DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

COMMUNITY HEALTH ADMINISTRATION

Improving Chronic Disease Outcomes:

A Community Health Worker Pilot

REQUEST FOR APPLICATIONS

RFA# CHA_CHWP_04.08.22

SUBMISSION DEADLINE:

TUESDAY, MAY 10, 2022, BY 6:00 PM

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

DC DEPARTMENT OF HEALTH

Community Health Administration &
Office of Health Equity

NOTICE OF FUNDING AVAILABILITY (NOFA)

RFA# CHA_CHWP_04.08.22
Health Literacy and Health Disparities in COVID-19 Projects

The District of Columbia, Department of Health (DC Health) is requesting proposals from qualified applicants to provide services in the program and service areas described in this Notice of Funding Availability (NOFA). This announcement is to provide public notice of the Department of 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:	Improving Chronic Disease Outcomes: A Community Health Worker Pilot
Funding Opportunity Number:	FO-CHA-PG-00004-061
Program RFA ID#:	CHA_CHWP_04.08.22
Opportunity Category:	Competitive
DC Health Administrative Unit:	Community Health Administration
DC Health Program Bureau	Healthcare Access Bureau
Program Contact:	Khalil Hassam Director, Primary Care Office Khalil.hassam@dc.gov
Program Description:	This funding opportunity is to request proposals from qualified applicants to implement a pilot model to improve chronic disease outcomes among District residents via home-visiting community health workers.
Eligible Applicants	Federally qualified health centers located and licensed to conduct business within the District of Columbia.
Anticipated # of Awards:	2
Anticipated Amount Available:	$1,000,000
Annual Floor Award Amount:	$250,000

Annual Ceiling Award Amount:	$500,000

Funding Authorization

Legislative Authorization	FY22 Budget Support Act of 2021
Associated CFDA#	Not Applicable
Associated Federal Award ID#	Not Applicable
Cost Sharing / Match Required?	No
RFA Release Date:	April 8, 2022
Pre-Application Conference	Visit DC Health's Eventbrite page for the virtual meeting information, https://OGMDCHealth.eventbrite.com
Letter of Intent Due date:	Not applicable
Application Deadline Date:	May 10, 2022
Application Deadline Time:	6:00 p.m.
Links to Additional Information about this Funding Opportunity	DC Grants Clearinghouse https://communityaffairs.dc.gov/content/community-grant-program#4 DC Health EGMS https://dcDC Health.force.com/GO__ApplicantLogin2

Notes:

1. DC Health reserves the right to issue addenda and/or amendments subsequent to the issuance of the NOFA or RFA, or to rescind the NOFA or RFA.
2. Awards are contingent upon the availability of funds.
3. Individuals are not eligible for DC Health grant funding.
4. Applicants must have a DUNS #, Tax ID#, be registered in the federal Systems for Award Management (SAM) and the DC Health Enterprise Grants Management System (EGMS)
5. Contact the program manager assigned to this funding opportunity for additional information.

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District of Columbia Department of Health

RFA Terms and Conditions

v11.2016

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

A. Funding for a DC Health subaward is contingent on DC Health's receipt of funding (local 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 must be met by the awardee.

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

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

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

1. 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:
    - Certificate of Clean Hands dated within 60 days of the application deadline
    - Current business license or certificate of licensure or proof to transact business in local jurisdiction
    - Current Certificate of Insurance
    - Copy of Cyber Liability Policy
    - IRS Tax-Exempt Determination Letter (for nonprofits only)
    - IRS 990 Form from most recent tax year (for nonprofits only)
    - Current list of Board of Directors, on letterhead, signed and dated by a certified official from the Board (this cannot be the Executive Director)
    - Assurances, Certifications and Disclosures (Appendix B)
    - Proposal Abstract
    - Project Narrative (30-page maximum)
    - Budget Table
    - Budget Justification
    - Organization Chart
    - Work Plan
    - Staffing Plan
- ☐ 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**. **Applications that do not conform to these requirements will not be forwarded to the review panel.**
- ☐ The application proposal format conforms to the "Proposal Components" (See section 6.2) listed in the RFA.
- ☐ The proposed budget is complete and complies with the budget forms provided in the RFA. The budget narrative is complete and describes the categories of items proposed.
- ☐ The proposed work plan and other attachments are complete and comply with the forms and format provided in the RFA.
- ☐ Submit your application via EGMS by **6:00pm** on the deadline of **05/10/2022.**

2. GENERAL INFORMATION

2.1 KEY DATES

- Notice of Funding Announcement Date: **March 25, 2022**
- Request for Application Release Date: **April 8, 2022**
- Pre-Application Meeting Date: **visit https://OGMDCHealth.eventbrite.com**
- Application Submission Deadline: **May 10, 2022**
- Anticipated Award Start Date: **July 1, 2022**

2.2 OVERVIEW

The purpose of this funding is to pilot the use of home-visiting community health workers (CHWs), integrated into the care team as part of the overall care model, to provide more effective patient care and improve health outcomes for housed patients with uncontrolled hypertension, many of whom will also experience other health issues, as well as social, environmental, and economic barriers to health. Ultimately, the goal of this pilot is to develop a model for a sustainable program to better treat hypertension and other chronic conditions through the use of CHWs.

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

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

The Healthcare Access Bureau (HCAB) within CHA leads initiatives to improve access to equitable, comprehensive, quality health care services for all District residents. The Bureau's programs promote and strengthen medical and dental homes so all residents can access the right care in the right place at the right time. HCAB is the organizational home of the Immunization Division and DC's Primary Care Office, which includes the Oral Health Program.

Multiple District agencies and stakeholders have prioritized reducing health inequities among District residents through improved clinical and non-clinical care coordination and addressing social determinants of health—including through the use of community health workers (CHWs)—in strategic plans, needs assessments, and other documents.

In 2016, DC Health released the *DC Healthy People 2020 Framework*, a shared community agenda setting forth goals, population-level health outcome objectives, and targets for the year 2020 along with recommended evidence-based strategies to improve key health outcomes. Recommended strategies include implementing an integrated clinical network and increasing use of patient-centered medical homes (PCMH) to improve care for chronically ill patients and reduce emergency room overutilization; providing residents comprehensive services through a person-centric, coordinated system; improving care coordination and integration; and increasing multi-sector partnerships to "further population health improvement through a coordinated focus on social determinants of health and health equity."[1]

In 2017, DC Health released the *District of Columbia Health Systems Plan,* which "serves as a guide for all stakeholders as they implement initiatives aimed at strengthening Washington DC's health system to improve the overall health status of residents by addressing social determinants of health and promoting health equity." Recommended strategies include "the use of community health workers, patient navigators, and/or community health educators who can engage community members, address risk factors, and promote healthy living" as a way to "promote engagement in appropriate, quality, and timely primary care services."[2]

In 2018, DC Health collaborated with the community to release a detailed assessment of the structural and social needs impacting District residents, *Health Equity Report: District of Columbia 2018.* This report highlights nine key interrelated drivers of health outcomes, including both clinical (medical care) and non-clinical (education, employment, income, housing, transportation, food environment, medical care, outdoor environment, and community safety) drivers, finding that only 20% of population health outcomes are driven by clinical care, whereas non-clinical factors accounted for the other 80% of population health outcomes. The report concluded that "opportunities for health in the District are limited by structural and cumulative disadvantage" within and outside of the health care system, "underscor(ing) the importance of working within and across all sectors, in simultaneous and complementary ways, to improve opportunities for health and achieve health equity."[3]

In 2019, the DC Health Matters Collaborative—a collaboration among five DC hospitals and four community health centers that partners with DC Health—released the *Community Health Needs Assessment, District of Columbia, 2019 (CHNA),* a data- and community-driven report providing the foundation for community health improvement efforts. The 2019 assessment prioritized and dug deeper into four needs areas previously identified in the 2016 CHNA: mental health, care coordination, health literacy, and place-based care. Increased utilization of CHWs

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[1] DC Department of Health (2016). *DC Healthy People 2020 Framework.* https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/FINAL%20DC%20HP2020%20Framework%20Report%205-23-16.pdf

[2] DC Department of Health (2017). *District of Columbia Health Systems Plan* (p. 38). https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/DC%20Health%20Systems%20Plan%202017_0.pdf

[3] DC Department of Health (2018). *Health Equity Report: District of Columbia 2018* (p. 22). https://app.box.com/s/yspij8v81cxqyebl7gj3uifjumb7ufsw

was a recurring theme throughout the report, including as a way to address mental health, promote and facilitate health literacy, and increase equity "by serving communities through trusted peers when trust or access may be barriers to 'traditional' health settings," noting that CHWs "may build rapport with community members through shared experiences, understanding of cultural circumstances affecting communities, and the additional time they can devote during appointments."[4]

In 2019, the Office of Planning released the *2020 Comprehensive Plan* (https://plandc.dc.gov/), a 20-year framework and guiding document for the future planning a development of the District. This long-range policy document addresses a wide variety of interconnected social, environmental, and economic topics and aims to build an inclusive, equitable, resilient city. Major themes in the Plan include a systemic approach to public resources including health, education, and food access.

DC Health is committed to proactively leading and engaging District partners in eliminating health disparities, achieving health equity, and addressing clinical and non-clinical drivers of health outcomes.

2.3 Source of Grant Funding

Funding is anticipated to be available using FY2022 local funds.

2.4 Award Information

2.4.1 Amount of Funding Available

The total funding amount of $700,000 in locally appropriated funds will be made available for two (2) awards for the first three-month budget period. The total funding amount of $1,000,000 per subsequent twelve-month budget period in locally appropriated funds will be made available for two (2) awards.

2.4.2 Performance and Funding Period

Awards are projected to begin July 1, 2022 and continue through September 30, 2024. There will be a three-month budget period (July 1, 2022 – September 30, 2022) for program development. After the first three-month budget period, there will be up to two additional 12-month periods (October 1, 2022 – September 30, 2023; October 1, 2023 – September 30, 2024) for program

[4] DC Health Matters Collaborative (2019). *Community Health Needs Assessment: District of Columbia, 2019.* https://www.dchealthmatters.org/content/sites/washingtondc/2019_DC_CHNA_FINAL.pdf

implementation. The number of awards, budget periods, and award amounts are contingent upon the continued availability of funds and the recipient performance.

2.4.3 Eligible Organizations/Entities

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

- Federally qualified health centers operating in the District of Columbia

Considered for funding shall be organizations meeting the above eligibility criteria and having documentation of providing services (health and social services) to the target populations. Priority will be given to those organizations with a demonstrated track record of successfully working with the priority population and demonstrated impact/improvement in at least one social determinant of health. Partnerships between organizations are welcomed. Applicants must provide letters of commitment, co-applicat ions, or letters of support for existing partnerships if performance will depend on another organization.

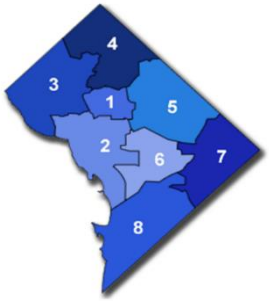
2.4.4 Non-Supplantation

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

3. BACKGROUND

3.1 DEMOGRAPHIC OVERVIEW

The District of Columbia (DC or the District) is a diverse and compact geographic area that covers 61 square miles with a population of 689,545 as of the 2020 US Census.[5,6] The District is organized into eight geopolitical wards, with the largest population in Ward 6 (108,202 residents) and the smallest population in Ward 7 (76,255 residents). Wards 1 and 2 have the largest proportion of adults ages 18-64 (80% and 84%), Wards 7 and 8 have the largest proportion of youth ages 0-18 years (24% and 30%), and Wards 3 and 4 have the largest proportion of adults over age 65 (18% and 15%).[7]



In terms of race and ethnicity, the District's population is highly diverse—approximately 41% Black/African American, 38% white, and 5% Asian, with Hispanic or Latino residents of any race making up 11% of the population.[8] However, the population is also highly segregated, with significant economic disparities observed by ward and race. For example, Wards 2 and 3 have the highest percentage of white residents and the lowest percentage of Black/African American residents, whereas Wards 7 and 8 have the highest percentage of Black/African American residents and the lowest percentage of white residents. While 2021 District-wide median household income was more than $91,000, median household income in Ward 3 was more than 3.6 times higher than in Ward 8; median household income among white District residents was approximately 1.7 times higher than among Hispanic/Latino residents and 3.1 times higher than among Black/African American residents.[9] In December 2021, District-wide unemployment was 5.8%; however, unemployment in Ward 8, the highest in the District, was more than 4 times higher than in Ward 3, the lowest in the District.[10]

[5] Government of the District of Columbia, Office of Planning. *District of Columbia Population Change by Ward: 2010 to 2020.* Published August 13, 2021. https://planning.dc.gov/sites/default/files/dc/sites/op/publication/attachments/Map%20-%20Population%20Change%20by%20Ward%202010-2020.pdf

[6] NOTE: In April 2020, the District decennial census data was collected. Some preliminary data analysis has been completed and disseminated; however, it is important to note that DC census takers continue to evaluate the 2020 census data and address data concerns surrounding undercounting of residents of color, discrepancies with the Census' American Community Survey (ACS) data, and the impact of the COVID-19 pandemic on data collection. https://planning.dc.gov/node/1553646

[7] United States Census Bureau. American Community Survey 1-year estimates. Census Reporter Profile: District of Columbia. https://censusreporter.org/profiles/04000US11-district-of-columbia/. Published 2019

[8] United States Census Bureau. QuickFacts: District of Columbia. https://www.census.gov/quickfacts/fact/dashboard/DC/POP010220

[8] DC Open Data. DC Health Planning Neighborhoods. https://opendata.dc.gov/datasets/DCGIS::dc-health-planning-neighborhoods/about. Updated December 8, 2021.

[9] DC Health Matters. *2021 Demographics.* https://www.dchealthmatters.org/?module=demographicdata&controller=index&action=index&id=130951&sectionId=936#sectionPiece_72

[10] DC Department of Employment Services. *Labor Force, Employment, Unemployment, and Unemployment Rate by Ward.* https://does.dc.gov/sites/default/files/dc/sites/does/page_content/attachments/DC%20Ward%20Data%20Dec21-Nov21-Dec20.pdf

Table 1: Selected Characteristics of DC Residents, by Ward.

	White, Non-Hispanic (2020)	Black/ African American, Non-Hispanic (2020)	Hispanic/ Latino, any race (2020)	Median Household Income (2021)	Unemployment Rate (Dec. 2021)
Ward 1	46.9%	21.5%	20.2%	$110,339	3.7%
Ward 2	64.3%	8.2%	10.9%	$112,244	3.1%
Ward 3	69.2%	7.0%	9.7%	$143,339	2.9%
Ward 4	26.9%	43.3%	22.0%	$94,163	4.9%
Ward 5	23.6%	56.5%	11.6%	$91,189	6.5%
Ward 6	55.3%	26.1%	7.3%	$113,922	4.4%
Ward 7	3.6%	87.5%	4.7%	$42,201	9.0%
Ward 8	4.5%	87.8%	3.3%	$39,473	12.1%
District-wide	38.0%	40.9%	11.3%	$91,414	5.8%

3.2 HEALTH DISPARITIES

Patients with hypertension often live with one or more comorbid chronic conditions—including diabetes, cardiovascular diseases, obesity, kidney disease, and joint diseases (e.g., arthritis)[11]—and uncontrolled hypertension increases the risk for an array of other poor health outcomes, including heart disease, stroke, chronic kidney disease or failure, and vision loss. [12]

As with economic disparities discussed above, chronic disease rates in the District also vary greatly by race, socioeconomic status, and geographic location. For example, rates of high blood pressure, coronary heart disease or heart attack, stroke, and diabetes range from 2.3 to 5.7 times higher among non-Hispanic Black District residents than among non-Hispanic White District residents. Similar trends are seen by income, with rates ranging from 2.1 to 6.7 times higher for residents in households earning less than $15,000 than those in households earning more than $50,000. [13] By ward, rates of diabetes among residents living in Wards 5 (17.9%), 7 (12.8%), and 8 (18.2%) are significantly higher than among residents living in Wards 1 (4.5%), 2 (3.6%), and 3 (3.0%). And although the District has the second lowest adult obesity rate in the nation, at 23.8%, significant geographic disparities in obesity rates are apparent with Wards 8 and 7 at 43.6% and 31.4%, respectively, compared to Ward 2 at just 10.7%.[14]

[11] Wong ND, Lopez VA, L'Italien G, Chen R, Kline SEJ, Franklin SS. Inadequate Control of Hypertension in US Adults With Cardiovascular Disease Comorbidities in 2003-2004. *Arch Intern Med.* 2007;167(22):2431–2436. doi:10.1001/archinte.167.22.2431

[12] American Heart Association. 2022. *Health Threats from High Blood Pressure.* https://www.heart.org/en/health-topics/high-blood-pressure/health-threats-from-high-blood-pressure

[13] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed Feb 05, 2022]. URL: https://www.cdc.gov/brfss/brfssprevalence/.

[14] Health Equity Report: District of Columbia 2018, DC Department of Health, https://app.box.com/s/yspij8v81cxqyebl7gj3uifjumb7ufsw

Table 2: Selected Characteristics of DC Residents by Race/Ethnicity and Household Income

	High Blood Pressure (2019)	Coronary Heart Disease (CHD) or Myocardial Infarction (MI) (2020)	Stroke (2020)	Diabetes (2020)
Race & Hispanic Ethnicity				
White, non-Hispanic	18.4%	2.0%	1.3%	2.4%
Black, non-Hispanic	41.6%	6.6%	5.3%	13.7%
Multiracial, non-Hispanic	32.4%	N/A*	N/A*	N/A*
Hispanic	12%	N/A*	N/A*	N/A*
Household Income				
< $15,000	46.0%	8.8%	8.0%	21.9%
$15,000-24,999	35.5%	9.0%	4.4%	13.5%
$25,000-34,999	29.8%	N/A*	N/A*	16.5%
$35,000-49,999	28.5%	N/A*	N/A*	8.9%
$50,000+	21.8%	1.6%	1.2%	3.4%

*Prevalence estimate not available if the unweighted sample size for the denominator was < 50 or the Relative Standard Error (RSE) is > 0.3 or if the state did not collect data for that calendar year.

Preexisting socioeconomic inequities, layered with COVID-19, have accentuated disparities among vulnerable populations, with health outcomes following anticipated patterns. Between 2015 and 2019, heart disease/cardiovascular disease (CVD), cancers, accidents, and strokes accounted for the four leading causes of death in the District. In 2020, COVID-19 became the third leading cause of death in the District, accompanied by observed increases between 2019 and 2020 in other leading causes of death, including heart diseases (+11%); accidents, including deaths due to drug overdose (+29%); diabetes mellitus (+36%); chronic lower respiratory diseases (+18%); and influenza and pneumonia (+20%).[15] Possible reasons for the increased number of non-COVID-19 deaths include poor continuity of preventative and chronic diseases care management, higher incidence of risk behaviors due to pandemic-related stress and trauma, and/or lower quality of high acuity healthcare delivery services due to resources being focused on the COVID-19 pandemic.

In 2020, approximately 72% of District residents reported having seen a doctor for a routine checkup within the previous year, while approximately 23% of District residents reported not having a primary health care provider.[16] However, only 50% of District Medicaid enrollees had a primary care visit in 2020, an approximately 15% decrease from 2019.[17] The ratio of primary

[15] DC Vital Records Division; data as of April 26, 2021.
[16] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed Feb 05, 2022]. URL: https://www.cdc.gov/brfss/brfssprevalence/.
[17] DHCF Medicaid Claims Data

care utilization to emergency department utilization in Wards 7 and 8 is about 2:1, compared to a primary care to emergency department utilization ratio of 4:1 in Wards 1 and 3—overutilization of the emergency department can indicate gaps and barriers to access in the primary care system.

DC Health continues to emphasize the value of the Patient-Centered Medical Home (PCMH)—a model that ensures care is comprehensive, patient-centered, coordinated, accessible, and committed to quality and safety—and continues to encourage partnerships between patients, primary care providers, and a range of health-related stakeholders to ensure residents can navigate the complexities of the health care system. However, while ensuring District residents' access to comprehensive, quality clinical care is critical, clinical care alone is not enough, particularly among persons in poverty and/or living with the legacy of racism—evidence also shows that 80% of health outcomes are driven by non-clinical determinants, commonly referred to as social determinants of health, which disproportionately impact vulnerable populations.[18]

3.3 Social Determinants of Health

Racial and ethnic minorities and other groups experiencing health disparities continue to bear disproportionate burdens of disease and illness, despite scientific and technological discoveries that have improved the health of the U.S. population overall. As highlighted above, the same trends and disparities described for health outcomes and healthcare access are apparent across an array of socioeconomic indicators, including educational outcomes, employment, income, housing, transportation and food access, and community safety. The DC Health 2018 *Health Equity Report* introduced a 51-statistical neighborhood (51-SN) method of analysis, highlighting improved but disparate health outcomes across the District, primarily tied to differences in income, place, and race. A racial dissimilarity index (RDI) score of 70.9 underscored the extent of racial and economic segregation. A 21-year difference between the neighborhood with the highest life expectancy and that with the lowest correlated with inequity across social and structural determinants and persistent, disproportionate health outcomes that negatively affect black and brown populations and neighborhoods.[19]

Such social and structural barriers combined with frequent comorbidities further exacerbate and interfere with successful treatment of hypertension and other chronic conditions; in turn, uncontrolled chronic health conditions can further exacerbate and interfere with successfully addressing social problems, creating a persistent cycle of health and social inequity. *Social determinants of health*—the conditions in which people are born, grow, live, work, and age—shape individual, community, and population health and wellbeing across the life course. Populations that experience health disparities generally have higher levels of cumulative exposure to adverse social and structural factors such as poverty, lower-quality education, unemployment, less access to healthy food, chronic and acute psychosocial stress, less access to

[18] DC Department of Health (2018). *Health Equity Report: District of Columbia 2018*. https://app.box.com/s/yspij8v81cxqyebl7gj3uifjumb7ufsw
[19] DC Department of Health (2018). *Health Equity Report: District of Columbia 2018*. https://app.box.com/s/yspij8v81cxqyebl7gj3uifjumb7ufsw

health care resources, and lifelong exposure to discrimination and structural racism, in addition to physical, biological and environmental hazards.

Conversely, access to the health promoting aspects of the environment, such as opportunities for health-enhancing physical activity and buffers against hazardous exposures, is often disproportionately lower in these populations. Inequitable distribution of health-promoting social determinants across various populations is understood as a significant contributor to persistent and pervasive health disparities and inequities. A focus on health equity calls for reducing or eliminating factors that put populations experiencing health disparities at a disadvantage, and for increasing factors that increase the likelihood for achieving positive health outcomes.

Taken together, these represent inequities in opportunities for good health; as such, addressing non-clinical drivers and mitigators is critical to improving health outcomes for DC residents, particularly those in under-resourced communities and populations.

3.4 COMMUNITY HEALTH WORKERS (CHW)

The American Public Health Association (APHA) defines a *community health worker (CHW)* as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served… enabl[ing] the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."[20] Working primarily in underserved communities, CHWs are "a resource to help advance goals of improved care coordination, health equity, and population health."[21] The Community Health Worker Core Consensus Project (C3 Project) identifies ten core roles for CHWs: 1) cultural mediation among individuals, communities, and health and social service systems; 2) providing culturally appropriate health education and information; 3) care coordination, case management, and system navigation; 4) providing coaching and social support; 5) advocating for individuals and communities; 6) building individual and community capacity; 7) providing direct service; 8) implementing individual and community assessments; 9) conducting outreach; and 10) participating in evaluation and research.[22]

Peer support within the primary care system has been shown to help reduce problematic health behaviors,[23] depression,[24] and, in several randomized controlled trials, has contributed to improved diabetes management, including improving behaviors related to medication adherence,

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[20] American Public Health Association. *Community Health Workers.* https://www.apha.org/apha-communities/member-sections/community-health-workers

[21] HRSA (n.d.). *Allied Health Workforce Projections, 2016-2030: Community Health Workers.* https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/community-health-workers-2016-2030.pdf

[22] The Community Health Worker Core Consensus Project (2018). C3 Project Findings: Roles and Competencies. https://www.c3project.org/roles-competencies

[23] Malchodi CS, Oncken C, Dornelas EA, Caramanica L, Gregonis E, Curry SL: The effects of peer counseling on smoking cessation and reduction. *Obstet Gynecol* **101**:504 –510, 2003 CrossRefPubMedWeb of ScienceGoogle Scholar

[24] Dennis CL: Peer support within a health care context: a concept analysis. *Int J Nurs Stud* **40**:321 –332, 2003 CrossRefPubMedWeb of ScienceGoogle Scholar

diet, exercise, and blood glucose monitoring.[25] The success of peer support appears to be due in part to the nonhierarchical, reciprocal relationship created through the sharing of similar life experiences. These findings are consistent with the longstanding tradition of group therapy and mutual support groups as a means of improving psychosocial outcomes for patients with substance abuse and other chronic conditions.[26] As highlighted in the *Community Health Worker Best Practice Guidelines* developed by the Sinai Urban Health Institute in Chicago:

> "A fundamental principal of the CHW profession is that CHWs are an active member of the community they serve. Communities are defined in many ways and often by a combination of factors, including residency, race, language, socioeconomic status or other demographics, culture, shared health condition (i.e., diabetes, HIV, asthma) or life experience (i.e., pregnancy, drug use, single parenthood, homelessness). It's important to know how the community served defines itself. Ideally, CHWs should reflect and relate to the most identifying or important characteristics of the community in relation to the intervention."[27]

Helping inform the creation of these guidelines, the *CHW in Chicago Health Care Setting Survey* found that among 21 Chicago-area employers of CHWs, shared cultural experience (81%), similar demographics as the target population (67%), and membership in the community (62%) were the most common factors qualifying CHWs as being culturally competent. Among 62 CHW survey respondents, racial/ethnic similarities (74%), cultural similarities (55%), living in the same community (54%), common life situation (39%), and common health condition (27%) were noted as characteristics they share with the community they serve; the average number of shared characteristics was 2.5/5, while only 5% of respondents reported not sharing any characteristics with the community they serve.[28] The HRSA *Community Health Worker National Workforce Study* found that among employers, CHWs "were viewed as having contributed to more effective delivery of health-related services because they were (1) effective in gaining access to hard-to-reach populations that had been avoided by other health workers; (2) able to patiently coach clients in culturally appropriate terms and induce behavioral changes; (3) able to successfully communicate with clients, after developing trusting and caring relationships, to impart or gather information and motivate key decisions such as participating in immunization programs; and (4) able to address certain client needs such as adapting health regimens to family and community dynamics."

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[25] Joseph DH, Griffin M, Hall RF, Sullivan ED: Peer coaching: an intervention for individuals struggling with diabetes. *Diabetes Educ***27** : 703–710,2001 Abstract/FREE Full TextGoogle Scholar

[26] Kownacki RJ, Shadish WR: Does Alcoholics Anonymous work? The results from a meta-analysis of controlled experiments. *Subst Use Misuse***34** : 1897–1916,1999 PubMedWeb of ScienceGoogle Scholar

[27] Sinai Urban Health Institute (2014). Best practice guidelines for implementing and evaluating community health worker programs in health care settings. https://chwcentral.org/wp-content/uploads/2014/01/CHW-BPG-for-CHW-programs-in-health-care-settings.pdf

[28] Guttieres Kapheim, M. and Campbell, J. (2013). *Community health worker programs in Chicago's health care institutions: Research and evaluation annual progress report.* https://www.sinaichicago.org/wp-content/uploads/2021/03/SUHI-CHW-Fry-Report-2.pdf

Research has shown that CHW models can improve self-management of hypertension, diabetes, and other chronic diseases.[29,30,31,32,33] CHWs can play a critical role as part of a clinical care team because of their ability to foster a deep trust and understanding with patients by sharing similar life experiences, participating in home visits, providing regular support and advocacy, and providing tailored support based on the patients' needs and preferences. However, without adequate support, integration, funding, and training, CHWs are not able to reach their full potential.[34] These and other factors—particularly lack of opportunities for professional advancement and inadequate compensation—have also been shown to contribute to decreased job satisfaction, motivation, and retention of CHWs.[35,36]

The incorporation of CHWs into clinical care teams has been discussed and recommended in recent reports from DC Health and non-governmental stakeholders. The 2017 DC Health Systems Plan recommended "the use of community health workers, patient navigators and/or community health educators who can engage community members, address risk factors, and promote healthy living" as a way to "promote engagement in appropriate, quality, and timely primary care services."[37] The 2019 DC Community Health Needs Assessment recommended use of CHWs to promote and facilitate health literacy, noting that "with appropriate training and oversight, employing CHWs can help community members overcome health literacy barriers related to navigating the healthcare system, coordinating referrals and follow-up care, connecting with community resources, providing health information, and supporting immigrants and patients with limited English proficiency."[38] CHWs have a reach beyond the primary care system in that they can engage patients in their homes and communities, identify barriers and perceived barriers to seeking care, and offer solutions to navigating these challenges. CHWs educate, encourage, and help their peers to effectively use and navigate community and health resources.[39]

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[29] Ursua, R. A., Aguilar, D. E., Wyatt, L. C., Trinh-Shevrin, C., Gamboa, L., Valdellon, P., Perrella, E. G., Dimaporo, M. Z., Nur, P. Q., Tandon, S. D., & Islam, N. S. (2018). A community health worker intervention to improve blood pressure among Filipino Americans with hypertension: A randomized controlled trial. *Preventive medicine reports*, *11*, 42–48. https://doi.org/10.1016/j.pmedr.2018.05.002

[30] Brownstein J.N., Chowdhury F.M., Norris S.L. Effectiveness of community health workers in the care of people with hypertension. Am. J. Prev. Med. 2007;32(5):435–447.

[31] Joseph DH, Griffin M, Hall RF, Sullivan ED: Peer coaching: an intervention for individuals struggling with diabetes. *Diabetes Educ***27** : 703–710,2001 Abstract/FREE Full TextGoogle Scholar

[32] Balcazar H.G., Byrd T.L., Ortiz M., Tondapu S.R., Chavez M. A randomized community intervention to improve hypertension control among Mexican Americans: using the promotoras de salud community outreach model. J. Health Care Poor Underserved. 2009;20(4):1079–1094.

[33] Kim K., Choi J.S., Choi E. Effects of community-based health worker interventions to improve chronic disease management and care among vulnerable populations: a systematic review. Am. J. Public Health. 2016;106(4)

[34] Pinto D, Carroll-Scott A, Christmas T, Heidig M, Turchi R. Community health workers: improving population health through integration into healthcare systems. Curr Opin Pediatr. 2020;32(5):674–682. doi: 10.1097/MOP.0000000000000940. - DOI - PubMed

[35] Strachan DL, Kallander K, ten Asbroek AH, et al. Interventions to improve motivation and retention of community health workers delivering integrated community case management (iCCM): stakeholder perceptions and priorities. Am J Trop Med Hyg. 2012;87(suppl 5):111-119. doi:10.4269/ajtmh.2012.12-0030.

[36] Anabui, O., Carter, T., Phillippi, M., Ruggieri, D.G., & Kangovi, S. Developing Sustainable Community Health Worker Career Paths. https://www.milbank.org/wp-content/uploads/2021/03/Issue_Brief_CHW-Career-Paths_final.pdf

[37] DC Department of Health (2017). *District of Columbia Health Systems Plan* (p. 38). https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/DC%20Health%20Systems%20Plan%202017_0.pdf

[38] DC Health Matters Collaborative

[39] Heisler, M. 'Overview of Peer Support Models to Improve Diabetes Self-Management and Clinical Outcomes'). *Diabetes Spectrum* (2007) **20**(4): 214–221

4. PURPOSE

The DC Health Community Health Administration (CHA) is requesting applications from Federally Qualified Health Centers (FQHCs) located within the District of Columbia to hire/identify at least two (2) new full-time equivalent (FTE) CHWs to be integrated as part of the full care team. The purpose of this funding is to provide more effective patient care and improve health outcomes for housed patients with uncontrolled hypertension—many of whom will have additional medical or psychosocial problems complicating their care—using home-visiting CHWs as part of the overall care model. Ultimately, the goal of this pilot is to develop a model for a sustainable program to better treat hypertension and other chronic conditions through the use of CHWs.

4.1 APPROACH

Grantee shall focus on improving health outcomes among, and reducing the number of patients with uncontrolled hypertension by employing strategies and implementing activities in the following service areas: 1) improving clinical care coordination, including medical information flow, patient and family engagement in care, and healthcare system navigation; 2) identifying and addressing social needs and social determinants of health impacting health outcomes through screening, referrals, and linkages to internal and external social support services and resources; 3) improving chronic disease self-management through patient and family health education, coaching, and social support; and 4) meeting data collection and reporting requirements to ensure long-term sustainability of programs.

Grantees shall:

- provide CHW support to at least 500 patients insured through Medicaid with uncontrolled hypertension during the two-year project period;
- hire or identify at least two (2) new FTE CHWs as fully integrated members of the care team; CHW candidates should meet the following minimum qualification requirements:
    - High school diploma or G.E.D. (Associate's degree or higher, preferred)
    - Two years of work experience (prior experience in health or human services and/or in a CHW or similar role, preferred)
    - Excellent interpersonal skills, ability to show empathy, and ability to interact professionally and gain trust with culturally diverse individuals
    - Prior experience working with community resources and social services in DC
    - Ability to understand and apply clinical, social, and environmental aspects of chronic disease, treatment, and self-management
    - Ability to handle confidential information with discretion and professionalism
    - Computer skills and proficiency in the use of handheld/mobile device technologies
    - Successful completion of a satisfactory background check

- hire CHW candidates with similar life experience (e.g., shared cultural experiences, similar demographics, common life situations, community membership) to the patients they will serve;
- provide CHWs compensation of at least $25/hour with full benefits;
- collaborate with CHW Technical Advisor (Institute for Public Health Innovation) on issues related to training, CHW intervention, FQHC-specific needs, and other identified needs during three-month development period and two-year project implementation period;
- train CHWs on organizational/care team-specific protocols;
- develop clear protocols for, and train CHWs on, use of EHR for recording key data points
- designate a CHW site supervisor, prioritizing candidates who have previous community health, public health, and/or social work experience;
- clearly define CHW and site supervisor roles and responsibilities, including processes for identifying and addressing patients' social needs, documenting CHW work, and communicating/coordinating with other members of the care team;
- define clear benchmarks for evaluating CHW performance, including patient feedback; and
- involve CHWs and site supervisors in organizational decision-making processes about their role and working conditions.

As fully integrated members of the care team, CHWs will work directly with patients and their families to enhance partnership between the patient and the primary care team, improve compliance with medical care plans (e.g., medication adherence, health screenings, maintaining healthcare appointments) and chronic disease self-management skills, identify and address nonclinical factors impacting patient and family health outcomes (i.e., social and structural determinants of health), and connect patients and their families with needed follow-up care and other social services and resources.

CHWs shall:

- complete 100-hour core training[40] facilitated by the Institute for Public Health Innovation (IPHI), at no additional cost to the grantee;
- participate in ongoing trainings, facilitated by IPHI and/or DC Health;
- participate in a learning community facilitated by IPHI; and
- provide services to patients with uncontrolled hypertension, via home visits and other means of contact, in accordance with those defined in Section 5.3 Scope of Services, below; and

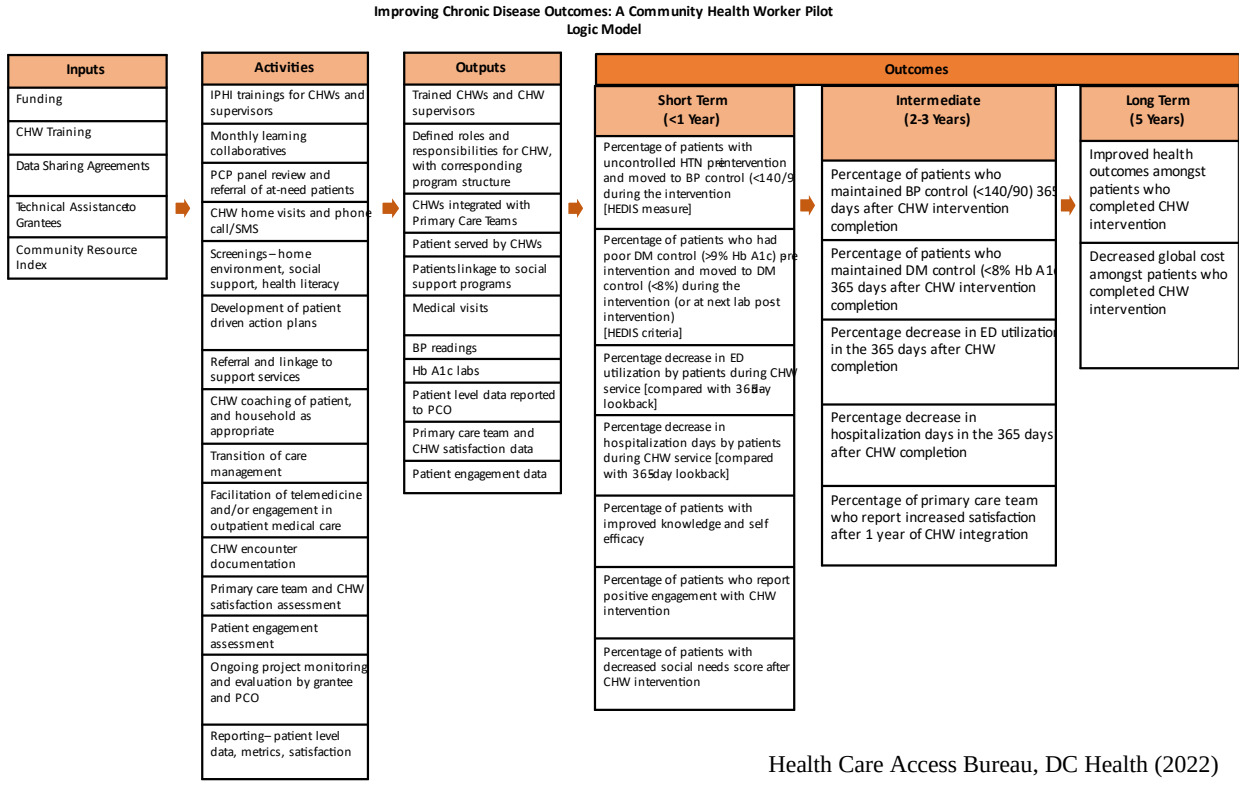
[40] Core training will include modules on perspective transformation (e.g., cultural competency, health disparities, social determinants of health); communication skills; public health; the role of CHWs; legal and ethical issues; documentation and data collection; teaching, capacity building skills, and clinical practice; health education and wellness; outreach and advocacy; organization and resource development; and chronic disease/chronic disease self-management, with particular emphasis on hypertension

- document services provided in each encounter, including visit type (e.g., face-to-face, virtual), and encounter duration to the nearest 15-minute increment.

Designated site supervisors shall:

- complete core CHW supervisor training facilitated by IPHI, at no additional cost to the grantee;
- participate in learning community facilitated by IPHI;
- meet regularly with CHWs to review patient cases; and
- meet quarterly with the CHW to discuss individual performance assessments and opportunities for improvement.

As noted above, grantees shall participate in a learning community with other grantees, which will meet monthly to discuss lessons learned, challenges, outcomes, and other issues as needed, and engage in professional development activities. CHWs, designated site supervisors, and others involved with this project under the grant will be required to attend all meetings. Additionally, CHWs will be required to complete comprehensive core training provided by IPHI (at no cost to the grantee) and attend other relevant ongoing trainings as determined by DC Health. Designated site supervisors will also be required to complete core CHW supervisor training provided by IPHI (at no additional cost to the grantee) and attend other relevant ongoing trainings as determined by DC Health.



Health Care Access Bureau, DC Health (2022)

5. PERFORMANCE REQUIREMENTS

Applicants should propose projects that meet the criteria listed below.

5.1 TARGET POPULATION

Grantees shall provide CHW services to at least 500 District residents insured through Medicaid with uncontrolled hypertension over the course of the two-year project period; CHW services should also be offered/provided to other household members, as appropriate.

5.2 LOCATION OF SERVICES

Grantees must be located within the District of Columbia. Services must be delivered in the following targeted setting:

Patients' homes and/or communities (in accordance with current COVID-19 restrictions).

5.3 SCOPE OF SERVICES

Grantees shall integrate CHWs as full members of the primary care team to provide more effective patient care, enhance patient experience and engagement, and improve health outcomes for housed patients with uncontrolled hypertension. CHWs shall provide services as defined throughout this section; this will include working with household members as necessary to address overlapping social needs and health behaviors.

Grantee shall employ strategies and implement activities in the following service areas: 1) improving clinical care coordination, including medical information flow, patient and family engagement in care, and healthcare system navigation; 2) identifying and addressing social needs and social determinants of health impacting health outcomes through screening, referrals, and linkages to internal and external social support services and resources; 3) improving chronic disease self-management through patient and family health education, coaching, and social support; and 4) meeting data collection and reporting requirements to ensure long-term sustainability of programs.

5.4 PROGRAM STRATEGIES

Grantee shall employ strategies and implement activities in the focus areas outlined in this section. Applicants shall demonstrate how the proposed project plan will impact each of these areas and demonstrate their organizational capacity to do so:

Focus Area 1: Health Outcomes: Applicants should address how the integration of CHWs as part of the care team will improve health outcomes for patients with uncontrolled hypertension, and as applicable, patients with comorbid Diabetes Mellitus and/or other identified chronic conditions.

Key Performance Indicators:

A. Improved hypertension control

- Percentage of patients that moved from uncontrolled to controlled hypertension during the intervention, defined as BP < 140/90
- Percentage of patients that maintained hypertension control 365 days after intervention completion

B. Improved diabetic control

- Percentage of patients that moved from uncontrolled to controlled Diabetes Mellitus, defined as Hemoglobin A1c < 8% at last reading
- Percentage of patients that maintained Diabetes Mellitus Hemoglobin A1c control 365 days after intervention completion

Focus Area 2: Clinical Care Coordination: Applicants should address how the integration of CHWs as part of the care team will improve clinical care coordination, defined as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services."[41] Effective care coordination should be 1) patient- and family- centered, ensuring that the patient's needs and preferences are accounted for in care planning; 2) team-based, ensuring information flow among all members of the primary care team; and 3) focused on points of care transition across healthcare settings, including specialty care, inpatient care, and emergency departments.

CHWs shall serve as a liaison between the clinical care team and patients and families; CHW activities shall include:

- reviewing provider treatment plan with patient;
- assessing and monitoring patients' needs, preferences, and goals;
- partnering with patients to develop a proactive comprehensive care plan, ensuring patient's needs and preferences are accounted for in care planning;
- communicating patients' needs, preferences, and goals with full care team;
- scheduling clinical appointments;
- facilitating telehealth appointments;
- identifying, including, and enhancing patient's social support network to assist and support patients; and
- assisting patients and families with navigating the healthcare system.

Key Performance Indicators:

A. Clinical care coordination

[41] AHRQ (2014). Chapter 2. What is Care Coordination?. Content last reviewed June 2014. https://www.ahrq.gov/ncepcr/care/coordination/atlas/chapter2.html

- Percentage of patients with Emergency Department (ED) discharge who had CHW home visit supporting transition of care management within two (2) business days of discharge
- Percentage of patients with hospitalization discharge who had CHW home visit supporting transition of care management within two (2) business days of discharge

B. Patient self-management

- Proportion of patients with comprehensive action plans jointly generated by CHW and patient

Focus Area 3: Social Needs Screening, Referrals, and Linkages: Applicants should address how patients will be screened for social needs impacting health outcomes, including, but not limited to, 1) who will conduct initial screening (e.g., member of primary care team, CHW, other FQHC staff), 2) when screening will occur (e.g., prior to initial CHW contact, during initial or subsequent CHW contact), 3) how screening will be administered (e.g., in clinic, electronically, by phone, during home visit), and 4) what validated social needs screening tools are currently used by FQHC and/or planned for use in CHW intervention.

CHWs shall conduct home visits and work with patients and families to identify and address environmental and social needs impacting health outcomes and chronic disease management; CHW activities shall include:

- screening for environmental and social needs and barriers impacting patient and family health;
- working with patient and family to address identified social and environmental needs as part of proactive care plan development;
- referring to and supporting patient engagement with relevant social support services and resources; and
- following up to ensure patients and families connect with and receive needed supports and services.

Key Performance Indicators:

A. Screening of social needs

- Percentage of patients screened for need
- Percentage of patients testing positive for social needs

B. Referrals for social needs

- Percentage of patients referred for social need

C. Linkage for social needs

- Percentage of patients linked to service from referral

Focus Area 4: Patient and Family Health Education, Coaching, and Social Support: Applicants should address 1) how CHWs and the care team will work with patients and families to build health knowledge, promote healthful behaviors, and improve patient self-management; and 2) process for surveying patients post-intervention on required self-report measures (i.e., health status, satisfaction with CHW intervention) and any other self-report measures identified

by the grantee (patients receiving CHW services longer than three months should be surveyed quarterly).

CHWs shall, through home visits (and other modes of contact, as necessary), work with patients and families to build health knowledge and self-sufficiency. CHWs will promote, encourage, and support positive, healthful self-management behaviors by providing culturally appropriate and accessible health education, information, and coaching on:

- hypertension, diabetes, and other identified chronic disease control and self-management;
- related health risks (e.g., heart disease, stroke, kidney disease), warning signs, and interventions;
- medication adherence; and
- positive lifestyle changes (e.g., dietary habits [e.g., avoiding sodium], weight control, cholesterol control, smoking cessation, physical activity).

Key Performance Indicators:

A. **Health education, coaching, and social support**
   - Percentage of patients provided evidence-informed health education for hypertension, diabetes, and/or other identified chronic diseases
   - Percentage of patient families provided health education for hypertension, diabetes, and/or other identified chronic diseases

B. Patient self-reported health status
   - Percentage of patients reporting excellent or very good health status (e.g., Behavioral Risk Factor Surveillance System [BRFSS] single-item measure: "How is your general health?"; response options: excellent, very good, good, fair, or poor)
   - Percentage of patients reporting feeling more engaged in care as result of CHW intervention
   - Percentage of patients reporting very or somewhat satisfied with CHW intervention (e.g., How satisfied are you with the help that the community health worker has provided you?; response options: very satisfied, somewhat satisfied, neither satisfied nor dissatisfied; somewhat dissatisfied; very dissatisfied)

Focus Area 5: Data Collection, Reporting, and Continuous Improvement: Applicants should address how data will be 1) collected by CHWs and recorded in the patient's EHR (e.g., will the CHW have EHR-connected hardware/software during home visits and what data will be recorded?); 2) shared across care team and used to inform clinical care decisions; 3) used to conduct ongoing evaluation and continuous improvement activities; and 4) reported to DC Health in a timely manner.

For each encounter, CHWs shall document

- patient-level health and social needs data;
- services provided (e.g., screening, health education, care coordination, referrals, etc.);
- visit type (e.g., face-to-face, virtual); and
- duration of encounter to the nearest 15-minute increment.

In conjunction with DC Health, grantees shall develop and implement an evaluation plan intended to measure the impact of CHWs on health outcomes for patients with uncontrolled hypertension in the District of Columbia.

Grantees shall complete monthly data reporting according to the DC Health Data Submission Manual, to be provided. Data reported to DC Health shall include identifiable patient information, to be matched with Medicaid data in order to make conclusions about changes in emergency department utilization, via reporting template provided by DC Health. Requested data points will include, but may not be limited to:

A. Process Measures

- Number of patients with uncontrolled hypertension
- Number of patients receiving CHW intervention for uncontrolled hypertension
- Number of patients receiving CHW intervention with comorbid Diabetes Mellitus
- Number of patients receiving CHW intervention with other comorbid chronic health condition(s)
- Number of families receiving CHW services as part of patient intervention
- Number of patients screened for social/environmental needs
- Number of referrals for social/environmental needs
- Number of patients linked to service from referral (i.e., resulted in kept appointment with referral organization)
- Number of patients with action plans jointly generated by CHW and patient
- Number of patients with ED discharge
    - who had CHW home visit supporting transition of care management
    - who had home visit within two (2) business days of discharge
- Number of patients with hospitalization discharge
    - who had CHW home visit supporting transition of care management
    - who had CHW home visit within two (2) business days of discharge

B. Patient-level Data

Population health data reported at the patient level (with Medicaid ID numbers) will be requested through a data submission template. Data should be reported monthly according to the DC Health Data Submission Manual.

Requested data points will include, but may not be limited to:

- Referred to CHW intervention
    - Patient demographics (age, race/ethnicity, gender)
- Linked to CHW intervention
    - Patient-level health data
        - Patient demographics (age, race/ethnicity, gender)
        - BP value and date, pre-intervention
        - A1c % and date, pre-intervention
        - Subsequent BP and A1c values

- Patient-level social needs data
    - Screened for social needs
    - Referrals for social needs
    - Linked to service from referral
- Patient self-report measures
    - Health status
    - Engagement in care
    - Empowerment

6. APPLICATION REQUIREMENTS

6.1 ELIGIBILITY DOCUMENTS

CERTIFICATE OF CLEAN HANDS

This document must be dated within 60 days of the application deadline.

CURRENT BUSINESS LICENSE

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

CURRENT CERTIFICATE OF INSURANCE

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

COPY OF CYBER LIABILITY POLICY

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

IRS TAX-EXEMPT DETERMINATION LETTER

This applies to nonprofits only.

IRS 990 FORM

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

CURRENT LIST OF BOARD OF DIRECTORS, ON LETTERHEAD, SIGNED AND DATED BY A CERTIFIED OFFICIAL FROM THE BOARD.

This CANNOT be signed by the executive director.

ASSURANCES, CERTIFICATIONS AND DISCLOSURES

This document must be signed by an authorized representative of the applicant organization. (Appendix B: Assurances, Certifications and Disclosures).

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

6.2 PROPOSAL COMPONENTS

PROJECT ABSTRACT

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

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

PROJECT NARRATIVE (30-page maximum)

The narrative section should describe the applicant's approach to initiate or enhance the use of CHWs to provide more effective patient care, enhance patient experience and engagement, address social and environmental needs and barriers impacting health, and improve health outcomes for housed patients with uncontrolled hypertension and their families. The narrative should include the following sections:

OVERVIEW

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

PROJECT OR POPULATION NEED

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

- Provide an overview of constituent population as relevant to the project, including rates of hypertension, uncontrolled hypertension, comorbid chronic conditions, and corresponding social determinants of health.
- Describe how the target population was identified for this proposal.
- Define the reach, boundaries, zip codes and/or geography of the target population.
- Describe the specific problem(s) and contributing factors to be addressed within the target population.
- Describe the ability to reach the priority population and how they will be served through this project.

PROJECT DESCRIPTION

This section should provide a clear and concise description of strategies and activities they will use to achieve the project outcomes and should detail how the program will be implemented. Applicants must base their strategies and activities on those described in Sections 4.1 Approach, 5.3 Scope of Work, and 5.4 Program Strategies, above. Describe activities for each strategy, how they will be implemented, and how they will be operationalized to achieve program goals, objectives, and outcomes

- Describe how CHWs will be recruited, trained, supervised, and integrated into the clinical care team.
- Describe how CHWs will provide services to patients, including but not limited to projected frequency and duration of contact between CHW and patient, average length of patient intervention, and modes of contact, which must include home visits, but may also include other modes (e.g., telephone check-ins)
- Describe how participants will be recruited, enrolled, and retained in the program.
- Describe how proposed plan provides a foundation for sustainability of efforts beyond the project funding period.

PARTNERSHIPS

This section should describe plans to involve other key partners in the applicant's work.

- Describe plans for how CHWs will engage partners to connect patients (and families, as applicable) to needed social services and supports.
- Describe applicant's experience working with organizations in other sectors to address social determinants of health and plans for engaging existing and establishing new cross-sector partnerships to improve patient health outcomes.

PERFORMANCE MONITORING

This section should describe applicant's plan for collecting and reporting data, including required metrics outlined in Section 5.4, Focus Area 5: Data Collection, Reporting, and Continuous Improvement.

- Describe what information will be collected and by whom (e.g., CHW, other staff).
- Describe plans for how data collected by CHW will be shared across the care team and used to inform clinical care decisions.

- Describe plans for how data will be recorded and tracked in patient's EHR (e.g., will CHWs have EHR-connected hardware/software?)
- Describe plans for how data will be used to conduct ongoing evaluation and continuous improvement activities.
- Describe plans for how data will be reported to DC Health in a timely manner.

ORGANIZATIONAL CAPACITY

This section should provide information on the applicant's current mission and structure and scope of current activities; describe how these all contribute to the organization's ability to conduct the program requirements and meet program expectations.

WORK PLAN

The Work Plan is required (Attachment 2). The work plan describes key process objectives and goals for successful program implementation. Under each objective, provide a list of the activities that will be used to achieve each of the objectives proposed and anticipated deliverables.

- The work plan should include a chronological list and description of activities to be performed. Each activity should have an identified responsible staff, target completion dates, and projected outcomes.
- The work plan should include process objectives and measures. Objectives should be SMART (Specific, Measurable, Achievable, Relevant, and Time-Framed)
    - The attributes of a SMART objective are as follows
        - Specific: includes the "who", "what", and "where". Use only one action verb to avoid issues with measuring success.
        - Measurable: focuses on "how much" change is expected.
        - Achievable: realistic given program resources and planned implementation.
        - Relevant: relates directly to program/activity goals.
        - Time-bound: focuses on "when" the objective will be achieved.
    - Objectives are different from listing program activities. Objectives are statements that describe the results to be achieved and help monitor progress towards program goals. Activities are the actual events that take place as part of the program

BUDGET TABLE

The application should include a project budget worksheet using the excel spreadsheet in District Grants Clearinghouse as noted in form provided (**Attachment 4**). The project budget and budget justification should be directly aligned with the work plan and project description. All expenses should relate directly to achieving the key grant outcomes. Budget should reflect two budget periods, as outlined below (Key Budget Requirements).

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

Key Budget Requirements

The budget should reflect a 15-month period, as follows:

- Year 1 (July 1, 2022 – September 30, 2022): development period, during which time grantee will prepare for deployment of CHWs (e.g., protocol development, hiring, training, equipment purchases, etc.), including collaboration with IPHI CHW technical advisor on these and other identified needs.
- Year 2 (October 1, 2022 – September 30, 2023): implementation period, during which time grantee will deploy CHW intervention, providing services to housed patients with uncontrolled hypertension (and other members of their household, as appropriate).

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

In the year 1 budget period, up to fifty percent of the award amount may be allocated to data collection and reporting needs (e.g., hardware, software, EHR integration); in subsequent budget periods, up to ten percent of the award amount may be allocated to data collection and reporting needs. The applicant should provide appropriate support for their data collection budget in the budget justification.

BUDGET JUSTIFICATION

The application should include a budget justification (Attachment 3). The budget justification is a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget justification MUST be concise. Do NOT use the justification to expand the proposed project narrative.

Include the following in the Budget Justification Narrative:

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

monitoring programmatic activities and use of funds, and staff responsible for data collection, quality, and reporting. This list must include the Project Director on the Notice of Award.

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

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

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

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

Equipment: Include the projected costs of project-specific equipment (e.g., blood pressure monitors, home health backpacks, hardware/software for data collection/tracking, etc.). Provide itemized costs, specifications, quantity, unit, unit cost, and basis for cost estimate (actual cost or price quotation).

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

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

ORGANIZATIONAL CHART

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

STAFFING PLAN

The applicant's staffing plan must be submitted *(no template provided)*. The staffing plan should describe staff qualifications and include type and number of FTEs. Staff CVs, resumes, and position descriptions may also be submitted.

7. EVALUATION CRITERIA

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

CRITERION 1: NEED

(10 POINTS) – Corresponds to Sections: Overview and Project or Population Need

Insufficient (0-1)	Minimal (2-3)	Satisfactory (4-5)	Excellent (6-7)	Total (Max 7)
• Applicant provides an overview of constituent population as relevant to the project, including rates of hypertension, uncontrolled hypertension, comorbid chronic conditions, and corresponding social determinants of health. • Applicant defines the reach, boundaries, zip codes and/or geography of the target population. • Applicant describes the ability to reach the priority population and how they will be served through this project. • Applicant demonstrates strong understanding of the specific problem(s) and contributing factors to be addressed within the target population.				
Insufficient (0)	**Minimal (1)**	**Satisfactory (2)**	**Excellent (3)**	**Total (Max 3)**
• Applicant demonstrates a strong understanding of hypertension/diabetes/chronic disease landscape in the District. • Applicant demonstrates a strong understanding of social and systemic factors that impact health and are barriers for the target population to manage hypertension, diabetes, and other chronic disease.				

CRITERION 2: IMPLEMENTATION

(50 POINTS) – Corresponds to Sections: Project Description and Work Plan

Insufficient (0-3)	Minimal (4-5)	Satisfactory (6-7)	Excellent (8-10)	Total (Max 10)
• Applicant demonstrates strong understanding of evidence-based interventions using CHWs to provide more effective patient care, enhance patient experience and engagement, and address social determinants of health within vulnerable populations				
Insufficient (0-3)	**Minimal (4-5)**	**Satisfactory (6-7)**	**Excellent (8-10)**	**Total (Max 10)**
• Applicant describes clear plan for how CHWs will be recruited, trained, supervised, and integrated into the clinical care team • Applicant describes clear plan for how participants will be recruited, enrolled, and retained in the program.				
Insufficient (0-4)	**Minimal (5-8)**	**Satisfactory (9-12)**	**Excellent (13-15)**	**Total (Max 15)**

• Applicant describes clear plan for how CHWs will provide services to patients, including but not limited to projected frequency and duration of contact between CHW and patient, average length of patient intervention, and modes of contact, which must include home visits, but may also include other modes (e.g., telephone check-ins) • Applicant describes how proposed strategies will lead to improved outcomes in self-management of hypertension, diabetes, and other chronic diseases. • Applicant demonstrates how proposed plan provides a foundation for sustainability of efforts beyond the project funding period.

Insufficient (0-4)	Minimal (5-8)	Satisfactory (9-12)	Excellent (13-15)	Total (Max 15)
• Applicant's work plan represents a logical and realistic plan of action for timely and successful achievement of objectives that support program goals. • Applicant's work plan clearly outlines goals and objectives for the project, describing how proposed goals and objectives are SMART (Specific, Measurable, Achievable, Relevant, and Time Bound). • For each key objective, applicant's work plan includes a chronological list and description of activities to be performed, identifying responsible staff, target completion dates, and projected outcomes for each activity.				

CRITERION 3: EVALUATIVE MEASURES

(10 POINTS) – Corresponds to Sections: Performance Monitoring

Insufficient (0-3)	Minimal (4-5)	Satisfactory (6-7)	Excellent (8-10)	Total (Max 10)
• Applicant describes clear plan for collecting and reporting data, including what information will be collected and by whom (e.g., CHW, other staff), minimizing burden on CHWs and patients. • Applicant describes clear plan for how data collected by CHW will be recorded and tracked in patient's EHR and shared across the care team and used to inform clinical care decisions • Applicant describes clear plan for how data will be used to monitor and evaluate ongoing progress toward project goals and objectives and conduct continuous improvement activities • Applicant demonstrates capacity to collect and manage large data sets**.**				

CRITERION 4: CAPACITY

(20 POINTS) – Corresponds to Sections: Partnerships, Organizational Capacity, and Organizational Information

Insufficient (0-3)	Minimal (4-5)	Satisfactory (6-7)	Excellent (8-10)	Total (Max 10)
• Applicant describes clear plans for engaging existing and/or establishing a new cross-sector network of partners to support the implementation of the applicant's program. • Applicant describes clear plans for how CHWs will engage with partners to connect patients (and families, as applicable) to needed social services and supports. • Applicant demonstrates capacity to fulfill the goals and objectives set forth and the quality and availability of facilities and personnel to fulfill the needs and requirements of the proposed project.				

Insufficient (0-3)	Minimal (4-5)	Satisfactory (6-7)	Excellent (8-10)	Total (Max 10)

- Organizational personnel have demonstrated qualifications (training and experience) in planning, implementing, and evaluating clinical and non-clinical interventions to address hypertension, diabetes, and other chronic disease management.
- Organization has experience and past successes working collaboratively with government agencies and non-government organizations from a variety of sectors to implement health and/or public health initiatives aimed to advance a public health goal.
- Organization has demonstrated reach and established relationships within target population.

CRITERION 5: SUPPORT REQUESTED

(10 Points) - Corresponds to Sections: Budget and Budget Justification

Insufficient (0-3)	Minimal (4-5)	Satisfactory (6-7)	Excellent (8-10)	Total (Max 10)

- The reasonableness of the proposed budget for the project period in relation to the objectives, the complexity of the activities, and the anticipated results.
- Costs outlined in the budget and required resources sections are reasonable given the scope of work.
- Key personnel have adequate time devoted to the project to achieve project objectives.

8. REVIEW AND SCORING OF APPLICATION

8.1 PRE-SCREENING

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.

8.2 EXTERNAL REVIEW PANEL

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

8.3 INTERNAL REVIEW

DC Health program managers will review the individual and summary recommendations of the external review panel and make recommendations for awards. Program Managers will weigh the results of the review panel against other internal and external factors in making the final

funding determinations. DC Health will also conduct an excluded parties list search (EPLS) of the organization and executives via the federal System for Award Management (SAM).

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

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

9. POST AWARD ASSURANCES & CERTIFICATIONS

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

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

Failure to submit the required assurance package will likely make the application ineligible to sign/execute grant agreements.

10. APPLICATION SUBMISSION

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

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

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

10.1 REGISTER IN EGMS

DC Health recommends that applicants create an EGMS account, establishing a Primary Account User as the authorized representative **at least two weeks** prior to the application submission deadline. There is no guarantee that the authorized representative would have an approved account if the registration process does not begin at least **two weeks** prior to the deadline. Deadline-day registrations will not be approved by the 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 –**EGMS 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#** in order to complete the registration. Your EGMS registration will also require your SAM (System for Award Management) expiration date to be entered into your agency profile. Please ensure that you have an active SAM registration (www.sam.gov).
5. 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: Jennifer Prats and Clara McLaughlin (202) 442-9237. Here are the most common registration issues:

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

10.2 Uploading the Application

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

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

- ***Proposal Documents***
    - Proposal Abstract
    - Project Narrative (30-page maximum)
    - Budget Table
    - Budget Justification
    - Organization Chart
    - Work Plan
    - Staffing Plan

10.3 Deadline

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

11. PRE-APPLICATION MEETING

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

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

- RFA Updates will also be posted on the District Grants Clearinghouse.

12. 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:

12.1 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 embedded within EGMS, where upon award, the applicant organization can accept the terms.

12.2 GRANT USES

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

12.3 CONDITIONS OF AWARD

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

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

12.4 Indirect Cost

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

12.5 Insurance

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

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

12.6 COVID-19 Grantee Requirement

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

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

12.7 Audits

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

12.8 Nondiscrimination in the Delivery of Services

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

12.9 Quality Assurance

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

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

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

13. GLOSSARY OF TERMS

Community Health Worker – a frontline public health worker who is a trusted member of a community or who has a thorough understanding of the community being served. This relationship allows CHWs to serve as a link between health and social service programs and the community to promote access to services and improve the quality and cultural competence of service delivery.

"Community Health Worker." Division for Heart Disease and Stroke Prevention. Centers for Disease Control and Prevention. Accessed January 14, 2022. https://www.cdc.gov/dhdsp/pubs/guides/best-practices/chw.htm

Cultural Competence – practices and behaviors that ensure that all patients receive high-quality, effective care irrespective of cultural background, language proficiency, socioeconomic status, and other factors that may be informed by a patient's characteristics."3 Improving the cultural competency of health materials, personal interactions, and services is an important step toward addressing low health literacy among diverse populations.

"Health Literacy and the Role of Culture." Center for Health Care Strategies, Inc. Center for Health Care Strategies. Accessed January 14, 2022. http://www.chcs.org/media/Health_Literacy_Role_of_Culture.pdf

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

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

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

Limited English Proficient (LEP) – Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or "LEP." These individuals may be entitled to language assistance with respect to a particular type or service, benefit, or encounter.

Organizational Health Literacy – The degree to which organizations equitable engage individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

"How Does Healthy People Define Health Literacy." Office of Disease Prevention and Health Promotion. Office of Disease Prevention and Health Promotion. Accessed January14, 2022. https://health.gov/our-work/healthy-people/healthy-people-2030/health-literacy-healthy-people-2030

Personal Health Literacy – The degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

"How Does Healthy People Define Health Literacy." Office of Disease Prevention and Health Promotion. Office of Disease Prevention and Health Promotion. Accessed January14, 2022. https://health.gov/our-work/healthy-people/healthy-people-2030/health-literacy-healthy-people-2030

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

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

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

14. ATTACHMENTS

Attachment 1: Work Plan

Attachment 2: Budget Justification

Attachment 3: Budget Table

Appendix A: Minimum Insurance Requirements

Appendix B: Assurances and Certifications

ATTACHMENT 1 – WORK PLAN

Grantee Work Plan

Agency/Organization Name:	
Program/ Grant Name:	
Project Title:	
Current Budget Request:	
Current Project Period:	
Total Budget Request:	
Total Project Period	
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.					

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

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

B. **Consultants/Contractual:** Grantees must ensure that their organization or institution has in place and follows an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Grantees must provide the following information in the budget justification:

1. **Name of Contractor/Consultant: Who is the contractor/consultant?**

   Include the name of the qualified contractor and indicate whether the contract is with an institution or organization if applicable. Identify the 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 a number of tasks, include the performance period for each task.

4. **Scope of Work: What will the contractor/consultant do?**

   List and describe the specific tasks the contractor is to perform.

5. **Criteria for Measuring Contractor/Consultant Accountability: How will contractor/consultant use the funds?**

   Include an itemized line item breakdown as well as total contract amount. If applicable, include any indirect costs paid under the contract and the indirect cost rate used.

   Grantees must have a written plan in place for contractor/consultant monitoring and must actively monitor contractor/consultant.

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

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

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

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

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

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

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

Agency/Organization Name

Budget Period __ Budget Justification

A. PERSONNEL

Position Title	Position Description

B. CONSULTANTS/CONTRACTUAL

Description of Services
1. Name of Contractor/Consultant: Who is the contractor/consultant? 2. Method of Selection: How was the contractor/consultant selected? 3. Period of Performance: How long is the contract period? 4. Scope of Work: What will the contractor/consultant do? 5. Criteria for Measuring Contractor/Consultant Accountability: How will contractor/consultant use the funds?

C. OCCUPANCY/RENT

Location of Services

D. TRAVEL

Traveler Name	Travel Destination	Reason for Travel

E. SUPPLIES

Item Name	Justification for Item	*Unit Cost of Each Item	*Number Needed	Total Amount

*Complete these columns only if supplies are over $10,000 total.

F. EQUIPMENT

Item Name	Justification for Item	Quantity	Unit	Unit Cost	Basis for cost estimate (actual cost or price quotation)

G. CLIENT/PARTCIPANT COSTS

Name of Client	Description of Services

H. COMMUNICATION

Item(s)	Purpose of Item

I. OTHER DIRECT

Type of Service	Purpose of Service

J. BUDGET SUMMARY:

Category	Cost
Personnel	
Salary	
Fringe	
Consultants/Contractual	
Occupancy	
Travel	
Supplies	
Equipment	
Client Costs	
Other Direct	
Total Direct Costs	
Indirect Costs	
Total Project Cost	**$**

ATTACHMENT 3: BUDGET TABLE

See excel spreadsheet in District Grants Clearinghouse.

APPENDIX A: MINIMUM INSURANCE REQUIREMENTS

INSURANCE

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

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

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

out of the performance of this Statement of Work by the Grantee or its subcontractors, or anyone for whom the Grantee or its subcontractors may be liable. These policies shall include a separation of insureds clause applicable to the additional insured.

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

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

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

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

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

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

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

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

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

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

amounts. So called "silent" coverage under a commercial general liability or professional liability policy will not be acceptable.

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

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

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

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

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

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

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

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

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

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

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

APPENDIX B: ASSURANCES CERTIFICATIONS & DISCLOSURES

APPLICANT / GRANTEE 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 must sign the disclosure certification

2. **Applicant/Grantee Mandatory Disclosures**

A. Per OMB 2 CFR §200.501– any recipient that expends $750,000 or more in federal funds within the recipient's last fiscal, must have an annual audit conducted by a third – party. In the Applicant/Grantee's last fiscal year, were you required to conduct a third-party audit?	☐ **YES** ☐ **NO**
B. Covered Entity Disclosure During the two-year period preceding the execution of the attached Agreement, were any principals or key personnel of the Applicant/Grantee / Recipient organization or any of its agents who will participate directly, extensively and substantially in the request for funding (i.e. application), pre-award negotiation or the administration or management of the funding, nor any agent of the above, is or will be a candidate for public office or a contributor to a campaign of a person who is a candidate for public office, as prohibited by local law.	☐ **YES** ☐ **NO**
C. Executive Compensation: For an award issued at $25,000 or above, do Applicant/Grantee's top five executives do not receive more than 80% of their annual gross revenues from the federal government, Applicant/Grantee's revenues are greater than $25 million dollars annually AND compensation information is not already available through reporting to the Security and Exchange Commission. *If No, the Applicant, if funded shall provide the names and salaries of the top five*	☐ **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: