DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

Community Health Administration

Colorectal Cancer Control Program

REQUEST FOR APPLICATIONS

FO# CHA-CRC-3.28.25

SUBMISSION DEADLINE: APRIL 29, 2025, BY 3:00 PM

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

DC DEPARTMENT OF HEALTH

COMMUNITY HEALTH ADMINISTRATION

NOTICE OF FUNDING AVAILABILITY (NOFA)

FO# CHA-CRC-3.28.25

COLORECTAL CANCER CONTROL PROGRAM

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

Funding Opportunity Title:	Colorectal Cancer Control Program
Funding Opportunity Number:	CHA-CRC-3.28.25
DC Health Administrative Unit:	Community Health Administration
DC Health Program Bureau	Health Promotion and Disease Prevention Bureau
Funding Opportunity Contact:	Senkuta Riverson, DC Cancer Programs Division Chief, dccancercoalition@dc.gov
Funding Opportunity Description:	DC Health is seeking proposals to increase screening for colorectal, breast, cervical, and lung cancers in primary care clinics by implementing evidence-based interventions; addressing patient barriers to screening by connecting individuals to health care and social needs resources; and enhancing clinical workflows and electronic health records.
Eligible Applicants	• Federally Qualified Health Centers (FQHCs), • FQHC look-alikes, and • Hospitals Note: The eligible organizations must provide primary care services to the Medicaid population, and/or adults 18 years old living in Wards 5,6,7 and 8.
Anticipated # of Awards:	Two to three
Anticipated Amount Available:	$300,000
Annual Floor Award Amount:	$ 50,000

Annual Ceiling Award Amount:	$ 220,000
Legislative Authorization	District of Columbia Budget Support Act 301(a) and 317(k)(2) of the Public Health Service Act, [42 U.S.C. Section 241(a) and 247b(k)(2)], as amended Public Health Service Act, as amended, Section 301(a) and Section 317K, 42 U.S.C. 241(a); 42 U.S.C. 247b12
Associated CFDA#	93.800-Oganized Approaches to Increase Colorectal Cancer Screening 93.898
Associated Federal Award ID#	5 NU58DP006834-05-00, 5 NU58DP007155-03-00
Cost Sharing/Match Required?	No
RFA Release Date:	March 28th, 2025
Letter of Intent Due date:	Not Applicable
Application Deadline Date:	April 29th, 2025
Application Deadline Time:	3:00 p.m.
Links to Additional Information about this Funding Opportunity	DC Grants Clearing house https://communityaffairs.dc.gov/content/community-grant-program#4 DC Health EGMS https://egrantsdchealth.my.site.com/sitesigninpage

Notes:

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

CONTENTS

RFA TERMS AND CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHECKLIST FOR APPLICATIONS

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

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

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

☐ Submit your application via EGMS by the application due date and time**. Late applications will not be accepted.**

1. GENERAL INFORMATION

1.1 KEY DATES

- Notice of Funding Announcement Date: **March 14th, 2025**
- Request for Application Release Date: **March 28th, 2025**
- Pre-Application Meeting Date: **visit https://OGMDCHealth.eventbrite.com**
- Deadline to Register in EGMS for New Applicants: **April 15th, 2025**
- Deadline to Submit Questions for Response in the FAQ: **April 21st, 2025**
- Application Submission Deadline: **April 29th, 2025**
- Anticipated Notice(s) of Intent to Fund: **May 30th, 2025**
- Anticipated Award Start Date: **July 1st, 2025**

1.2 OVERVIEW

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

The Community Health Administration (CHA) within DC Health works to prevent the leading causes of death, protect and promote the health of mothers and children and eliminate racial and ethnic health disparities in health. CHA's approach targets multiple factors that influence health through evidence-based programs, policies and systems change. Within CHA, the Health Promotion and Disease Prevention Bureau aims to build and empower healthy communities. Bureau strategies focus on 1) promoting safe, healthy behaviors, 2) improving access to care and early detection of disease and 3) supporting optimal disease management to avoid disease complications. Programs and initiatives center on improving data and surveillance capabilities, building healthy environments across communities, improving delivery and use of quality clinical services, and facilitating community-clinical linkages.

1.3 PURPOSE

DC Health implements the Centers for Disease Control and Prevention's (CDC) Colorectal Cancer Control Screening Program, known locally as the DC Colorectal Cancer Control Program (DC3C). DC3C works with hospitals, FQHCs or look alike primary clinics and other health care organizations to use and strengthen strategies that have been shown to increase colorectal cancer screening, outlined in the Guide to Community Preventive Services (www.thecommunityguide.org/).

1.4 SOURCE OF GRANT FUNDING

DC Health is the primary recipient of federal funds awarding these funds. As a primary recipient, DC Health has the responsibility to pass through requirements and objectives agreed to in our

federal notices of award. Funding is anticipated to be available using CDC-RFA-DP-25-0012 award of the CDC Funding Program: *Changing Health System Using Evidence-Based Interventions to Increase Colorectal Cancer Screening*.

1.5 Award Information

1.5.1 Amount of Funding Available

The total funding amount of $300,000 is anticipated for two – three (2–3) awards for the first budget period.

1.5.2 Period of Performance and Funding Availability

The first budget period of this award is anticipated to begin on July 1, 2025, and to continue through June 30, 2026. After the first budget period, there will be up to four (4) additional 12-month budget periods for a total project period of July 1, 2025 – June 30, 2030. The number of awards, budget periods, and award amounts are contingent upon the continued availability of funds and grantee performance and compliance. The table below breaks out the available funding for required and supplemental components per recipient.

Focus Area	Min	Max
Core Funding [Required]		
Colorectal Cancer Screening	$50,000	$100,000
Supplemental Funding [Optional]		
CRC GI Pilot	Additional $25,000	Additional $50,000
Breast and Cervical Cancer Screening	Additional $10,000	Additional $20,000
EMR enhancement – Tobacco & Lung	Additional $25,000	Additional $50,000

1.5.3 Eligible Organizations/Entities

The following are eligible organizations/entities who can apply for grant funds under this RFA: hospitals, FQHCs or FQHC look a-like primary care clinics located in the District of Columbia providing primary care services to adults 18 years old in Wards 5, 6, 7 and 8.

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.

1.5.4 Non-Supplantation

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

2. BACKGROUND

2.1 DEMOGRAPHIC OVERVIEW

In the District of Columbia, colorectal cancer (CRC) is the fourth leading cause of cancer death with age-adjusted mortality rate of 12.4 per 100,000 people[1]. The CRC incidence rate in the District is 35.2 per 100,000 people, similar to the national average of 36.0 per 100,000 people.[2] However, CRC cancer burden is not evenly distributed across the District. Residents of Wards 5, 6, 7, and 8, which also have greater prevalence of low household income, have higher rates of mortality. Moreover, high-risk DC residents are more likely to be diagnosed with late-stage CRC.

Despite a consensus on the effectiveness of screening for colorectal cancer, screening rates remain low among populations with lower income and higher social needs. According to the 2020 the Behavioral Risk Factor Surveillance System (BRFSS), the U.S. Preventive Services Task Force (USPSTF) recommended CRC screening rate for District residents was approximately 79%, a 5% increase from 2018 (74%) and higher than the 2020 national rate (73%). In May 2021, USPSTF amended the CRC screening recommendation by expanding the age-eligibility from 50-75 to 45-75 years. As a result, rates declined in the District (2020: 79%; 2022: 71%) and the nation (2020: 72%, 2022: 59%).[3] However, among the District's Federally Qualified Health Centers (FQHCs) serving populations with lower income and increased patient needs (89% below 200% Federal Poverty Guideline), the CRC screening rate was 41% in 2020 and 47% in 2022. The District's Healthy People 2030 goal is to reach 74% CRC screening rate.

In addition to access to screening, factors including patient knowledge, attitudes and behaviors, physician recommendations, insurance coverage, and state and clinic-level surveillance, and integrated health systems play a vital role in increasing cancer screening uptake. The Community Preventive Services Task Force (CPSTF) has published recommendations of evidence-based interventions proven to increase colorectal cancer screening. **Error! Bookmark not defined.Error! Bookmark not defined.**Successful screening relies on people being counseled on screening and offered a variety of screening test options including stool-based tests; tracking positive stool-based test results; and referring patients to follow-up colonoscopy to complete the screening process. Tracking people

[1] U.S. Cancer Statistics Data Visualizations Tool. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, 2021 data, released in June 2024.

[2] U.S. Cancer Statistics Data Visualizations Tool. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, 2021 data, released in June 2024.

[3] Behavioral Risk Factor Surveillance System (BRFSS), 2018, 2020, 2022.

with abnormal test results can be challenging, but patient navigation can help, especially for patients who may have more difficulty navigating the healthcare system.

In 2022, the Community Guide, published by the Centers for Disease Control and Prevention, officially recommended patient navigation services as an effective intervention to increase cancer screening rates, especially among historically disadvantaged populations and people with lower income, in addition to the other established evidence-based interventions (patient and provider reminders, provider assessment and feedback, and strategies that reduce structural barriers). Patient navigation involves dedicated individuals (navigators) who actively assist patients in navigating the complex healthcare system by addressing barriers like transportation, insurance issues, health literacy, and food insecurity, that were identified as key factors and ultimately improving access to timely care.[4] Evidence demonstrates that patient navigation significantly increases cancer screening rates, advances health equity, and reduces cancer mortality.[5]

Based on CPSTF recommendations, the DC Colorectal Cancer Control Program (DC3C) uses a health systems change framework to increase CRC screening rates, targeting populations with high social needs and ultimately reducing colorectal cancer in the District.[3]

3. PURPOSE

The DC Health Community Health Administration (CHA) is requesting proposals from qualified applicants to implement the following Evidence-Based Interventions (EBI) to increase CRC screening uptake among patients aged 45–75 years: patient navigation, client reminders, provider reminders, provider assessment and feedback, and reducing structural barriers. DC3C seeks to build on existing program successes, expand partnerships, enhance quality improvement (QI) and technical assistance methods, increase education, training and awareness for providers and the community, improve clinical data exchange processes, and bolster community-clinical linkages to implement EBIs that improve CRC screening and follow-up testing to eliminate CRC health disparities and improve colorectal cancer outcomes for District residents.

Priority will be given to healthcare facilities with a most recent CRC screening rate at or below 60%; demonstrated experience in quality improvement initiatives; and high proportion of the current patient population consistent with the program's target population: men and women age 45–75 years, low-income, Black or African American and Hispanic populations, and residents of Wards 5, 6, 7 and 8.

This funding opportunity includes three (3) cancer focus areas:

1. CRC screening [Required]
2. Breast and cervical cancer screening [Optional]

[4] https://www.cdc.gov/cancer/php/interventions/patient-navigation.html

[5] Community Guide, Center for Disease Control and Prevention (CDC)

3. Lung cancer screening [Optional]

The applicant must include CRC screening and has the option to include breast and cervical and/or lung cancer screening. The applicant selecting to implement *optional* cancer focus areas will receive commensurate funding support.

To implement the program, the applicant must have the capacity to:

1. Establish a clinical team (clinic champion, data analyst, patient navigator/care coordinator, specialists (Gastroenterologist) to work collaboratively on this project.
2. After award, conduct a readiness assessment which will include pulling baseline data on cancer screening rates from the past calendar year (January 2024 – December 2024) (see Baseline Data Worksheet.)
3. After award, track and submit high-quality, clinic-level data, including baseline, quarterly and annual aggregate data on cancer screening prevalence, CRC stool-based tests provided to and returned by patients, and aggregate data on follow-up colonoscopies (see Appendix B- Monitoring and Evaluation Data Elements).
4. After award, track and report patient-level data on patients navigated (Strategy 2 of this funding opportunity) and served through the Gastroenterology Nurse Pilot (Strategy 4 of this funding opportunity).

3.1 Approach

Informed by data and lessons learned, DC Health uses a multifaceted approach to increase CRC screening among target populations. DC3C aims to partner with health systems and primary care clinics to implement evidence-based interventions (EBIs) that increase CRC screening uptake among patients aged 45-75 years that are at higher risk of the disease (such as Black/African American, Hispanic, Medicaid, uninsured and underinsured populations). DC3C has adopted a policy, systems, and environmental change approach in its implementation of program activities with the goal of increasing CRC diagnosis at early-stage, when treatment has the best outcomes.

4. PERFORMANCE REQUIREMENTS

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

4.1 Target Population

CRC screening target population: The proposed program should focus on CRC screening eligible adults age 45-75 years, Black/African American, Hispanic, low-income populations, and residents of Wards 5, 6, 7, and 8.

Breast and cervical target population: Applicant that chooses to propose EBIs to increase breast and cervical cancer screening rates must propose programs targeting screening eligible populations

with the highest risk for incidence and mortality: Black/African American, Hispanic, low income, uninsured/underinsured populations and residents of Wards 5, 6, 7, and 8.

- Breast age eligible persons include adults with breasts and above the age of 40 or residents younger than 40 with a family history of breast cancer that are eligible for breast screenings as recommended by USPSTF.
- Cervical age eligible persons include adults with a cervix and above the age of 21 eligible for a cervical cancer screening.

Lung cancer screening target population: Applicants that choose to propose EBIs to increase tobacco cessation and lung cancer screening must address the following target population: people who are between 50 and 80 years old and have smoked at least one (1) pack a day for 20 years, or currently smoke or have quit within the last 15 years.

4.2 Location of Services

Grantees must be located within the District of Columbia. Services must be delivered within a primary care clinic(s)/practice(s) that are a part of a hospital or Federally Qualified Health Center or a look-a-like located in the District.

Hospitals, FQHCs, and FQHC look-alikes with multiple primary care clinics/practices, can participate in this project, however, the grant recipient must partner and implement program strategies and activities at the clinic level (i.e. at the specific primary care clinic/practice within the health system).

4.3 Allowable Activities

Funds must be used to implement evidence-based interventions (recommended by US Preventative Services Task Force (USPSTF)) to increase cancer screening and follow-up testing within primary care clinics. Funds should also be used to enhance clinical workflows and the electronic medical record to facilitate effective implementation of evidence-based interventions and track data on cancer screening and follow-up testing.

- The applicant's CRC strategies must align with DC3C Program's outcomes:

  Short-term outcomes:
  - Increased implementation of EBIs in partner clinics
  - Increased CRC screening and follow-up testing among patients in partner clinics (increased number in stool test returned, colonoscopy completed)
  - Increased CRC screening rate in partner clinics
  - Reduced time between screening and diagnostic test

  Intermediate outcomes:
  - Increased CRCs prevented
  - Increased diagnosis of early-stage CRC

  Long-term outcomes:
  - Decreased CRC incidence and mortality

- Decreased disparity in CRC cancer incidence and mortality

- Applicants that propose to implement EBIs to address breast and cervical cancer screening must aim to achieve the following outcomes:

  Short-term outcomes:
  - Increased breast screening and follow up screening among women in partner clinics (increased screening mammogram completed; diagnostic mammograms completed)
  - Increased breast screening rate in partner clinics
  - Reduce time between mammogram screening and diagnostic test

  Intermediate outcomes:
  - Increased diagnosis of early-stage breast cancer

  Long-term outcomes:
  - Decreased breast cancer incidence and mortality
  - Decreased disparity in breast cancer incidence and mortality

- The applicant that plans to apply for EBI's to address lung cancer screening must aim to achieve the following short-term outcomes

  Short-term outcomes:
  - Increased tobacco use documentation in EMR
  - Increased referrals for lung cancer screening rate in partner clinics
  - Reduce time between lung screening and diagnostic test

  Intermediate outcomes:
  - Increased diagnosis of early-stage lung cancer

  Long-term outcomes:
  - Decreased lung cancer incidence and mortality
  - Decreased disparity in lung cancer incidence and mortality

4.4 PROGRAM STRATEGIES

Grantee shall employ strategies and implement activities in the service 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:

- The applicant must propose activities for Strategies 1, 2, 3, and 5 as outlined below for CRC screening.
- The applicant has the option to implement Strategy 4 for CRC screening.
- The applicant has the option to implement Strategy 1, 2 and 3 for breast and cervical, and/or lung cancer screening for additional funding.

Strategies and activities have been labeled as ***"Required"*** and ***"Optional"*** components for clarity.

The applicant shall propose activities that:

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

STRATEGY 1: Implement Evidence Based Interventions (EBIs) to increase cancer screening and follow-up testing uptake [Required]

The applicant must propose a plan to **implement at least two (2) primary EBIs** and as many supportive activities to increase CRC screening uptake within their clinic(s). In addition, the applicant has the option to propose plans to implement EBIs to increase breast and cervical and/or lung cancer screening withing the clinic(s).

Primary EBIs include:

i) Provider Assessment and Feedback – Interventions that evaluate provider performance in delivering or offering screening to patients (*assessment*) and formal/written presentation of the information to providers about their performance in providing screening services (*feedback*).
ii) Provider Reminders – Reminders that inform health care providers when it is time for a client's cancer screening test (called a "reminder") or that a client is overdue for screening (called a "recall"). Usually electronic, written, email and/or visual.
iii) Client (or patient) Reminders – Written (letter, postcard, email) or telephone messages (including recorded/automated messages) advising people that they are due for screening. Client reminders can be general to reach the overall target population or tailored with the intent to reach one specific patient based on unique characteristics, related to the outcome of interest, and derived from an individual assessment. For example, reminder postcards for patients who previously missed a CRC screening appointment or patients due for a colonoscopy.
iv) Reducing Structural Barriers – Structural barriers are non-economic burdens or obstacles that make it difficult for people to access cancer screening (e.g., inconvenient clinic hours, lack of transportation).

Supportive Activities - the applicant must propose at least one Supportive Activities (SAs) (described below) to support delivery of EBIs:

i. Small Media – educational posters or distribute flyers in waiting areas that explains why cancer screenings are important.
ii. Provider Education – a workshop, training for providers to update them on the latest screening guidelines and follow up recommendations.
iii. Patient Education – in person patient education workshop or give handouts that explain the benefits of cancer screenings and how to prepare for them.
iv. Health Information Technology (HIT) – use an electronic system to send out automatic reminders to both providers and patients when a screening or follow up is due and tracks the results for quality improvement**.**

1. **Multi-Component** – the applicant must describe implementation of EBIs as a multi-component model, focusing on different areas of the clinical environment (such as clinician, patient, and process) to increase both community demand for screening and provider delivery of screening.
2. **Readiness Assessment** – the applicant must describe their capacity to collaborate with DC Health to participate in a readiness assessment that will identify exiting EBIs at the clinic, gaps in current EBIs, and opportunities for enhancement. The assessment findings will be used to inform the EBIs that will be enhanced or developed. The readiness assessment, which has three (3) components, must be completed withing the first six (6) months of the award. The applicant must demonstrate capacity (staffing, expertise, EMR functionality, experience) that will allow them to successfully complete the requirements three (3) components of the assessment:

a. Baseline data: the baseline data will include high quality, clinic level aggregate data on cancer screening prevalence, follow-up testing completion, and patient population for the January – December 2024 period based on the DC Health specifications outlined here DC3C Data deliverables guide 2024.pdf.
b. Clinic Capacity Survey: the survey will focus on the clinic's existing EBIs, EMR capabilities, and Quality Improvement (QI) capacity.
c. Workflow Assessment: DC Health will work closely with the awarded health systems to assess the current workflow through a series of key informant interviews and get input on gaps and feasible enhancements.

3. **Cancer Screening Champion –** the applicant must identify a cancer screening champion and describe a DC3C Team that will implement the program in the clinic.
   i) The applicant must propose a cancer screening champion that will lead the program and facilitate implementation. The champion will closely work with DC Health and DC Health's implementation support partners that will provide technical assistance to the program.
   ii) The applicant must propose a diverse group of clinical staff that will participate in the implementation of the program – forming the DC3C Team. Team members should include, at a minimum, medical director, data staff/QI staff, Patient Navigator/ referral coordinator/care coordinator, and clinical care team (such as a nurse, medical assistant, or physician).
4. **Electronic Medical Record (EMR) systems** – the applicant must describe their capacity and plans to monitor screening prevalence, track screening results, and completion (using internal and external supports). The proposal should describe the use of the EMR to identify patients due for screening; automate EBIs (e.g. provider reminder alerts); use of population management tools (e.g. Azara, BridgIT) to develop provide assessment and feedback to clinical team on screening rates (e.g. dashboards); document and track patient navigation; and integrate EBIs into clinical workflows to enhance screening uptake.
5. **Policy** – the applicant must describe their current organizational CRC screening policy with specified age categories, methods, and intervals for screening. If the clinic does not have a written CRC screening policy, the applicant must describe plans to develop or update one.

STRATEGY 2: Implement Patient Navigation (PN) to address barriers to screening and follow-up testing and link patients to resources. [Required]

The applicant must propose a plan to implement a patient navigation program to address patient barriers to screening and follow-up testing using the DC Health model as outlined below:

a. Identify Eligible Patients for Patient Navigation: The applicant must describe their plans to use the EMR to identify patients due or overdue for CRC screening. This includes utilization of care gap reports to flag patients who are due for screening, and who have not completed recommended follow-up tests after abnormal results for an initial screening (example, positive FIT/FOBT, Cologuard). The applicant must describe how their EMR can identify high risk patients (Black/African American, low-income, residents of Wards 5, 6, 7 and 8) to prioritize navigation. The applicant must clearly describe who is eligible for screening and the number of patients they anticipate navigating in the 12-month period given the eligibility criteria.

b. **Provide Direct Navigation Support to Patients**: The applicant must propose a set of criteria to identify patients for navigation. Patient Navigators (PNs) need to systematically assess, address and document barriers such as transportation, communication and health literacy, and financial challenges that impact screening completion. In addition, PNs must assess patients for co-morbidities, specifically focusing on uncontrolled hypertension, and patients who are current smokers that desire to quit.

   PNs should link patients to resources to resolve barriers. The proposal should describe at a minimum how:

   - PNs will assist with barriers to completing CRC screening and follow-up testing including scheduling CRC screenings (FIT/FOBT, colonoscopy); providing reminders and follow-ups for patients with abnormal stool test results to ensure diagnostic colonoscopy completion, and linkage to treatment, if needed.
   - PNs will resolve barriers for patients with uncontrolled hypertension linking them to internal clinic resources (e.g. self-management programs, MyHealth GPS) that help the patients manage hypertension.
   - PNs will screen patients for tobacco use and refer them to DC Health's DCQuitNow cessation services and other cessation resources available in the clinic.

c. **Document and track barriers and referral to resources:** The applicant must outline plans to document and track barriers to screening, resolution and navigation outcome. Patient-level, de-identified patient navigation data must be submitted to DC Health quarterly. The recipient must develop a sustainable mechanism to document and track navigation either in the clinic's EMR or using platforms such as LinkU, an online database of resources to refer and connect patients to social needs services. DC Health will provide training to LinkU for any recipients interested in using the tool.

d. **Coordinate Follow-Up for Patients with Abnormal Screening Results:** The applicant must propose a plan for referral pathways with gastroenterology (GI)/endoscopy centers to facilitate timely diagnostic testing. Patients with positive results for stool-based tests (e.g. FIT, Cologuard) must be prioritized for navigation to ensure timely completion of the follow-up colonoscopy.

e. **Increase colorectal cancer screening rates by improving stool-based test completion.** The applicant must describe their plans and capacity to implement patient navigation strategies that will further enhance the clinic's CRC stool-based test options by implementing bulk order campaign for stool-based CRC screenings where patients due/overdue are identified through EMR and mailed test kits to their home. This includes: (1) collaborate with Exact Science to develop the bulk order procedure, (2) train PNs and providers on best practices to implement bulk orders and engage patients in stool-based screening, (3) collect and analyze data on test distribution, kit return rates, and follow-up completion rate for abnormal results to identify barriers and refine interventions.

STRATEGY 3: Implement Electronic Medical Record (EMR) system enhancements that facilitate timely identification and referral of patients with abnormal screening results to follow-up testing [Required]

The applicant must describe how they will support completion of stool tests and colonoscopies, including tracking and follow-up of colonoscopies for positive stool tests by optimizing EMR to

improve cancer screening documentation and tracking (especially abnormal result and referral to follow-up) by following activities:

1) CRC Screening Enhancement *[Required]*

i. The applicant must describe how they will improve their clinic's ability to capture and track cancer screening data (including stool-based test return rates, results, and follow-up colonoscopy completion rate) in the clinic's EMR system.
ii. The applicant must establish protocols to identify patients with positive FIT/FOBT/Cologuard, track referrals to follow up colonoscopy, ensure completion through patient navigation and document data in the EMR.
iii. The applicant must propose a patient navigation model to systematically navigate patients with abnormal stool tests to follow up colonoscopy. The applicant must describe their capability for PN data tracking and documentation using their EMR system or if enhancements are needed.
iv. The applicant must describe how they will provide resources, training to provider and patient navigators on data documentation and EHR enhancements.
v. The applicant must include how they currently utilize the District's designated Health Information Exchange (HIE), Chesapeake Regional Information System for Patients (CRISP) to inform cancer screening, gaps in use, and possible improvements in leveraging the CRISP for cancer screening.

2) Breast and Cervical Cancer Screening Enhancements *[Optional]*

The applicant is encouraged to apply for supplemental funds and should describe how they will implement EMR enhancements to:

i. Identify patients due/overdue for breast and cervical cancer screenings.
ii. Identify patients with abnormal results after initial screening.
iii. Track referrals and ensure patients complete diagnostic tests.
iv. Implement automations such as patient reminder (text messaging), provider alerts, use of population management tools to track screening rates by providers.

3) Tobacco Cessation and Lung Cancer Screening Enhancements *[Optional]*

The applicant is encouraged to apply for supplemental funds and should describe how they will implement EMR enhancements to:

i. Improve comprehensive tobacco history documentation.
ii. Identify patients eligible for lung cancer screening.
iii. Implement processes to refer patients that need tobacco cessation support to DC Health's DCQuit Now and other cessation programs.

STRATEGY 4. Enhance clinical workflows to reduce the time between the initial cancer screening and diagnosis by improving care coordination and accessibility. [Optional]

The GI Pilot: This project is a collaborative effort between GI specialists, hospitals, and FQHCs to provide on-site colonoscopy consultations for FQHC patients with abnormal stool-based screening results, high-risk populations (e.g. due to family history), or those requiring repeat colonoscopy due to prior abnormal results or polyps. The goal is to enhance and streamline the process between primary care and GI/hospitals, eliminating or significantly reducing the median

time between abnormal stool-based test results and the completion of diagnostic colonoscopy procedures.

The applicant must propose a plan to reduce the time between the initial CRC screening and diagnosis by implementing the following:

i. The applicant must be part of an existing GI specialty department. If the applicant organization is a hospital they must collaborate with at least one (1) FQHC or look a-like FQHC. The applicant should name the FQHC/look-a-like in the application.
ii. The applicant must describe a plan that includes placement of a licensed nurse practitioner or physician assistant that provides GI consults within a FQHC.
iii. The applicant must propose a clear outline and timeline for the GI pilot implementation using a phased strategy (including MOU agreements, administrative logistics such as hiring, schedule setting, licensing accreditation, training etc.)
iv. The applicant must propose activities on how to eliminate long scheduling waits for follow up colonoscopy. This should include the documentation of data related to the pilot in the EHR or other existing data tool.
v. The applicant must propose activities to develop, test, and implement a structured referral system between the FQHC and GI specialist(s), and hospital(s) to facilitate timely access to diagnostic colonoscopies, and a follow-up process to improve EHR documentation of test results and timely result communication to primary care providers

STRATEGY 5: Monitoring and evaluation that ensure data quality informing continuous quality improvement and assessment of program outcomes. [Required]

The applicant must propose activities that ensure high quality data, monitor and assess program implementation and achievement of program goals:

1. **Baseline and Annual Data**: The applicant must describe how they will collect and report baseline and annual data at the facility level, as defined by DC Health. Data elements are listed in Monitoring and Evaluation Data Elements (Appendix B). Note: Applicant must submit a Baseline Data Worksheet using the template provided.
2. **Quarterly Data Submission**: The applicant must describe how they will track and report CRC screening data, and EBI process measures quarterly to inform course correction and continuous quality improvement. Data elements are listed in Monitoring and Evaluation Data Elements (Appendix B).
3. **Patient Navigation Data:** The applicant must describe how they will track and report patient navigation client level data. This may include tracking PN data by using existing EMR, population management data tools (e.g. Azara), care gap reports, EMR enhancements (to add PN structure data fields), or usage of an external data tool. Data elements are listed in Monitoring and Evaluation Data Elements (Appendix B).
4. **GI Pilot data, patient-level data:** the applicant must describe how they will document; track and report CRC follow up completion data including date of screening, follow up colonoscopy, diagnosis and results. Data elements are listed in Monitoring and Evaluation Data Elements (Appendix B).

5. **Capacity to Extract Data:** the applicant must describe staff capacity with knowledge/expertise in the clinic's EMR and the ability to extract required data for submission to DC Health. The proposal needs to also outline strategies (including data validation checks, chart reviews) which the applicant will use to ensure high quality data is submitted to DC Health. The applicant will use DC Health data collection tools to submit required data quarterly and annually.
6. **Use monitoring data for quality and program improvement:** The applicant must describe how they will continually monitor program progress through data collection, analysis and perform data quality assurance (QA) activities and validate data before submission to DC Health.

4.5 COLLABORATION

The applicant must describe how they will collaborate with partner organizations to address the clinic's capacity needs, as well as system level barriers**.** This includes DC Health Technical Assistance (TA) partners such as DC Primary Care Association (DCPCA), Chesapeake Regional Information System (CRISP), a health information technology (HIT) expert (Health Efficient). The applicant must provide clear description on how this comprehensive network of partners will support them in achieving programmatic goals by addressing gaps in clinical infrastructure, capacity, and workflow to ensure sustainability of EBIs to improve CRC, breast, cervical or lung cancer screening uptake, especially among high-risk population. This includes a plan for how the applicant will work closely with partner organizations to:

- Identify the clinic's infrastructure and capacity gaps and needs for effectively implementing the program. This would include an in-depth readiness assessment as mentioned in the Approach Section.
- Address system-level barriers such as delay in receipt of colonoscopy results from specialist; difficulty accessing CRC screening history; and multiple visits (consult visit and procedure visit) to perform colonoscopies. This will include participation in meetings and workshops to facilitate and collaborate on efforts.

5. APPLICATION REQUIREMENTS

5.1 ELIGIBILITY DOCUMENTS

CERTIFICATE OF CLEAN HANDS

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

CURRENT BUSINESS LICENSE

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

CURRENT CERTIFICATE OF INSURANCE

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

COPY OF CYBER LIABILITY POLICY

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

IRS TAX-EXEMPT DETERMINATION LETTER

This applies to nonprofits only.

IRS 990 FORM

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

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

This CANNOT be signed by the executive director.

ASSURANCES, CERTIFICATIONS AND DISCLOSURES

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

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

5.2 PROPOSAL COMPONENTS

PROJECT ABSTRACT

A one-page project abstract is required. 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**. Please provide a self-contained summary of your proposed project, including the purpose and outcomes. Do not include any proprietary or confidential information. We use this information when we receive public information requests about funded projects.

PROJECT NARRATIVE (20-page maximum)

The project narrative must be a maximum of 20 pages, single spaced, 12-point font, 1-inch margins, number all pages. **Content beyond the specified page number will not be reviewed.** The applicant must submit a Project Narrative with the application forms. The Project Narrative must include all of the following headings (including subheadings):

BACKGROUND

The applicant must provide a description of relevant background information that outlines the context of the problem.

PROJECT DESCRIPTION

i. Purpose

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

ii. Outcomes

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

iii. Strategies and Activities

The applicant must provide a clear and concise description of the strategies and activities they will use to achieve the project outcomes. The applicant must base their strategies and activities on those described in the Strategies and Activities section of the DC Health Project Description (Strategies 1–4). Strategies 1–4 must be addressed in applicants' response. Applicant must propose activities that align with the requirements of this RFA, that meet their clinic's needs and describe in the applicant evaluation and performance measurement section of the project narrative how these strategies will be evaluated over the course of the project period.

- Clearly address Strategies 1–5 from the Approach Section
    - For each strategy, describe the rationale for selected activity. Please include an assessment of current needs and assets in the health system.
    - For each strategy, clearly describe activities that will be implemented how they will be implemented; and how the strategies will be operationalized to achieve program goals, objectives, and outcomes.
- Indicate plans for sustainability of the initiative beyond the projected funding period.

PROJECT OR POPULATION NEED

The applicant should provide an overview of the clinic's ability, history and capacity to engage District adults aged 45-75 years who are eligible for CRC screening, specifically, Black/African American, Hispanic, low-income populations residing in Wards 5,6,7,8.

If applicant opts to apply for the ***"Optional"*** components, they must provide description of the target population for each cancer type in this section.

EVALUATION AND PERFORMANCE MEASUREMENT

The applicant must provide a description of how achievement of project goals will be assessed and monitored during implementation. The applicant should describe how key performance measure data (described in in Strategy 4 of the Strategy and Activity section) will be collected and used to assess project outcomes. At a minimum, the plan must describe:

- The applicant's experience and capacity to access and export the performance measures, data sources, feasibility of collected required data, and other relevant data information (e.g. performance measures listed under Strategy 4 as well as proposed by the applicant).
- How the applicant will collect the performance measures.
- How the applicant will ensure high quality data collection, including QA activities, data validation methods, and capacity to perform a chart review.
- How data will be monitored and used to improve implementation.

ORGANIZATIONAL CAPACITY

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

LOGIC MODEL

The applicant must attach a **Logic Model** that outlines activities within the following five (5) strategies (below) and achieve the outcomes delineated above.

- Strategy 1. Evidence Based Intervention Implementation
- Strategy 2. Patient Navigation Implementation
- Strategy 3. Workflow and EHR System Enhancements
- Strategy 4. Care Coordination and Accessibility to Diagnostic Colonoscopy
- Strategy 5. Monitor and Evaluate Data

WORK PLAN

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

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

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

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

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

BUDGET TABLE

The application should include a project budget worksheet using the excel spreadsheet in District Grants Clearinghouse. An attachment is provided for application preparation purposes but the budget data must be inputted into EGMS. The project budget and budget justification should be directly aligned with the work plan and project description. All expenses should relate directly to achieving the key grant outcomes. Budget should reflect the budget period, as outlined below (Key Budget Requirements).

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

Key Budget Requirements

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

- July1, 2025 – June 30th, 2025

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

BUDGET JUSTIFICATION

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

Include the following in the budget justification narrative:

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

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

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

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

Supplies: Funds can be used to cover supplies related to education/outreach. Applicant should provide a separate category total and description for each. Description should include a summary of the individual items, and their quantity included in each category; however, the items do not have to be priced out separately. Description should also include how the supplies directly support the project.

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

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

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

ORGANIZATIONAL CHART

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

RISK SELF-ASSESSMENT

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

BASELINE DATA

The applicant must use the data collection template (*see attachment*) to provide data on all required data fields including the clinic's cancer screening rate (numerator and denominator) for calendar year 2024 (at the facility-level for health systems); measure used (UDS, NQF etc.), number of clinic patients during reporting period, number of patients age eligible, proportion of patients by race and ethnicity. Applicants need to determine and name specific clinic facilities that will participate in the program. All data reported needs to be at the facility level and not at the Health Center level. Applicants applying for the optional strategies (Breast and Cervical) must submit baseline data as well.

6. EVALUATION CRITERIA

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

CRITERION 1: NEED

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

- The application includes a background and purpose that supports a clear problem to address**.** (5 points)
- The clinic has a clinic population consistent with RFA target population requirements and clearly describes the needs of the population. (5 points)

CRITERION 2: IMPLEMENTATION

(30 POINTS) – Corresponds to Sections: Approach and Work Plan

- The work plan aligns with the strategies, activities, outcomes and performance measures in the approach and consistent with the content and format outlined by DC Health in the RFA. (10 points)
- The proposed use of funds aligns with the work plan and is an efficient and effective way to implement strategies and activities and attain the program short-term outcomes. (6 points)

- Describe existing EBIs that can potentially be enhanced or new EBIs that can be implemented. (8 points)
- Identify (name, job title) a Champion, and the DC3C Team members. (1 point)
- Describe how the applicant will work with program partners including CRISP to facilitate identification of gaps in clinic's capacity and infrastructure; and enhancements to achieve program goals. (5 points)

CRITERION 3: EVALUATIVE MEASURES

(30 POINTS) – Corresponds to Sections: Evaluation and Performance Measurement, Organizational Capacity, Staffing Plan & Organizational Chart, Baseline Data Worksheet

- Applicant's ability and plans to document, track and use data to inform continuous quality improvement. (6 points)
- The applicant outlines staff with expertise in querying DC Health required data from the health system's EMR, QI, and data analysis. (6 points)
- Applicant clearly describes their plans to validate high quality data that will inform progress on implementation and achievement of short-term outcomes. (6 points)
- Applicant describes data quality activities; data collection and monitoring efforts that will ensure submission of required high-quality data to DC Health. (6 points)
- Applicant describes how data will be used routinely to inform program implementation. (6 points)

CRITERION 4: CAPACITY

(30 POINTS) – Corresponds to Sections: Organizational Capacity, Staffing Plan & Organization Chart

- Applicant's ability to successfully implement EBIs within health systems and primary care clinics, assess their effectiveness in improving screening, and implement strategies to improve the EBIs when needed. (10 points)
- Applicant's ability to use data from EMRs. (8 points)
- Applicant's ability to track stool-based testing and follow-up colonoscopies to screening completion and demonstrate the relationships needed to connect patients to follow-up colonoscopy services when needed. (8 points)
- The staffing plan is sufficient to achieve program outcomes that clearly define staff roles (specifying champion, navigator, and data staff with expertise in the EMR) and provides an organizational chart that supports the structure. (4 points)

7. REVIEW AND SCORING OF APPLICATION

7.1 ELIGIBILITY AND COMPLETENESS REVIEW

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

7.2 EXTERNAL REVIEW

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

7.3 INTERNAL REVIEW

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

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

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

8. POST AWARD ASSURANCES & CERTIFICATIONS

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

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

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

9. APPLICATION SUBMISSION

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

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

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

9.1 REGISTER IN EGMS

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

1. **Access EGMS**: The user must access the login page by entering the following URL: https://egrantsdchealth.my.site.com/sitesigninpage. Click the button REGISTER and following the instructions. You can also refer to the EGMS Reference Guides.
2. Determine the agency's Primary User (i.e. authorized to accept terms of agreement, certify and submit documents, request and accept modifications). The Primary User will determine a Secondary User and send a notification via EGMS for him/her to set-up an account.
3. Your EGMS registration will require your legal organization name, your **UEI# and Tax ID#** in order to complete the registration. Your EGMS registration will also require your SAM (System for Award Management) expiration date to be entered into your agency profile. Please ensure that you have an active SAM registration (www.sam.gov).

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

EGMS User Registration Assistance:

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

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

9.2 Uploading the Application

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

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

- ***Proposal Documents***
    - Proposal Abstract
    - Project Narrative
    - Budget Table
    - Budget Justification
    - Organization Chart

- Work Plan
- Risk self-assessment
- Logic Model
- Baseline Data worksheet

9.4 DEADLINE

Submit your application via EGMS by 3:00 p.m., on the deadline date of April 29, 2025. Applications will **not** be accepted after the deadline.

It is highly recommended that applicants submit their applications at least 48 hours before the deadline.

10. PRE-APPLICATION MEETING

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

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

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

Note that questions will only be accepted in writing. Answers to all questions submitted will be published on a Frequently Asked Questions (FAQ) document onto the District Grants Clearinghouse every three business days. Questions will not be accepted after April 21st, 2025.

11. GRANTEE REQUIREMENTS

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

11.1 GRANT TERMS & CONDITIONS

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

11.2 GRANT USES

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

11.3 Conditions of Award

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

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

11.4 Indirect Cost

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

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

11.6 Vendor Registration in DIFS

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

11.7 Insurance

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

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

11.8 Audits

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

11.9 Nondiscrimination in the Delivery of Services

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

11.10 Quality Assurance

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

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

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

12. GLOSSARY OF TERMS

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."[6] Improving the cultural competency of health materials, personal interactions, and services is an important step toward addressing low health literacy among diverse populations.

Health Disparity[7] – 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.

Cancer Screening Champion: A clinic or hospital staff member who actively leads and supports cancer screening activities. They work to get clinical staff on board, trouble shoot workflow gaps, challenges, and lead efforts to increase screenings for cancers such as colorectal, breast, cervical and lung.

Evidence-based Intervention: Strategies that are proven to work. For cancer screening, these interventions improve the quality of cancer screening and increase the number of people screened.

FQHC look-a-like: A clinic that provides medical services to low-income or underserved populations similar to a Federally Qualified Health Center (FQHC), even if it doesn't have the official FQHC designation.

High-quality, clinic-level data: High-quality, clinic-level data are reliable so that public health action may be taken based on the data. It reflects what happens in the clinic in an accurate and timely way. Some activities that ensure high-quality data systems include providing training, using systems with built-in data validation and error checks, providing technical support, and reviewing data before submissions.

Patient Navigation: Support services that help patients overcome barriers to getting care, such as scheduling appointments, transportation, interpretation, provide health literacy education, understanding treatment options, and finding necessary resources.

The Community Guide: The Community Preventive Services Task Force (CPSTF) makes evidence-based recommendations about the effectiveness and economic impact of public health programs, services, and other interventions used in real-world settings such as communities, worksites, schools, faith-based organizations, military bases, public health clinics and

---

[6] "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

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

departments, and integrated healthcare systems. The evidence based interventions (EBIs) outlined in this RFA are based on the recommendations and findings from the CPSTF.

U.S. Preventive Services Task Force (USPSTF): The U.S. Preventive Services Task Force is an independent, volunteer panel of national experts in disease prevention and evidence-based medicine. The Task Force works to improve the health of people nationwide by making evidence-based recommendations about clinical preventive services.

13. ATTACHMENTS

Attachment: Assurances and Certifications
Attachment: Budget Table
Attachment: Budget Justification
Attachment: Work Plan
Attachment: Baseline Data Worksheet
Attachment: Risk Self-assessment
Appendix A: Minimum Insurance Requirements

APPENDIX A: MINIMUM INSURANCE REQUIREMENTS

INSURANCE

A. GENERAL REQUIREMENTS. The Grantee at its sole expense shall procure and maintain, during the entire period of performance under this contract, the types of insurance specified below. The Grantee shall have its insurance broker or insurance company submit a Certificate of Insurance to the PM giving evidence of the required coverage prior to commencing performance under this grant. In no event shall any work be performed until the required Certificates of Insurance signed by an authorized representative of the insurer(s) have been provided to, and accepted by, the PM. All insurance shall be written with financially responsible companies authorized to do business in the District of Columbia or in the jurisdiction where the work is to be performed and have an A.M. Best Company rating of A- / VII or higher. Should the Grantee decide to engage a subcontractor for segments of the work under this contract, then, prior to commencement of work by the subcontractor, the Grantee shall submit in writing the name and brief description of work to be performed by the subcontractor on the Subcontractors Insurance Requirement Template provided by the CA, to the Office of Risk Management (ORM). ORM will determine the insurance requirements applicable to the subgrantee and promptly deliver such requirements in writing to the Contractor and the CA. The Grantee must provide proof of the subcontractor's required insurance 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: MONITORING AND EVALUATION DATA ELEMENTS

The data listed here is not exhaustive but gives the applicant an idea of the types of data that needs to be submitted. DC Health reserves the right to add additional data points that will be outlined once awarded.

Colorectal Cancer Screening		
Data Report	**Data Points**	**Reporting Period**
Baseline / Annual Data (aggregate, by clinic facility)	• Patient population data by age-group, race/ethnicity, insurance type • Patients age 45-75 years that are eligible for CRC screening (based on USPSTF guidelines) • Patients age 45-75 years of age received an appropriate CRC screening test within the recommended time frame (based on USPSTF guidelines) • The number of patients given a FIT/ FOBT/Cologuard kits and the percentage of patients that returned a kit to the clinic • The number of patients with a positive or abnormal screening test and percentage that completed a follow-up colonoscopy • Types of EBI implemented at the clinic	Annual
Quarterly Data Submission (aggregate, by clinic facility)	• Rolling 12-month CRC screening rate by quarter • Patients age 45-75 years that are eligible for CRC screening for the quarter • Patients adults age 45-75 years served by the clinic, the number that received an appropriate CRC screening test within the recommended time frame (based on USPSTF guidelines) for the quarter • Percent referred to CRC screening out of those who were eligible for CRC screening by modality (colonoscopy, Cologuard, FOBT/FIT, etc.). • Percent received CRC screening by screening modality (colonoscopy, Cologuard, FOBT/FIT, etc.)	Quarterly
Patient Navigation Data (patient-level data)	• Demographic information (unique Pt ID, DOB, Address, Race, etc.) • Navigation details (start and close date, reason for closure) • Screening information (Screening type, screening date, screening result) • Clinical information (Last Medical Visit date for essential hypertension management, Total visits for condition management during the reporting period) • List of social needs barriers identified (transportation, food insecurity, financial, health literacy) • Resolution to barriers (e.g. Patients referred to transportation, DCQuitNow, hypertension control resources) • Patient's tobacco use status (current smoker, former, never)	Quarterly
GI Pilot data (patient-level data)	• Number of abnormal stool tests by screening modality (Cologuard, FIT/FOBT) • Number of follow up diagnostic colonoscopies completed after an abnormal stool. • Number of GI consultations conducted by a Nurse Practitioner (NP) / Physician Assistant (PA) on-site within the FQHCs. • Number and Percentage of patients referred for follow up diagnostic colonoscopy after completing the GI Consultation within FQHCs • Number and percentage of patients who completed a follow-up diagnostic colonoscopy after completing the GI consultation within FQHC. • Date of abnormal stool test completion. • Date of GI consultation conducted within FQHCs. • Date of follow-up colonoscopy completion. • Results of diagnostic colonoscopies performed after an abnormal stool test.	Quarterly