DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

Community Health Administration

Community Access Innovations

REQUEST FOR APPLICATIONS

FO# CHA-CAI- 12.6.24

SUBMISSION DEADLINE:

THURSDAY, JANUARY 28, 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-CAI-12.6.24

Community Access Innovations

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:	Community Access Innovations
Funding Opportunity Number:	FO-CHA-CAI-12.6.24
DC Health Administrative Unit:	Community Health Administration
DC Health Program Bureau	Family Health Bureau
Funding Opportunity Contact:	Tiffany Gray, Program Manager fhb.dchealth@dc.gov
Funding Opportunity Description:	DC Health is requesting proposals to support implementation of innovative and evidence-based strategies to reduce racial/ethnic disparities in healthcare access in the District of Columbia. The Community Access Innovation aims to pilot development of community healthcare access hubs and assess the impact on preventing and reducing maternal morbidity and mortality.
Eligible Applicants	• Federally Qualified Health Centers (FQHCs), • FQHC Look-A-Likes, • nonprofit organizations (including nonprofit primary care clinics, and nonprofit birthing facilities, • For-profit organizations providing clinical services within a primary medical Health Professional Shortage Area
Anticipated # of Awards:	Up to 2

Anticipated Amount Available:	$1,200,000.00
Annual Floor Award Amount:	$200,000.00
Annual Ceiling Award Amount:	$604,000.00
Legislative Authorization	State Maternal Health Innovation Program (Federal) 42 U.S.C. §701(a)(2)
Associated CFDA#	93.110
Associated Federal Award ID#	5 U7AMC5050507-02-00
Cost Sharing/Match Required?	N/A
RFA Release Date:	December 6, 2024
Letter of Intent Due date:	N/A
Application Deadline Date:	January 28, 2025
Application Deadline Time:	3:00 p.m.
Links to Additional Information about this Funding Opportunity	DC Grants Clearinghouse https://communityaffairs.dc.gov/content/community-grant-program#4 DC Health EGMS https://egrantsdchealth.my.site.com/sitesigninpage

Notes:

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

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
  - ☐ Proposal abstract
  - ☐ Project narrative
  - ☐ Budget table
  - ☐ Budget justification
  - ☐ Organization chart
  - ☐ Logic Model
  - ☐ Work plan
  - ☐ Risk self-assessment
  - ☐ Letters of Support
  - ☐ Staffing Plan
- ☐ 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, 2.0 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: **November 22, 2024**
- Request for Application Release Date: **December 6, 2024**
- Pre-Application Meeting Date: **visit https://OGMDCHealth.eventbrite.com**
- Last Day for New EGMS Registrations: **January 14, 2024**
- Application Submission Deadline: **January 28, 2025**
- Anticipated Award Start Date: **April 1, 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 promotes healthy behaviors and healthy environments to improve health outcomes and reduce disparities in the leading causes of morbidity and mortality in the District. CHA focuses on population health strategies to prevent and control cancer, chronic disease, and vaccine preventable diseases; promote nutrition and physical fitness; ensure access to quality health care services; and support the health and well-being of families across the lifespan. CHA's approach targets the behavioral, clinical, and social determinants of health through evidence-based programs, policy, and systems change.

The Family Health Bureau works to protect, promote and improve the health of families through screening and surveillance, education, community-clinical linkages, family strengthening programs, preventive services, and positive youth development.

To achieve health equity, or the highest level of health for all District residents, we must be intentional about addressing social and structural determinants of health and eliminating health disparities.

The District of Columbia, Department of Health's (DC Health), Community Health Administration (CHA) is requesting proposals from qualified applicants to implement innovative and evidence-based strategies to provide healthcare access in the District of Columbia. The development and installation of community healthcare access hubs will aim to reduce barriers to establishing access to consistent care.

1.3 Purpose

The purpose of this funding is to pilot healthcare access hubs in the community and assess their impact on preventing and reducing inequities in maternal morbidity and mortality.

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. (42 U.S.C. §701(a)(2), 5 U7AMC50507-02-00), State Maternal Health Innovation Program, FAIN (U7A50507).

1.5 Award Information

1.5.1 Amount of Funding Available

The total funding amount of $1,200,000 is anticipated for two (2) awards for the first budget period.

1.5.2 Period of Performance and Funding Availability

The first budget period of this award is anticipated to begin on April 1, 2025, and to continue through March 31, 2026. After the first budget period, there will be up to two (2) additional 12-month budget periods for a total project period of April 1, 2025 - March 31, 2028. The number of awards, budget periods, and award amounts are contingent upon the continued availability of funds and grantee performance and compliance.

1.5.3 Eligible Organizations/Entities

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

- Federally Qualified Health Center (FQHC)
- FQHC Look-Alike
- Nonprofit organizations
- For-profit organizations providing clinical services within a primary medical health Professional Shortage Area

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.

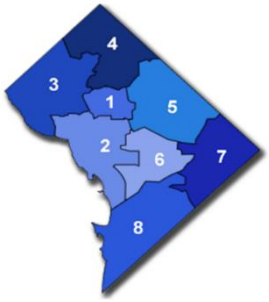
1.5.4 Non-Supplantation

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

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



In terms of race and ethnicity, the District's population is highly diverse—approximately 41% Black/African American, 38% white, and 5% Asian, with Hispanic or Latino residents of any race making up 11% of the population.[4] However, the population is also highly segregated, with significant economic disparities observed by ward and race. For example, Wards 2 and 3 have the highest percentage of white residents and the lowest percentage of Black/African American residents, whereas Wards 7 and 8 have the highest percentage of Black/African American residents and the lowest percentage of white residents. While 2021 District-wide median household income was more than $91,000, median household income in Ward 3 was more than 3.6 times higher than in Ward 8; median household income among white District residents was approximately 1.7 times higher than among Hispanic/Latino residents and 3.1 times higher than among Black/African American residents.[5] In December 2021, District-wide unemployment was 5.8%; however, unemployment in Ward 8, the highest in the District, was more than 4 times higher than in Ward 3, the lowest in the District.[6]

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

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

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

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

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

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

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

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

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

2.2 SEVERE MATERNAL MORBIDITY

Despite having some of the highest healthcare spending globally, rates of maternal mortality and severe maternal morbidity (SMM) in the United States (U.S.) have not improved. Birthing women in the District experience high rates of severe maternal morbidity (SMM).[7] In 2022, the overall rate of SMM for the District was 313.7 per 10,000 deliveries, which has been steadily climbing in the last decade, compared to 203.8 per 100,000 deliveries in 2016.[8] In 2022 the SMM rate in the District was 445.1 per 10,000 deliveries for Black women, compared to 323.3 per 10,000 deliveries in 2019.[9] Figure 1 below illustrates the SMM rate overall and by race in the District. The risk of experiencing an SMM is also disproportionally concentrated in certain geographic areas in the city. In Wards 7 and 8, where many residents are enrolled in public health insurance, residents of just three zip codes face SMM rates 1.5 times higher than those of all other DC zip codes combined[10].

The leading causes of SMM in the District are blood transfusion, eclampsia, acute renal failure, disseminated intravascular coagulation, shock, adult respiratory distress syndrome, pulmonary edema/acute heart-failure, ventilation, hysterectomy, and sepsis. Many of these leading SMM—such as blood transfusion, emergency hysterectomy and shock—often result from uncontrolled bleeding or rupture.

[7] 2019 DC Natality and Mortality Data, Vital Records Division, Center for Policy and Planning Evaluation, DC Department of Health

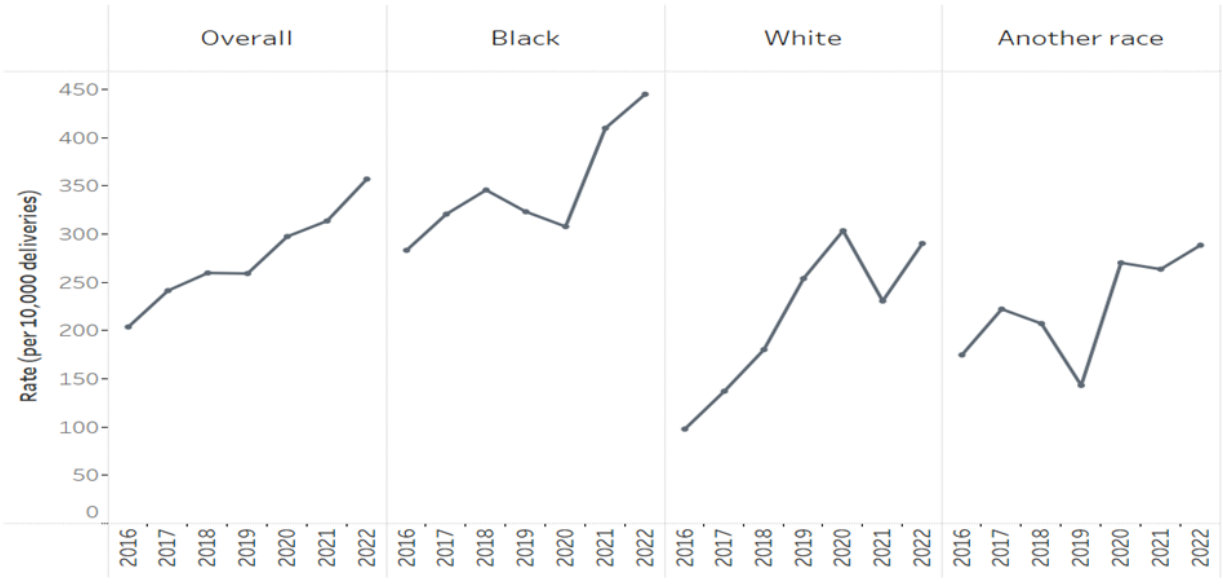
[8] 2016-2021 Inpatient Hospital Discharge Data Files, DC Hospital Association. Compiled by State Health Planning and Development Agency (SHPDA), Center for Policy, Planning and Evaluation, DC Department of Health

[9] DC Hospital Discharge data, 2016-2022

[10] Ibid

Reducing SMM is integral to improving maternal health outcomes. Sociodemographic factors, clinical factors, and access to health care are associated with a significantly higher risk of SMM.

Figure 1. Severe maternal morbidity rate (per 10,000 deliveries) overall and by race, District of Columbia, 2015-2022.



Data Source: DC Hopsital Discharge data, 2016-2022.

2.3 ACCESS TO QUALITY CARE

Clinical preventative care plays a critical role in protecting and promoting individual health and health of communities. Despite the benefits, millions of people in the United States do not receive the recommended services.[11] Given the link between women's reproductive health and SMM rates and adverse birth outcomes, improving access to and utilization of preventive care is critical.

Women face barriers to accessing care, including cost, not having a Primary Care Provider, no or limited providers in their area, and lack of awareness and education about recommended services.[12] In line with the greater SMM burden faced by low-income women and women of color, these groups face barriers such as quality health care, racism, and stress that result in disproportionally poor health outcomes.[13]

[11] Healthy People 2030. Presentative Care. https://health.gov/healthypeople/objectives-and-data/browse-objectives/preventive-care

[12] ibid

[13] Chinn JJ, Martin IK, Redmond N. Health Equity Among Black Women in the United States. J Womens Health (Larchmt). 2021 Feb;30(2):212-219. doi: 10.1089/jwh.2020.8868. Epub 2020 Nov 25. PMID: 33237831; PMCID: PMC8020496

During the prenatal period, prenatal care is a key opportunity for women and birthing persons to access the healthcare system and to receive preventative care services, education, nutritional support, and other social services to improve pregnancy outcomes.[14] However, Black women and birthing persons report inadequate patient provider communication, mistrust in providers, and discrimination.[15]

Quality, patient-centered, affordable, and comprehensive reproductive health care is critical to improving maternal health outcomes, including reducing SMM and addressing the inequities that exist in healthcare access and utilization.

Equity-centered interprofessional practice models utilizing community health workers (CHWs) as trusted community providers can play an essential role in providing women the trusted environment to receive the healthcare services they need. CHWs act as essential entry-level workers who are uniquely qualified because of the life experience and skill-based training. CHWs can provide tailored attention to woman's individual medical history and social needs and connect women to relevant resources.[16] Integrating CHWs into healthcare teams can positively improve outcomes for individuals who are not currently engaged in care.

While the District has made significant strides in recent years in establishing a systems level approach to improve birth outcomes for District residents, innovative and patient-centered approaches are critical to improving maternal health outcomes such as SMM and addressing the inequities that exist in healthcare.

2.3 MATERNAL HEALTH INNOVATION (MHI) FOCUS GROUPS

DC Health in collaboration with Community of Hope and Meta Consulting, LLC conducted focus groups with DC residents and District providers of maternal and reproductive care services. The purpose of the Maternal Health Focus Groups was to explore the lived experiences of DC residents who are pregnant, postpartum, or of child-bearing age as they seek reproductive health care and perinatal care. The goals of the ongoing project are to identify District-specific barriers to care and inform healthcare providers, healthcare insurers, community-based organizations (CBOs), government agencies, and other stakeholders, on strategies to improve access to and continued engagement in care.

The findings of the focus group yielded potential recommendations for quality and process improvements such as increased support services, improved access and transportation, telehealth

[14] Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increase-proportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08
[15] Dahlem CH, Villarruel AM, Ronis DL. African American women and prenatal care: perceptions of patient-provider interaction. West J Nurs Res. 2015 Feb;37(2):217-35. doi: 10.1177/0193945914533747. Epub 2014 May 16. PMID: 24838492; PMCID: PMC4233201.
[16] Straughen JK, Clement J, Schultz L, Alexander G, Hill-Ashford Y, Wisdom K. Community health workers as change agents in improving equity in birth outcomes in Detroit. PLoS One. 2023 Feb 14;18(2):e0281450. doi: 10.1371/journal.pone.0281450. PMID: 36787290; PMCID: PMC9928129

expansion, community-based care options, postpartum care support for birthing people, and strategies to assess quality of birthing center or hospital where birthing person will deliver. Based on the findings of the focus groups, DC residents and providers of maternal and reproductive care services participated in two in-person Experience Based Co-Design sessions.

The goal of these sessions was to develop key requirements for healthcare access hubs in key communities (which aim to reduce barriers to accessing quality healthcare) and inform the applications to this funding opportunity.

During these in-person sessions, residents and providers worked together to identify desired clinical and social support services, in addition to locations where they would feel comfortable receiving care in the community.

2.4 EXPERIENCE BASED CO-DESIGN FINDINGS

District residents and providers participated in two in-person Experienced Based Co-Design sessions designed to use the focus group findings to inform the creation of low barrier access hubs across DC. During the sessions participants had the opportunity to share their thoughts on the findings from the MHI Focus Groups and share any additional thoughts regarding key health priorities, access to care, and locations where they felt safe receiving care outside of the hospital or medical doctors' office.

Participants identified their top five key health priorities:

- Mental Health
- Postpartum Care
- Education
- Father/Partner Support
- Provider Education (Diversity and Empathy)

After top health priorities were identified, participants engaged in small group discussions to design the low barrier access hubs taking the following into consideration:

Access	Staff	Services	Locations
Wait Times On-Site Services Mobile Clinics Home Visiting Options Transportation Resources	Receptionist Community Health Worker (CHW) Certified Nurse Aid (CNA) Medical Assistant (MA) Physicians Doulas	Tangible Social Services • Connection to Resources and Referrals • Wrap Around Services (housing, food, and childcare) Clinical Services	Libraries Community/ Recreations Centers Mobile Clinics Local Pharmacies Childcare Facilities Churches Apartment Buildings

	Social Workers Therapists	• Vitals and Simple Bloodwork • Blood Pressure Monitoring and General Screenings • STI Testing • Contraception • Education (reproductive, prenatal, and postpartum) • Chronic Disease Management	

Participants prioritize a clean, comfortable, and welcoming atmosphere for the low barrier clinics. The clinics must ensure patients receive respectful and culturally competent care. Additionally, participants require they have adequate time to discuss needs and questions, with direct connections to the programs or resources being offered.

While many of the participants recommendations overlapped, the key recommendation was to address the social determinants of health within the hubs and engage fathers in maternal and child health. The participants in the Experienced Based Co- Design sessions shared locations that would increase access to care for birthing people but also their partners.

2.5 PROGRAM INFORMATION

The District of Columbia Department of Health (DC Health) has been awarded The State Maternal Health Innovation Program (MHI) Grant funded by The Health Resources and Services Administration (HRSA). Programing for MHI is strategically in alignment with DC Health's comprehensive approach to innovate with both statewide data and programmatic efforts to address the maternal health crisis. This aim relies on the implementation of the following strategies:

1) Establishment of a Maternal Health Task Force to serve as the overarching body for developing and implementing DC's strategic plans to improve maternal health outcomes
2) Enhancement of examination capability regarding maternal mortality and morbidity cases in the District of Columbia through more robust data collection and surveillance of severe maternal morbidity (SMM) and other perinatal and postnatal risk factors
3) Improvement of maternal health data capacity (data sharing and data linkages)
4) Sustain and scale effective innovative health care delivery model(s) that improve maternal health and/or reduce severe maternal morbidity

Applicants will be implementing an innovative health care delivery model and will be serving as key stakeholders on the established Maternal Health Task Force.

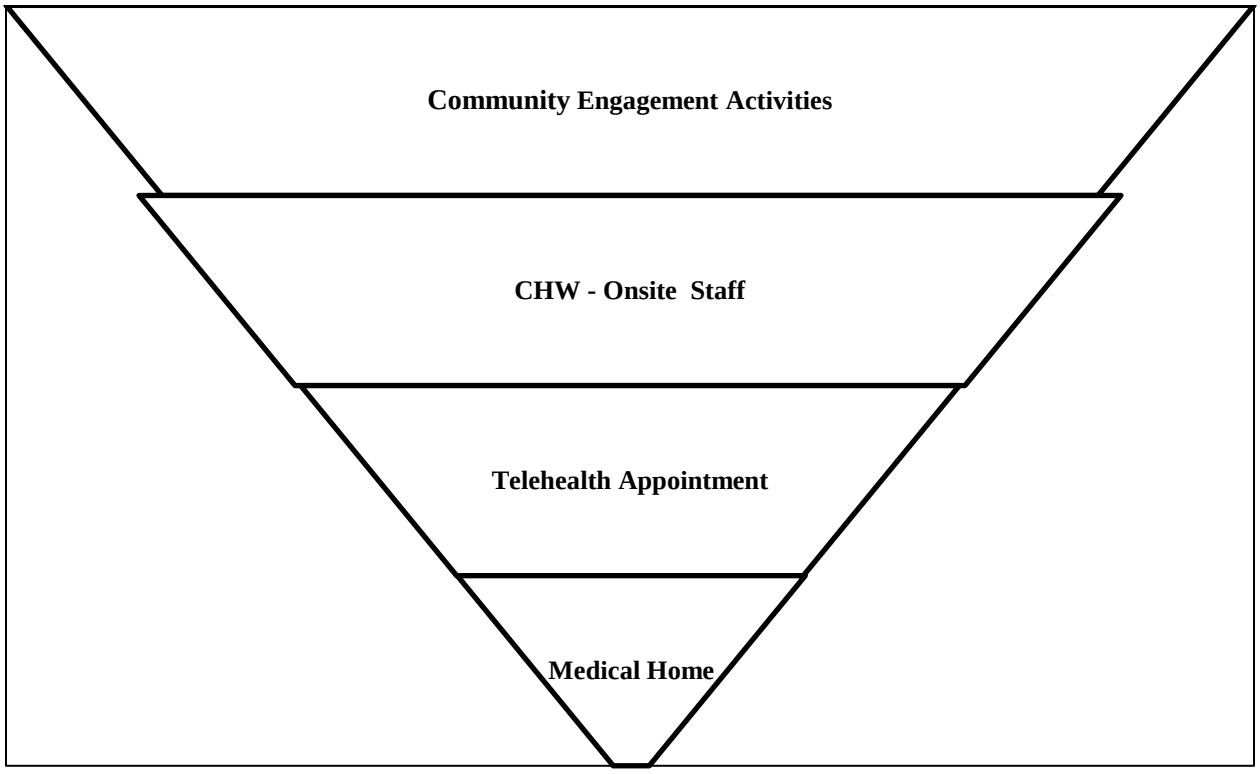
3. PURPOSE

The DC Department of Health (DC Health) Community Health Administration (CHA) is requesting proposals from qualified applicants to pilot healthcare access hubs in the community and assess their impact on preventing and reducing inequities in maternal morbidity and mortality.

3.1 APPROACH

To address inequities and gaps in care, DC Health proposes this funding opportunity to support implementation of a community- informed hub model of care: community health access hub (CHAH). CHAHs shall act as a low-barrier access points in community settings where reproductive age women, birthing people, and their families are already gathering (e.g. local pharmacy, fitness center, church, library).

Evidence-based models highlight the benefit of low-barrier healthcare in convenient locations. Diverse care teams, ranging from community health workers and doulas to mental health therapists, work together to facilitate healthcare access for underserved and vulnerable populations, particularly those not currently engaged in care. These staff, embedded in a primary care team of a Federally Qualified Health Center (FQHC), FQHC Look-Alike, Nonprofit, or For-profit organization providing clinical services within a primary medical health Professional Shortage Area, would be able to deliver care across the following services areas.



Service Area 1 –Community-Based Engagement

Social support is considered a key social determinant of health due to its impact on overall health and well-being. By providing protective resources (e.g. emotional, informational, psychological) in community settings, life stressors are better managed, contributing to increased self-efficacy skills and feelings of empowerment[17]. To support the 1) adoption of health-promoting attitudes and behavior as well as 2) fostering of connections between participants with shared experiences and health goals, the community building service area aims to provide patients with the necessary tools to improve health status across various levels. Applicants shall facilitate group-based activities, in-person and/or online, delivering relevant health promotion knowledge, skills, and resources based on patients' needs. Activities can be conducted by applicant staff.

This engagement strategy, in addition to grantee promotion of the hubs, should lead to increase familiarity with and usage of the hubs for additional services.

Service Area 2 –Onsite Services

In alignment with the Life Course Theory (LCT), a framework that considers the impact of biological, behavioral, psychological, and social environment factors on health outcomes[18], the onsite clinical service area aims to ensure that patients are successfully linked to a medical home with appropriate follow up. Applicants shall utilize closed-loop referral processes to ensure the capture of relevant data (e.g. timely linkage to medical home and follow-up) used to monitor referral impact on health outcomes and identify further opportunities for meeting patient care needs.

Applicants shall assess patient's needs. Based upon patient needs, additional screenings assessing SDOH barriers utilizing screening tools such as (e.g. PRAPARE) would be used to tailor action plans for a patient.

Findings from additional screenings administered should inform and encourage linkage to existing resources in the District such as, but not limited to, the LinkU DMV platform, DC Health's Help Me Grow, and doula services.

On-site healthcare services provided include, but are not limited to, pregnancy test, emergency contraception, vital sign assessments, and health education.

Service Area 3 – Telehealth

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[17] Mo, P. K. H., Wong, E. L. Y., Yeung, N. C. Y., Wong, S. Y. S., Chung, R. Y., Tong, A. C. Y., Ko, C. C. Y., Li, J., & Yeoh, E. (2022). Differential associations among social support, health promoting behaviors, health-related quality of life and subjective well-being in older and younger persons: a structural equation modelling approach. Health and Quality of Life Outcomes, 20(1), 1–12. https://doi.org/10.1186/s12955-022-01931-z

[18] The Life Course Theory | Florida Department of Health. (2021, March 9). Www.floridahealth.gov. https://www.floridahealth.gov/programs-and-services/womens-health/florida-life-course-indicator-report/life-course-theory-1.html

Clients who have had the aforementioned assessment(s) may voice an interest in engaging with medical care or be assessed by hub staff as benefitting from engagement with medical care. Applicants shall provide access to more immediate access to telehealth. and/or facilitate longer-term scheduling of an in-person appointment for linkage to a medical home.

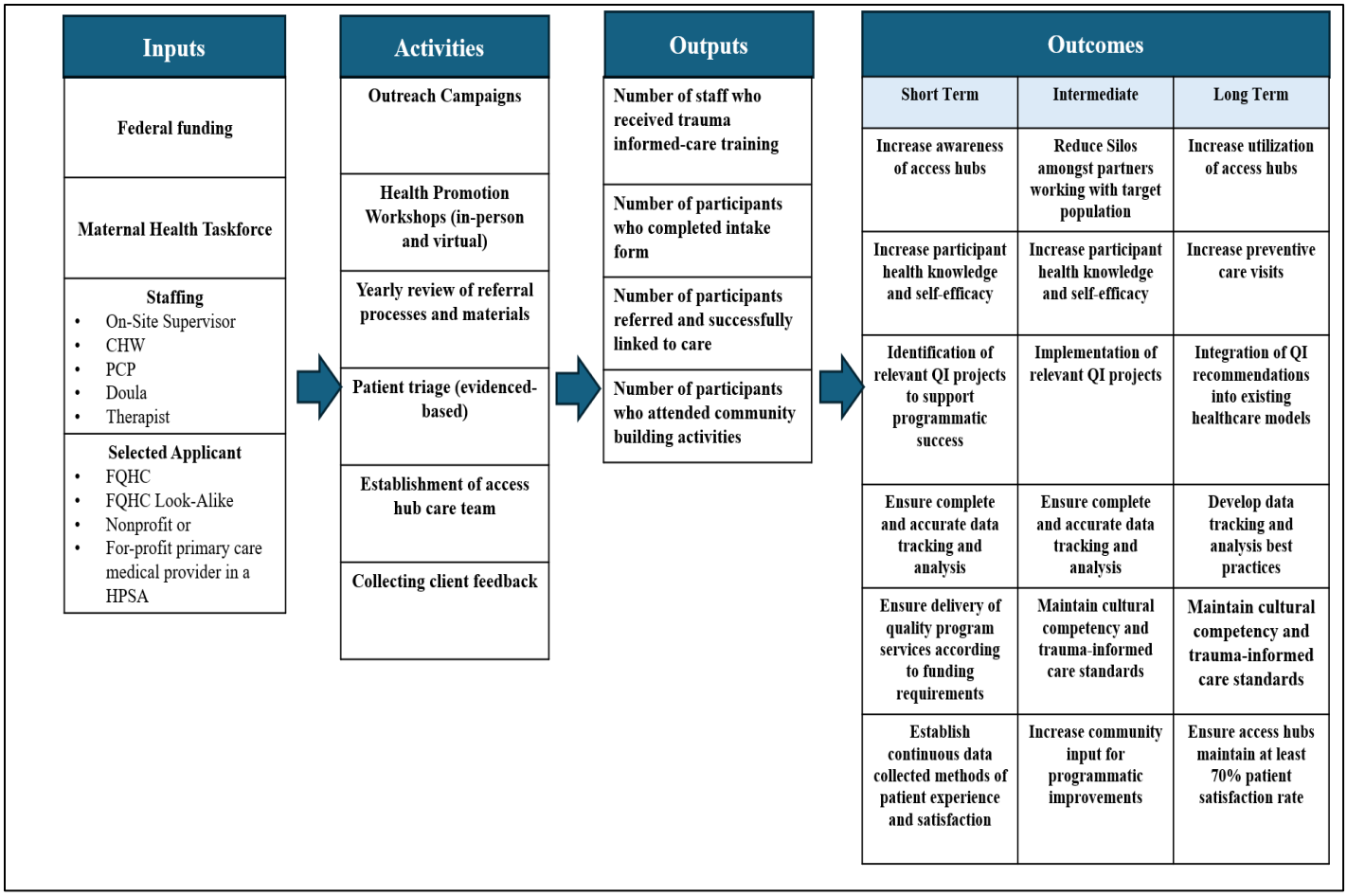
A key differentiation between hubs and traditional brick and mortar clinics is the ease in which a resident could complete paperwork and as medically appropriate (e.g. birthing person, or out of care woman seeking reproductive and preventive care) easily schedule care (through an on-site CHW) and receive care (through telehealth care available within the performance requirements listed in this grant).

Service Area 4 – Linkage to a Medical Home

Applicants shall refer and link clients back to the applicant's organization* for an in-person visit with the applicant's existing care model. As hub staff are part of the applicant organization, hub staff would have access to the applicants EMR and can schedule an appointment for the client. Hub staff would assess client needs to attend the visit (e.g. transportation) and support the client in attending the visit. Hub staff would monitor if the client attended the visit and as appropriate, follow up with non-engaging clients to reassess readiness and interest in engaging in medical care.

*If the client prefers to be referred to another organization for medical care, the applicant shall refer and coordinate (as needed) the scheduling of an initial appointment.

4. PERFORMANCE REQUIREMENTS



Applicants should propose projects that meet the criteria listed below.

4.1 Target Population

Programmatic efforts will target women of reproductive age (18-44 years of age), birthing persons, and their families. Participants with low incomes (e.g. publicly insured with Alliance, DC Medicaid, or Medicare), and not engaged with primary or preventive medical care within the past 12 months should be prioritized.

4.2 Location of Services

Grantees must be located within the District of Columbia. Eligible applicants shall have the capacity to provide clinical services for the target populations mentioned above.

Services location may vary depending on selected strategies.

4.3 Allowable Activities

Staffing

The applicants will have flexibility in utilizing the funds to best meet program objectives, including:

- Protecting key personnel's time to engage in community access hub model (e.g. strategic planning, training, implementation), including
    - One Community Health Worker (CHW) at 100% FTE
        - A frontline public health worker has a unique understanding of the community served. Certified using the CHW model, the CHW will work to establish and maintain trust, serving as a liaison between healthcare/social services and participants. The CHW will facilitate access to services in a high quality culturally competent manner, assisting participants navigating the health care system and supporting linkages to community resources based on social needs. CHW roles may be filled by doulas, nurses, social workers, and other health/human service providers with the goal of improving access to care and reducing SMM rates. NOTE: Applicants may ask for additional requirements of the role in accordance with updated requirements specified by the District.
    - Project Coordinator at 80–100% FTE
        - This key role is responsible for direct staff supervision and oversight of the day- to-day implementation of the program. It is required that the Project Coordinator be solely dedicated to the oversight of only the staff funded by this award and only the activities that are directly funded by this award. The Project Coordinator shall have a minimum education of a bachelor's degree in public health, social work, or a related field. Additionally, the Project Coordinator must have two years of experience in project management and/or process improvement.
    - One Primary Care Provider at 20% FTE
        - Qualified applicants must employ one part-time clinical provider to support access hub participants with telehealth services. The clinical provider must be a Physician, Nurse Practitioner (NP), Physician Assistant (PA) or Nurse Midwife (CNM). The Clinical Provider will have the following responsibilities:
            - Consult on intake for participants to help determine risk and related supports.
            - Conduct telehealth appointments as requested.
            - Provide guidance to the community health worker staff as needed.

Awarded applicant(s) may utilize funding to purchase and provide the following:

Service Area 1: Community-Based Engagement

- Incentives (e.g. gift cards, refreshments) to support program participant engagement.
- Event space and supplies (e.g. tables, chairs, decorations) to facilitate in-person community engagement events.
- Video conferencing subscriptions to facilitate virtual community engagement events.

Service Area 2: Onsite Clinical Services

- Dedicated space to house community access hub location
- Medical devices (e.g. blood pressure cuffs, thermometers) to administer clinical services.
- Medical supplies (e.g. bandages, ice packs, heating packs) to administer clinical services.
- Reproductive health supplies (e.g. pregnancy tests, emergency contraceptives, menstrual products) to deliver reproductive health services.
- Support resources (e.g. vouchers) to assist with transportation and childcare needs.
- Office supplies (e.g. paper, pens, highlighters) for administrative tasks.

Service Area 3: Telehealth

- Technological devices (e.g. tablets, headphones, Wi-Fi hotspots) to deliver telehealth sessions.

4.4 Program Outcomes and Strategies

Grantee(s) 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 implement programmatic strategies in the following areas:

Outcomes

All strategies are required and designed to reduce the prevalence of preterm births, maternal morbidity and mortality over the next four years as indicated:

Measure	Objective	Data Source	Baseline (2019)	Most Recent Data (2022)	Target-General (2026)	Baseline-African-American Women (2019)	Most Recent-African American Women (2022)	Target-African American Women (2026)

Severe Maternal Morbidity	Reduce severe maternal morbidity	Vital Statistics	259.2	313.7	233	323.3	445.1	290
Preterm Births	Reduce preterm births	Vital Statistics	9.8%	10.1% (2021)	9.4%	12.4% (2020)	13.61%	11.4%
Preventative Health Visit (women age 18-44)	Increase preventative health visit in the past 12 months (women age 18-44)	DHCF	54%	61%	70%	-	-	-

Performance indicators will include but not limited to the following:

Service Area 1: Community-Based Engagement

A. Success case: Participants are aware of and utilize the social support network

- Number of community events hosted in a program year
- Percentage of participants interested in social support networks
- Percentage of participants who attend facilitated social support network events that indicated interest during intake/screening
- Number of community partnerships established to deliver community engagement events for participants

Service Area 2: Onsite Clinical Services

A. Success case: Participants are successfully linked to a medical home in timely manner

- % of target population reached
- Number of participants who completed an intake form
- Percentage of high-risk pregnancy and postpartum (within 90 days of birth) participants who have successfully linked to medical home within 48 hours of initial intake
- Percentage of participants who were successfully linked to medical home within 14 days of initial intake
- # of resources distributed

Service Area 3: Telehealth

A. Success case: Timely access to telehealth appointment and scheduling of care post telemedicine session

- Percentage of participants who seek telehealth appointment and are seen within 60 minutes
- Percentage of participants with a scheduled appointment at the conclusion of the telemedicine session

Service Area 4: Linkage to Medical Home

- # of trainings conducted (Maternal Health Early Warning Signs and Symptoms, domestic violence, racial/implicit bias, respectful care, engagement and advocacy)
- % FTE staff

Strategies

- Increase the identification of innovative and effective approaches for improving health outcomes with the goal of promoting dissemination, adoption, and sustainability of these approaches
- Reduce the disparities in health that occur by categories such as gender, race or ethnicity, income and education, disability, neighborhood, or sexual orientation, informed by the target populations identified by the Disparity Impact Statement
- Improve access and utilization of healthcare
- Prevention of severe maternal morbidity
- Prevention of unintended pregnancies
- Access to preconception care services including screening, health promotion, and interventions which enable individuals to achieve high levels of wellness, minimize risks, and enter pregnancy in optimal health, including but not limited to:
    - Increased identification of current substance use, including tobacco and marijuana use and referral to DC Quitline and counseling services
    - Increase referral and enrollment into WIC and other nutritional services
    - Increase referral to chronic disease self-management programs, diabetes

To accomplish the outcomes outlined above, applicants must:

- Develop an organizational capacity, monitoring and evaluation plan
- Participate actively in the Maternal Health Taskforce (MHTF) and Maternal Health Learning Collaborative meetings to engage with other community-based organizations, federally qualified health centers (FQHCs), birthing facilities, and providers to share best practices around building continuous organization capacity to advance reducing maternal morbidity, infant mortality, and address health disparities

- Assist DC Health in the development and implementation of a District-wide Maternal Health Strategic Plan
- Increase staff and structural capacity to improve the timeliness of providing treatment to women of reproductive health age and pregnant and postpartum women before and after delivery
- Provide education, support and outreach services to women after they experience adverse birthing experiences
- Support implementation of Title V needs assessment in the District and utilize findings to develop and implement activities to improve maternal and infant health outcomes
- Develop and submit a success story on the program's impact in the community to advance maternal and infant health and well-being and reduce health disparities; and
- Implement activities from the service areas below.

Applicants shall demonstrate their organizational capacity to implement programmatic strategies in the following areas:

Service Area 1: Community-Based Engagement

Applicants shall facilitate the existence of social support networks that encourage opportunities for connection and support among participants and their families. Applicants should also describe approaches to health promotion via education across various topics.

Key Milestones:

- Year 1:
    - By the end of Year 1 applicants must submit a tentative list of community partners to facilitate community engagement events
- Year 2:
    - By the end of Year 2 applicants must have hosted at least one event (e.g. community fair, webinar, health education workshop) per quarter within the program year
- Year 3:
    - By the end of Year 3 applicants must have hosted at least eight events by the end of the award period
    - By the end of Year 3 applicants must have an established process on collecting community feedback
    - By the end of Year 3 applicants must demonstrate a process to identify and implement quality improvement activities for community-based engagement

Service Area 2: Onsite Clinical Services

<u>Initial Intake</u>

Applicants shall administer applicant designed initial screening. Applicants shall administer on-site healthcare services provided include, but are not limited to, pregnancy test, emergency contraception, primary care screenings, vital sign assessments, and health education.

Screenings

Applicants shall screen participants for risk and refer to the appropriate services if necessary. Applicants shall ensure that staff are appropriately trained to administer, score, and interpret screening tools, communicating assessment results in timely manner. Successful applicant is encouraged use the following screening tools:

- **Patient Health Questionnaire-9 (PHQ-9)** – Validated tool for depression screening, diagnosis, and management.
- **Trauma Event Questionnaire, PCL-5** – Self-report measure that assesses the 20 DSM-5 symptoms of Post-Traumatic Stress Disorder (PTSD).
- **Parents, Partners, Past and Pregnancy Screening tool (4P's)** – Screening tool with four questions intended to facilitate discussion regarding substance use with pregnant women and women of childbearing age.
- **Hurt, Insult, Threaten and Screen (HITS) Screening Tool** – Short screening tool questionnaire that is used to assess risk for Intimate Partner Violence (IPV).
- **Pregnancy Intention Screening Question (PISQ)** – Screening tool used to determine relevant reproductive health services based on patient's desire to become pregnant in the next 12 months.
- **General Health Screening** – Assessment performed via vital signs used to inform triaging of care.
- **PRAPARE** – Standardized patient risk assessment tool designed to engage patients in assessing & addressing social drivers of health (SDOH).

Follow Up Protocol

Applicants shall ensure there is a follow up is made with patients after referral to medical home is successful.

Applicants are encouraged to make the appropriate referrals based on the participant's needs and screening results from the screening tools listed above. Applicants are encouraged to also demonstrate processes for follow-up after referrals are made.

Key Milestones

- Year 1:
  - By the end of Year 1 applicants must have identified and onboarded program staff
  - By the end of Year 1 applicants must have identified and secured access hub location
  - By the end of Year 1 applicants must have purchased onsite supplies mentioned above in allowable activities

        - By the end of Year 1 applicants must have an established intake and linkage to care protocol
    - Year 2:
        - By the end of Year 2 applicants must have administered intake protocol to at least 100 patients
        - By the end of Year 2 applicant must successfully link at least 50 patients to a medical home
    - Year 3:
        - By the end of Year 3 applicants must demonstrate a comprehensive report of access hub services and patient experience
        - By the end of Year 3 applicants must demonstrate a process to identify and implement quality improvement activities for onsite clinical services

Service Area 3: Telehealth

Program/Evaluation Criteria Requirement

- Prioritize high risk patients (e.g. pregnant and postpartum (haven't had a visit within the last 30 days) and/or (within 60-90 minutes)

Patient	Telehealth Appointments	On site Appointments
No care past 30 days, pregnant and/or 90 days postpartum	Within 1 hour	48 hours
No care, not pregnant and/or 90 days postpartum	Same day	14 days

Key Milestones:

- Year 1:
    - By the end of Year 1 applicants must have purchased supplies mentioned above in allowable activities
    - By the end of Year 1 applicants must have established telehealth protocol

Service Area 4: Linkage to Medical Home

Key Milestones:

- Year 1:
    - By the end of Year 1 applicants must have an established protocol for referral and linkages
    - By the end of Year 1 applicants must have established MOUs/MOAs to support referral and linkages to care
- Year 2:

    - By the end of Year 2 applicants must have successfully linked at least 50 patients to a medical home
- Year 3:
    - By the end of Year 3 applicants must demonstrate a comprehensive report of linkages to a medical home, including follow-up and retention of patients
    - By the end of Year 3 applicants must demonstrate a process to identify and implement quality improvement activities for linkages and referrals to care. Applicants must have an established protocol for referral and linkages
    - By the end of Year 1 applicants must have established MOUs/MOAs to support referral and linkages to care

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**, and include the following sections:

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

PROJECT NARRATIVE (Up to 10-page maximum)

The narrative section should provide a detailed description of the proposed project, including project goals and strategies. The narrative section should describe the applicants' approach to establish and/or leverage existing partnerships to address social and environmental needs and barriers impacting health and access to care, utilize CHWs to provide education and linkages to medical homes, and improve health outcomes. Additionally, this section should include how the proposed project will be implemented.

The narrative should include the following sections:

OVERVIEW

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

PROJECT OR POPULATION NEED

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

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

PROJECT DESCRIPTION

This section should provide a clear and concise description of strategies and activities they will use to achieve the project outcomes and should detail how the program will be implemented. Applicants must base their strategies and activities on those described in Sections 3.1 Approach, 4.3 Scope of Services, and 4.4 Program Strategies, above. Describe activities for each strategy, how they will be implemented, and how they will be operationalized to achieve program goals, objectives, and outcomes

<u>Onsite Clinical Services</u>

Evidence-Based Community Health Worker (CHW) Model

- Describe current or prior experience with implementing the CHW model or alternate models, if any, as well as the current capacity to support implementation of the model
    - Applicants who have been implementing the CHW model for more than two years, please provide data on participant outcomes that have resulted from utilization of the appropriate model to date
- Describe the plan for CHW implementation, with fidelity to the model, including a description for the following:
    - the approach to project assessment and support of model fidelity
    - anticipated challenges and risks to maintaining quality and fidelity, and the proposed solutions to address the issues identified
    - any anticipated technical assistance needs
    - any anticipated expansion or model enhancement efforts
- Describe approach for CHW professional development trainings. Include plans for ensuring completion and documentation of the mandatory Maternal Health Warning Signs and Symptoms training within the first year of award period.

Patient Triage and Screenings

- Describe plan for patient triage and general intake process
- Describe prior experience with implementing the abovementioned screening tools or alternate tools, if any, as well as the current capacity to support implementation of the tools

<u>Telehealth</u>

- Describe capacity (e.g. technological, workforce, regulatory) for delivering telehealth services
- Describe clear protocols and strategies for providing care within the following timeframe(s):

Patient	Telehealth Appointments	Onsite Appointments
No care past 30 days, pregnant and/or 90 days postpartum	Within 1 hour	48 hours
No care, not pregnant and/or 90 days postpartum	Same day	14 days

- Encourage CoCM – DHCF (Collaborative Care Model) – Behavioral Health Topic Area

<u>Community Building</u>

  - Describe capacity to implement social support networks among participants and their families
    - Describe activities, current or anticipated, that will foster participant connection
    - Explain how implementation barriers will be identified and addressed in the project
  - Describe plans to incorporate and provide health promotion and education within the hub
    - Explain how barriers to facilitating health promotion activities will be identified and addressed in the project

PARTNERSHIPS

- Describe experience working collaboratively with government agencies, including public housing, labor/employment, education, behavioral health, and maternal and child health to implement community-based programs
- Describe the applicant's experience working with agencies and organizations in other sectors to advance a community or public health goal and achieve improved community health and social outcomes
- Describe plans for establishing a new, or engaging an existing, cross-sector network of partners to support the implementation of the applicant's program
  - As appropriate, identify meaningful support and collaboration with key stakeholders in planning, designing, and implementing all activities, including development of the application
- Describe prior and current experience with promoting/partnership with systems change efforts to improve healthcare access outcomes

PROGRAM STAFFING

- Describe the plan for recruiting, hiring, and retaining appropriate staff for all positions
- Describe the plan to ensure high quality supervision and reflective practice for all project staff
- Describe how and what types of initial and ongoing training and professional development activities will be provided for staff

PERFORMANCE MONITORING

The applicant must propose a plan for collecting and reporting data on participants engaging with the access hub. This section should address the following:

- Minimum qualifications or training requirements of personnel responsible for data management, and the time estimated for data collection-related activities by personnel categories.
- Plans for ensuring the quality of data collection and analysis.
- Plans for data safety and monitoring including privacy of data, and compliance with applicable regulations related to IRB/human subject protections and HIPAA. Training opportunities for all relevant staff on these topics must be included.
- Any anticipated barriers or challenges in the benchmark reporting process (including the data collection and analysis plan) and possible strategies for addressing these challenges.

ORGANIZATIONAL CAPACITY

This section should provide information on the applicant's current mission and structure and scope of current activities; describe how these all contribute to the organization's ability to conduct the program requirements and meet program expectations. Applicants should demonstrate capacity and infrastructure to implement service areas described in Program Strategies with the goal of addressing and reducing health disparities. The applicant should describe the scope of current community engagement and empowerment activities and demonstrate staff capacity to conduct activities as required by this RFA. Applicants should demonstrate the ability to meet performance requirements, follow project deadlines for deliverables, and provide accurate reporting. Applicants should affirm organizational leadership commitment to complete the project as proposed in the work plan.

WORK PLAN

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

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

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

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

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

BUDGET TABLE

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

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

Key Budget Requirements

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

- April 1, 2025- March 31, 2026

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

BUDGET JUSTIFICATION

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

Include the following in the budget justification narrative:

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

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

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

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

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

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

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

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

STAFFING PLAN

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

ORGANIZATIONAL CHART

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

LOGIC MODEL

A logic model 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.

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 Population Need

- The extent to which the applicant provides an overview of their currently served population as relevant to the project, including rates of engagement in medical care before and during pregnancy and corresponding social determinants of health (4 points)
- The extent to which the applicant demonstrates strong understanding of the specific problem(s) and contributing factors to be addressed within the target population (3 points)
- The extent to which the applicant demonstrates a strong understanding of social and systemic factors that impact health and are barriers for the target population to engage with preventive/reproductive and prenatal care (3 points)

CRITERION 2: IMPLEMENTATION

(50 POINTS) – Corresponds to Sections: Project Description, Performance Requirements, Work Plan, and Logic Model

- The extent to which the applicant provides a clear and feasible plan on how the hubs will be staffed and operated, outlining how CHWs will be recruited, trained, supervised, and integrated into the clinical care team (10 points)
- The extent to which the applicant describes a clear and feasible plan for multiple methods to engage the target populations and encouraging their use of the hubs (3 points)

- The extent to which the applicant describes clear plan for how patients seeking medical care will be triaged for timeliness of linkage to medical care (telehealth or in-person appointment) (3 points)
- The extent to which the applicant describes the structure and process for how they will meet timeliness standards for access to telehealth (Service Area 3) (5 points)
- The extent to which the applicant includes evidence-based and/or evidence-informed practice approaches that address reduction of maternal morbidity and mortality, and gaps in outreach efforts within target population (4 points)
- The extent to which the applicant describes clear plan for how CHWs will provide services to patients, including but not limited to projected frequency and duration of contact between CHW and patient after a patient has consented to services (7 points)
- The extent to which the applicant describes how proposed strategies will lead to improved linkage to care (3 points)
- The extent to which the applicant demonstrates how proposed plan provides a foundation for sustainability of efforts beyond the project funding period (5 points)
- The extent to which the applicant's workplan represents a logical and realistic plan of action for timely and successful achievement of objectives that support program goals (6 points)
- The extent to which the applicant's workplan clearly outlines goals and objectives for the project, describing how proposed goals and objectives are SMARTIE (Specific, Measurable, Achievable, Relevant, Time Bound, Inclusive and Equitable) (4 points)

CRITERION 3: EVALUATIVE MEASURES

(10 POINTS) – Corresponds to Sections: Performance Monitoring

- The extent to which the applicant describes clear plan for collecting and reporting quantitative data, including what information will be collected and by whom (e.g., CHW, other staff), minimizing burden on CHWs and patients (5 points)
- The extent to which the applicant describes clear plan for collecting and reporting experiential/qualitative data from residents, including what information will be collected and by whom (e.g., CHW, other staff), minimizing burden on CHWs and patients, and using the data for improvement of service delivery and patient experience. (2 points)
- The extent to which the applicant describes clear plan for how data collected by CHW will be recorded and tracked in patient's electronic health record (EHR) and shared across the care team and used to inform clinical care decisions (2 points)
- The extent to which the applicant describes clear plan for how quantitative and qualitative data will be used to monitor and evaluate ongoing progress toward project goals and objectives and conduct continuous improvement activities (2 points)
- The extent to which the applicant demonstrates capacity to collect and manage large data sets (1 point)

CRITERION 4: ORGANIZATIONAL CAPACITY

(25 POINTS) – Corresponds to Sections: Partnerships, Organizational Capacity

- The extent to which the applicant's personnel have demonstrated qualifications (training and experience) in planning, implementing, and evaluating the launch of new sites or access points for medical care (15 points)
- The extent to which the applicant has experience and past successes working collaboratively with government agencies and non-government organizations from a variety of sectors to implement health and/or public health initiatives aimed to advance a public health goal (2 points)
- The extent to which the applicant demonstrated reach and established relationships within target population (3 points)
- The extent to which the applicant has past experience with Community Health Workers as part of medical teams (3 points)
- The extent to which the applicant established direct relationships with the target population, and established relationships with community-based organizations serving the target population (2 points)

CRITERION 5: SUPPORT REQUESTED

(5 POINTS) – Corresponds to Sections: Budget and Budget Justification

- The extent to which the applicant demonstrates the reasonableness of the proposed budget for the project period in relation to the objectives, the complexity of the activities, and the anticipated results; and the extent to which the applicant demonstrates costs outlined in the budget and required resources section are reasonable given the scope of work. (3 points)
- The extent to which the applicant demonstrates how key personnel have adequate time devoted to the project to achieve project objectives (2 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 (10-page maximum)
    - Budget Table
    - Budget Justification
    - Organization Chart
    - Logic Model
    - Work Plan
    - Risk self-assessment
    - Letters of Support
    - Staffing Plan

9.3 Deadline

Submit your application via EGMS by 3:00 p.m., on the deadline date of January 28, 2025. Applications will **not** be accepted after the deadline.

10. PRE-APPLICATION MEETING

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

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

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

Note that questions will only be accepted in writing. Answers to all questions submitted will be published on a Frequently Asked Questions (FAQ) document onto the District Grants Clearinghouse every three business days. Questions will not be accepted after January 14, 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 funding opportunity shall be used exclusively to pay costs associated with the implementation of the grant. Payment requests will be monitored by DC Health to ensure compliance with the approved budget and work plan.

11.3 CONDITIONS OF AWARD

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

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

4. Utilize performance monitoring and reporting tools developed and approved by DC Health.

11.4 Indirect Cost

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

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

11.6 Vendor Registration in DIFS

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

11.7 Insurance

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

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

11.8 Audits

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

11.9 Nondiscrimination in the Delivery of Services

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

11.10 Quality Assurance

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

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

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

12. GLOSSARY OF TERMS

Health Care Access Hub(s)- a service or provider that aims to make help more accessible and user-friendly by reducing barriers to entry (low-barrier). Access hub sites may include libraries, churches, behavioral health centers, and recreational centers.

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

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

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

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

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

13. ATTACHMENTS

Attachment: Assurances and Certifications

Attachment: Budget Table

Attachment: Budget Justification

Attachment: Work Plan

Attachment: 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.