DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

Community Health Administration

Preventing Avoidable Dental Emergency Department Visits

REQUEST FOR APPLICATIONS

FO# CHA-PADEDV-6.14.24

SUBMISSION DEADLINE:

TUESDAY, JULY 16, 2024, BY 3:00 PM

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

DC DEPARTMENT OF HEALTH

Community Health Administration (CHA)

NOTICE OF FUNDING AVAILABILITY (NOFA)

FO# CHA-PADEDV-6.14.24

Preventing Avoidable Dental Emergency Department Visits

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:	Preventing Avoidable Dental Emergency Department Visits
Funding Opportunity Number:	CHA-PADEDV-6.14.24
DC Health Administrative Unit:	Community Health Administration
DC Health Program Bureau	Health Care Access Bureau
Funding Opportunity Contact:	Deborah Vishnevsky, Oral Health Program Manager PCORFA@dc.gov
Funding Opportunity Description:	The purpose of this funding is to reduce dental-related Low Acuity, Non-Emergent (LANE) use of Emergency Departments (EDs), to improve effective use of dental services, improve patient experience, and improve health outcomes.
Eligible Applicants	• Federally Qualified Health Centers (FQHC) or FQHC Look-a-likes • Nonprofit or for-profit organizations providing clinical services within a dental Health Professional Shortage Areas (HPSA).
Anticipated # of Awards:	1
Anticipated Amount Available:	$150,000
Annual Floor Award Amount:	$130,000
Annual Ceiling Award Amount:	$150,000

Legislative Authorization	42 U.S.C. § 256g FY25 Budget Support Act of 2024
Associated CFDA#	93.236
Associated Federal Award ID#	T1249073
Cost Sharing/Match Required?	Not applicable
RFA Release Date:	June 14, 2024
Letter of Intent Due date:	Not applicable
Application Deadline Date:	July 16, 2024
Application Deadline Time:	3:00 p.m.
Links to Additional Information about this Funding Opportunity	DC Grants Clearinghouse https://communityaffairs.dc.gov/content/community-grant-program#4 DC Health EGMS https://egrantsdchealth.my.site.com/sitesigninpage

Notes:

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

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
  - ☐ Work plan
  - ☐ Risk self-assessment
  - ☐ Logic Model
- ☐ Documents requiring signature have been signed by an organization head or authorized representative of the applicant organization.
- ☐ The applicant needs a Unique Entity Identifier number (UEI#) and an active registration in the System for Award Management to be awarded funds.
- ☐ The project narrative is written on 8½ by 11-inch paper, 1.0 spaced, Arial or Times New Roman font using 12-point type *(11–point font for tables and figures)* with a one-inch margins.
- ☐ The application proposal format conforms to the "Proposal Components" (See section 5.2) listed in the RFA.
- ☐ The proposed budget is complete and complies with the budget forms provided in the RFA. The budget narrative is complete and describes the categories of items proposed.
- ☐ The proposed work plan and other attachments are complete and comply with the forms and format provided in the RFA.
- ☐ Submit your application via EGMS by the application due date and time**. Late applications will not be accepted.**

1. GENERAL INFORMATION

1.1 KEY DATES

- Notice of Funding Announcement Date: **May 31, 2024**
- Request for Application Release Date: **June 14, 2024**
- EGMS Registration Deadline for New Applicants: **July 2, 2024**
- Pre-Application Meeting Date: **visit https://OGMDCHealth.eventbrite.com**
- Application Submission Deadline: **July 16, 2024**
- Anticipated Award Start Date: **Sept 1, 2024**

1.2 OVERVIEW

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

The Community Health Administration works to prevent the leading causes of death, protect and promote the health of mothers and children and eliminate racial and ethnic health disparities in health. CHA focuses on nutrition and physical activity promotion; cancer and chronic disease prevention and control; access to quality primary health care services; and the health of families across the lifespan. CHA's approach targets the multiple factors that influence health through evidence-based programs, policies and systems change.

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

The Oral Health Program (OHP) assesses and promotes oral health across the District of Columbia with an emphasis on access to comprehensive oral health services for all residents through a dental home. The Program prioritizes systems level changes to make improvements in equitable access and use of dental care.

1.3 PURPOSE

The purpose of this funding is to reduce dental-related Low Acuity, Non-Emergent (LANE) use of Emergency Departments (EDs), to ultimately improve use of the right dental care at the right place, as well as improve resident experience and health outcomes.

1.4 Source of Grant Funding

Funding is anticipated to be available using federal and local dollars.

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. § 256g, NOFO # HRSA-22-050, Grants to States to Support Oral Health Workforce Activities, and FAIN# T1249073).

1.5 Award Information

1.5.1 Amount of Funding Available

The funding amount of $150,000 is anticipated for one (1) award for the initial budget period.

The total funding amount of $200,000 is anticipated across the project period.

1.5.2 Period of Performance and Funding Availability

The first budget period of this award is anticipated to begin on September 1, 2024, and to continue through August 31, 2025. After the first budget period, there will be a second budget period of three (3) months for a total project period of September 1, 2025 – November 30, 2025.

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 Centers or Look-Alikes
- Non-profit or for-profit organizations in dental Health Professional Shortage Areas (HPSAs)

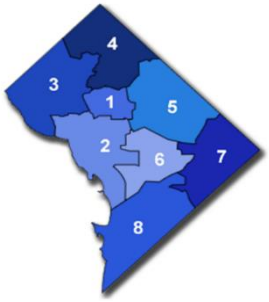
Considered for funding shall be organizations meeting the above eligibility criteria and having documentation of providing health services to the target populations.

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]

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[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 ED Utilization for "Preventable Care"

The term Low Acuity, Non-Emergent (LANE) refers to analysis of care received in emergency care settings which is avoidable, preventable, and/or "inappropriate" for the urgency or type of care necessary.

Research shows a correlation between nonurgent ED visits and a lack of primary care provider relationship,[7,8] dissatisfaction in a primary care provider relationship,[9] differing perspectives on the urgency of their health condition,[10] and timing and access issues.[11] "Access" involves being able to utilize necessary healthcare, at a physical location, from a healthcare provider who the patient feels comfortable with.[12,13]

[7] Afilalo, J., Marinovich, A., Afilalo, M., Colacone, A., Leger, R., Unger, B., & Giguere, C. (2004). Nonurgent emergency department patient characteristics and barriers to primary care. Academic emergency medicine, 11(12), 1302-1310.Available at https://onlinelibrary.wiley.com/doi/abs/10.1197/j.aem.2004.08.032

[8] Petersen LA, Burstin HR, O'Neil AC, Orav EJ, Brennan TA. Nonurgent emergency department visits: the effect of having a regular doctor. Med Care. 1998 Aug;36(8):1249-55. doi: 10.1097/00005650-199808000-00012. PMID: 9708596.

[9] Ware, John; Davis, Allyson. Behavioral consequences of consumer dissatisfaction with medical care, Evaluation and Program Planning, Volume 6, Issues 3–4, 1983, Pages 291-297, ISSN 0149-7189, Available at: https://doi.org/10.1016/0149-7189(83)90009-5.

[10] Gill JM, Riley AW. Nonurgent use of hospital emergency departments: urgency from the patient's perspective. J Fam Pract. 1996 May;42(5):491-6. PMID: 8642367.

[11] Panahpour Eslami, N., Nguyen, J., Navarro, L. et al. Factors associated with low-acuity hospital admissions in a public safety-net setting: a cross-sectional study. BMC Health Serv Res 20, 775 (2020). https://doi.org/10.1186/s12913-020-05456-3

[12] McLaughlin CG, Wyszewianski L. Access to care: remembering old lessons. Health Serv Res. 2002 Dec;37(6):1441-3. doi: 10.1111/1475-6773.12171. PMID: 12546280; PMCID: PMC1464050.

[13] National Healthcare Quality Report, 2013 [Internet]. Chapter 10: Access to Healthcare. Rockville: Agency for Healthcare Research and Quality; 2014. Available from: http://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/access.html.

When patients seek care in an ED that may be better served in primary/dental care or urgent care settings, this can result in increased cost of care, ED crowding, reduced quality of care, and, as a result of the combination of these outcomes, negative perceptions of ED care.[14]

2.3 Dental Care in Emergency Departments

In 2018, there were more than two million dental-related ED visits in the US.[15] Nontraumatic dental visits are estimated to represent approximately 2% of all ED visits.[16] These visits are often avoidable[17] and costly, with estimates at over $2 billion annually.[18]

According to the Community Health Administration Framework for Improving District Health, in 2019, there were 834 uses of the ED per 100,000 residents of the District; DC Health's goal is to reduce this by 25% to 666 per 100,00 residents by 2026.[19]

Most EDs are not equipped to provide comprehensive dental care,[20,21] with treatment of dental issues in the ED often limited to pain and infection management through analgesics and antibiotics.[22] However, many of the dental issues with which patients present in the ED are better treated, and potentially prevented, in a dental home. Many dental conditions including caries, pulpal lesions, and gingival or periodontal conditions can be treated in a dental office and when these conditions are treated in a hospital setting the care may be less effective and inefficient.[23]

In the 2018 study cited above, nearly 95% of visits resulted in same-day release; the majority of such "treat-and-release" ED visits were for three condition types: loss of teeth and similar disorders, diseases of pulp and periapical tissues, and dental caries.[24,25] Conditions like these generally require follow-up care beyond initial relief of pain and discomfort.

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[14] Moskop, J. Nonurgent Care in the Emergency Department: Bane or Boon? Virtual Mentor. 2010;12(6):476-482. doi: 10.1001/virtualmentor.2010.12.6.pfor1-1006.

[15] Owens PL, Manski RJ, Weiss AJ. Emergency Department Visits Involving Dental Conditions, 2018. 2021 Aug 19. In: Healthcare Cost and Utilization Project (HCUP) Statistical Briefs [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2006 Feb-. Statistical Brief #280. Available from: https://www.ncbi.nlm.nih.gov/books/NBK574495/

[16] Akinlotan, MA, Ferdinand, AO. Emergency department visits for nontraumatic dental conditions: a systematic literature review. J Public Health Dent. 2020; 80: 313–326. https://doi.org/10.1111/jphd.12386

[17] Renee Y Hsia, Matthew Niedzwiecki, Avoidable emergency department visits: a starting point, International Journal for Quality in Health Care, Volume 29, Issue 5, October 2017, Pages 642–645, https://doi.org/10.1093/intqhc/mzx081

[18] American Dental Association Health Policy Institute. Emergency Department Visits for Dental Conditions – A Snapshot. April 2020.Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/community-initiatives/action-for-dental-health/emergency-department-referrals/ed_referral_hpi_infographic.pdf

[19] DC Health. Framework for Improving Community Health.2022. Available from: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/Framework%20for%20Improving%20Community%20Health_r10.pdf

[20] Hsia and Niedzwiecki, Avoidable emergency department visits. 2017.

[21] Davis EE, Deinard AS, Maiga EW. Doctor, my tooth hurts: the costs of incomplete dental care in the emergency room. J Public Health Dent. 2010;70(3):205–210. Available at https://pubmed.ncbi.nlm.nih.gov/20337900

[22] Akinlotan and Ferdinand. Emergency department visits for nontraumatic dental conditions. 2020.

[23] Preventable Emergency Department Visits. Chartbook on Care Coordination. Content last reviewed June 2018. Agency for Healthcare Research and Quality, Rockville, MD. Available at https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html

[24] Owens et al.. Emergency Department Visits Involving Dental Conditions. 2021

[25] Akinlotan and Ferdinand. Emergency department visits for nontraumatic dental conditions. 2020.

These issues do not happen in a vacuum; barriers to receiving preventive dental care include affordability,[26,27] lack of provider options, transportation challenges,[28] and previous negative dental experiences.[29,30]

Most troublingly, the populations most likely to visit the ED for dental issues include young adults, individuals enrolled in Medicaid or those with no health insurance coverage, children with special needs, and individuals with low socioeconomic status and chronic health conditions.[31,32]

While research about redirecting low acuity patients seeking emergency care has seen mixed results,[33] the overuse of EDs for non-emergent dental issues, existing gaps in dental care available in most EDs,[34] and an array of barriers to accessing to dental care, highlight a clear opportunity to better support these patients.

2.4 District Resident Experiences and LANE ED Utilization Trends

In 2023, DC Health's Primary Care Office conducted focus groups with residents assessing their attitudes and experiences about primary medical and dental care. Residents consistently mentioned oral health concerns but also noted a dearth of local providers willing to provide necessary care under their coverage plans. As one participant shared, "*It is hard finding a dentist [in your area]. That's the problem. Especially on Medicaid*."

According to the 2022 Inpatient and Outpatient Hospital Discharge Data shared by the DC Hospital Association and compiled and analyzed by DC Health, in 2022 there were

[26] Gupta N, Vujicic M. Barriers to dental care are financial among adults of all income levels. Health Policy Institute Research Brief. American Dental Association. April 2019. Available from: https://www.ada.org/-/media/project/adaorganization/ada/ada-org/files/resources/research/hpi/hpibrief_0419_1.pdf.
[27] Vujicic M, Buchmueller T, Klein R. Dental Care Presents The Highest Level Of Financial Barriers, Compared To Other Types Of Health Care Services. Health Aff (Millwood). 2016 Dec 1;35(12):2176-2182. doi: 10.1377/hlthaff.2016.0800. PMID: 27920304
[28] Mahyar Mofidi, R. Gary Rozier, Rebecca S. King, "Problems With Access to Dental Care for Medicaid-Insured Children: What Caregivers Think", American Journal of Public Health 92, no. 1 (January 1, 2002): pp. 53-58. Available at https://doi.org/10.2105/AJPH.92.1.53
[29] Rajeev A, Patthi B, Janakiram C, Singla A, Malhi R, Kumari M. Influence of the previous dental visit experience in seeking dental care among young adults. J Family Med Prim Care. 2020 Feb 28;9(2):609-613. doi: 10.4103/jfmpc.jfmpc_1109_19. PMID: 32318390; PMCID: PMC7114027.
[30] Calladine H, Currie CC, Penlington C. A survey of patients' concerns about visiting the dentist and how dentists can help. J Oral Rehabil. 2022 Apr;49(4):414-421. doi: 10.1111/joor.13305. Epub 2022 Jan 22. PMID: 35032077; PMCID: PMC9306701.
[31] Sun BC, Chi DL, Schwarz E, Milgrom P, Yagapen A, Malveau S, Chen Z, Chan B, Danner S, Owen E, Morton V, Lowe RA. Emergency department visits for nontraumatic dental problems: a mixed-methods study. Am J Public Health. 2015 May;105(5):947-55. doi: 10.2105/AJPH.2014.302398. Epub 2015 Mar 19. PMID: 25790415; PMCID: PMC4386544.
[32] Amen, Troy B.; Kim, Inkyu; Peters, Gregory; Gutiérrez-Sacristán, Alba; Palmer, Nathan; Simon, Lisa. Emergency department visits for dental problems among adults with private dental insurance: A national observational study, The American Journal of Emergency Medicine, Volume 44, 2021, Pages 166-170, ISSN 0735-6757, Available from: https://doi.org/10.1016/j.ajem.2021.02.001
[33] Kirkland SW, Soleimani A, Rowe BH, Newton AS. A systematic review examining the impact of redirecting low-acuity patients seeking emergency department care: is the juice worth the squeeze? Emerg Med J. 2019 Feb;36(2):97-106. doi: 10.1136/emermed-2017-207045. Epub 2018 Dec 3. PMID: 30510034.
[34] Hsia and Niedzwiecki, Avoidable emergency department visits. 2017.

approximately 2,616 emergency visits that can be categorized as dental LANE ED visits for an average rate of 389 visits per 100,000 residents of the District of Columbia.[35]

These data are broken down as follows:

Gender	Rate of Dental LANE ED visits (per 100,000 residents)
Male	397
Female	382

Ethnicity	Rate of Dental LANE ED visits (per 100,000 residents)
Non-Hispanic	418
Hispanic	166

Race	Rate of Dental LANE ED visits (per 100,000 residents)
Asian	25
American Indian	224
Black	813
White	33

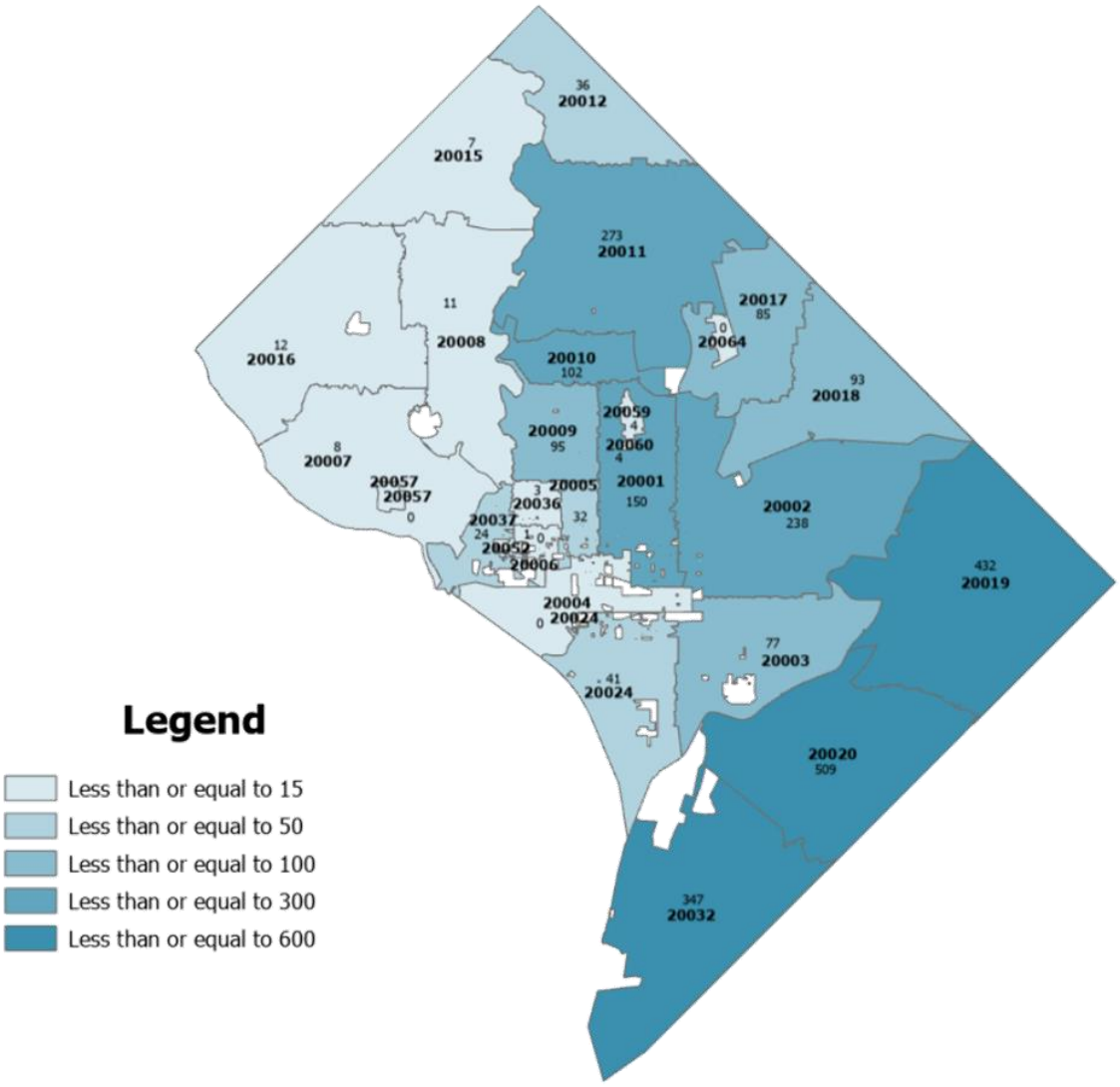
Age	Rate of Dental LANE ED visits (per 100,000 residents)
0 years -19 years	243
20 years – 65 years	480
66 years +	161

Day of the week	Percentage of Dental ED Visits	Percentage of Dental LANE ED visits
Sunday	13.2%	15.4%
Monday	15.1%	13.7%
Tuesday	15.2%	13.7%
Wednesday	14.8%	12.6%
Thursday	14.4%	13.2%
Friday	14.1%	14.1%
Saturday	13.2%	17.4%

Source of Coverage	Dental LANE ED visits

[35] Data Source: 2022 Inpatient and Outpatient Hospital Discharge Data, DC Hospital Association. Compiled by: Data Management and Analysis Division (DMAD)/State Health Planning and Development Agency (SHPDA), Center for Policy, Planning and Evaluation (CPPE), DC Department of Health (DC Health)

Medicaid	1,717
Commercial Insurance	454
Medicare	221
“Self-pay”	150
Other (Medicaid from another state, Medicaid pending, Military, Charity, Unknown, etc.)	74



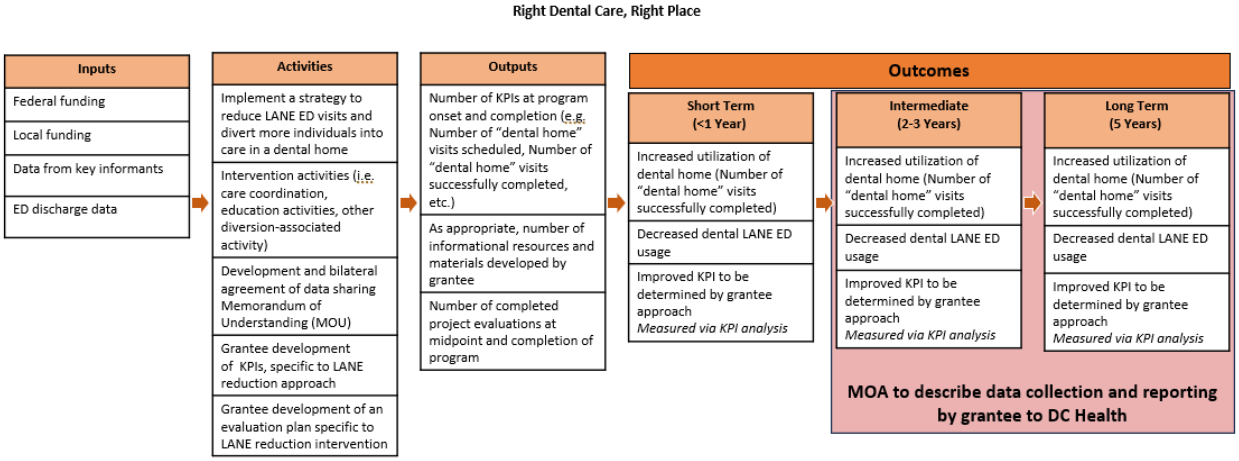
In sum, almost 50% of dental LANE ED visits were attributed to zip codes east of the Anacostia River (20019, 20020, and 20032). The average dental LANE ED utilization for each of these zip codes is twice as much as their relative resident population in the city.

3. PURPOSE

The purpose of this funding is to reduce dental-related Low Acuity, Non-Emergent (LANE) use of Emergency Departments (EDs), to ultimately improve use of the right dental care at the right place as well as improve resident experience and health outcomes.

3.1 APPROACH

Grantee shall focus on reducing dental-related Low Acuity, Non-Emergent (LANE) use of Emergency Departments (EDs), by implementing a targeted strategy to address concerns and/or needs of their local community. The grantee should build on findings, trends, and recommendations included in section 2 (Background) of this RFA, as well as observations from their own organization, to inform their strategy.



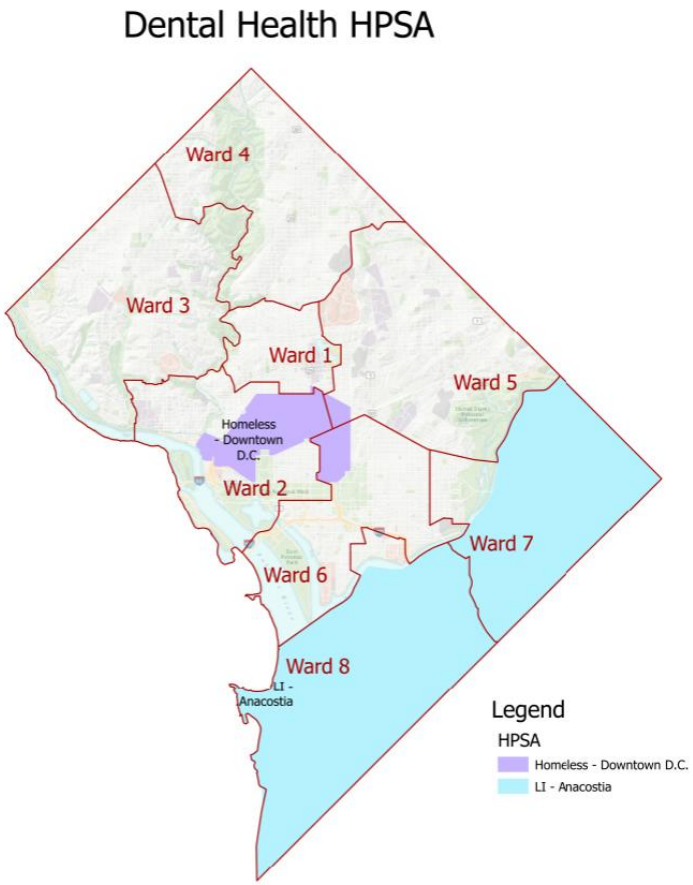
4. PERFORMANCE REQUIREMENTS

Applicants should propose projects that meet the criteria listed below.

4.1 TARGET POPULATION

Grantees shall provide services to communities that live in a dental Health Professional Shortage Areas (HPSAs) or seek care in dental HPSAs, Federally Qualified Health Centers (FQHCs), and FQHC Look-Alikes. FQHC Look-A-Likes are community-based health care providers that meet the requirements of the HRSA Health Center Program, but don't receive Health Center Program funding. As of 2022, the District of Columbia's dental HPSAs include areas east of the Anacostia River and a downtown HPSA responding to the needs of residents experiencing homelessness. For more information on definitions of these terms, please visit the Health Resources and Services Administration at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation. Organizations can confirm whether they are located in a HPSA by

looking up their address in the HRSA Shortage Area website: https://data.hrsa.gov/tools/shortage-area/by-address.



4.2 Location of Services

Grantees must deliver services within the District of Columbia in a dental HPSA (as defined above) or be an FQHC or an FQHC Look-Alike.

Depending on the nature of program activities, staff may be able to participate from other locations (for example, if the proposed activity is a virtual meeting or outreach program, organizations may determine whether employees can participate from their homes or another location). In-person activities should take place in the District of Columbia.

4.3 Allowable Activities

The grantee will have flexibility in utilizing the funds to best meet program objectives, including but not limited to:

- community educational initiatives, including promotion of dental homes;
- care coordination initiatives, including implementing Community Dental Health Coordinator models;

- expanding services hours/locations to increase access; or
- establishment of dental provider coordination services (including at an ED).

Proposals should include a clear description of the specific concerns to be addressed as well as descriptions of the intervention and how it will engage those concerns.

4.4 Program Strategies

Grantee shall employ strategies and implement activities in the service areas outlined in this section.

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

Service Area 1: Oral Health Services and Delivery System:

Key Performance Indicators:

Due to the broad nature of potential grantees, applicants are asked to select one KPI from section A that best suits their organization and approach.

A. Decreased dental utilization in the Emergency Department

- Percentage of visits at the emergency department that are for preventable dental conditions, out of total dental emergency department visits
- Percentage of visits at the emergency department that are for preventable dental conditions, out of total dental emergency department visit for the panel of patients served by the applicant

Service Area 2: Project-Specific Key Performance Indicators (KPIs):

Due to the broad nature of potential interventions, applicants are asked to develop KPIs relevant to the scope of activities and anticipated outcomes in their proposed approach. In addition to providing a focus for strategic improvement, these KPIs will serve as the analytical basis to determine the efficacy of the intervention. KPIs should include measurement of care coordination and linkage to a dental home, specific to the intervention. For example, an applicant proposing to divert residents from the ED may propose a KPI on residents who present to the ED for a LANE ED reason and are seen by a dental home within 24 hours; an applicant proposing to provide increased education and access to services may propose a KPI on residents who avoided an ED visit and were seen by a dental home within 72 hours.

For more information about KPI development expectations in proposals, please see section 5.2 Proposal Components.

Service Area 3: Data Collection, Reporting, and Evaluation

Grantees shall complete regular data reporting on project-specific KPIs. Proposals should address how data will be collected, plans for analysis, and systems in place to report those updates to DC Health in a timely manner.

In addition, in conjunction with DC Health, grantees shall develop and implement an evaluation plan intended to measure the impact of the selected intervention on workforce satisfaction and retention. Evaluations shall take place midway through the grant cycle and upon project completion.

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 including evidence or rationale behind approach.

PROJECT NARRATIVE (10-page maximum)

The narrative section should describe the applicant's approach to reducing dental-related Low Acuity, Non-Emergent (LANE) use of Emergency Departments (EDs), including describing concerns, potential root causes, and intentions and evidence informing their approach.

The narrative should include the following sections:

OVERVIEW

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

PROJECT OR POPULATION NEED

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

- Provide an overview of constituent population as relevant to the project, including rates of oral health concerns; as relevant, dental ED visits at your organization; 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.

- Describe activities, how they will be implemented, and how they will be operationalized to achieve program goals, objectives, and outcomes.
- If intervention is only targeting a subset of the community served by your organization, describe how that approach was selected and why targeted community members were selected.
- Describe short and long-term intended outcomes, including outcomes for individuals targeted in the intervention, the community, your organization, etc.
- Describe how proposed plan provides a foundation for sustainability of efforts beyond the project funding period

PARTNERSHIPS

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

EVIDENCE

This section should provide a clear description of how the proposed program is an evidence-based intervention to improve workforce recruitment and retention.

- Describe the evidence basis of your proposed approach including listing any relevant research studies and their "evidence level" based on the table below.
- Describe why this strategy is appropriate for your organization or any plans for special considerations or deviations from the approach described in the research.
- As applicable, describe any plans for building on this evidence including continued data collection past the project period, collaboration with research partners, or plans for potential publication.

Applicants should follow the below guidance in categorizing the evidence basis for their program:

Evidence Level	**Evidence Details/Study Design**
Level 1	Your program has a measurable objective but there is no evidence or root cause analysis

Level 2	Your program has a detailed rationale including a logic model and a root cause analysis
Level 3	Your approach is based on research with an implementation study to (e.g., observational study, survey) demonstrating evidence of program effectiveness or your approach is based on a correlational (or non-experimental) research design demonstrating improvement for program participants over time on one or more intended outcomes
Level 4	Your approach is based on quasi-experimental research comparing outcomes between a group receiving an intervention and a matched comparison group demonstrating evidence of program effectiveness (this may include studies like difference in differences, nonequivalent control groups, regression discontinuity)
Level 5	Your approach is based on results from randomized controlled trial(s) (RCTs) demonstrating evidence of program effectiveness

PERFORMANCE MONITORING

This section should describe applicant's plan for collecting and reporting data.

- Describe what information will be collected, at what frequency, and by whom.
- Describe plans for how data will be recorded and analyzed.
- Describe plans for how data will be used to conduct ongoing evaluation and continuous improvement activities.
- Describe plans for how data will be reported to DC Health in a timely manner.

Key Performance Indicators (KPIs)

Proposals should include a list of KPIs relevant to the scope of activities and anticipated outcomes of the proposal. These KPIs will serve as the analytical basis to determine the efficacy of the intervention.

KPIs should be the quantifiable indicators of progress toward an intended outcome. To that end, applicants should propose indicators that include process measures (measures of activities performed) as well as outcome measures (measures of final products or results). For example, if applicants propose a targeted educational program for their oral workforce, KPIs might include number of people who have completed training programs and average scores on assessments of comprehension, as well as measures that would be impacted by skills gained, like the rate of completion of certain tasks (i.e. patient intake or specific billing activities), the rate of occurrence of an activity or event (i.e. rate of healthcare-associated infections), or some other indicator of change (i.e. percentage of patients experiencing an outcome, percentage of staff members experiencing an outcome).

Along with defining KPI measures, proposals should outline when KPIs will be recorded, any internal quality control and review measures, and processes in place to ensure timely and secure delivery of those periodic reports.

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.

LOGIC MODEL (2-page maximum)

The logic model should demonstrate how contributing resources lead to short-term and long-term results. The logic model should detail key elements including inputs, activities, outputs, and outcomes of the proposed project and may be presented in a logic model chart or in a narrative format.

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:

- September 1, 2024 – August 31, 2025

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

BUDGET JUSTIFICATION

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

Include the following in the budget justification narrative:

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

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

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

hourly rate, and the number of hours of expected effort. Applicants must have a written plan in place for subrecipient monitoring and must actively monitor subrecipients.

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

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

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

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

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

ORGANIZATIONAL CHART

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

RISK SELF-ASSESSMENT

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

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 five review criteria are outlined below with specific detail and scoring points; points listed represent the maximum available points for each criterion, with potential scores ranging from 0 to the indicated maximum, unless otherwise noted with an asterisk.

These criteria are the basis upon which the reviewers will evaluate the application. The entire proposal will be considered during objective review:

- Strength of the evidence of root cause they have identified (e.g. what national or local data)
- Strength of intervention they propose to do (for example, clearly demonstrating that a training program on billing and coding improves organizational health, which improves overall employee wellness)
- Demonstrates ability to effectively implement proposed intervention

CRITERION 1: NEED

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

Applicant briefly and clearly describes the purpose of the proposed project; describes how the proposed project aligns with the RFA; summarizes the overarching problem to be addressed and contributing factors; and clearly defines project goal(s) and provides strong evidence, supported by internal/organizational quantitative and/or qualitative data, that goal(s) can be achieved.	**4**
Applicant clearly defines the population targeted for the proposed intervention, the rationale for choosing that population, the concerns/challenges and contributing factors to be addressed by the proposed intervention and is supported by internal/organizational quantitative and/or qualitative data relevant to the project (e.g., ED and preventive care utilization rates, indicators of patient/community concerns, and descriptions of root causes and/or contributing factors).	**6**

CRITERION 2: IMPLEMENTATION

(42 POINTS) – Corresponds to Sections: Project Description, Evidence, Logic Model, and Work Plan

The proposed project responds to the specific needs and/or barriers outlined in the Project or Population Need.	**5**
The applicant's Logic Model includes a comprehensive list of inputs, activities, outputs generated by project, and short and long-term outcomes anticipated for residents targeted by the intervention, the organization overall, and/or patients.	**6**
The applicant describes the evidence base for the proposed program/intervention (including references to existing research, a detailed logic model, and/or a root cause analysis), a clear understanding of the proposed strategy and why it is appropriate for the applicant's organization; and as needed, describes any plans for special considerations or deviations from the approach described in the research.	**5**
The applicant provides a list of relevant research studies and their "evidence level" (based on the table in 5.2 *Proposal Components,* in the *Project Narrative* section under *Evidence,* pg. 22 of this RFA); points will be awarded based on the strength of the evidence for the proposed intervention, as follows:	**4**

○ Level 1 (or no evidence provided): 0 ○ Level 2: 1 point ○ Level 3: 2 points ○ Level 4: 3 points ○ Level 5: 4 points	
The applicant lays out a clear, reasonable, and feasible plan for continued data collection and/or dissemination of findings such as describing formal plans for continued measurement and recording of KPIs, efforts to compile and share findings, plans to author and publish research, etc.	**5**
The applicant's workplan: • represents a logical and realistic plan of action for timely and successful achievement of objectives and specifically details how their intervention will address ED utilization; • clearly outlines goals, milestones, and objectives for the project, including description of how the proposed goals, milestones, and objectives are SMARTIE (Specific, Measurable, Achievable, Relevant, Time Bound, Inclusive, and Equitable); and • includes a detailed chronological list and description of activities to be performed for each key objective, identifying responsible staff, target completion dates, and projected outcomes for each activity.	**12**
The applicant describes realistic efforts for sustainability beyond project funding period such as potential new funding sources, modifying current processes, and/or strategic saving and sharing of resources gleaned from project activities.	**5**

CRITERION 3: EVALUATIVE MEASURES

(23 POINTS) – Corresponds to Sections: Performance Monitoring

The applicant describes a clear, reasonable, and feasible plan for collecting and reporting data, including: • what information will be collected, at what frequency, and by whom; • how data will be recorded and analyzed; • how data will be used to conduct ongoing evaluation and continuous improvement activities; and • how data will be reported to DC Health in a timely manner.	**8**
The applicant specifies appropriate infrastructure/staffing in place to adequately support evaluation activities.	**5**
The applicant proposes a detailed list of KPIs (i.e., quantifiable indicators of progress toward an intended outcome) that are relevant to the scope of proposed	**5**

activities (i.e., process measures) and anticipated outcomes (i.e., outcome measures).	
The applicant proposes reasonable, feasible, and competitive targets for each proposed KPI.	**5**

CRITERION 4: CAPACITY

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

Applicant describes the organization's current mission and scope of current activities and effectively demonstrates how grant activities align with current organizational mission and activities.	**5**
Applicant describes organizational infrastructure including staffing model, current staff, and available technology; and effectively describes how they support effective implementation (or development and implementation) of the project activities.	**7**
Applicant describes organization's data infrastructure and clearly demonstrates it is sufficient to support grant activities.	**3**

CRITERION 5: PROJECT BUDGET AND JUSTIFICATION

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

The estimated costs for the proposed project are competitive and clearly justified.	**5**
The applicant's proposed budget and budget justification are aligned with the project description.	**5**

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 – single spaced, size 12 Times New Roman)
    - Budget Table
    - Budget Justification
    - Organization Chart
    - Work Plan
    - Risk self-assessment
    - Logic Model

9.3 Deadline

Submit your application via EGMS by 3:00 p.m., on the deadline date of July 16, 2024. Applications will **not** be accepted after the deadline.

10. PRE-APPLICATION MEETING

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

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

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

Note that questions will only be accepted in writing. Answers to all questions submitted will be published on a Frequently Asked Questions (FAQ) document onto the District Grants Clearinghouse every three business days. Questions will not be accepted after July 9, 2024.

11. GRANTEE REQUIREMENTS

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

11.1 GRANT TERMS & CONDITIONS

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

11.2 GRANT USES

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

11.3 CONDITIONS OF AWARD

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

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

4. Utilize performance monitoring and reporting tools developed and approved by DC Health.
5. Complete an MOA with DC Health for the grantee to share data on Key Performance Indicators as articulated in this RFA and designed by the grantee, to evaluate the durability of interventions after the project period.

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. 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.