DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

COMMUNITY HEALTH ADMINISTRATION

Preterm Birth Reduction Initiative

REQUEST FOR APPLICATIONS

RFA# PBRI_07_01_2022

SUBMISSION DEADLINE:

WEDNESDAY, AUGUST 3, 2022, 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 the Department of 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

AMENDED NOTICE OF FUNDING AVAILABILITY (NOFA)
RFA# CHA_ PBRI_07.01.2022

Preterm Birth Reduction Initiative

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 the Department of Health's intent to make funds available for the purpose described herein. The applicable Request for Applications (RFA) will be released under a separate announcement with guidelines for submitting the application, review criteria and DC Health terms and conditions for applying for and receiving funding. The previous NOFA for this funding opportunity was published on June 17, 2022. The program description, anticipated number of awards, anticipated amount available, award floor, and award ceiling have been updated.

Funding Opportunity Title:	Preterm Birth Reduction Initiative
Funding Opportunity Number:	FO-CHA-PG-00006-013
Program RFA ID#:	CHA_PBRI_07.01.2022
Opportunity Category:	Competitive
DC Health Administrative Unit:	Community Health Administration
DC Health Program Bureau	Family Health Bureau
Program Contact:	Tiffany Gray Public Health Analyst perinatal.health@dc.gov
Program Description:	DC Health aims to reduce racial/ethnic disparities in preterm birth and infant mortality in the District of Columbia. Funding under this RFA will support the implementation of evidence-based strategies to reduce maternal risk factors and the occurrence of preterm births among high-risk District residents.
Eligible Applicants	Not-for profit organizations, primary care clinics, FQHCs, and birthing facilities located and licensed to conduct business within the District of Columbia and experienced in providing services to at-risk communities are eligible to apply.
Anticipated # of Awards:	Up to five (5)
Anticipated Amount Available:	$1,700,000
Annual Floor Award Amount:	$100,000
Annual Ceiling Award Amount:	$300,000
Legislative Authorization	District of Columbia Fiscal Year 2023 Budget Support Act of 2022

Associated CFDA#	N/A
Associated Federal Award ID#	N/A
Cost Sharing / Match Required?	No
RFA Release Date:	July 1, 2022
Pre-Application Conference	Visit DC Health's Eventbrite page for the virtual meeting information, https://OGMDCHealth.eventbrite.com
Letter of Intent Due date:	Not applicable
Application Deadline Date:	August 3, 2022
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://dcDC Health.force.com/GO ApplicantLogin2

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#, be registered in the federal Systems for Award Management (SAM) and the DC Health Enterprise Grants Management System (EGMS)
5. Contact the program manager assigned to this funding opportunity for additional information.

CONTENTS

District of Columbia Department of Health

RFA Terms and Conditions

v11.2016

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

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

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

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

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

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

F. DC Health reserves the right to issue addenda and/or amendments 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 on-site visits to verify information submitted in the application and to determine if the applicant's facilities are appropriate for the services intended.

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

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

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

L. DC Health may enter 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 (i.e., the total number of years for which funding has been approved) and define any segments of the Project Period (e.g. initial partial year, or a 12-month budget period). The NOGA shall outline conditions of award or restrictions.

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

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

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

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 agency 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 doh.grants@dc.gov. Your request for this document will not be shared with DC Health program staff or reviewers.

1. CHECKLIST FOR APPLICATIONS

☐ Applicants must be registered in the federal Systems for Award Management (SAM) and the DC Health Enterprise Grants Management System (EGMS).

☐ Complete your EGMS registration **two weeks** prior to the application deadline.

☐ Start constructing and uploading your application components into EGMS at least a week prior to the application deadline.

- The complete **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 (Appendix B)
    - Table of Contents
    - Project Abstract
    - Proposal Narrative
    - Budget Table
    - Budget Justification
    - Organization Chart
    - Work Plan
    - Staffing Plan
    - Two (2) Letters of Commitment

☐ Documents requiring signature have been signed by an agency head or AUTHORIZED Representative of the applicant organization.

☐ The Applicant needs a DUNS number to be awarded funds. Go to Dun and Bradstreet to apply for and obtain a DUNS # if needed.

☐ The Project Narrative is written on 8½ by 11-inch paper, **1.0 spaced**, **Arial or Times New Roman font using 12-point type** *(11 –point font for tables and figures)* **with a minimum of one-inch margins**. **Applications that do not conform to these requirements will not be forwarded to the review panel.**

☐ The application proposal format conforms to the "Proposal Components" (See section 6.2) 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 **6:00pm** on the deadline of **08/03/2022.**

2. GENERAL INFORMATION

2.1 KEY DATES

- Notice of Funding Announcement Date: **Friday, June 17, 2022**
- Request for Application Release Date: **Friday, July 1, 2022**
- Pre-Application Meeting Date: **visit https://OGMDCHealth.eventbrite.com**
- Application Submission Deadline: **Wednesday, August 3, 2022**
- Anticipated Award Start Date: **Monday, October 1, 2022**

2.2 OVERVIEW

The mission of DC Health is to promote health, wellness, and equity across the District and protect the safety of residents, visitors, and those doing business in the nation's capital. 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) promotes healthy behaviors and healthy environments to improve health outcomes and reduce disparities in the leading causes of mortality and morbidity in the District. CHA's approach targets the behavioral, clinical, and social determinants of health through evidence-based programs, policy, and systems change with an emphasis on vulnerable and underserved populations.

DC Health is committed to proactively leading and engaging District partners in eliminating health disparities, achieving health equity, and attaining health literacy to improve the health and well-being of all residents. In doing so, we apply the updated equity informed national framework focused on addressing both personal health literacy and organizational health literacy, as defined below.

Social Determinants of Health

The public health community has long understood that there is a link between the health of populations and communities, as well as individual residents and social determinants of health, including the social, environmental, and economic conditions within which they reside and interact. Social determinants of health include factors related to education, employment, income, housing, transportation, access to healthy food, access to health care, outdoor

environment, and community safety, and the structural context within which they interact. Systemic racism operates at different levels of society and is the driving force behind health inequities. To address health outcomes associated with social determinants of health, applicants should understand the role these factors play in individual and community health and strive to implement small, focused interventions that consider and aim to address the impacts of social determinants of health.

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

The Government of the District Columbia, Department of Health (DC Health), Community Health Administration (CHA) is requesting proposals from qualified organizations to implement a program to reduce the occurrence of preterm birth among at-risk DC residents. The purpose of this initiative is to demonstrate reductions in infant mortality and morbidities associated with preterm birth.

2.3 Source of Grant Funding

Funding is made available under the District of Columbia Fiscal Year 2023 (FY23) Budget Support Act of 2022.

2.4 Award Information

2.4.1 Amount of Funding Available

The total funding amount of $1,700,000 per year will be made available for up to five (5) awards for an anticipated project period of four (4) years. There will be two focus areas. Up to $300,000 will be made available to address Focus Area 1. Up to $100,000 will be made available for Focus Area 2. Funding after Year 1 will be commensurate with the level of effort required and availability of funds.

2.4.2 Performance and Funding Period

The projected project period is October 1, 2022 – September 30, 2026. Year 1 budget period is October 2022 – September 2023. After the first 12-month budget period, there will be up to three more budget periods. The number of awards, budget periods and award amounts are contingent upon the continued availability of funds and recipient performance.

2.4.3 Eligible Organizations/Entities

Non-profit organizations, primary care clinics, FQHCs, and birthing facilities located within the District of Columbia and experienced in providing services to at-risk communities are eligible to apply. Priority will be given to those organizations having documentation of providing

obstetrical services for women residing in the District of Columbia at greatest risk for preterm delivery, a demonstrated track record of working with the priority population and demonstrated impact/improvement in at least one social determinant of health.

2.4.4 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.

3. BACKGROUND

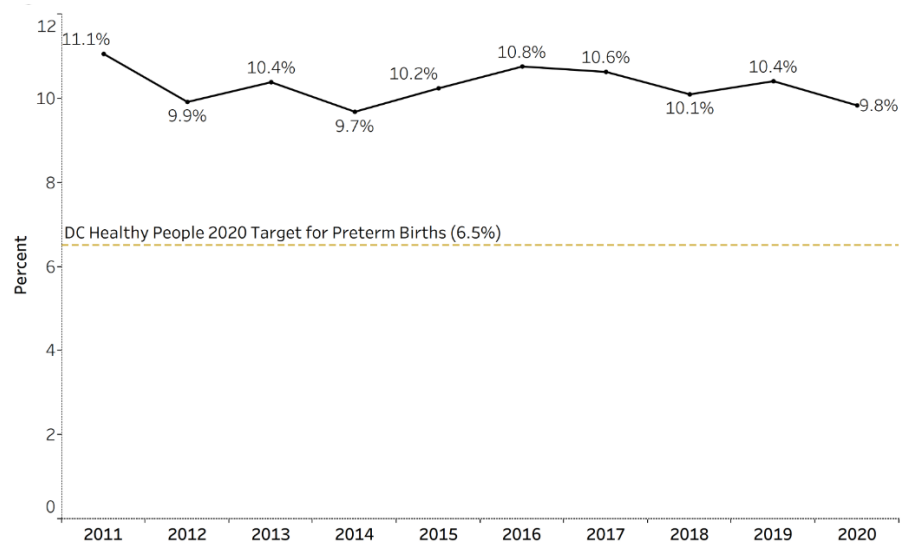
3.1 BACKGROUND

Important birth outcomes like preterm birth, low birthweight and infant deaths are some of the identified outcomes affecting the health of newborns and infants in the District of Columbia. Preterm birth is when a baby is born before 37 weeks of pregnancy. Extremely preterm birth describes babies born before 28 weeks of pregnancy.

The reduction in preterm birth rate continues to be a public health priority nationally and in the District of Columbia. There has been a small and uneven decrease in the preterm birth rate among DC residents between 2011 and 2020, from 11.1% to 9.8%. Non-Hispanic black or African American mothers are two times (12.4%) more likely than white (7%) and Hispanic (9.6%) mothers to deliver preterm[1]. Other pre-pregnancy and pregnancy characteristics and behaviors like maternal age, pre-pregnancy weight, hypertension, diabetes, substance use including alcohol and marijuana, pre-pregnancy smoking status, smoking status during pregnancy, and delayed prenatal care initiation are known to contribute to preterm birth. Birthing individuals with a previous history of a preterm birth and those that had twins and higher order multiple births have a significantly higher risk of preterm live births compared to their counterparts.

[1] Data Source: Perinatal Health Report 2022, Center for Policy Planning and Evaluation Community Health Administration DC. Department of Health.

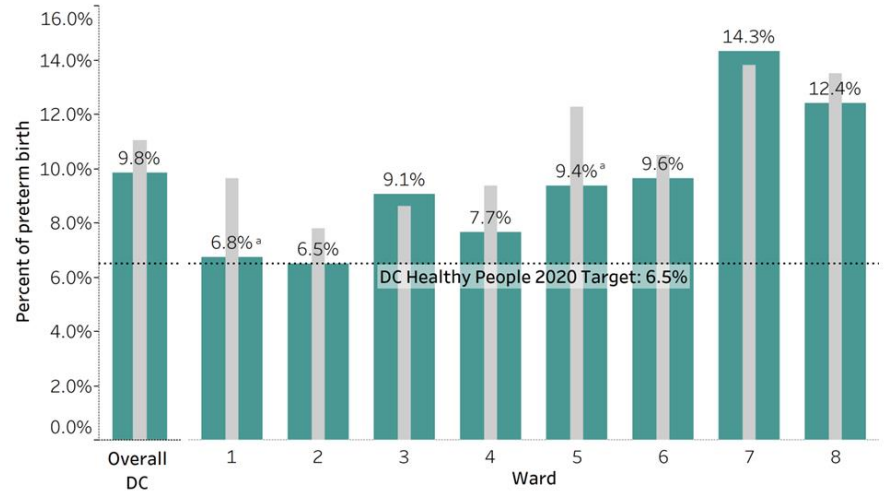
Figure 1: Percent of Preterm Live Births, District of Columbia 2011-2020



Data Source: DC Birth Data, Vital Records Division, Center for Policy, Planning and Evaluation, D.C. Department of Health.

The percentage of preterm births varies by Ward. In 2020 Ward 7 had the highest percentage of preterm births (14.3%), which was significantly higher than the percentage of preterm births in all other wards except Ward 8 (12.4%). To compare the trend for preterm birth rate in the District from 2011 to 2020, the percent of preterm live births across wards for 2011 and 2020 is shown in Figure 2 below.

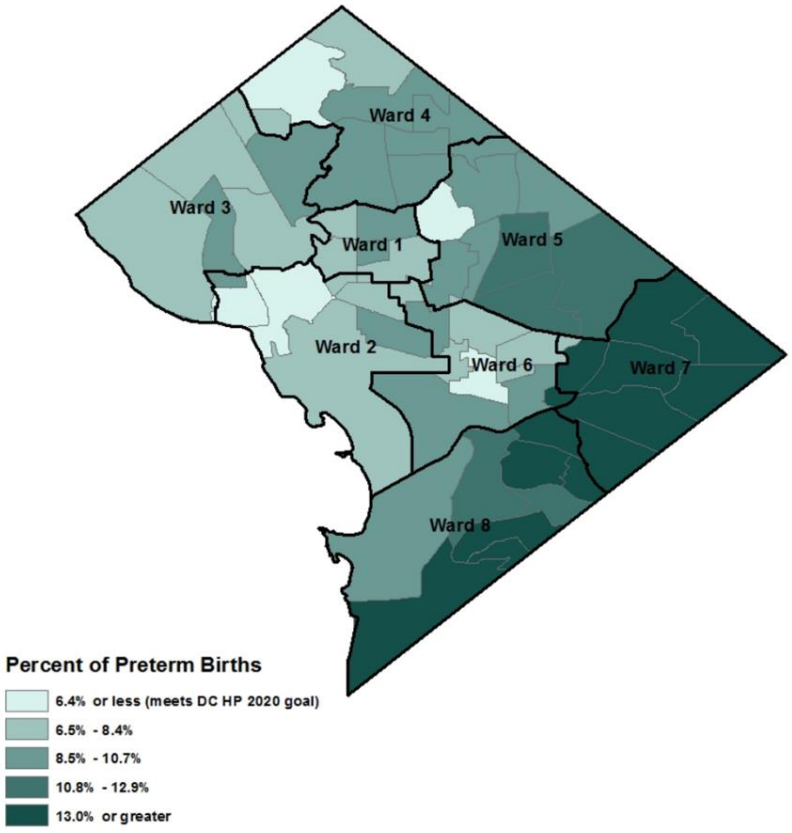
Figure 2. Percentage of Preterm Live Births across Wards, District of Columbia 2011 and 2020



Data Source: DC Birth Data, Vital Records Division, Center for Policy, Planning and Evaluation, D.C. Department of Health; DC Health 2020 Healthy People target: Putzer, E., DC Healthy People 2020 Framework, 2016, D.C. Department of Health: Washington, DC.
NOTE: Wards for 2011 and 2020 were based on 2012 Ward boundaries.
[a] The percentage of pre-term births was significantly higher in 2020 compared to the percentage of pre-term births in 2011 ($p<0.05$).

To examine the geographic distribution of preterm births at a local level, pre-term birth data by Ward for 2016-2020 are presented in Figure 3.

Figure 3. Percentage of Preterm Live Births by Neighborhood Cluster, District of Columbia 2016-2020



Neighborhood clusters were created within the Center for Policy, Planning and Evaluation by spatially joining contiguous census tracts.
Data Source: DC Birth Data, Vital Records Division, Center for Policy, Planning and Evaluation, D.C. Department of Health

The DC Health is committed to improving the health of District women and children. DC Health's comprehensive approach to improve perinatal health outcomes starts with every community understanding its health risks and its role in improving perinatal health outcomes. DC Health has identified seven core priorities that drive our programmatic efforts:

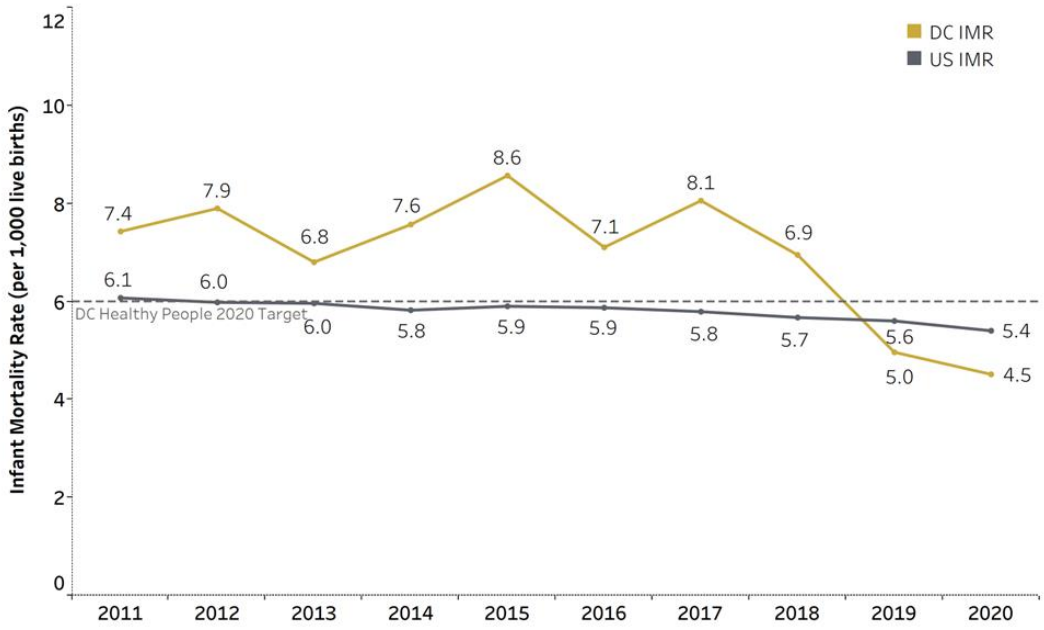
- Every teenage girl and woman in DC is in control of her reproductive health.
- Every pregnant woman receives patient-centered, high-quality prenatal care beginning in the first trimester.
- Every healthcare provider has the tools and resources they need to manage complex social needs of women and infants.
- Every maternal and infant care facility and provider has the tools and resources to practice evidence-based health care and to document Quality Improvement (QI) Quality Assurance (QA) activities.
- Every newborn receives high-quality neonatal care in the hospital and outpatient setting.
- Every parent has the life skills needed to nurture and provide for their family.

- Every infant, mom, and dad have a safe and healthy environment to thrive and receive the support they need to promote early childhood development and learning.

At the population level, poor perinatal health outcomes are closely related to social determinants of health such as income, employment, education, racism and exposure to trauma. Within that context, inefficiencies in the systems of care that support families and neighborhoods also contribute to poor outcomes. Of the approximately 1,000 preterm births each year in the District of Columbia, approximately one-third are to mothers with a previous preterm birth.

Infant mortality is the death of an infant before his or her first birthday. The infant mortality rate (IMR) is the number of deaths for every 1,000 live births. The IMR provides important information about maternal and infant health and is an important marker for the overall health of a society. According to the CDC, the top five leading causes of infant death in 2018 were birth defects, preterm birth and low birth weight, injuries, sudden infant death syndrome and maternal complications. In 2019, the infant mortality rate in the United States was 5.6 deaths per 1,000 live births. In the District, the IMR has shown a downward trend from7.4 per 1,000 live births in 2011 to 4.5 per 1,000 live births in 2020 (Figure 4). The infant mortality rates in the District in 2019 and 2020 showed a drastic decline, dipping below the 2020 national rate of (5.4 deaths per 1,000 live births) and the DC Healthy People 2020 (HP2020) target of 5.4 deaths per 1,000 live births.

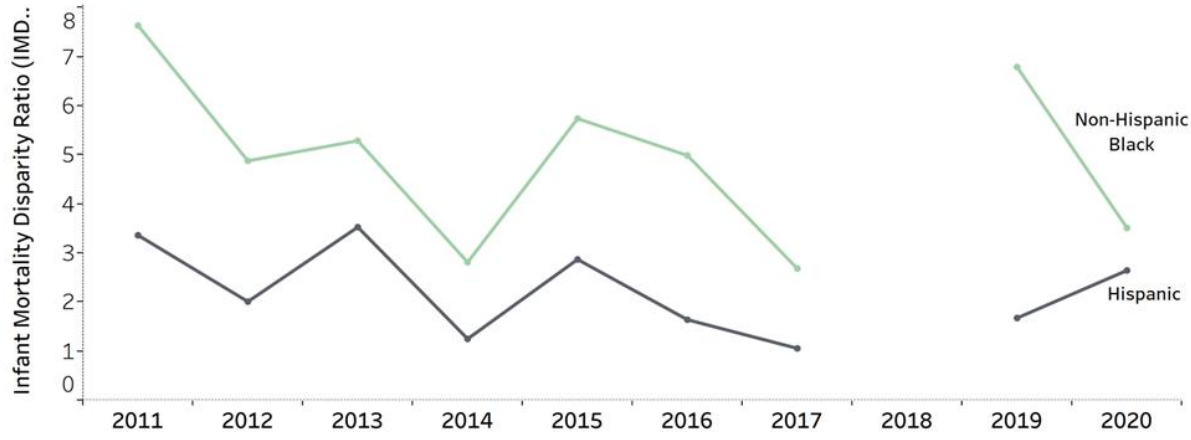
Figure 4. Infant Mortality Rate, US and District of Columbia 2011-2020



Data Source: DC Birth and Death Data, Vital Records Division, Center for Policy, Planning and Evaluation, D.C. Department of Health.
US Infant Death Data, 2010-2018: National Center for Health Statistics. Health, United States, 2022. Hyattsville, MD. 2021. Available from: https://www.cdc.gov/nchs/hus/contents2019.htm.
US Infant Death Data, 2019-2020: Murphy SL, Kochanek KD, Xu JQ, Arias E. Mortality in the United States, 2020. NCHS Data Brief, no 427. Hyattsville, MD: National Center for Health Statistics. 2021. DOI: https://dx.doi.org/10.15620/cdc:112079

Significant disparities between racial and ethnic groups persist in the District. In 2020, the non-Hispanic black to non-Hispanic white disparity ratio was 3.5, meaning that black infants were over three times more likely to die before their first birthday compared with their white counterparts.

Figure 5. Infant Mortality Disparity Ratio (IMDR), District of Columbia 2011-2020.



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Non-Hispanic Black IMDR	7.6	4.9	5.3	2.8	5.7	5.0	2.7	*	6.8	3.5
Hispanic IMDR	3.4	2.0	3.5	1.3	2.9	1.6	1.1	*	1.7	2.6

Data Source: DC Birth and Death Data, Vital Records Division, Center for Policy, Planning and Evaluation, D.C. Department of Health.
NOTE: The infant mortality rate for infants of non-Hispanic white mothers is used as the reference group. The non-HIspanic black infant mortality ratio is defined as the infant mortality rate for infants of non-Hispanic black mothers divded by the infant mortality rate for infants of non-Hispanic white mothers. The Hispanic infant mortality ratio is defined as the infant mortality rate for infants of Hispanic mothers divided by the infant moratlity for for infants of non-Hispanic white mothers.
*2018 data suppressed due to denominator values less than 1.

In the District of Columbia, preterm birth was listed among the top ten leading causes of infant death between 2019 to 2020. Among all the 85 infant deaths that occurred in the District between 2019–2020, neonatal deaths (death of newborns aged less than 28 days), accounted for more than half (59%) resulting in a neonatal mortality rate of 2.9 per 1,000 live births. Preterm birth accounted for 18% of neonatal death and was the third leading cause of neonatal death in the District (Table 1).

The neonatal mortality rate was significantly higher among non-Hispanic black infants (6.3 per 1,000 live births) compared to Hispanic infants (2.8 per 1,000 live births) and non-Hispanic white infants (1.5 per 1,000 live births).

Table 1. Ten leading causes of neonatal deaths, District of Columbia, 2019-2020

Cause of Death Category	ICD-10 Codes	Total neonatal deaths	Percent	Neonatal Mortality Rate (per 10,000 live births)
Total neonatal deaths		50	100.00	27.87
Congenital Anomalies	Q00-Q99	10	20.00	5.57
Maternal complications	P01	10	20.00	5.57
Prematurity	P07	9	18.00	5.02
Bacterial sepsis	P36	.	.	.
Intrauterine hypoxia and birth asphyxia	P20-P21	.	.	.
Neonatal hemorrhage	P50–P52,P54	.	.	.
Newborn affected by maternal hypertensive disorders	P00.0	.	.	.
Placenta, cord, membranes	P02	.	.	.
Accidents	V01-X59	0	0.00	0.00
SIDS	R95	0	0.00	0.00
Other		8	16.00	4.46

Source: Data Management and Analysis Division, Center for Policy, Planning and Evaluation, D.C. Department of Health.

*Data suppressed for less than 4 infant deaths

In addition to higher incidence of early death, preterm birth increases the risk for significant health problems and long-term developmental delays and disabilities. While prematurity rates have decreased overall in the last decade (from 11.1% in 2011 to 9.8% in 2020), the rate has remained relatively stable and well above the DC HP2020 target (6.5%) for the last ten years in the District. Preterm labor can affect any pregnancy. However, several known risk factors have been identified as contributing causes of preterm birth. These include a family or personal history of a prior preterm birth, being pregnant with multiples, substance or alcohol use, short time between pregnancies (less than 18 months), high blood pressure, obesity, structural abnormalities with the cervix or placenta, and some chronic diseases such as hypertension, obesity, and diabetes. Individuals with higher risk factors associated with having a preterm birth are those of the black race, below the age of 20 or after the age of 40, of low socioeconomic status, smoked cigarettes while pregnant and delayed entry into prenatal care.

The implementation of emerging initiatives addressing maternal health also has a positive impact on the reduction of preterm birth. Some of the initiatives include improved data and

surveillance; telehealth; patient education and clinical workforce training; comprehensive models and strategies; and clinical guidelines, protocols and bundles[2] (Reference 1).

Examples of successful initiatives include[3]:

- Progesterone supplementation, smoking cessation, judicious use of fertility treatments, dedicated preterm birth prevention clinics.
- Screening and identification of women at risk for preterm birth through risk assessment tools; universal cervical length screening; early cervical length screenings (16-24 weeks estimated gestational age); cervical length training modules for quality assurance; provider incentives; provider education and technical assistance; and decision tree support.
- Implementation and expansion of state-based Perinatal Quality Collaborative initiatives
- Development of leadership, building state, local and tribal level capacity, and improving surveillance, monitoring and evaluation through the Center of Disease Control and Prevention (CDC) Maternal and Child Health Epidemiology Program[4]

The District has implemented two key initiatives aimed at reducing preterm birth: a preterm birth pilot program and the District of Columbia Perinatal Quality Collaborative. In 2018, DC Health launched the Preterm Birth pilot program, in which four District birthing facilities were selected to implement evidence-based strategies to reduce the occurrence of preterm birth and improve health outcomes. The goals of the pilot were to 1) develop screening tools and/or procedures for women at risk for preterm birth; 2) reduce the rate of preterm birth through the management of associated risk factors; and 3) improve linkages to care, including prenatal care, labor and delivery options, social services, and community programs to influence patient outcomes. The initial pilot period will end September 2022.

4. PURPOSE

The District of Columbia Department of Health (DC Health), Community Health Administration (CHA) is requesting proposals from qualified organizations to implement evidence-based strategies to reduce the occurrence of preterm birth among at-risk District residents. Through this funding opportunity, DC Health will work with health providers to ensure women who are

2 Ahn, Gonzalez, G. P., Anderson, B., Vladutiu, C. J., Fowler, E. R., & Manning, L. (2020). Initiatives to Reduce Maternal Mortality and Severe Maternal Morbidity in the United States : A Narrative Review. Annals of Internal Medicine, 173(11 Suppl), S3–S10. https://doi.org/10.7326/M19-3258; Accessed here: https://www.acpjournals.org/doi/10.7326/M19-3258

3 Newnham, J. P., Dickinson, J. E., Hart, R. J., Pennell, C. E., Arrese, C. A., & Keelan, J. A. (2014). Strategies to prevent preterm birth. Frontiers in immunology, 5, 584. https://doi.org/10.3389/fimmu.2014.00584 Accessed: 5/25/22 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4237124/

4 Shapiro-Mendoza CK, Barfield WD, Henderson Z, et al. CDC Grand Rounds: Public Health Strategies to Prevent Preterm Birth. MMWR Morb Mortal Wkly Rep 2016;65:826–830.
DOI: http://dx.doi.org/10.15585/mmwr.mm6532a4external icon.

at risk for a preterm birth are offered high quality care, including identifying women who are at high risk for preterm births, implementing group prenatal care (e.g., Centering Pregnancy), promoting smoking and marijuana reduction and cessation, promotion of contraception, healthy weight management, chronic disease prevention and management, and nutrition education and referral. In partnership with DC Health, birthing facilities will adapt successful strategies that have been implemented in other states and jurisdictions to reduce the occurrence of preterm deliveries The ultimate purpose of this program is to demonstrate improved outcomes in infant mortality and morbidities associated with preterm birth.

Applicants must demonstrate their organizational capacity to implement program strategies in one or both of the following focus areas:

FOCUS AREA 1

Implementation of Clinical Best Practices

Applicants should adopt, adapt, and scale evidence-based preterm birth reduction strategies to reduce the occurrence of preterm birth, including addressing severe maternal morbidity and infant mortality. Organizations will be required to conduct and implement screening and identify birthing individuals at risk for preterm birth (prior pre-term birth, underweight, current smoker; hypertensive; African Americans); provide substance use screening, counseling, and referral, including tobacco and marijuana cessation. In addition, organizations will be required to offer group prenatal care (e.g., centering pregnancy) for eligible, low-risk birthing individuals to further promote positive pregnancy outcomes. Periodic reporting on key indicator data points outlined below will provide information on intervention impact on reduction of preterm birth and other health related outcomes.

Clinical Quality Improvement: Surveillance, Data Quality and Data Linkages

Applicants should identify and implement quality improvement strategies to further enhance surveillance and quality of data that are most relevant to preterm birth prevention and management. Strategies need to include demonstration of an effective tracking and management system and/or other health information technology solutions such as clinical decision support.

FOCUS AREA 2

Community-based Engagement: Health Literacy Assessment and Expansion

Applicants shall implement targeted, community-based approaches to advancing health literacy by engaging the priority population (black/African American residents, residents of Ward 4, 5, 7 8) to foster linkages to care, build relationships and leverage resources within the community. Applicants shall address how community-based organizations (CBOs) can adopt, adapt, and scale health literacy strategies for prevention of preterm birth.

Organizations will be required to implement multi-faceted, community-based program models/approaches to reduce preterm birth. Organizations shall implement health literacy strategies to educate women of reproductive age, pregnant women, health providers, and DC residents about the risk factors associated with preterm birth. Organizations shall integrate

evidence-based clinical interventions and public health services to improve health care system linkages and care systems at the community level that provide birthing individuals with consistent, comprehensive care that address social, psychological, and clinical needs (e.g., annual well-woman visits, WIC enrollment, smoking cessation counseling through referral to DC Quitline, chronic disease self-management (hypertension, diabetes). Projects must document or demonstrate meaningful collaboration and partnership with community-engaged leaders and change agents that represent the communities/populations of focus and that will be essential for development of strategic initiatives as well as acceptance, uptake, and sustainability of interventions and services. Applicants should provide details on the nature and extent of their partnerships, including clearly describing the roles and responsibilities of partners and providing evidence of support from partner organizations.

All strategies for the selected components should build the foundation for sustainable interventions that can be shared, duplicated, and/or expanded with minimal resources beyond the life of the grant.

5. PERFORMANCE REQUIREMENTS

Applicants should propose projects that meet the criteria listed below.

5.1 ELIGIBILITY

Not-for profit organizations, primary care clinics, FQHCs, and birthing facilities located within the District of Columbia and experienced in providing services to at-risk communities are eligible to apply for funding under this funding opportunity. Health care facilities serving high proportions of women with pre-term births, Medicaid-insured and residing in Wards 5, 7, and 8 will be given priority, along with community-based organizations that serve residents in Wards 4, 5, 7, and 8.

5.2 TARGET POPULATION

Efforts to reduce occurrences of preterm birth will focus on women at higher risk for early delivery and their associated risk factors as identified by the 2018 District of Columbia Perinatal Health and Infant Mortality Report. Programmatic efforts will target pregnant women at risk for preterm birth, prioritizing women with Medicaid insurance and residing in Wards 5, 7 or 8.

5.3 LOCATION OF SERVICES

Awardees will work with clinics, birthing facilities, community health centers providing prenatal health care and health services for individuals identified as high risk for preterm birth.

5.4 Scope of Services

The applicant shall implement a targeted, community-based approach to reducing preterm birth and health disparities by engaging the priority population, but not limited to Black/African American birthing persons and residents of Wards 4, 5, 7, and 8 to build relationships and leverage resources within the community.

DC Health has gathered information on best practices for implementation of evidence-based or evidence-informed interventions to reduce pre-term births, with focus on those initiatives that increase the appropriate use of identification, monitoring, and treatment of women at risk for preterm birth. Proposed strategies should build off efforts and lessons learned from other states and jurisdictions including North Carolina, Ohio, Louisiana, South Carolina, and Puerto Rico. Priority strategies include promotion of birth spacing, contraceptive education and access, including for long-acting reversible contraceptives (LARCs), nutrition education and referrals to WIC, and smoking and marijuana cessation. Project proposals should prioritize increasing the utilization of obstetric intake assessment tools among eligible patients; however, applicants may include additional plans and goals that reduce the occurrence of preterm births among the target populations. In designing a project proposal, applicants should address the following:

- Work collaboratively across health care systems.
    - The implementation of a clinical quality improvement pilot program requires the involvement of health care providers, patients, case managers, office managers, and payers.
- Ensure strategies are patient-centered and equity-focused.
    - Projects should address common barriers such as transportation; lack of perceived risk of preterm birth among patients, or lack of perceived benefit or value of the intervention; competing stressors and priorities (work, childcare); cost of the intervention.
- Utilize data to identify eligible patients and track project outcomes.
    - Project plans should delineate how electronic health record and other available data systems, may be utilized to identify patients who are eligible for proposed interventions. Projects should include relevant performance indicators to help track progress towards achieving programmatic goals.

Projects must document uptake, and sustainability of interventions and services proposed. Applicants should provide details on the nature and extent of their partnerships, including clearly describing the roles and responsibilities of partners and providing evidence of support from partner organizations.

Projects must document or demonstrate meaningful collaboration and partnership with local community-engaged leaders and change agents that represent the communities/populations of focus and that will be essential for development of strategic initiatives as well as acceptance,

uptake, and sustainability of interventions and services proposed. Applicants should provide details on the nature and extent of their partnerships, including clearly describing the roles and responsibilities of partners and providing evidence of support from partner organizations.

5.5 Program Outcomes and Strategies

The applicant shall propose activities during the four-year program period to support the following outcomes and strategies as aligned with anticipated outcomes of the project.

Outcomes

All strategies for the selected components are required and designed to reduce the prevalence of preterm birth over the next four years as indicated:

Measure	Objective	Data Source	Baseline	Target-General	Baseline- African American Women	Target-African American Women
Preterm Births	Reduce preterm births	Vital Stats	9.8%	9.4%	13.6%	11.4%

Focus Area 1:
Performance indicators will include but not limited to the following:

- % of pregnant women classified as high risk for spontaneous, recurrent preterm birth
- % of pregnant women that had a OB high risk assessment completed
- % of women that received a pharmaceutical intervention
- % of women receiving intervention that delivered preterm (<37 weeks)
- % of women receiving intervention that delivered early term (≥37 weeks to <39 weeks)
- % of women receiving intervention that delivered full term (≥ 39 weeks)
- % of women that did not receive intervention and delivered preterm (<37 weeks)

Focus Area 2:
Performance indicators will include but not limited to the following:

- % of target population reached
- Social media click-through rate
- Social media conversion rate
- # of impressions
- # of participants per event

Strategies

- Increase the identification of effective approaches for improving health outcomes with the goal of promoting dissemination, adoption and sustainability of these approaches
- Reduce the disparities in health that occur by categories such as gender, race or ethnicity, income and education, disability, neighborhood, or sexual orientation, informed by the target populations identified by the Disparity Impact Statement
- Improve access and utilization of health care
- Access to preconception care services including screening, health promotion, and interventions which enable individuals to achieve high levels of wellness, minimize risks, and enter pregnancy in optimal health, including but not limited to:
    - Increase identification of current substance use, including tobacco and marijuana use and referral to DC Quitline and counseling services
    - Increase referral and enrollment into WIC and other nutritional services
    - Increase referral to chronic disease self-management programs, diabetes self-management education, and nutritionists
    - Provide education on signs and symptoms of preterm birth
- Increase identification of women at risk for preterm delivery and offer access to effective treatment to prevent preterm birth and referral to Maternal Fetal Medicine (MFM) specialists
- Prevention of unintended pregnancies

To accomplish the outcomes outlined above, applicants must:

- Develop an organizational capacity, monitoring, and evaluation plan
- Participate actively in the Maternal Health Quality Improvement Learning Collaborative (MHQI) meetings to engage with other community-based organizations, federally qualified health centers (FQHCs), birthing facilities, and providers and share best practices around building continuous organizational capacity to advance reducing maternal morbidity, infant mortality and address health disparities
- Increase staff and structural capacity to improve the timeliness of providing prenatal care to women who are pregnant within 12 weeks of gestational age or within one (1) week of presenting into care
- Leverage existing electronic health records/health information exchange EHRs/HIE risk assessment tools to identify and screen individuals at risk for preterm birth
- Adopt and begin utilizing a city-wide perinatal care management and coordination system
- Establish process for providing education, support, and ensuring postpartum follow-up care
- Provide education, support, and outreach services to women after they experience a preterm birth
- Develop and submit a success story on the program's impact in the community to advance maternal and infant health and well-being and reduce health disparities; and
- Select and implement activities from one or both focus areas below

Focus Area 1:

Implementation of Clinical Best Practices

Applicants shall address how organizations can adopt, adapt, and scale preterm birth reduction strategies to improve prevention and management of risks of preterm birth.

A. Organizations shall conduct an organizational assessment at the start of the intervention and periodically report on the following data points/key indicators:

- **What is the organizational reach?**
  This includes data on the number, type and demographics of the residents served by your organization.

- **How are at risk individuals identified and where and how often is screening implemented?**
  This includes data on the number of birthing individuals identified as high-risk for preterm birth, number of screenings conducted, including type of screening (cervical length screening, social determinants of health screening, and hypertension and other chronic diseases), chronic disease management, and substance use.

- **What health education initiatives are implemented by the organization?**
  This includes the aims and descriptions of preterm birth and prevention initiatives, health education strategies used (including centering, smoking and marijuana cessation, chronic disease management), as well as communication techniques used (i.e. availability in multiple languages, virtual or in person sessions, availability through multiple communication channels, etc.), and evaluation of impact.

B. Using the data (referenced above) to drive intervention strategies, the organization(s) shall develop and implement a customized work plan and evaluation plan to address preterm birth to improve maternal and infant health outcomes.

Clinical Quality Improvement: Surveillance, Data Quality and Data Linkages

Applicants should implement organizational improvement strategies to address quality and education gaps through quality improvement methodology. Organizations should implement quality improvement strategies aimed at improving early detection and timely care of complications associated with preterm birth. Organizations shall include as a routine part of care, steps to providing information on prevention of preterm birth, chronic disease management, substance use prevention and cessation, and reduction of additional modifiable risk factors of preterm birth to residents whom they serve.

- Utilize data through electronic health records (EHR) and other health information technology (HIT) systems to improve healthcare delivery and optimized patient health outcomes.
- Implement customized social determinants of health (SDOH) assessment and referral process for your organization.

- Track and report to DC Health the outcomes of SDOH assessments for DC residents
- Develop referral workflow for District residents into prenatal and postnatal care appointments
- Develop referral workflow for District residents into chronic disease self-management programs
- Develop referral workflow for District residents into substance use (including alcohol, tobacco, marijuana, and opioids) cessation programs
- Implement quality improvement interventions related to preterm birth, as well as hypertension, such as: clinical decision support (CDS) systems to improve documentation of patients' health status; improve ability of providers to interpret clinical results through alerts, reminders, etc.; use telehealth applications for long distant patient/provider communication and care.
- Track and monitor clinical quality measures (CQMs) related to preterm birth
- Implement QI interventions strengthening referral processes of high-risk individuals to appropriate clinical facilities, as well as additional community programs and resources.
- Track and analyze evidence-based quality measures related to preterm birth and hypertension at the provider level to monitor health care disparities.

Focus Area 2:
Community-Based Engagement: Health Literacy Assessment and Expansion

Applicants shall address how organizations can adopt, adapt, and scale health literacy strategies for prevention of preterm birth. Organizations shall include as a routine part of their regular program operation, steps to providing information on preterm birth prevention, steps to providing information on identifying risk factors of preterm birth, medically unnecessary c-sections, elective inductions, tobacco and marijuana use cessation, healthy weight and chronic disease self-management to the target population, including providers and residents they serve.

Develop a toolkit for advancing organizational health literacy

- Assemble tools to facilitate implementation of the organizational health literacy plan including communication and education strategies to address prevention of preterm birth, including digital and print media and community engagement protocols for information dissemination, leveraging technical assistance from DC Health.

Support social marketing campaigns

- Engage target population in developing and implementing a social media campaign to disseminate targeted messages related to preterm birth to key audiences including birthing individuals, pregnant women, women of reproductive age, and health care providers and community-based providers.

Trusted Messengers Community Outreach

- Establish a team of trusted messengers who can be trained to deliver a media and educational campaign using health literacy principles and best practices
- Implement customized organizational health literacy plan (examples include "train the trainer" model for organizational staff on health literacy that they may provide residents accurate information and know what resources to link them to and training on the teach back method to measure clients' understanding of the information shared)
- Disseminate DC Health messaging in priority populations including Wards 4, 5, 7, and 8 using tailored materials and various/appropriate media channels (print, web, social media, video, etc.)
- Implement customized social determinants of health (SDOH) assessment and referral process for your organization
- Track and report to DC Health the outcomes of SDOH assessments for DC residents
- Develop referral workflow for District residents into annual well women visits, enrollment into prenatal care, WIC services, smoking cessation counseling services through DC Quitline, and other related social services
- Utilize trusted members of the community such as Community Health Workers (CHWs), doulas, outreach workers, faith-based leaders, health educators, community leaders etc. to promote preterm birth and infant health literacy and connect District residents to prenatal care, nutrition services (WIC), substance use counseling (DC Quitline), chronic disease management (hypertension, diabetes), behavioral health, and related services within priority Wards.
- Develop referral workflow for District residents into chronic disease self-management programs
- Partner with DC Health and Million Hearts Learning Collaborative to host Chronic Disease Self-Management Workshops and attend training
- Plan events (in person or virtual) to advance health literacy (topics examples include signs and symptoms of preterm birth, how to locate quality health information online, talking to your doctors and other health care providers and questions to ask to get the most out of your visit, and understanding your prescription and speaking with your pharmacist)
- Develop an evaluation plan to assess effectiveness of strategies, with technical assistance (TA) support from the DC Health evaluation team.

6. APPLICATION REQUIREMENTS

6.1 ELIGIBILITY DOCUMENTS

CERTIFICATE OF CLEAN HANDS

This document is issued by the Office of Tax and Revenue must be dated within 60 days of the application deadline.

CURRENT BUSINESS LICENSE

A business license issued by the Department of Consumer and Regulatory Affairs or certificate of licensure or proof to transact business in local jurisdiction.

CURRENT CERTIFICATE OF INSURANCE

This document must be issued by your insurance company. All DC Health grantees must meet the minimum insurance requirements as outlined in Appendix A: Minimum Insurance Requirements. Should an applicant be awarded the grant, the Office of Risk Management will conduct a review of exposures of the grantee organization based off the final approved workplan and may make changes to the insurance requirements.

COPY OF CYBER LIABILITY POLICY

This document must be issued by your insurance company. All DC Health grantees must meet the minimum insurance requirements as outlined in Appendix A: Minimum Insurance Requirements. Should an applicant be awarded the grant, the Office of Risk Management will conduct a review of exposures of the grantee organization based off the final approved workplan and may make changes to the insurance requirements.

IRS TAX-EXEMPT DETERMINATION LETTER

This applies to nonprofits only.

IRS 990 FORM

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

CURRENT LIST OF BOARD OF DIRECTORS, ON LETTERHEAD, SIGNED AND DATED BY A CERTIFIED OFFICIAL FROM THE BOARD.

This CANNOT be signed by the executive director.

ASSURANCES, CERTIFICATIONS AND DISCLOSURES

This document must be signed by an authorized representative of the applicant organization. (Appendix B: Assurances, Certifications and Disclosures).

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

6.2 PROPOSAL COMPONENTS

PROJECT NARRATIVE (10-page limit)

Background

Applicants must provide a description of relevant background information that includes the context of the problem.

Approach

Purpose

Applicants must describe in two to three (2–3) sentences specifically how their application will address the public health problem as described in the DC Health Background section.

Outcomes

Applicants must clearly identify the outcomes they expect to achieve by the end of the project period, as identified in the Purpose section of this RFA.

Target Population

This section should provide an overview of the organization's birthing population, including insurance status, rates or preterm birth, maternal race and maternal residence (Ward if known or zip code). Applicants may include other patient demographics (ex. age, parity), as relevant to the project, as well as additional relevant health indicators such as rates or preeclampsia. Population should be focused on women residing in the District of Columbia. Applicants should be able to demonstrate 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 the Scope of Work and Program Strategies.

- Describe activities for each strategy, how they will be implemented, and how they will be operationalized to achieve program goals, objectives, and outcomes.
- Describe how the proposed project meets the requirements in the Scope of Services section (please see Performance Requirements Section for more details).
- Indicate plans for sustainability of the initiative beyond the projected funding period.

Evaluation and Performance Measurement

Applicants should provide a brief description of how project goals will be assessed and monitored during implementation. Applicants should propose key outcomes and performance measures and describe how these key performance measures will be collected and used. At a minimum, this shall describe:

- The applicant's experience and capacity to engage community partners and stakeholders
- How applicants will measure community engagement and its impact
- How activities will be monitored and adapted to improve program success

Organizational Capacity

This section should provide an overview of the organizational infrastructure, mission and vision. Applicants should demonstrate capacity and infrastructure to implement focus areas described in the Program Strategies with the goal of advancing organizational and personal health literacy and reducing health disparities. The applicant should demonstrate their previous experience and success addressing social determinants of health (education, employment, income, housing, transportation, access to healthy food, access to health care, outdoor environment, and community safety) by reducing barriers to resources through a community-centered approach. The applicant should describe the scope of current community engagement and empowerment activities and demonstrate staff capacity to conduct activities as required by this RFA. Applicants should demonstrate ability to meet performance requirements, follow project deadlines for deliverables, and provide accurate reporting. Lastly, applicants should affirm organizational leadership commitment to complete the project as proposed in the work plan.

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:

- **Problem:** Describe the problem to be addressed by the project.
- **Purpose:** State the purpose of the project.
- **Goal(s) And Objectives:** Identify the major goal(s) and objectives of the project. Objectives should be SMART.
- **Performance Metrics:** Outline outcome and process metrics and associated targets that will be used to assess grantee performance.

BUDGET TABLE

The application should include a project budget worksheet using the excel spreadsheet in District Grants Clearinghouse as noted in (Attachment 3). The project budget should be directly aligned with the work plan and project description. All expenses should relate directly to achieving grant outcomes. Budget should reflect the first budget period, October 1, 2022-September 30, 2023.

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

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 (Attachment 2), 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:

Salary: Include the name of each staff member (or indicate a vacancy), position title, annual salary, and percentage of full-time equivalency dedicated to this project.

Fringe Benefits: Provide the fringe benefit rate. Indicate all positions/staff for which fringe benefits are charged.

Supplies: Funds can be used to cover provider training materials that are essential in ensuring successful program implementation.

Travel: The budget should reflect the travel expenses associated with local travel to partner sites, meetings, and activities related to implementation of the project, with breakdown of expenses, e.g., airfare, hotel, per diem, and mileage reimbursement.

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

Other Direct Costs: Provide information on other direct costs that have not otherwise been described.

Indirect Costs: Indirect costs shall not exceed 10% of direct costs.

ORGANIZATION CHART

The organization chart is a visual representation of the staff in the applicant organization (*no template provided*.)

WORK PLAN

The Work Plan is required (Attachment 1). The work plan describes key process objectives and goals for successful program implementation. Under each objective, provide a list of the activities that will be used to achieve each of the objectives proposed and anticipated deliverables.

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

- The work plan should include process objectives and measures. Objectives should be SMART (Specific, Measurable, Achievable, Relevant, and Time-Framed)

STAFFING PLAN

The applicant's staffing plan must be submitted *(no template provided)*. The staffing plan should describe staff qualifications and include type and number of FTEs. Staff CVs, resumes, and position descriptions should be included in this section.

LETTERS OF SUPPORT

Applicant should provide a minimum of two (2) letters of support from other agencies and organizations who will partner on of the proposed project *(no template provided)*.

7. EVALUATION CRITERIA

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

CRITERION 1: HEALTH AND RACIAL EQUITY

(25 POINTS) – Corresponds to Sections: *Background, Purpose and Target Population*

- The extent to which the applicant describes the problem within the context of the target populations: Black/African American residents and Limited English Proficient populations (5 points)
- The extent to which the applicant describes the unmet needs and community assets of the residents served by the organization who are at high risk for preterm birth (5 points)
- The extent to which the applicant demonstrates an understanding of the problem, potential barriers and challenges, and opportunities to address preterm birth (5 points)
- The extent to which the applicant demonstrates an understanding of how social determinants of health and other systemic barriers limit the priority population's ability to access prenatal care and postpartum care, and utilize health resources The extent to which the applicant demonstrates an understanding of factors contributing to occurrence of preterm birth (5 points)
- The extent to which the applicant describes an understanding of problems in clinical care contributing to occurrence of preterm births (5 points)

CRITERION 2: ORGANIZATIONAL CAPACITY

(25 POINTS) – Corresponds to Section: *Organizational Capacity, Partnerships, and Staffing Plan*

- The extent to which the applicant describes an adequate organizational infrastructure to support implementation of the proposed strategies including leadership commitment to implement the proposed strategies (5 points)
- The extent to which the applicant describes reach and established relationships with District residents within the target population and other community-based organizations serving target population (5 points)
- The extent to which the applicant describes experience achieving successful outcomes and/or addressing challenges/barriers with target population (5 points)
- The extent to which the applicant describes the feasibility of and experience with establishing new and engaging existing partners (i.e., government agencies and CBOs) in a cross-sector network to support the implementation and evaluation of the applicant's initiatives to address preterm birth and address social determinants of health (5 points)
- The extent to which the applicant describes experience working to address social determinants of health (i.e., food insecurity, housing, employment, transportation, active living and physical activity, access to healthcare, housing, and safe communities) (5 points)

CRITERION 3: IMPLEMENTATION FRAMEWORK

(30 POINTS) – Corresponds to Section: *Project Description*

- The extent to which the applicant's proposed project aligns with the purpose and strategies of this RFA, including the identified clinical care issues and other factors contributing to preterm birth (10 points)
- The extent to which the applicant's goals are logical and feasible reached through objectives that are Specific, Measurable, Achievable, Relevant and Time-Bound (SMART) (5 points)
- The extent to which the applicant describes the feasibility of the evidence-based and/or evidence-informed practice approaches that address reduction of preterm birth and gaps in outreach efforts within target population (5 points)
- The extent to which the applicant describes plans for community engagement and mobilization to drive project outcomes, including strategies for current or new partnerships (if any) that will be engaged to meeting program goals (10 points)

CRITERION 4: EVALUATION

(20 POINTS) – Corresponds to Section: *Evaluation and Performance Measurement; Outcomes*

- The extent to which measurable indicators to monitor the project's success are specified for the program objectives (5 points)
- The appropriateness of project monitoring plans that ensure reach and engagement of the priority population and the extent to which the applicant specifies a process to monitor progress and adapt strategies and objectives to improve outcomes (5 points)
- The extent and appropriateness of the proposed processes to collect qualitative and quantitative data related to project goals (5 points)
- The degree of skill and experience of proposed staff or contractor to analyze data aligned to the project's goals and objectives (5 points)

CRITERION 5: SUPPORT REQUESTED

(NOT SCORED) – Corresponds to Sections: *Budget and Budget Justification Narrative*

- The appropriateness of the budget for the project period in relation to the objectives, the complexity of the activities, and the anticipated results
- The adequacy of costs outlined in the budget and required resources sections
- The extent of which key personnel that have adequate time devoted to the project to achieve project objectives

8. REVIEW AND SCORING OF APPLICATION

8.1 PRE-SCREENING

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.

8.2 EXTERNAL REVIEW PANEL

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.

8.3 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.

9. 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 (NOGA).

10. 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.

10.1 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 DC Health Office of Grants Management in time for submission. To register, complete the following:

IMPORTANT: WEB BROWSER REQUIREMENTS

1. Check web browser requirements for EGMS –EGMS is supported by the following browser versions:
    - Microsoft ® Internet Explorer ® Version 11
    - Apple ® Safari ® version 8.x on Mac OS X
    - Mozilla ® Firefox ® version 35 & above (Most recent and stable version recommended)
    - Google Chrome ™ version 30 & above (Most recent and stable version recommended)
2. Access EGMS: The user must access the login page by entering the following URL in to a web browser: https://dcdoh.force.com/GO ApplicantLogin2 Click the button REGISTER and following the instructions. You can also refer to the EGMS External User Guide.
3. Determine the agency's Primary User (i.e. authorized to accept terms of agreement, certify and submit documents, request and accept modifications). The Primary User will determine a Secondary User and send a notification via EGMS for him/her to set-up an account.
4. Your EGMS registration will require your legal organization name, your **DUNS # 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).
5. When your Primary Account User request is submitted in EGMS, the DC Health Office of Grants Management will review the request. If the requester is NOT the identified Executive Director, DC Health Office of Grants Management will make an additional request for the Executive Director to send an email to DC Health to confirm that the requester is the authorized representative for EGMS. When requested, your authorized representative should send to doh.grants@dc.gov the name, title, telephone number and email address of the desired Primary User for the account. **SUBJECT LINE: EGMS PRIMARY USER AGENCYNAME**. Note: The email will help to support the validation of authorized users for EGMS. DC Health official grant records will also be used. Please reply ASAP to any requests from Office of Grants Management to provide additional information, if needed.
6. Once you register, your Primary Account User will get an auto-notice to upload a "DUNS Certification" – this will provide documentation of your organization's DUNS. You can simply upload a scanned copy of the cover page of your SAM Registration.

EGMS User Registration Assistance:

Office of Grants Management at 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

- Wrong DUNS, Tax ID or expired SAM registration
- Web browser

10.2 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 and Disclosures
- ***Proposal Documents***
    - Proposal Abstract
    - Project Narrative
    - Budget Table
    - Budget Justification
    - Organization Chart
    - Work Plan
    - Staffing Plan
    - Two (2) Letters of Commitment

10.3 Deadline

Submit your application via EGMS by 6:00 p.m., on the deadline date of **Friday, August 3, 2022.** Applications will **not** be accepted after the deadline.

11. PRE-APPLICATION MEETING AND FAQ

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 to do so. ***Registration is required***.

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

Questions about this funding opportunity will only be accepted in writing. All responses to questions received will be published to the District Grants Clearinghouse in a Frequently Asked Questions (FAQ) document.

12. 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:

12.1 GRANT TERMS & CONDITIONS

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

12.2 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.

12.3 CONDITIONS OF AWARD

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

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

reporting requirements, fund distribution terms and any special provisions required by federal agreements.

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

12.4 Indirect Cost

Indirect costs are costs that are not readily identifiable with a particular project or activity but are required for operating the organization and conducting the grant-related activities it performs. Indirect costs encompass expenditures for operation and maintenance of building and equipment, depreciation, administrative salaries, general telephone services and general travel and supplies. Grant awardees will be allowed to budget for indirect costs of no more than ten percent (10%) of total direct costs.

12.5 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 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.

12.6 COVID-19 Grantee Requirement

All applicants that receive awards under this RFA are required to ensure that their employees, agents, and subgrantees ("grantee personnel") are in compliance with Mayor's Order 2021-099, available at: https://coronavirus.dc.gov/page/mayor%E2%80%99s-order-2021-099-covid-19-vaccination-certification-requirement-district-government. Frequently asked questions about the vaccine certification requirement are made available online, here.

To ensure compliance with this item, grantees shall upload a signed attestation from an authorized representative from your organization into the organization profile in EGMS before the Notice of Grant Award is released. A template for an attestation form and step-by-step guide on how to upload the document into EGMS will be provided.

12.7 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 CRF part 200, subpart F rules must have available and submit as requested the most recent audit reports, as requested by DC Health personnel.

12.8 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.

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

13. GLOSSARY OF TERMS

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

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

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

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

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

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

14. ATTACHMENTS

Attachment 1: Work Plan

Attachment 2: Budget Justification

Attachment 3: Budget Table

Attachment: Assurances and Certifications

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.