DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Community Health Administration

Request for Applications

Equitable Food Access: Home Delivered Meals

Submission Deadline: June 4, 2021 by 6:00 p.m.

The DC 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 DOH terms of agreement.

DC DEPARTMENT OF HEALTH (DC Health)
Community Health Administration (CHA)
NOTICE OF FUNDING AVAILABILITY (NOFA)
RFA# CHA_HDMP_04.30.21
Equitable Food Access: Home Delivered Meals

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

General Information:

Funding Opportunity Title:	Equitable Food Access: Home Delivered Meals
Funding Opportunity Number:	FO-CHA-PG-00023-002
Program RFA ID#:	CHA_HDMP_04.30.21
Opportunity Category:	Competitive
DC Health Administrative Unit:	Community Health Administration
DC Health Program Bureau	Nutrition and Physical Fitness Bureau
Program Contact:	Jo-Ann Jolly, joann.jolly@dc.gov, 202-658-9680
Program Description:	Funding under this RFA is to solicit qualified applicants to implement evidence-based or evidence-informed strategies to increase food access and improve food environments for District residents.
Eligible Applicants	Not-for profit, public and private organizations located and licensed to conduct business within the District of Columbia.
Anticipated # of Awards:	1
Anticipated Amount Available:	$820,000
Floor Award Amount:	$50,000
Ceiling Award Amount:	$820,000

Funding Authorization

Legislative Authorization	FY2022 local funds
Associated CFDA#	Not Applicable
Associated Federal Award ID#	Not Applicable
Cost Sharing / Match Required?	No
RFA Release Date:	Friday, April 30, 2021
Pre-Application Meeting (Date)	Thursday, May 6, 2021
Pre-Application Meeting (Time)	3:00pm-4:30pm
Pre-Application Meeting (Location/Conference Call Access)	Visit DC Health's Eventbrite page for pre-application conference information, https://OGMDCHealth.eventbrite.com
Letter of Intent Due date:	Not applicable
Application Deadline Date:	Friday, June 4, 2021
Application Deadline Time:	6:00 PM
Links to Additional Information about this Funding Opportunity	DC Grants Clearinghouse https://communityaffairs.dc.gov/content/community-grant-program#4 DC Health EGMS https://dcDC Health.force.com/GO__ApplicantLogin2

Notes:

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

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District of Columbia Department of Health RFA Terms and Conditions

v11.2016

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

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

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

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

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

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

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

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

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

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

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

K. DC Health reserves the right to require registry into local and federal systems for award management at any point prior to or during the Project Period. This includes DC Health electronic grants management systems, for which the awardee will be required to register and maintain registration of the organization and all users.

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

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

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

O. DC Health shall provide the citations to the local or federal statute/s and implementing regulations that authorize the award; all applicable District of Columbia and Federal regulations, including OMB Circulars 2 CFR 200 (effective December 26, 2014) and Department of Health and Services (HHS) published 45 CFR Part 75, and supersedes requirements for any funds received and distributed by DC Health under legacy OMB circulars A-102, A-133, 2 CFR 180, 2 CFR 225, 2 CFR 220, and 2 CFR 215; payment provisions identifying how the awardee will be paid for performing under the award; reporting requirements, including programmatic, financial and any special reports required by the funding Agency; and compliance conditions that must be met by the awardee.

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

If your agency would like to obtain a copy of the **DC Health RFA Dispute Resolution Policy,** please contact the Office of Grants Management and Resource Development at doh.grants@dc.gov or call (202) 442- 9237. A copy is available on the District Clearinghouse website with this RFA.

CHECKLIST FOR APPLICATIONS

☐ Applicants must be registered in the federal Systems for Award Management (SAM) and the DC Health Enterprise Grants Management System (EGMS).
☐ Complete your EGMS registration **two weeks** prior to the application deadline.
☐ Start constructing and uploading your application components into EGMS at least a week prior to the application deadline.
☐ The complete **<u>Application Package</u>** should include the following:

- DC Health Application Profile (Attachment 7)
- Table of Contents
- Project Abstract (Attachment 1)
- Logic Model
- Project Narrative
- Project Budget (Attachment 3)
- Budget Justification (Attachment 4)
- Organizational Chart
- Staffing Plan
- Partnerships Documentation
- Work Plan (Attachment 2)
- Evaluation Plan (Attachment 5)
- Mandatory Certification Documents (Attachment 6)

☐ Documents requiring signature have been signed by an agency head or <u>AUTHORIZED</u> Representative of the applicant organization.
☐ The Applicant needs a DUNS number to be awarded funds. Go to Dun and Bradstreet to apply for and obtain a DUNS # if needed.
☐ The Project Narrative is written on 8½ by 11-inch paper, **1.0 spaced**, **Arial or Times New Roman font using 12-point type** *(11 –point font for tables and figures)* **with a minimum of one-inch margins**. **The total size of all uploaded files may not exceed the equivalent of 50 pages when printed. <u>Applications that do not conform to these requirements will not be forwarded</u> to the review panel.**
☐ The application proposal format conforms to the "Application Elements" listed in the RFA.
☐ The proposed budget is complete and complies with the budget forms provided in the RFA. The budget narrative is complete and describes the categories of items proposed.
☐ The proposed work plan, logic model, and other attachments are complete and comply with the forms and format provided in the RFA
☐ Submit your application via EGMS by **6:00 p.m.** on the deadline of **Friday, June 4, 2021.**

1 GENERAL INFORMATION

1.1 KEY DATES

- Notice of Funding Opportunity Date: April 16, 2021
- Request for Application Release Date: April 30, 2021
- Pre-Application Meeting Date: May 6, 2021
- Application Submission Deadline: June 4, 2021
- Anticipated Award Start Date: October 1, 2021

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 mortality and morbidity in the District. CHA's approach targets the behavioral, clinical, and social determinants of health through evidence-based programs, policy, and systems change with an emphasis on vulnerable and underserved populations.

The Nutrition and Physical Fitness Bureau (NPFB) under CHA promotes health and wellness by encouraging behavior change through healthful food access, nutrition and physical activity education, and multi-sector partnership building. The Bureau also facilitates policy, systems, and environmental changes that make healthy choices the easy choice in every community. NPFB programs and strategies aim to improve the health and wellness of city residents across the life course by increasing access to (1) healthful, locally sourced foods, (2) evidence-based wellness education provided by public health educators and licensed dietitians, and (3) increased opportunities for physical activity.

Multiple District agencies prioritize food environments, access and security in strategic plans and documents. In 2016, DC Health released the *DC Healthy People 2020 Framework* (https://dchealth.dc.gov/page/dc-healthy-people-2020), a shared community agenda setting forth goals, population-level health outcome objectives, and targets for the year 2020 along with recommended evidence-based strategies to improve key health outcomes. Recommended strategies to improve food security included improved access to affordable, nutritious food through full-service grocery stores, mobile markets, and programs that provide financial assistance and incentives for buying fresh fruits and vegetables.

In 2018, DC Health collaborated with the community to release a detailed assessment of the structural and social needs impacting District residents, *Health Equity Report: District of Columbia 2018*

(https://app.box.com/s/yspij8v81cxqyebl7gj3uifjumb7ufsw). This report identifies the food environment as a driver of health equity in the district. With 11.1% of the District's population reported as food insecure, a major part of a healthy food environment is affordable healthy food in the neighborhoods where it is needed.

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

Released in September 2020, the District of Columbia Food Policy Council's *Food Access and Food Security in the District of Columbia: Responding to the COVID-19 Public Health Emergency* (https://dcfoodpolicy.org/foodsecurity2020/) evaluates and makes recommendations to address food access needs during and following the public health emergency. According to the report, COVID-19 exacerbated food insecurity in the District, and the source projects that the District's food insecurity rate will be at least 16%, higher among vulnerable populations including the elderly, children, undocumented individuals and unhoused individuals. The report provides a framework for recovery following the public health emergency.

1.3 SOURCE OF GRANT FUNDING

Funding is anticipated to be available using FY2022 local funds.

1.4 AWARD INFORMATION

1.4.1 Amount of Funding Available

Approximately **$820,000** in locally appropriated funds will become available for at least one award.

1.4.2 Performance and Funding Period

Awards are projected to begin October 1, 2021 and continue through September 30, 2024. There will be a one-year budget period. After the first 12-month budget period, there will be up to two additional 12-month periods. The number of awards, budget periods and award amounts are contingent upon the continued availability of funds and the recipient performance.

1.4.3 Eligible Organizations/Entities

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

- Non-profit organizations
- Private organizations
- Public organizations
- Faith-based organizations

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 in each of the four funding opportunities. Partnerships between organizations are welcomed. Applicants must provide letters of commitment, co-applications, or letters of support for existing partnerships if performance will depend on another organization.

1.4.4 Non-Supplantation

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

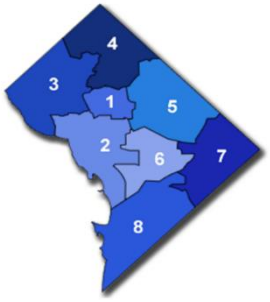
1.4.5 Application Page Limit

The total size of all uploaded files may not exceed the equivalent of **50 pages** when printed by DC Health. The page limit includes the following documents:

- DC Health Application Profile
- Table of Contents
- Project Abstract
- Logic Model
- Project Narrative
- Project Budget
- Budget Justification
- Organizational Chart
- Staffing Plan
- Partnerships Documentation
- Work Plan
- Evaluation Plan
- Mandatory Certification Documents

2 BACKGROUND & PURPOSE

2.1 BACKGROUND



The District of Columbia (DC or the District) is an ethnically-diverse and compact geographic area that covers 61 square miles.[1] The District has eight geographical Wards, 39 neighborhood clusters, 57 historic districts, including 37 residential and commercial neighborhood districts, 16 government and institutional districts, and 4 park and parkway districts.[2,3] According to the United States Census Bureau, there are 705,749 people living in the District of Columbia.[1] This represents a 17.3% population increase since 2010 (601,723).[4] The smallest population is in Ward 2 (approximately 77,855), and the largest population is in Ward 6 (approximately 99,786 residents). The eight wards are further divided into 51 proximal neighborhood groups (PNG). CHA uses both Ward and PNG level data to inform program planning and resource allocation.

The median age for residents is 34.3 years old. Wards 1 and 2 have the largest proportion of adults age 18-64 (80% and 84%). Wards 7 and 8 have the largest proportion of youth age 0-18 years (24% and 30%). And lastly, Wards 3 and 4 have the largest proportion of adults over age 65 (18% and 15%).[5]

Overall, the District's racial distribution is 46% African American, 46% white, and 4.5% Asian. Hispanic residents of any race make up more than 11.3% of the population[1]. Wards 7 and 8 have the highest percentage of African American residents, 93.1% and 90% respectively[6].

The District reflects high levels of median wealth and health intermixed with an unequitable distribution of these societal benefits. Median household income in the District ($86,420) is 26% higher than in the US ($68,703)[1.] Yet, in Ward 7, median income is $40,021, less than half the District average, and among Ward 8 residents, median income ($31,954) is half of the national average.[7] Ward level unemployment rates also highlight disparities with Wards 2 and 3 at 2.9%, compared to Wards 7 and 8 at 9.9% and 11.6% respectively. Ward level SNAP participation shows similar patterns; Ward 2 (3.4%), Ward 3 (1.1%), Ward 7 (32.5%), and Ward 8 (41.2%)[7]. In addition, educational attainment varies throughout geographic locations in the District with 17% and 16% of Ward 7 and Ward 8 residents, respectively, attaining a bachelor's degree or higher compared to 73% of neighboring Ward 6 residents, 85% of Ward 2 residents, or 87% of Ward 3 residents[7].

Despite continual ranking within the top "fittest cities" in the nation by the American College of Sport's Medicine, only 48.8% of District adults age 18 years and older meet physical activity recommendations from the *2018 Physical Activity Guidelines for Americans*. Here again, 2017 BRFSS data reveal geographic disparities in physical activity levels as District residents struggle to meet these

[1] United States Census Bureau. U.S. Census Bureau QuickFacts: District of Columbia; UNITED STATES https://www.census.gov/quickfacts/fact/dashboard/districtofcolumbiadistrictofcolumbia,US/PST045218
[2] Urban Institute. DC Neighborhood Clusters. Data Explorer | Greater DC. https://greaterdc.urban.org/data-explorer?geography=cl17&topic=population. Published 2019
[3] District of Columbia Office of Planning. DC Historic Districts. https://planning.dc.gov/page/dc-historic-districts. https://planning.dc.gov/page/dc-historic-districts. Published 2019
[4] United States Census Bureau. National Population Totals: 2010-2018. https://www.census.gov/data/datasets/time-series/demo/popest/2010s-national-total.html
[5] 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 2017
[6] District of Columbia Office of Planning, Ward Demographic Indicators, https://dcdataviz.dc.gov/node/1371176#2
[7] 2013-2017 American Community Survey 5-year Estimates 2013-2017. Government of the District of Columbia, Office of Planning State Data Center. https://planning.dc.gov/node/1128597

recommendations[6]. In Ward 3, the rate of adults reporting no physical activity was lowest at 6%; compared with Ward 7 at 38%, Ward 5 at 28%, and Ward 8 at 26%[8].

Chronic disease rates in the District vary greatly by race, socioeconomic status, and geographic location. In DC, the rate of heart disease or cardiovascular disease (CVD) and stroke are the 1st and 3rd leading causes of death, respectively[8]. According to 2015 Behavioral Risk Factor Surveillance System (BRFSS) data[7], 29.4% of DC residents reported having high blood pressure, like the national average at 30.1%[9]. However, high blood pressure prevalence rates among African Americans in the District are almost 2.5 times higher than white, non-Hispanic residents (43.4% vs. 17.9% respectively). The rate of high blood pressure among residents with incomes less than $15,000 is 47.4% compared to 20.1% among residents with incomes above $75,000.

Similar trends are seen regarding diabetes with an overall District rate of 7.7%, comparable to the national average at 10.0%, but prevalence among African American residents is 7.5 times higher compared to white, non-Hispanic residents (15.0% vs 2.0% respectively). The rate of diabetes among residents with annual incomes less than $15,000 is 15.7% compared to 2.4% for incomes greater than $75,000. Geographically, residents living in Wards 5, 7 and 8 have rates of diabetes at 17.9%, 12.8%, and 18.2% compared to Wards 1, 2, and 3 at 4.5%, 3.6%, and 3.0% respectively. Finally, although the District has the second lowest adult obesity rate in the nation, at 23.8%[10], significant geographic disparities in obesity rates are apparent with Ward 8 at 44%, Ward 7 at 31%, and Ward 2 at just 10%[10].

The food environment landscape across the District is an important factor when designing strategies to increase food access and decrease food insecurity across communities. In 2018, an estimated 11.1% of all households in the United States were food insecure; meaning they were not sure they could access enough food for an active, healthy lifestyle for their households. In addition, 4.3% of US households experienced very low food insecurity. In the District, approximately 34,000 or 10.6% of households were food insecure, with 4.5% experiencing very low food insecurity from 2016-2018[11].

The 2018 Health Equity Report[10] outlined how food environments and opportunities for healthy food purchase differ across the District. The mix of healthy options, from full-service grocery stores and supermarkets to farmers' markets, as well as healthy corner stores, varies at the neighborhood level. With a total of 45 full-service grocery stores in the District, the city has an overall grocery store density score of 0.069 (i.e. approx. 0.07 stores per 1,000 population), placing the District in the lowest quartile among states[12]. That said, because of the relatively small geographic size of the District, at 61 square miles, most residents live within one mile of a grocery store.

Based on the US Department of Agriculture Food Environment Atlas, there have been improvements in the District between 2010 and 2015. Overall, the number of District residents living within Low Income/Low Access (LILA) areas, based on the one-mile or greater food desert threshold, declined by

[8] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed Mar 31, 2019]. URL: https://www.cdc.gov/brfss/brfssprevalence/.
[9] Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion. 2017 Behavioral Risk Factor Surveillance System. https://www.cdc.gov/obesity/data/prevalence-maps.html
[10] Health Equity Report: District of Columbia 2018, DC Department of Health, https://app.box.com/s/yspij8v81cxqyebl7gj3uifjumb7ufsw
[11] Coleman-Jensen, Alisha, Matthew P. Rabbitt, Christian A. Gregory, and Anita Singh. 2019. Household Food Security in the United States in 2018, ERR-270, U.S. Department of Agriculture, Economic Research Service. Retrieved from https://www.ers.usda.gov/webdocs/publications/94849/err-270.pdf?v=963.1
[12] Be Well Placer Community Dashboard. (2017, October). Grocery store density. Conduent Health Communities Institute. http://www.placerdashboard.org/index.php?module=indicatorsandcontroller=indexandaction=viewandindicatorId=250andlocaleId=26824

25%, to a total of 12,688 (2.11% of the population) in 2015. Of these, about one-third are low-income; 27% were households with children, about 15% with seniors, and 10% are households without cars[13].

Most recently, the COVID-19 Public Health Emergency has impacted food access across neighborhoods in the District. Between February and May 2020, reported rates of food insecurity in Washington, D.C. almost doubled from 10.6% to 21.2%, with even higher rates expected within vulnerable elderly populations due to higher rates of isolation secondary to fear of exposure leading to greater complications from COVID-19. This increase in food insecurity was higher than 40 other states[14]. During the public health emergency, food providers such as DC Public Schools pivoted operations to provide grab and go breakfasts and lunches as well as free groceries to families. In addition, the Department of Aging and Community Living's Senior Congregate Meal Sites transitioned to a home delivered meals model. SNAP enrollment increased considerably in DC, and Pandemic EBT was made available to families in addition to SNAP benefits. However, rates of food insecurity are expected to remain high in DC long after the public health emergency ends, underscoring the importance of long-term system changes to ensure that every resident has meaningful access to healthy, affordable, and culturally appropriate food[15].

2.2. PURPOSE

The purpose of this funding is to improve food access and food environments in communities experiencing inequities in access to food that lead to food insecurity. The District of Columbia, Department of Health (DC Health), Community Health Administration (CHA), is soliciting applications from qualified organizations located and licensed to conduct business within the District of Columbia to implement evidence-based, multi-level interventions designed to improve food environments, food access, and food security for vulnerable residents across the life span. Organizations will focus on enhancing systems alignment, promoting community engagement, and improving data collection and reporting to ensure long-term sustainability of programs.

2.2.1 Approach

In order to improve food access and food environments in Washington, D.C. applicants will be employ strategies and implement activities in the following service areas: 1) healthy food access 2) systems alignment 3) nutrition education 4) partnerships 5) outreach, promotion, and marketing 6) data collection and reporting.

[13] Economic Research Service (ERS), US Department of Agriculture (USDA). (n.d.). Food access research atlas —District of Columbia. Retrieved from https://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas.aspx
[14] Feeding America, Child Food Insecurity 2019. 2017-map-the-meal-gap-child-food-insecurity_0.pdf (feedingamerica.org)
[15] District of Columbia Food Policy Council *Food Access and Food Security in the District of Columbia: Responding to the COVID-19 Public Health Emergency* 2020. https://dcfoodpolicycouncilorg.files.wordpress.com/2020/09/food-security-report-9-24-20.pdf

Strategies and Activities	Short-Term Outcomes (1-2 Years)	Medium-Term Outcomes (2-4 Years)	Long-Term Outcomes (5 Years)
• Increase access to fresh, healthy foods and utilization of local and federal food benefits • Improve food environments • Increase systems alignment • Increase evidence-based nutrition education • Enhance multi-sector partnerships • Increase community engagement • Enhance data collection and evaluation	• Implementation of equitable food access initiatives targeting residents with the highest rates of food insecurity, chronic disease, and overweight/obesity • Increased capacity to support community clinical linkages and referrals from equitable food access initiatives into other local and federal food access programs and social supports • Increased implementation of evidence-based nutrition education in targeted settings • Increased capacity to provide support for residents' utilization equitable food access benefits • Implementation of standardized data collection and reporting across equitable food access initiatives	• **Increased access to healthy foods for District residents with low socioeconomic status** • **Improved food environments for District residents with low socioeconomic status** • **Increased referrals from equitable food access initiative program participants into local and federal nutrition/food access programs** • **Increased partnerships and coordination between federal and local food access programs** • **Improved nutritional literacy and food agency* for District residents with low socioeconomic status** • **Increased community engagement in local food access programs** • **Increased utilization of equitable food access program benefits** • **Increased use of health information technology to increase enrollment into local and federal food access benefits**	• Increased food security for District residents with low socioeconomic status • Decreased incidence and improvement management of Type II Diabetes and Hypertension for District residents with low socioeconomic status • Decreased incidence and prevalence of obesity for District residents with low socioeconomic status
Bold indicates period of performance outcome.			

2.2.2 Outcomes

Applicants shall demonstrate how the proposed project plan will measure the impact of the following Outcome Areas.

Outcome Area 1: Healthy Food Access

A. Increased access to healthy foods for District residents with low socio-economic status.
Performance Indicators:
- Number of home delivered meal participants by zip code by quarter
- Number of *new* home delivered meal participants by zip code by quarter

B. Increased utilization of food access benefits District residents with low socio-economic status
Performance Indicators:
- Number of meals delivered to participants by zip code by quarter
- Number of meals delivered to caregivers by zip code by quarter
- Percentage of participants terminating service by zip code by quarter
- Participant survey results at minimum bi-annually

C. Improved food environments for District residents with low socio-economic status
Performance Indicators:
- Food Safety/Quality Assurance Audit Scores of applicant site by quarter
- Percentage of produce sourced from local farmers and producers by quarter

Outcome Area 2: Systems Alignment

***A.* Increased referrals of participants into other local and federal nutrition/food access programs**
Performance Indicators:
- Number of partnerships between the applicant and federal and local nutrition/food access programs by quarter
- Number of participants referred into federal and local nutrition/food access programs by quarter

B. Increased utilization of health information technology to increase enrollment in the Home-Delivered Meals Program.
Performance Indicators:
- Number of formalized agreements with clinical partners and/or government agencies to provide referrals into the home delivered meals program by quarter

Outcome Area 3: Nutrition Education

A. Improved nutritional literacy and food agency for District residents with low-socioeconomic status
Performance Indicators:

- Number of evidence-based nutrition education classes held by quarter
- Number of participants enrolled in evidence-based nutrition education classes by quarter
- Number of Medical Nutrition Therapy visits completed by quarter
- Participant survey results at minimum bi-annually

Outcome Area 4: Partnerships

A. Increased partnerships and coordination between the Home Delivered Meals Program and federal and local nutrition/food access programs

Performance Indicators:

- Number of formalized agreements with federal and local nutrition/food access programs to provide bi-directional referrals by quarter

Outcome Area 5: Outreach, Promotion, and Marketing

A. Increased community engagement in the Home Delivered Meals Program

Performance Indicators:

- Participant Survey Results at minimum bi-annually

Outcome Area 6: Data Collection and Reporting

A. Increased reported food security by District residents enrolled in the Home Delivered Meals Program

Performance Indicators:

- Hunger Vital Signs Results at minimum bi-annually
- Participant Survey Results at minimum bi-annually

3 PERFORMANCE REQUIREMENTS

3.1 TARGET POPULATION

Applicants shall provide services to at least 500 District residents aged 18 years and older who are diagnosed with or at risk for high blood pressure, high blood cholesterol, pre-diabetes, diabetes, and/or obesity, AND participate in one or more of the following programs:

- SNAP
- Medicaid
- WIC
- TANF
- Commodity Supplemental Food Program
- SSI Disability
- Medicare QMB

3.2 LOCATION OF SERVICES

The organization must be located within the District of Columbia. Applicant shall serve home-bound residents in wards within the District of Columbia with the highest burden of high blood pressure, high blood cholesterol, pre-diabetes, diabetes, and/or obesity (Wards 5, 7, and 8).

3.3 SCOPE OF SERVICES

Applicants shall design, implement, and evaluate a multi-level intervention to increase availability, access, and consumption of healthy, medically tailored, home-delivered meals and groceries for residents in the District of Columbia who are at risk for or are diagnosed with chronic medical conditions. Applicants shall focus on the following strategy areas for implementation:

1. **Healthy Food Access:** Applicants shall provide free, home-delivered, medically tailored meals and/or groceries to participants with, or at risk for chronic medical conditions and their caregivers. Program models shall include all of the following:
   a. Screening: Organization shall incorporate screening questions related to pre-diabetes, diabetes, hypertension, high blood cholesterol, and obesity within the intake screening form for new clients. Examples of intake screening assessments can include:
   American Diabetes Association Diabetes Risk Test
   Hunger Vital Signs Food Insecurity Screening Algorithm for Adults

   b. Medically Tailored Meals: Applicants shall develop and serve medically tailored meals and groceries suitable for the following conditions: hypertension, diabetes, and general healthy diet for weight loss/maintenance. Recipes and menus shall be reviewed and approved by Registered Dietitians to ensure they meet standards for therapeutic diets as determined by the Academy of Nutrition and Dietetics, the American Heart Association, and the American Diabetes Association.
   c. Increased Procurement of Local Produce: Applicant shall source at least 10% of all produce in corner stores from local vendors. For the purposes of this funding opportunity, local shall be defined by the Healthy Schools Act which states "from a grower in Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, Virginia, and West Virginia".

2. **Systems Alignment:** Applicants shall develop processes for the following activities to increase systems alignment with other local and federal nutrition/food access programs, as well as social support programs:

   a. Community Clinical Linkages: Applicants shall establish formalized referral pathways with at least five (5) total federally qualified health centers (FQHC), community-based organizations (CBO), and/or government agencies to increase enrollment into the applicant's produce incentive program. Applicant shall provide training and technical assistance to FQHC and CBO staff on program operations, enrollment mechanisms, and referral pathway.
   b. Referral Pathway to Food Access Programs: Applicant shall develop referral pathways for participants enrolled in the program into other local and federal nutrition food access

programs including WIC, SNAP/EBT, Commodity Supplemental Food Program, Healthy Corner Stores, Produce Incentives, and School Based Nutrition Markets

c. Linkages to Social Supports: Applicant shall implement partnerships with at least five (5) outside organizations or enhance internal processes to ensure that participants are linked with support services to address factors that social determinants of health. Key priority areas for support services include access to quality primary care, social isolation and mental health services, and economic support services.

3. **Nutrition Education**: Applicant shall increase access to evidence-based nutrition education to home delivered medically tailored meals program participants through the following:
    a. Medical Nutrition Therapy: Applicant shall provide medical nutrition therapy with a Registered Dietitian in order to promote healthy behavior and lifestyle changes. MNT sessions shall be available at no cost to all program participants on a monthly basis as requested. Registered Dietitians should follow-up with all program participants at least one time annually to complete nutrition screening assessment and determine needs related to diet.
    b. Evidence-Based Nutrition Education: Applicant shall implement evidence-based series-based nutrition education programs on a quarterly basis (at minimum) for all program participants, led by a Registered Dietitian Nutritionist (RDN).

4. **Partnerships**: Applicants shall partner with at least five (5) community-based organizations, FQHC's, and/or District agencies to develop or enhance protocols and processes for patient care coordination that focus on continuum of care for chronic disease prevention and management.

5. **Outreach, Promotion, and Marketing**:
    a. Marketing Materials: Applicant shall develop and disseminate digital and print marketing and outreach materials to community partners, District residents, and participants to increase enrollment into the program. At minimum, these materials shall provide specific program information that assist with increasing program engagement. Other materials shall include additional information on local and federal nutrition/food access programs available to participants, their caregivers, and program volunteers.
    b. Food Navigator: Applicant shall train and deploy food navigators to assist in engaging with program participants and community residents to increase interest and demand for the program. Food navigators shall conduct community outreach (virtual and/or in-person) and assist in building awareness of additional federal and local nutrition/food assistance programs in the community.

6. **Data Collection and Reporting**: In conjunction with DC Health, applicant shall develop and implement an evaluation plan intended to measure the impact of medically tailored home delivered meals and referrals to lifestyle change programs and social support services. Applicant shall focus on developing a system to collect value-based results such as hospital outcomes, medication adherence, and emergency room visits. Applicant shall collect, track, and report data on process and outcome measures related to the project, and report program activities and metrics to DC Health in a timely manner.

4 APPLICATION REQUIREMENTS

4.1 PROJECT NARRATIVE

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.

- Describe how the target population was identified for this proposal
- Provide a detailed description of the health disparities and challenges that the target population faces in relation to food insecurity, food access, poverty, nutrition and physical activity behaviors, other health-related behaviors, and chronic disease incidence including high blood pressure and high blood cholesterol, including relevant data.
- 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.

PROJECT DESCRIPTION

This section should provide a comprehensive framework and description of all aspects of the proposed project. Additionally, this section should include how the program will be implemented. It should also highlight the overarching problem to be addressed. It should be succinct, self-explanatory and well organized.

- Identify and describe the at-risk community that will be served through this project.
- Describe the applicant's strategies for selecting and implementing an evidence-based or evidence-informed initiative and how strategies will be operationalized to achieve program goals, objectives and outcomes.
- Describe how the proposed project meets the requirements in Section 3.3 Scope of Service Section
- Outline the rationale for selecting the proposed activities and objective, including an assessment of the current needs and assets in the community. Describe how strategies are based upon evidence-based, evidenced-informed or promising practices/programs.
- Describe how participants will be recruited, enrolled, and retained in the program.

- Describe how objectives will maximize public health impact, building, sustaining and operationalizing enhanced community capacity.
- Describe how the project will apply a health equity lens and consider DC Health's strategic priorities to program planning:
    - 1) create a culture of health and wellness, 2) address the social determinants of health, 3) close the chasm between clinical and public health, 4) strengthen public and private partnerships, and 5) implement data-driven programming
- Indicate plans for sustainability of the initiative beyond the projected funding period.

PARTNERSHIPS & COLLABORATIONS

In this section, the applicant must describe the plan to involve other key partners in their work.

- Describe the applicant's experience working collaboratively with government agencies, including public health, behavioral health, education and health care financing, to implement health and/or public health 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 outcomes.
- Describe plans for establishing a new, or engaging an existing, cross-sector network of partners to support the implementation, and evaluation, if applicable, 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.

PERFORMANCE MONITORING AND EVALUATION

Applicants must propose an process and outcome evaluation that will include appropriate evaluation methods to monitor ongoing processes and the progress towards the goals and objectives of the project, including a description of data collection, sampling strategies (if appropriate), timeline, Institutional Review Board (IRB) review (if appropriate), and data analysis.

In developing an evaluation plan, applicants are encouraged to utilize existing, validated evaluation tools or instruments and submit these tools and instrument in their application. Grantees shall submit all evaluation tools and instruments to DC Health for review prior to use.

- The evaluation methodology should be specific and related to the stated goals, objectives, and priorities of the project. Additionally, the evaluation plan should be linked to the project's logic model.
- Applicant shall describe evaluation methods and tools, data collection, analysis and security for any personal information.
- Applicant shall include a logic model that demonstrates the linkages between the proposed planning and implementation activities and the outcomes that these are designed to achieve.
- Applicant shall complete the Evaluation Plan (**Attachment 5**), which should include evaluation questions, evaluation design, and measures (i.e. process and outcome)

- Describe how data will be collected and manage data (e.g., assign skilled staff, data management software) in a way that allows for accurate and timely reporting of performance outcomes.
- Describe the process for tracking outcomes for referrals and linkages for health services, social services and other community providers.
- Applicant shall demonstrate evidence of organizational experience and capability to coordinate, support planning, and implementation of a comprehensive evaluation of a program.
- Budgets for evaluation activities should be: (1) appropriate for the evaluation design and question(s); (2) adequate to ensure quality and rigor, and; (3) in line with available program and organizational resources. The recommended maximum funding ceiling of 10% of the total requested budget for evaluation activities. The applicant should provide appropriate support for their evaluation budget in the budget justification.

ORGANIZATIONAL INFORMATION

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

- Describe the applicant's experience designing, implementing, and evaluating systems-aligned initiatives to improve food environments, access and security across the lifespan
- Describe the applicant's experience engaging communities to improve community capacity supporting improved health and social determinant of health outcomes.
- Describe the staff recruitment plan, including a projected time line for recruitment and hiring.
- Describe the applicant's accounting structure. The structure should demonstrate the organization's ability to maintain effective internal controls and demonstrate the ability to provide accurate and complete information about all financial transactions related to this program

4.2 APPLICATION FORMS AND TEMPLATES

Some attachments for this application have required templates. The sections below will indicate which documents require the uses of a template.

PROJECT ABSTRACT

A one-page project abstract is required (**Attachment 1**). 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

LOGIC MODEL

A one-page logic model is required *(no template provided)*. A logic model is a one-page diagram that presents the conceptual framework for a proposed project and explains the links among program elements. While there are many versions of logic models, for the purposes of this announcement the logic model should summarize the connections between the:

- Goals of the project (e.g., objectives, reasons for proposing the intervention, if applicable);
- Assumptions (e.g., beliefs about how the program will work and is supporting resources. Assumptions should be based on research, best practices, and experience.)
- Inputs (e.g., organizational profile, collaborative partners, key staff, budget, other resources);
- Target population (e.g., the individuals to be served);
- Activities (e.g., approach, listing key intervention, if applicable);
- Outputs (i.e., the direct products or deliverables of program activities); and
- Outcomes (i.e., the results of a program, typically describing a change in people or community).

WORK PLAN

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

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

EVALUATION PLAN

The Evaluation Plan is required (**Attachment 5**). All grantees are required to conduct ongoing evaluation of program activities. The evaluation plan describes process and outcome measures used to assess program effectiveness. For each activity listed in the work plan, provide an evaluation question that will be used to measure effectiveness of objectives proposed and anticipated deliverables. As well, evaluation instrument or tool and frequency of data collection.

PARTNERSHIPS

Applicant should provide letters of commitment or support from other agencies and organizations pertinent to the success of the proposed project *(no template provided)*.

ORGANIZATIONAL INFORMATION

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

PROJECT BUDGET

The application should include a project budget using the form provided (**Attachment** 4). The project budget and budget justification should be directly aligned with the work plan and project description. All expenses should relate directly to achieving the key grant outcomes.

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

Key Requirements

The budget should reflect a 12-month period. 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

Five to ten percent of the award amount shall be allocated to evaluation activities to include formative, process, and outcome evaluation. Budgets for evaluation activities should be: (1) appropriate for the evaluation design and question(s); (2) adequate to ensure quality and rigor, and; (3) in line with available program and organizational resources. The applicant should provide appropriate support for their evaluation budget in the budget justification.

BUDGET JUSTIFICATION

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

Include the following in the Budget Justification Narrative:

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

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

Supplies: Office supplies, food expenses, as well as educational supplies including handouts, pamphlets, posters, cooking demonstration items, nutrition and/or physical activity reinforcement items.

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

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.

Other Direct Costs: Other Direct Costs may include some or all expense categories below:

- ***Materials and supplies:*** (if not included in a separate cost category): include the project costs of project-specific supply items (computers, software programs, postage, CDs, etc.) and items costing less than $5,000 and not considered equipment.
- ***Publication costs:*** include funds requested for the publication of the results and the preparation of presentations and posters.

5 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 six 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:

5.1CRITERION 1: NEED

(10 POINTS) – Corresponds to Sections: Overview and Population Needs

- Demonstrates understanding of food access landscape in the District
- Describes in detail the health disparities and challenges target population face in relation to food insecurity, food access, poverty, nutrition and physical activity behaviors, and chronic disease such as pre-diabetes, diabetes, high blood pressure, and high blood cholesterol.
- Defines the reach, scope, zip codes, and/or geography of the target population
- Demonstrates understanding of factors that affect social determinants of health that are barriers for the target population to access healthy food
- Illustrates understanding of DC Health Key Strategic Priorities
- Demonstrates understanding of the problem and identifies barriers, challenges, and opportunities to address the problem

5.2 CRITERION 2: IMPLEMENTATION

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

- Demonstrates clear understanding of multi-level evidence-based intervention to address food insecurity within vulnerable populations
- Describes how proposed strategies will lead to improved outcomes in food insecurity, and chronic disease prevention and management
- Describes how activities will address the problem and attain the project activities
- Work plan represents a logical and realistic plan of action for timely and successful achievement of objectives that support program goals
- Demonstrates that proposed plan provides a foundation for sustainability of efforts beyond the project funding period

5.3 CRITERION 3: EVALUATIVE MEASURES

(25 POINTS) – Corresponds to Sections: Logic Model, Evaluation Plan, Performance Monitoring and Evaluation

- Presents a logic model that is clear, and concise with descriptive inputs, activities, and outputs and achievable short, medium, and long-term outcomes for the program.
- Clearly outlines goals and objectives of the project, and describes how proposed goals and objectives are SMART (Specific, Measurable, Achievable, Relevant, and Time Bound)
- Presents an evaluation strategy that succinctly aligns with activities listed in the work plan, describes performance indicators, outcome measures, evaluation instrument or tool, and frequency of collection

- Demonstrates the ability to successfully analyze data to assess program effectiveness
- Describes how data will be collected; and demonstrates the capacity to collect and manage large data set
- Describes the appropriate evaluation methods to monitor ongoing progress towards the goals and objectives of the project

5.4 CRITERION 4: CAPACITY

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

This section is to describe the extent to which the applicant is can fulfill the goals and objectives set forth and the quality and availability of facilities and personnel to fulfill the needs and requirements of the proposed project. Also, consider the extent to which the applicant demonstrates:

- Describe plans for establishing a new, or engaging an existing, cross-sector network of partners to support the implementation, and evaluation, if applicable, of the applicant's program.
- Organizational personnel have demonstrated qualifications (training and experience) in planning, implementing, and evaluating large scale public health interventions to address food security, food access, nutrition education, and chronic disease prevention and management.
- Organization has experience and past successes working collaboratively with government agencies and non-government organizations from a variety of sectors to implement health and/or public health initiatives aimed to advance a public health goal.
- Organization has demonstrated reach, and established relationships within target population

5.5 CRITERION 5: SUPPORT REQUESTED

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

The reasonableness of the proposed budget for the project period in relation to the objectives, the complexity of the activities, and the anticipated results.

- Costs outlined in the budget and required resources sections are reasonable given the scope of work
- Key personnel have adequate time devoted to the project to achieve project objectives

6 REVIEW AND SCORING OF APPLICATION

6.1 PRE-SCREENING TECHNICAL REVIEW

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

6.2 EXTERNAL REVIEW PANEL

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

6.3 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. Those factors will include minimally a past performance review, risk assessment and eligibility assessment, including a review of assurances and certifications, and business documents submitted by the applicant, as required in the RFA. DC Health will also conduct an excluded parties list search (EPLS) of the organization and executives via the federal System for Award Management (SAM) and conduct a DC Clean Hands review to obtain DC Department of Employment Services and DC Office of Tax and Revenue compliance status.

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

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

7 APPLICATION PREPARATION & SUBMISSION

7.1 APPLICATION PACKAGE

Only one (1) application per organization will be accepted. An application package consists of **three pdf files**, to be **uploaded separately into EGMS**: 1) Mandatory Certification Documents, 2) Core Application, 3) Supplemental Documents. The 50-page limit includes the Project Abstract, Project Narrative (10-page limit), Budget, Budget Justification, Staffing Plan, Logic Model, Work Plan, and Evaluation Plan. See section 8.1, Uploading the Application.

ATTACHMENTS

The following attachments **are not** included in the 50 page limit:

- DC Health Application Profile (**Attachment 7**)
- Table of Contents - Lists major sections of the application with quick reference page indexing. Failure to include an accurate Table of Contents may result in the application not being reviewed fully or completely
- Organizational Chart (1 page)
- Project Budget (**Attachment 4**)
- Budget Justification (**Attachment 3)**
- Partnerships Documentation(s)
- DC Health Standard Grant Terms and Conditions (Reviewed and Accepted via EGMS)
- –**Mandatory Certification Documents** (Scan and upload one pdf file containing all the following business documents required for submission uploaded into EGMS):
    i. A current business license, registration, or certificate to transact business in the District of Columbia.
    ii. 501(c)(3) certification (for non-profit organizations)
    iii. City Wide Clean Hands Compliance Status Letter (formerly Certificate of Clean hands). Clean Hands Compliance Status letter must be dated no more than 3 months prior to the due date of application.
    iv. Official list of Board of Directors for the current year and the position that each member holds on letterhead and signed by the authorized executive of the applicant organization; not the CEO.
    v. Assurances Certifications and Disclosures (**Attachment 6**). Scan and upload **one copy SIGNED** by the Agency Head or authorized official.

The following attachments **are** included in the 50 page limit:

- Project Abstract (1 page)
- Logic Model (1 page)
- Project Narrative (10 page limit)
- Staffing Plan
- Work Plan (**Attachment 2**)
- Evaluation Plan (**Attachment 5**)

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

8 APPLICATION SUBMISSION

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.

8.1 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 may not be approved by the DC Health Office of Grants Management in time for submission. To register, complete the following:

IMPORTANT: WEB BROWSER REQUIREMENTS

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

2. **Access EGMS**: The user must access the login page by entering the following URL in to a web browser: https://dcdoh.force.com/GO__ApplicantLogin2. Click the button REGISTER and following the instructions. You can also refer to the EGMS External User Guide.

3. Determine the agency's Primary User (i.e. authorized to accept terms of agreement, certify and submit documents, request and accept modifications). A Secondary User may also be added by requesting an account. The account must be approved by the Primary Account User.

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

5. When your Primary Account User request is submitted in EGMS, the DC Health, Office of Grants Management, will review the request. If the requester is NOT the identified Executive

Director, DC Health Office of Grants Management will make an additional request for the Executive Director to send an email to DC Health to confirm that the requester is the authorized representative for EGMS. When requested, your authorized representative should send to doh.grants@dc.gov the name, title, telephone number and email address of the desired Primary User for the account. **SUBJECT LINE: EGMS PRIMARY USER ___AGENCYNAME**. Note: The email will help to support the validation of authorized users for EGMS. DC Health official grant records will also be used. Please reply ASAP to any requests from Office of Grants Management to provide additional information, if needed.

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

EGMS User Registration Assistance:

Office of Grants Management at egms.support@dc.gov assists with all end-user registration if you have a question or need assistance: Primary Points of Contact: Jennifer Prats (202) 442-8983. Here are the most common registration issues:

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

8.2 UPLOADING THE APPLICATION

All application documents should be submitted in EGMS as 3 **separate pdf attachments**. Documents included in each is below. All of these must be aligned with what has been requested in other sections of the RFA.

- **1. Mandatory Certification Documents:** 1) DC Health Application Profile (**Attachment 7**), 2) a current business license, registration, or certificate to transact business in the relevant jurisdiction, 3) 501 (c) 3 certification (for non-profit organizations), 4) City Wide Clean Hands Status Letter, 5) Official signed list of the board of directors, 6) Medicaid certifications, if applicable, 7) Assurances Certifications Disclosures (signed) (**Attachment 6**).
- **2. Core Application**: Table of contents, project abstract **(Attachment 1)**, project narrative, project budget & budget justification (**Attachments 3&4**), staffing plan, work plan (**Attachment 2**), logic model, evaluation plan (**Attachment 5**)
- **3. Supplemental Documents:** Organizational Chart, Partnerships Documentation(s)

8.3 DEADLINE IS FIRM:

Submit your application via EGMS by 6:00 p.m., on the deadline date of **June 4, 2021.** Applications will not be accepted after the deadline.

9 PRE-APPLICATION MEETING

A Pre-Application Meeting will be held on **Thursday, May 6th from 3:00 pm to 4:30 pm** Visit DC Health's Eventbrite page for pre-application conference information https://OGMDCHealth.eventbrite.com. The meeting will provide an overview of CHA's RFA requirements and address specific issues and concerns about the RFA. No applications shall be accepted by any DC Health personnel at this conference. Do not submit drafts, outlines or summaries for review, comment, or technical assistance.

10 PRE-AWARD ASSURANCES & CERTIFICATIONS

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

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

- City Wide Clean Hands Compliance Status Letter (formerly Certificate of Clean Hands).
- 501 (c) 3 certification
- Official List of Board of Directors on letterhead, for current year, signed and dated by the authorized executive of the Board. (cannot be the CEO)
- All Applicable Medicaid Certifications
- A Current Business license, registration, or certificate to transact business in the relevant jurisdiction
- Certificate of Insurance
- Copy of Cyber Policy

B. Assurances required for signing grant agreements for funds awarded through this RFA (Post-Award)

- Certification Regarding Lobbying; Debarment, Suspension and Other Responsibility Matters; and Drug-Free Workplace Requirements
- Comprehensive Automobile Insurance, if applicable for organizations that use company vehicles to administer programs for services.
- Certification of current/active Articles of Incorporation from DCRA.
- Proof of Insurance for: Commercial, General Liability, Professional Liability, Comprehensive Automobile and Worker's Compensation
- Certificate of Occupancy
- Most Recent Audit and Financial Statements

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

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 Condition for all DC Health – issued grants. The Terms and Conditions are in the Attachments and in the Enterprise Grants Management System, where links to the terms and a sign and accept provision is imbedded.

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 grant agreement shall outline the scope of work, standards, reporting requirements, fund distribution terms and any special provisions required by federal agreements.
4. Utilize Performance Monitoring & Reporting tools developed and 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. Grant awardees will be allowed to budget for indirect costs of no more than ten percent (10%) of total direct costs.

11.5 INSURANCE

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

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

11.7 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.

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

11.9 CONTACT INFORMATION:

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12 GLOSSARY OF TERMS

Community Linkages- Community-clinical linkages are connections between community and clinical sectors to improve population health. Building community-clinical linkages helps to ensure that people with or at high risk for chronic diseases such as high blood pressure and high blood cholesterol have access to the resources they need to prevent, delay or manage chronic conditions once they occur.

Evidence-Based/Evidence-Based Public Health Approach - is defined as the integration of the best research evidence with the best available practice-based evidence. The best research evidence refers to relevant rigorous nutrition and public health nutrition research including systematically reviewed scientific evidence. Practice-based evidence refers to case studies, pilot studies, and evidence from the field on nutrition education interventions that demonstrate obesity prevention potential. For more information on Evidence-Based Public Health Approach please visit: https://www.astho.org/Evidence-Based-Public-Health/Toolkit/Issues-and-Concepts-Executive-Summary/

Food Access - According to the U.S. Department of Agriculture (USDA), Economic Research Service (ERS), consumer choices about food spending and diet are likely to be influenced by accessibility and affordability of food retailers—travel time to shopping, availability of healthy foods, and food prices. Some people and places, especially those with low income, may face greater barriers in accessing healthy and affordable food retailers, which may negatively affect diet and food security[1]. To improve health outcomes, access to healthy food is essential. [1] U.S. Department of Agriculture Economic *Food Access* n.d. https://www.ers.usda.gov/topics/food-choices-health/food-access/

Food Security - Food security, as defined by the 1996 World Food Summit[1], means that all people, at all times, have physical, social, and economic access to sufficient, safe, and nutritious food that meets their food preferences and dietary needs for an active and healthy life. From this definition, four dimensions of food security are defined: availability, access, utilization, and stability[2]. Lack of access to healthy food options increases the probability for food insecurity.

[1] World Food Summit 1996, Rome Declaration on World Food Security.

[2] Food and Agriculture Organization of the United Nations *Food Security Policy Brief 2006.* http://www.fao.org/fileadmin/templates/faoitaly/documents/pdf/pdf_Food_Security_Cocept_Note.pdf

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

Interventions - a specific set of evidence-based, behaviorally focused activities and/or actions to promote healthy eating and active lifestyles.

Low-Income - means a household income equal to, or less than, 80% of the area median income and greater than 50% of the area median income. For data on low income or low access populations please visit: https://www.ers.usda.gov/data-products/food-access-research-atlas/state-level-estimates-of-low-income-and-low-access-populations/

Low Socioeconomic Status – is defined as the social standing or class of an individual or group. Often it is measured as a combination of education, income, and occupation American Psychological Association, https://www.apa.org/topics/socioeconomic-status

Multi-level interventions - reach the target audience at more than one level of the Social Ecological Model (SEM) and mutually reinforce each other. Multi-level interventions generally are thought of as having three or more levels of influence.

Poverty Guidelines - an administrative version of the Federal poverty measure and are issued annually by the Department of Health and Human Services in the Federal Register. Sometimes referred to as the Federal Poverty Level, these guidelines are often used to set eligibility for certain programs. http://aspe.hhs.gov/poverty/index.shtml.

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

SNAP eligible individuals - a label that refers to SNAP participants and other low-income individuals who qualify to receive SNAP benefits or other means-tested Federal assistance programs, such as

Medicaid or Temporary Assistance for Needy Families. It also includes individuals residing in communities with a significant low-income population.

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, 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)[1].

[1] 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

Systems Alignment - Building connections and alignment across systems is key to improving health outcomes in the District of Columbia. Multiple systems impact District residents as they live, learn, eat, work, worship and play including health care, housing, education, employment, public safety, agriculture, social services, transportation, and more. In 2017, the District of Columbia's State Health Planning and Development Agency in partnership with DC Health's Healthcare Access Bureau Primary Care Office and John Snow Institute developed a Health Systems Plan (HSP) to expressively serve as a guide to the development of community programming that will meet the needs of District residents. The HSP encourages DC Health along with other DC government agencies to collaborate and adopt a Health in All Policies (HiAP)[1] approach. HiAP is a collaborative approach that aligns health considerations into policymaking across sectors to improve the health of all communities and people. A HiAP approach ensures that DC government maintains the health of its residents at the forefront of decision making. DC Health relies on community partners as well as other agencies to expand the reach of programs and build connections across systems to better serve residents and reduce barriers to optimal health outcomes.

[1] Centers for Disease Control and Prevention Office of the Associate Director for Policy and Strategy *Health in All Policies* June 2016. https://www.cdc.gov/policy/hiap/index.html

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13 ATTACHMENTS

- Attachment 1 - Project Abstract
- Attachment 2 - Work Plan
- Attachment 3 - Budget Justification
- Attachment 4 – Budget
- Attachment 5 – Evaluation Plan
- Attachment 6- Assurances Certifications and Disclosures
- Attachment 7 - DC Health Application Profile