GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

COMMUNITY HEALTH ADMINISTRATION

HOME VISITING EXPANSION

REQUEST FOR APPLICATIONS

FO# CHA-HVE-5.3.24

SUBMISSION DEADLINE:

TUESDAY, JUNE 4TH, 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

NOTICE OF FUNDING AVAILABILITY (NOFA)

FO# CHA-HVE-5.3.24

Home Visiting Expansion RFA

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:	Home Visiting Program Expansion
Funding Opportunity Number:	FO# CHA-HVE-5.3.24
DC Health Administrative Unit:	Community Health Administration
DC Health Program Bureau	Family Health Bureau
Funding Opportunity Contact:	Dr. Ericka Peterson Early Childhood Health Division Family Health Bureau Community Health Administration ECHD.DCHealth@dc.gov
Funding Opportunity Description:	This funding opportunity seeks to expand home visiting services using a promising practice home visiting model to provide comprehensive and culturally appropriate maternal and child health services. Options may include a promising practice expansion with or without a workforce development component.
Eligible Applicants	Nonprofit, faith-based, and community-based organizations
Anticipated # of Awards:	1
Anticipated Amount Available:	$310,000
Annual Floor Award Amount:	$100,000
Annual Ceiling Award Amount:	$310,000

Legislative Authorization	FY25 Budget Support Act of 2024
Associated CFDA#	Not Applicable
Associated Federal Award ID#	Not Applicable
Cost Sharing/Match Required?	No
RFA Release Date:	May 3, 2024
Letter of Intent Due date:	Not applicable
Application Deadline Date:	June 4, 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
  - ☐ Letter of Commitment/Letter of Support (2)
  - ☐ 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: **April 19, 2024**
- Request for Application Release Date: **May 3, 2024**
- Pre-Application Meeting Date: **visit https://OGMDCHealth.eventbrite.com**
- Application Submission Deadline: **June 4, 2024**
- Anticipated Award Start Date: **October 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 (CHA) 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 Family Health Bureau works to protect, promote and improve the health of families through screening and surveillance, education, community-clinical linkages, family strengthening programs, preventive services, and positive youth development.

1.3 PURPOSE

The purpose of this funding is to empower individuals by providing comprehensive and culturally appropriate maternal and child health services, ensuring support for pregnant persons and their families, while also equipping them with the skills, knowledge, and support necessary to secure and maintain employment.

1.4 SOURCE OF GRANT FUNDING

Funding is anticipated to be available using FY25 Budget Support Act of 2024. **Funding is subject to change based on availability.**

1.5 Award Information

1.5.1 Amount of Funding Available

The total funding amount of up to $310,000 is anticipated for one (1) award for the first budget period.

1.5.2 Period of Performance and Funding Availability

The first budget period of this award is anticipated to begin on October 1, 2024 and to continue through September 30, 2025. After the first budget period, there will be up to four (4) additional 12-month budget periods for a total project period of October 1, 2024– September 30, 2029. 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:

- Nonprofit organizations
- Community-based organizations
- Faith-based organizations

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

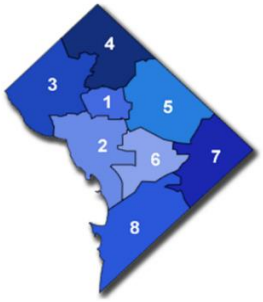
1.5.4 Non-Supplantation

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

2. BACKGROUND

2.1 DEMOGRAPHIC OVERVIEW

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



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

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

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

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

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

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

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

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

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

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

Health of District Residents

While the overall health of District residents has improved during the past decade, health disparities and inequities are evident by race, income, and geography across the District of Columbia.[7] Infant mortality, which is the death of a baby before his or her first birthday, is an important indicator of the health and well-being of a population. Infant mortality in the District has declined, with the rate per 1,000 live births falling from 13.6 in 2005 to 4.5 in 2020 with an upward tick to 6.8 in 2021.[8] While all groups saw a decrease, the infant mortality rate was significantly higher for infants of non-Hispanic Black mothers (9.4 per 1,000 live births) compared to infants of Hispanic mothers (3.5 per 1,000 live births) and infants of non-Hispanic White mothers (1.9 per 1,000 live births). [9] Differential health outcomes also persist across the life course, as evidenced by self-reported fair or poor health by race and gender. While 3.9% of White residents fall into this category, nearly 1 in 5 Black residents (19.5%) report fair/poor health, which is over twice that of all other races, at 9.1%.[10]

[7] Health Equity Report: District of Columbia 2018. https://app.box.com/s/yspij8v81cxqyebl7gj3uifjumb7ufsw

[8] https://www.marchofdimes.org/peristats/state-summaries/district-of-columbia?lev=1&obj=3&reg=99&slev=4&sreg=11&stop=55&top=3

[9] *2023 March of Dimes Report Card for District of Columbia*. (n.d.). March of Dimes | PeriStats. https://www.marchofdimes.org/peristats/reports/district-of-columbia/report-card

[10] DC Health, BRFSS Surveillance System

Child Health

About 18% of the District's population is comprised of children under 18 years of age, with the majority of children under the age of six (43%). Most children are Black/African American (58.5%) followed by White (26.5%) and Hispanic/Latino (15.9%). The median income for families with children is $78,633; however, 25% of families live below poverty level and about 39% use public assistance (i.e., SSI, cash public assistance, or Food Stamp/SNAP benefits). Within households, most children live with their biological parent (83.5%), followed by their grandparent (11.6%). A strong predictor of positive health outcomes is one's health at birth. Poverty during a child's life under the age of five can increase the risk of experiencing lower socioeconomic status later in adulthood and contribute to a cycle of poverty among future generations. Neighborhoods in Wards 7 and 8 (Lincoln Heights, Stadium-Armory and Douglass, St. Elizabeth's, respectively), and some neighborhoods in Wards 2 and 5, have the highest concentrations of children under five living in poverty.[11]

2.2 PROGRAM INFORMATION

The program initiative seeks to improve maternal and child health outcomes in the District of Columbia by implementing an innovative home-visiting model that addresses the unique needs of expectant mothers and their families. Programs may also seek to create pathways for individuals interested in pursuing careers in doula support, midwifery, lactation consulting, and other perinatal health professions.

Promising Practice Home Visiting model:

According to the Health Resources and Services Administration (HRSA) guidelines[12], a "promising practice" in the context of home visiting refers to an activity, procedure, approach, or policy that may lead to improved outcomes or increased efficiency. A promising practice approach in home visiting is a new or innovative approach that is expected to lead to improved outcomes, is based on evidence, serves the needs of the community, and is subject to rigorous evaluation.

Promising Practice and Workforce Development:

A promising practice approach with a workforce development component. A Workforce Development program targeted to empower women in underserved areas by providing them with perinatal health or doula training opportunities. This program aims to equip these women with the necessary skills and knowledge to make a significant impact in their communities.

[11] District of Columbia Department of Health Five-Year Maternal Needs Assessment Summary 2021-2025. September 2020.pg. 9

[12] https://www.govinfo.gov/content/pkg/USCODE-2022-title42/html/USCODE-2022-title42-chap7-subchapV-sec711.htm

3. PURPOSE

The DC Health Community Health Administration (CHA) is requesting applications from qualified applicants to provide the following:

Option 1: Promising Practice Home Visitation Program

Option 2: Promising Practice Program with a Workforce Development component.

3.1 APPROACH

Option 1: Promising Practice Home Visiting model or expansion to an existing model:

The applicant should propose an innovative program model that targets expectant mothers, and their families, who reside in the District of Columbia. The model should prioritize culturally competent care, and the integration of social determinants of health. Proposals should outline strategies for reaching underserved populations, leveraging technology, and fostering collaboration with existing healthcare providers and community organizations. Applicants shall provide a detailed implementation plan 60 days from the date of the award that, at minimum, includes the following requirements:

- A defined model structure and empirical research used to develop the promising practice model.
- Applicant shall provide intended outcomes of program implementation.
- An annual training plan for staff and procedures to ensure compliance with training requirements.
- Protocols for data collection and reporting, and monitoring program core components and dosage
- A work plan with activities to be performed, a responsible person, target dates for completion, and anticipated outcomes

Option 2: Promising Practice and Workforce Development

The applicant should propose a workforce development program that creates pathways for women interested in pursuing careers in perinatal health, including but not limited to doula, midwifery, and lactation consulting. The program should offer training, mentorship, and support services to ensure the success and retention of participants. Additionally, proposals should emphasize recruitment efforts targeting individuals from underrepresented communities in the perinatal health workforce.

Evaluation

Applicants who propose to implement a home visiting model that qualifies as a promising practice are obligated to carry out a comprehensive and rigorous evaluation of that model. The evaluation of the Workforce Development program should be comprehensive and multi-faceted, focusing on both the process and the outcomes. Recipients must submit an evaluation plan for approval. No more than 25 percent of the total fiscal year grant award may be expended to conduct and evaluate a program. The objective of the evaluation is to showcase improvements in

the outcomes of the participants, particularly in the areas of maternal and child health. An evaluation plan describing the technical details of the evaluation is due to DC Health no later than 90 days from the project start date. DC Health will provide further guidance and technical assistance after the award is issued. The applicant should utilize DC Health's approved evaluator throughout the duration of the grant award. (See *Appendix B: Evaluation* for additional information)

***Please note**: Awardees must participate in any evaluation, data collection, and data monitoring activities that DC Health and its agents may have during the grant award.*

Reporting

The applicant shall be required to adhere to the reporting schedule established by DC Health, which includes, but is not limited to, data and updates on the following[13]:

- Monthly time study logs for staff that are funded 25% or more from this award.
- Primary data entry into DC Health's Data Collection and Reporting System, including but not limited to:
    - Demographic data on participants
    - Clients and children enrolled status
    - Clients and children screening data
    - Client contact logs (home visits, email, letters, etc.)
      Clients and children's referrals
- Coordination/linkages of data feeds from applicant's Electronic Medical Record (eMR)/Electronic Health Record (eHR) data feeds
- Quarterly spend plans
- Copies of model/program developer's reports, included but is not limited to annual reports
- Process and Outcome Measures

Screenings

The applicant shall screen families for risk and refer families and children to the appropriate services if necessary. The applicants shall ensure that home visiting staff are appropriately trained to administer, score and interpret screening tools; and communicate assessment results to families. A successful applicant must use the following screening tools in addition to program specific tools:

[13] DC Health will provide templates and technical assistance where appropriate. Reporting requirements are also subject to change.

- **Ages & Stages Questionnaires (ASQ-3)** *[14]- Developmental screeners given to parents to see how a child's development compares with other children of the same age;
- **Ages & Stages Social and** Emotional (ASQ:SE-2) * - Parent-completed tool with a deep, exclusive focus on children's social and emotional development, used for early identification of social-emotional problems; Patient Health Questionnaire-9 (PHQ-9) - Self-test that measures depressive feelings and behaviors during the past week to determine a person's depression quotient;
- **Abusive Behavior Inventory (ABI)** - Self-report, 30-item screening tool that asks participants on a Likert scale (1-5) to report the frequency of abusive behaviors during a 6-month period.
- **Patient Health Questionnaire-9 (PHQ-9)** - Self-test that measures depressive feelings and behaviors during the past week to determine a person's depression quotient;
- **Adult Adolescent Parenting Inventory** - Widely used tool to identify adolescents and adults at risk for inadequate parenting behaviors;
- **Abusive Behavior Inventory** - self-report, 30-item screening tool that seeks to understand the extent of intimate partner violence occurring within a relationship
- **Protective Factors** (PFS-2) - 19-item measure designed for use with parents and caregivers participating in child maltreatment prevention services, such as home visiting, parent education, and family support.

4. PERFORMANCE REQUIREMENTS

Applicants should propose projects that meet the criteria listed below.

4.1 TARGET POPULATION

Grantees shall provide services to pregnant women and families with children ages zero through three years old residing in communities with high or disproportionate concentrations of the following indicators:

- premature births;
- low-birth weight infants;
- infant mortality (including infant death due to neglect);
- child maltreatment; and,
- other indicators conferring risk for poor perinatal, newborn, or child health outcomes
    - (ex. poverty; crime; domestic violence; less than high-school education; substance abuse; unemployment).

In addition to serving communities with high concentrations of the indicators listed above, the following sub-populations must be given priority in providing services:

[14]* Participation in DC Health's Screening HUB or alternate Data Collection Platform. The Screening HUB collects screening data from state and local organizations, early intervention programs, and early childhood education programs to reduce the duplication of services and connect families to timely and appropriate services.

- Families with mothers under the age of 21 years;
- Families with a history of child abuse or neglect or who have had interactions with child welfare services;
- Families with a history of substance abuse or in need of substance abuse treatment;
- Families experiencing unstable housing or homelessness;
- Families with caregivers who are currently incarcerated or previously incarcerated within the last 12 months;
- Families with caregivers who have intellectual disabilities caring for children ages zero through five years; and
- Families of children with developmental delays or disabilities.

4.2 Location of Services

Grantees must be located within the District of Columbia. Services must be delivered in Wards 5, 7 & 8.

4.3 Allowable Activities

- Program Development and Implementation:
    - Designing and implementing an innovative promising practice home visiting model and perinatal health workforce development program
    - Developing curriculum, training materials, and resources for both the home visiting model and workforce development program.
    - Recruiting and hiring staff, including program coordinators, instructors, and support personnel.
- Community Outreach and Engagement:
    - Conducting outreach activities to raise awareness about the programs among expectant mothers, families, community organizations, healthcare providers, and other stakeholders.
    - Establishing partnerships with local community organizations, healthcare facilities, educational institutions, and government agencies to support program implementation and referral pathways.
- Participant Recruitment and Enrollment:
    - Developing strategies for participant recruitment, targeting underserved populations, and ensuring inclusivity and cultural sensitivity in outreach efforts.
    - Facilitating the enrollment process for participants in both the home visiting model and the workforce development program, providing support and guidance as needed.
- Training and Education:
    - Providing comprehensive training and education for program participants in perinatal health topics, including prenatal care, childbirth, postpartum support, breastfeeding, and infant care.
    - Offering skill-building workshops, seminars, and hands-on experiences to prepare individuals for careers as doulas, midwives, lactation consultants, and other perinatal health professionals.
- Technology Integration:

    - Integrating technology-enabled solutions into the home visiting model and workforce development program to enhance accessibility, communication, and service delivery.
    - Developing and implementing telehealth services, mobile applications, online learning platforms, and virtual support groups to supplement in-person activities.
- Monitoring, Evaluation, and Quality Improvement:
    - Establishing systems for monitoring program activities, collecting data, and evaluating outcomes related to maternal health, participant engagement, workforce development, and program effectiveness.
    - Conducting regular evaluations to assess the impact of the programs, identify strengths and areas for improvement, and make data-driven decisions to enhance program quality and sustainability.

Centralized Intake System:

Applicants shall participate in DC Health's Help Me Grow Centralized Intake Process[15]. In 2018, the Birth-to-Three for All DC Amendment Act of 2018 initiated the development of a centralized intake system in the District. The legislation mandated that a centralized screening and referral mechanism be developed to facilitate the provision of home visiting services to families with infants and toddlers. This may be in the form of the DC Health Data Reporting System or similar system such as LinkU[16]. The applicant shall provide updated enrollment numbers as well as opening for referrals[17].

Referrals

The applicant's home visitors shall make the appropriate referrals based on the family's needs and screening results from the screening tools listed above. The home visitor and/or other designated staff shall also follow up on any referral made and provide assistance in completing referrals as participants' circumstances necessitate.

4.4 PROGRAM STRATEGIES

In alignment with the Framework for Improving Community Health[18] the 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. More outcomes and/or indicators may be required during the duration of the grant award.

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[15] https://dchealth.dc.gov/service/help-me-grow-dc#:~:text=HMG%20DC%20provides%20a%20free,ensure%20a%20connection%20is%20made.

[16] https://linkudmv.org/

[17] Technical Assistance will be provided on Centralized Intake System participation

[18] https://dchealth.dc.gov/sites/default/files/dc/sites/doh/Framework%20for%20Improving%20Community%20Health_r10.pdf

Service Area 1: Promising Practice

- *Key Performance Indicators:* Applicants should address the following key performance indicators and/or similar key performance indicators. Increase the number of at-risk families with children under the age of 5 enrolled in home visiting or home visiting support services
- Enrollment
    - Maintain 85% of at-risk families enrolled
- Depression Screening/Referral
    - 90% of caregivers participating in home visiting will be screened for depression
    - Identify the percent of caregivers screened and had a positive screen for depression
    - 100% of caregivers whom screened positive for depression will receive a referral to services
    - 90% of primary caregivers referred to services for a positive screen for depression, will receive one or more service contacts
- Postpartum Health Care Visit
    - 90% of mothers enrolled in home visiting prenatally or within 30 days of giving birth will receive a postpartum visit with their health provider within 8 weeks (56 days) following birth.
- Preterm Birth
    - Reduce the percent of infants (among mothers who enrolled in home visiting prenatally before 37 weeks) who are born preterm following program enrollment to less than 12.5%
- Safe Sleep
    - 100% of infants enrolled in home visiting will always be placed to sleep on their backs, without bed-sharing or soft bedding.
- Child Development Screening
        - 90% of children enrolled in home visiting will be screened for developmental delays using the ASQ-3
        - Identify the percent of children screened and had a positive ("refer") ASQ-3
        - 100% of children enrolled in home visiting who screen positive for developmental delays will be referred for follow-up evaluation and intervention as indicated by developmental screening with ASQ-3.
        - 90% of children enrolled in home visiting will be screened for developmental delays using the ASQ-SE.
        - Identify the percent of children screened and had a positive ("refer") ASQ-SE.
        - 100% of children enrolled in home visiting who screened positive for developmental delays will be referred for follow-up evaluation and intervention as indicated by developmental screening with ASQ-SE.
- Well-child Visits

    - 85% percent of children enrolled in home visiting will receive their last recommended visit based on AAP Bright Futures schedule.
- Maternal Smoking or Tobacco Use
    - Reduce the percent of primary caregivers enrolled in home visiting who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment to less than 12.5%.
    - Reduce the percent of marijuana use during pregnancy to less than 2.5%.
- Breastfeeding
    - 85% percent of infants (among mothers who enrolled in home visiting prenatally) will be breastfed for any amount by 8 weeks of age

Service Area 2: Workforce Development:

Key Performance Indicators: Applicants should address the below key performance indicators or similar key performance indicators.

- Enrollment and Graduation Rates:
    - Enrolled a minimum of 50 individuals in the workforce development program annually.
    - 75% percent of program participants will successfully complete certification requirements.
- Diversity and Inclusion:
    - 85% percent of program participants will be from underrepresented communities in the perinatal health workforce.
    - Collect participant feedback regarding the inclusivity and cultural responsiveness of the program.
- Employment Placement:
    - 75% percentage of program graduates will secure employment in perinatal health-related roles within six months of program completion.
    - Assess employer satisfaction with the skills and preparedness of program graduates.
- Long-Term Impact:
    - 50% of program graduates will maintain employment as a perinatal health professionals in the workforce one-year post-program completion.
    - 50% of program graduates will report career advancement opportunities and professional growth.
    - Stakeholder feedback from healthcare providers, community organizations, and policymakers regarding the effectiveness and value of the programs.
- Maternal Health Outcomes:

- Rates of preterm birth, low birth weight, and maternal complications among program participants.
    - 75% of women who enrolled prenatally will initiate prenatal care in the first trimester
    - Reduce the percent birth to teens age 15-19 (/1,000)[19] to less than 10.4%
    - Reduce the percent of births that are unintended to less than 28%

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

[19] (per 1,000 people).

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.
- **Outcomes, Goal(s) And Objectives:** Identify the outcome measures, major goal(s) and objectives for the project. Typically, the outcome measures are overarching, the goal(s) are stated in a sentence, and the objectives are presented in a numbered list
- **Methodology:** Briefly list the major activities used to attain the goal(s) and objectives

PROJECT NARRATIVE (10-page maximum)

The narrative section should describe the applicant's 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 population as relevant to the project, including rates 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.

Applicants that propose a promising practice as their home visiting program, must:

- Describe the model(s) proposed as a promising approach and/or workforce development program (e.g., description, empirical research citation(s), program goals and outcomes, supervisor to staff ratio, staff to participant ratio, target population, caregiver outcomes, child outcomes, program model components, program model intensity/dosage and length, specify how the proposed promising practice or workforce development meets the needs identified in the target community (communities), describe the overall approach to quality assurance and improvement; and describe current and past prior experience with implementing the promising practice model).
- Provide any existing data or results stemming from involvement in either the proposed home visitation program and/or the workforce development program. If this is a new program provide the proposed information requested above.

PARTNERSHIPS

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

- Describe the applicant's experience working collaboratively with government agencies, including public health, behavioral health, education and child welfare, to implement community-based programs.
- Describe the applicant's experience working with agencies and organizations in other sectors to advance a community or public health goal and achieve improved community health and social outcomes.
- Describe plans for establishing a new, or engaging an existing, cross-sector network of partners to support the implementation, and evaluation, if applicable, of the applicant's program.
- Applicants should provide two (2) letters of commitment or support from other agencies and organizations pertinent to the success of the proposed project. As appropriate, identify meaningful support and collaboration with key stakeholders in planning, designing, and implementing all activities, including development of the application.
- Applicant describes ability to partner with DC Health in initiatives that impact residents around the topics outlined in this RFA.

IMPLEMENTATION

This section should provide an overview for the project implementation and for ongoing monitoring of the quality of implementation of the program at the community, agency, and participant level. Applicants should address all areas described below:

Participant Engagement:

- The estimated number of families served,
- Plans to identify, recruit, enroll, and retain participants in the program,
- A plan for minimizing the attrition rates for participants enrolled in the program,
- An estimated timeline to reach the maximum caseload,
- Assurance that priority will be given to serve participants from priority subpopulations *(please see Target Population Section for more details)*,
- Assurance that required screenings *(please see Target Population Section for more details)* will be conducted with participant families and that services and referrals will be provided in accordance with those individual assessments; and
- Assurance that services will be provided on a voluntary basis.

Community Engagement:

- A description of the process for engaging the target community (communities) in the implementation of the proposed home visiting model or workforce development program, including identifying the organizations, institutions or other groups and individuals consulted.
- Describe coordination among the proposed home visiting model or workforce development program and other existing programs and resources in those communities, especially regarding health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services.

Program Staffing:

- Describe the plan for recruiting, hiring, and retaining appropriate staff. Also include a plan for implementation and oversight during vacancies or extended absences for all positions.
- Describe the plan to ensure high quality supervision and reflective practice for all home visitors and supervisors.
- Describe how and what types of initial and ongoing training and professional development activities will be provided for staff.

Program Monitoring:

- Describe the management information system(s) that will be used to track data on program implementation, referrals, and participants' outcomes.
- Describe incorporating and management of DC Health Data Reporting Platforms.
- Describe collaboration efforts with DC Health regarding data sharing, evaluation, and monitoring activities.
- Explain the approach to monitoring, assessing, and supporting implementation with fidelity to the chosen model(s) and maintaining quality assurance.
- Describe how ongoing continuous quality improvement will be incorporated; and,

- Discussion of anticipated challenges to maintaining quality and fidelity, and the proposed response to the issues identified.

Sustainability:

- Propose a plan for project sustainability after the period of funding ends, which sustains key methods and activities of the project.

EVALUATION

Applicants that propose to implement a promising practice home visiting program or workforce development are required to conduct an evaluation that is well-designed, rigorous, and effectively executed. The evaluation plans should follow an established scientific framework, such as the Centers for Disease Control's Framework for Program Evaluation for Public Health Programs or the Reach Effectiveness Adoption Implementation Maintenance (RE-AIM) framework. Include an evaluation plan specifying how the proposed promising approach (es) will be evaluated (*Appendix B: Evaluation*). <u>If awarded, the applicant</u> <u>must submit an updated evaluation plan within 90 days after the receipt of the award</u>.

- The evaluation methodology should be specific and related to the stated goals, objectives, and priorities of the project. Additionally, the evaluation should be linked to the project's logic model.
- Describe questions the evaluation will address. The question should be listed in a table in this section of the application.
- Describe how data will be collected and managed (e.g., assign skilled staff, data management software) in a way that allows for accurate and timely reporting of performance outcomes.
- Describe how you plan to use evaluation findings.
- 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. Applicants will be required to allocate 10% of the total requested budget for evaluation activities. The applicant should provide appropriate support for their evaluation budget in the budget justification.
- Discuss the anticipated challenges to implementing or evaluating the promising practice or workforce development, proposed response to issues identified, and any anticipated technical assistance needs.

PERFORMANCE MONITORING

This section should describe applicant's plan for collecting and reporting individual-level demographic and service-utilization data on the participants in their program as necessary to reach 85% capacity of the target population based on a needs assessment, analyze and understand the progress children and families are making. Individual-level demographic and service utilization data may include but are not limited to the following:

- Family's participation rate in the home visiting program (e.g., number of sessions/numbers of possible sessions, duration of sessions).
- Demographic data for the participant child or children, pregnant woman, expectant father. parent(s), or primary caregiver(s) receiving home visiting services including child's

gender, age of all (including age in month for child) at each data collection point and racial and ethnic background of all participants in the family.
- Family socioeconomic indicators (e.g., family income, employment status).

In addition to the reporting demographic and service-utilization data, applicants must collect all performance measures (*See Performance Measure table*) data. The applicant must propose a plan for collecting data on all families that have been enrolled in the home visiting/ workforce development program. This section should address the following:

- A plan for a data collection schedule including how often the measure will be collected and analyzed. Include a plan for participation and management of DC Health Data Reporting Platforms.
- Describes the minimum qualifications or training requirements for administrators of measures, qualifications of personnel responsible for data management, and the time estimated for the data collection-related activities by personnel categories.
- A plan for ensuring the quality of data collection and analysis.
- Plans for gathering and analyzing demographic and service-utilization data on the children and families served to better understand the progress children and families are making and inform *quality assurance* and *quality improvement* (*QA*/*QI*) activities.
- A plan for data safety and monitoring including privacy of data, administration procedures that do not place individuals at risk of harm (e.g., questions related to domestic violence and child maltreatment reporting), and compliance with applicable regulations related to IRB/human subject protections, HIPAA, and FERPA. The plan must include training for all relevant staff on these topics.
- Any anticipated barriers or challenges in the benchmark reporting process (including the data collection and analysis plan) and possible strategies for addressing these challenges.

ORGANIZATIONAL CAPACITY

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

LOGIC MODEL

A one-page logic model is required. 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 (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 SMART. 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:

- October 1, 2024 – September 30, 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 consultants and/or contractual.

ORGANIZATIONAL CHART

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

LETTERS OF COMMITMENT OR SUPPORT

A Letter of Commitment indicates the signatory's intent to commit specific resources to the funded project, as specified in the letter, should the proposal be funded. It serves as a formal commitment from an organization or individual to provide support, whether it's financial, in-kind, or other resources. The letter may also highlight the partner's rationale for supporting the project and emphasize the strengths of the organization that could contribute to successful implementation or sustainability.

A Letter of Support expresses an organization's knowledge of and support for the project. It goes beyond commitment and provides additional context:

- Why the project is important.
- How it aligns with the organization's mission or goals.
- Any unique qualifications or abilities of the proposing organization.

Applicants must provide two (2) letters of commitment or letters of support for existing partnerships if performance will depend on another organization.

- Identify the organizations, agencies, or individuals who will provide support or collaborate on the project.
- These partners could be other nonprofits, government agencies, community organizations, or businesses.
- Each letter should be personalized and specific to the project.
    - Confirmation of their commitment to the project.
    - Description of their role or contribution.
    - Assurance of their support during project implementation.
    - Any resources (financial, in-kind, expertise) they will provide.
    - Letters should be on official letterhead and signed by an authorized representative
    - Ensure that the letters are dated and addressed to the grantor.

RISK SELF-ASSESSMENT

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

6. EVALUATION CRITERIA

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

CRITERION 1: NEED

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

- The applicant provided a comprehensive and clear explanation of the proposed project, ensuring alignment with the Request for Applications (RFA). This alignment demonstrates a thorough understanding of the project's purpose and scope. (10 points)
- The applicant identified the overarching problems or challenges that the project aims to address. These problems are well-defined and relevant to the project's context. Additionally, the applicant outlined contributing factors that exacerbate these problems. (5 points)
- The applicant described how the proposed project intends to tackle the identified problems. This included specific strategies, interventions, or approaches. It has highlighted the potential impact on mitigating or resolving the identified issues. (5 points)

CRITERION 2: IMPLEMENTATION

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

- The applicant outlined a clear plan for recruiting, hiring, training/professional development, and retaining appropriate staff. This plan addresses implementation and oversight during staff vacancies or extended absences. (5 points)
- The applicant addresses how they intend to minimize attrition rates among participants. This could involve engagement strategies, personalized support, or other relevant approaches. (5 points)
- The applicant included two (2) letters from relevant agencies and organizations expressing commitment or support for the proposed project. These letters demonstrate external backing and contribute to the project's success. (5 points)

- The applicant explains how the target community (or communities) will be involved in implementing the proposed home visiting model or workforce development program. Organizations, institutions, or individuals consulted during the planning process, and their contributions have been identified. (5 points)
- The applicant provided a detailed work plan that outlines goals that are Specific, Measurable, Achievable, Relevant, and Time-bound, Inclusive and Equitable (SMARTIE). (5 points)
- The applicant describes how the project aims to achieve sustainability beyond its initial implementation phase. Consider financial, organizational, and community aspects. (5 points)

CRITERION 3: EVALUATIVE MEASURES

(25 POINTS) – Corresponds to Sections: Performance Monitoring

- Includes a logic model that is clear and concise and demonstrates achievable inputs (resources), activities, outputs (deliverables), and outcomes (impact) that are interconnected and in alignment with the Request for Applications (RFA). (10 points)
- The applicant provides evidence demonstrating how and their ability to assess and analyze the proposed program(s). The applicant provides a detailed explanation of how data will be collected, shared, and managed (e.g., assign skilled staff, data management software, and use of DC Health's DCRS) to report on the proposed program process and outcome measures accurately. (5 points)
- The applicant provided evidence demonstrating their ability to implement both the home visiting and workforce development models effectively. Consideration is given to past experiences, available resources, and organizational structures that support successful implementation. (*see Evaluation sections*). (10 points)

CRITERION 4: CAPACITY

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

- The applicant has demonstrated qualifications of the project personnel (by training and/or experience) to implement and carry out the project. The experience of project personnel may include maternal health, early childhood systems development, and leadership; children's developmental health, family well-being, home-visiting, and place-based community involvement. (5 points)
- Evaluate whether the applicant demonstrates an adequate information management infrastructure with consideration to their ability to collect, analyze, and manage program data effectively. (5 points)
- The extent to which the applicant described how quality assurance and improvement Quality Assurance and Quality Improvement (QA/QI) activities will be incorporated into programmatic implementation. (5 points)
- The applicant describes their experience and success working with agencies and organizations in other sectors and plans to support implementation and to advance a

community or public health goal and achieve improved community health and social outcomes (see partnerships section). (5 points)

- The applicant describes how the participation with/of other partners will be incorporated in the project (e.g., Healthy Start, Home Visiting, WIC, housing, public-private, perinatal and early childhood partnerships, and businesses) that support maternal health and children's developmental health and family well-being. (5 points)

7. REVIEW AND SCORING OF APPLICATION

7.1 ELIGIBILITY AND COMPLETENESS REVIEW

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

7.2 EXTERNAL REVIEW

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

7.3 INTERNAL REVIEW

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

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

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

8. POST AWARD ASSURANCES & CERTIFICATIONS

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

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

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

9. APPLICATION SUBMISSION

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

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

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

9.1 REGISTER IN EGMS

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

1. **Access EGMS**: The user must access the login page by entering the following URL: https://egrantsdchealth.my.site.com/sitesigninpage. Click the button REGISTER and following the instructions. You can also refer to the EGMS Reference Guides.
2. Determine the agency's Primary User (i.e. authorized to accept terms of agreement, certify and submit documents, request and accept modifications). The Primary User will determine a Secondary User and send a notification via EGMS for him/her to set-up an account.

3. Your EGMS registration will require your legal organization name, your **UEI# and Tax ID#** in order to complete the registration. Your EGMS registration will also require your SAM (System for Award Management) expiration date to be entered into your agency profile. Please ensure that you have an active SAM registration (www.sam.gov).
4. When your Primary Account User request is submitted in EGMS, the Office of Grants Management will review the request. If the requester is NOT the identified Executive Director, DC Health Office of Grants Management will make an additional request for the Executive Director to send an email to DC Health to confirm that the requester is the authorized representative for EGMS. When requested, your authorized representative should send to doh.grants@dc.gov the name, title, telephone number and email address of the desired Primary User for the account. Note: The email will help to support the validation of authorized users for EGMS. DC Health official grant records will also be used. Please reply ASAP to any requests from Office of Grants Management to provide additional information, if needed.

EGMS User Registration Assistance:

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

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

9.2 Uploading the Application

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

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

- ***Proposal Documents***

- Proposal Abstract
- Project Narrative (10-page maximum)
- Budget Table
- Budget Justification
- Organization Chart
- Work Plan
- Logic Model
- Letters of Commitment (2) (*see partnerships section*)
- Risk self-assessment

9.3 DEADLINE

Submit your application via EGMS by 3:00 p.m., on the deadline date of June 4, 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. A3pplicants are not required to attend but it is highly recommended. ***Registration is required***.

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

Note that questions will only be accepted in writing. Answers to all questions submitted will be published on a Frequently Asked Questions (FAQ) document onto the District Grants Clearinghouse every three business days. Questions will not be accepted after April 25, 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.

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 B: Evaluation

Appendix C: Performance Measures Table

APPENDIX A: MINIMUM INSURANCE REQUIREMENTS

INSURANCE

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Sexual/Physical Abuse & Molestation - The Grantee shall provide evidence satisfactory to the PM with respect to the services performed that it carries $1,000,000 per occurrence limits; $2,000,000 aggregate of affirmative abuse and molestation liability coverage. Coverage should include physical abuse, such as sexual or other bodily harm and non-physical abuse, such as verbal, emotional or mental abuse; any actual, threatened or alleged act; errors, omission or misconduct. This insurance requirement will be considered met if the general liability insurance includes an affirmative sexual abuse and molestation endorsement for the required amounts. So called "silent" coverage under a commercial general liability or professional liability policy will not be acceptable.

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

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

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

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

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

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

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

H. CERTIFICATES OF INSURANCE. The Grantee shall submit certificates of insurance giving evidence of the required coverage as specified in this section prior to commencing

work. Certificates of insurance must reference the corresponding contract number. Evidence of insurance must be submitted to the: Enterprise Grants Management System.

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

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

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

APPENDIX B – EVALUATION

DC Health expects that the program funded under this RFA will develop a knowledge base around successful strategies for the effectiveness, implementation, adoption and sustainability of evidence-informed home visiting programs. There is a particular interest in understanding:

- Efficacy in achieving improvements in maternal and child health outcomes.
- Effective strategies to adapt an existing evidence-based model to meet the needs of communities.

Furthermore, DC Health is especially interested in the use of evaluation strategies that emphasize the use of research to help guide program planning and implementation. To support the evaluation efforts around promising practice programs, applicants must allocate a minimum of 10% of funds for a rigorous evaluation in all years of the award.

DC Health expects applicants to engage in an evaluation of sufficient rigor to demonstrate potential linkages between project activities and improved outcomes. Rigorous research incorporates the four following criteria:

- **Credibility**: Ensuring what is intended to be evaluated is actually what is being evaluated; making sure that descriptions of the phenomena or experience being studied are accurate and recognizable to others; ensuring that the method used is the most definitive and compelling approach that is available and feasible for the question being addressed. If conclusions about program efficacy are being examined, the study design should include a comparison group.
- **Applicability**: Generalizability of findings beyond current project (i.e., when findings "fit" into contexts outside the study situation). Ensuring the population being studied represents one or more of the populations being served by the program.
- **Consistency**: When processes and methods are consistently followed and clearly described, someone else could replicate the approach, and other studies can confirm what is found.
- **Neutrality**: Producing results that are as objective as possible and acknowledge the bias brought to the collection, analysis, and interpretation of the results.

The project narrative should address how the evaluation of the program will be conducted – including evaluation methods, measurement, data collection, sample and sampling (if appropriate), timeline for activities, plan for securing IRB review, and analysis. It is highly recommended applicants subcontract with an institution of higher education, or a third-party evaluator specializing in social sciences research and evaluation, to conduct the evaluation. It is important that the evaluators have the necessary independence from the project to assure objectivity. A skilled evaluator can help develop a logic model and assist in designing an evaluation strategy that is rigorous and appropriate given the goals and objectives of the proposed project.

APPENDIX C– PERFORMANCE MEASURE TABLE

Topic Area	Indicator	Numerator	Denominator:
Depression Screening/Referral	Percent of caregivers participating in home visiting screened for depression	Number of mothers participating in home visiting who received maternal depression screen with PHQ-9	Number of mothers enrolled in home visiting
	Percent of caregivers screened and had a positive screen depression	Number of primary caregivers enrolled in home visiting who had a positive screen for depression	Number of mothers enrolled in home visiting
	Percent of caregivers whom screened positive and a referral is made.	Number of primary caregivers enrolled in home visiting who received a referral for services	Number of primary caregivers enrolled in home visiting who had a positive screen for depression
	Percent of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts	Number of primary caregivers enrolled in home visiting who received recommended services for depression (and met the conditions specified in the denominator)	Number of primary caregivers enrolled in home visiting who had a positive screen for depression within 3 months of enrollment and were referred for services
Postpartum Health Care Visit	Percent of mothers enrolled in home visiting prenatally or within 30 days of giving birth who received postpartum visit with health provider within 8 weeks (56 days) following birth.	Number of mothers enrolled in home visiting prenatally or within 30 days of giving birth who completed postpartum visit with a health provider within 8 weeks (56 days) following birth.	Number of mothers enrolled in home visiting prenatally or within 30 days of giving birth and remained enrolled for at least 8 weeks (56 days) after delivery.
Preterm Birth	Percent of infants (among mothers who enrolled in home visiting prenatally before 37 weeks) who are born preterm following program enrollment	Number of live births (index child or subsequent children among mothers who enrolled in home visiting prenatally before 37 weeks) born before 37 completed weeks of gestation and after enrollment	Number of live births after enrollment who were born to mothers enrolled in home visiting prenatally before 37 weeks

Safe Sleep	Percent of infants enrolled in home visiting that are always placed to sleep on their backs, without bed-sharing or soft bedding	Number of infants (index child aged less than 1 year) enrolled in home visiting whose primary caregiver reports that they are always placed to sleep on their backs, without bed-sharing or soft bedding.	Number of infants (index child) enrolled in home visiting who were aged less than 1 year during the reporting period.
Child Development Screening	Percent of children enrolled in home visiting screen for developmental delays using the ASQ-3	Number of children enrolled in home visiting with at least one screening within the American Academy of Pediatrics (AAP) schedule -defined age groups during the reporting period	Number of children enrolled in home visiting reaching the specified time frame during the reporting period
	Percent of children screened and had a positive ("refer") ASQ-3	Number of children enrolled in home visiting whom had a positive ("refer") ASQ-3	Number of children enrolled in home visiting with positive screens for developmental delays (measured using the ASQ-3)
	Percent of children enrolled in home visiting referred for follow-up evaluation and intervention as indicated by developmental screening with ASQ-3.	Number of children enrolled in home visiting who received developmental screening with ASQ-3 that indicated need for referral who were referred for follow-up evaluation and intervention as indicated.	Number of children enrolled in home visiting who received developmental screening with ASQ-3 and whose screening results indicated need for referral.
	Percent of children enrolled in home visiting screen for developmental delays using the ASQ-SE	Number of children enrolled in home visiting with at least one screening within the AAP-defined age groups during the reporting period	Number of children enrolled in home visiting reaching the specified time frame during the reporting period
	Percent of children screened and had a positive ("refer") ASQ-SE	Number of children enrolled in home visiting whom had a positive ("refer") ASQ-SE	Number of children enrolled in home visiting with positive screens for developmental delays (measured using the ASQ-SE)
	Percent of children enrolled in home visiting referred for follow-up evaluation and intervention as indicated by developmental screening with ASQ-SE.	Number of children enrolled in home visiting who received developmental screening with ASQ-SE that indicated need for referral who were referred for follow-up evaluation and intervention as indicated.	Number of children enrolled in home visiting who received developmental screening with ASQ-SE and whose screening results indicated need for referral.

Well-child Visits	Percent of children enrolled in home visiting who received last recommended visit based on AAP Bright Futures schedule	Number of children enrolled in home visiting who received their last recommended well-child visit since enrollment, based on AAP schedule.	Number of children enrolled in home visiting
Maternal Smoking or Tobacco Use	Percent of primary caregivers enrolled in home visiting who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment.	Number of primary caregivers enrolled in home visiting who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment	Number of primary caregivers enrolled in home visiting who reported using tobacco or cigarettes at enrollment and were enrolled for at least 3 months
Breastfeeding	Percent of infants (among mothers who enrolled in home visiting prenatally) who were breastfed any amount at 6 months of age	Number of infants aged 6-12 months (among mothers who enrolled in home visiting prenatally) who were breastfed any amount at 6 months of age	Number of infants aged 6-12 months (among mothers who enrolled in home visiting prenatally) enrolled in home visiting for at least 6 months