DEPARTMENT OF HEALTH

Community Health Administration

Improving Pediatric Asthma Outcomes

REQUEST FOR APPLICATIONS

FO# CHA-IPAO-6.21.24

SUBMISSION DEADLINE:

JULY 23, 2024, BY 3:00 PM

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

DC DEPARTMENT OF HEALTH

Community Health Administration

NOTICE OF FUNDING AVAILABILITY (NOFA)

FO# CHA-IPAO-6.21.24

Improving Pediatric Asthma Outcomes

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

Funding Opportunity Title:	Improving Pediatric Asthma Outcomes
Funding Opportunity Number:	CHA-IPAO-6.21.24
DC Health Administrative Unit:	Community Health Administration
DC Health Program Bureau	Cancer & Chronic Disease Prevention Bureau
Funding Opportunity Contact:	Tesha Coleman, Program Manager, Phiac.DOH.dc.gov
Funding Opportunity Description:	This funding opportunity will support the implementation of asthma prevention and control strategies aimed at increasing achievement of guidelines based medical management among primary care clinics, health systems, and federally qualified health centers (FQHCs).
Eligible Applicants	• Nonprofit organizations • For-profit organizations • Healthcare systems • 501(c)(6) healthcare professional membership organizations • Institutions of higher education • Managed care organizations serving DC residents
Anticipated # of Awards:	2
Anticipated Amount Available:	$300,000
Annual Floor Award Amount:	$100,000

Annual Ceiling Award Amount:	$150,000
Legislative Authorization	301(A)AND317(K)(2)PHS42USC241(A)247B(K)2
Associated CFDA#	93.991
Associated Federal Award ID#	1 NB01TO000052-01-00
Cost Sharing/Match Required?	No
RFA Release Date:	June 21, 2024
Letter of Intent Due date:	July 2, 2024 (Strongly encouraged)
Application Deadline Date:	July 23, 2024
Application Deadline Time:	3:00 p.m.
Links to Additional Information about this Funding Opportunity	DC Grants Clearinghouse https://communityaffairs.dc.gov/content/community-grant-program#4 DC Health EGMS https://egrantsdchealth.my.site.com/sitesigninpage

Notes:

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

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RFA TERMS AND CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHECKLIST FOR APPLICATIONS

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

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

  - ☐ Certificate of Clean Hands dated within 60 days of the application deadline
  - ☐ Current business license or certificate of licensure or proof to transact business in local jurisdiction
  - ☐ Current certificate of insurance
  - ☐ Copy of cyber liability policy
  - ☐ IRS tax-exempt determination letter (for nonprofits only)
  - ☐ IRS 990 form from most recent tax year (for nonprofits only)
  - ☐ Current list of Board of Directors, on letterhead, signed and dated by a certified official from the Board (this cannot be the executive director)
  - ☐ Assurances, certifications and disclosures
  - ☐ Proposal abstract
  - ☐ Project narrative
  - ☐ Budget table
  - ☐ Budget justification
  - ☐ Organization chart
  - ☐ Work plan
  - ☐ Evaluation plan
  - ☐ Risk self-assessment
- ☐ Documents requiring signature have been signed by an organization head or authorized representative of the applicant organization.
- ☐ The applicant needs a Unique Entity Identifier number (UEI#) and an active registration in the System for Award Management to be awarded funds.
- ☐ The project narrative is written on 8½ by 11-inch paper, 1.0 spaced, Arial or Times New Roman font using 12-point type *(11–point font for tables and figures)* with a one-inch margins.
- ☐ The application proposal format conforms to the "Proposal Components" (See section 5.2) listed in the RFA.
- ☐ The proposed budget is complete and complies with the budget forms provided in the RFA. The budget narrative is complete and describes the categories of items proposed.
- ☐ The proposed work plan and other attachments are complete and comply with the forms and format provided in the RFA.
- ☐ Submit your application via EGMS by the application due date and time**. Late applications will not be accepted.**

1. GENERAL INFORMATION

1.1 Key Dates

- Notice of Funding Announcement Date: **June 7, 2024**
- Request for Application Release Date: **June 21, 2024**
- Final Day to Register in EGMS for New Applicants: **July 9, 2024**
- Pre-Application Meeting Date: **visit https://OGMDCHealth.eventbrite.com**
- Application Submission Deadline: **July 23, 2024**
- Anticipated Award Start Date: **October 1, 2024**

1.2 Overview

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

The Community Health Administration (CHA) of the District of Columbia Department of Health (DC Health) promotes healthy behaviors and healthy environments to improve health outcomes and reduce disparities in the leading causes of disease and death in the District.

Within CHA, the Cancer and Chronic Disease Prevention Bureau (CCDPB) works closely with health systems, community-based organizations, governmental agencies, and other key partners to improve cancer and chronic disease health outcomes among District residents. Activities within CCDPB are designed to close the chasm between clinical medicine and public health, strengthen public-private partnerships, and implement outcomes-oriented public health interventions. DC Health's Population Health and Prevention Programs aim to improve the health of District residents using community and data driven approaches with a strategic focus on achieving health equity for all through policy, and systems and environmental change interventions. Funding for this proposal is supported by the Preventative Health Services Block Grant which seeks to advance public health efforts by supporting and promoting implementation of community and data driven approaches to reduce the leading causes of death and address emerging health issues. DC Health's Asthma Control Program implements data driven strategies to reduce the burden of asthma and eliminate asthma related inequities among District residents.

1.3 Purpose

DC Health's Community Health Administration (CHA) is requesting proposals from qualified organizations to implement community-focused and data-driven strategies within health care systems and school health suites to improve asthma outcomes of racial and ethnic minority District children, age 0-17 years, with low household incomes, while collaborating with multi-sector partners across various settings to ensure broad population reach.

1.4 Source of Grant Funding

Funding is anticipated to be available using funding from the Preventative Health Services Block Grant. DC Health is the primary recipient of federal funds awarding these funds. As a primary recipient, DC Health has the responsibility to pass through requirements and objectives agreed to in our federal notices of award.

NOFO#	Federal Award Title	FAIN#
1 NB01TO000052	Preventive Health & Health Services Block Grant	NB01TO000052

1.5 Award Information

1.5.1 Amount of Funding Available

The total funding amount of $300,000 is anticipated for up to two (2) awards for the first budget period.

1.5.2 Period of Performance and Funding Availability

The first budget period of this award is anticipated to begin on October 1, 2024 and to continue through September 30, 2025. After the first budget period, there will be up to four (4) additional 12-month budget periods for a total project period of October 1, 2024-September 30, 2029. The number of awards, budget periods, and award amounts are contingent upon the continued availability of funds and grantee performance and compliance.

1.5.3 Eligible Organizations/Entities

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

- Nonprofit organizations
- For-profit organizations
- Healthcare systems
- 501(c)(6) healthcare progressional membership organizations
- Institutions of higher education
- Managed care organizations serving DC residents

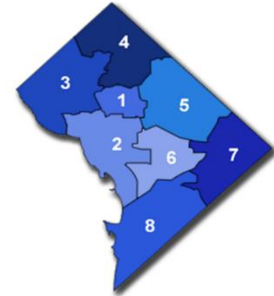
To be considered for funding, organizations shall meet the above eligibility criteria and have documentation of providing services (health and social services) to the target populations.

1.5.4 Non-Supplantation

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

2. BACKGROUND

2.1 Demographic Overview



The District of Columbia (DC or the District) is a diverse and compact geographic area that covers 61 square miles with a population of 678,972 as of the 2023 US Census (District of Columbia, 2024; United States Census Bureau, 2024) (DC Office of Planning, District of Columbia, Population Change By Ward: 2010 to 2020, 2021; DC Office of Planning, Summary Tables for the District of Columbia, 2021). The District is organized into eight geopolitical wards, with the largest population in Ward 7 (89,870 residents) and the smallest population in Ward 2 (77,904 residents; District of Columbia, 2024). Wards 1 and 2 have the largest proportion of adults ages 18-64 (80% and 84%), Wards 7 and 8 have the largest proportion of youth ages 0-18 years (24% and 30%), and Wards 3 and 4 have the largest proportion of adults over age 65 (18% and 15% (United States Census Bureau, 2019).

In terms of race and ethnicity, the District's population is highly diverse—approximately 45% Black/African American, 46% white, and 5% Asian, with Hispanic or Latino residents of any race making up 11% of the population (United States Census Bureau, 2024; DC Open Data, 2021) (United States Census Bureau, District of Columbia: Quick Facts, 2020; DC Open Data, 2021). However, the population is also highly segregated, with significant economic disparities observed by ward and race. As illustrated in Table 1,Wards 2 and 3 have the highest percentage of white residents and the lowest percentage of Black/African American residents, whereas Wards 7 and 8 have the highest percentage of Black/African American residents and the lowest percentage of white residents. While 2022 District-wide median household income was more than $91,000, median household income in Ward 3 was more than 3.6 times higher than in Ward 8; median household income among white District residents was approximately 1.7 times higher than among Hispanic/Latino residents and 3.1 times higher than among Black/African American residents (Black/AA) (DC Health Matters, 2021) (DC Health Matters, 2021). In December 2021, District-wide unemployment was 5.8%; however, unemployment in Ward 8, the highest among all eight Wards in the District, was more than 4 times higher than in Ward 3 (12.1% vs, 2.9%) (DC Department of Employment Services, n.d.) (DC Department of Employment Services, 2021).

Table 1:Selected Characteristics of DC Residents, by Ward

	White, Non-Hispanic (2020)	Black/ African American, Non-Hispanic (2020)	Hispanic/ Latino, any race (2020)	Median Household Income (2021)	Unemployment Rate (Dec. 2021)
Ward 1	46.9%	21.5%	20.2%	$110,339	3.7%

Ward 2	64.3%	8.2%	10.9%	$112,244	3.1%
Ward 3	69.2%	7.0%	9.7%	$143,339	2.9%
Ward 4	26.9%	43.3%	22.0%	$94,163	4.9%
Ward 5	23.6%	56.5%	11.6%	$91,189	6.5%
Ward 6	55.3%	26.1%	7.3%	$113,922	4.4%
Ward 7	3.6%	87.5%	4.7%	$42,201	9.0%
Ward 8	4.5%	87.8%	3.3%	$39,473	12.1%
District-wide	38.0%	40.9%	11.3%	$91,414	5.8%

2.2 Asthma Burden

Overall Asthma Prevalence and Health Disparities

The burden of asthma in the District continues to be a major public health problem with asthma rates consistently trending higher than national rates (BRFSS, 2022) (Figure 1). Asthma disproportionately affects specific demographic groups, with higher prevalence rates among residents with annual household incomes less than $50,000 (13.6% among <$50,000 vs. 10.6% among $75,000 or more group) and with less than high school education (16% among less than high school education vs. 9.1% among college graduates) (DC Health, 2021).

Current BRFSS data show that the prevalence rates of current childhood asthma is 9.7% in the District, compared to 6.5% nationally (CDC BRFSS, 2021). An estimated 12,265 children (ages 0-17) in the District reported having current asthma. Asthma is a chronic disease of the lungs that causes wheezing, breathlessness, chest tightness, and coughing. When not well controlled, asthma can affect quality of life, resulting in significant morbidity and mortality. Asthma is also one of the most common chronic conditions affecting children. The burden of childhood asthma not only affects the child, but also their caregivers and families in terms of missed school and workdays due to asthma and other impacts on quality of life.

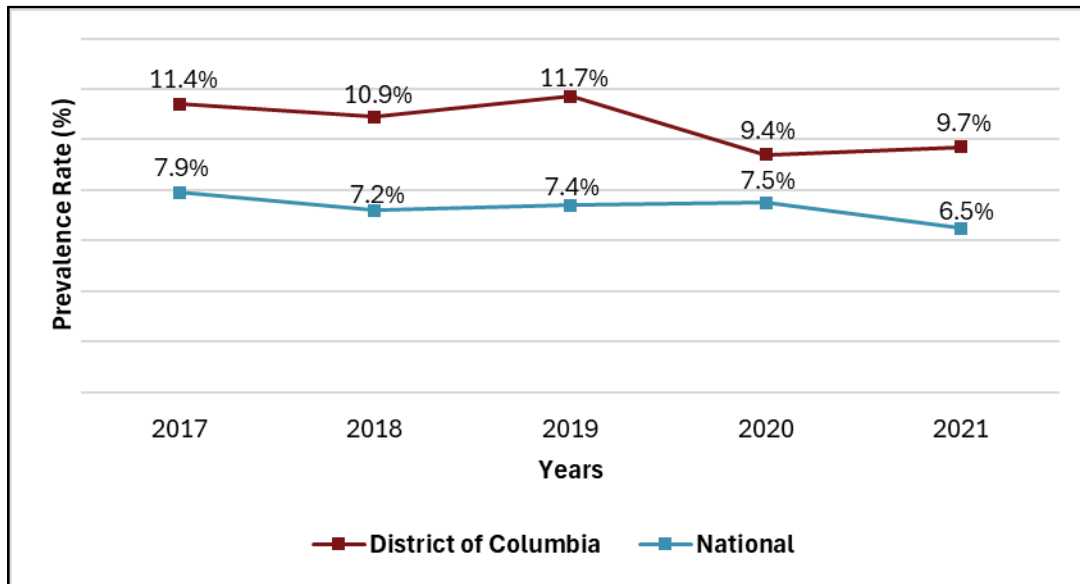


Figure 1:Trends in prevalence of Current Childhood Asthma– District of Columbia & United States (CDC BRFSS 2017 to 2022)

Asthma was more prevalent among females compared to males (10.3% vs. 9.2%) in children. When analyzed by age, childhood asthma rates were highest among those 15-17 years old (12.2%) (Figure 2) (CDC BRFSS, 2021).

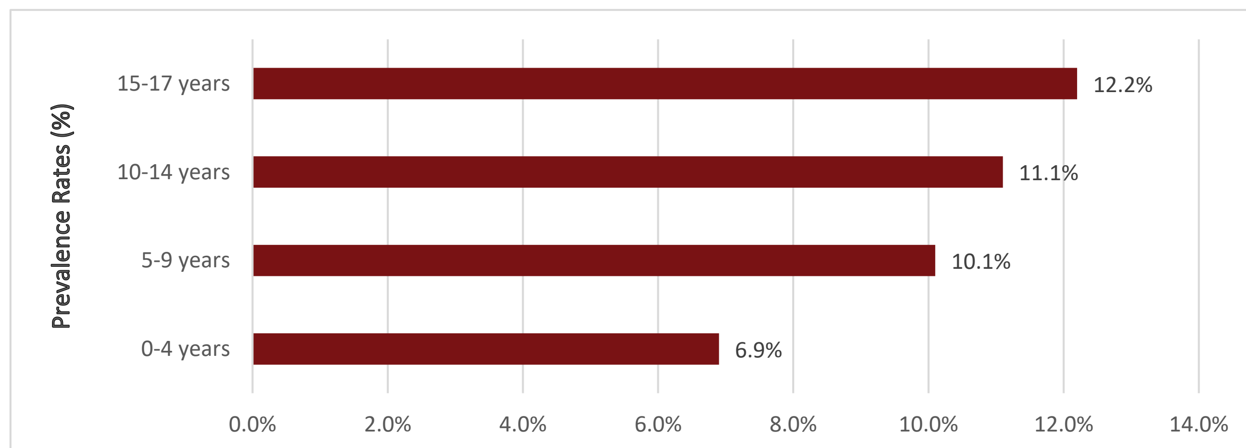


Figure 2: Age group specific Current Asthma Prevalence among Children Ages 0-17 – District of Columbia (DC BRFSS 2021)

Asthma Healthcare System Burden

Data show a decline in childhood asthma-related emergency department (ED) visits from 2017 to 2020. However, between 2021 to 2022, childhood asthma related ED visit rates increased from 1542.5 to 1948.6/100,000. In 2022, the highest proportion (38.1%) of asthma related ED visits were among children 0-4 years. Childhood asthma related ED visits were higher among males compared to females (58% vs. 42%) (CPPE, 2022). Asthma *hospitalization* rates for children also showed a similar trend with decrease from 2017 to 2020 and increase for children from 77.9 in 2020 to 178.0/100,000 population in 2022. The majority of hospitalizations among children occurred among the 0-4 year age group (38.8%). The reduction in pediatric asthma outcomes, such as morbidity during the pandemic year in 2020 is likely due to various factors including mask-wearing, social distancing, exposure avoidance, and online school learning. This finding was consistent with ED data from the National Hospital Ambulatory Medical Care Survey which showed a 33% decline in asthma related emergency visits during the pandemic (Sheehan WJ, 2021; Gaffney A, 2023). Although Black/AA residents make up 41% of the District population, they represent an overwhelming number of ED visits and hospitalizations. More than 85% of ED visits and hospitalizations related to asthma were among Black/African American children (**Error! Reference source not found.**).

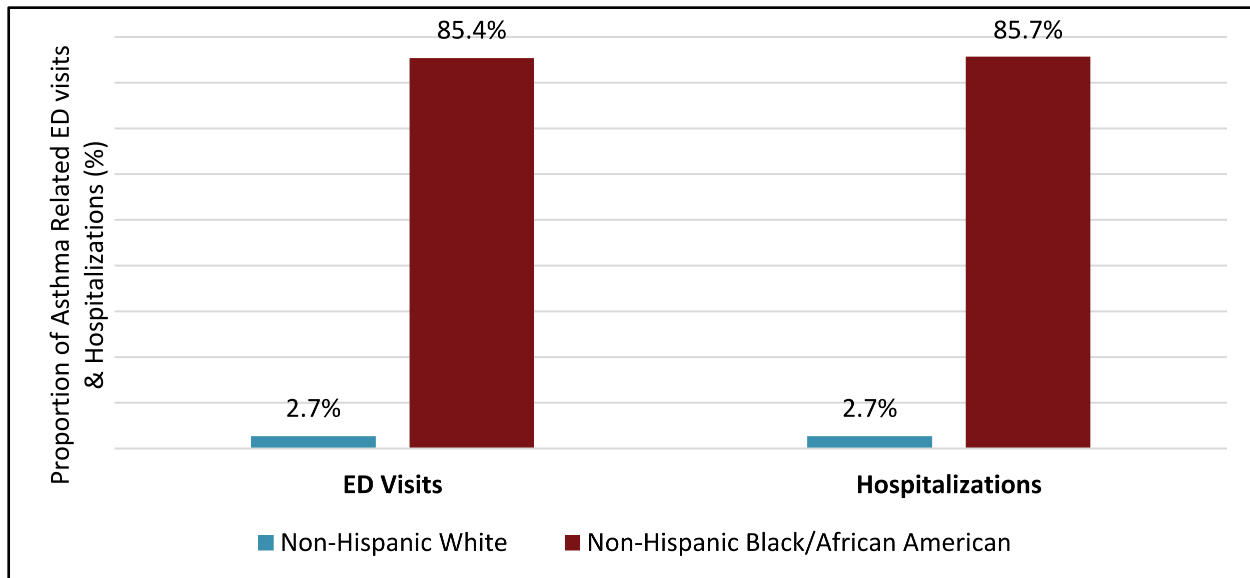


Figure 3:Proportion of Asthma related ED Visits and Hospitalizations among children and adolescents 0-17 years in the District of Columbia – Data Year 2022 - 2022 (DC Hospital Association Inpatient and Outpatient Hospital Discharge Data, Data Management and Analysis Division, Center for Policy, Planning and Evaluation, D.C. Department of Health)

Based on the most recent available data (combined adults and children), the largest proportion of asthma related ED visits and hospitalizations were among residents of Wards 7 & 8 (Figure 5 and Figure 4) (CPPE, 2022).

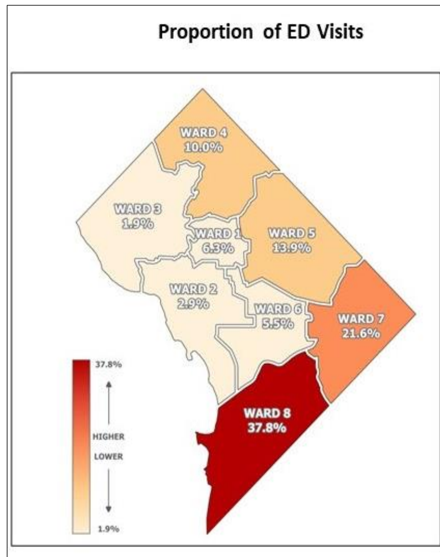


Figure 5: Proportion of Asthma related ED visits by District Wards (%) (Adults & Children) (DC Health, 2022)

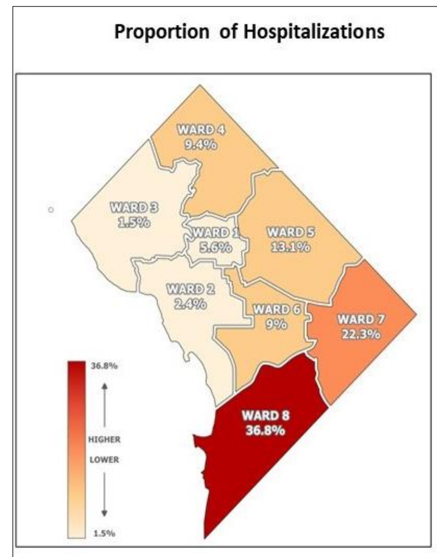


Figure 4: Proportion of Asthma related hospitalizations by District Wards (%) (Adults & Children) (DC Health, 2022)

Impact of Asthma Burden

The economic burden of asthma (calculated by undiscounted total direct costs, indirect costs, and quality-adjusted life years (QALY) lost attributable to uncontrolled asthma) is substantial, and adherence to evidence-informed asthma management strategies by care providers and patients can substantially reduce costs and improve quality of life.[1] Studies indicate approximately 20% of direct costs of asthma can potentially be prevented by achieving asthma control. Projections on the economic burden of asthma from 2015 to 2020 in the District of Columbia estimated the total 5-year costs associated with asthma to be $336.7 million with the corresponding 5-year per capita values to be about $521 in the District (Nurmagambetov T, 2017).

Several modifiable risk factors are known to aggravate asthma. Current asthma is almost two times more prevalent among District residents with obesity compared to normal weight (17.2% vs. 9.4%), current smokers versus never smokers (20.3% vs.10.4%), and among those who reported not participating in physical activity compared to those who exercised regularly (14.1% vs. 10.5%) (DC BRFSS, 2022). Other modifiable factors affecting asthma include home environment, health care access, pets, molds at home, secondhand smoke, etc. (Hsu J, 2016).

Asthma is a leading cause of chronic disease-related school absenteeism which can result from asthma exacerbations, lack of asthma control, and lack of routine clinic visits. A national study using a sample of children from 35 states and the District of Columbia investigating asthma-

[1] Yaghoubi M, Adibi A, Safari A, FitzGerald JM, Sadatsafavi M. The Projected Economic and Health Burden of Uncontrolled Asthma in the United States. Am J Respir Crit Care Med. 2019 Nov 1;200(9):1102-1112.

related absenteeism suggested that inadequately controlled or very poorly controlled asthma (prevalence ratio: 1.50; 95% CI: 1.34–1.69) and visit to an emergency department or urgent care center for asthma (prevalence ratio: 3.27; 95% CI: 2.44–4.38) to be primary causes for asthma related school absenteeism. Data from a national study (including the District) revealed that over half of children missed at least one school day because of asthma in the past 12 months. Barriers to asthma-related health care are also significantly associated with asthma-related absenteeism (Hsu J, 2016).

2.3 Program Information

Within the Community Health Administration, the Cancer and Chronic Disease Prevention Bureau (CCDPB) develops, implements, and evaluates programming and policies to prevent and control the leading causes of death in the District. CCDPB works closely with health systems, community-based organizations, government agencies and other key partners to provide data, consultation, technical assistance, and leadership to improve cancer and chronic disease health outcomes among all District residents. The bureau implements population-based strategies to strengthen cancer and chronic disease prevention and management infrastructure, address common risk factors like tobacco use, poor nutrition, and physical inactivity, and eliminate health disparities. The bureau drives innovation in community-driven approaches, fosters community partnerships, and supports clinical quality improvement initiatives to scale up data-driven, evidence-based and sustainable approaches.

Within the Community Health Administration's Family Health Bureau, the School Health Services Program (SHSP) aims to bridge the gap between health and learning by supporting over 80,000 students in more than 200 District of Columbia Public Schools and DC Public Charter Schools. School health suites staffed by Registered Nurses (RN), Licensed Practical Nurses (LPN), or Health Technicians collaborate with families, school staff, and other health providers to provide basic health services and ensure student health needs are met during the school day. The program includes primary care services, care coordination and quality improvement. It is designed to enable District students to reach their optimal health so they can learn in a safe and supportive environment. DC Health's Asthma Program collaborates with SHSP staff to link and coordinate care of students with clinical providers, develop asthma action plans and increase adherence with their daily asthma maintenance medication regimen.

DC Health is a recipient of the Center's for Disease Control and Prevention Preventive Health Services Block Grant (Block Grant), which advances public health efforts by supporting and promoting implementation of community and data driven approaches to reduce the leading causes of death and address emerging health issues. The Block Grant is managed by CCDPB and supports District-wide activities such as obesity prevention, improved cancer data collection and surveillance, sexual assault awareness and asthma management and control.

DC Health's Asthma Control Program implements community and data driven approaches to reduce the burden of asthma and eliminate asthma related inequities among District residents. The Asthma Control Program promotes and supports implementation of CDC's

EXHALE strategies (https://www.cdc.gov/asthma/exhale/index.htm) to reduce the number of deaths, hospitalizations, emergency department visits, and physical activity limitations due to asthma among the District's highest risk populations. To achieve these overarching goals and ensure widespread implementation of CDC's EXHALE strategies, DC's Asthma Control Program efforts prioritize (Figure 6):

1) Promoting awareness and education of asthma self-management and trigger reduction methods.
2) Implementation of asthma related policy, systems and environmental strategies across settings.
3) Facilitating cross-sector collaborations to assess current activities/resources, establish strategic priorities for collective action and update and implement the District's Asthma Control Plan.
4) Increasing utilization of Medicaid covered asthma control medication and services.
5) Evaluating program effectiveness/impact.
6) Disseminating data to improve asthma outcomes among DC residents at highest risk.

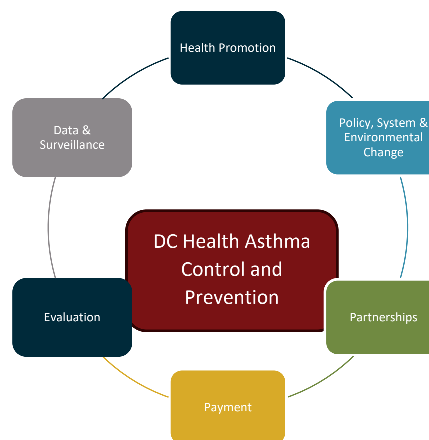


Figure 6: DC Health Asthma Prevention & Control Program Components

Below are additional details on approaches used.

Quality Improvement

DC's Asthma Control Program supports health system partners to utilize appropriate local population-level data to identify, develop and implement strategies to improve asthma management of District children, ages 0-17, through health system interventions and community-clinical linkages using quality improvement processes such as Plan-Do-Study-Act (PDSA). Quality improvement interventions seek to identify, implement, test, evaluate, and sustain evidence-based interventions across health systems. Utilizing the quality improvement framework, DC Health aims to increase adoption of best practices for asthma management through health care system interventions and community-clinical linkages.

Policy, Systems and Environmental Change

The Asthma Control Program's strategies incorporate a policy, systems, and environmental change (PSE) framework. PSE modifies a community's physical surroundings to support healthy lifestyle choices. This model incorporates "health in all policies" by affecting policies not typically thought of as health-related, such as environmental, housing, taxes, transportation, etc. This approach is critical to achieving health equity by addressing the social determinants of health that cause disparities. *Policy change* interventions create or amend laws, ordinances, resolutions, mandates, regulations, or rules that drive systems and environmental changes. These can include legislative policies or business and organizational policies as well as enforcement of current existing polices. **Note that this funding cannot be used for lobbying activities**. *Systems change* interventions impact all elements of an organization, institution, or system.

Environmental change interventions involve material or structural changes to economic, social, or physical settings. Figure 7 provides an example of how policy, system and environmental changes can be used to improve asthma health outcomes.

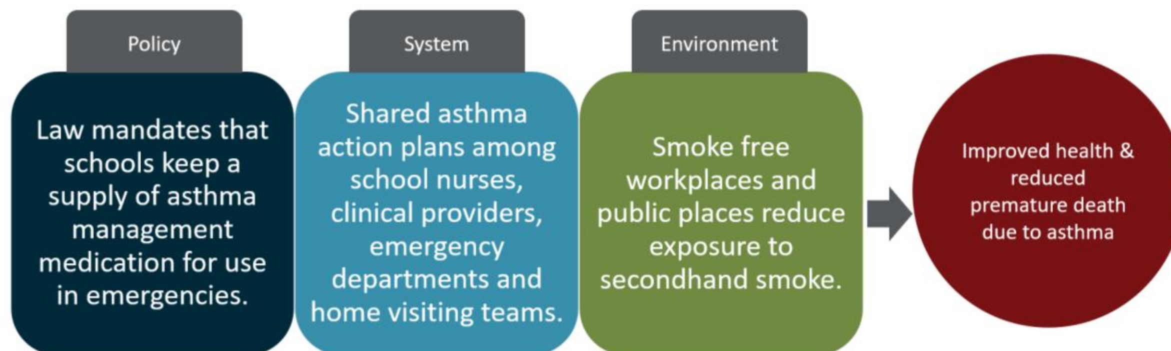


Figure 7:Policy, System & Environmental Change Example

CDC EXHALE Strategies

CDC's National Asthma Control Program disseminated the EXHALE Technical Package which includes six recommended evidenced based strategies for states, organizations, and stakeholders to use to improve asthma control (Hsu, 2018). Figure below (from the EXHALE Technical Package) outlines the six strategies and includes example approaches. These strategies are intended to be used by multi-sector partners to drive statewide impact.

	Strategy	Approach
E	Education on asthma self-management	• Expanding access to and delivery of asthma self-management education (AS-ME)
X	X-tinguishing smoking and secondhand smoke	• Reducing tobacco smoking • Reducing exposure to secondhand smoke
H	Home visits for trigger reduction and asthma self-management education	• Expanding access to and delivery of home visits (as needed) for asthma trigger reduction and AS-ME
A	Achievement of guidelines-based medical management	• Strengthening systems supporting guidelines-based medical care, including appropriate prescribing and use of inhaled corticosteroids • Improving access and adherence to asthma medications and devices
L	Linkages and coordination of care across settings	• Promoting coordinated care for people with asthma
E	Environmental policies or best practices to reduce asthma triggers from indoor, outdoor, and occupational sources	• Facilitating home energy efficiency, including home weatherization assistance programs • Facilitating smokefree policies • Facilitating clean diesel school buses • Eliminating exposure to asthma triggers in the workplace whenever possible • Reducing exposure to asthma triggers in the workplace (if eliminating exposures is not possible)

Figure : CDC EXHALE Strategies Summary (Hsu, 2018)

3. PURPOSE

3.1 APPROACH

DC Health's Community Health Administration (CHA) is requesting proposals from qualified applicants to identify, develop and implement community and data-driven strategies to improve asthma management of District children, age 0-17 years, through quality improvement/health system change interventions and promoting community-clinical linkages. The grantee must propose to implement asthma prevention and control activities using CDC's recommended EXHALE strategies in various settings within communities at highest risk. Utilizing a quality improvement framework, DC Health aims to increase adoption of best practices for asthma management focusing specifically on two of CDC's EXHALE strategies: *Achievement of Guidelines-Based Medical Management & Linkages and Coordination of Care Across Settings (https://www.cdc.gov/asthma/exhale/achievement.htm).* Funding components include:

- Component 1: Health System Change: Achievement of Guidelines-Based Medical Management
- Component 2: Linkages and Coordination of Care with the School Health Services Program (SHSP)
- Component 3: Community Engagement and Patient/Community Feedback
- Component 4: Surveillance

4. PERFORMANCE REQUIREMENTS

Applicants should propose projects that meet the criteria listed below.

4.1 TARGET POPULATION

Grantees shall provide services to children and youth (ages 0-17) living in communities with high asthma prevalence (special emphasis on the District's Wards 7 and 8) and children who live with current smokers.

4.2 LOCATION OF SERVICES

Grantees must be located within the District of Columbia. Implement strategies across various settings including each of the following;

a. Hospital emergency department

b. Community-based clinic or primary care practice

    c. School health or home-visiting program

4.3 Allowable Activities

Activities in the proposed application should directly align with Guidelines for the Diagnosis and Management of Asthma (EPR-3) (https://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines).

The applicant must implement all activities below:

Component 1: Health System Change: Achievement of Guidelines-Based Medical Management

1. Conduct continuous quality improvement (CQI) strategies using evidence-based, evidence-informed or promising practices for asthma management focusing on target pediatric populations at highest risk of emergency department visits and hospitalizations.
   For example;
   a. Implementing guidelines based medical management strategies for pediatric patients using a clinical quality improvement framework.
   b. Identifying and implementing best practices for health system-level change in asthma management.

Component 2: Linkages and Coordination of Care with the School Health Services Program (SHSP)

1. Select and implement asthma management strategies that focus on system-level changes to improve communication between SHSP staff and clinical providers.
   For example;
   - Implementing an electronic system to alert SHSPs of a student's asthma action plan and/or emergency room visit.
   - Implement a system of care coordination for making appointments and tracking systematic follow up on referrals for asthma care visits.
2. Refer children with uncontrolled asthma to home-based environmental services to reduce asthma triggers.
3. Establish and provide asthma education and awareness for school faculty, students and families.

Component 3: Community Engagement and Patient/Community Feedback

1. Join and maintain consistent participation in the DC Asthma Coalition to ensure District wide implementation of the DC Asthma Control Plan (*pending finalization*).
2. Involve patients/participants and community feedback to inform the design, implementation, and evaluation of programming that centers the needs of the community and target population.

Component 4: Surveillance:

1. Support a central registry of children with asthma, collect, maintain and use data to evaluate actions by health care providers to provide consistent preventive treatment and refer those with uncontrolled asthma for home environmental services.

2. Select data variables to use data to inform CQI activities and strategies.

Resources:

- https://www.cdc.gov/asthma/pdfs/EXHALE_technical_package-508.pdf
- https://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5128769/
- https://www.cdc.gov/nccdphp/dnpao/health-equity/health-equity-guide/pdf/health-equity-guide/Health-Equity-Guide-sect-1-2.pdf

4.4 Program Outcomes

Applicants shall demonstrate how the proposed project plan will impact each of the indicators below and demonstrate their organizational capacity to do so:

Key Performance Indicators:

- Increase the number of asthma action plans (AAP) completed by health care providers and given to children and parents
- Increased number of asthma action plans shared with school-based health centers
- Increase pediatric asthma care coordination among home, clinical, school and community settings to improve asthma medication adherence
- Increase precision of pediatric asthma diagnosis by health care providers based upon NIH EPR-3 Guidelines
- Increase appropriate medication prescribing practices by health care providers to improve pediatric medication adherence for long-term controller medications
- Increase medication adherence for children using asthma long-term controller medications
- Reduce the number of asthma-related emergency department visits among children

5. APPLICATION REQUIREMENTS

5.1 Eligibility Documents

Certificate of Clean Hands

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

Current Business License

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

Current Certificate of Insurance

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

Copy of Cyber Liability Policy

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

IRS Tax-Exempt Determination Letter

This applies to nonprofits only.

IRS 990 Form

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

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

This CANNOT be signed by the executive director.

Assurances, Certifications and Disclosures

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

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

5.2 Proposal Components

Project Abstract

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

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

<u>PROJECT NARRATIVE</u> (20-page maximum)

The narrative section should describe the applicant's approach and how the applicant will implement the strategies outlined above.

The narrative should include the following sections:

OVERVIEW

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

This section should briefly describe the purpose of the proposed project. Reviewers should understand the needs and health disparities of the population served by the applicant. Applicants must describe in two to three sentences specifically how their application will address the public health problem as described in the background section of this RFA. Applicant must clearly identify the goal(s) of this project.

PROJECT OR POPULATION NEED

This section should help reviewers understand the needs of the population intended to be served by the proposed project.

- Provide an overview of asthma burden within target population, include asthma prevalence, health disparities and corresponding social determinants of health.
- Describe how the target population was identified for this proposal.
- Define the reach, boundaries, zip codes and/or geography of the target population.
- Describe the specific problem(s) and contributing factors to be addressed within the target population(s) using data to justify the selection.
- Indicate how the proposed project will address health disparities and challenges faced by the target population.
- Describe how the target population(s) will be reached in the identified settings through strategies implemented in this project.
- Described how strategies implemented in this project will impact health outcomes within the target population(s).

PROJECT DESCRIPTION

This section should provide a clear and concise description of strategies and activities that will be used to achieve the project outcomes and should detail how the program will be implemented. Applicants must base their strategies and activities on those described in Sections 3.1 Approach, and 4.4 Program Strategies, above. Describe activities for each component, how they will be implemented, and how they will be operationalized to achieve program goals, objectives, and outcomes.

For Components 1-4:

- Describe the rationale for selecting the proposed goals and activities, including an assessment of the current needs and assets in the community.
- Describe the evidence-based interventions, promising practices and/or frameworks that will be used.
- Describe how the selected strategies will be operationalized to achieve program goals, objectives, and outcomes.
- Describe how objectives will maximize public health impact.
- Indicate plans for sustainability of the initiative beyond the projected funding period.

Additional Component Specific Requirements:

Component 1: Health System Change: Achievement of Guidelines-Based Medical Management

- Clearly identify three (3) performance indicators that the applicant plans to utilize to track CQI program impact.
    - For each indicator, clearly describe the proposed strategies for tracking the indicator, utilizing that data to perform PDSA QI interventions.
    - For each indicator, describe the rationale for selecting the corresponding strategies. Please include assessment of current needs and assets within the health system.

Component 2: Linkages and Coordination of Care with the School Health Services Program

- Describe current status of linkages and care across settings.
- Describe how proposed strategies will address identified gaps and sustain improvement.

Component 3: Community Engagement and Patient/Community Feedback:

- Describe how feedback collected through patient and community engagement will be operationalized to inform activities.
- Describe how patient engagement and community feedback will include representation from target populations.

Component 4: Surveillance

- Describe the development and/or maintenance of a central registry of children with asthma.
- Describe how the surveillance system will be used to inform program planning, implementation and evaluation.

DATA COLLECTION & EVALUATION

Applicants must propose a process and outcome evaluation strategy to monitor ongoing processes and assess success in program implementation and achievement of programmatic goals. Applicants are encouraged to utilize existing, validated evaluation tools or instruments and submit these tools and instruments in their application. Grantees shall submit all evaluation tools and instruments to DC Health for review prior to use. DC Health will work with selected applicants to finalize evaluation plans. The proposed project shall:

- Describe evaluation methods and tools, data collection, analysis, and security for any personal information.
- Complete the Evaluation Plan Template (see attachments), which should include evaluation questions, evaluation design, and measures (i.e. process and outcome) related to the proposed strategies and activities specified in the application.
- Describe how the proposed strategies and activities will achieve the intended program outcomes and goal outlined in the *Overview* and *Project or Population Need and Targeted Setting.*
- Demonstrate evidence of organizational experience and capacity to coordinate, support planning, and implementation of a comprehensive evaluation of a program.
- Describe how evaluation findings will be used for continuous program quality improvement.
- Demonstrate ability to identify, collect and analyze clinical data from at least one health system.
- Describe access to appropriate data sources for quality measures as related to the intervention population such as:
    a. Asthma-related Pediatric Hospital Admission Rates;
    b. Asthma-related Pediatric Emergency Department Visit Rates;
    c. Asthma-related Pediatric Ambulatory Visit Rates;
    d. Appropriate Asthma Medication Use for Persistent Asthma;
    e. Asthma Medication Ratios; and
    f. Asthma Action Plan completion

ORGANIZATIONAL CAPACITY

In this section, applicants are expected to demonstrate sufficient organizational capacity and readiness to implement the required strategies. Applicants should:

- Provide information on the applicant's current mission and structure and scope of current activities and describe how these all contribute to the organization's ability to conduct the program requirements and meet program expectations.
- Describe the organization's leadership capacity (including presence of clinical champions) to support implementation of the proposed strategies and affirm leadership commitment to complete project as proposed in the work plan. Applicants may submit letters of commitment to the program from the organization leadership.
- Describe past successes working collaboratively with agencies and organizations in public health and other sectors to advance a public health goal and achieve improved community health outcomes.
- Describe plans for establishing a new or engaging an existing, cross-sector network of partners in support of the proposed program. Where applicable, letters of commitment and support from agencies and organizations should be submitted as attachments.
- Describe past policy, systems, and environmental change successes related to improving health system outcomes, including lessons learned.

- Describe past experiences with and ability to implement continuous quality improvement (CQI) activities for public health programs.
- Describe the applicant's financial accounting structure. The structure should demonstrate the applicant's ability to maintain effective internal controls and demonstrate the ability to provide accurate and complete information about all financial transactions related to this program.
- Provide a staffing plan and project management structure that includes at a minimum a part-time (0.5 FTE) project coordinator. Describe program staff (existing and proposed) qualifications and responsibilities. For vacant proposed positions, identify duties, responsibilities and projected timeline for recruitment and hiring. CVs, resumes and position descriptions may be submitted as attachments.

WORK PLAN

The Work Plan is required (see attachment). The work plan describes key process objectives and goals for successful program implementation. Under each objective, provide a list of the activities that will be used to achieve each of the objectives proposed and anticipated deliverables.

The work plan should include a chronological list and description of activities to be performed. Each activity should have an identified responsible staff, target completion dates, and projected outcomes.

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

- Specific: includes the "who," "what," and "where." Use only one action verb to avoid issues with measuring success.
- Measurable: focuses on "how much" change is expected.
- Achievable: realistic given program resources and planned implementation.
- Relevant: relates directly to program/activity goals.
- Time-bound: focuses on "when" the objective will be achieved.
- Inclusive: brings traditionally marginalized or impacted groups into focus.
- Equitable: aims to address injustice or inequity.

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

BUDGET TABLE

The application should include a project budget worksheet using the excel spreadsheet in District Grants Clearinghouse. An attachment is provided for application preparation purposes but the budget data must be inputted into EGMS. The project budget and budget justification should be directly aligned with the work plan and project description. All expenses should relate directly to

achieving the key grant outcomes. Budget should reflect the budget period, as outlined below (Key Budget Requirements).

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

Key Budget Requirements

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

- October 1, 2024 – September 30, 2025

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

BUDGET JUSTIFICATION

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

Include the following in the budget justification narrative:

Personnel Costs: List each staff member to be supported by (1) funds, the percent of effort each staff member spends on this project, and (2) in-kind contributions. If personnel costs are supported by in-kind contributions, please indicate the source of funds. Please include the full name of each staff member, or indicate a vacancy, position title, percentage of full-time equivalency dedicated to this project, and annual salary. Personnel includes, at a minimum, the program director responsible for the oversight and day-to-day management of the proposed program, staff responsible for service delivery and/or coordination, staff responsible for monitoring programmatic activities and use of funds, and staff responsible for data collection, quality, and reporting.

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

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

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

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

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

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

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

ORGANIZATIONAL CHART

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

RISK SELF-ASSESSMENT

The risk self-assessment (see attachment) is to assess the risk of applicants. The form should be completed by the Executive Director, Board Chairperson or a delegate knowledgeable of the organization's current and past capabilities.

EVALUATION PLAN

The Evaluation Plan Template (see attachment) is to be completed and is to include evaluation questions, evaluation design, and measures (i.e. process and outcome) related to the proposed strategies and activities specified in section 6. Evaluation Criteria.

6. EVALUATION CRITERIA

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

Criterion 1: Need

(20 points) – Corresponds to Sections: Overview and Project or Population Need

- Clearly and succinctly describe goals of the proposed project and how they align with the RFA and provides evidence of the degree to which the goals can be achieved through the proposed project including timeline for completion (6 points)
- Describes in detail the rationale by which target populations and location of services were selected and extent of applicant's previous involvement with target populations and service locations (3 points)
- Demonstrates a clear understanding of health disparities and challenges of the target populations selected by the applicant related to pediatric asthma control, clinical outcomes, and school and home visiting outcomes including relevant data points (3 points)
- Clearly describes and aligns the specific problem(s) and associated contributing factors addressed by the proposed project with the health disparities and challenges of the target population (3 points)
- Outlines strategies to reach the target populations (3 points)
- Demonstrates a strong understanding of the underlying causes of childhood asthma and the asthma healthcare systems, as it pertains to burden childhood asthma-related emergency department (ED) visits, and their relationship as well as an understanding of the potential barriers, challenges, and opportunities to address the problem (2 points)

Criterion 2: Implementation

(40 points) – Corresponds to Sections: Project Description, Work Plan, and Patient and Community Feedback

- Describes the rationale for selecting the proposed goals and activities, including demonstration of the applicants ability to address the problem to achieve project objectives using CDC's recommended EXHALE strategies and how proposed strategies will lead to improved pediatric outcomes in the District (8 points)
- Describes the frameworks to develop, implement, monitor clinical quality improvement interventions, facilitate and sustain linkages and coordination of care across targeted settings with the School Health Services Program (5 points)
- Incorporates how funding the proposed project will support capacity-building with emphasis on sustaining the project beyond the project period outlined in the RFA (4 points)
- Proposes a work plan that represents a logical and realistic plan of action for timely and successful achievement of objectives that support program goals, objectives, and activities (5 points)
- Describes how feedback from residents from the target population(s) will be included and utilized in project planning, implementation, and evaluation (6 points)
- Describes plan for development and/or enhancement of a central registry of children with asthma (7 points)
- Describes how engagement and consistent participation in the DC Asthma Coalition will be established and maintained for implementation of the DC Asthma Control Plan (5 points)

Criterion 3: Evaluative Measures

(20 points) – Corresponds to Sections: Data Collection and Evaluation

- Clearly describes the rationale and framework for data collection and analysis related to key performance indicators (2 points);
- Demonstrates the ability to identify, collect and analyze clinical data from at least one health system (2 points);
- Specifies a clear process to collect and analyze quantitative and qualitative data and monitor progress of proposed activities using a QI framework (3 points);
- Proposes an evaluation strategy that (9 points):
  - appropriately measures the problem defined by the proposed project in the *Overview* and *Project or Population Need and Targeted Settings* sections;
  - describes how the evaluation will be conducted and includes methods and tools, data collection, analysis, and security for personal information (e.g., assign skilled staff, data management software, sampling strategies);
  - demonstrates effective evaluation questions, evaluation design, and measures related to the goal set forth in the application;
- Outlines a clear plan for dissemination of products to internal and external partners that document successes and lessons learned from project results (2 points);
- Demonstrate evidence of organizational commitment, capacity, and experience to coordinate a comprehensive program evaluation and apply results to program operations to ensure continuous quality improvement (2 points).

CRITERION 4: CAPACITY

(20 POINTS) – Corresponds to Sections: Organizational Capacity

- Demonstrates the qualifications of the organization and project personnel (by training and/or experience) in implementing and carrying out the proposed project as described, including (7 points):
  - the capacity to meet performance requirements, follow project deadlines, and provide accurate reporting and
  - the applicant’s accounting structure (e.g., maintaining internal controls, providing accurate and complete information about project-related financial transactions);
- Describe plans for establishing a new or engaging an existing, cross-sector network of partners in support of the proposed project including school based health centers (6 points)
- Describe the applicant’s level of experience (7 points)
  - implementing policy, systems, and environmental change successes related to improving health system outcomes as it pertains to pediatric asthma;
  - implementing continuous quality improvement (CQI) activities for health system and public health programs.

7. REVIEW AND SCORING OF APPLICATION

7.1 ELIGIBILITY AND COMPLETENESS REVIEW

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

advance to the external review. Applicants will be notified that their applications did not meet eligibility.

7.2 External Review

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

7.3 Internal Review

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

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

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

8. POST AWARD ASSURANCES & CERTIFICATIONS

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

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

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

9. APPLICATION SUBMISSION

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

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

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

9.1 Register in EGMS

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

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

EGMS User Registration Assistance:

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

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

9.2 Uploading the Application

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

- ***Eligibility Documents***
  - Certificate of Clean Hands dated within 60 days of the application deadline
  - Current business license or certificate of licensure or proof to transact business in local jurisdiction
  - Current Certificate of Insurance
  - Copy of Cyber Liability Policy
  - IRS Tax-Exempt Determination Letter (for nonprofits only)
  - IRS 990 Form from most recent tax year (for nonprofits only)
  - Current list of Board of Directors, on letterhead, signed and dated by a certified official from the Board (this cannot be the Executive Director)
  - Assurances Certifications Disclosures

- ***Proposal Documents***
  - Proposal Abstract
  - Project Narrative (40-page maximum)
  - Budget Table
  - Budget Justification
  - Organization Chart
  - Work Plan
  - Risk self-assessment
  - Evaluation Plan

9.3 Deadline

Submit your application via EGMS by 3:00 p.m., on the deadline date of July 23, 2024. Applications will **not** be accepted after the deadline.

10. PRE-APPLICATION MEETING

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

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

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

Note that questions will only be accepted in writing. Answers to all questions submitted will be published in a Frequently Asked Questions (FAQ) document onto the District Grants Clearinghouse every three business days. Questions will not be accepted after July 16, 2024.

11. GRANTEE REQUIREMENTS

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

11.1 Grant Terms & Conditions

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

11.2 Grant Uses

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

11.3 Conditions of Award

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

1. Revise and resubmit a work plan and budget with justification in accordance with the approved scope of work and assignments prescribed by a DC Health Notice of Intent to Fund and any pre-award negotiations with assigned DC Health project and grants management personnel.
2. Meet pre-award requirements, including submission and approval of required assurances and certification documents, documentation of non-disbarment or suspension (current or pending) of eligibility to receive local or federal funds.

3. Adhere to mutually agreed upon terms and conditions of a grant agreement and Notice of Grant Award issued by the Department of Health and accepted by the grantee organization. The NOGA shall outline the scope of work, standards, reporting requirements, fund distribution terms and any special provisions required by federal agreements.
4. Utilize performance monitoring and reporting tools developed and approved by DC Health.

11.4 Indirect Cost

Indirect costs are costs that are not readily identifiable with a particular project or activity but are required for operating the organization and conducting the grant-related activities it performs. Indirect costs encompass expenditures for operation and maintenance of building and equipment, depreciation, administrative salaries, general telephone services and general travel and supplies. For federally-funded grants, indirect costs are applied in compliance with 2 CFR 200.332.

For locally-funded grants, DC Law 23-185, the Nonprofit Fair Compensation Act of 2020 (D.C. Official Code sec. 2-222.01 et seq.) allows any grantee to apply a federal Negotiated Indirect Cost Rate Agreement (NICRA) to the grant funds and approved budget, negotiate a new percentage indirect cost rate with the District grantmaking agency, use a previously negotiated rate within the last two years from another District government agency, or use an independent certified public accountant's calculated rate using OMB guidelines. If a grantee does not have an indirect rate from one of the four aforementioned approaches, the grantee may apply a de minimis indirect rate of 10% of total direct costs.

11.6 Vendor Registration in DIFS

All applicants that that are new vendors with any agency of the District of Columbia government require registration in DIFS, the District's payment system. To do so, applicants must register with the Office of Contracting and Procurement. It is recommended that all potential new vendors with the District begin the registration process prior to the application submission.

11.7 Insurance

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

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

11.8 Audits

At any time or times before final payment and three (3) years thereafter, the District may have the applicant's expenditure statements and source documentation audited. Grantees subject to 2

CFR 200, subpart F rules must have available and submit as requested the most recent audit reports, as requested by DC Health personnel.

11.9 Nondiscrimination in the Delivery of Services

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

11.10 Quality Assurance

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

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

A final performance rating shall be completed by DC Health and provided and held for record and use by DC Health in making additional funding or future funding available to the applicant. All performance reports are subject to review and oversight by the DC Health Office of Grants Management.

12. GLOSSARY OF TERMS

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

"Disparities." Disparities. Office of Disease Prevention and Health Promotion. Accessed June 29, 2021. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

Health Equity – The attainment of the highest level of health for all people. It is the removal of any and all differences (disparities) in health that are avoidable, unfair, and unjust. It requires "valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." (MCHB proposed definition)

SMARTIE Goal – one that is specific, measurable, achievable, results-focused, time- bound, inclusive and equitable.

Social Determinants of Health – Social determinants of health are the conditions in which people are born, live, work, play and age that influence health. The public health community has long understood that there is a link between an individual's health and the social, environmental and economic conditions within which an individual resides and interacts. Social determinants of health include access to healthy foods, housing, economic and social relationships, transportation, education, employment and access to health. The higher the quality of these resources and supports, and the more open the access for all community members, the more community outcomes will be tipped toward positive health outcomes. Thus, improving conditions at the individual and community level involve improving societal conditions, Page 36 of 36 including social and economic conditions (freedom from racism and discrimination, job opportunities and food security), the physical environment (housing, safety, access to health care), the psycho-social conditions (social network and civic engagement), and psychological conditions (positive self-concept, resourcefulness and hopefulness).

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

13. ATTACHMENTS

Attachment: Assurances and Certifications

Attachment: Budget Table

Attachment: Budget Justification

Attachment: Work Plan

Attachment: Evaluation Plan

Attachment: Risk Self-assessment

Appendix A: Minimum Insurance Requirements

APPENDIX A: MINIMUM INSURANCE REQUIREMENTS

INSURANCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX B: REFERENCES

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