registered in the federal Systems for Award Management (SAM) and the DC Health Enterprise Grants Management System (EGMS).
- ☐ Complete your EGMS registration at least **two weeks** prior to the application deadline.
- ☐ Start constructing and uploading your application components into EGMS at least a week prior to the application deadline.

The complete **Application Package** should include the following:

- ☐ Certificate of Clean Hands dated within 60 days of the application deadline
- ☐ Current business license or certificate of licensure or proof to transact business in local jurisdiction
- ☐ Current certificate of insurance
- ☐ Copy of cyber liability policy
- ☐ IRS tax-exempt determination letter (for nonprofits only)
- ☐ IRS 990 form from most recent tax year (for nonprofits only)
- ☐ Current list of Board of Directors, on letterhead, signed and dated by a certified official from the Board (this cannot be the executive director)
- ☐ Assurances, certifications and disclosures
- ☐ Proposal abstract
- ☐ Project narrative
- ☐ Organizational chart
- ☐ Staffing plan
- ☐ Work plan
- ☐ Budget table
- ☐ Budget justification
- ☐ Letter(s) of support (minimum of 2)

- ☐ Documents requiring signature have been signed by a organization leader or authorized representative of the applicant organization.
- ☐ The applicant needs a Unique Entity Identifier number (UEI#) and an active registration in the System for Award Management to be awarded funds.
- ☐ The applicant needs a DUNS number to be awarded funds. Go to Dun and Bradstreet to apply for and obtain a DUNS # if needed.
- ☐ The project narrative is formatted with 8.5 x 11-inch pages, single-spaced, Arial or Times New Roman font using 12-point type *(11–point font for tables and figures)* with a minimum of one-inch margins. Applications that do not conform to these requirements will not be forwarded to the review panel.
- ☐ The application proposal format conforms to the "Proposal Components" (See section 5.2) listed in the RFA.
- ☐ The proposed budget is complete and complies with the budget forms provided in the RFA. The budget narrative is complete and describes the categories of items proposed.

- ☐ The proposed work plan and other attachments are complete and comply with the forms and format provided in the RFA.
- ☐ Submit your application via EGMS by the application due date and time**. Late applications will not be accepted.**

# 1. GENERAL INFORMATION

## 1.1 KEY DATES

- Notice of Funding Announcement Date: **June 24, 2022**
- Request for Application Release Date: **July 8, 2022**
- Pre-Application Meeting Date: **visit https://OGMDCHealth.eventbrite.com**
- Application Submission Deadline: **August 10, 2022**
- Anticipated Award Start Date: **October 1, 2022**

## 1.2 OVERVIEW

The mission of DC Health is to promote and protect the health, safety, and quality of life of residents, visitors, and those doing business in the District of Columbia. The agency is responsible for identifying health risks; educating the public; preventing and controlling diseases, injuries, and exposure to environmental hazards; promoting effective community collaborations; and optimizing equitable access to community resources.

The Community Health Administration (CHA) within DC Health promotes healthy behaviors and healthy environments to improve health outcomes and reduce disparities in the leading causes of mortality and morbidity in the District. CHA focuses on population health strategies to prevent and control cancer, chronic disease, and vaccine preventable diseases; promote nutrition and physical activity; ensure access to quality health care services; and support the health and well-being of families across the lifespan. CHA's approach targets the behavioral, clinical, and social determinants of health through evidence-based programs, policy, and systems change.

As part of that mission, DC Health's Tobacco Control Programs (TCP) applies evidence-based approaches to reduce disease, disability, and death related to tobacco use. The Program works with government, community, and clinical partners to ensure that residents of all ages can achieve health by preventing the initiation of tobacco use, promoting cessation of tobacco, eliminating exposure to secondhand smoke (SHS), and identifying and eliminating tobacco-related health disparities.

## 1.3 PURPOSE

The purpose of this funding is to support implementation of tobacco control strategies and activities to address tobacco use disparities among Black/African American DC residents who are experiencing food insecurity, a key social determinant of health. The recipient will collaborate with key stakeholders to utilize a community-based policy, systems, and environmental (PSE) change approach guided by the latest data, best practices, and partner feedback. Applicants must demonstrate how their proposed strategies and activities will address disparities in tobacco use together with food insecurity, while applying a health equity lens.

## 1.4 Source of Grant Funding

Funding is anticipated to be available using the District of Columbia Fiscal Year 2023 Budget Support Act of 2022 and DC Health National Tobacco Control Program (State-based) and Commercial Tobacco Use and Dependence Treatment Support System (Federal Award Identification #5NU58DP006834). DC Health is the primary reciepient of federal funds awarding these funds. As a primary recipient, DC Health has the responsibility to pass through requirements and objectives agreed to in our federal notices of award.

## 1.5 Award Information

### 1.5.1 Amount of Funding Available

The total funding amount of $300,000 is anticipated for one (1) award for the first budget period.

### 1.5.2 Period of Performance and Funding Availability

The first budget period of this award is anticipated to begin on October 1, 2022 and will continue through September 30, 2023. After the first budget period, there will be up to three (3) additional 12-month budget periods for a total project period of October 1, 2022 – September 30, 2026. The number of awards, budget periods, and award amounts are contingent upon the continued availability of funds and grantee performance and compliance.

### 1.5.3 Eligible Organizations/Entities

The following are eligible organizations/entities who can apply for grant funds under this RFA:

- Community-based or national non-profit or for-profit organizations
- Institutes of higher education
- Research centers
- Healthcare organizations

Considered for funding shall be organizations meeting the above eligibility criteria and having documentation of providing services (health and social services) to the target populations. Priority will be given to those organizations with a demonstrated track record of successfully working with the priority population and demonstrated impact/improvement in at least one social determinant of health.

### 1.5.4 Non-Supplantation

Recipients may supplement, but not supplant funds from other sources for initiatives that are the same or similar to the initiatives being proposed in this award.

# 2. BACKGROUND

## 2.1 Demographic Overview

Cigarette smoking is the leading cause of disease, disability, and death in the United States. Over 16 million people live with at least one disease caused by smoking, and 58 million nonsmoking Americans are exposed to secondhand smoke.[1] Smoking harms nearly every organ of the body and affects a person's overall health. Smokers are more likely than nonsmokers to develop heart disease, stroke, and lung cancer. Smoking is also a cause of type 2 diabetes mellitus and can make it harder to control. Smoking is a risk factor for dementia. Smoking during pregnancy increases risk of pregnancy complications.

While the District of Columbia ("DC" or "District") has been ranked one of the healthiest cities in the United States, further analysis reveals metrics such as median income, educational attainment, physical activity, rates of obesity, and tobacco use are not consistent across populations. The burdens of poverty, chronic disease, and poor health are considerably higher for non-Hispanic Black/African American (Black/AA) District residents than for their non-Hispanic White (White) counterparts. Black/AA residents in DC are disproportionately burdened by lower socio-economic status, unemployment, and lower educational attainment compared to white residents.[2] Black/AA residents are also less likely to have access to affordable, nutritious foods and opportunities to engage in physical activity compared to White residents. Rates for chronic conditions including cardiovascular disease, hypertension, obesity, and diabetes follow this pattern and are more prevalent among Black/African American than White DC residents.[3]

Though only 11.3% of District residents identified as smokers in 2020, 18% of Blacks/African Americans smoked compared to 5.7% of Whites.[4] This disparity is a leading cause of higher rates of cardiovascular disease, hypertension, diabetes, asthma, and cancer seen among Black/African American residents, as shown in Figures 1 and 2.

[1] Centers for Disease Control and Prevention. (2021, November 16). *Office on smoking and health (OSH)*. Centers for Disease Control and Prevention. Retrieved April 8, 2022, from https://www.cdc.gov/tobacco/about/osh/index.htm
[2] Jackson, M., King, C. J., Brown, T., Kurgatt, S., Marino, E., Nwodim, O., et al. (2016). *The health of the African American community in the District of Columbia: Disparities and recommendations. Washington, DC: DC Commission on African American Affairs*.
[3] Centers for Disease Control and Prevention. Racism and Health. (2021, November 24). Retrieved April 8, 2022, from https://www.cdc.gov/healthequity/racism-disparities/index.html
[4] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed Feb 22, 2022]. URL: https://www.cdc.gov/brfss/brfssprevalence/.

*Figure 1*: Tobacco use and disease prevalence in the District *(Behavioral Risk Factor Surveillance System, 2019)*

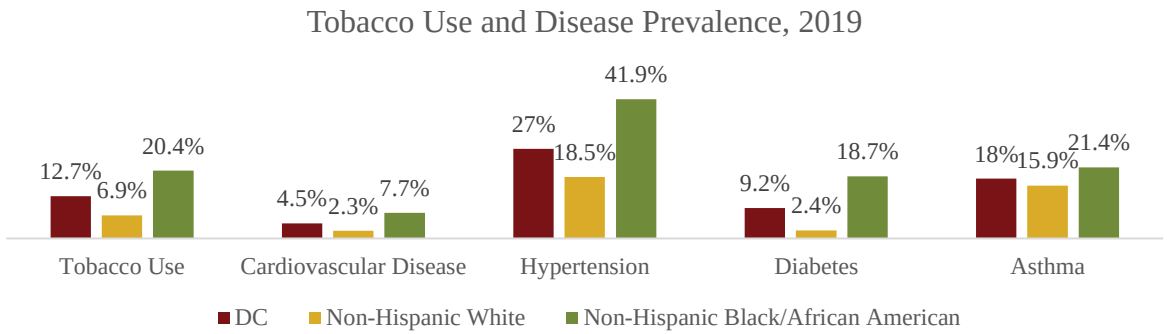
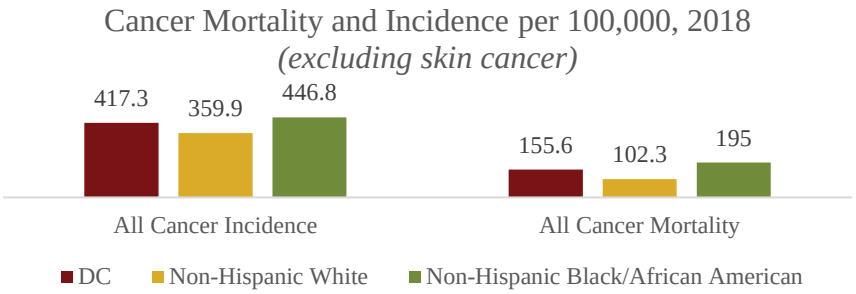



*Figure 2*: Cancer mortality and incidence in the District *(DC Cancer Registry, 2018)*



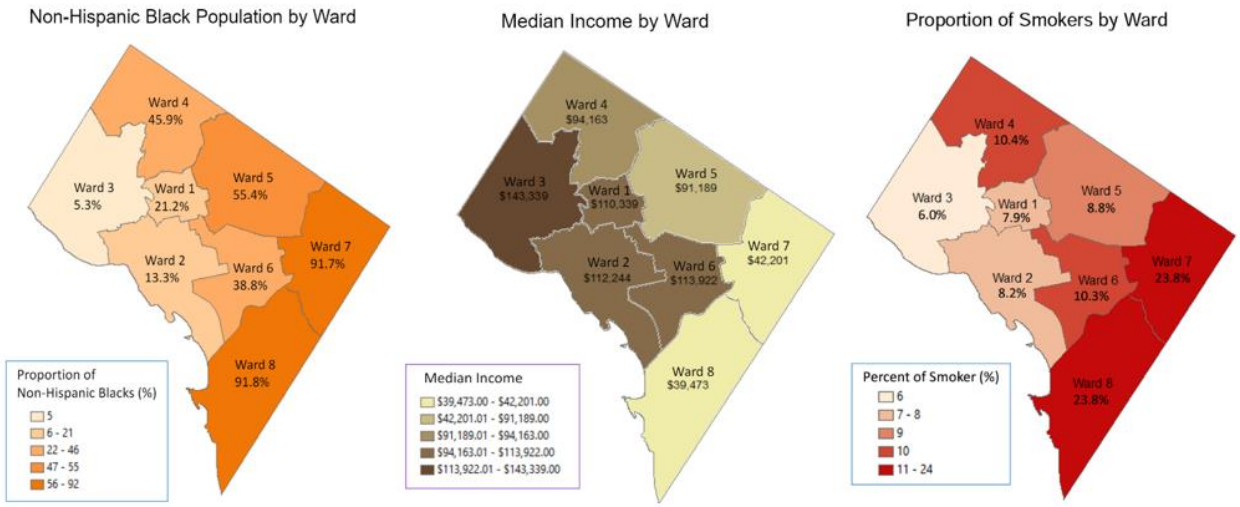

## 2.2 Social Determinants of Health & Tobacco Use

While smoking is viewed as a lifestyle choice, that choice is influenced by the social and physical environments in which people live, work, and play. These elements, known as *social determinants of health (SDOH)*, include discrimination, socioeconomic status, employment, education, access to healthy foods and healthcare, safe neighborhoods, active living, housing, and transportation. Furthermore, a growing body of research describes how a history racism in the United States has had a pervasive and negative impact on communities of color—affecting where one lives, learns, works, worships and plays and creating inequities in access to social and economic benefits such as housing, education, wealth, and employment. They are grounded in the structural racism and implicit bias that have shaped our society and its institutions, resulting in limited access and opportunity for minority populations. Social determinants of health thus impact community resources and opportunities as well as individuals' ability to live a smoke-free life.

*Race/Ethnicity, Socioeconomic Status & Smoking:* Smoking prevalence and race/ethnicity are correlated to income and ward of residence, as seen in Figure 3. In 2019, 25.4% of District residents with household incomes less than $35,000 smoked cigarettes compared to 6.7% of

residents with a household income over $75,000.[4] Geographically, over half (53.7%) of District residents who are current smokers reside in Wards 7 and 8. In both Wards 7 and 8, 23.8% of residents reported currently smoking, compared with only 6% in Ward 3. Smokers with lower incomes experience chronic stressors and trauma including underemployment and unemployment, financial strain, housing instability, and neighborhood crime.[5] This chronic stress can complicate attempts to quit as the perceived stress relief from smoking is often reported as a driver of smoking among people who use tobacco.[6] Lower socioeconomic status (SES) presents its own barriers, such as limited social support, no knowledge of cessation resources, lack of access to timely medical care, and lower health literacy, which can result in a lack of understanding of the importance or health impact of quitting and lower comprehension of medical instruction[7]

*Figure 3:* The Correlation of Ward of Residence, Race/Ethnicity, Income, and Smoking in the District *(Behavioral Risk Factor Surveillance System, 2019)*




*The Built Environment and Tobacco Use:* One environmental factor driving tobacco use initiation and continued smoking is the pervasive presence of marketing. The tobacco industry targets marketing to specific populations using radio, billboards, in-store promotions, and print ads. This advertising creates an environment where smoking is deemed acceptable. Research has shown a ten-fold increase in the number of tobacco advertisements in predominantly Black/AA

[5] Widome, R., Joseph, A. M., Hammett, P., Van Ryn, M., Nelson, D. B., Nyman, J. A., & Fu, S. S. (2015). Associations between smoking behaviors and financial stress among low-income smokers. *Preventive Medicine Reports*, *2*, 911–915. https://doi.org/10.1016/j.pmedr.2015.10.011

[6] Kim-Mozeleski JE, Pandey R. The Intersection of Food Insecurity and Tobacco Use: A Scoping Review. *Health Promotion Practice*. 2020;21(1_suppl):124S-138S. doi:10.1177/1524839919874054

[7] Muennig, Dr. Peter. Issue brief. (2006). Healthier and wealthier: decreasing health care costs by increasing educational attainment. *MetLife Foundation*, November 2006. https://all4ed.org/wp-content/uploads/HandW.pdf

neighborhoods compared to other neighborhoods.[8] Other widely known promotional tactics utilized are direct marketing and increased advertisement in Black/African American neighborhoods and sponsorship of cultural events with large African American audiences.[9]

Nationally, the higher rate of menthol tobacco use among Black/African Americans (85% compared to 29% among white smokers) is directly related to the predatory marketing tactics of the tobacco industry. Advertisements for menthol cigarettes were more common in the magazine *Ebony* than in the magazine *People*, and Black/AA children were more likely to recognize popular menthol brands in advertisements than other children[10,11] Research has shown that for DC retailers in predominantly Black/African American neighborhoods, pervasive marketing in-and-outside of the store were ten times more prevalent than in neighborhoods with less Black/African American residents.[12]

## 2.3 The Relationship Between Tobacco Use & Food Insecurity

*The Built Environment and Food Insecurity.* Similar to tobacco use, the built environment also influences food access and food security. Three full-service grocery stores serve more than 160,000 residents of Wards 7 and 8 combined.[13] Meanwhile in Ward 3, sixteen full-service grocery stores serve 80,000 people. Food insecurity is defined by the US Department of Agriculture as a lack of consistent access to enough food for every person in a household to live an active, healthy life. While it is estimated that rates of food insecurity in the District almost doubled to 21.1% during the COVID-19 Public Health Emergency, recent figures estimate the rate of food insecurity in the District has returned to near pre-pandemic levels at 10.3% in 2020.[14,15] Significant disparities, however, exist by race and ethnicity with 19.5% of Black

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[8] Kirchner, T.R., Villanti, A.C., Cantrell, J., et al. Tobacco retail outlet advertising practices and proximity to schools, parks and public housing affect Synar underage sales violations in Washington, DC. *Tobacco Control*, 2015;24:e52-e58.

[9] University of California San Francisco. (n.d.) Truth Tobacco Industry Documents. *UCSF Industry Documents Database.* Retrieved 4/18/2022 from https://www.industrydocuments.ucsf.edu/tobacco/results/#q=cultural%20event&h=%7B%22hideDuplicates%22%3Atrue%2C%22hideFolders%22%3Atrue%7D&subsite=tobacco&cache=true&count=619

[10] Rising, J., & Alexander, L. (2011). Marketing of menthol cigarettes and consumer perceptions. *Tobacco induced diseases*, *9 Suppl 1*(Suppl 1), S2. https://doi.org/10.1186/1617-9625-9-S1-S2

[11] Dauphinee, A. L., Doxey, J. R., Schleicher, N. C., Fortmann, S. P., & Henriksen, L. (2013). Racial differences in cigarette brand recognition and impact on youth smoking. *BMC public health*, *13*, 170. https://doi.org/10.1186/1471-2458-13-170

[12] Kirchner, T. R, Villanti, A. C., Cantrell, J., *et al*. Tobacco retail outlet advertising practices and proximity to schools, parks and public housing affect Synar underage sales violations in Washington, DC *Tobacco Control* 2015;24:e52-e58.

[13] DC Hunger Solutions. (2020). *Still minding the grocery gap in DC: 10th anniversary grocery store report*. https://www.dchunger.org/wp-content/uploads/2021/01/StillMindingGroceryGap.pdf

[14] Government of the District of Columbia, Office of Planning *The Road Ahead: 2021 Update on Food Access and Food Security in the District of Columbia.* 2021.

[15] Alisha Coleman-Jensen, Matthew P. Rabbitt, Christian A. Gregory, and Anita Singh. 2021. Household Food Security in the United States in 2020, ERR-298, U.S. Department of Agriculture, Economic Research Service.

households and 12.2% of Hispanic households experiencing food insecurity compared to 1.9% of white households.[16] "Food desert" is a familiar but neutral term. Instead, "*food apartheid* more accurately captures the deliberate and racialized nature of food segregation in cities across America."[17]

*Smoking and Food Insecurity:* Studies have shown a robust relationship between tobacco use and food insecurity. Vulnerable and disadvantaged populations – racial /ethnic minorities and those with lower educational attainment, living below the federal poverty level, and those experiencing psychological distress – are more— – are more likely to smoke and more likely to be food insecure.[18,19] The risk of severe food insecurity among children and adults is two to three times higher in households where an adult smokes than in non-smoking households.[20] Compared to food secure nonsmokers, becoming food insecure increased the likelihood of starting smoking or relapsing after successfully quitting.[21]

The relationship between smoking and food insecurity is complex. Just as financial stress can contribute to smoking, limited access to food or worrying about running out of food increases stress and can be a trigger for smoking. For many smokers, cigarettes are identified as a coping mechanism and stress reliever even given nicotine's stimulant properties.[22] Nicotine can also act as an appetite suppressant, an effect that can be desired among food insecure populations. Withdrawal from nicotine increases hunger sensations, making smoking more appealing and possibly driving a relapse to smoking among those who have quit.[23]

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[16] United States Census Bureau. Current Population Survey Food Security Supplement (CPS-FSS). 2016-2020.

[17] Toussaint, Etienne C., and Sabine O'Hara. Food, Fitness, and Fatalities. *American Bar Association*. December 14, 2020. https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/rbgs-impact-on-civil-rights/food-fitness-and-fatalities/

[18] Poghosyan, H., Moen, E. L., Kim, D., Manjourides, J., & Cooley, M. E. (2019). Social and structural determinants of smoking and quit attempts among adults living in 12 US states, 2015. American Journal of Health Promotion, 33(4):498-506. https://doi.org/10.1177%2F0890117118792827

[19] Farrelly, M., C., & Shafer, P. R. (2017). Comparing trends between food insecurity and cigarette smoking among adults in the United States, 1998 – 20011. *American Journal of Health Promotion, 31*(5)413-416. https://doi.org/10.1177%2F0890117116660773

[20] Cutler-Triggs, C., Fryer, G. E., Miyoshi, T. J., and Weitzman, M. (2008). Increased rates and severity of child and adult food insecurity in households with adult smokers. *The Archives of Pediatric and Adolescent Medicine, 162*(11):1056-2062. Michigan Population Studies Center. Doi:10.1001/archpediatrics.2008.2

[21] Kim-Mozeleski, J. E., Pandey, R., & Tsoh, J. Y. (2019). Psychological distress and cigarette smoking among U.S. households by income: Considering the role of food insecurity. *Preventive Medicine Reports, 16*. https://doi.org/10.1016/j.pmedr.2019.100983

[22] Kim- Mozeleski, J., & Pandey, R. (2020). The intersection of food insecurity and tobacco use: A scoping review. *Health Promotion Practice*, 21(1 Suppl): 124S-138S. https://dx.doi.org/10.1177%2F1524839919874054

[23] Kim-Mozeleski, J. E., Pandey, R., & Tsoh, J. Y. (2019). Psychological distress and cigarette smoking among U.S. households by income: Considering the role of food insecurity. *Preventive Medicine Reports, 16*. https://doi.org/10.1016/j.pmedr.2019.100983

## 2.4 Cessation Support for District Residents

For smokers who wish to quit, there are several evidence-based treatment options available. The most effective cessation therapy is a combination of counseling and FDA-approved medication (nicotine replacement therapy or other cessation medications), with a quit rate of 23-32%. The least successful method is self-help, with a quit rate of 9-12%.[24]

DCQuitNow supports tobacco cessation attempts through evidence-based interventions for residents of the District of Columbia. By the end of fiscal year 2022, DC Quitline will transition to DCQuitNow, reflecting a broader range of options for participants to engage and receive cessation support. In addition to phone counseling, DCQuitNow will offer live text or chat sessions with a Quit Coach, online group video sessions, online ordering of nicotine replacement therapy, and online courses, articles, trackers, and artificial intelligence-based text messaging support. These enhanced features will facilitate a new milestone-based digital journey that keeps participants engaged in the quitting process through individually tailored strategies. While DCQuitNow provides support in several languages, a local number (202-333-4488) directly connects Spanish-speaking callers to DCQuitNow . Individuals can access the services directly or be referred by a healthcare provider or community organization through direct referral options such as electronic health record integration, secure email, secure FTP site, and an online portal (coming soon).

DCQuitNow data shows that the majority of users are Blacks/AA residents (85%), the population most likely to smoke in the District.[25] While studies have shown that 70% of Black/African American smokers want to quit, they are less likely to be successful in a quit attempt than their White counterparts.[26] Even though Blacks/African Americans attempt to quit more than their White counterparts who smoke[27], there is a gap in those who make a quit attempt utilizing the evidence-based services of the DCQuitNow and those who do not. This gap reveals an opportunity to raise awareness and utilization of this evidence-based service.

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[24] U.S. Department of Health and Human Services. (2008 May). Treating tobacco use and dependence: 2008 update. *Agency for Healthcare Research and Quality*. https://www.ahrq.gov/prevention/guidelines/tobacco/index.html
[25] Consumer Wellness Solutions, Inc. (Optum). (2021). DC Quitline statistics.
[26] Centers for Disease Control and Prevention. (2017, January 6). Quitting smoking among adults – United States, 2000-2015. MMWR, 65(52): 1457-1464. https://www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6552a1.pdf
[27] Babb S, Malarcher A, Schauer G, et al. Quitting Smoking Among Adults—United States, 2000–2015. Morbidity and Mortality Weekly Report, 2017;65(52):1457-64 [accessed 2018 Jun 12].

# 3. PURPOSE

The DC Health Community Health Administration (CHA) is requesting applications from qualified applicants to reduce disparities in tobacco use and tobacco-related health outcomes among Black/African Americans experiencing food insecurity in the District of Columbia. DC Health aims to identify a qualified organization that will serve as a tobacco control change agent by working collaboratively with community stakeholders. The lead organization and community partners will implement and evaluate policy, systems, and environmental (PSE) change interventions to reduce tobacco use initiation and maximize tobacco cessation support within food access organizations and promote tobacco-free living and healthy nutrition in the environment.

## 3.1 APPROACH

To reduce the burden of tobacco among Black/African American residents of the District who also experience food insecurity, applicants will work to reduce triggers to smoke, identify and address barriers that undermine cessation success, and promote opportunities to pursue good health. Culturally appropriate strategies and activities should incorporate evidence-based and promising practices as well as best practices to mitigate these barriers through a policy-systems-environmental (PSE) change approach. PSE approaches change the environment to make healthy choices practical and available to everyone in the community. This approach shifts away from just educating the community about the health impact of tobacco to reducing access, opportunity, and acceptability of tobacco use while providing support to those who wish to quit. Activities proposed should support living smoke-free with minimal resources beyond the life of the grant, such as integrating tobacco cessation support in settings beyond the health clinic. Sustainability of the proposed tobacco control initiatives beyond the grant should be prioritized through these approaches.

Policy, systems, and environmental change activities that can be considered for this project are detailed in ***Section 4.2: Allowable Activities***.

The project timeline is detailed below:

- **Year 1**: Recruit and orient project work group members; identify barriers to be addressed; participate in development of the DC Tobacco Control Strategic Plan; implement activities; monitor progress and evaluate processes
- **Year 2 and 3**: Implement activities; monitor progress and evaluate impact in the community; build capacity and sustainability of activities; and identify and promote success stories of the project
- **Year 4**: Monitor sustainability of interventions, conduct program evaluation, develop best practices toolkit and final report

**Outcomes**

Below are strategies that applicants should include and implement that lead to the outlined short, medium, and long-term outcomes. ***All strategies are required.***

| Strategies | Short Term Outcomes | Medium Outcomes | Long Term Outcomes |
|---|---|---|---|
| **Mobilize multi-sector stakeholders to identify opportunities to ensure living, working, and community environments are supportive of a healthy lifestyle**<br><br>**Increase partnerships and coordination between tobacco control and food access programs**<br><br>**Integrate tobacco use assessment and referral to cessation services in CBOs and service agencies**<br><br>**Improve food environments for residents where tobacco use is high**<br><br>**Increase promotion of healthy food options where both food and tobacco are sold**<br><br>**Promote policies and environmental changes that support tobacco cessation and healthy alternatives to tobacco initiation** | Increased capacity to connect residents to services that support tobacco cessation<br><br>Increased referrals to tobacco cessation services from federal and local food access program partners<br><br>Increased utilization of DCQuitNow cessation services<br><br>Increased number of smoke-free policies in businesses, organizations, faith communities, etc.<br><br>Reduced influence of tobacco marketing in retail settings in Wards 7 & 8<br><br>Increased referrals to local and federal food access and nutrition education programs such as WIC, SNAP, SNAP-Ed | Increased successful quit attempts<br><br>Decreased tobacco use and dependence among DC adults<br><br>Reduced exposure to secondhand smoke<br><br>Increased use of food access and nutrition education programs such as WIC, SNAP, SNAP-Ed | Decreased morbidity and mortality related to tobacco use<br><br>Decreased tobacco use disparities among Black/African Americans with low socioeconomic status<br><br>Increased food security for District populations with high prevalence of tobacco use |

Applicants shall demonstrate how the proposed project plan will mobilize community and stakeholder support, measure the following key performance indicators, and evaluate their impact:

**Support Tobacco Cessation**

- Proportion of community-based organizations (CBOs) and agencies incorporating tobacco use assessment and direct referral to DCQuitNow cessation services for clients served *(Required)*
- Proportion of adult smokers referred to DCQuitNow cessation services by organizations and agencies supporting food access *(Required)*
- Proportion of adult smokers referred to DCQuitNow cessation services by organizations and agencies addressing social determinants of health such as employments, housing, social services, healthcare access, transportation, active living, and public safety (*optional*)

**Facilitate Healthier Environments** *(Required)*

- Proportion of CBOs and government agencies incorporating tobacco use assessment and direct referral to DCQuitNow for clients served
- Proportion of smoke-free policies adopted by community organizations, government agencies, places of worship, and/or businesses with a high percentage of hourly and/or part-time employees
- Proportion of smoking cessation support initiatives adopted by community organizations, government agencies, places of worship, and/or businesses with a high percentage of hourly and/or part-time employees
- Number of retail establishments selling tobacco that post DCQuitNow signage

**Mobilize Community and Stakeholder Support** *(Applicant should select at least one)*

- Proportion of community organizations newly engaged in tobacco control efforts because of this grant
- Proportion of businesses with high percentage of hourly and/or part-time employees newly engaged in tobacco control efforts because of this grant
- Proportion of government agencies newly engaged in tobacco control efforts because of this grant

# 4. PERFORMANCE REQUIREMENTS

Applicants should propose projects that meet the criteria listed below.

## 4.1 TARGET POPULATION

Grantees shall provide services focused on policy, systems and environmental changes that support better health outcomes through healthy food access and tobacco free environments. Black/African Americans in DC have the highest prevalence of smoking, are disproportionately affected by the burden of tobacco, and are more likely to experience lack of access to adequate

food. The primary geographic focus is Wards 7 and 8, which have the highest proportion of smokers and food insecure residents in the District.

## 4.2 Location of Services

Grantees must be located within the District of Columbia. Services must be delivered in the following settings, but not limited to large, medium, and small businesses; faith-based, service, and social organizations; government agencies; community centers; and clinics serving residents of DC.

## 4.3 Allowable Activities

Policy, systems, and environmental (PSE) change approaches are designed to affect the social acceptability of smoking and limit access to tobacco products while supporting those who wish to quit. Activities proposed within the PSE change context should build the foundation for sustainable interventions and create an environment that supports smoke-free living with minimal resources beyond the life of the grant.

**Policy Change** Interventions that create or amend and support enforcement of laws, ordinances, resolutions, mandates, regulations, or rules that drive systems and environmental changes.

*Examples of policy change activities that could be included within the workplan:*

- Collaborate with organizations that provide direct distribution of food or other food resources to reach residents within DC Housing Authority properties and provide regular monitoring and enforcement of smoke-free policy implementation
- Collaborate with multi-unit housing management to develop, implement, and enforce smoke-free policies, provide cessation resources for residents who smoke, and connect residents to federal and local food assistance programs
- Provide technical assistance to small, medium-sized, and large businesses and organizations to develop and implement comprehensive tobacco control policies that include smoke-free campuses
- Partner with DC Health and other governmental agencies to ensure policies such as smoke-free workplaces and smoke-free multi-unit housing properties are enforced
- Engage Advisory Neighborhood Commissions to support smoke-free policies as well as policies designed to improve access to tobacco cessation and food access resources
- Support policy change at the retail business level to eliminate the sale of products taxed at the higher tobacco rate

*This initiative should promote non-legislative smoke-free policies, such as smoke-free multi-unit housing and smoke-free public spaces, that drive systems and environmental change.* ***Lobbying and development of legislation is prohibited through this funding****.*

**Systems Change** Interventions that transform and redesign processes/procedures and structures to create environments that promote healthy outcomes in populations the organization, institution, or system serves. *Examples of this type of change that could be included in the workplan:*

- ***REQUIRED***: Collaborate with local and federal food assistance programs to incorporate tobacco use assessment and referral to DCQuitNow at enrollment or intake
    - *Provide communication tips and training on Ask-Advise-Connect tobacco use intervention*
    - *Implement direct referral to DCQuitNow through the online portal*
- ***REQUIRED***: Advise governmental agencies, CBOs, and social service agencies on processes to assess tobacco use and food security and refer constituents to evidence-based support services (such as DCQuitNow, WIC, SNAP)
- ***REQUIRED***: Provide technical assistance to small, medium-sized, and large businesses and/or organizations to offer cessation support to employees who use tobacco
- ***REQUIRED***: Incorporate referrals to tobacco cessation resources and to federal and local food assistance programs into community outreach programs, such as vaccine education initiatives and community health worker efforts
- Work with DC Health and other governmental agencies to institutionalize processes and procedures that are supportive of tobacco cessation and healthy living goals
    - *Incorporate comprehensive smoke-free campuses*
    - *Adopt healthy meeting standards (offering healthy snacks, regular breaks to encourage movement)*
    - *Sponsor cessation support groups and movement activities and promote cessation benefits through health insurance and employee assistance programs (EAPs)*
- Integrate Hunger Vital Signs™ screening and other social determinants of health with tobacco use assessment in the clinical setting
- Work with clinics to implement evidence-based interventions to assess patients for food insecurity and tobacco use and incorporate referrals to local and federal food assistance programs and tobacco cessation services and treatment
- Offer continuing education on tobacco use and available cessation resources to allied health professionals providing medical nutrition therapy in hospitals, clinics, FQHCs and community-based organizations

**Environmental Change** Interventions that involve material or structural changes to economic, social, or physical settings. *Examples of this type of change that could be included in the workplan:*

- Promote smoke-free public places
    - Distribute "no smoking allowed" signs to business owners, multi-unit housing properties, and organizations, particularly in wards with highest smoking rates
    - Recognize businesses that are compliant with smoke-free laws
- Implement environmental changes in retail food venues to reduce the impact of tobacco marketing.
    - Implement interventions that feature healthier food choices at point-of-sale
    - Provide posters, brochures, and other print collateral that promotes DCQuitNow to retailers
- Implement interventions to increase targeted advertising of fruits and vegetables in online grocery shopping portals. Reduce the impact of predatory tobacco advertising in the community with an emphasis on WIC- and SNAP-authorized retailers by expanding health-related messaging in the community

## 4.4 Program Outcomes and Strategies

The Grantee shall implement a targeted community-led approach engaging the priority population that seeks to build relationships and leverage resources among organizations providing access to food and/or addressing other social needs in the community. The applicant shall seek to integrate tobacco control initiatives with established programs that address food insecurity. The applicant shall engage the community to break down barriers to access tobacco cessation resources.

All strategies for the selected components are required and should build the foundation for sustainable interventions that can be shared, duplicated, and/or expanded with minimal resources beyond the life of the grant. The strategies are designed to reduce tobacco use prevalence (smoking cigarettes every day or most days) as indicated:

| | 2020 Baseline* | 2025 Target |
|---|---|---|
| Black/African American Adults | 18% | 13% |
| All Adults | 11.7% | |

*Data: Behavioral Risk Surveillance System, 2022*

**3-YEAR PROGRAM STRATEGIES (*with Option for 4th Year*)**

The applicant shall propose activities to support the following strategies as aligned with anticipated outcomes of the project.

- Increased multi-sector partnerships to implement PSE change activities supporting tobacco control and food access efforts
- Increased engagement of community stakeholders in tobacco control and food access efforts
- Increased links to cessation and food access resources shared among service and community organizations, healthcare systems, and businesses

While the applicant will have latitude in developing activities to support these strategies, there are foundational activities, listed below, that must be included in the project. Throughout the entire project period, the awardee will have access to guidance and technical assistance from DC Tobacco Control Programs (TCP). Funding for option year 4 will be granted contingent upon funding availability and program success.

**Program Year 1 (October 2022 – September 2023)**
During Year 1, the selected organization shall complete the following foundational activities:

- Attend a project orientation with DC Health TCP
- **Workgroup**: Recruit and convene a workgroup of diverse stakeholders operating within the DC Tobacco Free Coalition that shall actively engage in the development, promotion, and implementation of activities related to this grant.
    - The workgroup shall serve as an interface with the broader community and serve as subject matter experts on working within the priority population, addressing social determinants of health, emphasizing food insecurity, and identifying and implementing evidence-based public health initiatives.
    - The workgroup should include stakeholders such as:
        - Organizations and agencies addressing food insecurity
        - Community leadership such as Advisory Neighborhood Commissioners (ANCs)
        - Community Centers
        - DC Cancer Coalition
        - Local businesses (including grocery and corner stores)
        - Multi-disciplinary and diverse organizations (e.g., healthcare systems, faith-based organizations, fraternities and sororities, and social organizations, including those addressing food insecurity and other social determinants of health)
        - Government agencies including Department of Human Services and Department of Consumer and Regulatory Affairs
- Ensure organization staff and workgroup members complete the *Action for Policy Systems, and Environmental (PSE) Change: A Training*, available online at no cost through GW Cancer Center

- Analyze results from the DC Community Health Needs Assessment, DC Health Equity Report, Behavioral Risk Factor Surveillance System (BRFSS), DC Healthy People 2020 and United States (US) Census Data to inform development of culturally appropriate policy, systems, and environmental change (PSEC) strategies and activities
- Conduct an environmental scan to identify legislative and systems policies influencing tobacco use, currently available resources to address tobacco use and food insecurity, and the barriers to accessing them
- Identify tobacco cessation and food access resources that are content-specific and socio-culturally appropriate to share with/promote to community stakeholders
- Provide training opportunities to the workgroup and community stakeholders on evidence-based interventions and best practices in tobacco control, PSE change, and the intersection of social determinants of health and tobacco use to project partners and community stakeholders
- Collaborate with DC Health Tobacco Control Programs and the DC Tobacco Free Coalition community disparities workgroup to develop:
    - A memorandum of agreement (MOA) between the applicant and the DC Tobacco Free Coalition and between the applicant and workgroup members setting parameters of engagement and participation
    - Detailed work plans aligned with the District of Columbia Tobacco Control Strategic Plan featuring culturally appropriate policy, systems, and environmental (PSE) change strategies and activities which seek to improve health equity in tobacco use, including integration of tobacco control in programs addressing food insecurity
- Partner or collaborate Networking2Save and the African American Tobacco Control Leadership Council for technical assistance and resources
    - Center for Black Health and Equity
    - National LGBT Tobacco-Related Cancer Network
    - SelfMade Health Network

**Program Years 1-3** *(and through option Year 4, if implemented)*
For each project year, the applicant will:

- Conduct trainings and professional development opportunities for staff, the project work group, and community partners on topics related to implicit bias; cultural competency and humility; diversity, equity, and inclusion; and data collection on social determinants of health.

  *Training modules must have DC Health approval. The applicant may budget up to 10% of the total budget (including indirect cost) for trainings offered virtually or in-person. The applicant is encouraged to explore low- or no-cost trainings such as those offered through CDC's Networking2Save.*

- Submit a minimum of one success story that conveys:

    - The impact of stakeholder engagement in strategic planning and program development (*Year 1*)
    - The program's impact in the community to reduce disparities in tobacco use and tobacco-related morbidity and mortality *(Years 2-4)*
- Designate point-of-contact and participate in monthly and ad-hoc meetings with the TCP Project Officer
- Submit monthly and annual reports

**Program Year 2-3 (October 2023 – September 2025)**
The applicant in collaboration with TCP will:

- Implement and adjust as needed the strategies and activities detailed in the work plan
- Identify resources that are content-specific and socio-culturally appropriate
- Provide training opportunities on evidence-based interventions and best practices in tobacco control, PSE change, and the intersection of social determinants of health and tobacco use to project partners and community stakeholders
- Conduct a program evaluation to assess progress and identify barriers to success and propose mitigating actions
- Develop a sustainability plan that ensures continuous improvement to target population health beyond the life of the grant *(to be completed by the end of Year 3)*

**Program Year 3 (October 2024 – September 2025)**
The applicant will:

- Monitor sustainability of interventions to continue beyond the grant cycle
- Collect and analyze program and public health data (BRFSS, ATS – provided by TCP)
- Conduct a program evaluation and develop a best practices toolkit and final report of lessons learned to be disseminated to stakeholders

**Optional Program Year 4 (October 2025 – September 2026)**
The applicant will:

- Continue to monitor sustainability of interventions beyond the initial grant cycle
- Engage other organizations to incorporate tobacco control initiatives in their core programming

## 4.5 Resources for Applicants

The resources listed below will assist you in developing your proposals and aligning your strategies and approaches to the outcomes within this RFA.

American Lung Association & African American Tobacco Leadership Council. *Addressing Tobacco Use in Black Communities Toolkit*. https://www.lung.org/getmedia/a13f1949-8d58-4e99-bed0-f28bcd18acfc/addressing-tobacco-use-in-black-comm-toolkit.pdf

The African American Tobacco Control Leadership Council: www.savingsblacklives.org

Behavioral Risk Factor Surveillance System (BRFSS): https://www.cdc.gov/brfss/brfssprevalence/index.html

Centers for Disease Control and Prevention. *CDC Best Practices Cessation in Tobacco Prevention and Control*. https://www.cdc.gov/tobacco/stateandcommunity/best-practices-cessation/pdfs/best-practices-cessation-user-guide-508c.pdf

CDC *Tips From Former Smokers*®: https://www.cdc.gov/tobacco/campaign/tips/index.html

Center for Black Health & Equity: https://centerforblackhealth.org

The Center for Black Health and Equity. *Health Justice Training Guide*. https://centerforblackhealth.org/healthjusticeguide/

Children's Health Watch. The Hunger Vital Sign™. https://childrenshealthwatch.org/public-policy/hunger-vital-sign/

DC Community Needs Assessment: https://ourhealthydc.org/dc-chna/

DC Health. (2018) *DC Health Equity Report.* Government of the District of Columbia. https://app.box.com/s/yspij8v81cxqyebl7gj3uifjumb7ufsw

DC Healthy. Health People 2020. Government of the District of Columbia https://dchealth.dc.gov/page/dc-healthy-people-2020

GW School of Medicine & Health Sciences. (2022). *Action for Policy, Systems and Environmental (PSE) Change: A Training*. George Washington University. https://cme.smhs.gwu.edu/gw-cancer-center-/content/action-policy-systems-and-environmental-pse-change-training#group-tabs-node-course-default1

GW School of Medicine & Health Sciences. (2021). *Seven Steps for Policy, Systems and Environmental Change: Worksheets for Action*. George Washington University. https://cancercontroltap.smhs.gwu.edu/news/seven-steps-policy-systems-and-environmental-change-worksheets-action

Office of Disease Prevention and Health Promotion. *Healthy People 2030*. U.S. Department of Health and Human Services. https://health.gov/healthypeople

National LGBT Tobacco-Related Cancer Network: https://cancer-network.org/

Networking2Save: https://www.cdc.gov/tobacco/stateandcommunity/tobacco_control_programs/coop-agreement/index.html

Policy, Systems, and Environmental Change Resource Guide: https://smhs.gwu.edu/cancercontroltap/sites/cancercontroltap/files/PSE_Resource_Guide_FINAL_05.15.15.pdf

SelfMade Health Network: https://selfmadehealth.org/

SNAP-Ed Toolkit: snapedtoolkit.org

United States (US) Census Data: https://www.census.gov/data.html

# 5. APPLICATION REQUIREMENTS

## 5.1 Eligibility Documents

### Certificate of Clean Hands

This document is issued by the Office of Tax and Revenue and must be dated within 60 days of the application deadline.

### Current Business License

A business license issued by the Department of Consumer and Regulatory Affairs or certificate of licensure or proof to transact business in local jurisdiction.

### Current Certificate of Insurance

This document must be issued by your insurance company. All DC Health grantees must meet the minimum insurance requirements as outlined in Appendix A: Minimum Insurance Requirements. Should an applicant be awarded the grant, the Office of Risk Management will conduct a review of exposures of the grantee organization based off the final approved workplan and may make changes to the insurance requirements.

### Copy of Cyber Liability Policy

This document must be issued by your insurance company. All DC Health grantees must meet the minimum insurance requirements as outlined in Appendix A: Minimum Insurance Requirements. Should an applicant be awarded the grant, the Office of Risk Management will conduct a review of exposures of the grantee organization based off the final approved workplan and may make changes to the insurance requirements.

### IRS Tax-Exempt Determination Letter

This applies to nonprofits only.

### IRS 990 Form

This must be from the most recent tax year. This applies to nonprofits only.

### Current List of Board of Directors, on letterhead, signed and dated by a certified official from the Board.

This CANNOT be signed by the executive director.

### Assurances, Certifications and Disclosures

This document must be signed by an authorized representative of the applicant organization. (Attachment 1).

Note: Failure to submit **ALL** the above attachments will result in a rejection of the application from the review process. The application will not qualify for review.

## 5.2 Proposal Components

### Project Abstract

A one-page project abstract is required. Please provide a one-page abstract that is clear, accurate, concise, and without reference to other parts of the Project Narrative. The project abstract must be **single-spaced, limited to one page in length**, and include the following sections:

- **Overview:** Provide a three-to-five-sentence description of your project that identifies the population and/or community needs that are addressed.
- **Problem:** Describe the principal needs and problems addressed by the project.
- **Purpose:** State the purpose of the project.
- **Goal(s) And Objectives:** Identify the major goal(s) and objectives for the project. Typically, the goal(s) are stated in a sentence, and the objectives are presented in a numbered list.
- **Methodology:** Briefly list the major activities used to attain the goal(s) and objectives

### Project Narrative (10-page maximum)

The narrative section should describe the applicant's approach of relevant background information that includes the context of the problem.

The narrative should include the following sections:

#### *Overview*

This section should briefly describe the purpose of the proposed project and how the application aligns with the RFA. It should also summarize the overarching problem to be addressed and the contributing factors. Applicant must clearly identify the goal(s) of this project.

#### *Project or population need*

Applicants should provide an overview of their constituent population as relevant to the project including rates of smoking, race, age, and residence (ward and/or zip code) and corresponding social determinants of health. Applicants should be able to demonstrate the ability to reach the priority population and how they will be served through this project.

#### *Project Description*

Applicants must demonstrate how their proposed strategies and activities will increase tobacco use quit attempts and improve food security in under-resourced communities through a health equity lens and reduce barriers undermining access to resources, social support, and opportunities to pursue optimal health. This section should provide a clear and concise description of strategies and activities described in the Program Outcomes and Strategies section that the applicant will use to achieve the project outcomes and should detail how the program will be implemented.

- Describe how the activities will reach the priority population detailed in the RFA
- Describe activities for each strategy, how they will be implemented, and how they will be operationalized to achieve program goals, objectives, and outcomes
- Describe how the proposed project meets the requirements in the Scope of Work section (please see Performance Requirements Section for more details)
- Indicate plans for sustainability of the initiative beyond the projected funding period

***PERFORMANCE MONITORING***

Applicants should provide a brief description of how project goals will be assessed and monitored during implementation. Applicants should describe how key performance measures will be collected and used to assess project outcomes. At a minimum, this shall describe:

- The applicant's experience and capacity to engage community partners and stakeholders
- How applicant will measure community engagement and its impact
- How applicant will ensure activities reduce social acceptance and use of tobacco products in the African American population
- How activities will be monitored and adapted to improve program success

***ORGANIZATIONAL CAPACITY***

This section should provide an overview of the organizational infrastructure, mission, and vision. Applicants should demonstrate capacity and infrastructure to implement evidence-based or promising practices to reduce health disparities in Blacks/African Americans by addressing tobacco dependence through PSE change. The applicant should demonstrate their previous success addressing social determinants of health (food security, healthcare access, housing, employment, transportation, active living, or public safety) by reducing barriers to resources through a community-centered approach. The applicant should describe the scope of current community engagement and empowerment activities and demonstrate staff capacity to conduct activities as required by this RFA. Applicants should demonstrate ability to meet performance requirements, collect data, follow project deadlines for deliverables, and provide accurate reporting. Lastly, applicants should affirm organizational leadership commitment to complete the project as proposed in the work plan.

## WORK PLAN

The Work Plan is required (Attachment 2). The work plan describes key process objectives and goals for successful program implementation. Under each objective, provide a list of the activities that will be used to achieve each of the objectives proposed and anticipated deliverables. A workplan should be provided for Year 1 (October 2022 – September 2023).

- The work plan should include a chronological list and description of activities to be performed. Each activity should have an identified responsible staff, target completion dates and projected outcomes.
- The work plan should include process objectives and measures. Objectives should be SMART (Specific, Measurable, Achievable, Relevant, and Time-Framed).

The work plan should include process objectives and measures. Objectives should be SMART. The attributes of a SMART objective are as follows:

- Specific: includes the "who," "what," and "where." Use only one action verb to avoid issues with measuring success.
- Measurable: focuses on "how much" change is expected.
- Achievable: realistic given program resources and planned implementation.
- Relevant: relates directly to program/activity goals.
- Time-bound: focuses on "when" the objective will be achieved.

Objectives are different from listing program activities. Objectives are statements that describe the results to be achieved and help monitor progress towards program goals. Activities are the actual events that take place as part of the program

## BUDGET TABLE

The application should include a project budget worksheet using the excel spreadsheet in District Grants Clearinghouse as noted in form provided (Attachment 3). The project budget and budget justification should be directly aligned with the work plan and project description. All expenses should relate directly to achieving the key grant outcomes. Budget should reflect the budget period, as outlined below (Key Budget Requirements).

**Note:** Enterprise Grants Management System (EGMS) will require additional entry of budget line items and details. This entry does not replace the required upload of a budget narrative using the required templates.

### *Key Budget Requirements*

The budget should reflect a 12-month period, as follows:

- October 1, 2022 – September 30, 2023

Costs charged to the award must be reasonable, allowable, and allocable under this program. Documentation must be maintained to support all grant expenditures. Personnel charges must be based on actual, not budgeted labor. Salaries and other expenditures charged to the grant must be for services that occurred during the grant's period of availability.

## BUDGET JUSTIFICATION

The application should include a budget justification (Attachment 4). The budget justification is a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget justification MUST be concise. Do NOT use the justification to expand the proposed project narrative.

Include the following in the budget justification narrative:

***Personnel Costs:*** List each staff member to be supported by (1) funds, the percent of effort each staff member spends on this project, and (2) in-kind contributions. If personnel costs are

supported by in-kind contributions, please indicate the source of funds. Please include the full name of each staff member, or indicate a vacancy, position title, percentage of full-time equivalency dedicated to this project, and annual salary. Personnel includes, at a minimum, the program director responsible for the oversight and day-to-day management of the proposed program, staff responsible for service delivery and/or coordination, staff responsible for monitoring programmatic activities and use of funds, and staff responsible for data collection, quality, and reporting. **This list must include the Project Director on the Notice of Award.**

***Fringe Benefits:*** Fringe benefits change yearly and should be confirmed before submitting your budget. List all components that make up the fringe benefits rate.

***Consultants/Contracts/Subgrantees:*** Applicants must ensure that their organization or institution has in place and follows an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts and grants. Applicants must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. For each consultant, specify the scope of work for the consultant, the hourly rate, and the number of hours of expected effort. Applicants must have a written plan in place for subrecipient monitoring and must actively monitor subrecipients.

***Travel:*** The budget should reflect the travel expenses associated with implementation of the program and other proposed trainings or workshops, with breakdown of expenses, e.g., airfare, hotel, per diem, and mileage reimbursement.

***Supplies:*** Office supplies, educational supplies (handouts, pamphlets, posters, etc.), personal protective equipment (PPE).

***Equipment:*** Include the projected costs of project-specific equipment. Provide itemized costs, specifications, quantity, unit, unit cost, and basis for cost estimate (actual cost or price quotation).

***Communication:*** Cost estimates for any communications and dissemination activities included in the work plan should be covered in the budget.

***Other Direct Costs:*** Other direct costs category contains items not included in the previous categories. Give justification for all the items in the "other" category (e.g., separate justification for printing, publication costs for presentations/posters, telephone, postage, software programs, computers, etc.). All costs associated with training activities should be placed in the "other direct cost" category except costs for consultant and/or contractual.

## ORGANIZATIONAL CHART

A one-page organizational chart is required *(no template provided)*.

## STAFFING PLAN

The applicant's staffing plan must be submitted *(no template provided)*. The staffing plan should describe staff qualifications and include type and number of FTEs. Staff CVs, resumes, and position descriptions may also be submitted but are not required.

### LETTER(S) OF SUPPORT

Applicant should provide a minimum of two (2) letters of support from other agencies and organizations who will partner on of the proposed project *(no template provided)*. One letter of support must be from an organization currently addressing food insecurity or from an organization currently addressing a social determinant of health (for applicants actively addressing food insecurity).

# 6. EVALUATION CRITERIA

Indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. The four review criteria are outlined below with specific detail and scoring points. These criteria are the basis upon which the reviewers will evaluate the application. The entire proposal will be considered during objective review:

## CRITERION 1: HEALTH AND RACIAL EQUITY

**(15 POINTS) –** Corresponds to Sections: *Background, Purpose, and Project Description*

The extent to which the applicant:

- Understands how social determinants of health (specifically food access) and systemic barriers relate to the prevalence of tobacco use and limit the priority population's ability to access resources that support a healthy lifestyle (5 points)
- Demonstrates a strong understanding of food access organizations and resources in the District (5 points)
- Demonstrates an understanding of underlying causes of tobacco use and food insecurity and their relationship as well as an understanding of the potential barriers, challenges, and opportunities to address the problem (5 points)

## CRITERION 2: CAPACITY

**(25 POINTS) –** Corresponds to Sections: *Organizational Capacity, Staffing Plan, and Partnerships*

The extent to which the applicant:

- Describes an organizational infrastructure to support the implementation of the proposed strategies (5 points)
- Demonstrates proven experience in building capacity and mobilizing communities through policy, systems, and environment change approaches/strategiesExplains how the applicant currently serves the priority population – Black/African American residents – or other vulnerable populations described in this RFA – by working to address at least one social determinant of health (food security, socioeconomic status, active living, access to healthcare, employment opportunities, safe housing, or safe communities) (10 points)

- Demonstrates experience and past successes working collaboratively with government agencies, community-based organizations, and ancillary community groups to implement initiatives to advance a public health goal and/or address a social determinant of health (5 points)
- Organizational personnel have demonstrated qualifications (training and experience) in planning, implementing, and evaluating large scale public health interventions to address tobacco use and food access (5 points)

## CRITERION 3: IMPLEMENTATION FRAMEWORK

**(35 POINTS) –** Corresponds to Sections: *Project Descriptions and Workplan*

The extent to which the applicant:

- Describes evidence-informed and/or best practice approaches that engage and mobilize the community to address social acceptability and use of tobacco within target population (7 points)
- Demonstrates that the proposed plan provides a foundation for sustainability of efforts beyond the projected funding period (7 points)
- Provides a clear description of proposed project objectives and activities that are tied to one or more PSE change strategies (7 points)
- Describes how proposed strategies will lead to improved outcomes in tobacco use and cessation (7 points)
- Provides a detailed program narrative on activities and current or new partnerships (if any) that will be engaged to meeting program goals (7 points)

## CRITERION 4: EVALUATION

**(25 POINTS)** – Corresponds to Sections: *Evaluation*

The extent to which the applicant:

- Identifies measurable indicators to monitor the project's success (4 points)
- Describes how the project will be monitored to ensure reach and engagement of the priority population (4 points)
- Describes processes to collect qualitative and quantitative data related to project goals (4 points)
- Identifies skilled staff to analyze data aligned to the project's goals (4 points)
- Specifies a process to monitor progress and adapt strategies and objectives to improve outcomes (4 points)
- Describes how the priority population will be engaged in evaluation of the project (5 points)

## CRITERION 5: SUPPORT REQUESTED

**(NOT SCORED)** - Corresponds to Sections: *Budget and Budget Justification Narrative*

The extent to which the applicant:

- Proposes a budget for the project period that is reasonable in relation to the objectives, the complexity of the activities, and the anticipated results
- Outlines costs in the budget and required resources sections appear reasonable given the scope of work
- Ensure key personnel will have adequate time devoted to the project to achieve project objectives

# 7. REVIEW AND SCORING OF APPLICATION

## 7.1 Eligibility and Completeness Review

All applications will be reviewed initially for completeness, formatting and eligibility requirements by DC Health personnel prior to being forwarded to the external review panel. **Incomplete applications and applications that do not meet the eligibility criteria will not advance to the external review**. Applicants will be notified that their applications did not meet eligibility.

## 7.2 External Review

The review panel will be composed of neutral, qualified, professional individuals who have been selected for their unique experiences in public health program planning and implementation, health communications planning and evaluation, and social services planning and implementation. The panel will review, score and rank each applicant's proposal based on the criteria outlined in the RFA. Individual panel members are required to provide a summary of strengths and weaknesses found in the application.

## 7.3 Internal Review

DC Health program managers will review the individual and summary recommendations of the external review panel and make recommendations for awards. Program Managers will weigh the results of the review panel against other internal and external factors in making the final funding determinations. DC Health will also conduct an excluded parties list search (EPLS) of the organization and executives via the federal System for Award Management (SAM).

In this phase of the review process, DC Health reserves the right to request clarifying supplemental information from applicants and request on-site pre-decisional reviews for those applicants being considered for award. Any request for supplemental information or on-site visits is not a commitment by DC Health to fund the applicant.

The internal review panel prepares and submits a formal recommendation of prospective awardees, funding levels and service/activities to the DC Health Director for signature. The DC Health Office of Grants Management is responsible for certifying that all District rules and standards were followed for the RFA process.

# 8. POST AWARD ASSURANCES & CERTIFICATIONS

Should DC Health move forward with an award, additional assurances may be requested in the post award phase. These documents include:

- Certification Regarding Lobbying; Debarment, Suspension and Other Responsibility Matters; and Drug-Free Workplace Requirements
- Certification of current/active Articles of Incorporation from DCRA.
- Certificate of Occupancy
- Most Recent Audit and Financial Statements

Failure to submit the required assurance package will likely make the applicant ineligible to receive a Notice of Grant Award.

# 9. APPLICATION SUBMISSION

In order to submit an application under this funding opportunity, the applicant organization must register in EGMS and establish an account for the authorized representative.

If the applicant organization has an account already, please ensure that the Primary Account User is authorized to submit an application on behalf of the organization and his/her account is active. Currently, Secondary Account Users **do not** have submission privileges but can work in EGMS to prepare (e.g., upload documents, complete forms) the application.

IMPORTANT: When the Primary Account User is submitting an application, ensure that there are no other transactions on another device being attempted in EGMS under that Primary Account User's credentials. For security purposes, the system will only acknowledge one transaction and one of the transaction attempts may fail, if done simultaneously.

## 9.1 REGISTER IN EGMS

DC Health recommends that applicants create an EGMS account, establishing a Primary Account User as the authorized representative **at least two weeks** prior to the application submission deadline. There is no guarantee that the authorized representative would have an approved account if the registration process does not begin at least **two weeks** prior to the deadline. Deadline-day registrations will not be approved by the Office of Grants Management in time for submission. To register, complete the following:

1. **Access EGMS**: The user must access the login page by entering the following URL: https://dcdoh.force.com/GO ApplicantLogin2. Click the button REGISTER and following the instructions. You can also refer to the EGMS External User Guide.
2. Determine the agency's Primary User (i.e. authorized to accept terms of agreement, certify and submit documents, request and accept modifications). The Primary User will determine a Secondary User and send a notification via EGMS for him/her to set-up an account.
3. Your EGMS registration will require your legal organization name, your **DUNS#, UEI# and Tax ID#** in order to complete the registration. Your EGMS registration will also require your SAM (System for Award Management) expiration date to be entered into your agency profile. Please ensure that you have an active SAM registration (www.sam.gov).
4. When your Primary Account User request is submitted in EGMS, the Office of Grants Management will review the request. If the requester is NOT the identified Executive Director, DC Health Office of Grants Management will make an additional request for the Executive Director to send an email to DC Health to confirm that the requester is the authorized representative for EGMS. When requested, your authorized representative should send to doh.grants@dc.gov the name, title, telephone number and email address of the desired Primary User for the account. Note: The email will help to support the validation of authorized users for EGMS. DC Health official grant records will also be used. Please reply ASAP to any requests from Office of Grants Management to provide additional information, if needed.

**EGMS User Registration Assistance:**

Office of Grants Management at doh.grants@dc.gov assists with all end-user registration if you have a question or need assistance. Primary Points of Contact: Jennifer Prats and Clara McLaughlin (202) 442-9237. Here are the most common registration issues:

- Validation of the authorized primary account user
- Tax ID or expired SAM registration
- Web browser

## 9.2 Uploading the Application

All required application documents must be uploaded and submitted in EGMS. Required documents are detailed below. All of these must be aligned with what has been requested in other sections of the RFA.

- ***Eligibility Documents***
    - Certificate of Clean Hands dated within 60 days of the application deadline
    - Current business license or certificate of licensure or proof to transact business in local jurisdiction
    - Current Certificate of Insurance
    - Copy of Cyber Liability Policy

- IRS Tax-Exempt Determination Letter (for nonprofits only)
- IRS 990 Form from most recent tax year (for nonprofits only)
- Current list of Board of Directors, on letterhead, signed and dated by a certified official from the Board (this cannot be the Executive Director)
- Assurances Certifications Disclosures

- ***Proposal Documents***
  - Proposal Abstract
  - Project Narrative (10-page maximum)
  - Organizational Chart
  - Staffing Plan
  - Work Plan
  - Budget Justification
  - Budget Table
  - Letters of Support

### 9.3 DEADLINE

Submit your application via EGMS by 6:00 p.m., on the deadline date of August 10, 2022. Applications will **not** be accepted after the deadline.

# 10. PRE-APPLICATION MEETING

Please visit the Office of Grants Management Eventbrite page to learn the date/time and to register for the event.

The meeting will provide an overview of the RFA requirements and address specific issues and concerns about the RFA. Applicants are not required to attend but it is highly recommended. ***Registration is required***.

RFA updates will also be posted on the District Grants Clearinghouse.

Note that questions will only be accepted in writing. Answers to all questions submitted will be published on a Frequently Asked Questions (FAQ) document onto the District Grants Clearinghouse every three business days.

# 11. GRANTEE REQUIREMENTS

If the applicant is considered for funding based on the results of the completion and receives a Notice of Intent to Fund and subsequently accepts grants award, the following requirements are in effect:

## 11.1 Grant Terms & Conditions

All grants awarded under this program shall be subject to the DC Health Standard Terms and Conditions. The Terms and Conditions are embedded within EGMS, where upon award, the applicant organization can accept the terms.

## 11.2 Grant Uses

The grant awarded under this RFA shall be used exclusively to pay costs associated with the implementation of the grant. Payment requests will be monitored by DC Health to ensure compliance with the approved budget and work plan.

## 11.3 Conditions of Award

As a condition of award, a successful applicant who is issued a Notice of Grant Award (NOGA) will be required to:

1. Revise and resubmit a work plan and budget with justification in accordance with the approved scope of work and assignments prescribed by a DC Health Notice of Intent to Fund and any pre-award negotiations with assigned DC Health project and grants management personnel.
2. Meet pre-award requirements, including submission and approval of required assurances and certification documents, documentation of non-disbarment or suspension (current or pending) of eligibility to receive local or federal funds.
3. Adhere to mutually agreed upon terms and conditions of a grant agreement and Notice of Grant Award issued by the Department of Health and accepted by the grantee organization. The NOGA shall outline the scope of work, standards, reporting requirements, fund distribution terms and any special provisions required by federal agreements.
4. Utilize performance monitoring and reporting tools developed and approved by DC Health.

## 11.4 Indirect Cost

Indirect costs are costs that are not readily identifiable with a particular project or activity but are required for operating the organization and conducting the grant-related activities it performs. Indirect costs encompass expenditures for operation and maintenance of building and equipment, depreciation, administrative salaries, general telephone services and general travel and supplies. Grant awardees will be allowed to budget for indirect costs of no more than ten percent (10%) of total direct costs.

## 11.5 Insurance

All applicants that receive awards under this RFA must show proof of all insurance coverage required by law prior to receiving funds.

DC Health reserves the right to request certificates of liability and liability policies pre-award and post-award and make adjustments to coverage limits for programs per requirements promulgated by the District of Columbia Office of Risk Management.

## 11.6 COVID-19 Grantee Requirement

All applicants that receive awards under this RFA are required to ensure that their employees, agents, and subgrantees ("grantee personnel") are in compliance with Mayor's Order 2021-099, available at: https://coronavirus.dc.gov/page/mayor%E2%80%99s-order-2021-099-covid-19-vaccination-certification-requirement-district-government. Frequently asked questions about the vaccine certification requirement are made available online, here.

To ensure compliance with this item, grantees shall upload a signed attestation from an authorized representative from your organization into the organization profile in EGMS before the Notice of Grant Award is released. A template for an attestation form and step-by-step guide on how to upload the document into EGMS will be provided.

## 11.7 Audits

At any time or times before final payment and three (3) years thereafter, the District may have the applicant's expenditure statements and source documentation audited. Grantees subject to 2 CFR 200, subpart F rules must have available and submit as requested the most recent audit reports, as requested by DC Health personnel.

## 11.8 Nondiscrimination in the Delivery of Services

In accordance with Title VI of the Civil Rights Act of 1964 (Public Law 88-352), as amended, no person shall, on the grounds of race, color, religion, nationality, sex, or political opinion, be denied the benefits of, or be subjected to discrimination under, any program activity receiving funds under this RFA.

## 11.9 Quality Assurance

DC Health will utilize a risk-based management and monitoring assessment to establish a monitoring plan for the grantee. Grantees will submit interim and final reports on progress, successes, and barriers.

Funding is contingent upon the Grantee's compliance with terms of the agreement and progress in meeting milestones and targets outlined in the approved work plan and evaluation plan. All programs shall be monitored and assessed by assigned project and grants management personnel. The Grantee will receive a performance rating and subject to review at any time during the budget period.

A final performance rating shall be completed by DC Health and provided and held for record and use by DC Health in making additional funding or future funding available to the applicant.

All performance reports are subject to review and oversight by the DC Health Office of Grants Management.

# 12. GLOSSARY OF TERMS

**Adult Tobacco Survey** – Created to assess the prevalence of tobacco use, as well as the factors promoting and impeding tobacco use among adults. The National Adult Tobacco Survey also establishes a comprehensive framework for evaluating both the national and state-specific tobacco control programs. The survey questionnaire is built around key outcome indicators from each of the following four goal areas: (1) Preventing initiation of tobacco use among young people; (2) Eliminating nonsmokers' exposure to secondhand smoke; (3) Promoting quitting among adults and young people, and (4) Identifying and eliminating tobacco-related disparities.

Centers for Disease Control and Prevention (2018, December 18). National Adult Tobacco Survey (NATS). *U. S. Department of Health and Human Services, Centers for Disease Control and Prevention*. https://www.cdc.gov/tobacco/data_statistics/surveys/nats/index.htm#:~:text=The%20National%20Adult%20Tobacco%20Survey,state%2Dspecific%20tobacco%20control%20programs.

**Behavioral Risk Factor Surveillance System** – BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions and use of preventive services. BRFSS collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest conducted health survey system in the world.

Centers for Disease Control and Prevention (2018, January 2). Behavioral Risk Factor Surveillance System Frequently Asked Questions (FAQs). *U.S. Department of Health and Human Services, Centers for Disease Control and Prevention*. https://www.cdc.gov/brfss/about/brfss_faq.htm.

**Health Disparity** – A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identify; geographic location; or other characteristics historically linked to discrimination or exclusion.

Office of Disease Prevention and Health Promotion. Disparities. *U. S. Health and Human Services, Centers for Disease Control and Prevention, Office of Disease Prevention and Health Promotion*. Reviewed on June 29, 2021 at https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

**Health Equity** – The state in which everyone has the opportunity to attain their full health potential without barriers due to social determinants of health. No person is "disadvantaged from achieving this potential because of social position or other social determined circumstances

Centers for Disease Control and Prevention. (2022, March 3). Health equity. *U. S. Health and Human Services, Centers for Disease Control and Prevention*. Retrieved May 25, 2022, from https://www.cdc.gov/chronicdisease/healthequity/index.htm

**Policy, Systems and Environmental (PSE) Change** – Strategies that are designed to promote healthy behaviors by making healthy choices readily available and easily accessible in the community. *Policy* is a tool for achieving health promotion and disease prevention program goals. Policy decisions are made by organizations, agencies, and stakeholders.

Policy approaches include legislative advocacy, fiscal measures, taxation, and regulatory oversight. *Systems change* refers to a fundamental shift in the way problems are solved. With an organization, systems change affects organizational purpose, function, and connections by addressing organizational culture, beliefs, relationships, policies, and goals. *Environmental change* strategies involve changing the economic, social, or physical surroundings or contexts that affect health outcomes. Environmental strategies address population health outcomes and are best used in combination with other strategies.

Rural Health and Information Hub. *Policy, Systems, and Environmental Change*. Reviewed on June 29, 2021 at https://www.ruralhealthinfo.org/toolkits/health-promotion/2/strategies/policy-systems-environmental.

**SMART Goal/Objective** – a goal or objective that is specific, measurable, achievable, results-focused, and time- bound.

**Social Determinants of Health -** Social determinants of health are the conditions in which people are born, live, work, play and age that influence health. Social determinants of health include access to healthy foods, housing, economic and social relationships, transportation, education, employment, and access to health. The higher the quality of these resources and supports, and the more open the access for all community members, the more community outcomes will be tipped toward positive health outcomes.

Office of Disease Prevention and Health Promotion. Healthy People 2030. *U. S. Department of Health and Human Service, Centers for Disease Control and Prevention, Office of Disease Prevention and Health Promotion*. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

# 13. ATTACHMENTS AND APPENDIX

Attachment 1: Assurances and Certifications

Attachment 2: Work Plan

Attachment 3: Budget Table

Attachment 4: Budget Justification

Appendix A: Minimum Insurance Requirements

# APPENDIX A: MINIMUM INSURANCE REQUIREMENTS

INSURANCE

A. GENERAL REQUIREMENTS. The Grantee at its sole expense shall procure and maintain, during the entire period of performance under this contract, the types of insurance specified below. The Grantee shall have its insurance broker or insurance company submit a Certificate of Insurance to the PM giving evidence of the required coverage prior to commencing performance under this grant. In no event shall any work be performed until the required Certificates of Insurance signed by an authorized representative of the insurer(s) have been provided to, and accepted by, the PM. All insurance shall be written with financially responsible companies authorized to do business in the District of Columbia or in the jurisdiction where the work is to be performed and have an A.M. Best Company rating of A- / VII or higher. Should the Grantee decide to engage a subcontractor for segments of the work under this contract, then, prior to commencement of work by the subcontractor, the Grantee shall submit in writing the name and brief description of work to be performed by the subcontractor on the Subcontractors Insurance Requirement Template provided by the CA, to the Office of Risk Management (ORM). ORM will determine the insurance requirements applicable to the subgrantee and promptly deliver such requirements in writing to the Contractor and the CA. The Grantee must provide proof of the subcontractor's required insurance to prior to commencement of work by the subcontractor. If the Grantee decides to engage a subcontractor without requesting from ORM specific insurance requirements for the subcontractor, such subcontractor shall have the same insurance requirements as the Contractor.

   All required policies shall contain a waiver of subrogation provision in favor of the Government of the District of Columbia.

   The Government of the District of Columbia shall be included in all policies required hereunder to be maintained by the Grantee and its subcontractors (except for workers' compensation and professional liability insurance) as an additional insureds for claims against The Government of the District of Columbia relating to this grant, with the understanding that any affirmative obligation imposed upon the insured Grantee or its subcontractors (including without limitation the liability to pay premiums) shall be the sole obligation of the Grantee or its subcontractors, and not the additional insured. The additional insured status under the Grantee and its subcontractors' Commercial General Liability insurance policies shall be effected using the ISO Additional Insured Endorsement form CG 20 10 11 85 (or CG 20 10 07 04 **and** CG 20 37 07 04) or such other endorsement or combination of endorsements providing coverage at least as broad and approved by the PM in writing. All of the Grantee's and its subcontractors' liability policies (except for workers' compensation and professional liability insurance) shall be endorsed using ISO form CG 20 01 04 13 or its equivalent so as to indicate that such policies provide primary coverage (without any right of contribution by any other insurance, reinsurance or self-insurance, including any deductible or retention,

maintained by an Additional Insured) for all claims against the additional insured arising out of the performance of this Statement of Work by the Grantee or its subcontractors, or anyone for whom the Grantee or its subcontractors may be liable. These policies shall include a separation of insureds clause applicable to the additional insured.

If the Grantee and/or its subcontractors maintain broader coverage and/or higher limits than the minimums shown below, the District requires and shall be entitled to the broader coverage and/or the higher limits maintained by the Grantee and subcontractors.

1. Commercial General Liability Insurance ("CGL") - The Grantee shall provide evidence satisfactory to the PM with respect to the services performed that it carries a CGL policy, written on an occurrence (not claims-made) basis, on Insurance Services Office, Inc. ("ISO") form CG 00 01 04 13 (or another occurrence-based form with coverage at least as broad and approved by the PM in writing), covering liability for all ongoing and completed operations of the Contractor, including ongoing and completed operations under all subcontracts, and covering claims for bodily injury, including without limitation sickness, disease or death of any persons, injury to or destruction of property, including loss of use resulting therefrom, personal and advertising injury, and including coverage for liability arising out of an Insured Contract (including the tort liability of another assumed in a contract) and acts of terrorism (whether caused by a foreign or domestic source). Such coverage shall have limits of liability of not less than $1,000,000 each occurrence, a $2,000,000 general aggregate (including a per location or per project aggregate limit endorsement, if applicable) limit, a $1,000,000 personal and advertising injury limit, and a $2,000,000 products-completed operations aggregate limit including explosion, collapse and underground hazards.

2. Automobile Liability Insurance - The Grantee shall provide evidence satisfactory to the PM of commercial (business) automobile liability insurance written on ISO form CA 00 01 10 13 (or another form with coverage at least as broad and approved by the PM in writing) including coverage for all owned, hired, borrowed and non-owned vehicles and equipment used by the Contractor, with minimum per accident limits equal to the greater of (i) the limits set forth in the Contractor's commercial automobile liability policy or (ii) $1,000,000 per occurrence combined single limit for bodily injury and property damage.

3. Workers' Compensation Insurance - The Grantee shall provide evidence satisfactory to the PM of Workers' Compensation insurance in accordance with the statutory mandates of the District of Columbia or the jurisdiction in which the grant is performed.

   Employer's Liability Insurance - The Grantee shall provide evidence satisfactory to the PM of employer's liability insurance as follows: $500,000 per accident for injury; $500,000 per employee for disease; and $500,000 for policy disease limit.

All insurance required by this paragraph 3 shall include a waiver of subrogation endorsement for the benefit of Government of the District of Columbia.

4. Cyber Liability Insurance - The Grantee shall provide evidence satisfactory to the PM of Cyber Liability Insurance, with limits not less than $2,000,000 per occurrence or claim, $2,000,000 aggregate. Coverage shall be sufficiently broad to respond to the duties and obligations as is undertaken by Grantee in this agreement and shall include, but not limited to, claims involving infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion and network security. The policy shall provide coverage for breach response costs as well as regulatory fines and penalties as well as credit monitoring expenses with limits sufficient to respond to these obligations. This insurance requirement will be considered met if the general liability insurance includes an affirmative cyber endorsement for the required amounts and coverages.

5. Medical Professional Liability - The Grantee shall provide evidence satisfactory to the PM of a Medical Professional Liability policy with limits of not less than $1,000,000 each incident and $2,000,000 in the annual aggregate. The definition of insured shall include the Grantee and all Grantee's employees and agents. The policy shall be either (1) written on an occurrence basis or (2) written on a claims-made basis. If the coverage is on a claims-made basis, Contractor hereby agrees that prior to the expiration date of Contractor's current insurance coverage, Contractor shall purchase, at Contractors sole expense, either a replacement policy annually thereafter having a retroactive date no later than the effective date of this Contract or unlimited tail coverage in the above stated amounts for all claims arising out of this Contract.

6. Professional Liability Insurance (Errors & Omissions) - The Grantee shall provide Professional Liability Insurance (Errors and Omissions) to cover liability resulting from any error or omission in the performance of professional services under this Contract. The policy shall provide limits of $1,000,000 per claim or per occurrence for each wrongful act and $2,000,000 annual aggregate. The Grantee warrants that any applicable retroactive date precedes the date the Grantee first performed any professional services for the Government of the District of Columbia and that continuous coverage will be maintained or an extended reporting period will be exercised for a period of at least ten years after the completion of the professional services.

7. Sexual/Physical Abuse & Molestation - The Grantee shall provide evidence satisfactory to the PM with respect to the services performed that it carries $1,000,000 per occurrence limits; $2,000,000 aggregate of affirmative abuse and molestation liability coverage. Coverage should include physical abuse, such as sexual or other bodily harm and non-physical abuse, such as verbal, emotional or mental abuse; any actual, threatened or alleged act; errors, omission or misconduct.

This insurance requirement will be considered met if the general liability insurance includes an affirmative sexual abuse and molestation endorsement for the required amounts. So called "silent" coverage under a commercial general liability or professional liability policy will not be acceptable.

8. Commercial Umbrella or Excess Liability - The Grantee shall provide evidence satisfactory to the PM of commercial umbrella or excess liability insurance with minimum limits equal to the greater of (i) the limits set forth in the Grantee's umbrella or excess liability policy or (ii) $2,000,000 per occurrence and $2,000,000 in the annual aggregate, following the form and in excess of all liability policies. **All** liability coverages must be scheduled under the umbrella and/or excess policy. The insurance required under this paragraph shall be written in a form that annually reinstates all required limits. Coverage shall be primary to any insurance, self-insurance or reinsurance maintained by the District and the "other insurance" provision must be amended in accordance with this requirement and principles of vertical exhaustion.

B. PRIMARY AND NONCONTRIBUTORY INSURANCE
The insurance required herein shall be primary to and will not seek contribution from any other insurance, reinsurance or self-insurance including any deductible or retention, maintained by the Government of the District of Columbia.

C. DURATION. The Grantee shall carry all required insurance until all grant work is accepted by the District of Columbia and shall carry listed coverages for ten years for construction projects following final acceptance of the work performed under this contract and two years for non-construction related contracts.

D. LIABILITY. These are the required minimum insurance requirements established by the District of Columbia. However, the required minimum insurance requirements provided above will not in any way limit the contractor's liability under this contract.

E. CONTRACTOR'S PROPERTY. Contractor and subcontractors are solely responsible for any loss or damage to their personal property, including but not limited to tools and equipment, scaffolding and temporary structures, rented machinery, or owned and leased equipment. A waiver of subrogation shall apply in favor of the District of Columbia.

F. MEASURE OF PAYMENT. The District shall not make any separate measure or payment for the cost of insurance and bonds. The Grantee shall include all of the costs of insurance and bonds in the grant price.

G. NOTIFICATION. The Grantee shall ensure that all policies provide that the CO shall be given thirty (30) days prior written notice in the event of coverage and / or limit changes or if the policy is canceled prior to the expiration date shown on the certificate. The Grantee shall provide the PM with ten (10) days prior written notice in the event of non-payment of premium. The Grantee will also provide the PM with an updated Certificate of Insurance should its insurance coverages renew during the contract.

H. CERTIFICATES OF INSURANCE. The Grantee shall submit certificates of insurance giving evidence of the required coverage as specified in this section prior to commencing work. Certificates of insurance must reference the corresponding contract number. Evidence of insurance must be submitted to the: Enterprise Grants Management System.

The PM may request and the Grantee shall promptly deliver updated certificates of insurance, endorsements indicating the required coverages, and/or certified copies of the insurance policies. If the insurance initially obtained by the Grantee expires prior to completion of the contract, renewal certificates of insurance and additional insured and other endorsements shall be furnished to the CO prior to the date of expiration of all such initial insurance. For all coverage required to be maintained after completion, an additional certificate of insurance evidencing such coverage shall be submitted to the CO on an annual basis as the coverage is renewed (or replaced).

I. DISCLOSURE OF INFORMATION. The Grantee agrees that the District may disclose the name and contact information of its insurers to any third party which presents a claim against the District for any damages or claims resulting from or arising out of work performed by the Grantee, its agents, employees, servants or subcontractors in the performance of this contract.

J. CARRIER RATINGS. All Grantee's and its subcontractors' insurance required in connection with this contract shall be written by insurance companies with an A.M. Best Insurance Guide rating of at least A- VII (or the equivalent by any other rating agency) and licensed in the District.