DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

COMMUNITY HEALTH ADMINISTRATION (CHA)

REQUEST FOR APPLICATIONS

School Health Services Program
RFA#: CHA-SHSP-6.18.21

AMENDED 07.01.21

Submission Deadline: July 23, 2021 at 6:00 PM (Revised)

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 the Department of 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.

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH (DC HEALTH)

NOTICE OF FUNDING AVAILABILITY (NOFA)

COMMUNITY HEALTH ADMINISTRATION (CHA)

Request for Grant Applications (RFA) # CHA-SHSP-6.18.21

School Health Services Program

The District of Columbia, Department of Health (DC Health) is soliciting applications 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.

General Information:

Funding Opportunity Title:	School Health Services Program
Funding Opportunity Number:	FO-CHA-PG-00006-010
Program RFA ID#:	CHA-SHSP-6.18.21
Opportunity Category:	Competitive
DC Health Administrative Unit:	Community Health Administration
DC Health Bureau	Family Health
Program Contact:	Kafui Doe, EdD, MPH, CHES Child, Adolescent & School Health Division Chief Community Health Administration DC Department of Health 899 North Capitol Street, NE Washington, 3rd Floor Washington, DC 20002 shs.program@dc.gov
Program Description:	This funding opportunity seeks applications from qualified entities to manage and operate the District's School Health Services Program. Qualified applicants will coordinate and provide school health services for students in elementary and secondary public and public charter schools in the District of Columbia, which are schools that provide pre-Kindergarten to high school grade education or its equivalent, including adult education programs, STAY Opportunity Academy programs, and ungraded special needs schools. Grantees will provide services in one or more of the four components: 1) In-Person Health Suite Staffing & Direct Services; 2) On-Demand Telehealth Services; 3) Care Coordination & School Health Integrations Services; and 4) Training, Technical Assistance, and Support. The foundation for services will be based on the Whole School, Whole Community, Whole Child model and in accordance with the standards and guidelines of the National Association of School Nurses, American Academy of Pediatrics, Centers

	for Disease Control and Prevention and relevant Federal and District of Columbia laws and regulations.
Eligible Applicants	Not-for profit, public and private organizations, primary care clinics and FQHCs located and licensed to conduct business within the District of Columbia and experienced in providing and/or coordinating pediatric and adolescent health services in an academic setting.
Anticipated # of Awards:	Four (4) awards; one (1) in each category
Anticipated Amount Available:	$24,100,000
Floor Award Amount:	$550,000
Ceiling Award Amount:	$24,100,000

Funding Authorization

Authorization (Legislation)	Local
Associated CFDA#	N/A
Associated Federal Award ID#	N/A
Cost Sharing / Match Required?	No
RFA Release Date:	June 18, 2021
Pre-Application Meeting (Date)	June 30, 2021 10:00 a.m. Visit DC Health's Eventbrite page for pre-application conference information, https://OGMDCHealth.eventbrite.com.
Pre-Application Meeting (Time)	
Pre-Application Meeting (Location/ Conference Call Access)	
Letter of Intent	N/A
Application Deadline Date:	**July 23, 2021 (revised)**
Application Deadline Time:	6:00 PM
Links to Additional Information about this Funding Opportunity	Applicants can download a copy of the RFA from the DC Grants Clearinghouse website at https://communityaffairs.dc.gov/content/community-grant-program.

Notes:

1. DC Health reserves the right to issue addenda and/or amendments after 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#, be registered in the federal Systems for Award Management (SAM) and the DC Health Enterprise Grants Management System (EGMS).
5. Contact the program manager assigned to this funding opportunity for additional information.
6. Late submissions and incomplete applications will not be forwarded to the review panel.

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I. DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
RFA TERMS AND CONDITIONS

V.06.2021

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:

- Funding for a DC Health subaward is contingent on DC Health's receipt of funding (local or federal) to support the services and activities to be provided under this RFA.
- DC Health may suspend or terminate an RFA pursuant to its own grant making rule(s) or any applicable federal regulation or requirement.
- The RFA does not commit DC Health to make any award.
- Individual persons are not eligible to apply or receive funding under any DC Health RFA.
- DC Health reserves the right to accept or deny any or all applications if 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.
- DC Health reserves the right to issue addenda and/or amendments after 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).
- 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.
- DC Health may conduct pre-award on-site visits to verify information submitted in the application and to determine if the applicant's facilities are appropriate for the services intended.
- 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.
- 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.
- 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. This includes DC Health electronic grants management systems, for which the awardee will be required to register and maintain registration of the organization and all users.
- DC Health may enter negotiations with an applicant and adopt a firm funding amount or other revision of the applicant's proposal that may result from negotiations.
- 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 (i.e. the total number of years for which funding has been approved) 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.

- 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.
- 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 OMB Circulars 2 CFR 200 (effective December 26, 2014) and Department of Health and Services (HHS) published 45 CFR Part 75, and supersedes requirements for any funds received and distributed by DC Health under legacy OMB circulars A-102, A-133, 2 CFR 180, 2 CFR 225, 2 CFR 220, and 2 CFR 215; 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.
- 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://communityaffairs.dc.gov/content/community-grant-program (click on Information) or click here: City-Wide Grants Manual.

If your agency would like to obtain a copy of the **DC Health RFA Dispute Resolution Policy,** please contact the Office of Grants Management and Resource Development at doh.grants@dc.gov or call (202) 442- 9237. Your request for this document will not be shared with DOH program staff or reviewers. Copies will be attached with this RFA on the District Clearinghouse website.

II. 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 **two weeks** prior to the application deadline.

❑ The applicant has completed a DC Health Application for Funding via EGMS.

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

- DC Health Application for Funding (via EGMS)
- Application Proposal:
  - Executive Summary (1 page)
  - Experience Section
  - Organizational Capacity Section
  - Organizational Chart (1 page)
  - Staffing Plan
  - Implementation Plan
  - Logic Model (1 page)
- List of References
- Personnel Resumes
- Work Plan
- Evaluation Plan
- Budget and Budget Justification
- Assurances, Certifications and Certification Documents
- Other Attachments allowed or requested by the RFA (e.g. letters of support, Past Performance Review, etc.)

❑ Documents requiring signature have been signed by an agency head or AUTHORIZED Representative of the applicant organization.

❑ The Applicant needs a DUNS number to be awarded funds. Go to Dun and Bradstreet to apply for and obtain a DUNS number if needed.

❑ The Application Proposal is written on 8½ by 11-inch paper, 1.0 spaced, Arial or Times New Roman font using 12-point type *(10–point font for tables and figures)* with a minimum of one-inch margins. The total size of all uploaded files must conform to the page-length guidelines outlined in the RFA. The application must be submitted in PDF format with page numbers on each page. **Applications that do not conform to these requirements will not be forwarded to the review panel.**

❑ The application proposal format conforms to the "Application Elements" 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, logic model, and other attachments are complete and comply with the forms and format provided in the RFA.

❑ The appropriate attachments, including program descriptions, staff qualifications, individual resumes, licenses (if applicable), and other supporting documentation are enclosed.

❑ Submit your application via EGMS by **6:00 pm** on the deadline of **July 23. 2021 (revised).**

III. GENERAL INFORMATION

A. Key Dates

- Notice of Funding Announcement Date: June 4, 2021
- Request for Application Release Date: June 18, 2021
- Pre-Application Meeting Date: June 30, 2021 at 10:00 AM
- Application Submission Deadline: **July 23, 2021 at 6:00 PM (revised)**
- Anticipated Award Start Date: August 19, 2021

B. Overview

The Government of the District of Columbia's Department of Health is soliciting applications from qualified ~~**not-for-profit**~~ organizations located and licensed to conduct business within the District of Columbia to provide management and daily operation of the School Health Services Program. This program encompasses the management and oversight of health professionals serving students of public schools, public charter schools, public special needs schools, and community-based organizations in the District of Columbia. The grantee shall be responsible for providing the required professional staff to deliver services promoting school health for District public schools, public charter schools, public special need schools, and selected community-based organizations while ensuring the program adheres to national best practice standards for the provision of school health services, as well as local and federal protocols and policies. Each grantee will provide services in one of the following performance areas: 1) In-Person Health Suite Staffing & Direct Services; 2) On-Demand Telehealth Services; 3) Care Coordination & School Health Integrations Services; and 4) Training, Technical Assistance, and Support

C. Award Information

Source of Grant Funding

Funding is made available under the School Health Services Program through Local Appropriation funds and, authorization is Fiscal Year 2022 Budget Support Act of 2021 **and the Centers for Disease Control and Prevention's Cooperative Agreement for Emergency Response: Public Health Crisis Response Federal Award.**

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Amount of Funding Available

This RFA will make available up to $24,100,000 to fund four (4) awards, one (1) in each category, in FY 2022 to implement evidence-based school health programs and services for students in the District. Proposed budgets cannot exceed the allowable amount of $22,000,000 for In-Person Health Suite Staffing & Direct Services, $550,000 for On-Demand Telehealth Services, $1,100,000 for Care Coordination & School Health Integration Services, $450,000 for Training, Technical Assistance, and Support.

Performance and Funding Period

The anticipated performance and funding period are August 19, 2021 through September 30, 2024 with four (4) budget periods. The first budget period is prorated to two (2) months, ending September 30, 2021. Subsequent budget periods will be for 12 months, with the second beginning October 1, 2021.

Annual continuation of awards for up to one (1) year is contingent upon the continued availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

Eligible Organizations/Entities

Organizations and entities that are eligible to apply for funding under this announcement include not-for profit, public and private organizations located and licensed to conduct business within the District of Columbia. Eligible applicants must demonstrate experience in providing and/or coordinating services relevant to their chosen performance area, including but not limited to, technological support, technical assistance, clinical healthcare, and training services.

Organizations considered for funding must meet the above eligibility criteria and have the following experience and support in place: demonstrated success working with multiple sectors or experience working with community, or other leaders, as appropriate, and demonstrated track record of improving community outcomes (including documented evaluations) through policy, environmental, programmatic and infrastructure strategies; and demonstrated ability to meet reporting requirements related to programmatic, financial, and management benchmarks as required by the RFA. ~~**Organizations must have an annual budget that is at minimum 40% funded by private sources**~~**.** Applicants must submit letters of commitment for existing partnerships if performance depends on another organization.

Administrative Cost

Applicants' budget submissions must adhere to a **ten percent (10%) maximum** for indirect costs. All proposed costs must be reflected as either a direct charge to specific budget line items, or as an indirect cost.

Application Formatting

The application must be written on 8½ by 11-inch paper, 1.0 spaced, Arial or Times New Roman font using 12-point type *(10–point font for tables and figures)* with a minimum of one-inch margins. The application must be submitted in PDF format with page numbers on each page. Applications that do not conform to these requirements will not be forwarded to the review panel.

Non-Supplantation

Applicants' must supplement, and not supplant, funds from other sources for initiatives that are the same or like the initiatives being proposed in this award.

Application Page Limit

The total size of all uploaded files may not exceed the equivalent of **25 pages for one performance area or 40 pages for two or more performance areas** when printed by DC Health. The page limit does not include attachments and appendices.

IV. BACKGROUND & PURPOSE

A. Background

A large body of research demonstrates the critical link between student health and academic performance. This understanding informed the development of the Whole School, Whole Community, Whole Child (WSCC) model from the Centers for Disease Control and Prevention (CDC). The model calls for cross-disciplinary collaboration between agencies, organizations, community members, and schools to comprehensively support student well-being, keeping children and adolescents healthy, safe, engaged, supported, and challenged. As all children are required to attend school starting at the age of five, school-based health personnel are in a unique position to support student health while working in tandem with

school personnel and other community resources. The District has prioritized having school health services available for all public-school students, as evidenced by its significant investments allocated for school nursing services and school-based health centers. Merging current best practices for school health services and priorities of District residents, the District of Columbia Department of Health (DC Health) seeks to implement a comprehensive, integrated, and collaborative model of school health services to support the whole child.

As of the 2019-2020 school year, the District of Columbia public education system serves more than 94,500 children and adolescents between the ages of three years and 18+ years. Approximately 51,000 students are enrolled at District of Columbia Public Schools, and about 43,000 students attend a public charter school.[1] During the 2018-19 school year, 47% of District students were identified as at-risk, which is defined as students who qualify for the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families, are identified as homeless, are under the care of the Child and Family Services Agency, or are high school students at least one year older than the expected age for their grade.[2] Most of the aforementioned criteria serve as proxy measures of student poverty. In addition, the 2019 Youth Risk Behavior Survey (YRBS) found that 74.9% of District high school students did not eat breakfast at least one day in the seven days prior to survey administration (compared to 66.9% of high school students nationally), and 18.8% of high school students did not eat breakfast on any day in the seven days prior to survey administration (compared to 16.7% nationally).[3] Students who have gone hungry are more likely to have lower grades, and children growing up in poverty complete less schooling, work and earn less as adults, are more likely to receive public assistance and have poorer health.[4]

In addition to their exposure to poverty, District public school students experience chronic health issues such as seizures, anaphylaxis, and seizures, with about 33% of the entire student body requiring care beyond routine health services. One of the most significant health needs for children and adolescents in the District of Columbia is asthma. The 2017 YRBS found that 33.4% of high school students in the District had ever been told by a provider that they had asthma, compared with 22.5% of high school students nationally.[3] During 2019-20 school year, DC Health-supported school health services documented 15,525 students with an asthma diagnosis.

Alongside asthma, child and adolescent mental health is of concern in the District. The burden has been higher among female students, according to the 2019 YRBS, as 37.3% of female middle school students and 23.5% of female high school students have seriously thought about killing themselves, compared to 20.9% of male middle school students and 14.3% of male high school students. Further, 17.9% of all surveyed high schoolers made a plan about how they would attempt suicide, and 14.9% actually attempted suicide – figures that are considerably higher than the national rates of 15.7% and 8.9%, respectively.[3-4] The statistics are more alarming for lesbian, gay, bisexual (LGB), and transgender students in the District. LGB middle school students were found to be 2.5 to 3 times more likely than heterosexual students to have seriously thought about, planned to, or tried to commit suicide, and the rates are more than two times higher in LGB high school students than heterosexual high school students.[4] When it comes to transgender

[1] Office of the State Superintendent of Education (2020). 2019-2020 School Year Enrollment Audit Report Data. Retrieved from, https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/SY19-20%20Annual%20Enrollment%20Audit%20Report%20Supplemental%20Tables.xlsx.
[2] Office of the State Superintendent of Education (n.d.). Data and Reports. Retrieved from, https://osse.dc.gov/page/data-and-reports-0.
[3] Centers for Disease Control and Prevention (n.d.). 1991-2019 High School Youth Risk Behavior Survey Data. Retrieved from, http://nccd.cdc.gov/youthonline/.
[4] Office of the State Superintendent of Education (2019). District of Columbia Youth Risk Behavior Survey 2019. Retrieved from, https://osse.dc.gov/node/1486106.

high school students, the rate of attempted suicide is more than 3.5 times higher than the rate for students who are not transgender. Prior to the pandemic, some researchers attributed the increased prevalence of mental health conditions among children and adolescents to high social media usage, low face-to-face interaction, and declines in sleep duration.[5] However, the presence of a school-based supportive adult may impact student mental health, as one in four high school students who reported lacking a supportive adult at school had attempted suicide.[4] Therefore, school health personnel and other school staff have a unique opportunity to connect with students, be integrated within school and community mental health services, and facilitate students' linkage to mental health services, while understanding their clear limits as personnel who are not mental health professionals.

COVID-19 Pandemic and its Impact on Children and Adolescents in the District

Among these existing needs, the Coronavirus Disease 2019 (COVID-19) pandemic has exacerbated health issues and inequities both nationwide and in the District. According to the CDC, the pandemic has led to changes in children's routines, a lack of continuity of learning and healthcare, missed significant life events, and a loss of security and safety – all of which influence students' current social, emotional, physical, and mental health.[6] In addition, children with certain conditions, such as diabetes, obesity, and asthma, may be at an increased risk for severe illness with COVID-19.[7] This is important to the District, as the 2019 YRBS found that 17% of high school youth in the city are obese and 18% are overweight.[8] Due to these effects, it is imperative that schools are equipped to foster connectedness, health, and wellness among students while promoting safety in both in-person and remote environments.

The pandemic has also generated a need to expand telemedicine services in order to abide by social distancing guidelines while still serving patients. According to the CDC, there was a 154% increase in telehealth visits during the last week of March 2020 when compared with the same period in 2019. The increase did not hold for children and adolescents, however, as there was a decrease in children's telehealth visits during the same period. Three and a half percent of telehealth encounters were for children under 5 years old, compared to 4.0% in 2019, and 8.6% were for children aged 5-17 years old, compared to 10.0% in 2019.[9] Therefore, there is a need to connect with students virtually and ensure their health needs are still met despite social distancing requirements. Services that can be provided to children through telemedicine methods include, but are not limited to, chronic disease management, behavioral health, cold treatment, and minor infection management.[10]

School Health Services

School health programs play a significant role in addressing the needs of children and adolescents in the

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[5] Twenge, J. M., Cooper, A. B., Joiner, T. E., Duffy, M. E., & Binau, S. G. (2019). Age, period, and cohort trends in mood disorder indicators and suicide-related outcomes in a nationally representative dataset, 2005–2017. *Journal of abnormal psychology*, *128*(3), 185.

[6] Centers for Disease Control and Prevention (2020). COVID-19 Parental Resources Kit: Ensuring Children and Young People's Social, Emotional, and Mental Well-being. Retrieved from, https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/parental-resource-kit/index.html.

[7] Centers for Disease Control and Prevention (2020). People with Certain Medical Conditions. Retrieved from, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

[8] Centers for Disease Control and Prevention (n.d.). 1991-2019 High School Youth Risk Behavior Survey Data. Retrieved from, http://nccd.cdc.gov/youthonline/.

[9] Koonin LM, Hoots B, Tsang CA, et al. Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020. MMWR Morb Mortal Wkly Rep 2020;69:1595–1599. DOI: http://dx.doi.org/10.15585/mmwr.mm6943a3.

[10] School-Based Health Alliance (2020). SBHA Telehealth Recommendations for Education Partners. Retrieved from, https://www.sbh4all.org/wp-content/uploads/2020/05/Telehealth-guidelines-for-education-partners-5.6.20.pdf.

public education system, as outlined in the CDC's Whole School, Whole Community, Whole Child (WSCC) framework. The model calls for alignment, integration, and coordination between public health agencies, school health services, and community resources in order to cultivate an environment for healthy, safe, engaged, supported, and challenged children. According to the WSCC model, the role of school health services in the endeavor is to:

- Address current and potential health problems (i.e. first aid, emergency care, chronic condition management, etc.), including through the use of preventive services by qualified professionals such as school nurses, dentists, health educators, physicians, and allied health personnel
- Connect and collaborate with school personnel, students and their families, and community providers to promote student health and help students and their families manage various health and social stressors
- Provide care coordination services to increase access and/or linkage to community providers or medical homes[11]

Within school health services, school nurses may play a number of support roles, including providing health education, triaging acute medical problems, and coordinating preventive and chronic disease care with a child's primary physician or medical home. Research has demonstrated that school nurses may positively impact student health by helping reduce absenteeism[12], identifying health needs[13], and reducing time other school staff spend dealing with student health issues.[14] In addition, the National Association of School Nurses (NASN) notes the integral role of school nurses in promoting school mental health as "advocates, facilitators, and counselors of behavioral health services within the school environment and in the community."[15] Despite their integral role in ensuring widespread school health, the nation has experienced a shortage of nurses due to the aging population, retirement levels, slow growth in nursing school enrollment, the stress of the nursing role, and concerns about health and safety during the COVID-19 pandemic. A 2017 study found that 25.2% of schools in the United States do not have a school nurse, and it is estimated that 200,000 nurses will be needed every year to meet the United States' need for nurses.[16]

Therefore, the District of Columbia (DC) School Health Services Program (SHSP) aims to create greater alignment, integration, and collaboration between education and health by supporting school nurses and school health suite personnel in the promotion of each child's cognitive, physical, social, and emotional development. The SHSP has three active components in line with the WSCC model: the provision of clinical services to students, care coordination to ensure linkages to care for students and families, and quality improvement/assurance to evaluate the program's services and improve upon its practices for

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[11] Centers for Disease Control and Prevention (2019). Components of the Whole School, Whole Community, Whole Child (WSCC). Retrieved from, http://www.cdc.gov/healthyschools/wscc/components.htm.

[12] Wang, L. Y., Vernon-Smiley, M., Gapinski, M. A., Desisto, M., Maughan, E., & Sheetz, A. (2014). Cost-benefit study of school nursing services. *JAMA Pediatrics*, 168(7), 642; Pennington, N., & Delaney, E. (2008). The number of students sent home by school nurses compared to unlicensed personnel. *The Journal of School Nursing*, 24(5), 290-297; Wyman, L. L. (2005). Comparing the number of ill or injured students who are released early from school by school nursing and nonnursing personnel. *The Journal of School Nursing*, 21(6), 350-355.

[13] Baisch, M. J., Lundeen, S. P., & Murphy, M. K. (2011). Evidence-based research on the value of school nurses in an urban school system. *Journal of School Health*, 81(2), 74-80.

[14] Wang, L. Y., Vernon-Smiley, M., Gapinski, M. A., Desisto, M., Maughan, E., & Sheetz, A. (2014). Cost-Benefit Study of School Nursing Services. *JAMA Pediatrics*, 168(7), 642.

[15] National Association of School Nurses (2018). The School Nurse's Role in Behavioral/Mental Health of Students. Retrieved from, https://www.nasn.org/advocacy/professional-practice-documents/position-statements/ps-behavioral-health.

[16] Willgerodt, M.A., Brock, D. M., & Maughan, E.M. (2018). Public School Nursing Practice in the United States. *Journal of School Nursing*, 34(3), 232-244.

consistent, high-quality care.

During the 2019-20 school year DC Health provided health services at 199 schools, and the program hopes to continue expanding their offerings and populations served in the coming years to accommodate 100% of active District schools that opt into the program.

B. Purpose

The Government of the District of Columbia, Department of Health (DC Health), is soliciting applications from qualified entities to provide comprehensive school health services to improve student health outcomes. Qualified applicants will coordinate and implement programs to include care coordination, clinical and allied health services, community engagement and navigation, and quality improvement/program evaluation for public school students in the District of Columbia. Applicants must incorporate the WSCC approach in their proposal and describe their alignment and integration with other performance areas and the school environment. Applications are being solicited for the following performance areas, where one award will be granted per performance area. Applicants may apply for more than one performance area under one complete application. The performance areas are as follows:

1. **In-Person Health Suite Staffing & Direct Services:** The grantee will staff one (1) Director of Nursing, eight (8) Nurse Managers, a minimum of two (2) Administrative Staff, and multiple Registered Nurses to work directly with SHSP schools and provide clinical services in school health suites. The number of nursing personnel should be sufficient to serve and accommodate the ~~191~~ 199 schools participating in the SHSP by the start of school, for a minimum of 40 hours per week in-person. Additional schools that are approved will also need to be accommodated through the duration of the grant period. However, other allied staff (i.e., Health Technicians, Licensed Practical Nurses, etc.) may be used to supplement the registered nurse workforce in meeting the hourly minimum in the event of a shortage in Registered Nurses for nursing coverage, if approved by DC Health. In addition to providing direct care services, staff are expected start care coordination processes and collaborate with Care Coordination and School Health Integration Services.

2. **On-Demand Telehealth Services:** In light of the COVID-19 pandemic and demand for remote health services, the grantee will build and implement telehealth access in all SHSP schools. The grantee will be responsible for effectively integrating telehealth services into existing and new protocols, services, and technologies in a manner that aligns with policies from the Government of the District of Columbia, local education agencies, and federal requirements such as the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA).

3. **Care Coordination & School Health Integration Services:** The grantee will staff Case Managers, Health Navigators, and Clinician Consultants to provide care coordination services and support for all schools within the District as well as select community-based organizations (CBOs) that work with children and adolescents in the District. The grantee will be expected to coordinate with health suite personnel and selected CBO partners when performing their services. The grantee will also provide integration services such as outreach, education, family engagement, school health teams coordination, and emergency preparedness for all schools and CBOs that are affiliated with SHSP.

4. **Training, Technical Assistance, and Support:** The grantee will coordinate all training programs relevant to school health services, including Administration of Medication training, for all individuals associated with SHSP and school health services, including but not limited to, school staff, health suite staff, other grantees, select CBOs, and other individuals identified by DC Health. One of the training programs the grantee will have to oversee is the Administration of Medication (AOM) training, which requires coordinating the implementation of the compulsory skills check for health suite staff and conferring with the Clinician Consultant for their clinical expertise and support as it relates to AOM. Further, the grantee will provide SHSP schools with implementation support for health suite operations, health suite approvals, compliance protocols, corrective actions, and health supply acquisition. The staffing ratios for these performance areas should be sufficient to accommodate 100% of active District schools that opt into the SHSP, as well as non-SHSP schools and CBOs, if applicable. DC Health will assign the algorithm necessary to support sufficient coverage, though it is grantees' responsibility to supply enough staff that have the skills and competencies to perform the task(s) necessary. Grantees must also utilize DC Health's identified algorithms or receive approval for staffing coverage before making assignments.

Applicants shall address one or more performance areas in a single application but may prioritize the performance area for which they would prefer to receive funding. Given the potential for more than one awarded grantee, any awarded grantees must work in coordination with each other to further the goals of SHSP and provide cohesive services. In addition, irrespective of the performance area chosen, any grantee will be expected to provide support for shifting District priorities and may experience reassignments due to changing priorities and public health emergencies, including COVID-19 and post-pandemic response efforts. Further, all grantees will report to DC Health and operate under DC Health protocols, serving as an agent of DC Health and following all applicable local and federal laws and regulations (i.e. HIPAA and FERPA). During the COVID-19 pandemic, grantees will also be expected to follow COVID-19-specific guidance from the Government of the District of Columbia and CDC, so it is recommended that grantees check these websites often for the most updated information.

In addition to relying on protocols and regulations from DC Health and other entities, grantees will be expected to develop their own protocols relevant to their performance area for feedback and approval by DC Health prior to implementation.

V. Performance Requirements

A. Target Population

The target population includes students attending elementary and secondary public and public charter schools in the District of Columbia, which are schools that provide pre-Kindergarten to high school grade education or its equivalent, including adult education programs, STAY Opportunity Academy programs, and ungraded special needs schools. However, grantees will also be required to interact with school administration, DC Health personnel, select community-based partners, and other entities throughout the duration of the grant period in order to coordinate services for the primary target population.

All staff who work directly with students must pass and complete a background check with the District of Columbia Public Schools and the Public Charter Schools within 30 days of the award period and prior to the provision of services. Grantees will be responsible for coordinating with schools to ensure the necessary background checks are addressed and documentation of the checks are provided to DC Health.

B. Location of Services

Services will be delivered within schools and community-based organizations selected by DC Health, in coordination with other grantees and District agencies.

C. Performance Areas

The SHSP aims to improve student health and academic outcomes through the provision of three critical activities: 1) clinical services in school, 2) care coordination for ensuring linkages to services available in and out of school, and 3) quality improvement/assurance services to evaluate and improve upon its practices for consistent, high-quality, student- and family-centered care. Some of the services SHSP clinical and care coordination staff may provide to students include:

- Assistance with immunization compliance
- Care of acute illnesses and injuries
- Care coordination for preventive care, proactive disease management, immunizations, and annual wellness exams through collaboration and communication with school staff, families, and healthcare providers outside of the school setting
- Chronic disease management
- Communicable disease surveillance and reporting
- Medication and treatment administration
- Hearing and vision screenings for students
- Student health record review
- Referrals for care and follow-up services, including behavioral health services
- Participation in the Individualized Education Program (IEP) and 504 Process for students
- Monitoring school staff trained in Administration of Medication (AOM)

Although all grantees will not directly provide these services, each grantee must aim to further the achievement of the SHSP's goals through their work and collaboration with other grantees, schools, selected community-based partners, and DC Health.

Within this framework, the SHSP will provide the following services to District schools and their students: 1) Nurse Coordination, 2) In-Person Health Suite Staffing & Direct Services, 3) On-Demand Telehealth Services, 4) Care Coordination & School Health Integration Services, 5) Training, Technical Assistance, and Support, 6) Compliance and Data Management. While grantees are expected to staff personnel for performance areas 2-5, DC Health will retain Nurse Coordination and Compliance and Data Management functions directly within the agency in an effort to centralize services. A logic model of the SHSP and its core functions is provided in Appendix B.

All grantees must comply with DC Health's and schools' standards and procedures for service care, including behavioral health care, referrals, and crisis prevention processes. The behavioral health referral process that must be followed is included in Appendix C.

More detail on the performance areas is provided below.

Nurse Coordination (DC Health Internal)

Nurse Coordinators will be responsible for bridging communication between education partners and SHSP personnel to promote coordination and collaboration for an integrated, comprehensive, and systems-wide approach to school health. School nurses have expressed frustration at "poor system supports" when completing their duties, so Nurse Consultants will be essential to ensuring all pieces of the SHSP work

cohesively to improve student health.[17] Nurse Coordinators within DC Health will also control where staff will be placed, based on algorithms and recommendations, and must approve all staffing schedules prior to implementation. They will also work with the *Training, Technical Assistance, and Support* grantee to ensure nurses and other SHSP personnel are provided with the proper guidance and support to complete their duties.

In-Person Health Suite Staffing & Direct Services

Clinical staff within the health suite, including Registered Nurses, Community Health Nurses, Licensed Practical Nurses, Certified Nursing Assistants, and Health Technicians will be expected to provide direct health services to students at the school. All clinical staff should deliver services within their respective scope of practice based on their licensure and certifications. 40 hours of coverage **per week** is required under the SHSP grant, so grantees must ensure that they have enough skilled staff to serve the number of students in the selected schools and partners for that amount of time. Other health professionals and allied staff, such as floating nurse staff or health technicians, may be used to supplement the registered nurse workforce in meeting the 40 hours per week minimum in the event of a shortage in nursing coverage, but these additions must be approved by DC Health. Telehealth services can be available when in-person services are not available, but telehealth services may not replace in-person service hours. Health suite staff must also collaborate and coordinate with other grantees and partners to conduct care coordination activities, ensure linkages to care and up-to-date student files.

Health Administration

In addition to clinical staff, the *In-Person Health Suite Staffing & Direct Services* grantee must also provide at least two administrative staff members. Administrative staff will be responsible for clerical items such as human resources, organizing internal clinical training opportunities, and coordinating logistics that pertain to internal employee relations and professional licensure credentialing. Logistics may include supporting the Director of Nursing in managing the SHSP grant (i.e. submitting and reporting grant deliverables) and handling communications between parties. The administrative staff will also ensure that DC Health has direct access to staff for the provision of work assignments. Further, administrative staff will be expected to provide support for ad hoc requests and/or special projects that align with District priorities and policies. Staff members may include, but are not limited to, an Inventory Control Specialist, Professional Development Specialist, Administrative Assistant, and Office Manager.

Although staffing administrative team members is only required for the *In-Person Health Suite Staffing & Direct Services* grantee, health administration is applicable to all program areas. Therefore, all grantees may benefit from including health administration personnel in their staffing model.

On-Demand Telehealth Services (Audio and Visual)

Clinical services will also be supported through the *On-Demand Telehealth Services* grant, as some services may be provided through telehealth platforms. These services are particularly relevant during the COVID-19 pandemic due to social distancing requirements, but telehealth services should also be provided in the event that in-person coverage is unavailable outside of public health emergencies.

Telehealth services must comply with privacy and security regulations, including HIPAA and FERPA, along with regulations from the Government of the District of Columbia. The Department of Healthcare Finance (DHCF) provides guidance on the provision of telehealth services on their webpage, including

[17] Klein, N. J., & Evans-Agnew, R. (2019). Flying by the seat of their pants: A grounded theory of school nurse case management. *Journal of advanced nursing*, 75(12), 3677-3688

which platforms are compliant with privacy laws. According to the DHCF, grantees may utilize telemedicine modules integrated within electronic health records vendors, such as eClinicalWorks, as well as standalone products such as Doxy.me, Microsoft Teams, Updox, and Zoom with established business associate agreements outlining HIPAA compliant features. Every audio/visual telehealth visit must be documented in the electronic health record system with the patient's contact information.

In order to support health suite clinical services provided through telehealth platforms, the *On-Demand Telehealth Services* grantee will be responsible for providing telehealth platform, working with the clinical services, case management and health navigation awardees and DC Health to coordinate and integrate telehealth services into existing protocols, services, and systems (i.e. billing and student medical records) while ensuring ease of use for students, families, and staff through hosting user training sessions (on-demand and live). Grantees will also be responsible for providing resources and technical assistance related to the use of telehealth services, as well as tracking key data points on the use of the service. Lastly, telehealth personnel will be required to coordinate with other grantees and select partners to ensure access to telehealth platforms.

Care Coordination & School Health Integration Services

Case Management

Case managers will be responsible for assessing the needs of students with chronic conditions (i.e., asthma, diabetes, seizures, sickle cell anemia, mental health concerns, pregnancy, allergies, weight management, etc.) and other children with special healthcare needs to determine interventions and care coordination strategies that will help them achieve their academic and personal goals in alignment with other grants, protocols, and regulations. Engelke et al (2009) identify three essential components of case management in their definition of the role:

1. "Case management is a process by which the school nurse identifies children who are not achieving their optimal level of health or academic success because they have a chronic condition that is limiting their potential. It is based on a thorough assessment by the school nurse including input from the family and teachers."
2. "Case management involves activities that not only help the child deal with problems but also prevent and reduce their occurrence. Interventions include direct nursing care for the child and coordination and communication with parents, teachers, and other care providers."
3. "Case management is goal oriented based on the specific needs of the child and evaluated based on the impact on the child."[18]

Case managers are integral to school health services, particularly because many school nurses have limited time and resources taking care of students with acute illnesses.[15-16] In one four-year study, 84% of students who received case management services experienced improvements in one or more of the following areas: attendance, behavior, academic performance, quality of life, and health compliance.[19] Case management has also been associated with bettering students' abilities to build relationships with peers and supportive adults.[20] In relation to asthma specifically, school case management programs have helped reduce asthma

[18] Engelke, M. K., Guttu, M., & Warren, M. B. (2009). Defining, delivering, and documenting the outcomes of case management by school nurses. *The Journal of School Nursing*, 25(6), 417-426.
[19] Bonaiuto, M. M. (2007). School nurse case management: Achieving health and educational outcomes. *The Journal of School Nursing*, 23(4), 202-209.
[20] Parise, L., Corrin, W., Granito, K., Haider, Z., Somers, M. A., & Cerna, O. (2017). Two years of case management: Final findings from the Communities in Schools random assignment evaluation. *MDRC, Project: Communities In Schools.*

symptoms and improve students' self-management of their condition through helping them use their inhaler, be responsible for their own medications, and control their asthma.[5]

Case managers' goals should center around the following areas: promotion of a safe school environment, symptom management, self-care management, academic success, family support, and healthcare coordination for students.[16] Some strategies in doing so include developing emergency action plans, teaching school personnel about students' conditions, helping students understand their medications, and ensuring that supplies are available at the school.[16,21] These functions require regular meetings and check-ins with students and other relevant individuals (i.e. parents and teachers) to anticipate and proactively address any challenges that may arise.

Case managers should utilize a team-based approach to care that includes families, school staff, health suite personnel, student support teams, students' primary care providers, and relevant CBOs in order to ensure alignment in goals and approaches across these parties. The engagement of all these individuals will help create a holistic care plan for the student that includes strategies to manage their condition outside of school.[19] In addition, including families in students' care has been associated with increased parental receptivity to the student needs and the case management program.[19]

Health Navigation

Health Navigators will be responsible for supporting students and families in linkage to services and continuity of care outside the health suite. In the District, some student needs are going unmet partially due to a lack of care coordination. For instance, in the 2019-2020 school year, 6,360 referrals were made for student oral health assessments, but only 2,404 students (38%) actually received one after referral. The presence of health navigators, on the other hand, can promote completion of referrals due to the individualized support and facilitation of connections to community resources. Health Navigators should also be aware of the resources available to children, adolescents, and families in the greater District community.

School Health Integration

The grantee will also be responsible for ensuring all new and existing policies from the SHSP, schools and CBOs, and local and federal policies align with each other. Specifically, the grantee will provide integration services such as outreach, education, family engagement, school health teams coordination, and emergency preparedness for all schools and CBOs that are affiliated with SHSP.

Training, Technical Assistance, and Support

Training, Technical Assistance, and Support personnel will be responsible for creating and administering training materials to all individuals associated with SHSP and school health services, including but not limited to, school staff, health suite staff, other grantees, select CBOs, and other individuals identified by DC Health. The grantee will also be responsible for offering individualized guidance on program implementation procedures and challenges, particularly as they relate to health suite approvals, corrective actions, health supply acquisition, and compliance with data requirements, Occupational Safety and Health Administration requirements, and governmental guidelines. Researchers have found that school nurses feel that there is a lack of guidance for their roles, leaving them to rely on resources from national organizations rather than their local governments.[15] Therefore, training and technical assistance will be important to

[21] Engelke, M. K., Swanson, M., & Guttu, M. (2014). Process and outcomes of school nurse case management for students with asthma. *The Journal of School Nursing*, 30(3), 196-205.

tailoring training materials and best practices to the DC community served by the SHSP, and thereby helping nurses feel prepared for their roles.

The team will also develop and identify continuing education opportunities for SHSP personnel, such as training on pediatric best practices, emerging health issues, customer service, communication, District resources, and providing care to students experiencing developmental, behavioral, or other challenges using principles of WSCC and human-centered approaches. The training opportunities must be approved by and aligned with DC Health protocols, and the grantee should collaborate with accrediting bodies and licensure boards to ensure that the training sessions align with their requirements so that school nurses, educators and other professionals can receive continuing education credits for participating. One training program that must be coordinated and overseen by the grantee is Administration of Medication training, where the grantee will manage the training, development, credentialing, and oversight of all Administration of Medication staff. The grantee will maintain Administration of Medication training with initial and refresher courses, which include education on medication administration routes, monitoring, relation to medication disease management, written instructions for school staff to reference in practice, visual aids, and assessments. The grantee will also coordinate the compulsory skills check for health suite staff and confer with the Clinician Consultant for advising regarding the Administration of Medication. All services and training opportunities provided should be tracked, along with the parties who received the services.

DC Health Compliance and Data Management Responsibilities

Compliance and Data Management is integral to ensuring compliance with regulations and protocols, facilitating the evaluation of the SHSP program, and understanding the successes and challenges experienced at each SHSP site. Personnel in this sector verify, assurance of compliance with appropriate state and federal regulations, risk minimization/management procedures, clinical protocol and guideline development, and utilization reviews. Although the Compliance and Data Management team will be directed internally within DC Health, grantees must have designated personnel to coordinate the implementation of compliance and data management-related duties within the organization, including data collection, data sharing, and data reporting, as well as the retention of proper consent and data sharing agreements to facilitate the successful completion of the functions of this component.

The team will also assess the quality of implementation and program outcomes, develop, or identify tools to measure program impact and fidelity, and assure compliance with best practices and appropriate state and federal regulations. Data will be collected to understand how the program was implemented at each site, such as through tracking nurse attendance, as well as the outcomes of the program, such as through noting successful linkages to care or changes in physiological measures. Grantees will be responsible for tracking and providing the data to the *Compliance and Data Management* team. The Grantee is expected to work with DC Health on the recommended systems. The data collected and evaluations conducted should be aligned with any objectives and goals established at the start of the program. Grantees will be expected to share data, protocols, standards, processes, staffing, credentialing, and continuing education with the DC Health Compliance and Data Management team. Applicants will be expected to outline training plan for staff to ensure staff are trained on collecting timely, complete, and quality data.

D. Data Requirements

Applicants should describe how they will ensure that an electronic clinical records system with the ability to produce population health reports and outcomes-oriented reports is fully operational on the first day of School Year 2021-2022. This electronic records system will be the central health information repository to monitor ~~DC~~SHSP and evaluate student outcomes.

Applicants shall propose how data will be collected and stored to track students and schools individually and in aggregate, as well as possible ways to align or integrate health information systems. Grantees will be expected to develop and provide specific reports to DC Health, which are outlined below based on the service area staffed. There may also be additional reports required as requested by DC Health to monitor program progress and outcomes. Due to the nature of the work surrounding SHSP, grantees should expect to receive additional requests for data with short deadlines, including additional reports that may not be included as examples below.

Grantees will also be expected to provide data directly to school sites, selected partners, and DC Health as requested, in accordance to predetermined reporting schedules and unscheduled deadlines. Grantees will be responsible for having dedicated personnel coordinate with DC Health to ensure that the proper consent and data sharing agreements are in place to facilitate the provision of data to these entities. All templates used for data sharing, data agreements, and consent forms must be approved by DC Health prior to use and distribution.

In-Person Health Suite Staffing & Direct Services

Grantees in this component are expected to generate and monitor the following reports in order to perform their prescribed duties. Mandated reports are expected to be provided ***at minimum*** to DC Health. Below are examples of what is to be followed:

- **Daily Coverage Report:** details plan to address staffing changes due to changes in health needs of the student body, unexpected personnel absences, facility closures or other emerging issues.
- **Monthly Student Health Data Reports:** Population data describes known medical conditions in schools. Utilization data describes service usage. All reported data should be delineated by student gender, grade, school name and ward, and race and ethnicity as appropriate. DC Health will provide templates for reports. Report shall include at minimum:
    - Asthma: report should detail those students requiring daily medications vs. those requiring medications as needed (e.g. mild intermittent asthma diagnosis)
    - Diabetes: report should delineate insulin and non-insulin dependent students
    - Anaphylaxis: report should include number of students with known history of anaphylaxis due to allergens
    - Children with Special Health Care Needs: report should detail students meeting criteria for CYSHCN including diagnoses and presence of IHP, IEP and/or 504; and number of consultations for 504 and IEP plans
    - Universal Health Certificates: report to include UHC compliance by school and by student
    - Oral Health Assessment Forms: report to include OHA compliance by school and by student
    - Immunization Surveillance: report to detail immunization surveillance activities and compliance
    - Contraception Distribution:
    - AOM trained staff: report to detail AOM training for school staff
    - Telemedicine Services**:** DHCF's documentation standards for telemedicine services include additional documentation of:
        a. The modality of service used to deliver the service (i.e. audio/visual, audio-only, etc.)
        b. The patient's telephone number, cell phone number, or other information on how communications were established with the patient based on the mode of communication used to deliver the service via telemedicine
- ~~**Quarterly Population Health Report:** describes the known medical conditions of students in schools. Reports shall be delineated by student gender, grade, school name and ward, and race/ethnicity, and shall be generated for the following health conditions:~~
    - ~~Asthma: report should detail those students requiring daily medications vs. those requiring~~

~~medications as needed (e.g. mild intermittent asthma diagnosis)~~
    - ~~Diabetes: report should delineate insulin and non-insulin dependent students~~
    - ~~Anaphylaxis: report should include number of students with known history of anaphylaxis due to allergens~~
    - ~~Children with Special Health Care Needs: report should detail students meeting criteria for CSHCN including diagnoses and presence of IHP, IEP and/or 504; and number of consultations for 504 and IEP plans~~
    - ~~Pregnancy: number of pregnant students (by trimester, if available)~~
    - ~~Other conditions as requested by DC Health~~
- ~~**Monthly Health Suite Utilization Report:** delineated by student gender, grade, school name and ward, and race/ethnicity and shall include:~~
    - ~~Reason for visit~~
    - ~~Chronic disease management, such as diabetic glucose testing, medication administration (by disease)~~
    - ~~Preventive care, such as vision screenings and health certificate submission~~
    - ~~Acute care management, such as injury or illness by type (i.e. burn injury, musculoskeletal injury, abdominal pain, asthma exacerbation, etc.)~~
    - ~~Procedures, such as tracheostomy care, bladder catheterization, ostomy care, nasogastric feeding, orthopedic device maintenance, chest physical therapy and ventilator care.~~
    - ~~Condom distribution, including number of health suite visits for condom access, at minimum. Student demographic information may be included in reporting if available.~~
    - ~~Time in the health suite: less than 10 minutes, 10-20 minutes, 21-30 minutes, 31-60 minutes, 61-120 minutes, more than 2 hours, etc.~~
    - ~~Disposition: Returned to class, home, transferred to ambulatory facility (primary or urgent care), and emergency medical transfer, etc.~~
    - ~~**For Telemedicine Services:** DHCF's documentation standards for telemedicine services include additional documentation of:~~
        - ~~The modality of service used to deliver the service (i.e. audio/visual, audio-only, etc.)~~
        - ~~The patient's telephone number, cell phone number, or other information on how communications were established with the patient based on the mode of communication used to deliver the service via telemedicine~~
- **Biannual Screening Report:** Vision and hearing screening reports shall be available at the start and middle of the school year.
- ~~**Quarterly**~~ **Monthly Quality Assurance Reports**
    - Continuous Quality Improvement Activity Report with description of project and outcomes
    - Unusual Occurrences Report with description of unusual occurrence and outcome
    - Grievance Report detailing person filing grievance (i.e. parent, student, or school staff), reason for grievance and outcome.
- **Monthly Staffing Report:** details all public schools with school health service personnel including school name, school type (DCPS or public charter), ward, enrollment number, principal, grades offered, name of SHSP staff and coverage hours.
- **Cumulative Annual Report** to include all reports generated

On-Demand Telehealth Services

Grantees in this component will be expected to develop and provide the following reports ***at minimum*** to DC Health:

- **Monthly Utilization Report:** delineated by student gender, grade, school name and ward, and

race/ethnicity **as necessary. DC Health will provide templates for reports. Reports and** shall include:

- Reason for visit
- Chronic disease management, such as diabetic glucose testing, medication administration (by disease)
- Preventive care, such as vision screenings and health certificate submission
- Acute care management, such as injury or illness by type (i.e. burn injury, musculoskeletal injury, abdominal pain, asthma exacerbation, etc.)
- Procedures, such as tracheostomy care, bladder catheterization, ostomy care, nasogastric feeding, orthopedic device maintenance, chest physical therapy and ventilator care.
- Condom distribution, including number of health suite visits for condom access, at minimum. Student demographic information may be included in reporting if available.
- Time in the health suite: less than 10 minutes, 10-20 minutes, 21-30 minutes, 31-60 minutes, 61-120 minutes, more than 2 hours, etc.
- Disposition: Returned to class, home, transferred to ambulatory facility (primary or urgent care), and emergency medical transfer, etc.

- ~~**Quarterly**~~ **Monthly Quality Assurance Reports**
  - Continuous Quality Improvement Activity Report with description of project and outcomes
  - Unusual Occurrences Report with description of unusual occurrence and outcome
  - Grievance Report detailing person filing grievance (i.e. parent, student, or school staff), reason for grievance and outcome.
- **Monthly Staffing Report:** details all public schools with school health service personnel including school name, school type (DCPS or public charter), ward, enrollment number, principal, grades offered, name of SHSP staff and coverage hours.
- **Cumulative Annual Report** to include all reports generated

Care Coordination & School Health Integrations Services

Grantees in this component will be expected to develop and provide the following reports ***at minimum*** to DC Health:

- **Monthly Case Management and Health Navigation Report:** describes the number of referrals and linkages opened and closed monthly, delineated by student gender, grade, school name and ward and race/ethnicity. While referrals are the directing of students to specialized resources, linkages are the successful completion of a referral, where students access the service to which they were referred. Closed referrals are those referrals that result in the student and/or parent linking to and receiving the service. **DC Health will provide templates for reports**. Referral types shall include:
  - Referrals to medical services (primary, behavioral health, oral health, and specialty services)
  - Referrals to social services (ex. TANF, WIC, housing, legal, child protective services, etc.)
  - Referrals to community resources (ex. food pantry, aftercare, parenting, child, and adolescent development, etc.)
- ~~**Quarterly**~~ **Monthly Quality Assurance Reports**
  - Continuous Quality Improvement Activity Report with description of project and outcomes
  - Unusual Occurrences Report with description of unusual occurrence and outcome
  - Grievance Report detailing person filing grievance (i.e. parent, student, or school staff), reason for grievance and outcome.

- **Monthly Staffing Report:** details all public schools with school health service personnel including school name, school type (DCPS or public charter), ward, enrollment number, principal, grades offered, name of SHSP staff and coverage hours. Report should also include information from community-based organizations and non-SHSP schools.
- **Monthly School Integration Report:** describes all activities undertaken to integrate SHSP processes and policies with those of schools, CBOs, and governmental guidelines. Include a description of stakeholders consulted in the process.
- **Cumulative Annual Report** to include all reports generated

Training, Technical Assistance, and Support

Grantees in this component will be expected to develop and provide the following reports ***at minimum*** to DC Health:

- **Monthly Training and Technical Assistance Report:** provides a summary of technical assistance and training services provided, with the following information:
    - Description of the type(s) of service(s) provided
    - Schools and community-based partners that received services
    - Type of individuals that received services (i.e. nurses, school administration, etc.)
    - Dates that cases were open and/or closed
    - Number of trainings provided, and number of people served by training
    - Breakdown of health suites that have and have not been approved
- ~~**Quarterly**~~ **Monthly Quality Assurance Reports**
    - Continuous Quality Improvement Activity Report with description of project and outcomes
    - Unusual Occurrences Report with description of unusual occurrence and outcome
    - Grievance Report detailing person filing grievance (i.e. parent, student, or school staff), reason for grievance and outcome.
- **Cumulative Annual Report** to include all reports generated

E. Performance Area Evaluation

Grantees shall collaborate with the Department of Health/Community Health Administration, Quality Assurance/Quality Improvement personnel, and Program Evaluation personnel to monitor and evaluate the implementation of core functions and assure quality as determined by DC Health. Grantees are responsible for ensuring their plans, protocols, and performance evaluation activities are approved by DC Health.

F. Policy Development and Compliance

Grantees shall collaborate with the Department of Health/Community Health Administration on the development of school health policies and procedures. The protocols that are applicable to the program must be approved by DC Health. Grantees must also follow all DC Health protocols, guidance, and regulations, as well as local and federal laws and mandates, as applicable.

VI. APPLICATION CONTENT

A. Executive Summary

A one-page **executive summary** is required. Please provide an executive summary that is clear, accurate, and concise. The executive summary must be **single-spaced, limited to one page in length**, and include the following sections:

1. **Annotation:** Provide a three-to-five-sentence description of your project that identifies the population and/or community needs that are addressed, as well as the intended target audience for services.
2. **Problem:** Describe the principal needs and problems addressed by the project.
3. **Purpose:** State the purpose of the project.
4. **Goal(s) And Objectives:** Identify the major SMART 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.
5. **Methodology:** Briefly list the major activities used to attain the goal(s) and objectives.
6. **Point of Contact:** List the name, title, phone number, email address of the primary point of contact for the grant.
7. **Organization Information:** List the organization name and address.
8. **Funding:** Identify the total amount of funding being requested.

B. Experience

The **experience section** is a narrative that describes your organization's background and past experiences that align with the core functions of the performance area to which you are applying. Applicants should include a **list of references** that may speak to their past work and suitability for the chosen performance area. A template for the list of references has been provided in Appendix D.

1. What is your understanding of the health and wellness needs of the District's school-aged population, including children with special healthcare needs?
2. What is your understanding of the Whole School, Whole Community, Whole Child model and the role of school health services within that framework? Describe any past experience implementing the WSCC framework within your specialty area, the results of the implementation efforts, and any lessons learned.
3. What additional frameworks and best practices have you previously utilized to guide your services? Describe the results of the implementation efforts and any lessons learned.
4. Describe any past experience developing a strategic plan and implementing those services.
5. How have you previously worked collaboratively with clinical service providers, CBOs, and/or government agencies (including those in public health, behavioral health, education, and health care financing) to implement large-scale health programs? Describe any past cross-departmental collaborations and/or collaborations with external organizations and partners. Please also describe any experience obtaining consent for data sharing and executing Memoranda of Agreements in these collaborations.
6. Describe any past experience with data collection, tracking, and analyzing health outcomes. What was the data used for, what lessons were learned from it, and how were service users engaged when sharing the results of the data? Did any data reveal concerning trends, and if so, how did you address the concerns and challenges in collaboration with your partners?
7. How have you previously measured, evaluated, and improved your services and constituent satisfaction based on feedback collected from users? Describe any past experience handling the concerns of users and partners, how they were addressed, and how improvements in the areas of

concern were assessed.

8. How have you previously ensured that your staff are trained and equipped to deliver services, particularly for new initiatives and services?
9. Describe your familiarity with local and federal policies as they relate to your chosen performance area, as well as any past experience following and adhering to relevant guidelines.
10. Have you previously received a grant? If so, describe your experience adhering to the grant agreement(s), scope of work, and reporting requirements. What performance-based metrics have you measured during the grant period(s) to ensure compliance with grant requirements, and how?
11. What lessons have you learned from your past experiences with programs relevant to your chosen performance area, and how will you apply those lessons in the implementation of this grant project?
12. What are your goals for the award?

In-Person Health Suite Staffing & Direct Services

a. Describe any past experience delivering health services to school-aged children, including children with special health care needs, with an awareness of and adherence to national best practice standards. Include the level of care provided, based on the level definitions provided in Appendix A for *Children with Special Health Care Needs*.
b. Describe any past experience collaborating with partners and external organizations in the coordination of clinical care.
c. How have you previously ensured adequate staffing coverage for your population's healthcare needs?

On-Demand Telehealth Services

a. Describe any past experience delivering telehealth services to school staff, families, and school-aged children, including children with special health care needs, with an awareness of and adherence to national best practice standards.
b. Describe any past experience setting up and coordinating the utilization of telehealth services and platforms in a manner that is secure, user-friendly, and compliant with local and federal regulations.
c. Describe any past experience providing training programs and/or technical assistance for the use of telehealth services.

Care Coordination & School Health Integrations Services

a. Describe any past experience delivering care coordination services to school-aged children, including children with special health care needs, with an awareness of and adherence to national best practice standards. Be sure to describe case management, health navigation, and clinical consultation experience specifically, if applicable.
b. Describe any past experience successfully linking clients to community resources to which they were referred.
c. Describe any past experience working collaboratively with students, parents, and medical homes to ensure student health needs are met. Include information about outreach and family engagement efforts.
d. Describe any past experience coordinating school health teams.
e. Describe any experience and familiarity with school system policies, including emergency preparedness.

Training, Technical Assistance, and Support

a. Describe any past experience coordinating training programs and providing technical

assistance to ensure compliance with protocols, governmental regulations (i.e. Occupational Safety and Health Administration), and national practice standards.

b. Describe any existing partnerships and linkages that reflect an ability to work with, provide feedback to, and evaluate diverse partners.
c. Describe any past experience with coordinating accredited training programs, licensure renewals, and professional development for clinical staff, school staff, or other personnel, including Administration of Medication training, if applicable. Training programs described in this section may include both in-person and virtual training opportunities, whether on-demand or live. Provide information about the target audience, number of trainees, accompanying accreditation programs, and professional hours earned.
d. Describe any past experience providing support with health suite operations and health suite approvals.
e. Describe any past experience providing support with compliance and corrective action implementation.
f. Describe any past experience with securing adequate supplies for facilities, with a particular interest in health supplies.

C. Organizational Capacity

The **organizational capacity section** should describe the organizational infrastructure, the organization's mission and vision, and how these components contribute to the ability of the organization to conduct the program requirements and meet program expectations. Applicants should clearly describe their ability to manage staff and policies enforced to overseeing completion of tasks. Applicants should affirm organizational leadership commitment to complete the project as proposed in the work plan.

1. What are your organization's mission, vision, and values, and how do they align with the SHSP?
2. What is your current organizational structure? Provide an **organizational chart** (1-page) that includes position titles, staff names (noting vacancies), contractors, and other significant collaborators for the program. The chart should also include a depiction of where the grant program staff will lie within your greater organization.
3. Describe your organization's current system to respond to communications with partners and constituents regarding tasks, complaints, and requests. How do you ensure every message is met with a timely and appropriate response? Please describe what a timely response means to your organization.
4. Describe how decisions are made within your organization, including when there is disagreement.
5. How does your organization ensure employees' needs are being met and their wellness is prioritized? What avenues of communication exist for employees to vocalize concerns or provide feedback to the organization?
6. What is your organization's approach to team building and career development?
7. How will your staff reflect the cultural, racial, linguistic, and geographic diversity of the populations and communities served?
8. Describe your organizational capacity to provide all the service functions within your chosen performance area to at least 225 schools and at selected ~~**least**~~ 20 CBOs **(up to 20)** for a four-year period. Service functions include collaboration with other grantees and selected partners, as well as the ability to complete data collection, tracking, and analysis.
9. Describe your current process for obtaining consent and executing data sharing agreements with partners.
10. What is your organization's capacity to implement quality assurance activities for your chosen performance area?

11. Describe your organization's ability to utilize a mixed staffing model to ensure student health needs are met while all staff are performing at their highest level of skill.
12. What partnerships and linkages does your organization have that will allow for the appropriate referrals, collaboration, and/or communication necessary to perform the functions of your chosen performance area? What new partners do you hope to engage?
13. Describe your organization's ability to work collaboratively with government agencies and non-governmental organizations from a variety of sectors to implement health and/or public health initiatives aimed to advance a public health goal and improve community outcomes.
14. Describe the hardware and software you have access to as an organization.
15. What health system technology is currently used at your organization (i.e. registry for care coordination)? Please describe the system, who has access to it, and any data sharing and terms of use associated with the system. How can the SHSP be integrated into this existing system, or how can the system be replicated for the SHSP?
16. What accounting structure will you use to maintain effective internal controls and provide accurate and complete information about all financial transactions related to this program?
17. Describe your organization's fiscal practices that will facilitate the capturing of funds leveraged from other sources and additional sources of funding you will pursue.
18. Describe your organization's flexibility and ability to adjust to public health emergencies and District priorities in a timely manner.
19. Describe your organization's ability to follow and remain in compliance with required protocols.

D. Staffing Plan

The **staffing section** should detail your proposed staffing model and recruitment strategies. All personnel's actions should be rooted in public health practice, where grantees consider the social determinants of health and ecological approaches to their points of care and performance areas. Grantees will be operating under DC Health protocols, so all personnel should adhere to guidelines put forth by DC Health and other applicable local and federal regulations when supporting SHSP and promoting student health at both an individual and population-level scale. In addition to relying on protocols and regulations from DC Health and other entities, grantees will be expected to develop their own protocols relevant to their performance area for feedback and approval by DC Health prior to implementation.

Applicants shall describe how they will ensure all staff deliver services within their scope of practice, meet the standards and requirements of the appropriate professional licensing board, and comply with safety and security requirements. The applicant shall also discuss how they will ensure sufficient supervisory, administrative, clinical, quality assurance, and technology personnel to support the clinical and allied health services performance areas of SHSP.

All staff who work directly with students must pass and complete a background check with the District of Columbia Public Schools and the Public Charter Schools within 30 days of the award period and prior to the provision of services. Grantees will be responsible for coordinating with schools to ensure the necessary background checks are addressed and documentation of the checks are provided to DC Health.

Applicants should address the following questions and components in this section:

1. How do you plan to recruit and retain personnel for this program to adequately address student health needs and the SHSP's collaborative, non-traditional structure (i.e. pipelines, incentives, etc.)? Include information about how you will build on your past experience recruiting and retaining personnel, as well as any lessons learned from the past experiences.

2. What is your proposed staffing model, and how does it align with the functions of your chosen performance area? Describe staff qualifications, as well as the type and number of full-time employees necessary for ensuring adequate personnel for all District schools and CBOs participating in the program for the duration of the award period. Include ~~**employees for coverage outside of traditional work hours (i.e. evenings and weekends) for all eight wards, as well as**~~ any additional support for specific targeted areas based on equity models.
3. What key personnel will be included in the oversight and implementation of the functions of your chosen performance area? Include position descriptions for all proposed personnel. **Resumes or CVs for key senior personnel should be included in the Attachments.**
4. How will you ensure all staff deliver services within their scope of practice, meet the standards and requirements of the appropriate professional licensing board, and comply with safety and security requirements?
5. How will you ensure sufficient supervisory, administrative, clinical, quality assurance, and technological personnel to support the clinical and allied health services performance areas of SHSP?
6. How does your proposed staffing model accommodate the data-related needs of this proposal including data collection, sharing, and reporting?
7. How does your staffing model comply with District regulations, including requirements for minimum coverage hours and privacy? How will you ensure that all staff working directly with students undergo the proper background checks as required by District of Columbia Public Schools and Public Charter School policies?
8. How does your staffing model provide for flexibility in the event that you have to rapidly adjust it in response to changes in the health needs of the student body, personal absences, facility closures, or potential emerging issues?
9. How would you work with DC Health and selected partners to modify staff's duties to align with District priorities and public health emergencies, if necessary? How would you ensure new or revised grant deliverables are met?
10. Those applying to *In-Person Health Suite Staffing & Direct Services* or *Care Coordination & School Health Integration Services* must, ***at minimum***, include how they will ensure staffing of the following personnel within their narrative response:

In-Person Health Suite Staffing & Direct Services

The following staff members will work directly with SHSP schools in health suites.

a. **One (1) Director of Nursing:** The Director of Nursing will be responsible for closely collaborating with DC Health and reporting required items to DC Health from the health suite. The Director of Nursing will also oversee health suite approvals and the integration of work products with the overall SHSP. They will also work more closely with other grantees and DC Health to create and adhere to protocols and a health suite workflow that facilitates the timely completion of grant requirements and requests.
b. **Eight (8) Nurse Managers:** Freed from direct clinical care, nurse managers will provide nursing leadership within the school system and coordinate the clinical aspects of the school health program, receiving direct guidance from DC Health and the Director of Nursing while collaborating with other members of the health services and health education teams. They may also:
    i. Ensure staff with Administration of Medication training complete skills checks.
    ii. Oversee transition of care between staff with Administration of Medication training and health suite staff, updating student medical records accordingly.
    iii. Collaborate with DC Health, community providers, school, staff, and community organizations to address health issues holistically, develop needs

assessments, and plan implementation of services in alignment with the Whole School, Whole Community, Whole Child Model.

iv. Carry out communicable disease prevention and infection control.

v. Collaborate with the *Training, Technical Assistance, and Support* grantee to ensure that there is an emergency care plan in place for all emergencies, including but not limited to, medical, natural disaster, safety, fire, and infectious disease emergencies. The emergency care plan should be communicated to all staff and closely coordinated with community emergency care protocols.

vi. Develop a plan to provide vision and hearing screenings during the school day to children without a documented screening within the past year. Provide surge screenings at the beginning of each school year.

1. Develop a mechanism to track abnormal vision/hearing screenings and referral outcomes, including behavioral health referrals.
2. Prepare vision and hearing screening reports for school administration review during the first week of November and first week of April of each school year.

vii. Develop and implement a telephonic and telehealth nurse coverage plan. This plan will describe functions, staffing, detail hours of availability, and a decision tree for triage purposes to allow for standardization.

c. Health Suite Clinical Staff: Clinical staff will provide direct health services to SHSP schools. Teams should include health technicians, community health nurses, and licensed practical nurses. Staff may:

i. Provide population-based primary prevention and healthcare services, including health education, physical and mental health assessment, referral for care, implementation of healthcare plans for students with special health care needs, health counseling, mandated screenings, infectious disease monitoring, enforcement of public health precautions, interpretation of student health care needs to school personnel, implementation of emergency care plans, and collaboration with other school professionals.

ii. Short-term medical management of illness and injuries, medication management, and first aid within scope of practice.

iii. Lead in the development of policies, programs, and procedures for the provision of school health services at an individual or district level, relying on student-centered, evidence-based practice and performance data to inform care

iv. Coordinate distribution of condoms in schools in conjunction with DC Health's Condom Distribution Program.

v. Develop general protocols for student care in the event of an urgency or emergency that delineates roles and responsibilities of an individual trained in administration of medication and that of staff in general.

vi. Track parent/guardian notifications of student illness and injuries in all schools.

vii. Ambulatory nursing procedures such as gastric tube feeding, tracheostomy care, insulin administration, orthopedic device maintenance, and bladder catheterization.

viii. Keep up to date with changing health practices and insurance procedures.

ix. Provide coverage, either in-person or via telephone, daily between 8:00 am and 4:30 pm at all schools in the District covered under this award.

x. Assist with immunization compliance as part of the health team led by schools' Immunization Point of Contact. Support may be needed for gathering immunization information from the District of Columbia Immunization

Information System and students' Universal Health Certificates, communicating with families about immunization programs, identifying non-compliant students, implementing appropriate methods (i.e. letters, in-person meetings, parent-teacher association meetings, workshops, etc.) to encourage compliance, adhering to the established timeline for meetings to monitor immunization compliance, collecting feedback, and reflecting on lessons learned.

xi. Collaborate with school administration for communication with staff, students, and families to address public health concerns.

xii. Collaborate with nutrition staff for nutrition education in chronic disease management.

xiii. Collaborate with behavioral health clinicians and schools' 504 teams to address crisis prevention processes and behavioral health referrals, as outlined by the Behavioral Health Referral Plan (Appendix C).

xiv. Continuous quality improvement: assessment, identification of the issue, development of a plan of action, implementation of the plan, and evaluation of the outcome.

xv. Additional clinical activities that align with District priorities and any public health emergencies that may arise.

d. Two (2) Administrative Staff: Administrative staff will handle communications between parties, including health suite staff, DC Health, Nurse Managers, selected partners, and other personnel while supporting the Director of Nursing in managing the SHSP grant. They may also:

i. Respond to school staff, patient inquiries, other grantees, and select community-partners regarding referrals, authorizations, and scheduling in an efficient manner.

ii. Keep an accurate record of staff attendance and staff meetings, distributing information as necessary.

iii. Organize internal clinical training sessions that are in alignment with DC Health priorities and enhance personnel's skill set for effectively providing health-related and customer services to students, including those with chronic conditions and special health care needs, in a collaborative manner, per the Whole School, Whole Community, Whole Child model.

iv. Support the Director of Nursing in managing the SHSP grant, including in the submission and reporting of grant deliverables.

v. Ensure DC Health has direct access to staff for the provision of work assignments.

vi. Ensure staff is documenting and meeting requests, protocols, and services (i.e. student medical records).

vii. Act as a thought partner in the monitoring and integration of health suite personnel into the school environment, as well as facilitating the response to school and health needs, per the WSCC framework.

Care Coordination & School Health Integrations Services

Staff will provide care coordination services and integration services for all schools within the District as well as select CBOs that work with children and adolescents in the District. Care coordination includes making referrals and linkages related to behavioral health services.

a. Case Managers: Case Managers (social workers, registered nurses, and/or licensed practical nurses) will identify (through the review of relevant records) children with special healthcare needs, defined as students who have or at an increased risk for a chronic

physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. Conditions include Attention-Deficit/Hyperactivity Disorder, asthma, diabetes, severe food allergies, seizures, post-cancer treatments, post-surgical treatments, cerebral palsy, intellectual disabilities, developmental delays, multiple disabilities, severe emotional disturbances, sickle cell anemia, mental health concerns, and pregnancy. They will be expected to integrate with the schools and CBOs they serve, maintaining consistent communication with all parties to ensure all cases are appropriately addressed with all the appropriate personnel involved. Case Managers may also:

i. Determine students' need for periodic, daily, or more frequent interventions, as well as close monitoring of condition.
ii. Develop Individualized Health Plans (IHPs) for students with a chronic condition that requires in-school management as determined by universal health certificate information, or the provision of a doctor's order.
    1. Should be developed in collaboration with the parent or guardian and the student's medical home.
    2. Include medical diagnosis, in-school treatment required, frequency of intervention anticipated, and subsequent adherence to the plan.
    3. Collaborate with the 504 Accommodation/Individualized Education Plan Coordinators, Behavioral Health Clinicians/Coordinators, and School Administration to ensure the student's IHP incorporates goals and interventions to support academic success, as per the Behavioral Health Referral Plan (Appendix C).
iii. Identify and communicate to the designated school staff all students with medical conditions that require medical intervention during the school day in a format determined in conjunction with DOH. This communication will occur monthly and in real time with any changes.
iv. Coordinate with other school health staff for accommodation of students with severe disabilities. Communication and coordination shall assure the transfer and sharing of pertinent student information, keeping student medical records updated, ensuring the necessary parties have engagement with the student/family, ensuring the safety and wellbeing of students, and delineating roles and responsibilities for care.
v. Additional duties that align with District priorities and any public health emergencies that may arise.

b. Health Navigators: Health Navigators will coordinate preventive care, proactive disease management, immunizations, and annual wellness exams through collaboration and communication with school staff, families, and healthcare providers outside of the school setting. They may also:

i. Utilize existing Universal Health Certificates, Oral Health Assessment data, and available past history from established IHPs to identify students overdue or due for immunizations, chronic medical conditions in need of preventive care, and behavioral health needs, as per the Behavioral Health Referral Plan (Appendix C).
    1. Outreach to families that are out of compliance and in need of resources and support.
ii. Identify service gaps in schools in order to inform efforts to expand school resources and linkages to community resources.
iii. Engage families and primary medical providers to secure medical action plans,

medication and/or treatment authorization, and related medical orders to assist with the development of IHPs and allow for the provision of care by Health Suite Clinical Staff.

iv. Coordinate and ensure completion of referrals to primary and specialty medical services, behavioral health services, social services, and community-based programs.

v. Collaborate with other school staff who provide student/family support services (i.e. school counselors).

vi. Outreach and support to students and families as needed for care coordination and clinical health services.

c. **Outreach Coordinators:** Outreach Coordinators will establish and maintain relationships with community resources and providers to understand what they're able to offer and how their services may be accessed to share with Case Managers, Health Navigators, health suite staff, and other grantees. They may also ask community resources and providers about the current gaps and barriers seen within their practice setting so that Case Managers and Health Navigators are better able to understand community needs and provide assistance. They may also:

i. In collaboration with DC Health, develop an active and up-to-date directory of school-based and external resources in the District.

ii. Support the recruitment and participation of external providers and services as a potential referral destination for student health services.

d. **One (1) Clinician Consultant:** The Clinician Consultant should have at least five years of experience caring for children with special health care needs, as they will provide medical technical assistance and consultation on students with special health care needs as needed by school staff and other grantees. They may also:

i. Support interpretation of physician orders.

ii. Consult on patients, medical cases, and the provision of health services at school sites.

iii. Provides expert feedback and support on the clinical content included in training materials, guidance, manuals, and protocols.

iv. Establish screening, education programs, and treatment specific to their specialty (i.e. asthma, orthopedics, etc.).

v. Attend requested meetings and telehealth sessions with school staff, families, and/or students to support the development of health plans and guidance.

E. Implementation Plan

The **implementation plan** is a narrative that describes how the performance area functions will be implemented. The implementation plan should be accompanied by a **logic model**, which is a one-page diagram that presents the conceptual framework for a proposed project and explains the links among program elements. Applicants should also provide an annual **work plan**, which describes key process objectives and goals for successful implementation of those functions.

1. Provide an **implementation plan** for your program describing your organization's strategies for implementing services utilizing the WSCC framework. Strategies should specify how core functions will be operationalized, potential challenges in the operation of each core function, and how you will proactively address those challenges. Describe the rationale for your selected activities and strategies. The following questions should also be addressed:

a. How does your implementation plan incorporate the WSCC framework?
b. How do you propose to establish a universal consent process so that all grantees are able to access the data required for optimal coordination across sectors?
c. How will you ensure cases that are open are closed and that personnel follow-up with open cases as necessary?
d. What data points may you collect to facilitate the tracking of progress in your chosen performance area? How will you ensure the security and privacy of that data in a manner that is HIPAA and FERPA compliant?
e. How will you ensure ongoing technical assistance requests and updates are provided within your grant deliverables?
f. How will you address complaints and requests for information within an appropriate time frame?
g. How will you communicate with DC Health about any approvals necessary for your implementation activities?
h. How will your delivery of services accommodate COVID-19 safety and engagement considerations? How will you maintain flexibility to keep up with and implement evolving COVID-19 guidance in a timely manner? How will your delivery of services be flexible to any accommodations necessary for other public health emergencies that may arise?
i. How will you keep track of ad hoc requests and/or special projects that may be assigned as District priorities and policies shift?
j. How does your implementation plan account for alignment and integration with other grantees' performance areas?
k. What potential challenges do you anticipate in the operation of your chosen performance area? How will you proactively address patterns of challenges and concerns?

In-Person Health Suite Staffing & Direct Services

a. Outline the process flow for students seeking school health services, including the potential use of collaboration with DC Health and selected partners.
b. How will you maintain an open line of communication with DC Health and personnel from other SHSP performance areas? How will you facilitate efficient and accurate communication across these performance areas?
c. How will you coordinate with personnel from *On-Demand Telehealth Services* and *Care Coordination & School Health Integrations Services* to track referrals, services provided, students served, and other identified outcomes?

On-Demand Telehealth Services

a. Describe the platform(s) you plan to introduce to SHSP for school health services personnel to provide telehealth services.
b. How will you ensure all school health services personnel (particularly health suite personnel, case managers, and health navigators) have access to telehealth services?
c. What features will your proposed telehealth platform have, and how will they support the implementation of the SHSP (i.e. area to meet and discuss cases, student vs. health suite personnel portal, file sharing, fillable documents, synchronization of information from documents into electronic health records)?
d. How will you address accessibility challenges, such as poor internet connectivity, that may arise when utilizing telehealth services? How will you accommodate users with disabilities (i.e. provide closed captioning)?
e. How will you ensure the telehealth service is feasible and easy-to-use? How will you orient users to the telehealth service platform(s) (i.e. hosting training sessions)?

f. How will telehealth services be secured? How will you ensure compliance with privacy guidelines, such as FERPA and HIPAA?
g. How will you determine when telehealth services can and cannot be utilized?
h. How will you track telehealth service usage, complaints, and challenges?

Care Coordination & School Health Integrations Services

a. How will schools, community-based organizations, and families be able to contact health navigators and case managers directly?
b. How will you achieve proper and adequate follow-ups, even in the face of challenges such as non-response?
c. How will you establish and maintain partnerships to allow for appropriate referrals, linkages, and follow-up with primary and specialty medical care and social services?
d. What are the processes that will be followed, and the criteria required to close student cases?
e. How will you engage stakeholders within schools to integrate school health services into existing school policies?
f. How will you coordinate health teams to perform outreach, education, family engagement, and emergency preparedness activities?

Training, Technical Assistance, and Support

a. What training programs do you anticipate leading and providing to SHSP personnel, selected partners, school staff, families, and other interested parties? How will you adapt the training programs to be understandable to these varying audiences? Be sure to describe Administration of Medication training in your response.
b. How will you seek accreditation for the training programs provided?
c. What modalities are you able to use for training programs (i.e. on-demand virtual training, live virtual training, in-person training, or all of the above)?
d. How will you ensure virtual training sessions are accessible to attendees and in alignment with the technological systems and security requirements in place?
e. How many people do you plan to accommodate for each training session, both virtual and in-person?
f. How will you track attendees' completion of training programs?
g. How will you field requests for technical assistance?
h. How will you prioritize and address technical assistance requests?
i. How will you track progress after the provision of technical assistance?
j. What will be your process for monitoring inventory of health suite supplies and restocking them as necessary?
k. How will you secure and support health suite approval for all SHSP schools, per the Health Suite Approval Checklist (Appendix E)?
l. How will you ensure and support compliance with protocols (i.e. Occupational Safety and Health Administration requirements, DC Health guidelines, etc.) in health suites?

2. Provide a **logic model** for your program, as well as a narrative describing the logic model. While there are many versions of logic models, for the purposes of this announcement the logic model should summarize the connections between the:
    a. Goals of the project (e.g., objectives, reasons for proposing the intervention, if applicable);
    b. Assumptions (e.g., beliefs about how the program will work and is supporting resources. Assumptions should be based on research, best practices, and experience.)

c. Inputs (e.g., organizational profile, collaborative partners, key staff, budget, other resources);
d. Activities (e.g., approach, listing key intervention components);
e. Outputs (i.e., the direct products or deliverables of program activities); and
f. Outcomes (i.e., the results of a program, typically describing a change in people or community).

3. Provide an annual **work plan**, using the template provided (Appendix F). Under each objective, provide a list of activities that will be used to achieve each of the objectives proposed and anticipated deliverables.
    a. 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.
    b. Include process objectives and measures. Objectives should be SMART (Specific, Measurable, Achievable, Relevant, and Time-Framed).
    c. Include a startup work period and implementation work plan period.

F. Evaluation Plan

The **evaluation plan** should provide a description of how project goals will be assessed and monitored during project implementation, including data to be collected and data sources used. You should describe how key performance measure data will be collected and used to assess project outcomes.

1. How will you monitor, assess, and support implementation with fidelity to the chosen program component and maintain quality assurance of the functions performed under your performance area? Identify the measurable indicators that align with the program goal.
2. How will you incorporate ongoing continuous quality improvement?
3. How will lessons learned be captured and disseminated?
4. Which staff members will be responsible for data collection and analysis?
5. What are the anticipated challenges to monitoring quality and fidelity, and how do you propose to respond to the issues you identified?
6. How will you work with DC Health and selected partners to ensure that the Evaluation Plan is being followed and updated as needed or requested?

G. Budget and Budget Justification

The application should include a project **budget and budget justification** using the form provided in Appendix G. The budget and budget justification should be directly aligned with the stated goals, objectives, outcomes, and milestones in the work plan, including funding to support all requirements of the RFA. The budget should also list all in-kind supports and funding sources.

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.

Note: The electronic submission platform, Enterprise Grants Management System (EGMS), will require additional entry of budget line items and detail. This entry does not replace the required upload of a budget narrative using the required templates.

VII. EVALUATION CRITERIA

Critical 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 five 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. Where appropriate, the driving principles of the WSCC model should be incorporated into the applicants' proposal.

A. Experience ~~Criteria~~ (20 Points)

- Demonstrates an understanding of the health and wellness needs of the District's school-aged population, including children with special health care needs
- Demonstrates an understanding and past experience implementing the WSCC framework, or other frameworks/best practices, within their specialty area with the inclusion of lessons learned
- Demonstrates past experience and past performance in the functions outlined in section VI B
- Demonstrates past experience in the selected performance area(s) functions as outlined in section VI B

B. Organizational Capacity (25 Points)

- Describe the organizational infrastructure, the organization's mission and vision, and how these components contribute to the ability of the organization to conduct the program requirements and meet program expectations
- Demonstrates ability to meet the areas outlined in section VI C and included required attachments to support narrative provided
- Demonstrates system to respond to communications methods and processes with partners and users in a timely manner this includes outlining decision-making process within the organization as requested in section VI C
- Demonstrates strategies and methods for employee satisfaction, team building, wellness and employee input including how staff reflect the cultural, racial, linguistic, and geographic diversity of the populations and community (communities) served
- Demonstrates an organizational capacity to provide all the service functions within their chosen performance area to at least 225 schools and ~~**at least**~~ **up to** 20 CBOs within the entire program period
- Describes ability to execute sharing agreements, implement quality assurance activities, and utilize mixed staffing models as defined in section VI.
- Describes experience and past successes working collaboratively with government agencies and non-government organizations from a variety of sectors to implement health and/or public health initiatives aimed to advance a public health goal (include linking and identifying new partnerships)
- Demonstrate access and use to needed hardware, software, and school health technology and how it may be integrated within the program
- Defines an accounting structure that clearly demonstrates the organization's ability to maintain effective internal controls and provide accurate and complete information about all financial transactions and funding sources related to the program
- Demonstrates flexibility and ability to adjust to public health emergencies and District priorities in

a timely manner

C. Staffing Plan (10 Points)

- Demonstrate experience and ability with personnel recruitment and retention, along with addressing student's needs, as outlined under section VI D
- Describes the key personnel that will be included in the oversight and implementation of the functions of their chosen performance area
- Demonstrate the ability to implement the functions of the performance area for the duration of the award period as outlined under section VI D
- Demonstrates compliance with applicable District regulations, scope of practices, standards and requirements of appropriate professional licensing boards, safety and security requirements, privacy requirements, protocols, and proper background checks
- Demonstrates the ability to rapidly adjust the staffing model in response to changes in health needs of the student body, school, personnel absences, facility closures, or potential emerging issues within selected performance area

D. Implementation Plan (30 Points)

- Applicant described and provided the implementation plan as outlined in Section VI E with supporting required attachments
- The applicant's strategies to implement services meet the functions of the program and align with the WSCC framework
- Describe HIPAA and FERPA compliant process, and tracking progress and adherence within the program and selected performance area(s)
- Define process to address, close out, and communicate complaints and requests in a timely manner within the scope of the program and with DC Health
- Describes service delivery implementation with public health emergencies and COVID-19 safety and engagement considerations
- Demonstrate an awareness of the potential challenges in the operation of the selected performance area(s) and program fidelity as well as strategies to proactively address them
- Comprehensively address functions described in this funding announcement under selected performance area as defined in section VI E and describes alignment and integration with other grantee's performance area
- Demonstrates achievable inputs, activities, outputs, and outcomes in logic model
- Demonstrates SMART objectives in work plan that supports overall program goals

E. Evaluation Plan (15 Points)

- Demonstrates monitoring approaches and the incorporation of continuous quality improvement, including the identification of anticipated challenges and potential resolutions
- Demonstrates measurable indicators that align with program goals
- Demonstrates qualified staff members responsible for data collection and analysis
- Demonstrates proactive collaboration with DC Health and partners for evaluation plan alignment and updates

F. Budget and Budget Justification (Reviewed, but not Scored)

- Applicant includes an itemized budget and reasonable justification consistent with the program plan. The budget and budget justification directly aligned with the stated goals, objectives, outcomes, and milestones in the work plan, including funding to support all requirements of the RFA

VIII. REVIEW AND SCORING OF APPLICATION

A. Pre-Screening Technical 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.

B. External Review Panel

The review panel will be composed of neutral, qualified, professional individuals who have been selected for their unique experiences in human services, public health, health program planning and evaluation, and social services planning and implementation. The panel will review, score and rank each applicant's package 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.

C. 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. Those factors will include minimally a past performance review, risk assessment and eligibility assessment, including a review of assurances and certifications, and business documents submitted by the applicant, as required in the RFA. DC Health will also conduct an excluded parties list search (EPLS) of the organization and executives via the federal System for Award Management (SAM) and conduct a DC Clean Hands review to obtain DC Department of Employment Services and DC Office of Tax and Revenue compliance status.

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.

IX. APPLICATION PREPARATION & SUBMISSION

A. Application Package

Submissions for multiple project areas must be submitted under one application. Only one (1) application will be accepted. The total size of the applicable documents may not exceed the equivalent of **25 pages for one performance area or 40 pages for two or more performance areas (excluding attachments)** when printed by DC Health.

The following applicable sections **are** included in the 25-page limit for one performance area or 40 pages for two or more performance areas:

- Executive Summary (1 page)
- Experience
- Organizational Capacity
- Organizational Chart (1 page)
- Staffing Plan
- Implementation Plan
- Logic Model (1 page)

The following documents **are not** included in the page limit:

- List of References (Appendix D)
- Personnel Resumes
- Work Plan (Appendix F)
- Evaluation Plan
- Budget Worksheet and Justification (Appendix G)
- Application for Funding (Completed via EGMS)
- Assurances Certifications and Disclosures. Reviewed and Accepted via EGMS (Appendix H).
- DC Health Standard Grant Terms and Conditions (Reviewed and Accepted via EGMS)
- Mandatory Certification Documents (Scan and upload)

B. Pre-Application Conference

Visit DC Health's Eventbrite page for pre-application conference information, https://OGMDCHealth.eventbrite.com The meeting will provide an overview of CHA's RFA requirements and address specific issues and concerns about the RFA. No applications shall be accepted by any DC Health personnel at this conference. Do not submit drafts, outlines or summaries for review, comment, or technical assistance.

Applicants who received this RFA via the Internet shall provide the District of Columbia, Department of Health, and Office of Partnerships and Grants Services with the information listed below, by contacting shs.program@dc.gov.

- Name of Organization Key Contact(s)
- Mailing Address
- Telephone and Fax Number
- E-mail Address

Please be sure to put "RFA Contact Information" in the subject box. This information shall be used to

provide updates and/or addenda to the RFA.

C. Assurances & Certifications

DC Health requires all applicants to submit various certifications, licenses, and assurances at the time the application is submitted to help ensure all potential awardees are operating with proper D.C. licenses. The complete compilation of the requested documents is referred to as the **Assurances Package**. Only ONE Assurances Package is required per submission.

DC Health classifies Assurances Packages into two categories: 1) Those "required to be submitted along with applications," and 2) Those "required to sign grant agreements." Failure to submit the required Assurances Package may result in the application being either ineligible for funding consideration [required to submit assurances] or ineligible to sign/execute award agreements [required to sign grant agreements assurances]. If the applicant does not have current versions of the required documents on file with DC Health, they must be submitted with the application.

Assurances Required to Submit Applications (Pre-Application Assurances)

The following documents are required at the time of application submission:

- City Wide Clean Hands Compliance Status Letter (formerly Certificate of Clean Hands).
- ~~**501 (c) 3 certification**~~
- Official List of Board of Directors on letterhead, for current year, signed and dated by the authorized executive of the Board. (cannot be the CEO)
- ~~**All Applicable Medicaid Certifications**~~
- A Current Business license, registration, or certificate to transact business in the relevant jurisdiction

Assurances Required to Sign Grant Agreements for Funds Awarded through this RFA (Post-Award Assurances)

The following documents are required before signing grant agreements:

- Certification Regarding Lobbying; Debarment, Suspension and Other Responsibility Matters; and Drug-Free Workplace Requirements
- Comprehensive Automobile Insurance, if applicable for organizations that use company vehicles to administer programs for services.
- Certification of current/active Articles of Incorporation from DCRA
- Proof of Insurance for: Commercial, General Liability, Professional Liability, Comprehensive Automobile and Worker's Compensation
- Certificate of Occupancy
- Most Recent Audit and Financial Statements
- Copy of Cyber Policy
- Certificate of insurance. Insurance requirements are determined by the ORM and are finalized following issuance of the grant award. A sample template of insurance requirements can be found in Appendix I, though it may be changed by ORM per a review of any exposures under the grant.

D. Uploading the Application

All applications must be submitted through EGMS. Documents to include in each of the uploaded files are below. All of these must be aligned with what has been requested in other sections of the RFA. All file names should include your organization's name and the performance area for which you are applying.

1. **Mandatory Business Documents** - Scan and upload **ONE** .pdf file that contains the following:
    a. Current business license, registration, or certificate to transact business in the District of Columbia
    b. 501(c) (3) Certification (for non-profit organizations)
    c. Current certificate of good standing from local tax authority
    d. Official List of Board of Directors for the current year on agency letterhead and signed by the authorized executive of the applicant organization; not the CEO. The list should include names and the position that each member holds.
    e. City Wide Clean Hands Compliance Status Letter (formerly Certificate of Clean hands). Clean Hands Compliance Status letter must be dated no more than 3 months prior to the due date of application,
    ~~**f. Medicaid Certifications, if applicable**~~
    ~~**g. FQHC designation letter, if applicable**~~
    h. Appendix H (signed Assurances Certifications & Disclosures). Scan and upload one SIGNED copy (Appendix H) by the Agency Head or authorized official.

2. **Application Proposal -** Upload **ONE .**pdf file containing:
    a. Executive Summary **(1 page)**
    b. Experience Section
    c. Organizational Capacity
    d. Organizational Chart (1 page)
    e. Staffing Plan
    f. Implementation Plan
    g. Logic Model (1 page)

3. **Attachments** - Upload separate .pdf files for each of the following documents:
    a. List of References
    b. Personnel Resumes
    c. Work Plan
    d. Evaluation Plan
    e. Budget and Budget Justification

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

E. Format

Prepare the application according to the following format:

- **Font Size:** Times New Roman or Arial 12-point unreduced
- **Spacing:** single-spaced
- **Paper Size:** 8.5 by 11 inches
- **Page Margin Size:** 1 inch
- **Page Limit:** 25 pages for one performance area or 40 pages for two or more performance areas
- **Header or Footer:** Specifies Chosen Performance Area

F. Application Submission

Department of Health application submissions must be done electronically via the Department of Health's Enterprise Grants Management System (EGMS), DC Health's web-based system for grant-making and grants management. In order to apply 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 apply 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.

Note: 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.

Submit your application via EGMS by 6:00 p.m., on the deadline date of **Monday, July 19, 2021.** **Applications will not be accepted after the deadline.**

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 may not be approved by the DC Health Office of Grants Management in time for submission. To register, complete the following:

1. **Check Web Browser Requirements for EGMS:** The DC Health EGMS Portal is supported by the following browser versions:
    a. Microsoft ® Internet Explorer ® Version11
    b. Apple ® Safari ® version 8.x on Mac OS X
    c. Mozilla ® Firefox ® version 35 & above (Most recent and stable version recommended)
    d. Google Chrome ™ version 30 & above (Most recent and stable version recommended)

2. **Access EGMS**: The user must access the login page by entering the following URL into a web browser: https://dcdoh.force.com/GO ApplicantLogin2. Click the button **REGISTER** and follow the instructions. You can also refer to the EGMS External User Guide.

3. **Determine the Agency's Primary User:** The Primary User is authorized to accept terms of agreement, certify and submit documents, and request and accept modification. The Primary User will determine a Secondary User and send a notification via EGMS for them to set-up an account.

4. **Gather Organization Information:** Your EGMS registration will require your legal organization name, your DUNS#, 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).

5. **Submit and Await Review:** When your Primary Account User request is submitted in EGMS, the

DC Health 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 with the subject line: "EGMS Primary User [Agency Name]." 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 the Office of Grants Management to provide additional information, if needed.

6. **Upload DUNS Certification:** Once you register, your Primary Account User will get an auto-notice to upload a "DUNS Certification." This will provide documentation of your organization's DUNS. You can simply upload a scanned copy of the cover page of your SAM Registration.

The Office of Grants Management at doh.grants@dc.gov assists with all end-user registration if you have a question or need assistance. The primary point of contact is Jennifer Prats at (202) 306- 9684. Here are the most common registration issues:

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

X. 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:

A. Grant Terms & Conditions

All grants awarded under this program shall be subject to the DC Health Standard Terms and Conditions for all DC Health-issued grants. The Terms and Conditions are in the Attachments and in the Enterprise Grants Management System, where links to the terms and a sign and accept provision is embedded.

B. 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.

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. Promotional gifts and other expenditures which do not support the program are unallowable. Salaries and other expenditures charged to the grant must be for services that occurred during the grant's period of availability.

C. 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 (see Appendix F: Assurances & Certifications and Mandatory Disclosures), 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 grant agreement shall outline the scope of work, standards, reporting requirements, fund distribution terms and any special provisions required by District and federal agreements.
4. Utilize Performance Monitoring & Reporting tools developed and approved by DC Health.
5. Develop a sustainability plan for the proposed initiative

D. 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.**

E. Insurance

All applicants that receive awards under this RFA must show proof of all insurance coverage required by the Office of Risk Management (ORM) by law prior to receiving funds. Insurance requirements are determined by the ORM and are finalized following issuance of the grant award. A sample template of insurance requirements can be found in Appendix I, though it may be changed by ORM per a review of any exposures under the grant.

F. 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 A-133 rules must have available and submit the most recent audit reports, as requested by DC Health personnel.

G. 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.

H. 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 report shall be completed by the Department of 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.

XI. CONTACT INFORMATION

A. Grants Management

Patricia Greenaway
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Community Health Administration
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899 North Capitol Street, NE Washington, 3rd Floor
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B. Program Contact

Kafui Doe, EdD, MPH, CHES
Child, Adolescent & School Health Division Chief
Community Health Administration
DC Department of Health
899 North Capitol Street, NE Washington, 3rd Floor
Washington, DC 20002
shs.program@dc.gov

XII. APPENDICES

Appendix A: Definitions

For the purposes of this RFA, the following terms shall have the meaning as described below.

Adverse Intervention shall mean an action or ministration that produces an untoward/unwanted effect.

Behavioral Health Referral Plan is a protocol for school health personnel to follow in order to address students' behavioral health needs. The Plan must be utilized in line with schools' current processes and crisis prevention plans.

Care Coordination (CC), as defined by the Agency for Healthcare Research and Quality, is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

Case Management means a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers, and the community. The Case Management process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of Case Management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient's right to self-determination.

Children with Special Health Care Needs (CSHCN) are those [students] who have or are at an increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. For the purposes of the DCSHSP students with special care needs shall be stratified using the following criteria:

Level	Population	Diagnosis	Services	IHP
One	Children with Chronic Illness	Stable Chronic Disease (ex. ADHD, asthma, diabetes, etc.)	No regular services	Not required
Two	Children with Chronic Illness	Stable Chronic Disease (ex. ADHD, asthma, diabetes, etc.)	Periodic intervention (ex. medication administration, glucose monitoring	Required (annual updates)
Three	Medically Fragile and mainstreamed in regular school setting	Unstable Chronic Disease or Other High-Risk Conditions (ex. severe food allergies, unstable diabetes, uncontrolled seizures, post- cancer treatments, post-surgical, etc.)	Daily intervention and/or monitoring (ex. bladder catheterizations, tube feedings, frequent glucose surveillance, post-op wound care, tracheostomy care)	Required (annual and as-needed updates)
Four	Severely Medically Fragile Students	Severe Illnesses/Conditions (ex. cerebral palsy, intellectual disability, developmental	Close and/or continuous monitoring and frequent interventions (i.e.	N/A

		delays, multiple disabilities, severe emotional disturbance, etc.)	interventions/treatments listed in Level 3 required more than once daily)	

Consumable Supplies mean a quantity of medical and clerical goods used ordinarily in the practice of nursing and administration, including, but not limited to, gloves, bandages, water cups, and tongue depressors.

Continuous Quality Improvement is the process-based, data-driven approach to improving the quality of a product or service. It operates under the belief that there is always room for improving operations, processes, and activities to increase quality.

Covered School means a public school that receives school health services supported by the Department of Health.

Early Childhood means children in preschool or pre-kindergarten (i.e. age 3 or 4 by September 30th).

Early and Periodic Screening/Diagnosis and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

Health Equity means the highest level of attainment of health for all people. Everyone is valued equally, and there are focused and ongoing efforts to address avoidable inequalities and the elimination of health and healthcare disparities.

Individuals with Disabilities Education Act (IDEA) is the federal law that outlines rights and regulations for students with disabilities who require special education and related services. Under the IDEA, all children with disabilities are entitled to a Free Appropriate Public Education (FAPE) in the Least-Restrictive Environment (LRE).

Individualized Educational Programs (IEP) means a plan developed for a child who is determined eligible for IDEA Part B services. Part B directs the manner in which educational services shall be provided for children with disabilities (age 3 to 21). IEP contains a description of the child's disability and appropriate placement, individualized goals and objectives and a schedule of services to be provided to the child.

Individualized Healthcare Plan (IHP) means a plan of action to be used by the school nurse and other members of the school team, as appropriate, to meet actual and potential health care needs of a student during the school day. IHP includes a list of health problems that require care in school and nursing diagnoses (by date) determined by the school nurse. For each health problem and nursing diagnosis identified, the plan shall specify interventions, specific student outcomes and evaluation criteria.

Linkages are the desired outcomes of referrals, where students access and utilize the service to which they are referred.

Local Wellness Policies are comprehensive policies to be implemented by each school as required by federal law. Local wellness policies aim to improve the environmental sustainability of schools, improve

nutrition education and promotion, physical activity and other activities that promote student wellness. (DC Law 18-209, DC Code §38-821.01 et seq., Healthy Schools Act of 2010).

Local Education Agency (LEA), as defined in the Federal Elementary and Secondary Education Act (ESEA), means a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary schools or secondary schools in a city, county, school district, or other political subdivision of a State. In the District, DCPS serves as the LEA for all traditional public schools and each public charter school serves as a LEA for the school or schools in its network.

Medical Home is described by the American Association of Pediatrics as a system of care that is accessible, family centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.

Medically Fragile Students mean students with healthcare needs that may require specialized healthcare procedures for life support and/or health support during the school day. This category does not include students who require one-on-one skilled nursing care throughout the day.

Non-Fixed Equipment means equipment and furnishings valued at less than five-thousand dollars (< $5,000), including but not limited to chairs, privacy screens, and office phones.

Outcome Evaluation measures program effects in the target population by assessing the progress in the outcomes that the program is to address.

Process Evaluation determines whether program activities have been implemented as intended and resulted in certain outputs.

Public Schools are District of Columbia Public Schools and public charter schools.

Referrals are the directing of students and other patients to specialized resources, including but not limited to, behavioral health services/professionals and ophthalmologists.

Required Health Forms refer to the DC Universal Health Certificate and the Oral Health Assessment Form which are completed by a child's primary care physician, or nurse practitioner following a physical exam, and by a dentist after an oral health exam. These forms provide the school system with pertinent medical information on the status of a child's health. Parents of school-aged students are required to have the DC Universal Health Certificate completed and submitted to each school principal or designated school official annually. The Oral Health Assessment Form is completed by the student's oral health care provider following a dental examination as required by DC Official Code § 38-602 and is also submitted to the school principal.

School Health Suites means a physical location within a school that meets the standards of the District of Columbia Department of Health.

Section 504 of the Rehabilitation Act of 1973 is a federal civil rights law that prohibits discrimination against individuals on the basis of disabilities and guarantees access to federally funded programs, including public school, for disabled individuals.

Special Education refers to a range of educational and social services provided by the public school

system and other educational institutions to individuals with disabilities who are between three and 21 years of age.

Special Needs Schools are schools exclusively providing health and education services to children who have or are at an increased risk for a chronic physical, developmental, behavioral or emotional condition and who require services of a type or amount beyond those required by children generally.

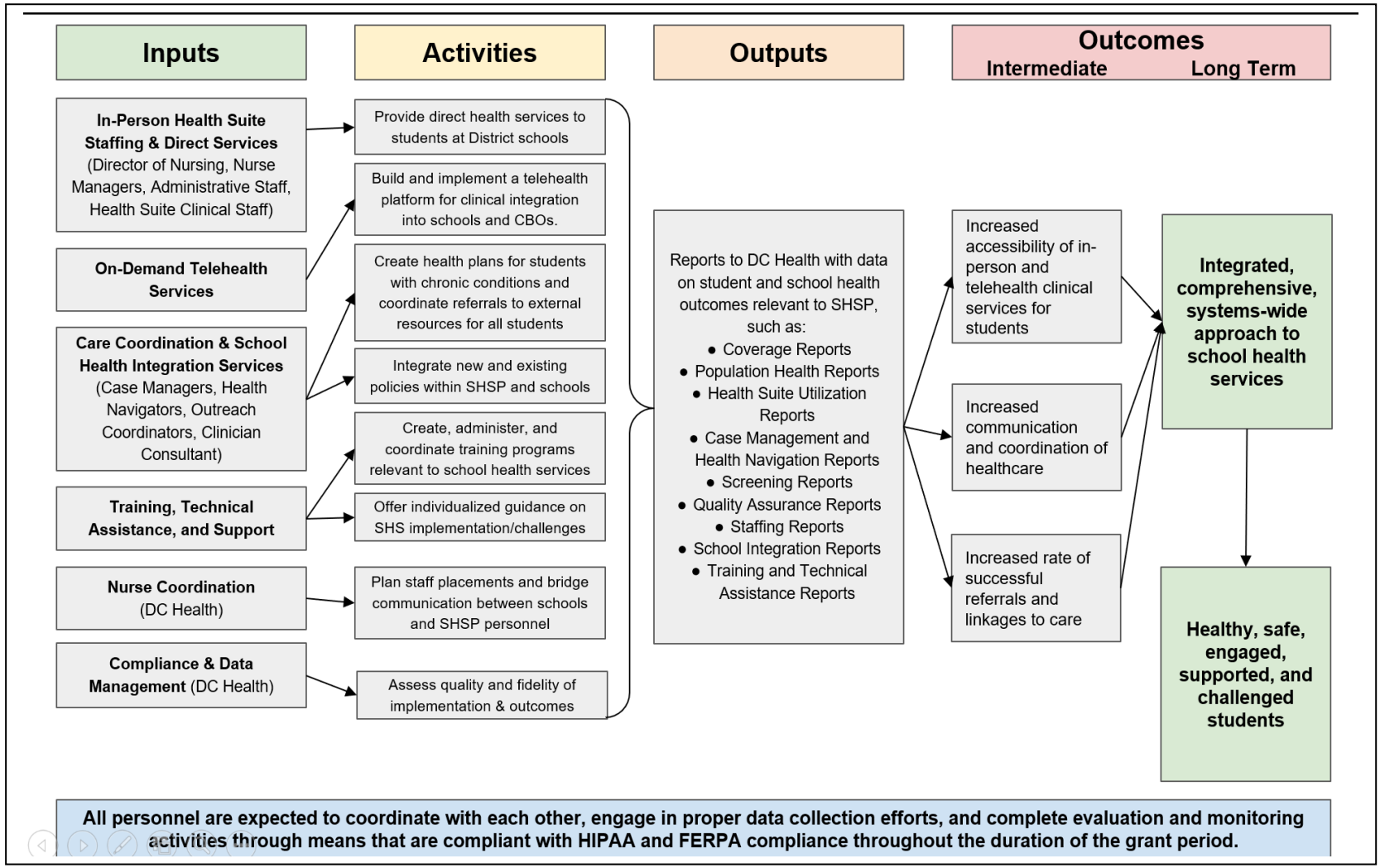
Students shall include all public-school students Pre-K thru grade twelve (12) and the ungraded special needs school.

Trauma-Informed Approach realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.

Unusual Incident means any happening, event, or situation, not consistent with the desired operation of the District of Columbia School Health Services Program and which may have caused or may have the potential for causing injury to clients, visitors, students, or staff, or resulting in the loss or damage to property.

Whole School, Whole Community, Whole Child (WSCC) Model means a child-focused model of health and academic services that emphasizes a school wide approach and that acknowledges the school being a part and reflection of the local community. This model aligns, integrates and coordinates health, education and behavioral services to serve the needs of the whole child.

Appendix B: SHSP Logic Model



Appendix C: Behavioral Health Referral Plan

To: Local Education Agencies (LEAs)
From: DC Department of Health (DC Health)
Date: September 4, 2020

RE: Role of Nurse within Local Education Agencies (LEAs) for the Behavioral Health Referral Process

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The nurse has the primary responsibility for determining the health statuses of students within the school environment. Furthermore, the nurse should consult responsible staff members to bring awareness to the student's needs. In situations where behavioral health services and support are needed, nurses assigned within local education agencies (LEAs) will be the primary lead in developing an individualized health plan that supports proper medical interventions and medication adherence through care coordination with the student's primary care provider (PCP) and guardian, when applicable. Any changes to medical documentation and medication updates for students will need to be reflected in the student's medical files and shared weekly with school mental health clinicians and 504 team members. It is further required that nurses assigned within a local education agency attend 504 eligibility meetings, behavioral health intervention meetings, and meetings organized by the School-Based Health Center Staff, when applicable. An understanding of the local education agency's referral process should occur at the originalmeeting with school administrators, nurses, and school staff. In this capacity, the role of the nurse is to interpret the health status of the student and interpret any impairment that may affect daily life activities, such as chronic illness or long-term medication administration.

Relationship between 504 Coordinator, Mental Health Clinician, and Nurse

The assigned nurse will routinely communicate with both mental health and behavioral health clinicians regarding the health statuses of students. To support the nurse and the behavioral health referral process, reoccurring meetings, processes, and review of protocols should be conducted frequently and be updated or modified based on the needs of the student, respectively. Nurses and School-Based Health Center staff, when applicable, will update and coordinate on data sharing for student's medical files and specific care coordination services such as medication adherence, family engagement, primary care provider (PCP), and external referrals and linkages. The nurse will regularlynotify behavioral health support staff of students with complex medical conditions, students who require medications, and students who are at risk for medical complicationsor require health services.

Referral Process:

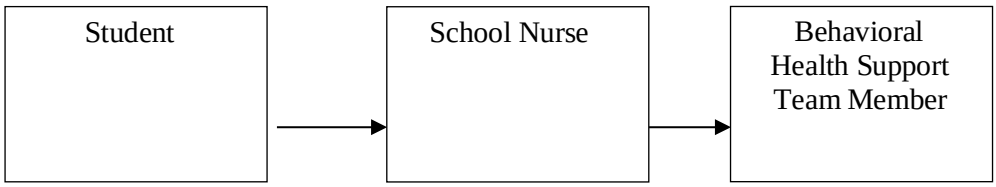
The notification process can begin if either:

a. The student has a self-referral request
b. A student is identified by the nurse as needing routine mental health services
c. A parent, teacher, or community leader approaches the nurse about a studentneeding routine mental health services
d. The nurse identifies a student as having chronic mental health episodes orrequiring mental health services

Once the nurse is notified, the nurse can begin the referral process by immediately notifying the

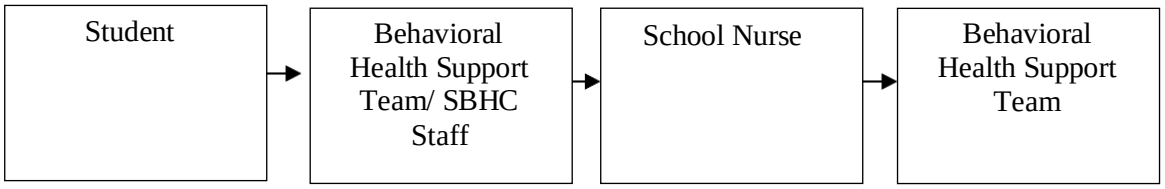
designated mental health clinician assigned at the student's school. Each local education agency should send an updated list of their primary mental health clinician points of contact to the School Health Services Program at shs.program@dc.gov. The School Health Services team will ensure that assigned nursingstaff receive their assigned primary points of contact. Similarly, the nurse will send students identification information along with historical context and medical documentation to school staff.

Nurses must follow the school's processes and protocols by allowing the School Behavioral Health Coordinators to close the feedback loop. The School Behavioral Health Coordinators are the primary contact in regard to the referral source and ensuringcontact is made with both the student and family, when applicable. Please note that underthe DCMR 22-B600, the Minor's Health Consent regulation, minors have a right to self –refer and receive the required mental health services without the consent of a parent or guardian. Under this regulation, a minor must provide consent for information to be shared with parents/guardians.



If the 504 coordinator, mental health clinician, or the School-Based Health Center staff,are the first to identify a student needing services, please immediately notify the nurse ifthe student requires one or more of the following:

a. Administration of Medication
b. Care coordination or medical services
c. Individualized Health Plan



It is highly recommended that the 504 coordinator, mental health clinician, or the School-Based Health Center staff, when applicable, notify the assigned nurse within 24 hours of receiving a referral from a student, family member, or staff member. Within this time, the504 coordinator, mental health clinician, or the School-Based Health Center staff, when necessary, shall provide potential dates and times to nursing staff for the initial behavioralhealth care coordination meeting to convene. The assigned nurse will have two calendar days to notify and receive confirming responses from the Nurse Manager, Health Suite Staff, and School-Based Health Center Staff, if necessary. The initiator of the process shall notify the staff of the official date and time of the meeting.

Upon receipt of information from the 504 coordinators and/or mental health clinician, theassigned nurse will begin to submit the required medical documentation to school staff for a finalized behavioral health plan. All required and necessary medical documentation will be specific to each case and will need to be clearly specified by the nurse. During this time, the nurse will work to develop an individualized health plan. If the student already has an individualized health plan, the nurse will work closely with the primary care provider (PCP) regarding updated guidelines of necessary accommodations to include administration of medication and to determine if self-administration is permissible. During 504 coordination meetings and/or behavioral health care coordination meetings, nurses should review medical documentation to determine accommodations for the individualized health plan. The nurse shall request all documentation concerning the student's medical history from the student's primary care provider (PCP) and the School-Based Health Center Staff, if necessary. If the assigned nurse is unable to make or update necessary accommodations within five days of determining eligibility, the nurse must request an extension through the behavioral healthclinician, 504 coordinators, or the principal based upon the given timeline.

Additionally, during the school year, if the IHP, behavioral health plan, or 504 plan requires an amendment to the student's health status, the nurse will need to be notified within five working days in advance. This recommendation is based on the summer breakand weekly rotation of the nurse schedule.

As previously stated, the nurse will consult with the responsible staff members and bring awareness to the student's needs. Nurses will need to implement care coordination guidelines with the primary care provider (PCP). Below is an outlined list of responsibilities during the referral process:

Overall Responsibilities of the Nurse:

Care Coordination	• Draft/Finalize IHP • Work with behavioral supports within schools to ensure medication adherence and student medical files are up to date.
Identification and Assessment	• Assess the child's health status by consulting with the student, family,and primary care provider. • Assist in identifying other studentswho may need behavioral health-related services.
Planning and Implementation	• Develop individual healthcare plans and emergency care plans. • Assist the team in developing an IHP that addresses the health needsand enables the student to participate in educational activities. • Develop the student's health- related goals and objectives, aswell as nursing protocol. • Serve as team liaison to themedical community. • Assist the family in identifying andutilizing community resources. • Provide training to teachers and staff regarding the health needs ofthe child.
Monitoring and Evaluation	• Evaluate the effectiveness of health-related components of the IHP and make revisions as needed.

Adapted from "School Nurses: Roles and Responsibilities in the School Setting" by The IRIS Center (https://iris.peabody.vanderbilt.edu/module/nur01-personnel/)

If you have any questions or concerns in regards to technical assistance and/orcoordination stated please contact the School Health Services Program at shs.program@dc.gov.

Appendix D: List of References Template

To better understand applicants' experiences, DC Health requests a list of references who can speak to applicants' past work and suitability for their chosen performance area. The list of references should be formatted as a chart, with the information requested below:

Organization Served by the Project	Point of Contact (PoC) Name	PoC Role	PoC Email	PoC Phone Number	Dates of Project Duration	Description of Services Provided in the Project

Appendix E: Health Suite Approval Checklist

Health Suite Design, Equipment and Supplies

Provision of the School Health Services Program (SHSP) must include health suites with supplies, equipment, technology and privacy to ensure effective and efficient assessment and triage of sick and injured students, provision of care, and evaluation of increasingly complex health needs. Schools must include consideration of and provide for projected school enrollment, health status of the student population, necessary supplies and equipment, services required, confidentiality and safety. If you have questions please contact SHSP at shs.program@dc.gov.

Part I - Health Suite Design

This section details the facility requirements for the health suite. The health suite design must facilitate federal privacy requirements under the Family Educational Rights and Privacy Act (FERPA) of 1974 which protects the privacy of student records, including health information. The District of Columbia School Health Services Program has established this checklist to assist public schools in determining the facility standards to which the school health suites must adhere.

Criteria	Met	Not Met	NA	Comments
Health suite should be located in a quiet area, easily accessible to all areas of the building, including the administrative offices.				
There should be at least one (1) bathroom that conforms to the Americans with Disabilities Act (ADA) guidelines to include ADA accessible water sources within the bathroom for washing hands and facilitating special needs.				
Health suite should be accessible for the disabled, with doors leading to the main office, outer hallway and/or outside for access to emergency medical services and transportation.				
Health suite is a non-shared space used only for services provided by SHSP and provides for the privacy of students' health information.				

Health suite contains incandescent and natural lighting adequate for viewing rashes, injuries, etc.				
Adjustable overhead lighting in the rest area.				
Provision of emergency lighting in case of a power outage.				
At least one (1) outside window that may be opened for natural lighting and ventilation.				
At least one electrical outlet every six (6) feet, with surge protection distributed throughout the health suite including in the bathroom.				
Adequate plumbing to ensure hot and cold running water for the assessment and treatment area.				

Criteria	Met	Not Met	NA	Comments
Water source outside of the bathroom to allow for administration of medication, washing hands and providing first aid with sink(s) equipped with gooseneck faucets, liquid soap, and a paper towel dispenser.				
Lockable wall and base cabinets for the storage of medications, supplies and equipment. (Avoid storage of medications in cabinets with glass doors since they provide visual access and minimal security.)				
Base cabinets with cleanable counter tops to provide treatment areas.				
Floor to ceiling closet for storage of large equipment.				

Lockable refrigerator of adequate size for storing medications and food items for special needs students.				
A tile or seamless anti-microbial resinous floor which facilitates disinfection of soiled areas.				
Easily cleanable, hard walls.				
Heating and air conditioning controls that are separate from the rest of the building.				
Access to fresh air and exhaust fans to provide adequate ventilation.				
A waiting and triage area with four chairs for approximately every 300 students enrolled at the school.				
An assessment and treatment area where injuries are cared for; include an exam table, sink with eyewash attached, countertop, supply cabinet, and access to a refrigerator and icemaker.				
A medication area, including locked cabinet, sink, and access to a refrigerator.				
Private nurse's office for administrative work, counseling, and meetings to include: windows to provide visual access to cot and waiting areas for monitoring students; blinds or one-way glass to provide privacy; a standard office desk; computer linked to internet; printer; fax; telephone; file cabinets; chairs.				
Rest area with one cot for every 300 students.				

Part II - Health Suite Equipment

In order to implement the District of Columbia School Health Services Program (SHSP) school partners must accept responsibility for providing health suite supplies for immediate care. Supplies are ordered as necessary. The nurse should assume the responsibility to confer with the principal and/or designee in order to recommend supplies and equipment necessary for the provision of care.

Criteria	Met	Not Met	NA	Comments
Sink with hot and cold running water.				
Eye wash station attached to water source for irrigating foreign substance eye injuries.				
Wall mounted liquid soap dispensers adjacent to all sinks.				
Wall-mounted paper towel dispensers adjacent to all sinks.				
Double locked medication cabinet, or single locked medication cabinet with locked box to go inside.				
One resting cot for every 300 students, separated by privacy curtains or screens.				
Locked Refrigerator with ice maker or ice trays.				
Desk with lockable drawers, adequate surface for telephone, work area and computer.				
Networked computer with monitor • USB ports • Printer • Fax • Security software to ensure confidentiality of information • Microsoft office suite Excel, PowerPoint, Access, Word, Publisher				

Separate dedicated phone line for the health suite office and fax. ● Phone line not shared among multiple users ● One dedicated telephone number that routes directly to the health suite				
Lockable file cabinets with a minimum of four drawers for the storage of confidential files and other materials.				
Balanced scale with height measuring device and/or a wall mounted height- measuring device and a scale.				
Pedal controlled, covered waste receptacle with disposable liners.				
Resting cot with washable surfaces or disposable sheeting to allow for disinfecting between students.				

Criteria	Met	Not Met	NA	Comments
Sharps container for disposal of hazardous medical waste and procedures for disposal of hazardous waste containers.				
Blankets and pillows with disposable or plastic covers.				
First aid station with washable counter tops and adequate storage space.				
Clock with second hand, chairs, paper wastebasket, flashlight, and wheelchair.				
Screening equipment as required by District of Columbia statutory and regulatory mandates.				
Office supplies (pens, pencils, etc.)				

Part III - First Aid Supplies

At the time of the Health Suite Assessment please inventory the supplies listed below to determine the current supply.

Criteria	Met	Not Met	NA	Comments
Band-Aids ● 1000 1”1400 Students ● 1000 ¾ “1400 Students				
Tape of various widths, hypoallergic				
Alcohol pads				
Emesis basins, 12 disposable				
Cold packs, reusable and disposable, 100 per 400 students				
Cotton-topped applicators, one (1) box CPR masks, pediatric and adult				
Germicidal wipes, one (1) container				
Eye pads, 100 sterile/400 students				
Synthetic or non-latex gloves, 20 boxes				
Masks, one (1) box				
Drinking water				
Cups ● Drinking: paper, 200 per 400 students ● Medicine: plastic, 200/40 students				

Paper towels with dispenser, one (1) case of 24 rolls				
Plastic bags, small and large re-sealable, 1000/400 student				
Roll paper for cots or examination table, One (1) case of 24 rolls				
Assorted safety pins, one (1) bag				
Feminine sanitary napkins, 200 per 200 students (for middle and high schools)				
Three (3) pairs of scissors (2 bandage and 1 office)				

Criteria	Met	Not Met	NA	Comments
Slings and/or triangular bandages,				
Soap (in a dispenser)				
Hand sanitizer				
Assorted pills				
Tissue, one (1) case of 24				
Air freshener (In bathroom only)				
Tongue blades, adult and pediatric, one (1) box /400 students				
Digital thermometers,				

Probe covers, 400/400 student				
Non-sterile 4 X 4's, 200/400 student				
Non-sterile 2 X 2's. 400/400 student				
Kling wrap, 10 yards each of 2", 3", and 4"				
Portable crisis kit (to-go bag)				
First Aid Kits It is recommended that first aid kits be located in designated classrooms one on each floor of the school building. The number of kits will vary according to the size of the facility. The kits can be restocked from the health suite supplies.				
Non-sterile 4 X 4's, 200/400 student				
Non-sterile 2 X 2's. 400/400 student				
Kling wrap, 10 yards each of 2", 3", and 4"				
Portable crisis kit (to-go bag)				

Appendix F: Work Plan Template

Government of the District of Columbia
Department of Health
Community Health Administration
Grantee Work Plan

Agency/Organization Name:	
Program/ Grant Name:	
Chosen Performance Area:	
Project Title:	
Total Request:	
Primary Target Population:	
Estimated Reach:	
Programmatic Contact Person:	
Telephone:	
Email:	

Guidance:

Using the following instructions please complete the chart below:

- Goal: Make sure your goals are clear and reachable, each one should be:
  - Specific (simple, sensible, significant)
  - Measurable (meaningful, motivating)
  - Achievable (agreed, attainable)
  - Relevant (reasonable, realistic and resourced, results-based)
  - Time bound (time-based, time limited, time/cost limited, timely, time-sensitive)
- Objective (SMART): Measurable steps your organization would take to achieve the goal

- Key Indicator: A measurable value that effectively demonstrates how you will achieve your objective(s)
- Key External Partner: Who you work with outside of your organization to achieve the goal
- Key Activity: Actions you plan carry out in order to fulfill the associated objective
- Start Date and Completion Date: The dates you plan to complete the associated activity
- Actual Start Date and Completion Date: The dates you started and completed the activity
    - Note: These columns should be entered by you and submitted to your project officer at the end of the budget period
- Key Personnel: Title of individuals from your organization who will work on the activity

GOAL 1:					
Measurable Objectives/Activities:					
Objective #1:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
Objective #2:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
Objective #3:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**

A.					

B.					

GOAL 2:					
Measurable Objectives/Activities:					
Objective #1:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #2:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #3:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					

GOAL 3:					
Measurable Objectives/Activities:					
Objective #1:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #2:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #3:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					

GOAL 4:					
Measurable Objectives/Activities:					
Objective #1:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #2:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #3:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					

Appendix G: Budget and Budget Justification Template

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Budget/Budget Justification Instructions

Provide 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. This document should be submitted with the Excel budget template that was provided to you.

A. **Personnel:** Personnel costs should be explained by listing each staff member who will **(1)** be supported from funds 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, 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 quality improvement activities, staff responsible for monitoring programmatic activities and use of funds, and staff responsible for data collection, quality and reporting. **Note:** Final personnel charges must be based on actual, not budgeted labor. **Fringe Benefits:** Fringe Benefits change yearly and should be confirmed before submitting your budget. List all components that make up the fringe benefits rate.

B. **Consultants/Contractual:** Grantees 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. Grantees must provide the following information in the budget justification:

1. **Name of Contractor/Consultant: Who is the contractor/consultant?**
   Include the name of the qualified contractor and indicate whether the contract is with an institution or organization if applicable. Identify the principal supervisor of the contract.

2. **Method of Selection: How was the contractor/consultant selected?**
   If an institution is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract services. If the contract is with an institution or organization, include the contract supervisor's qualifications.

3. **Period of Performance: How long is the contract period?**
   Include the complete length of contract. If the contract involves a number of tasks, include the performance period for each task

4. **Scope of Work: What will the contractor/consultant do?**
   List and describe the specific tasks the contractor is to perform.

5. **Criteria for Measuring Contractor/Consultant Accountability: How will the contractor/consultant use the funds?**
   Include an itemized line item breakdown as well as total contract amount. If applicable, include any indirect costs paid under the contract and the indirect cost rate used. Grantees must have a written plan in place for contractor/consultant monitoring and must actively

monitor contractor/consultant.

C. **Occupancy/Rent:** This cost includes rent, utilities, insurance for the building, repairs and maintenance, depreciation, etc. Include in your description the cost allocation method used to allocate this line item.

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

E. **Supplies:** Provide justification of the supply items and relate them to specific program objectives. It is recommended that when training materials are kept on hand as a supply item, that it be included in the "supplies" category. **When training materials (pamphlets, notebooks, videos, and other various handouts) are ordered for specific training activities, these items should be itemized and shown in the "Other Direct Costs" category.** If appropriate, general office supplies may be shown by an estimated amount per month multiplied by the number of months in the budget period. If total supplies are over $10,000 it must be itemized.

F. **Equipment:** Provide itemized costs, specifications, quantity, unit, unit cost, and basis for cost estimate (actual cost or price quotation).

G. **Client / Participant Costs:** Includes client travel. Client/Participant costs are costs paid to (or on behalf of) participants or trainees (not employees) for participation in meetings, conferences, symposia, and workshops or other training projects, when there is a category for participant support costs in the project.

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

I. **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.

Agency/Organization Name Budget Period								
Personnel								
Name of Staff	**Position Title**	**Percent Charge to Grant**	**Annual Salary**	**Salary Charged**	**Fringe Benefits Rates**	**Fringe Benefits Cost**	**Total Salary and Benefits**	**In-kind Contributions (Yes/No)**
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	

		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
Total Personnel			**$ -**	**$ -**		**$ -**	**$ -**	

Non-Personnel Costs				
Consultants/Contractual				**Total**
Occupancy (List the location of each service below)		**Cost**	**Monthly**	**Total**
		$ -	0	
		$ -	0	
		$ -	0	
		$ -	0	
Travel (List each traveler name below)	**Travel Destination**	**Time (Date s of Travel)**		**Total**
Supplies			**Quantity**	**Total**
			0	
			0	
			0	
Equipment			**Quantity**	**Total**
			0	
			0	
			0	
Client Costs				**Total**
Communication				**Total**

Total Non-Personnel Cost	**$ -**

Other Direct Costs	
Type of Service	**Total**
Total Other Direct Cost	**$ -**

Total Direct and Indirect Costs		
Direct Cost (Personnel + Non-Personnel + Other Direct)	**$**	**-**
Indirect Cost (10%)	**$**	**-**
Total Project Cost	**$**	**-**

Appendix H: Assurances, Certifications, and Disclosures

This section includes certifications, assurances and disclosures made by the authorized representative of the Applicant/Grantee organization. These assurances and certifications reflect requirements for recipients of local and pass-through federal funding.

A. Applicant/Grantee Representations

1. The Applicant/Grantee has provided the individuals, by name, title, address, and phone number who are authorized to negotiate with the Department of Health on behalf of the organization;
2. The Applicant/Grantee can maintain adequate files and records and can and will meet all reporting requirements;
3. All fiscal records are kept in accordance with Generally Accepted Accounting Principles (GAAP) and account for all funds, tangible assets, revenue, and expenditures whatsoever; all fiscal records are accurate, complete and current at all times; and these records will be made available for audit and inspection as required;
4. The Applicant/Grantee is current on payment of all federal and District taxes, including Unemployment Insurance taxes and Workers' Compensation premiums. This statement of certification shall be accompanied by a certificate from the District of Columbia OTR stating that the entity has complied with the filing requirements of District of Columbia tax laws and is current on all payment obligations to the District of Columbia, or is in compliance with any payment agreement with the Office of Tax and Revenue; (attach)
5. The Applicant/Grantee has the administrative and financial capability to provide and manage the proposed services and ensure an adequate administrative, performance and audit trail;
6. If required by DC Health, the Applicant/Grantee is able to secure a bond, in an amount not less than the total amount of the funds awarded, against losses of money and other property caused by a fraudulent or dishonest act committed by Applicant/Grantee or any of its employees, board members, officers, partners, shareholders, or trainees;
7. The Applicant/Grantee is not proposed for debarment or presently debarred, suspended, or declared ineligible, as required by Executive Order 12549, "Debarment and Suspension," and implemented by 2 CFR 180, for prospective participants in primary covered transactions and is not proposed for debarment or presently debarred as a result of any actions by the District of Columbia Contract Appeals Board, the Office of Contracting and Procurement, or any other District contract regulating Agency;
8. The Applicant/Grantee either has the financial resources and technical expertise necessary for the production, construction, equipment and facilities adequate to perform the grant or subgrant, or the ability to obtain them;
9. The Applicant/Grantee can comply with the required or proposed delivery or performance schedule, taking into consideration all existing and reasonably expected commercial and governmental business commitments;
10. The Applicant/Grantee has a satisfactory record of performing similar activities as detailed in the award or, if the grant award is intended to encourage the development and support of organizations without significant previous experience, has otherwise established that it has the skills and resources necessary to perform the services required by this Grant.
11. The Applicant/Grantee has a satisfactory record of integrity and business ethics;
12. The Applicant/Grantee either has the necessary organization, experience, accounting and operational controls, and technical skills to implement the grant, or the ability to obtain

them;

13. The Applicant/Grantee is following the applicable District licensing and tax laws and regulations;
14. The Applicant/Grantee is following the Drug-Free Workplace Act and any regulations promulgated thereunder; and
15. The Applicant/Grantee meets all other qualifications and eligibility criteria necessary to receive an award; and
16. The Applicant/Grantee agrees to indemnify, defend and hold harmless the Government of the District of Columbia and its authorized officers, employees, agents and volunteers from any and all claims, actions, losses, damages, and/or liability arising out of or related to this grant including the acts, errors or omissions of any person and for any costs or expenses incurred by the District on account of any claim therefrom, except where such indemnification is prohibited by law.

B. Federal Assurances and Certifications

The Applicant/Grantee shall comply with all applicable District and federal statutes and regulations, including, but not limited to, the following:

1. The Americans with Disabilities Act of 1990, Pub. L. 101-336, July 26, 1990; 104 Stat. 327 (42 U.S.C. 12101 et seq.);
2. Rehabilitation Act of 1973, Pub. L. 93-112, Sept. 26, 1973; 87 Stat. 355 (29 U.S.C. 701 et seq.);
3. The Hatch Act, ch. 314, 24 Stat. 440 (7 U.S.C. 361a et seq.);
4. The Fair Labor Standards Act, ch. 676, 52 Stat. 1060 (29 U.S.C.201 et seq.);
5. The Clean Air Act (Subgrants over $100,000), Pub. L. 108-201, February 24, 2004; 42 USC ch. 85 et.seq.);
6. The Occupational Safety and Health Act of 1970, Pub. L. 91-596, Dec. 29, 1970; 84 Stat. 1590 (26 U.S.C. 651 et.seq.);
7. The Hobbs Act (Anti-Corruption), ch. 537, 60 Stat. 420 (see 18 U.S.C. § 1951);
8. Equal Pay Act of 1963, Pub. L. 88-38, June 10, 1963; 77 Stat.56 (29 U.S.C. 201);
9. Age Discrimination Act of 1975, Pub. L. 94-135, Nov. 28, 1975; 89 Stat. 728 (42 U.S.C. 6101 et. seq.)
10. Age Discrimination in Employment Act, Pub. L. 90-202, Dec. 15, 1967; 81 Stat. 602 (29 U.S.C. 621 et. seq.);
11. Military Selective Service Act of 1973;
12. Title IX of the Education Amendments of 1972, Pub. L. 92-318, June 23, 1972; 86 Stat. 235, (20 U.S.C. 1001);
13. Immigration Reform and Control Act of 1986, Pub. L. 99-603, Nov 6, 1986; 100 Stat. 3359, (8 U.S.C.1101);
14. Executive Order 12459 (Debarment, Suspension and Exclusion);
15. Medical Leave Act of 1993, Pub. L. 103-3, Feb. 5, 1993, 107 Stat. 6 (5 U.S.C. 6381 et seq.);
16. Drug Free Workplace Act of 1988, Pub. L. 100-690, 102 Stat. 4304 (41 U.S.C.) to include the following requirements:
    a. Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Applicant/Grantee's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

b. Establish a drug-free awareness program to inform employees about:
    i. The dangers of drug abuse in the workplace;
    ii. The Applicant/Grantee's policy of maintaining a drug-free workplace;
    iii. Any available drug counseling, rehabilitation, and employee assistance programs; and
    iv. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace; and
c. Provide all employees engaged in performance of the grant with a copy of the statement required by the law;

17. Assurance of Nondiscrimination and Equal Opportunity, found in 29 CFR 34.20;
18. District of Columbia Human Rights Act of 1977 (D.C. Official Code § 2- 1401.01 et seq.);
19. Title VI of the Civil Rights Act of 1964;
20. District of Columbia Language Access Act of 2004, DC Law 15 - 414 (D.C. Official Code § 2-1931 et seq.);
21. Lobbying Disclosure Act of 1995, Pub. L. 104-65, Dec 19, 1995; 109 Stat. 693, (31 U.S.C. 1352); and
22. Child and Youth, Safety and Health Omnibus Amendment Act of 2004, effective April 13, 2005 (D.C. Law §15-353; D.C. Official Code § 4-1501.01 et seq.) (CYSHA). In accordance with the CYSHA any person who may, pursuant to the grant, potentially work directly with any child (meaning a person younger than age thirteen (13)), or any youth (meaning a person between the ages of thirteen (13) and seventeen (17) years, inclusive) shall complete a background check that meets the requirements of the District's Department of Human Resources and HIPAA.

C. Mandatory Disclosures

1. The Applicant/Grantee certifies that the information disclosed in the table below is true at the time of submission of the application for funding and at the time of award if funded. If the information changes, the Grantee shall notify the Grant Administrator within 24 hours of the change in status. A duly authorized representative must sign the disclosure certification

2. Applicant/Grantee Mandatory Disclosures

A. Per OMB 2 CFR §200.501– any recipient that expends $750,000 or more in federal funds within the recipient's last fiscal, must have an annual audit conducted by a third – party. In the Applicant/Grantee's last fiscal year, were you required to conduct a third-party audit?	☐ **YES** ☐ **NO**
B. Covered Entity Disclosure During the two-year period preceding the execution of the attached Agreement, were any principals or key personnel of the Applicant/Grantee / Recipient organization or any of its agents who will participate directly, extensively and substantially in the request for funding (i.e. application), pre-award negotiation or the administration or management of the funding, nor any agent of the above, is or will be a candidate for public office or a contributor to a campaign of a person who is a candidate for public office, as prohibited by local law.	☐ **YES** ☐ **NO**

C. Executive Compensation: For an award issued at $25,000 or above, do Applicant/Grantee's top five executives do not receive more than 80% of their annual gross revenues from the federal government, Applicant/Grantee's revenues are greater than $25 million dollars annually AND compensation information is not already available through reporting to the Security and Exchange Commission.	☐ **YES** ☐ **NO**
D. The Applicant/Grantee organization has a federally negotiated Indirect Cost Rate Agreement. If yes, insert issue date for the IDCR: _____. If yes, insert the name of the cognizant federal agency: _____.	☐ **YES** ☐ **NO**
E. No key personnel or agent of the Applicant/Grantee organization who will participate directly, extensively and substantially in the request for funding (i.e. application), pre-award negotiation or the administration or management of the funding is currently in violation of federal and local criminal laws involving fraud, bribery or gratuity violations potentially affecting the DC Health award.	☐ **YES** ☐ **NO**

ACCEPTANCE OF ASSURANCES, CERTIFICATIONS AND DISCLOSURES

I am authorized to submit this application for funding and if considered for funding by DC Health, to negotiate and accept terms of Agreement on behalf of the Applicant/Grantee organization; and

I have read and accept the terms, requirements and conditions outlined in all sections of the RFA, and understand that the acceptance will be incorporated by reference into any agreements with the Department of Health, if funded; and I, as the authorized representative of the Grantee organization, certify that to the best of my knowledge the information disclosed in the Table: Applicant/Grantee Mandatory Disclosures is accurate and true as of the date of the submission of the application for funding or at the time of issuance of award, whichever is the latter.

Sign: _____ Date: _____

NAME: _____

TITLE: _____

AGENCY NAME: _____

Appendix I: Sample Insurance Requirements

DC HEALTH – GRANT PROGRAM SAMPLE
V24 06 2020

Insurance requirements may change following grant award per a review of exposures by theOffice of Risk Management

INSURANCE

A. GENERAL REQUIREMENTS. The Contractor at its sole expense shall procure and maintain, during the entire period of performance under this contract, the types of insurance specified below. The Contractor shall have its insurance broker or insurancecompany submit a Certificate of Insurance to the PM giving evidence of the required coverage prior to commencing performance under this contract. In no event shall any work be performed until the required Certificates of Insurance signed by an authorizedrepresentative 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 Contractor decide to engage a subcontractor for segments of the work under this contract,then, prior to commencement of work by the subcontractor, the Contractor shall submit inwriting 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 ofRisk Management (ORM). ORM will determine the insurance requirements applicable tothe subcontractor and promptly deliver such requirements in writing to the Contractor andthe CA. The Contractor must provide proof of the subcontractor's required insurance to prior to commencement of work by the subcontractor. If the Contractor decides to engagea 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 Contractor 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 contract, with the understanding that any affirmative obligation imposed upon the insured Contractor or itssubcontractors (including without limitation the liability to pay premiums) shall be the sole obligation of the Contractor or its subcontractors, and not the additional insured.
The additional insured status under the Contractor's and its subcontractors' CommercialGeneral 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 broadand approved by the PM in writing. All of the Contractor'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 arisingout of the performance of this Statement of Work by the Contractor or its subcontractors,or anyone for whom the Contractor or its subcontractors may be liable. These policies shall include a separation of insureds clause applicable to the additional insured.

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

1. Commercial General Liability Insurance ("CGL") - The Contractor shall provide evidence satisfactory to the PM with respect to the services performed that it carries aCGL policy, written on an occurrence (not claims-made) basis, on Insurance ServicesOffice, 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 $2,000,000products-completed operations aggregate limit including explosion, collapse and underground hazards.

2. Automobile Liability Insurance - The Contractor shall provide evidence satisfactoryto 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 approvedby 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 forbodily injury and property damage.

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

Employer's Liability Insurance - The Contractor shall provide evidence satisfactoryto 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 Contractor shall provide evidence satisfactory to thePM of Cyber Liability Insurance, with limits not less than $2,000,000 per occurrenceor claim, $2,000,000 aggregate. Coverage shall be sufficiently broad to respond to the duties and obligations as is undertaken by Contractor 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 Contractor shall provide evidence satisfactory tothe 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 Contractor and all Contractor's employees and agents. Thepolicy 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 thatprior 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 arisingout of this Contract.

6. Professional Liability Insurance (Errors & Omissions) - The Contractor 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 Contractor warrants thatany applicable retroactive date precedes the date the Contractor 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 Contractor 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 insuranceincludes 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 Contractor 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 Contractor'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 ofvertical exhaustion.

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

C. DURATION. The Contractor shall carry all required insurance until all contract 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 theDistrict 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 leasedequipment. 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 Contractor shall include all of the costsof insurance and bonds in the contract price.

G. NOTIFICATION. The Contractor 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 limitchanges or if the policy is canceled prior to the expiration date shown on the certificate.The Contractor shall provide the CO with ten (10) days prior written notice in the eventof non-payment of premium. The Contractor will also provide the CO with an updated Certificate of Insurance should its insurance coverages renew during the contract.

H. CERTIFICATES OF INSURANCE. The Contractor 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 contractnumber. Evidence of insurance must be submitted to the: Enterprise Grants Management System.

The PM may request and the Contractor 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 Contractor 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 suchinitial insurance. For all coverage required to be maintained after completion, an additional certificate of insurance evidencing such coverage shall be submitted to the COon an annual basis as the coverage is renewed (or replaced).

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

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