DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

Community Health Administration

Improving Health Care Workforce Wellness: A Pilot to Reduce EMR Burden

REQUEST FOR APPLICATIONS (AMENDED Section 1.5.3)

FO# CHA-IWW-8.4.23

SUBMISSION DEADLINE:

WEDNESDAY SEPTEMBER 6, 2023 BY 6:00 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-IWW-8.4.23

Improving Health Care Workforce Wellness: A Pilot to Reduce EMR Burden

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:	Improving Health Care Workforce Wellness: A Pilot to Reduce EMR Burden
Funding Opportunity Number:	CHA-IWW-8.4.23
DC Health Administrative Unit:	Community Health Administration
DC Health Program Bureau	Health Care Access Bureau
Funding Opportunity Contact:	Khalil Hassam, Primary Care Office Director, PCORFA@dc.gov
Funding Opportunity Description:	This funding opportunity is to request proposals from qualified applicants to serve as an administrative agent to distribute funds to District primary care providers. Primary care providers should purchase and implement technology solutions that improve the use of electronic health records.
Eligible Applicants	Non-profit organizations
Anticipated # of Awards:	1
Anticipated Amount Available:	$440,000
Annual Floor Award Amount:	$440,000
Annual Ceiling Award Amount:	$440,000
Legislative Authorization	FY24 Budget Support Act of 2023
Associated CFDA#	N/A

Associated Federal Award ID#	N/A
Cost Sharing/Match Required?	N/A
RFA Release Date:	August 4, 2023
Letter of Intent Due date:	Not applicable
Application Deadline Date:	September 6, 2023
Application Deadline Time:	6:00 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.

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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
  - ☐ Letters of Support
- ☐ 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: **July 21, 2023**
- Request for Application Release Date: **August 4, 2023**
- Pre-Application Meeting Date: **visit https://OGMDCHealth.eventbrite.com**
- Application Submission Deadline: **September 6, 2023**
- Anticipated Award Start Date: **November 1, 2023**

1.2 OVERVIEW

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

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

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

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* The *medical home* is a team-based model for providing safe, high quality primary care that is accessible, patient- and family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective; the *dental home* is a more recent adaptation of this model for oral health care.

American Academy of Pediatrics. 2022. *What is a Medical Home?* https://www.aap.org/en/practice-management/medical-home/medical-home-overview/what-is-medical-home/

American Academy of Pediatric Dentistry. 2023. *Definition of Dental Home.* https://www.aapd.org/research/oral-health-policies--recommendations/Dental-Home/

1.3 Purpose

The purpose of this funding is to test and evaluate technology solutions to reduce Electronic Medical Records (EMR) documentation time, a key driver of primary care provider burnout. The funding, distributed by an administrative agent, will cover the up-front cost to purchase technology and protected time for providers to train on and implement a technology solution.

As a part of this pilot, DC Health will separately fund technical assistance to primary care providers to implement technology solutions for eClinical Works, an EMR highly utilized by primary care providers in the District.

1.4 Source of Grant Funding

Funding is anticipated to be available using local FY24 Budget Support Act of 2023 funds.

1.5 Award Information

1.5.1 Amount of Funding Available

The total funding amount of $440,000 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 November 1, 2023 and to continue through September 30, 2024. After the first budget period, there will be one additional budget period for a total grant project period of November 1, 2023 – September 30, 2025. The number of awards, budget periods, and award amounts are contingent upon the continued availability of funds, grantee performance and compliance, and strategic priorities of DC Health.

1.5.3 Eligible Organizations/Entities

Non-profit, community-based organizations are eligible to apply for grant funds under this funding opportunity. As DC Primary Care Association (DCPCA) has been identified as the primary technical assistance provider for the sub-grantees, they are not eligible to compete for this award.

Considered for funding shall be organizations meeting the above eligibility criteria and having documentation of having previously served as an administrative agent and distributing funds to sub-grantees.

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 HEALTHCARE WORKFORCE BURNOUT

Between January 2021 and December 2022, nearly 98 million Americans quit their jobs in what has commonly been referred to as the Great Resignation; this includes more than 12.6 million workers in the healthcare and social assistance sector, at a rate of approximately 2.6 percent of the workforce each month.[1] Attributable to an array of factors, and exacerbated by the global COVID-19 pandemic, workers across all sectors are increasingly reconsidering and reprioritizing the role of work in their lives, "especially those who were burning out in demanding jobs that intruded on their ability to care for their families."[2]

Burnout and related factors impacting worker health and wellness (e.g., chronic work-related stress, anxiety, depression, exhaustion) have been widely reported among the healthcare workforce, and are also often discussed among the primary drivers of healthcare workforce attrition.[3,4,5,6,7] Consequences of unaddressed chronic work-related stress and burnout among the healthcare workforce are wide-ranging, including increased risk for poor mental (e.g., anxiety, depression, substance use/abuse) and physical (e.g., insomnia, cardiovascular disease, diabetes, occupational injury) health outcomes, relationship and interpersonal challenges and conflict, moral distress and injury, and suicide.[8,9,10] Beyond individual worker impacts, burnout also impacts patients (e.g., decreased time with healthcare workers, delays in care and diagnosis, lower quality of care, medical errors), health care organizations (e.g., retention challenges, increased attrition, increased costs, increased risk of malpractice, decreased patient satisfaction, limited service availability), and communities/society more broadly (e.g., population health outcomes, increased health inequities/disparities, lack of preparedness for public health crises).[11,12,13] In a 2020 survey of healthcare workers,[14] burnout, COVID-19 related anxiety and depression, and workload were each found to be independently related to intent to reduce work hours and intent to leave.[15]

Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce calls attention to burnout as an urgent and significant U.S. public health challenge needing immediate attention, noting, "it is especially worrisome among health workers given the potential impacts on our health care system and therefore, our collective health and well-being."[16]

2.2 ORGANIZATIONAL DRIVERS OF BURNOUT

The *Surgeon General's Advisory* highlights that while "burnout is associated with risk of mental health challenges, such as anxiety and depression… [it] is not an individual mental health diagnosis. While addressing burnout may include individual-level support, *burnout is a distinct workplace phenomenon that primarily calls for a prioritization of systems-oriented, organizational-level solutions*."[17]

The research literature identifies a wide range of organizational drivers and/or mitigators commonly correlated with burnout, including those related to organizational culture, climate, and

work environment factors (e.g., leadership, communications, collaboration)[18,19,20,21] and work system factors (e.g., excessive workload, unmanageable work schedules, long work hours, inefficient work processes and environments, administrative and technical burden, and pay).[22,23,24,25,26]

In October 2022, the DC Health PCO published a request for stakeholder input on the DC Health website, providing opportunities for District stakeholders[3] to submit written comments or schedule a 30-minute meeting with DC PCO staff to discuss key factors impacting workforce wellness and opportunities and approaches to support the District's healthcare workforce, reduce and prevent provider burnout, promote and improve provider health and wellness, and ultimately, increase provider retention in the District. Between November 1, 2022 and January 3, 2023, DC PCO received one (1) written response and conducted 16 listening sessions with an array of stakeholders, including providers and leaders from healthcare provider organizations (i.e., FQHCs, community health centers, hospitals, health systems) and in private practice, as well as representatives of professional organizations/trade associations. The results of this process reflected the research literature, with respondents citing several key factors contributing to burnout among District healthcare professionals, including workload and intensity; inadequate staffing, turnover, and attrition, leadership, both organizational and frontline managers; and most often, administrative burden, particularly related to the EMR.

2.3 EMR Burden

The impact of EMR burden has been widely explored in the academic literature, and is commonly cited by clinicians as the **most important stressor** in their practice. [27,28,29] A 2022 scoping review of EMR-related burnout in healthcare providers identified associations between EMR-related burnout and message and alert load, time spent on EMRs, organizational support, EMR functionality and usability, and general use of EMRs.[30] Similarly, a 2023 literature review examining EMR-related burnout in primary care found "contributors to EMR-related burnout may be organized into broad categories of time demands, documentation and clerical burdens, complex usability, cognitive load, and electronic messaging volume."[31]

Similarly, respondents to the DC PCO's request for stakeholder input cited the increasing volume of administrative tasks—particularly related to the electronic health record and patient portal messaging—as among, if not the primary driver of stress and burnout. Commonly cited issues included difficulty working in and navigating the EMR; lack of comprehensive and/or ongoing training; drastically increased volume of electronic messages received through patient portals in recent years; and the need to continue working on EMR documentation and responding to patient messages at home outside of paid work hours.

2.4 Speech Recognition-Assisted Documentation

One approach to reducing EMR-related administrative burden and time spent in the EMR is the use of speech recognition software to automate documentation. In a 2016-2017 survey of clinicians at two large medical centers, approximately 79 percent of respondents self-reported satisfaction with speech recognition and 77 percent reported improved efficiency.[32] A 2022 comparative review of four modes of EMR documentation—speech recognition, medical scribes, EMR shortcuts and templates, and digital scribes (artificial intelligence)—the authors noted "the current literature has a dearth of evidence-based studies to support any one initiative over another." Regarding speech recognition technologies, they found "no clear consensus on the benefits of speech recognition over transcription/self-typing for charting purposes… variables such as turnaround time, accuracy, documentation time, and recognition rates were measured but the results are inconclusive, mainly because there was low subject participation and poor stratification of providers."[33] A 2018 systematic review of the literature from 1990 to 2018 identified mixed results among research examining documentation time (n=20), with seven reporting decreases in documentation time ranging from 19 to 92 percent (as compared to conventional transcription or keyboard and touchscreen interface); nine reporting increased documentation times; and four reporting no significant change. However, the authors noted, "studies also varied in which aspect of the documentation process they evaluated" (e.g., impact of speech recognition on clinicians vs. transcriptionists' productivity, with transcriptionists more likely to experience increased documentation times). All studies reporting on turnaround time (i.e., amount of time between dictation completion and report availability; n=19) "found that implementing SR technology reduced mean and/or median turnaround times, often by more than 90%."[34] Reduced turnaround time is important not only because it indicates reduced time for the whole documentation process, but because incomplete medical records can negatively impact patients (e.g., quality of care, safety, doctor/patient communication and treatment plan adherence), organizational finances (e.g., insurance reimbursement), and put both organizations and providers at increased legal risk.

Respondents to the DC PCO's request for stakeholder input also discussed promising practices related to reducing EMR-related task load through various efforts, including EMR optimizations, templates, dedicated weekly support hours, and the adoption and integration of speech recognition/dictation technologies into EMRs. One health system senior executive described how organization-wide adoption of Dragon Medical One speech recognition and documentation software has demonstrated significant reductions in time clinicians spend in the EMR. However, as another primary care provider whose health system has also adopted transcription technologies noted, while they have found the technology to be helpful, there is also a need for a better approach to training on the implementation of new technologies.

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[5] Maunder RG, Heeney ND, Strudwick G, et al. 2021. Burnout in hospital-based healthcare workers during COVID19. Science Briefs of the Ontario COVID-19 Science Advisory Table. 2(46). https://doi.org/10.47326/ocsat.2021.02.46.1.0
[6] Edwards, S.T., M. Marino, L.I. Solberg, et al. 2021. Cultural and Structural Features of Zero-Burnout Primary Care Practices. Health Affairs. 40(6). https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2020.02391
[7] Mete M, Goldman C, Shanafelt T, et al. 2022. Impact of Leadership Behaviour on Physician Well-Being, Burnout, Professional Fulfilment and Intent to Leave: A Multicentre Cross-Sectional Survey Study. BMJ Open. 12(6). https://bmjopen.bmj.com/content/12/6/e057554
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[11] U.S. Office of the Surgeon General. 2022. Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce. https://www.hhs.gov/sites/default/files/health-workerwellbeing-advisory.pdf
[12] Leo, C.G., S. Sabina, M.R. Tumolo, et al. 2021. Burnout Among Healthcare Workers in the COVID 19 Era: A Review of the Existing Literature. Frontiers in Public Health. 9. https://www.frontiersin.org/articles/10.3389/fpubh.2021.750529/full
[13] Shanafelt, T., J. Goh, & C. Sinsky. 2017. The Business Case for Investing in Physician Well-being. 177(12):18261832. https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2653912
[14] Respondents included healthcare workers in clinical and nonclinical roles across 124 large healthcare organizations (i.e., employing more that 100 physicians).
[15] Sinsky, C.A., R.L. Brown, M.J. Stillman, & M. Linzer. 2021. COVID-Related Stress and Work Intentions in a Sample of US Health Care Workers. Mayo Clinic Proceedings: Innovations, Quality & Outcomes 5(6):1165-1173. https://www.sciencedirect.com/science/article/pii/S2542454821001260
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[26] Ontario Medical Association Burnout Task Force. 2021. Healing the Healers: Systems-Level Solutions to Physician Burnout. https://www.oma.org/uploadedfiles/oma/media/pagetree/advocacy/health-policyrecommendations/burnout-paper.pdf
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3. PURPOSE

3.1 APPROACH

DC Health is requesting proposals from qualified applicants to serve as an administrative agent. The key functions are to

1. Advertise the funding to a wide variety of primary care providers, ranging from single practitioner or multi-provider practices, to Federally Qualified Health Centers and health systems.
2. Review and confirm eligibility (Sections 4.1 and 4.2) of organizations.
3. Distribute the funds to at least eight (8) unique organizations.
4. Provide funding up to the allowable amount (Section 4.3).
5. Ensure funds are used only for allowable activities (Section 4.3).
6. Collect data (Section 4.4) from sites before and after implementation of a technology solution.

4. PERFORMANCE REQUIREMENTS

Applicants should propose projects that meet the criteria listed below.

4.1 TARGET POPULATION

Grantee shall provide sub awardee funds to outpatient health sites, that provide primary care to underserved populations, as evidenced by forty-five percent or greater of site's primary care encounter volume allocated to Department of Health Care Finance beneficiaries (Medicaid, Alliance), sliding-fee, or uncompensated care.

4.2 LOCATION OF SERVICES

Grantees must be located within the District of Columbia. Funds must be delivered to sub-awardees in the following settings:

- Outpatient ambulatory health sites providing primary medical care
- Outpatient clinical sites located in a Primary Care Health Professional Shortage Area (can be verified through HRSA Data Warehouse [link])

4.3 Allowable Activities

Grantee funds can be used for:

- Personnel, to manage and disburse funds, and collect data from sub-awardees, not to exceed 12% of total funds
- Administrative costs
- Direct payments to primary care organizations for technology enhancements

Sub-awardee primary care organizations can use the funds for:

- Up to $2,500 per full time (32 hours of direct patient care per week) primary care provider for
    - The purchase of a technology solution to reduce documentation time;
    - Primary care provider time to train on and implement the technology solution;
    - Staff time to collect, analyze, and report EMR event logging data (see 4.4 KPI)
    - A maximum of $1,250 per full time primary care provider can be used for non-technology costs.

4.4 Program Strategies

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

- Grantee shall advertise the program (co-branded with DC Health) to primary care providers in the District.
- Grantee shall manage eligibility of providers and disbursement of funds.
    - Sub-awarded funds must be delivered to at least eight (8) unique qualified organizations in the District.
- Grantee shall collect the below data from sub-awardees and report to DC Health for 90% or more of the primary care providers awarded funding.

Evaluation Area 1: Provider Burnout and Intent to Leave

Key Performance Indicators:

A. Outcome

- Intent to Leave, measured before and after implementation of the technology solution
    - "How often during the course of the past year have you thought about leaving the healthcare profession completely?"
    - "How often during the course of the past year have you seriously considered leaving your current job?"
- Wellness Scale, measured before and after implementation of the technology solution
    - Mini Z 2.0 [link]

Evaluation Area 2: Provider Documentation Time

Key Performance Indicators:

A. Process

- Primary Care Provider reported documentation time over 7-day periods
  - Primary medical visits
    - Average time (minutes) to chart/document visits (stratified by in-person or telemedicine) *preceding* implementation of the technology solution
    - Average time (minutes) to chart/document visits (stratified by in-person or telemedicine) *after* implementation of the technology solution
  - Patient portal/telephone encounters/web messages
    - Average time (minutes) to chart/document *preceding* implementation of the technology solution
    - Average time (minutes) to chart/document visits *after* implementation of the technology solution
- Electronic health record data from EMR event logging* over 30-day periods
  - Primary medical visits
    - Average time (minutes) to chart/document visits (stratified by in-person or telemedicine) *preceding* implementation of the technology solution
    - Average time (minutes) to chart/document visits (stratified by in-person or telemedicine) *after* implementation of the technology solution
  - Patient portal/telephone encounters/web messages
    - Average time (minutes) to chart/document *preceding* implementation of the technology solution
    - Average time (minutes) to chart/document visits *after* implementation of the technology solution
- Number of primary care encounters/visits with the provider during the grant period
- Number of primary care encounters/visits with the provider during the grant period from Medicaid, Alliance, sliding fee, and/or uncompensated care.

* Event logging is an automated tracking feature in electronic health records (EMR) that monitors the accessing of and interaction with the EMR, such as moving from prescriptions to progress notes; a record of these events and the time of the event is documented in the EMR and available for analysis.

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 work plan 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 work plan and may make changes to the insurance requirements.

IRS Tax-Exempt Determination Letter

This applies to nonprofits only.

IRS 990 Form

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

Current List of Board of Directors, on letterhead, signed and dated by a certified official from the Board.

This CANNOT be signed by the executive director. It must be dated with 90 days of the application deadline.

Assurances, Certifications and Disclosures

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

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 experience serving as an administrative agent.
- **Problem:** Describe the principal needs and problems addressed by the project.
- **Purpose:** State the purpose of the project.
- **Goal(s) And Objectives:** Identify the major goal(s) and objectives for the project. Typically, the goal(s) are stated in a sentence, and the objectives are presented in a numbered list.
- **Methodology:** Briefly list the major activities used to attain the goal(s) and objectives

Project Narrative (10-page maximum)

The narrative section should describe the applicant's approach using 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 Experience

This section should help reviewers understand the applicant's ability to meet the needs of the population intended to be served by the proposed project.

- Describe previous experience functioning as an administrative agent, including:
    - Identifying, recruiting, and supporting sub-awarded organizations
    - identifying, recruiting, and supporting sub-awarded healthcare and/or public health organizations
    - disbursing sub-awarded funds (including information on previous/current funders, dates, funding amounts managed, numbers of sub-awardees)
    - collecting data from sub-awardees/program participants and reporting data to funding agencies/organizations

Project Strategy

This section should provide a clear description of strategies and activities the applicant 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 Allowable Activities, and
- 4.4 Program Strategies, above.

The applicant's project strategy should provide a clear description of strategies and activities to achieve project outcomes, including:

- methods and frequency of program advertising to reach eligible primary care provider organizations in the District;
- recruiting eligible District primary care provider organizations into the program;
- reviewing and validating eligibility of providers;
- managing disbursements of funds; and
- collecting required data from sub-awardees and meeting completeness requirements before reporting to DC Health

Describe activities for each strategy, how they will be implemented, and how they will be operationalized to achieve program goals, objectives, and outcomes.

PERFORMANCE MONITORING

This section should describe applicant's plan for collecting, managing, and reporting data as described in section 4.4 Program Strategies. The performance monitoring plan should include:

- clearly identified personnel to collect and manage data;
- guidelines for sub-awardee data reporting;
- plans for provision of technical assistance to sub-awardees to ensure data quality and completeness;
- description of organizational data controls to safeguard data; and
- plan for reporting required data, data quality, and data completeness, and surfacing challenges, root causes, and improvement plans to improve quality and completeness.

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.

LETTERS OF SUPPORT

Applicants should provide two (2) letters of support from previous funders demonstrating applicant's effectiveness serving as an administrative agent, including recruitment, funds distribution, and data collection and reporting.

WORK PLAN

The work plan is required. It must be entered into EGMS but a template is provided as an attachment to facilitate application preparation. 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 SMART objective are as follows:

- **S**pecific: includes the "who," "what," and "where." Use only one action verb to avoid issues with measuring success.
- **M**easurable: focuses on "how much" change is expected.
- **A**chievable: realistic given program resources and planned implementation.
- **R**elevant: relates directly to program/activity goals.
- **T**ime-bound: focuses on "when" the objective will be achieved.

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

BUDGET TABLE

The application should include a project budget worksheet using the Excel spreadsheet in the District Grants Clearinghouse as noted in the form provided (attached). 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 additional entry of budget line items and details. This entry does not replace the required upload of a budget narrative using the required templates.

Key Budget Requirements

The budget should reflect a 11-month period: November 1, 2023 – September 30, 2024

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

Include the following in the budget justification narrative:

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

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

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

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

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

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

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

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

ORGANIZATIONAL CHART

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

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: ADMINISTRATIVE EXPERIENCE

(20 POINTS) – Corresponds to Sections: Overview and Project Experience

• Applicant provides clear and concise overview of proposal, including how the application aligns with RFA	**2**
• Applicant clearly describes adequate previous experience successfully performing RFA requirements, including:	
○ identifying, recruiting, and supporting sub-awarded organizations	**5**
○ identifying, recruiting, and supporting sub-awarded healthcare and/or public health organizations	**3**
○ disbursing sub-awarded funds (including information on previous/current funders, dates, funding amounts managed, numbers of sub-awardees)	**5**
○ collecting data from sub-awardees/program participants and reporting data to funding agencies/organizations	**5**

CRITERION 2: IMPLEMENTATION

(40 POINTS) – Corresponds to Sections: Project Strategy, Work Plan, Budget, and Budget Justification

• Applicant's project strategy provides clear, reasonable, and feasible description of strategies and activities to achieve project outcomes, including:	
○ methods and frequency of program advertising to reach eligible primary care provider organizations in the District;	**5**
○ recruiting eligible District primary care provider organizations into the program;	**5**
○ reviewing and validating eligibility of providers;	**5**
○ managing disbursements of funds; and	**5**
○ collecting required data from sub-awardees and meeting completeness requirements before reporting to DC Health	**5**
• Applicant's work plan:	
○ represents a logical and realistic plan of action for timely and successful achievement of objectives that support program goals;	**3**

○ clearly outlines goals and objectives for the project, describing how proposed goals and objectives are SMART (Specific, Measurable, Achievable, Relevant, and Time Bound); and	**3**
○ includes a detailed chronological list and description of activities to be performed for each key objective, identifying responsible staff, target completion dates, and projected outcomes for each activity.	**4**
• Applicant's budget/budget justification reflects reasonable and feasible personnel allocations to manage all aspects of project, including outreach/recruitment, funds management and disbursement, and data collection from sub-awardees (not to exceed 12% of total funds)	**5**

CRITERION 3: DATA COLLECTION AND REPORTING

(30 POINTS) – Corresponds to Sections: Performance Monitoring

• Applicant provides reasonable and feasible plan for collecting and managing required sub-awardee data, including:	
○ clearly identified personnel to collect and manage data	**6**
○ guidelines for sub-awardee data reporting	**6**
○ provision of technical assistance to sub-awardees to ensure data quality and completeness	**6**
○ organizational data controls to safeguard data	**6**
• Applicant provides reasonable and feasible plan for reporting required data, data quality, and data completeness, and surfacing challenges, root causes and improvement plans to improve quality and completeness, to DC Health.	**6**

CRITERION 4: CAPACITY

(10 POINTS) – Corresponds to Sections: Organizational Capacity

• Applicant provides two (2) letters of support from previous funders demonstrating applicant's effectiveness serving as an administrative agent, including recruitment, funds distribution, and data collection and reporting	**5**
• Applicant describes how mission, capacity, and past experience contribute to the organization's ability to conduct the program requirements and meet program expectations	**5**

7. REVIEW AND SCORING OF APPLICATION

7.1 Eligibility and Completeness Review

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

7.2 External Review

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

7.3 Internal Review

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

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

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

8. POST AWARD ASSURANCES & CERTIFICATIONS

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

- Certification Regarding Lobbying; Debarment, Suspension and Other Responsibility Matters; and Drug-Free Workplace Requirements

- Certification of current/active Articles of Incorporation from DCRA.
- 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 User is authorized to submit an application on behalf of the organization and his/her account is active. Currently, Secondary 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 User is submitting an application, ensure that there are no other transactions on another device being attempted in EGMS under that Primary 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 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 REGISTER button and follow 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).
3. Your EGMS registration will require your legal organization name, your **UEI# and Tax ID# (EIN)** in order to complete the registration. The EGMS registration will also require your SAM (System for Award Management) expiration date to be entered into your organization profile. Please ensure that you have an active SAM registration (www.sam.gov).
4. When your Primary User request is submitted in EGMS, the Office of Grants Management will review the request. If the requester is NOT the identified Executive Director, an automated notice will be sent from DC Health Office of Grants Management to the Executive Director for approval.

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
    - Letters of Support

9.3 Deadline

Submit your application via EGMS by the deadline – September 6th, 2023 at 6:00 p.m. Applications will **not** be accepted after the deadline.

10. PRE-APPLICATION MEETING

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

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

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

Note that questions will only be accepted in writing. Answers to all questions submitted will be published on a Frequently Asked Questions (FAQ) document onto the District Grants Clearinghouse every three business days. Questions will not be accepted after August 30, 2023.

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.

11.5 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.

11.6 Audits

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

11.7 Nondiscrimination in the Delivery of Services

In accordance with Title VI of the Civil Rights Act of 1964 (Public Law 88-352), as amended, no person shall, on the grounds of race, color, religion, nationality, sex, or political opinion, be

denied the benefits of, or be subjected to discrimination under, any program activity receiving funds under this RFA.

11.8 Quality Assurance

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

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

A final performance 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 1: Assurances and Certifications

Attachment 2: Budget Table

Attachment 3: Budget Justification

Attachment 4: Work Plan

Appendix A: Minimum Insurance Requirements

APPENDIX A: MINIMUM INSURANCE REQUIREMENTS

INSURANCE

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Sexual/Physical Abuse & Molestation - The Grantee shall provide evidence satisfactory to the PM with respect to the services performed that it carries $1,000,000 per occurrence limits; $2,000,000 aggregate of affirmative abuse and molestation liability coverage. Coverage should include physical abuse, such as sexual or other bodily harm and non-physical abuse, such as verbal, emotional or mental abuse; any actual, threatened or alleged act; errors, omission or misconduct. This insurance requirement will be considered met if the general liability insurance includes an affirmative sexual abuse and molestation endorsement for the required

amounts. So called "silent" coverage under a commercial general liability or professional liability policy will not be acceptable.

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

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

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

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

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

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

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

H. CERTIFICATES OF INSURANCE. The Grantee shall submit certificates of insurance giving evidence of the required coverage as specified in this section prior to commencing work. Certificates of insurance must reference the corresponding contract number. Evidence of insurance must be submitted to the: Enterprise Grants Management System.

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

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

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