Department of Health

DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Community Health Administration

REQUEST FOR APPLICATIONS

Colorectal Cancer Control Program

RFA# CHA_CCCP.10.16.20

Submission Deadline:
November 17th, 2020 at 6:00pm

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

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DEPARTMENT OF HEALTH (DC HEALTH)
NOTICE OF FUNDING AVAILABILITY
COMMUNITY HEALTH ADMINISTRATION (CHA)
RFA# CHA_CCCP.10.16.20

Colorectal Cancer Control Program

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

General Information:

Funding Opportunity Title	Colorectal Cancer Control Program
Funding Opportunity #	FO-CHA-PG-00178-002
Program RFA ID#	CHA_CCCP.10.16.20
Opportunity Category	Competitive
DC Health Administrative Unit	Community Health Administration
DC Health Program Bureau	Cancer and Chronic Disease Prevention Bureau
Program Contact	Senkuta Riverson at 202-442-5901 or senkuta.riverson@dc.gov
Program Description	Funding under this RFA will support the implementation of evidence-based interventions (EBIs) that increase colorectal cancer screening (based on The Community Guide recommendations https://www.thecommunityguide.org/) among primary care clinics, health systems, and federally qualified health centers (FQHCs). The program will include implementing electronic health record (EHR) data quality improvement strategies; continuous quality improvement (CQI) processes; systematically integrating recommended EBIs into clinical workflows; and sustaining the interventions long-term. The target populations are primary care patients age 50-75 years, eligible for colorectal cancer screening, racial and ethnic minorities, low income and residents of Wards 5,6,7 and 8.

Eligible Applicants	Organizations authorized and licensed to do business in the District of Columbia and meeting the following criteria: 1) A health system not previously funded by DC Health to implement evidence-based intervention to increase colorectal cancer screening at primary care clinics; 2) Health system with primary care clinic(s)/ practice(s) that seek(s) to expand existing evidence-based interventions to increase colorectal cancer screening; 3) A colorectal cancer screening eligible population of at least 3,500; 4) Health system with the capacity to access cancer screening data from an Electronic Health Record (EHR).
Anticipated # of Awards	One (1)
Anticipated Amount Available	$75,000
Floor Award Amount	$ 50,000
Ceiling Award Amount	$ 75,000

Funding Authorization:

Legislative Authorization	301(a) of the Public Health Service Act, [42 U.S.C. Section 241(a)1. as amended
Associated CFDA#	93.800-Oganized Approaches to Increase Colorectal Cancer Screening
Associated Federal Award	4 NU58DP006771-01-00
Cost Sharing / Match	No
RFA Release Date:	**October 16, 2020**
Pre-Application Meeting	**November 4, 2020 2:00pm-4:00pm**
Pre-Application Meeting Location Conference Call Access	WebEx Virtual Meeting **Meeting number: 172 678 5570** **Password: sHiVc3JB3z5** **https://dcnet.webex.com/dcnet/j.php?MTID=m8c7232b74bac50fa6b686e5d78d3992d** Join by phone **+1-202-860-2110 United States Toll (Washington D.C.)** **1-650-479-3208 Call-in toll number (US/Canada)** Access code: 172 678 5570
Letter of Intent Due date	Not applicable
Application Deadline Date	**November 17, 2020**
Application Deadline Time	6:00 pm

Links to Additional Information about this Funding Opportunity	DC Grants Clearinghouse http://opgs.dc.gov/page/opgs-district-grants-clearinghouse DC Health EGMS https://dcdoh.force.com/GO_ApplicantLogin2

District of Columbia Department of Health 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 sub-award is contingent on DC Health's receipt of funding (local or federal) to support the services and activities to be provided under this RFA.

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

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

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

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

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

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

H. DC Health may conduct pre-award on-site visits 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. This includes DC Health electronic grants management systems, for which the awardee will be required to register and maintain registration of the organization and all users.

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 (i.e. the total number of years for which funding has been approved) and define any segments of the Project Period (e.g. initial partial year, or a 12-month budget period). The NOGA shall outline conditions of award or restrictions.

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 OMB Circulars 2 CFR 200 (effective December 26, 2014) and Department of Health and Services (HHS) published 45 CFR Part 75, and supersedes requirements for any funds received and distributed by DC Health under legacy OMB circulars A-102, A-133, 2 CFR 180, 2 CFR 225, 2 CFR 220, and 2 CFR 215; payment provisions identifying how the awardee will be paid for performing under the award; reporting requirements, including programmatic, financial and any special reports required by the funding Agency; and compliance conditions that shall 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: www.opgs.dc.gov (click on Information) or click here: City-Wide Grants Manual.

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

CHECKLIST FOR APPLICATIONS

☐ Applicants must be registered in the federal Systems for Award Management (SAM) and the DC Health Enterprise Grants Management System (EGMS).

☐ Complete your EGMS registration **two weeks** prior to the application deadline.

☐ 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:

- Table of Contents
- Application Proposal
- Project Abstract
- Project Narrative (10-page limit)
- Work Plan (Attachment 1)
- Budget Worksheet and Budget Justification (Attachment 2)
- Staffing Plan & Organizational Chart
- CRC Baseline Screening Rate and Clinic Population Data (Attachment 3)

- Assurances, Certifications and Certification Documents (Appendix A)
- Business Documents

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

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

☐ 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 minimum of one inch margins, single spaced**. **The total size of all uploaded files must conform to the page-length guidelines outlined in the RFA. Applications that do not conform to these requirements will not be forwarded to the review panel.**

☐ The application proposal format conforms to the "Application Elements" listed in the RFA.

☐ The proposed budget is complete and complies with the budget forms provided in the RFA. The budget narrative is complete and describes the categories of items proposed.

☐ The proposed work plan, logic model, and other attachments are complete and comply with the forms and format provided in the RFA

☐ Submit your application via EGMS by **6:00 pm** on the deadline of **November 17, 2020.**

GENERAL INFORMATION

Key Dates

- Request for Application Release Date: Tuesday, October 20, 2020
- Pre-Application Meeting Date: Wednesday, November 4, 2020
- Application Submission Deadline: Tuesday, November 17, 2020
- Anticipated Award Start Date: Tuesday, January 1, 2021

Overview

Funding under this RFA will support the implementation of the DC Colorectal Cancer Control Program's (DC3C) Health Systems Change initiative. DC Health's CDC-funded Colorectal Cancer Control Program (DC3C) recognizes that screening represents the best opportunity to reduce the colorectal cancer (CRC) burden among District residents. DC3C aims to implement evidence-based interventions (EBIs) (per The Community Guide recommendations https://www.thecommunityguide.org/) including - client reminders, provider reminders, provider assessment and feedback, reduction of structural barriers, and patient navigation (PN) to increase community demand, community access, provider referral and delivery of CRC screening services. DC3C will support the District's primary care clinics, health systems and FQHCs serving disproportionately affected populations (racial/ethnic minorities, low-income, Wards 5, 6, 7 & 8) to implement recommended strategies to improve CRC screening uptake and ultimately eliminate disparities and decrease disease burden.

Key project activities will include developing and implementing at least two (2) recommended primary EBIs at a primary care clinic; and one (1) secondary EBI focused on increasing CRC uptake among target population. *Primary EBIs* include client reminders, provider reminders, provider assessment and feedback, and reducing structural barriers. *Supporting Activities (SAs)* include patient navigation (PN); small media, patient education, provider education, and Health Information Technology. Grantee shall also participate in the following activities: Data Quality Assurance, Workflow Assessment, Data Monitoring and reporting; and follow-up to positive screening results. Grantee will also participate in DC Health's DC3C Learning Collaborative (LC) comprised of a diverse group of partners participating in the program including community-based organizations, local health care systems, and academic organizations. The LC is a communal learning experience used to discuss and share best practices in EBI implementation, CRC screening written policy development, evidence-based QI tools, promising practices to guide system-level QI interventions, including clinical-community linkages, and EHR data quality improvement strategies. DC3C targets patients who are 50-75 years, eligible for CRC screening, low income residents, African American and Hispanic residents, and residents of Wards 5, 6, 7, and 8.

The Community Health Administration (CHA) within DC Health promotes healthy behaviors and healthy environments to improve health outcomes and reduce disparities in the leading causes of mortality and morbidity in the District. CHA's approach targets the behavioral, clinical, and social determinants of health through evidence-based programs, policy, and systems change with an emphasis on vulnerable and underserved populations. The goal of this RFA is to

support the District's primary care clinics in increasing CRC screening uptake among their clinic population, especially populations disproportionately affected by CRC.

Source of Grant Funding

Funding is made available under: "Organized Approaches to Increase Cancer Screening" Cooperative Agreement (NU58DP006771).

Award Information

Amount of Funding Available

This RFA will make available $75,000 for one award per year for a maximum of three years.

Performance and Funding Period

The anticipated project period is January 1, 2021 – June 29, 2023. The anticipated first budget period is January 1, 2021 – June 29, 2021. The number of awards, budget periods and award amounts are contingent upon the continued availability of funds and the recipient performance. The anticipated projected project is three years. The focus of each year

- **Year 1**: readiness assessment, data quality activities, EBI planning, and initiating implementation.
- **Year 2**: EBI implementation, quality improvement activities, and monitoring. Clinics can adopt EBI processes to increase screening for breast and cervical cancer in year 2.
- **Year 3**: sustainability of EBIs, and monitoring.

Funding for each year will be commensurate on level of effort required for each year. We anticipate highest level of funding will be necessary in year one.

Eligible Organizations/Entities

Eligible entities who can apply for grant funds under this RFA are health systems located in the District of Columbia providing primary care services to adults 18 years old and above and have not previously received DC Health funding for implementing evidence-based interventions to increase colorectal cancer screening. Priority will be given to healthcare facilities with a most recent CRC screening rate at or below 60%; health systems with the capacity to provide technical assistance and support for successful implementation of the program; demonstrated experience in quality improvement initiatives; have a colorectal cancer screening eligible population (patients age 50-75 years) of at least 3,5000; and high proportion of the current patient population consistent with the program's target population - men and women age 50-75 years, low-income residents, African American residents, Hispanic residents, and residents of Wards 5, 6, 7 and 8.

Non-Supplantation

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

Application Page Limit

The Project Narrative should not exceed **10 pages**. The total size of uploaded files that will be counted in the application proposal page limit may not exceed the equivalent of **20 pages** when printed by DC Health. The application proposal includes the following documents:

- Table of Contents (not included in 20-page limit)
- Project Abstract (No Template Provided)
- Project Narrative (10 Page Limit)
- Work Plan (Template provided)
- Budget Worksheet & Budget Justification (Template provided)
- Staffing Plan & Organizational Chart
- CRC Baseline Screening Rate and Clinic Population Data (Template provided)

Project Description

Background

The District of Columbia (DC or the District) is an ethnically diverse and compact geographic area measuring 61 square miles of land and comprised of a population of 672,931 (as reported in US Census 2017). This represents a 17.6% population increase since 2000 (572,059)[1]. The District of Columbia is divided into eight geographical wards, with the smallest population in Ward 2 (approximately 77,940 residents) and the largest population in Ward 6 (approximately 91,093 residents)[2]. The median age for residents is 37.7 years old. Table 1 shows, Wards 1 and 2 have the largest proportion of adults ages 18 through 64 (87.20% and 94.10%). Wards 7 and 8 have the largest proportion of youth aged 0-18 (23.60% and 30.30%). And lastly, the wards with the largest proportions of adults over age 65 are Wards 3 and 4 (16.4% and 15.0% respectively).

Table 1: District of Columbia State Data Center 2013-2017 ACS Key Demographics Indicators

Wards	**Total Population**	**Youth aged 0-18**	**Adults aged 18 -64**	**Older adults 65 and older**	**Black/African American**	**Median Household Income**	**Educational Attainment (Bachelor's Degree or Higher) among Population 25 years and over**
District Total	672,931	17.60%	70.50%	11.90%	47.71%	77,649	56.60%
Ward 1	83,598	12.80%	79.00%	8.20%	28.55%	93,284	68.40%
Ward 2	77,940	5.90%	84.70%	9.40%	9.08%	104,504	84.60%
Ward 3	84,021	16.00%	67.60%	16.40%	6.76%	122,680	87.10%
Ward 4	84,643	20.30%	64.70%	15.00%	54.28%	82,625	49.40%
Ward 5	86,136	17.00%	68.90%	14.10%	66.44%	63,552	44.10%
Ward 6	91,093	14.10%	75.60%	10.30%	32.51%	102,214	72.90%
Ward 7	79,800	23.60%	63.40%	13.00%	93.09%	40,021	17.40%
Ward 8	85,160	30.30%	61.30%	8.40%	90.84%	31,954	15.70%

Overall, the District's racial distribution is 47.71% African American, 35.95% White, and 3.8% Asian. Hispanic residents of any race make up more than 10% of the population. Wards 7 and 8 have the highest percentages of African American residents, 93.09% and 90.84% respectively[2].

[1] DC Health Equity Report. Part 2: Demographics and Population Health. https://app.box.com/s/yspij8v81cxqyebl7gj3uifjumb7ufsw July 2018.

[2] Key Demographic indicators District of Columbia and the United States American Community Survey 5-year Estimates 2011-2015. Government of the District of Columbia, Office of Planning State Data Center. https://planning.dc.gov/sites/default/files/dc/sites/op/page_content/attachments/Key%20Indicators%202011-2015.pdf July 2018.

While the median household income in the District is $77,649, Wards 7 and 8 have median income levels of $40,021 and $31,954, respectively, demonstrating the economic disparities that exist in the region. In addition, educational attainment varies throughout geographic locations in the District with 17.40% and 15.7% of Ward 7 and Ward 8 residents, respectively, attaining a bachelor's degree or higher, compared to 72.90% of neighboring Ward 6 residents or 87.10% of Ward 3 residents[2].

Colorectal cancer is the fourth most commonly diagnosed cancer and the fourth leading cause of cancer deaths in the District (DCCR, 2016). The District's 5-year incidence rate was similar to the national rate (38.7 vs 39 per 100,000). However, the mortality rate was 9% higher than the national rate (15.3 vs 14 per 100,000) (CDC 2012-2016). Moreover, the burden of CRC is unevenly distributed across the District's populations. Specifically, CRC incidence is nearly 18% higher in men than women (46.6 vs 39.0 per 100,000). Similarly, the CRC mortality is 36% higher among men than women (18.2 vs 13.2 per 100,000). African American residents are diagnosed with CRC twice as often as Whites (White-24.3, Other-27.7, AA-49.0 per 100,000). The CRC mortality rate is almost three times higher among African American than White residents (20.7 vs 7.8 per 100,000) (DCCR, 2012-2016). CRC risk factors include physical inactivity, smoking, and obesity (American Cancer Society, 2014). Among DC adults age 50-75 years, African Americans and Hispanics reported a higher prevalence of physical inactivity than Whites (32% of African American, 28% of Hispanic, 9% of White). Current smoking is more prevalent among African Americans than Hispanic and White residents (28%, 10%, 8%, respectively). Additionally, there is a disproportionately higher prevalence of obesity among African Americans (41%) than Hispanics (22%) and Whites (15%) (BRFSS, 2016-2018). These risk factors may explain the CRC burden and racial disparities in CRC incidence and mortality.

As screening represents the best opportunity for reducing CRC burden among residents, effective, evidence-based CRC screening activities are critical to reducing mortality, particularly for those at highest risk. Despite strong evidence that screening for CRC is effective, screening rates vary widely among District sub-populations. In 2018, the District had an overall screening rate of 73.8%, with a Healthy People 2020 goal of 74.7% (BRFSS, 2018). However, the CRC screening rate among low-income populations was significantly lower at 45.9% (HRSA, 2018). Specifically, a higher proportion of men tend to forgo screening compared to women (31.1% vs 22%). By race/ethnicity, 21.8% of Whites, 27.3% of African Americans, and 34.3% of Hispanics did not receive CRC screening. Additionally, 34% of individuals with high school or lower educational attainment and 36% of residents with an annual household income less than $35,000 did not receive CRC screening. Lastly, a higher proportion of District residents living in Wards 5, 7, and 8 did not receive CRC screening (27%, 29%, and 27% respectively). CRCs detected at an early-localized stage have a 90% 5- year survival rate. In the District, a slightly higher rate of late stage CRC is diagnosed (20 per 100,000) compared to early stage (16 per 100,000), further underscoring the need for continued focus on increasing CRC screening uptake.

Based on population and surveillance data, African American, Hispanic, low income and residents of Wards 5, 6, 7 and 8 tend to have lower uptake of CRC screening. Similarly, those living in Wards 1, 5, 6, 7 and 8 have high rates of CRC mortality, with the highest in Ward 8 (Figure 1). Wards 5 and 6 have high rates of death from late stage diagnosed CRC. As shown in Figures 3 and 4, wards with high rates of late stage diagnosis and mortality overlap with those

affected by the social determinants of health. Wards 7 and 8 have the highest proportion of Non-Hispanic Black (Ward 7: 93%; Ward 8: 90%), unemployed (Ward 7: 11%; Ward 8 14%); and families living in poverty (Ward 7: 23%; Ward 8: 34%) (Figure 1). Wards 7 and 8 have the highest prevalence of residents age 50-75 years with a poverty income ratio less than 250%. As outlined by the District's Health Equity Report (2018), these populations tend to experience poor health outcomes; lowest life expectancy, and the highest rates of ED visits (**Error! Reference source not found.**).

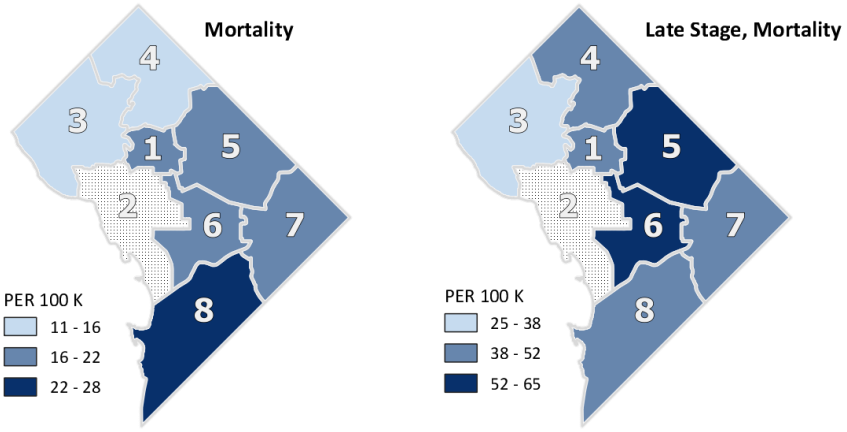

Figure 1. Colorectal Cancer Overall Mortality Rate and Late Stage Mortality Rate, DC, 2012-2016

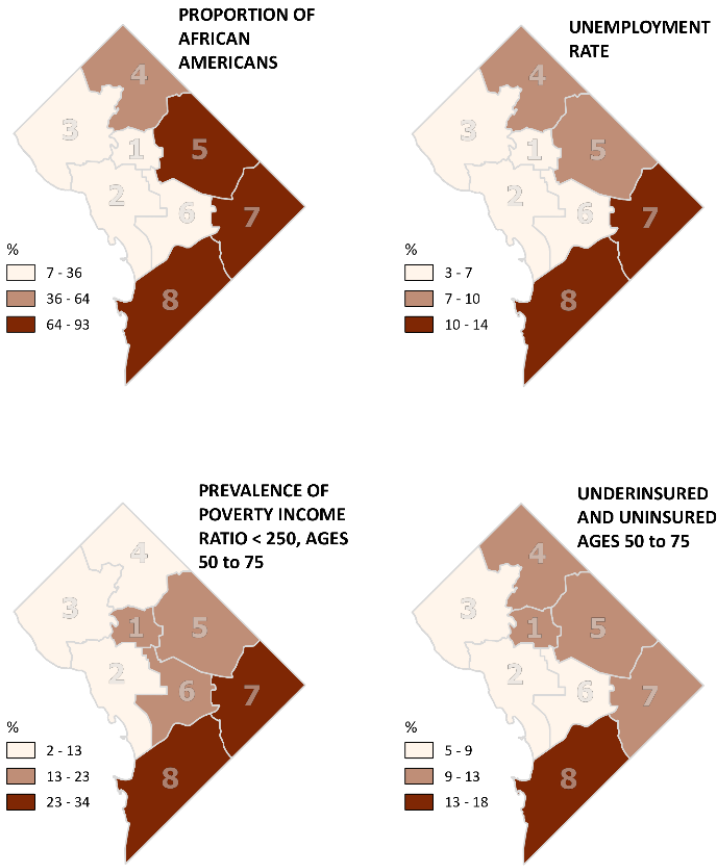

Figure 2. Distribution of Socioeconomic Factors by Ward, 2017

In 2015, DC Health was awarded CDC funding to implement EBIs to increase CRC screening uptake in Federally Qualified Health Centers (FQHCs), look-a-likes, and hospital-based primary care clinics serving at-risk populations primarily in Wards 5, 6, 7 and 8. DC3C successfully increased CRC screening rates among participating clinics, from 19% to 35% among clinics recruited in program year 1 and increased the number of patients who are up-to-date with CRC screening from 2,415 in 2015 to 5,085 in 2018. In targeted Wards, the CRC screening rate increased by 6 percentage points from 68.8% in 2016 to 74.8% in 2018.

To date, DC Health has supported EBIs that increase cancer screening; QI initiatives; and community-clinical linkages within health systems, primary care clinics, and FQHCs. Through this funding opportunity, DC Health will build on the existing DC3C program successes, expand partnerships, enhance quality improvement (QI) and technical assistance methods, increase education, training and awareness for providers and the community, improve clinical data exchange processes, and bolster community-clinical linkages to implement EBIs that improve CRC screening and follow-up testing to tackle critical CRC health disparities and improve health outcomes for District residents.

Purpose

The District of Columbia Department of Health, Community Health Administration is soliciting applications from eligible organizations to implement the following recommended Evidence-Based Interventions to increase CRC screening uptake among patients age 50-75 years, disproportionately affected, high-risk populations (such as low-income, racial/ethnic minorities, uninsured and underinsured populations).

Primary EBI's- client reminder, provider reminder, provider assessment & feedback and reducing structural barriers

Supportive activities - patient navigation, small media, provider education, patient education, Health Information Technology (HIT)

Performance Requirements

Applicants should propose projects that meet all criteria listed below. Recipient is encouraged to engage the community that they serve in the planning, implementation, and evaluation of the project to ensure that it is tailored to meet the unique needs of the target population.

Target Population

Projects should focus on District adults age 50-75 years who are eligible for CRC screening, as recommended by the USPFTS, and receiving care in primary care clinics. In addition, applicants should be able to demonstrate a strong ability to reach priority populations, including disproportionately affected populations - racial and ethnic minorities, people with low annual household income, people who are uninsured or underinsured and live in Wards 5, 6, 7 and 8.

Location of Services

Services shall be delivered within a primary care clinic(s)/practice(s) that are a part of a health system located in the District.

A health systems with multiple primary care clinics/practices (hereafter referred to as health systems), can participate in this project, however, the grant recipient should plan to partner and implement program strategies and activities at the clinic level (i.e. at the specific primary care clinic/practice within the health system).

Scope of Services

Grantee shall implement recommended EBIs to improve CRC screening rates and follow-up among disproportionately affected populations (racial/ethnic minorities, low-income, Wards 5, 6, 7 & 8) to eliminate disparities and decrease the disease burden. The program uses a collaborative approach with a broad range of partners including;

1. The DC Primary Care Association (DCPCA) providing group technical assistance through a learning collaborative model;
2. The regions' health information exchange provider (Chesapeake Regional Information System for our Patients [CRISP]) to improve PCP access to CRC screening results;

3. A health information technology (HIT) expert (Health Efficient) specializing in IT management, data reporting and clinical quality improvement (CQI); and
4. Multiple community-based stakeholders such as the DC Cancer Coalition, the DCCR Advisory Board, and the Patient Navigator Network.

This comprehensive network of partners will support partner clinics in achieving programmatic goals by addressing gaps in clinical infrastructure, capacity, and workflow to ensure sustainability of EBIs to improve CRC health outcomes, especially among those most vulnerable to the disease.

DC Health seeks to build on the existing DC3C program successes, expand partnerships, enhance quality improvement (QI) and technical assistance methods, increase education, training and awareness for providers and the community, improve clinical data exchange processes, and bolster community-clinical linkages to implement EBIs that improve CRC screening and follow-up testing to tackle critical CRC health disparities and improve health outcomes for District residents.

Approach

1. Purpose

The purpose of this program is to implement EBIs in primary care clinics that provide clinical services to populations with low CRC screening rates to increase clinic-level CRC screening rates.

2. Outcome

As displayed in the logic model in Table 1, the key outcome of this program by the end of the period of performance is to increase clinic level CRC screening rates:

i) Increased clinic-level CRC screening rates.

Over time, increased screening is expected to lead to the intermediate outcomes of increased number of cancers prevented, increased diagnosis of early stage CRC, and ultimately the long-term outcomes of decreased CRC incidence and mortality among the population reached/served by program activities.

Table 1: Logic Model – DC3C Intended Program Outcomes

Strategies	Output	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
A: Participate in readiness assessment and implement recommended changes B: Design and implement evidence-based interventions (EBIs)	Written CRC screening policy CRC Screening Best Practice Manual	**Increased clinic-level CRC screening rates**	Increased number of cancers prevented Increased diagnosis of early stage CRC	Reduced CRC incidence and mortality

C: Facilitate patients' linkage to follow-up colonoscopy D: Data quality, program monitoring and evaluation E: Collaboration with DC Health partners to address system level barriers to CRC screening	EBIs incorporated into clinic workflow Routine cancer screening rate monitoring Improved CRC data quality			

3. Strategies and Activities

Applicants shall propose activities for <u>all</u> strategies as outlined below. Applicants shall clearly demonstrate ability to reach target population and the capacity to implement proposed activities and develop a plan to sustain successful strategies over time.

Applicants are encouraged to utilize strategies that:

- **Develop** sustainable interventions that can be shared, duplicated and-or expanded with minimal resources beyond the life of the grant
- **Align** with DC3C goals and objectives

Strategy A: PRIMARY CARE CLINIC/PRACTICE PARTNER: Partner with a primary care clinic/practice within the applicant's health system.

1. The grantee shall identify and establish a formal partnership (though an MOU/MOA) with at least one primary care clinic/practice within the grantee's health system. The clinic/practice would implement the DC3C program and provide required data (as outlined in this RFA) for their specific clinic/practice.

Strategy B: READINESS ASSESSMENT: Participate in an in-depth readiness assessment and use findings from the assessment to inform planning and implementation.

1. Prior to implementation of EBIs, an implementation readiness assessment shall be performed by DC Health with clinic staff. The purpose of the implementation readiness assessment is to document the clinic's current CRC screening process, the quality of CRC screening data in the electronic health record (EHR), and available clinic resources in order to 1) guide the selection of EBIs to address identified gaps and opportunities, and 2) identify and conduct any needed quality improvement activities prior to implementation of EBIs (e.g., improving the quality of EHR screening data). DC Health will review the results of the implementation readiness assessments and provide recommendations prior to the implementation of EBIs in the clinic.

   The readiness assessment includes:

i) Calculation of the clinics baseline CRC screening rate;
ii) Process or workflow mapping of the CRC screening process (e.g., how the clinic identifies patients due or overdue for screening; how patients are notified that they are due for screening; how and by whom CRC screening tests are ordered; how people receive their CRC screening test kit or order; how people are referred for colonoscopy; how the clinic tracks completion of ordered or referred tests; how the clinic ensures that people with an abnormal test receive appropriate follow-up testing);
iii) An assessment of the clinic's EHR (e.g., how and where CRC screening test information is captured, how CRC screening rates are calculated, validation of the CRC screening rate through manual record review);
iv) An assessment of EBIs currently used by the clinic to determine implementation quality;
v) An assessment of clinic resources and capacity available to support EBI implementation (e.g., staff, policies, leadership support).

2. The completed assessment will be used to identify gaps and opportunities for improving the clinic screening process, identify opportunities to improve EHR data quality, select appropriate EBIs to address identified gaps, and develop a plan to implement the selected EBIs.
3. Applicants shall describe their plans to ensure successful completion of the readiness assessment tool and how they will use the findings of the readiness assessment in planning and implementing EBIs.

Strategy C: EBI IMPLEMENTATION: Implement multiple EBIs (a new evidence-based intervention or enhance an existing intervention) consistent with the clinics' readiness assessment findings.

1. ***Required EBI's-*** the recipient shall implement at least two of the four required EBIs described below. Interventions should be chosen based on clinic readiness assessment results. The required EBIs include:
    i) **Provider Assessment and Feedback** – Interventions that evaluate provider performance in delivering or offering screening to patients (*assessment*) and formal/written presentation of the information to providers about their performance in providing screening services (*feedback*).
    ii) **Provider Reminders** – Reminders that inform health care providers when it is time for a client's cancer screening test (called a "reminder") or that a client is overdue for screening (called a "recall"). Usually electronic, written, email and/or visual.
    iii) **Client (or patient) Reminders** – Written (letter, postcard, email) or telephone messages (including recorded/automated messages) advising people that they are due for screening. Client reminders can be general to reach the overall target population or tailored with the intent to reach one specific patient based on unique characteristics, related to the outcome of interest, and derived from an individual assessment. For example, reminder postcards for patients who previously missed a CRC screening appointment or patients due for a colonoscopy.

iv) **Reducing Structural Barriers** – Structural barriers are non-economic burdens or obstacles that make it difficult for people to access cancer screening (e.g., inconvenient clinic hours, lack of transportation).

2. ***Supportive Activities*-**Recipient may utilize patient navigation as well as other Supportive Activities (SAs) to support delivery of EBIs.
    i) Patient navigators may be used to help patients overcome barriers and support adherence to screening completion (e.g., ensuring return of FITs), follow-up testing (colonoscopy), and initiation of cancer treatment if relevant, and to support implementation of required clinic based EBIs.
    ii) Existing small media materials may be used, or adapted for use, to support implementation of patient navigation and client reminder interventions.

3. Recipient shall identify a clinic champion and establish a DC3C Team to oversee implementation of the program in the clinic.
    i) Recipient should identify a CRC screening champion to facilitate implementation of the program and monitor progress. The CRC screening champion will actively work with DC Health and DC Health implementation support partners that will provide technical assistance to the program.

    CRC Screening Champions: Individuals who are passionate about CRC screening and want to increase CRC screening rates in their clinic/setting/community. They are willing to support, market, and drive CRC screening activities, overcome organizational indifference or resistance to CRC screening, and foster a collaborative learning environment to actively improve CRC screening processes and rates.

    ii) Recipient should identify and assemble a diverse group of clinical staff that will participate in the implementation of the program – forming the DC3C Team. Team members should include, at a minimum, Medical Director, QI staff, IT staff, PN (if applicable), referral coordinator/care coordinator, front desk staff, MA, nurse and administrative leadership.
4. Recipient shall develop an Action Plan (implementation work plan) outlining plans for program implementation. DC Health will provide an Action Plan tool, once completed, will be approved by DC Health prior to implementation of the program.

Strategy D: FOLLOW-UP COLONOSCOPY: Facilitate patients' linkages to follow-up colonoscopy.

1. Recipient shall provide resources to patients to pay for follow-up colonoscopies.
    i) Recipient may use limited funds with DC Health approval to pay for follow-up colonoscopies for asymptomatic uninsured adults age 50-75 who are screened for colorectal cancer by partner clinics. Funds may not be used to pay for colonoscopies to evaluate or diagnose symptomatic patients.
    ii) Recipient may use awarded funds to pay for a colonoscopy following a positive or abnormal fecal immunochemical test (FIT), fecal occult blood test (FOBT), sigmoidoscopy, computed tomographic colonography (CTC), or multi-target stool

DNA test (mts-DNA) if these tests were ordered or performed by a partner clinic (e.g., a clinic in which the recipient is implementing EBIs and clinic-level data are being reported on screening rates) for the purpose of screening asymptomatic adults for CRC. Colonoscopies provided by the program should meet national quality standards.

iii) Reimbursement for colonoscopy may not exceed the Medicare rate (the reimbursement rate by the federal government as established by the Centers for Medicare and Medicaid 9 of 52 Services).

iv) The Federal government is the payor of last resort. Awarded funds shall be used as the payment of last resort and may not supplant other available sources of payment for colonoscopy.

v) Recipient shall report, in aggregate, on follow-up colonoscopies paid for with DC Health funds: the number of patients provided a follow-up colonoscopy, the final test results (cancer, adenomatous polyp, non-adenomatous polyp, other abnormal finding, or normal), the number of patients referred for cancer treatment, and the number of patients that start cancer treatment.

vi) Patients with positive FOBT/FIT results need to be navigated to follow-up colonoscopy. The navigation process needs to be documented in the DC Health navigation database system.

vii) Applicants shall describe how they will secure treatment resources for patients diagnosed with cancer or those needing additional evaluation or treatment.

viii) All applicants shall describe how they will facilitate linkage to follow-up colonoscopy regardless of whether the applicant intends to use awarded funds to support this activity.

2. Recipient shall provide support to patients to facilitate the completion of follow-up colonoscopies.

Patient navigators, care coordinators, referral coordinators and/or appropriate clinic staff should be used to facilitate screening and reduce barriers to colonoscopy completion regardless of the source of payment for the colonoscopy (e.g., educating patients about the procedure, assisting with scheduling, providing instructions for bowel preparation, providing appointment reminders, assisting with transportation or translation services, other related activities).

Strategy E: DATA MONITORING: Conduct data quality, collection and monitoring activities to evaluate attainment of goals and improve program implementation.

1. **Collect high quality clinic-level data on implementation and outcomes**: Recipient must be able to report a baseline and annual data record at the facility level, as defined by DC Health, including:
    i) Characteristics of health systems/clinics and their patient populations;
    ii) The EBIs that are implemented;
    iii) The total number of adults age 50-75 years that are eligible for CRC screening;
    iv) Of the total number of adults age 50-75 years served by the clinic, the number that received an appropriate CRC screening test within the recommended time frame;

v) The baseline CRC screening prevalence (referred to as CRC screening rate) prior to implementation of any EBIs (based on U.S. Preventative Services Task Force (USPSTF) guidelines https://www.uspreventiveservicestaskforce.org;
    a. CRC screening rate = number of adults age 50-75 years that received an appropriate CRC screening test within the recommended time frame/total number of adult age 50-75 years served by the clinic who are eligible for CRC screening (based on USPSTF guidelines).

vi) Annual CRC screening rate post EBI implementation for each year the clinic participates in the program;

vii) The number of patients given a FIT or FOBT kit and the percentage of patients that returned a kit to the clinic;

viii) The number of patients with a positive or abnormal screening test and percentage that completed a follow-up colonoscopy;

ix) The total number of colonoscopies paid for with DC Health funds;

x) Final results of colonoscopies paid for with CDC CRCCP funds (in aggregate, the number of colonoscopies provided and the final results [cancer, adenomatous polyp, non-adenomatous polyp, other abnormal finding, or normal], the total number of patients diagnosed with CRC and percent starting treatment).

2. **Quarterly Data Reporting**: Recipient will track and report CRC screening data quarterly including (but not limited to):
    i) Rolling 12-month CRC screening rate by quarter
    ii) The total number of adults age 50-75 years that are eligible for CRC screening for the quarter
    iii) Of the total number of adults age 50-75 years served by the clinic, the number that received an appropriate CRC screening test within the recommended time frame (based on USPSTF guidelines) for the quarter;
    iv) Percent referred to CRC screening out of those who were eligible for CRC screening by modality (colonoscopy, FOBT/FIT, etc.).
    v) Percent received CRC screening by screening modality (colonoscopy, FOBT/FIT, etc.)
3. **Capacity to Extract Data:** Recipient must have staff with knowledge/expertise in the clinic's electronic health record (EHR) and the ability to extract required data for submission to DC Health. Recipient will use DC Health data collection tools to submit required data (including those mentioned above) quarterly and annually.
4. **Improve Colorectal Cancer Screening Data Quality:** Recipient will work with DC Health partners serving as subject matter experts in extracting population health data from electronic health records (EHRs) and to improve the quality of data entered into and extracted from EHRs. Recipient should validate clinic's reported EHR CRC screening rate through manual chart review within the first year of a clinic's participation in the program, and if discrepancies exist, identify and address issues to improve data quality. Clinics with screening rates below 10%, and clinics with data quality issues will be required to conduct a chart review in subsequent years.

5. **Use monitoring data for quality and program improvement:** Recipient will continually monitor program progress through data collection and analysis. Recipient will also perform data quality assurance (QA) activities and validate data before submission. Monitoring data will be used to inform EBI implementation and program improvement.
    i) Routinely analyze clinic and other program data to assess data quality and identify areas for quality improvement.
    ii) Hold regular meetings of the DC3C Team to review clinic data, including screening rate (e.g., monthly, quarterly), implementation successes and challenges, and other program monitoring data with the DC3C Team to monitor progress and improve implementation of EBIs.
    iii) Participate in DC Health-led data review process.
    iv) Conduct data-driven planning to maximize program resources and effectiveness.

Strategy F: SUPPORT and TECHNICAL ASSISTANCE: provide support to primary care clinics/practices implementing EBIs. Grantee shall provide technical assistance in effective EBI implementation to participating clinics within the Grantee's health system as needed. This includes (but not limited to) helping clinics develop workflow documentation/process maps; complete EBI Action Plan, develop written screening policies and procedures; develop QI activities to improve EBI implementation and data quality; and report required data to DC Health. Additionally, grantee will provide support to assist clinics with conducting chart reviews. To this end, grantee will

i) Orient clinic staff on program goals, activities and requirements
ii) Assist the clinic champion(s) in coordinating EBI implementation and monitoring of progress. This may include convening monthly meetings with champion(s) to assess need for technical assistance and support.
iii) Support the clinic(s) in extracting data from the EHR; data validation processes (including chart review); and reporting required data to DC Health.
iv) Provide guidance on quality improvement activities to inform continuous quality improvement of program implementation.

Strategy G: COLLABORATION: collaborate with partner organizations to address the clinic's capacity needs, as well as system level barriers. The program uses a collaborative approach with a broad range of partners including the DC Primary Care Association (DCPCA), that will provide technical assistance and QI support, the regions' health information exchange provider (Chesapeake Regional Information System for our Patients [CRISP]), a health information technology (HIT) expert (HealthEfficient) specializing in IT management, data reporting and clinical quality improvement (CQI). This comprehensive network of partners will support partner clinics in achieving programmatic goals by addressing gaps in clinical infrastructure, capacity, and workflow to ensure sustainability of EBIs to improve CRC health outcomes, especially among those most vulnerable to the disease. To this end, grantee will work closely with partner organizations to:

i) Identify the clinic's infrastructure and capacity gaps and needs for effectively implementing the program. This would include an in-depth readiness assessment as mentioned in the Approach Section – Strategy A of this RFA.
ii) Collaborate with CRISP and other program partners to determine how to address system level barriers such as, delay in receipt of colonoscopy results from

specialist; difficulty accessing CRC screening history; and multiple visits (consult visit and procedure visit) to preform colonoscopies. This will include participation in meetings and workshops to facilitate and collaborate on efforts.

APPLICATION REQUIREMENTS

A. Project Narrative (10-page limit)

(The project narrative must be a maximum of 10 pages, single spaced, 12-point font, 1-inch margins, number all pages. Content beyond the specified page number will not be reviewed.) Applicants must submit a Project Narrative with the application forms. The Project Narrative must include all the following headings (including subheadings): Background, Approach, Evaluation and Performance Measurement Plan, and Organizational Capacity. The Work Plan does not count toward the 10-page Project Narrative page limit. The Project Narrative must be succinct, self-explanatory, and in the order outlined below. The Project Narrative must describe outcomes and activities to be conducted over the entire period of performance as identified in this RFA.

Background

Applicants must provide a description of relevant background information that includes the context of the problem.

Approach

i. Purpose

Applicants must describe in 2-3 sentences specifically how their application will address the public health problem as described in the DC Health Background section.

ii. Outcomes

Applicants must clearly identify the outcomes they expect to achieve by the end of the project period, as identified in the logic model in the Approach section of this RFA. Outcomes are the results that the program intends to achieve and usually indicate the intended direction of change (e.g., increase, decrease).

iii. Strategies and Activities

Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the project outcomes. Applicants must base their strategies and activities on those described in the Strategies and Activities section of the DC Health Project Description (Strategies A-G). Strategies A – G must be addressed in applicants' response. Applicants must propose activities that align with the requirements of this RFA, that meet their clinic's needs, and describe in the Applicant Evaluation and Performance Measurement Plan how these strategies will be evaluated over the course of the project period.

- Clearly address Strategies A-G from the Approach Section
    - For each strategy, describe the rationale for selected activity. Please include assessment of current needs and assets in the health system.
    - For each strategy, clearly describe activities that will be implemented how they will be implemented; and how the strategies will be operationalized to achieve program goals, objectives, and outcomes.
- Indicate plans for sustainability of the initiative beyond the projected funding period.

iv. Target Population

This section should provide an overview of the applicant's ability, history and capacity to engage District adults aged 50-75 years who are eligible for CRC screening, specifically, African American, Hispanic, low-income populations residing in Wards 5,6,7,8.

Evaluation and Performance Measure Plan

Applicants should provide a description of how project goals will be assessed and monitored during implementation. The applicant should describe how key performance measure data (described in in Strategy E of the Strategy and Activity section) will be collected and used to assess project outcomes. At a minimum, the plan shall describe:

- The applicant's experience and capacity to access and export the performance measures, data sources, feasibility of collected required data, and other relevant data information (e.g. performance measures proposed by the applicant).
- How applicant will collect the performance measures
- How applicant will ensure quality data collection, including QA activities, data validation methods, and capacity to perform a chart review.
- How data will be monitored and used to improve implementation.

Organizational Capacity

Applicants should provide information on the organizational infrastructure, as well as the organization's mission and vision. Applicants should demonstrate capacity and experience working with key internal and external stakeholders to implement cancer prevention and QI initiatives and detail a scope of cancer prevention focused programs that are in place within their organization. Applicants should identify the 'clinical champion' who will drive and coordinate the program activities, in addition to monitoring practice data to inform improvements to implementation. Applicants should demonstrate the capacity of the organization to develop and implement work plans and explain any experience with implementing the proposed strategies (with an emphasis on the target population under this funding opportunity). In addition, applicants should demonstrate their ability to meet performance requirements, collect data, follow project deadlines for deliverables, and provide accurate reporting. Lastly, applicants should affirm organizational leadership commitment to complete the project as proposed in the work plan.

B. Additional Required Documents

Some documents to be included with this application have required templates that the applicants must use (noted below). The required documents will not count towards the Project Narrative 10-page limit; however, they will count towards the proposal overall 20-page limit.

Project Abstract

A one-page project abstract is required. Please provide a one-page abstract that is clear, accurate, concise, and without reference to other parts of the Project Narrative. The project abstract must be **single-spaced, limited to one page in length**, and include the following sections (*no template provided*):

- **Project Description:** Briefly outline how the organization will implement the project in service of the goal and objectives.
- **Performance Metrics**: Outline the key outcome and process metrics and associated targets that will be used to assess grantee performance.

Work Plan (Attachment 1)

The Work Plan, (template provided by DC Health), is required. The work plan describes key activities and tasks to successfully deliver the project strategies and activities. The activities and tasks should be organized chronologically, and each should have an identified responsible staff, target completion date, and associated output.

Budget Worksheet & Budget Justification (Attachment 2)

The application should include a Budget Worksheet and Budget Justification (template provided by DC Health). The Budget Worksheet 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. The project budget should reflect a 12-month budget period. Costs charged to the award must be reasonable, allowable and allocable under this program. Salaries and other expenditures budgeted in the grant must be for services that will occur during the 12-month grant period.

Budget Worksheet*: The Budget Worksheet is required (template provided by DC Health). Using the spreadsheet, enter the proposed budgeted amounts in the sections outlined below (in the Budget Justification).

Budget Justification: The budget justification should include a full narrative description of each of the following sections as listed below, as well as a total of all proposed costs (template provided by DC Health).

> ***Salary:*** Include the name of each staff member (or indicate vacancy when appropriate), position title, annual salary, and percentage of full-time equivalency dedicated to this project.
>
> ***Fringe:*** Provide the fringe benefit rate and list all components that make up the rate. Indicate all positions/staff for which fringe benefits will be charged.
>
> ***Supplies:*** Funds can be used to cover supplies related to education/outreach. Applicant should provide a separate category total and description for each. Description should include a summary of the individual items and their quantity included in each category; however, the items do not have to be priced out separately. Description should also include how the supplies directly support the project.

Travel: Only local travel related to project activities will be approved in the grant budget. Narrative justification should provide details on how costs were calculated and how the travel supports the project.

Contractual: Provide the cost and explanation as to the purpose of each contract, how the costs were estimated, and the expected contract deliverables.

***Other Direct Costs*:** Provide information on other direct costs that have not been otherwise described.

Indirect Costs: Indirect costs should not exceed 10% of direct costs.

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

Staffing Plan & Organizational Chart

Provide an organizational chart and staffing plan that includes a minimum of one full or part-time Quality Improvement coordinator and one data analysis support staff member. The applicant must specify the clinic champion for this project (name, job title). If applicant is proposing a patient navigation program, applicant must include staffing plan. Position descriptions (not to exceed 1/2 page for each) of all proposed staff should be included with this section. No DC Health template is provided.

CRC Screening Baseline and Clinic Population Data (template provided)

Applicant must use the data collection template (template provided by DC Health to provide data on all required data fields including the clinic's CRC screening rate (numerator & denominator) for calendar year 2019 (at the facility-level-for health systems); measure used (UDS, NQF etc.), number of clinic patients during reporting period, number of patients age 50-75 years, proportion of patients by race and ethnicity. Applicants need to determine and name specific clinic facilities that will participate in the program. All data reported needs to be at the facility level and not at the Health Center level.

EVALUATION CRITERIA

Indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and provide the reviewer with a standard for evaluation. The four review criteria are outlined below with specific detail and scoring points. While 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 (Corresponds to Sections *Background and Target Population*) - 20 points

- Does the applicant fully describe the target population?
- Does the applicant demonstrate an understanding of the geographic area and patient population the applicant is targeting, including demographics, sociodemographic indicators, and CRC screening rate?

- Does the applicant demonstrate an understanding of the health indicators/outcomes for the population they serve and challenges to improving health outcomes?
- Does the applicant describe existing EBIs and identify gaps in current EBI implementation?
- Does the applicant serve a high proportion of the target subpopulations?
- Does the applicant identify clear goals for the project? Does the project implementation plan align with stated goals?

Criterion 2: Strategic Framework (Corresponds to Sections *Approach and Work Plan*) - 30 points

- Did applicant outline activities for all required strategies?
    - Identify and describe the primary care clinic(s)/practice(s), the health system proposes to partner with on this project.
    - Propose methods to facilitate the completion of a readiness assessment
    - Describe existing EBIs that can potentially be enhanced or new EBIs that can be implemented
    - Identify (name, job title) a CRC Screening Champion, and the DC3C Team members
        - The applicant should describe the proposed DC3C Team, the role of each member, and the activities of the team including the frequency of team meetings.
    - Describe how applicant will secure treatment resources for patients diagnosed with CRC and those needing additional evaluation or treatment.
    - Outline how applicant will ensure linkage and completion of follow-up colonoscopy after a positive FIT/FOBT or screening colonoscopy.
    - Identify source(s) for follow-up treatment for patients diagnosed with cancer.
    - Identify source(s) for follow-up colonoscopies with program funds utilized as payer of last resort.
    - Describe data quality activities; data collection and monitoring efforts that will ensure submission of required high-quality data to DC Health.
    - Describe the type and frequency of technical assistance provided to support clinics in EBI implementation, data extraction and reporting, data quality and continuous quality improvement efforts.
    - Describe how data will be used routinely to inform program implementation.
    - Describe how applicant will work with program partners (DCPCA, CRISP, HealthEfficient) to facilitate identification of gaps in clinic's capacity and infrastructure to achieve program goals; and participate in efforts to address system level barriers.
- Do the activities align with demonstrated needs of the patient population?
- Do the activities support the associated strategy?
- Are objectives SMART?
- Does the proposed project have the potential to achieve the stated goals?
- Is the proposed project feasible given the expected timeline and current infrastructure?

Criterion 3: Capacity (Corresponds to Sections *Organizational Capacity*) - 20 points

- Does the applicant's organizational infrastructure support the implementation of the proposed strategies?
- Does the applicant demonstrate commitment from the organization's leadership to implement the proposed strategies? (Applicants may submit letters of commitment to the program from the organizations leadership.)
- Does the applicant demonstrate commitment to implement an in-depth readiness assessment, and implement or expand recommended EBIs based on readiness assessment findings?
- Does the applicant provide evidence of successful implementation of initiatives to prevent cancers and/or cancer risk factors and improve cancer screening?
- Does the applicant identify a project lead?
- Does the applicant have staff with expertise in data extraction from the clinic's EHR and/or utilizing EHR overlays (e.g. BridgeIT, Azara)?
- Does the applicant have staff with expertise in augmenting the EHR (e.g. adding fields, creating provider alerts)?

Criterion 4: Evaluation (Corresponds to Section *Evaluation and Performance Plan*)-25 points

- Does the applicant identify staff who will be responsible for data collection and analysis?
- Does the applicant specify a process to collect and analyze data that tracks progress towards project goals?
- Does the applicant demonstrate how the implementation of QI projects will lead to improvements in program implementation?
- Does the applicant identify measurable indicators that align with the project goal?

REVIEW AND SCORING OF APPLICATION

Pre-Screening Technical Review

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

External Review Panel

The review panel will be composed of neutral, qualified, professional individuals who have been selected for their unique experiences in cancer and chronic disease prevention and control, public health and preventative health program 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.

Internal Review

DC Health program managers will review the individual and summary recommendations of the external review panel and make recommendations for awards. Program Managers will weigh the results of the review panel against other internal and external factors in making the final funding determinations. Those factors will include (minimally) a past performance review, risk assessment and eligibility assessment, including a review of assurances and certifications, and business documents submitted by the applicant, as required in the RFA. DC Health will also conduct an excluded parties list search (EPLS) of the organization and executives via the federal System for Award Management (SAM) and conduct a DC Clean Hands review to obtain DC Department of Employment Services and DC Office of Tax and Revenue compliance status.

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

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

PRE-AWARD ASSURANCES & CERTIFICATIONS

DC Health requires all applicants to submit various Certifications, Licenses, and Assurances at the time the application is submitted. Those documents are listed in Section VII.A. DC Health classifies assurances packages as two types: those "*required to be submitted with applications*" and those "*required to sign grant agreements*."

A. Assurances *Required to Submit Applications* (Pre-Application)

- City Wide Clean Hands Compliance Status Letter (formerly Certificate of Clean Hands). Clean Hands Compliance Status letter must be dated no more than 3 months prior to the due date of application.
- 501 (c) 3 certification, as applicable
- Official List of Board of Directors on letterhead, for current year, signed and dated by the authorized executive of the Board. (cannot be the CEO), as applicable
- All Applicable Medicaid Certifications
- A Current Business license, registration, or certificate to transact business in the District of Columbia
- FQHC certification, if applicable

B. Assurances *Required to sign grant agreements* for funds awarded through this RFA (Post-Award)

- Certification Regarding Lobbying; Debarment, Suspension and Other Responsibility Matters; and Drug-Free Workplace Requirements
- Comprehensive Automobile Insurance, if applicable for organizations that use company vehicles to administer programs for services.

- Certification of current/active Articles of Incorporation from DCRA (Certificate of Good Standing).
- Proof of Insurance for: Commercial, General Liability, Professional Liability, Comprehensive Automobile and Worker's Compensation
- Certificate of Occupancy
- Most Recent Audit and Financial Statements

APPLICATION PREPARATION

Application Package

Only one (1) application per organization will be accepted.

The following applicable documents **are** included in the 20-page limit:

- Project Abstract
- Project Narrative (10-page limit)
- Work Plan – Attachment 1
- Budget Worksheet & Budget Justification - Attachment 2
- Staffing Plan and Organizational Chart – Template not provided in RFA

The following documents **are not** included in the 20-page limit:

- Table of Contents - Lists major sections of the application with quick reference page indexing. Failure to include an accurate Table of Contents may result in the application not being reviewed fully or completely.
- CRC Baseline Screening Rate and Clinic Population Data – Attachment 3
- Assurances Certifications and Disclosures (See Appendix A): *reviewed and accepted via EGMS.* Scan and upload **one copy SIGNED** by the Agency Head or authorized official.
- DC Health Standard Grant Terms and Conditions (*Reviewed and Accepted via EGMS*)

Uploading the Application

All applications must be submitted through EGMS. Documents to include in each uploaded file are below. All of these must be aligned with what has been requested in other sections of the RFA.

Business Documents - Scan and upload **ONE .**pdf file to be named **Business Documents** that contains the following: 501(c) 3 Certification; City Wide Clean Hands Compliance Status Letter; Official List of Board of Directors(signed); Medicaid Certifications, current business license: FQHC designation letter, and Appendix A (Assurances Certifications & Disclosures (signed)) documents.

Application Proposal - Upload **ONE .pdf file** to be named **Application Proposal** that contains the following: Table of Contents, Project Abstract, Project Narrative, Work Plan, Budget

Worksheet & Budget Justification, Staffing Plan & Organizational Chart and CRC Screening Baseline and Population Data.

Failure to submit the required assurance package will likely make the application either ineligible for funding consideration [required to submit assurances] or ineligible to sign/execute grant agreements [required to sign grant agreements assurances].

APPLICATION SUBMISSION

All District of Columbia Department of Health application submissions must be done electronically via Department of Health's Enterprise Grants Management System (EGMS), DC Health's web-based system for grant-making and grants management. To apply under this funding opportunity, the applicant organization must register in EGMS and establish an account for the authorized representative.

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

IMPORTANT: When the Primary Account User is applying, 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.

Register in EGMS

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

IMPORTANT: WEB BROWSER REQUIREMENTS

1. **Check web browser requirements for EGMS –** The DC Health EGMS Portal is supported by the following browser versions:
    - Microsoft ® Internet Explorer ® Version 11
    - Apple ® Safari ® version 8.x on Mac OS X
    - Mozilla ® Firefox ® version 35 & above (Most recent and stable version recommended)
    - Google Chrome ™ version 30 & above (Most recent and stable version recommended)

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

3. 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.

4. Your EGMS registration will require your legal organization name, your **DUNS # and Tax ID#** to complete the registration. Your EGMS registration will also require your SAM (System for Award Management) expiration date to be entered into your agency profile. Please ensure that you have an active SAM registration (www.sam.gov).

5. When your Primary Account User request is submitted in EGMS, the DC Health Office of Grants Management will review the request. If the requester is NOT the identified Executive Director, DC Health Office of Grants Management will make an additional request for the Executive Director to send an email to DC Health to confirm that the requester is the authorized representative for EGMS. When requested, your authorized representative should send to doh.grants@dc.gov the name, title, telephone number and email address of the desired Primary User for the account. **SUBJECT LINE: EGMS PRIMARY USER AGENCYNAME**. Note: The email will help to support the validation of authorized users for EGMS. DC Health official grant records will also be used. Please reply ASAP to any requests from Office of Grants Management to provide additional information, if needed.

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

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: Arif Wadood (202) 442-5841 and Jennifer Prat (202) 442-8983. Here are the most common registration issues:

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

Deadline Is Firm

Submit your application via EGMS by 6:00pm, on the deadline date of **Tuesday, November 17, 2020.** Applications will not be accepted after the deadline.

PRE-APPLICATION MEETING

A pre-application virtual meeting will be held via WebEx (See page 5). The meeting will provide an overview of CHA's RFA requirements and address specific issues and concerns about the RFA. No applications shall be accepted by any DC Health personnel at this conference. Do not submit drafts, outlines or summaries for review, comment, or technical assistance.

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:

Grant Terms & Conditions

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

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.

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 grant agreement shall outline the scope of work, standards, reporting requirements, fund distribution terms and any special provisions required by federal agreements.

4. Utilize Performance Monitoring & Reporting tools developed and/or approved by DC Health.

Indirect Cost

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

Insurance

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

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

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.

Quality Assurance

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

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

A final performance report shall be completed by the District of Columbia Department of Health and provided and held for record and use by DC Health in making additional funding or future

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

CONTACT INFORMATION

Grants Management

Brenda Ramsey-Boone
Office of Grants Monitoring & Program Evaluation
Community Health Administration
DC Department of Health
899 North Capitol Street, NE, 3rd Floor
Washington, DC 20002
Email: brenda.ramsey-boone@dc.gov

Program Contact

Senkuta Riverson, MPH
Public Health Analyst
Cancer Programs Division
Bureau of Cancer and Chronic Disease Prevention
Community Health Administration
District of Columbia Department of Health
899 North Capitol Street, NE, 3rd Floor
Washington, DC 20002
Email: Senkuta.Riverson@dc.gov

ATTACHMENTS

- Attachment 1 - Work Plan
- Attachment 2 – Budget Worksheet & Budget Justification
- Attachment 3 – CRC Baseline Screening Rate and Clinic Population Data

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

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

WE ARE WASHINGTON GOVERNMENT OF THE DISTRICT OF COLUMBIA
DC MURIEL BOWSER, MAYOR

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

Guidance:

Using the following instructions please complete the chart below:

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

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

GOAL 1: *Expand the availability of health care transition (HCT) training to school-based health centers (SBHCs) and to community-based mental health providers using evidence-informed HCT interventions and tested quality improvement (QI) methodologies.*

Measurable Objectives/Activities:

Objective #1: *By the end of month 12, partner with School-Based Health Centers and move from customizing and piloting the Six Core Elements of HCT to full implementation in routine preventive and primary care.*

Key Indicator(s): *Number of students completing HCT readiness assessments, preparation of article on DC SBHC transition quality improvement initiative, number of presentations of SBHC transition results locally and nationally.*

Key External Partner(s): *DC DOH and SBHCs*

Key Activities to Meet this Objective:	Start Date:	Completion Date:	Actual Start Date:	Actual Completion Date:	Key Personnel (Title)
A. *In months 1-9, continue training/coaching SBHC clinical teams as they incorporate transition into routine clinic processes.*	*10/1/17*	*6/30/18*			*Primary Investigator Consultant*
B.					

Objective #2:

Key Indicator(s):

Key External Partner(s):

Key Activities to Meet this Objective:	Start Date:	Completion Date:	Actual Start Date:	Actual Completion Date:	Key Personnel (Title)
A.					
B.					

Objective #3:

Key Indicator(s):

Key External Partner(s):

Key Activities to Meet this Objective:	Start Date:	Completion Date:	Actual Start Date:	Actual Completion Date:	Key Personnel (Title)
A.					
B.					

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

B.					
C.					

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

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

ATTACHMENT 2 (Part 1)–Budget Justification

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Budget/ Budget Justification Instructions

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. This document should be submitted with the Excel budget template that was provided to you.

A. **Personnel:** Personnel costs should be explained by listing each staff member who will **(1)** be supported from funds and **(2)** in-kind contributions. If personnel costs are supported by in-kind contributions, please indicate the source of funds. Please include the full name of each staff member (or indicate a vacancy), position title, percentage of full-time equivalency, and annual salary. Personnel includes, at a minimum, the program director responsible for the oversight and day-to-day management of the proposed program, staff responsible for quality improvement activities, staff responsible for monitoring programmatic activities and use of funds, and staff responsible for data collection, quality and reporting. **Note:** Final personnel charges shall be based on actual, not budgeted labor. **Fringe Benefits:** Fringe Benefits change yearly and should be confirmed before submitting your budget. List all components that make up the fringe benefits rate.

B. **Consultants/Contractual:** Grantee shall 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. Grantee shall provide the following information in the budget justification:

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT 2 (Part 2) –Budget Worksheet

Agency/Organization Name

Budget Period __

Personnel

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

Non-Personnel Costs

Consultants/Contractual	Total

Occupancy (List the location of each service below)	Cost	Monthly	Total
	$ -	0	
	$ -	0	
	$ -	0	
	$ -	0	

Travel (List each travelers name below)	Travel Destination	Time (Dates of Travel)	Total

Supplies	Quantity	Total
	0	
	0	
	0	

Equipment	Quantity	Total
	0	
	0	
	0	

Client Costs	Total

Communication	Total
Total Non-Personnel Cost	$ -

Other Direct Costs

Type of Service	Total
Total Other Direct Cost	$ -

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

ATTACHMENT 3 – CRC Baseline Screening Rate and Population Data

	Clinic Site (facility or practice) Name							
	Clinic 1	Clinic 2	Clinic 3	Clinic 4	Clinic 5	Clinic 6	Clinic 7	Clinic 8
CRC Numerator (Number of patients up-to date with appropriate screening based on USPSTF guidelines and measure definition (e.g. NQF)								
CRC Denominator (Number of patients eligible for CRC screening, that received at least one medical visit (should follow measure definition))								
CRC Type of Measure Reported (e.g., GPRA, HEDIS, NQF)								
CRC Start Date (reporting period start date)								
CRC End Date (reporting period end date)								
Target Screening Rate (screening rate the clinic aims to achieve during the reporting period)								
Total # clinic patients, **age 50-75**								
% of patients, **age 50-75, men**								
% of patients, **age 50-75, women**								
% of patients, **age 50-75, uninsured**								
% of patients, **age 50-75, Hispanic**								
% of patients, **age 50-75, White**								
% of patients, **age 50-75, Black or African American**								
% of patients, **age 50-75, Asian**								
% of patients, **age 50-75, Native Hawaiian or Other Pacific Islander**								
% of patients, **age 50-75, American Indian or Alaskan Native**								
% of patients, **age 50-75, Other**								

APPENDICES

- Appendix A – Assurances, Certifications, and Disclosures

APPENDIX A: Assurances Certifications & Disclosures

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

A. Applicant/Grantee Representations

1. The Applicant/Grantee has provided the individuals, by name, title, address, and phone number who are authorized to negotiate with the Department of Health on behalf of the organization;
2. The Applicant/Grantee is able to maintain adequate files and records and can and will meet all reporting requirements;
3. All fiscal records are kept in accordance with Generally Accepted Accounting Principles (GAAP) and account for all funds, tangible assets, revenue, and expenditures whatsoever; all fiscal records are accurate, complete and current at all times; and these records will be made available for audit and inspection as required;
4. The Applicant/Grantee is current on payment of all federal and District taxes, including Unemployment Insurance taxes and Workers' Compensation premiums. This statement of certification shall be accompanied by a certificate from the District of Columbia OTR stating that the entity has complied with the filing requirements of District of Columbia tax laws and is current on all payment obligations to the District of Columbia, or is in compliance with any payment agreement with the Office of Tax and Revenue; (attach)
5. The Applicant/Grantee has the administrative and financial capability to provide and manage the proposed services and ensure an adequate administrative, performance and audit trail;
6. If required by DC Health, the Applicant/Grantee is able to secure a bond, in an amount not less than the total amount of the funds awarded, against losses of money and other property caused by a fraudulent or dishonest act committed by Applicant/Grantee or any of its employees, board members, officers, partners, shareholders, or trainees;
7. The Applicant/Grantee is not proposed for debarment or presently debarred, suspended, or declared ineligible, as required by Executive Order 12549, "Debarment and Suspension," and implemented by 2 CFR 180, for prospective participants in primary covered transactions and is not proposed for debarment or presently debarred as a result of any actions by the District of Columbia Contract Appeals Board, the Office of Contracting and Procurement, or any other District contract regulating Agency;
8. The Applicant/Grantee either has the financial resources and technical expertise necessary for the production, construction, equipment and facilities adequate to perform the grant or subgrant, or the ability to obtain them;

9. The Applicant/Grantee has the ability to comply with the required or proposed delivery or performance schedule, taking into consideration all existing and reasonably expected commercial and governmental business commitments;
10. The Applicant/Grantee has a satisfactory record of performing similar activities as detailed in the award or, if the grant award is intended to encourage the development and support of organizations without significant previous experience, has otherwise established that it has the skills and resources necessary to perform the services required by this Grant.
11. The Applicant/Grantee has a satisfactory record of integrity and business ethics;
12. The Applicant/Grantee either has the necessary organization, experience, accounting and operational controls, and technical skills to implement the grant, or the ability to obtain them;
13. The Applicant/Grantee is in compliance with the applicable District licensing and tax laws and regulations;
14. The Applicant/Grantee is in compliance with the Drug-Free Workplace Act and any regulations promulgated thereunder; and
15. The Applicant/Grantee meets all other qualifications and eligibility criteria necessary to receive an award; and
16. The Applicant/Grantee agrees to indemnify, defend and hold harmless the Government of the District of Columbia and its authorized officers, employees, agents and volunteers from any and all claims, actions, losses, damages, and/or liability arising out of or related to this grant including the acts, errors or omissions of any person and for any costs or expenses incurred by the District on account of any claim therefrom, except where such indemnification is prohibited by law.

B. Federal Assurances and Certifications

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

1. The Americans with Disabilities Act of 1990, Pub. L. 101-336, July 26, 1990; 104 Stat. 327 (42

   U.S.C. 12101 et seq.);

2. Rehabilitation Act of 1973, Pub. L. 93-112, Sept. 26, 1973; 87 Stat. 355 (29 U.S.C. 701 et seq.);
3. The Hatch Act, ch. 314, 24 Stat. 440 (7 U.S.C. 361a et seq.);
4. The Fair Labor Standards Act, ch. 676, 52 Stat. 1060 (29 U.S.C.201 et seq.);
5. The Clean Air Act (Subgrants over $100,000), Pub. L. 108-201, February 24, 2004; 42 USC ch. 85 et.seq.).

6. The Occupational Safety and Health Act of 1970, Pub. L. 91-596, Dec. 29, 1970; 84 Stat. 1590 (26

   U.S.C. 651 et.seq.).

7. The Hobbs Act (Anti-Corruption), ch. 537, 60 Stat. 420 (see 18 U.S.C. § 1951).

8. Equal Pay Act of 1963, Pub. L. 88-38, June 10, 1963; 77 Stat.56 (29 U.S.C. 201).

9. Age Discrimination Act of 1975, Pub. L. 94-135, Nov. 28, 1975; 89 Stat. 728 (42 U.S.C. 6101 et. seq.)

10. Age Discrimination in Employment Act, Pub. L. 90-202, Dec. 15, 1967; 81 Stat. 602 (29 U.S.C. 621 et. seq.).

11. Military Selective Service Act of 1973.

12. Title IX of the Education Amendments of 1972, Pub. L. 92-318, June 23, 1972; 86 Stat. 235, (20 U.S.C. 1001).

13. Immigration Reform and Control Act of 1986, Pub. L. 99-603, Nov 6, 1986; 100 Stat. 3359, (8 U.S.C. 1101).

14. Executive Order 12459 (Debarment, Suspension and Exclusion).

15. Medical Leave Act of 1993, Pub. L. 103-3, Feb. 5, 1993, 107 Stat. 6 (5 U.S.C. 6381 et seq.).

16. Drug Free Workplace Act of 1988, Pub. L. 100-690, 102 Stat. 4304 (41 U.S.C.) to include the following requirements:

    1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Applicant/Grantee's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

    2) Establish a drug-free awareness program to inform employees about:

       a. The dangers of drug abuse in the workplace.
       b. The Applicant/Grantee's policy of maintaining a drug-free workplace.
       c. Any available drug counseling, rehabilitation, and employee assistance programs; and
       d. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace; and

    3) Provide all employees engaged in performance of the grant with a copy of the statement required by the law.

17. Assurance of Nondiscrimination and Equal Opportunity, found in 29 CFR 34.20.

18. District of Columbia Human Rights Act of 1977 (D.C. Official Code § 2-1401.01 et seq.).

19. Title VI of the Civil Rights Act of 1964.

20. District of Columbia Language Access Act of 2004, DC Law 15 - 414 (D.C. Official Code § 2-1931 et seq.).

21. Lobbying Disclosure Act of 1995, Pub. L. 104-65, Dec 19, 1995; 109 Stat. 693, (31 U.S.C. 1352); and

22. Child and Youth, Safety and Health Omnibus Amendment Act of 2004, effective April 13, 2005 (D.C. Law §15-353; D.C. Official Code § 4-1501.01 et seq.) (CYSHA). In accordance with the CYSHA any person who may, pursuant to the grant, potentially work directly with any child (meaning a person younger than age thirteen (13)), or any youth (meaning a person between the ages of thirteen (13) and seventeen (17) years, inclusive) shall complete a background check that meets the requirements of the District's Department of Human Resources and HIPAA.

C. Mandatory Disclosures

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

2. **Applicant/Grantee Mandatory Disclosures**

A. Per OMB 2 CFR §200.501– any recipient that expends $750,000 or more in federal funds within the recipient's last fiscal, must have an annual audit conducted by a third – party. In the Applicant/Grantee's last fiscal year, were you required to conduct a third-party audit?	☐ **YES** ☐ **NO**
B. Covered Entity Disclosure During the two-year period preceding the execution of the attached Agreement, were any principals or key personnel of the Applicant/Grantee / Recipient organization or any of its agents who will participate directly, extensively and substantially in the request for funding (i.e. application), pre-award negotiation or the administration or management of the funding, nor any agent of the above, is or will be a candidate for public office or a contributor to a campaign of a person who is a candidate for public office, as prohibited by local law.	☐ **YES** ☐ **NO**
C. Executive Compensation: For an award issued at $25,000 or above, do Applicant/Grantee's top five executives do not receive more than 80% of their annual gross revenues from the federal government, Applicant/Grantee's revenues are greater than $25 million dollars annually AND compensation information is not already available through reporting to the Security and Exchange Commission.	☐ **YES** ☐ **NO**
D. The Applicant/Grantee organization has a federally-negotiated Indirect Cost Rate Agreement. If yes, insert issue date for the IDCR:___If yes, insert the name of the cognizant federal agency? ___	☐ **YES** ☐ **NO**
E. No key personnel or agent of the Applicant/Grantee organization who will participate directly, extensively and substantially in the request for funding (i.e. application), pre-award negotiation or the administration or management of the funding is currently in violation of federal and local criminal laws involving fraud, bribery or gratuity violations potentially affecting the DC Health award.	☐ **YES** ☐ **NO**

ACCEPTANCE OF ASSURANCES, CERTIFICATIONS AND DISCLOSURES

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

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

Date:

Sign:

NAME: INSERT NAME TITLE: INSERT TITLE

AGENCY NAME: