DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

DEPARTMENT OF HEALTH

COMMUNITY HEALTH ADMINISTRATION (CHA)

Sustainable Tobacco Control Health Systems Change in the Primary Care Setting

REQUEST FOR APPLICATIONS

RFA# CHA_TCLS_8.20.21 (revised)

SUBMISSION DEADLINE:

MONDAY, SEPTEMBER 20, 2021 BY 6:00 P.M.

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.

DEPARTMENT OF HEALTH (DC Health)

NOTICE OF FUNDING AVAILABILITY (NOFA)

Sustainable Tobacco Control Health Systems Change in the Clinic Setting

Tobacco Control Program

The District of Columbia, Department of Health (DC Health) is seeking 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.

General Information:

Funding Opportunity Title:	Sustainable Tobacco Control Health Systems Change in the Clinic Setting
Funding Opportunity Number:	FO-CHA-PG-00179-008
Program RFA ID#:	CHA_TCLS_8.20.2021
Opportunity Category:	Competitive
DC Health Administrative Unit:	Community Health Administration
DC Health Program Bureau	Cancer and Chronic Disease Prevention Bureau
Program Contact:	Carrie Dahlquist Manager, Tobacco Control Program 202.442.9176 carrie.dahlquist@dc.gov
Program Description:	DC Health seeks to ensure that tobacco use is recognized as a chronic, relapsing condition and that dependence treatment and lung cancer screening are fully integrated into the continuum of healthcare, because of the health risks it poses. Funding under this RFA will support the integration of evidence-based tobacco dependence assessment and management into the continuum of care. Applicants must demonstrate how their proposed strategies will change health care systems processes, leading to a seamless, integrated, sustainable approach to addressing tobacco use dependence

	and improving lung cancer screening rates, particularly patients living in wards with high tobacco use prevalence (Wards 7 and 8).
Eligible Applicants	Health centers, including federally qualified health centers (FQHCs), and private medical practices serving residents of the District of Columbia.
Anticipated # of Awards:	1
Anticipated Amount Available:	$150,000
Floor Award Amount:	$100,000
Ceiling Award Amount:	$150,000

Funding Authorization

Legislative Authorization	FY 2022 local funds
Associated CFDA#	Not Applicable
Associated Federal Award ID#	Not Applicable
Cost Sharing / Match Required?	No
RFA Release Date:	August 20, 2021
Pre-Application Conference**,** Date/Time	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:	September 20, 2021
Application Deadline Time:	6:00 p.m.
Links to Additional Information about this Funding Opportunity	DC Grants Clearinghouse http://opgs.dc.gov/page/opgs-district-grants-clearinghouse DC Health EGMS https://dcDC Health.force.com/GO__ApplicantLogin2

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District of Columbia Department of Health

RFA Terms and Conditions

V.01.2020

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://dc.gov/page/grants-management (click on Information).

If your agency would like to obtain a copy of the **DC Health RFA Dispute Resolution Policy,** please contact the Office of Grants Management and Resource Development at clara.mclaughlin@dc.gov or call (202) 442- 5973. Your request for this document will not be shared with DC Health program staff or reviewers. Copies will be made available with the RFA on the Clearinghouse website.

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:

- Table of Contents
- Application Proposal
  - Project Abstract
  - Project Narrative
  - Work Plan
  - Logic Model
  - Project Budget
  - Budget Justification
  - Staffing Plan & Organizational Chart
  - Letters of Commitment
- Assurances, Certifications, and Certification Documents
- Mandatory Business Documents

☐ 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**. **The total size of all uploaded files may not exceed the equivalent of 50 pages when printed. Applications that do not conform to these requirements will not be forwarded to the review panel.**
☐ The application proposal format conforms to the "Application Elements" listed in the RFA.
☐ The proposed budget is complete and complies with the budget forms provided in the RFA. The budget narrative is complete and describes the categories of items proposed.
☐ The proposed work plan, logic model, and other attachments are complete and comply with the forms and format provided in the RFA
☐ Submit your application via EGMS by **6:00 p.m.** on the deadline of **September 20, 2021.**

GENERAL INFORMATION

KEY DATES

- Notice of Funding Announcement Date: August 9, 2021
- Request for Application Release Date: August 20, 2021
- Pre-Application Meeting Date: Visit DC Health's Eventbrite page for the virtual meeting information, **https://OGMDCHealth.eventbrite.com**
- Application Submission Deadline: September 20, 2021
- Anticipated Award Start Date: November 1, 2021

OVERVIEW

Funding under this RFA will support the integration of evidence-based tobacco cessation interventions and lung cancer screening into the continuum of care. Through systemizing the management of tobacco dependence, including appropriate screening for lung cancer, within the health care environment, DC Health anticipates improvements in patient health outcomes, particularly for those patients living in Wards with high tobacco use prevalence (Wards 7 and 8), and cost savings for the health care system. Applicants must be able to demonstrate how their proposed strategies will improve health care systems' processes to ensure appropriate assessment and management of tobacco use for all patients. Applicants are required to use a quality improvement framework (Plan-Do-Study-Act) to design, implement, monitor and evaluate interventions.

The Community Health Administration (CHA) within DC Health promotes healthy behaviors and healthy environments to improve health outcomes and reduce disparities in the leading causes of mortality and morbidity in the District. CHA's approach targets the behavioral, clinical, and social determinants of health through evidence-based programs, policy, and systems change with an emphasis on vulnerable and underserved populations. The goal of this RFA is to support the implementation of sustainable systems change and quality improvement to achieve increased tobacco use cessation attempts and reduce tobacco use among residents seen at healthcare facilities located in the District of Columbia providing primary care services.

SOURCE OF GRANT FUNDING

Funding is made available under the District of Columbia Fiscal Year 2022 local funds.

AWARD INFORMATION

Amount of Funding Available

This RFA will make available $150,000 for one award per fiscal year. Funding each year will be commensurate on level of effort required. The highest level of funding is anticipated for Year 1.

Performance and Funding Period

The projected project period is November 1, 2021 – September 30, 2024. Year 1 budget period is October 2021 – September 2022. The number of awards, budget periods and award amounts are contingent upon the continued availability of funds and the recipient performance.

Eligible Organizations/Entities

Health centers, FQHCs and private practices located in the District of Columbia providing primary care services to adults 18 years and older. Priority will be given to those organizations with:

- A high proportion of the patient population consistent with the program's priority populations (African American/black, low SES, low educational attainment, LGBTQ adults, residents of Wards 7 & 8, persons who can become pregnant)
- Demonstrated experience in quality improvement activities
- Capacity to access and report program measures from electronic health records system (EHR)

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.

BACKGROUND & PURPOSE

BACKGROUND

Tobacco use is the leading cause of preventable illness and death due to lung cancer, heart disease and stroke. In the United States, for every person who dies from tobacco use, at least thirty people live with a serious tobacco-related illness such as heart disease, diabetes and chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema.[1] Since the release of the Surgeon General's Report on Smoking and Health in 1964, significant progress has been made to reduce smoking prevalence in the United States. Over the past decade,

[1] Center for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance Systems (BRFSS), 2018.

the District of Columbia has seen a reduction in smoking prevalence from 20.8% in 2011 to 12.7% in 2019, which is lower than the national average of 16%.[2] However, this overall decline camouflages the existing disparities in tobacco use and health outcomes within the District. The smoking rate in non-Hispanic African American/black residents is more than three times higher than the rate for white, non-Hispanic residents. An estimated 800 residents in the District of Columbia die each year because of a tobacco-related illness (e.g. cancer, heart disease, etc.).[3] Nearly one-third (28.2%) of cancer deaths in Washington, DC are attributable to smoking. [4] Because of the high rate of smoking in vulnerable populations such as AA/black residents and those identifying as lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ), they are more likely to bear the burden of premature death from smoking.

In 2019, 30.3% of District residents with household incomes less than $35,000 smoked cigarettes; in comparison, 12.7% of the overall District population smoked cigarettes. In addition, tobacco use is disproportionately higher among District residents with high school or less educational attainment. Residents with high school education or lower make up more than half (50.2%) of the current cigarette smoking population, while 23.0% of non-smoking population are residents with high school education or lower. Income and ward of residence, like race/ethnicity, are closely related to smoking prevalence. Geographically, about half (53.7%) of the District residents who are current smokers reside in Wards 7 and 8. The rate of current smokers in Ward 3, which has the highest income and highest percentage of whites, is only 6%, much lower than Wards 7 & 8, which have the lowest income and highest percentage of AA/black residents, at 23.8%. This demonstrates the stark disparities in smoking prevalence.[5] Infant mortality rates in the United States are disproportionally high among those who smoke during pregnancy. There are health risks that endanger the health of the mother and the unborn child to include premature birth weight and congenital disabilities.[6] In many subpopulations, tobacco use rates are disproportionately high. Within the District, this rings true for many

[2] Centers for Disease Control and Prevention (CDC), Behavioral Risk Fact Surveillance System (BRFSS). https://www.cdc.gov/brfss/brfssprevalence/

[3] CDC State Fact Sheets: Extinguishing the Tobacco Epidemic in Washington, DC (2017). Retrieved from https://www.cdc.gov/tobacco/about/osh/state-fact-sheets/washington-dc/

[4] CDC – BRFSS Online Adult Smoking Data (2016). Retrieved from https://www.cdc.gov/brfss/brfssprevalence/index.html

[5] District of Columbia Department of Health (DC Health), DC Behavioral Risk Factor Surveillance Systems (DC BRFSS), 2018.

[6] Azagba, S., Manzione, L., Shan, L. et al. Trends in smoking during pregnancy by socioeconomic characteristics in the United States, 2010–2017. BMC Pregnancy Childbirth 20, 52 (2020). https://doi.org/10.1186/s12884-020-2748-y

AA/black residents and those identifying as and LGBTQ adults with 20.4% and 34%, respectively using tobacco.[7]

Data reveals that African-Americans are more likely to try to quit; however, compared to white smokers are less successful. The targeted marketing tactics of Big Tobacco to communities of color resulted in increased usage of menthol cigarettes among AA/blacks than in whites. Consequently, white smokers account for only 29% of menthol cigarette users, compared to 85% of blacks. Data shows that usage of menthol cigarettes has profound addictive effects in youth and adults leading to decreased success in cessation.[8] Higher rates of marketing in AA/black neighborhoods, up to 10 times that in predominantly white neighborhoods, has contributed to smoking-related health inequities.[9]

Most smokers usually require several attempts to quit before being able to attain long term cessation. To support smokers in their attempt to quit, the DC Quitline provides free cessation services to any District of Columbia resident who needs help quitting tobacco. Through the Quitline, a variety of coaching services are made available, including web, phone and mobile-based (Text2Quit) services. These services can be used individually or combined to help any tobacco user give up tobacco.

Overview of Health Systems Change

Systems change is a process-focused, integrated, sustainable solution at the organization level to improve healthcare delivery and reduce health disparities of patient populations. While the District's long-term goal is reduction in both the use of tobacco products and lung cancer mortality, the short-term goal of this grant is to improve clinical workflow processes that support cessation and screening. According to the U.S. Public Health Service *Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update*, systems change leads to improvements in care delivery and improves clinician interventions.

This initiative aligns with the tobacco use screening and cessation intervention clinical quality measures set by the Centers for Medicare and Medicaid Services (CMS). Process-focused initiatives to improve screening and intervention begin with an assessment of current clinic policies and workflow to identify where changes can be implemented. Continuous quality improvement (CQI) initiatives identify gaps where additional work might be needed, then test interventions to address those gaps, with the goal of identifying a long-term strategy to improve

[7] CDC – Community Profile Washington, DC Communities Putting Prevention to Work (2013). Retrieved from https://www.cdc.gov/nccdphp/dch/programs/communitiesputtingpreventiontowork/communities/profiles/tobacco-dc_washington.htm

[8] "TOBACCO USE AMONG AFRICAN AMERICANS." Campaign for Tobacco-Free Kids. February 21, 2021. Accessed June 23, 2021. https://www.tobaccofreekids.org/assets/factsheets/0006.pdf.

[9] "Tracing the Racist Tactics of the Tobacco Industry." Truth Initiative, October 16, 2020. https://truthinitiative.org/research-resources/targeted-communities/tracing-racist-tactics-tobacco-industry.

processes. Through this approach, tobacco use assessment, cessation support, and lung cancer screening referral are then integrated into clinic protocols to enhance healthcare delivery. Because the processes become part of standard operating procedures, they become sustainable beyond grant funding.

Foundational systems change work includes workflow assessment, baseline data collection, policy review and modification, professional development and training for all clinic staff, and infrastructure upgrades (if needed to support data collection and patient referral).

Overview of Tobacco Cessation Frameworks (5As and 2As & R)

The most recent report of the Surgeon General states that "the current rate of progress in tobacco control is not fast enough, and much more needs to be done to end the tobacco epidemic.[10] Since roughly 70% of smokers see a clinician in a given year, health systems can play a key role in identifying tobacco users and facilitating cessation, such as providing and/or referring patients to evidence-based cessation services.[11] The US Preventive Services Task Force (USPSTF) identifies the 5-A's as a tobacco cessation counseling framework and an effective strategy for providers to begin conversations with patients about smoking cessation.[12] The 5-As are: 1) Ask about tobacco use; 2) Advise to quit using clear, personalized messages; 3) Assess willingness to make a quit attempt; 4) Assist in quit attempt and, 5) Arrange follow-up and support. Additionally, to address the known sequelae of tobacco use, the USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) for adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.

Overview of Quitline Services

Quitline tools help smokers overcome physical and emotional urges to smoke. Various phone and web-based cessation tools and resources are made available to District residents. The DC Quitline (1-800-QUIT-NOW) is available to help District of Columbia residents quit tobacco at no cost to residents. While DC Quitline provides counseling supports in several languages, a local number (202-333-4488) directly connects Spanish-speaking callers to the Quitline. The Quitline provides one-on-one private counseling sessions to District of Columbia residents. Beyond phone-based enrollment, residents can enroll for the Quitline services through text

[10] U.S. Department of Health and Human Services (2014). The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Retrieved from https://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf

[11] Jansen, A.L., Capesius, T.R., Lachter, R.B., Greenseid, L.O., & Keller, P.A. (2014). Facilitators of health systems change for tobacco dependence treatment: a qualitative study of stakeholders' perceptions. BMC health services research.

[12] Tobacco Use Counseling. Content last reviewed December 2018. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/ncepcr/tools/healthier-pregnancy/fact-sheets/tobacco.htm

messages and the website. While the counseling and coaching services of the DC Quitline is often emphasized, the DC Quitline also offers other individualized services to residents, including Text2Quit, email and/or text messaging support, educational and quit-guide materials, and up to 8-weeks supply of nicotine replacement therapy (NRT) starter kit that includes NicodermCQ patches or Commit lozenges. Provision of these services provides flexibility, allowing individuals to choose which services they would like to receive. Each resident who signs up to receive DC Quitline services may utilize one or more services to address individual needs. The overall goal of the DC Quitline is to assist District residents' cessation attempts by reducing barriers to access and to increase cessation attempts and tobacco cessation success rates in the District of Columbia. The goal of individualized services is to increase the likelihood of retention in the program by tailoring services to fit each resident's needs. (See Appendix B)

Provider Referral to DC Quitline

To encourage referrals to evidence-based cessation services, DC Health offers a streamlined referral process to the Quitline. The e-referral program allows providers to use integrated EHR technology, secure email or fax to refer patients confidentially to the Quitline. Using these referrals, Quitline coaches will contact patients directly to enroll them in cessation services. In turn, providers will receive secure HIPAA-compliant reports, which include whether individuals accepted and received services as well as the type of services delivered.

Overview of Lung Cancer Screening

Lung cancer is the leading cause of cancer death in the United States. Those diagnosed with lung cancer at an early stage have reduced mortality rates compared to those with late-stage disease diagnosis. Detection of the disease and subsequent treatment at this earlier stage may be beneficial, particularly for those at highest risk of lung cancer. Despite this, lung cancer screening rates remain low among populations who qualify. The U.S. Preventive Services Task Force (USPSTF) recommends the use of low-dose computed tomography (LDCT) screening for earlier detection of lung cancer in high-risk populations.[13] High-risk is defined as an adult aged 50 to 80 who has a 20 pack-year smoking history and (1) currently smokes or (2) quit within the past 15 years. For current and previous smokers, pack-year history should be assessed in the first step of 5As and 2As & R.

[13] Final Recommendation Statement Lung Cancer: Screening." 2021. U.S. Preventative Services Task Force. March 9, 2021. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening

PURPOSE

The purpose of this funding is to reduce the burden of tobacco by decreasing smoking prevalence and increasing early diagnosis of lung cancer. DC Health Community Health Administration (CHA) is soliciting applications from qualified health systems providing primary care to incorporate sustainable systems changes supporting implementation of evidence-based tobacco cessation and lung cancer screening interventions for District residents. These changes aim to make the treatment of tobacco dependence within the health care environment a routine part of clinical practice and support improved health outcomes. The focus is on populations disproportionately affected by the burden of tobacco due to higher rates of tobacco use, lower rates of cessation success, and higher rates of morbidity and mortality.

Approach

To reduce the burden of tobacco on District residents, applicants will employ system-wide process changes to support implementation of evidence-based tobacco cessation and lung cancer screening interventions for District residents. Strategies and activities should be administered in a phased approach, building the foundation for sustainable interventions that can be shared, duplicated, and/or expanded with minimal resources beyond the life of the grant as follows:

- **Year 1**: development of project team, completion of workflow assessment and process mapping, upgrades to EHR, analyzing data quality, conducting staff training, planning and initiating interventions
- **Year 2**: continued implementation, quality improvement activities, program monitoring
- **Year 3**: sustainability of workflow processes, program monitoring and evaluation

Outcomes

To improve tobacco cessation, reduce tobacco use disparities, and decrease tobacco-related mortality, applicants will employ strategies and activities to improve workflow processes that are sustainable practices in the primary care clinical setting.

Strategies and Activities	Short Term Outcomes (1-2 Years)	Intermediate Outcomes (2-4 Years)	Long Term Outcomes
• Implement process to facilitate systematic assessment of tobacco use, treatment of tobacco dependence, and referral to lung cancer screening • Utilize data through EHR systems to improve healthcare	• Increased number of providers trained on and conducting tobacco use screening and providing cessation support • Increased referral to cessation services through the Quitline and other community cessation programs	• Increased successful quit attempts • Decreased tobacco use and dependence among DC adults	• Decreased incidence of tobacco-related morbidity and mortality • Decreased tobacco-related disparities

delivery and optimize patient outcomes • Implement, track and analyze evidence-based quality improvement measures	• Increased utilization of cessation resources such as the Quitline • Increased utilization of pharmacotherapy to support cessation • Increased referral to lung cancer screening		

Applicants shall demonstrate how the proposed project plan will measure the impact of the following performance measures:

Tobacco Use Assessment and Cessation Support

- Percent of adult patient population screened for tobacco use
- Percent of patients who use tobacco and are referred to the DC Quitline
- Percent of patients who use tobacco and are referred to other cessation resources
- Percent of patients who are prescribed nicotine replacement therapy (NRT)
- Percent of patients who are prescribed cessation medication other than NRT
- Percent of patients referred to cessation resources or prescribed medication who report quitting at any time during the measurement period
- Percent of patients in priority populations (residents disproportionately affected by the burden of tobacco: residents with low income and low educational attainment, African American/blacks, adults identifying as LGBTQ, residents living in Wards 7 and 8, and women of reproductive age), assessed for tobacco use, referred to the DC Quitline and other cessation resources, and prescribed NRT or other cessation medications

Lung Cancer Screening Assessment, Referral and Follow-up

- Percent of adult patient population eligible for lung cancer screening
- Percent of adult patient population eligible for and referred to lung cancer screening
- Percent of patients eligible for lung cancer screening who completed annual screening
- Percent of patients in priority populations (residents disproportionately affected by the burden of tobacco: residents with low income and low educational attainment, African American/blacks, adults identifying as LGBTQ, residents living in Wards 7 and 8, and women of reproductive age). eligible for, referred to, and completed lung cancer screening

PERFORMANCE REQUIREMENTS

Applicants should propose projects that meet the criteria listed below.

TARGET POPULATION

Projects will focus on District residents who use tobacco, with priority placed on residents disproportionately affected by the burden of tobacco: residents with low income and low educational attainment, African American/black residents, adults identifying as LGBTQ, residents living in Wards 7 and 8, and women of reproductive age). These populations experience higher rates of tobacco use often driven by deceptive marketing practices and are less likely to be successful in a quit attempt. These populations are also vulnerable to the harmful effects of tobacco use and secondhand smoke such as cardiovascular disease, cancer, COPD, diabetes, and preterm and/or low-weight births.

LOCATION OF SERVICES

Services must be provided within a primary care clinic(s)/practice(s) that is part of a community health center or federally qualified health center (FQHC) located in the District.

SCOPE OF WORK

The grantee shall implement processes and activities that identify adult patients who use tobacco, refer them to appropriate cessation services, and follow-up on their progress. Patients who meet current lung cancer screening guidelines as outlined by the US Preventive Services Task Force should be referred to screening and supported through patient navigation services.

Health systems shall implement quality improvement processes that enable integration of tobacco dependence treatment and lung cancer screening best practices into routine care. Possible activities include, but are not limited to: linking tobacco cessation activities to internal and external quality improvement initiatives to ensure tobacco dependence treatment is an ongoing priority for the health system; using rapid cycle improvement processes to build upon the current state of tobacco dependence treatment and lung cancer screening referral; and implementing referrals and reporting provider feedback to ensure all who are involved in tobacco dependence treatment and lung cancer screening are aware of their (or their team's) performance and are supported to improve.

DC Health is seeking applicant organizations to utilize health systems change interventions to identify and treat tobacco dependence and to refer to lung cancer screening for eligible patients at every visit.

Strategy A: Implement processes to facilitate systematic assessment of tobacco use among adult patients and referral to cessation resources and appropriate lung cancer screening.

A1. Convene a multidisciplinary team to implement and monitor activities and outcomes throughout the project.

A1.1 Designate a point of contact (POC) to participate in monthly meetings with the TCP to discuss implementation activities related to all strategies outlined in the work plan to include gaps, opportunities for improvement, and successful interventions.

A1.2. Designate one staff (Clinic Champion) and an alternate dedicated to oversight of project activities, evaluation, and reports. The Clinic Champion may also serve as the POC and should have authority to make program-related decisions to implement activities within the scope of work and work plan.

A1.3. Designate staff from across departments (including non-physician team members) to serve on the team.

A1.4. Conduct regular project team meetings to monitor progress and identify technical assistance needs.

A2. Implement a workflow process to ensure tobacco use assessment and screening is completed.

A2.1. Participate in a readiness and workflow assessment of current clinical processes to determine inefficiencies and gaps in implementation of tobacco dependence identification and treatment and lung cancer screening referral.

A2.2. Develop clinical workflows for all staff to support tobacco dependence identification and treatment and lung cancer screening referral, including the use of physician and patient reminders.

A2.3. Create mechanisms or processes to ensure that delivery of tobacco dependence treatment and lung cancer screening -- and treatment if necessary -- is coordinated as patients navigate their continuum of care and follow-up occurs (e.g., between clinic and DC Quitline, between clinic and CT provider, between clinic and hospital).

A2.4 Incorporate tobacco use assessment and lung cancer screening in telehealth visits and utilize telehealth as a follow-up tool for patients during their cessation journey.

A3. Implement evidence-based interventions (EBIs) – 5As or 2As & R or an adaptation thereof – to assess tobacco use and support cessation.

A3.1. Conduct training for all clinic staff on quality improvement and the evidence-based interventions selected by the multidisciplinary team in project year one and as needed.

A3.2. Integrate the 5As or the 2As & R tobacco intervention steps in the clinic's workflow process.

A4. Implement lung cancer screening referral and follow-up.

A4.1. Develop and implement screening referral and follow-up protocols.

A4.2. Utilize evidence-based interventions to support screening and follow-up, such as provider prompts in EHR, patient reminders (letter, postcard, email; telephone or text messages), and patient navigation to address barriers to care.

Strategy B: Utilize data through EHR systems to improve healthcare delivery and optimize patient outcomes.

B1. Upgrade current EHR system to support tobacco use assessment, cessation, and referral activities. *(Funding to modify EHR is capped at 25 percent of the total grant award including indirect costs during year one only. This includes EHR system upgrades and data clean-up efforts).*

B1.1. Utilize EHR to refer patients to the DC Quitline by generating referral forms for fax, secure email, or FTP site delivery or through EHR integration.

B1.2. Create prompts in the EHR aligned with the selected intervention (5As or 2As & R) and screening protocols.

B1.3. Integrate tobacco dependence diagnoses in problem lists and create order sets for tobacco dependence treatment, including pharmacy orders.

B1.4. Develop EHR algorithms to identify patients at high-risk of lung cancer to refer to appropriate screening.

B1.5. Produce routine aggregate reports for provider assessment and feedback and to document follow-up care or care coordination for treatment or screening.

B2. Establish and implement a written protocol that details the process and steps used to create grant-required data reports from the EHR. The protocol must outline EHR queries and/or Standard Query Language (SQL) procedures used for reports.

Strategy C: Implement, track and analyze evidence-based quality improvement measures related to tobacco use assessment, cessation referral, and lung cancer screening compliance.

C1. Routinely analyze clinic and program data to assess data quality and identify areas for quality improvement.

C1.1. Validate EHR reports with a manual chart review during the first year of the project. *(Significant data quality issues will require a chart review in project year 2.)*

C2. Develop and utilize QI processes such as Plan-Do-Study-Act (PDSA) cycles, fishbone analysis, processes mapping and/or flow charting to identify gaps and optimize

assessment of patients for tobacco use and referral of adults who use tobacco to cessation resources and lung cancer screening (if appropriate).

C3. Implement provider assessment and feedback to inform staff about their performance in providing tobacco use assessment, cessation support, and screening referral.

Strategy D: Meet requirements for effective management of the project.

D1. Participate in project kick-off to orient clinic staff on program goals, activities, and requirements.

D2. Participate in monthly meetings with DC Health Tobacco Control Program project officer to discuss current best practices in clinical quality improvement (QI), challenges and success, and technical assistance needs.

D3. Conduct annual staff trainings on topics related to implicit bias; cultural competency and humility; diversity, equity, and inclusion; and data collection on social determinants of health. Training modules must have DC Health approval. The applicant may budget up to 10% of the total budget (including indirect cost) for trainings offered virtually or in-person. The applicant is encouraged to explore low- or no-cost trainings offered through CDC's Networking2Save.

D4. Submit required monthly invoices and quarterly/annual reports.

D45 Participate in peer-to-peer and subject matter expert-led learning opportunities related to tobacco use and assessment, quality improvement.

D6. Attend webinars and training sessions to augment and complement technical assistance support.

D7. Prepare a succession plan including the transfer of knowledge as staff turnover occurs.

D8. Collect qualitative data to develop and submit one success story each project year. The success story should convey program impact at the clinic level in year 1 and the community level in years 2 and 3.

Evidence of and Best Practices for Health Systems Change

U.S. Public Health Service Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update. https://www.ahrq.gov/prevention/guidelines/tobacco/index.html

Millions Hearts® Tobacco Cessation Change Package, Intervention Protocol, and Clinician Action Guide: https://millionhearts.hhs.gov/tools-protocols/action-guides/tobacco-change-package/index.html

Centers for Disease Control and Prevention – Health Systems Change FAQ

https://www.cdc.gov/tobacco/quit_smoking/cessation/pdfs/using-health-systems-change508.pdf

Networking2Save: CDC's National Network Approach to Preventing and Controlling Tobacco-related Cancers in Special Populations.
https://www.cdc.gov/tobacco/stateandcommunity/tobacco_control_programs/coop-agreement/index.html

APPLICATION REQUIREMENTS

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 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 logical model in the Approach section of this RFA.

Target Population

Applicants should provide an overview of their patient population as relevant to the project including rates of smoking, race, age and residence (ward and/or zip code) and other relevant health indicators, such as comorbid disease (i.e., hypertension, cardiovascular disease, chronic lung disease). Applicants should be able to demonstrate the ability to reach the priority populations (residents with low income and low educational attainment, African American/blacks, adults identifying as LGBTQ, residents living in Wards 7 and 8, and women of reproductive age) 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.

- 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 Work 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 describe how key performance measures will be collected and used to assess project outcomes. At a minimum, this shall describe:

- The applicant's experience and capacity to access and export the performance measures, data sources, feasibility of collected required data
- How applicant will collect performance measures data
- How applicant will ensure quality data collection, including QA activities, data validation methods, and capacity to perform a chart review
- How applicant will ensure that priority populations identified in this RFA are assessed for tobacco use, referred to cessation services, prescribed NRT or other cessation medications, and referred to lung cancer screening as indicated
- How data will be monitored and used to improve implementation

ORGANIZATIONAL CAPACITY

This section should provide an overview of the organizational infrastructure, mission and vision. Applicants should demonstrate capacity and infrastructure to implement culturally competent tobacco use dependence and quality improvement initiatives. The applicant should also describe the scope of current activities to address tobacco dependence, data systems capabilities and care delivery teams to support tobacco use identification and treatment as well as identify current gaps that can be addressed through this RFA. The applicant should describe the scope of current QI activities and demonstrate staff capacity to conduct QI activities as required by this RFA. Applicants should demonstrate ability to meet performance requirements, collect data, 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.

ADDITIONAL REQUIRED DOCUMENTS

Some of the attachments for this application will have required templates that the applicant must use. The sections below will indicate which documents require the use of a template. These documents will not count towards the Project Narrative 10-page limit; however, they will count towards the overall 50-page limit.

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.

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.

PROJECT BUDGET

The application should include a project budget using the form provided in (Attachment 2). The project budget and budget justification should be directly aligned with the work plan and project description. All expenses should relate directly to achieving grant outcomes. Budget should reflect a 12-month period.

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

Include the following in the Budget Justification Narrative:

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 travel to local and national tobacco cessation conferences directly related to program goals and process, such as data and evaluation, 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.

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

(20 POINTS) – Corresponds to Sections: *Introduction and Target Population*

- Does the applicant currently serve the priority populations described in this RFA?
- Does the applicant currently serve a high proportion of residents who are tobacco users?
- Does the applicant well demonstrate an understanding of the benefits of health systems changes to integrate smoking cessation and treatment and lung cancer screening interventions?
- Does the applicant demonstrate an understanding of the intersection of social determinants of health and health disparities?
- Does the applicant well understand the need for health systems change interventions that address health disparities by appropriately targeting vulnerable populations?

- Does the applicant's proposed project align with the goals of this RFA and are the goals logical and feasible?

CRITERION 2: CAPACITY

(20 POINTS) – Corresponds to Sections: *Organization and Partnerships*

- Does the applicant's organizational infrastructure support the implementation of the proposed strategies and reporting requirements?
- Does the applicant demonstrate experience working with and improving health outcomes of the priority populations identified in this RFA?
- Does the applicant demonstrate experience with EHR upgrades and modifications?
- Does the organization have demonstrated experience implementing and evaluating clinical quality improvement activities to improve aggregate patient outcomes?
- Does the applicant well demonstrate commitment from the organization's leadership to implement the proposed strategies?
- Does the applicant have staff with quality improvement expertise to champion and implement QI initiatives?
- Does the applicant identify a project lead?
- Does the applicant collaborate with other health care systems, FQHCs, and other stakeholders to support tobacco dependence treatment and integrate it into electronic heath records and workflows?
- Does the applicant collaborate with other health care systems, FQHCs, and other stakeholders to integrate lung cancer screening referral and follow-up into electronic health records and workflows?
- Does the applicant demonstrate the cultural competency and capacity to address diversity, equity, and inclusion in its operations (such as staff training, communications, hiring processes, etc.)?

CRITERION 3: IMPLEMENTATION FRAMEWORK

(35 POINTS) – Corresponds to Sections: *Project Description*

- Does the applicant describe realistic/feasible approaches that are grounded in current systems change and clinical quality improvement evidence-based practice?
- Does the applicant propose evidence-based, sustainable processes to identify the required referral of current smokers to tailored cessation services (including but not limited to the DC Quitline) and to follow-up on the outcome of the referrals?
- Does the applicant propose evidence-based, sustainable processes to identify and refer eligible patients to lung cancer screenings who are at high risk for developing the disease because of their smoking history and age per US Preventive Services Task Force guidelines and the framework to support completion of the referral?
- Does the applicant provide a clear description of proposed project objectives and activities that are tied to one or more systems change strategies?

CRITERION 4: EVALUATION

(20 POINTS) – Corresponds to Section: *Evaluation*

- Does the applicant identify skilled staff to collect and analyze data?
- Does the applicant specify a process to collect and analyze data and monitor progress using a QI framework?
- Does the applicant specify a process to collect and analyze data and monitor progress for the priority populations identified in this RFA?
- Does the applicant identify measurable indicators and does their infrastructure support the ability to collect and report relevant data that align with the project goal?

CRITERION 5: SUPPORT REQUESTED

(5 POINTS) Corresponds to Sections: Budget and Budget Justification Narrative

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

- Do the budget and budget justification align with the scope of work and the applicant's proposed work plan?
- Does the cost as outlined in the budget and required resources sections appear reasonable given the scope of work?
- Do key personnel have adequate time devoted to the project to achieve project objectives?

REVIEW AND SCORING OF APPLICATION

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.

EXTERNAL REVIEW PANEL

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

INTERNAL REVIEW

DC Health program managers will review the individual and summary recommendations of the external review panel and make recommendations for awards. Program Managers will weigh the results of the review panel against other internal and external factors in making the final funding determinations. Those factors will include minimally a past performance review, risk assessment and eligibility assessment, including a review of assurances and certifications, and business documents submitted by the applicant, as required in the RFA. DC Health will also conduct an excluded party's list search (EPLS) of the organization and executives via the federal System for Award Management (SAM) and conduct a DC Clean Hands review to obtain DC Department of Employment Services and DC Office of Tax and Revenue compliance status.

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

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

ASSURANCES & CERTIFICATIONS

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

A. Assurances Required to Submit Applications (Pre-Application Assurances/Mandatory Business Documents)

- City Wide Clean Hands Compliance Status Letter (formerly Certificate of Clean Hands) not older than 3 months prior to August 31, 2021.
- 501 (c) 3 certification
- Official List of Board of Directors on letterhead, for current year, signed and dated by the authorized executive of the Board. (cannot be the CEO)
- All applicable Medicaid Certifications
- FQHC designation letter, if applicable
- A Current Business license, registration, or certificate to transact business in the relevant jurisdiction
- Signed Assurances, Certifications & Disclosures

- Certificate of Insurance
- Copy of Cyber Liability Policy

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

- Certification Regarding Lobbying; Debarment, Suspension and Other Responsibility Matters; and Drug-Free Workplace Requirements
- 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 either ineligible for funding consideration [required to submit assurances] or ineligible to sign/execute grant agreements [required to sign grant agreements assurances].

APPLICATION PREPARATION

APPLICATION PACKAGE

Only one (1) application per organization will be accepted. The total size of the applicable attachments may not exceed the equivalent of **50 pages** when printed by DC Health.

APPLICATION PACKAGE

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

- Project Abstract
- Project Narrative (10-page limit; see page 9)
- Staffing Plan
- Organizational Chart
- Work Plan – Attachment 1
- Budget/Budget Justification – Attachment 2

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

- Table of Contents - Lists major sections of the application with quick reference page indexing. Failure to include an accurate Table of Contents may result in the application not being reviewed fully or completely.
- Assurances Certifications and Disclosures (See Appendix C): *reviewed and accepted via EGMS.* Scan and upload **one copy SIGNED** by the Agency Head or authorized official.
- DC Health Standard Grant Terms and Conditions (*Reviewed and Accepted via EGMS*)
- **Mandatory Certification Documents** (Scan and upload **ONE PDF** file containing all of the following business documents required for submission):

i. A current business license, registration, or certificate to transact business in the District of Columbia.

ii. 501(c)(3) certification (for non-profit organizations)

iii. City Wide Clean Hands Compliance Status Letter (formerly Certificate of Clean hands). Clean Hands Compliance Status letter must be dated no more than 60 months prior to the due date of application.

iv. Official list of Board of Directors for the current year and the position that each member holds on letterhead and signed by the authorized executive of the applicant organization, not the CEO.

v. Medicaid certifications.

vi. Certificate of Insurance

vii. Copy of Cyber Liability Policy

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.

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.

REGISTER IN EGMS

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

IMPORTANT: WEB BROWSER REQUIREMENTS

1. **Check web browser requirements for EGMS –** The DC Health EGMS Portal is supported by the following browser versions:

- Microsoft ® Internet Explorer ® Version 11
- Apple ® Safari ® version 8.x on Mac OS X
- Mozilla ® Firefox ® version 35 & above (Most recent and stable version recommended)
- Google Chrome ™ version 30 & above (Most recent and stable version recommended)

2. **Access EGMS**: The user must access the login page by entering the following URL in to a web browser: https://dcdoh.force.com/GO ApplicantLogin2 Click the button REGISTER and following the instructions. You can also refer to the EGMS External User Guide.
3. Determine the agency's Primary User (i.e. authorized to accept terms of agreement, certify and submit documents, request and accept modifications). 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 jennifer.prats@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 jennifer.prats@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

UPLOADING THE APPLICATION

All applications documents submitted in EGMS shall be as 3 separate attachments. Required components are included in each is below. All of these must be aligned with what has been requested in other sections of the RFA.

- **Document 1** – ***Mandatory Business Documents:*** A current business license, registration, or certificate to transact business in the relevant jurisdiction, 501 (c) 3 certification (for non-profit organizations), City Wide Clean Hands Status Letter, official signed board of directors letter on letterhead, Medicaid certifications, certificate of insurance, copy of cyber liability policy
- **Document 2** – ***Proposal***: table of contents, project abstract, project narrative, logic model, work plan, staffing plan, organizational chart, budget, budget justification, letters of commitment
- **Document 3 – *Other:*** Assurances Certifications Disclosures (signed), any other required documents

DEADLINE:

Submit your application via EGMS by 6:00 p.m., on the deadline date of Monday, September 20, 2021 Applications will not be accepted after the deadline.

PRE-APPLICATION MEETING

One Pre-Application Meeting will be held virtually:

Visit DC Health's Eventbrite page for the virtual meeting information, https://OGMDCHealth.eventbrite.com.

All questions regarding this RFA **must** be submitted in writing. Questions will not be answered over the phone.

This information will be used to provide updates and/or addenda to the RFA. Updates will be posted on the District Grants Clearinghouse.

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:

GRANT TERMS & CONDITIONS

All grants awarded under this program shall be subject to the DC Health Standard Terms and Condition for all DC Health – issued grants. The Terms and Conditions are located in the

Attachments and in the Enterprise Grants Management System, where links to the terms and a sign and accept provision is imbedded.

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.

Conditions of Award

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

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

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.

Insurance

All applicants that receive awards under this RFA must show proof of all insurance coverages required by the Office of Risk Management (ORM) prior to receiving funds. At minimum, the awardee must meet the insurance coverage requirements outlined in the Appendix D. The coverage levels may be adjusted by ORM following issuance of the NOGA per a review of activities performed under the grant and any other grants with DC Health or other District

agencies. DC Health reserves the right to request certificates of liability pre-award and post-award and make adjustments to coverage limits for school-based programs per requirements promulgated by the District of Columbia Office of Risk Management.

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.

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.

QUALITY ASSURANCE

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

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

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

CONTACT INFORMATION:

Grants Management

Brenda Ramsey-Boone
Office of Grants Monitoring & Program Evaluation
Community Health Administration
DC Department of Health
899 North Capitol Street, N.E., 3rd Floor Washington, DC 20002
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Program Contact

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GLOSSARY OF TERMS

Electronic Health Record (EHR) - is a digital form of the paper-based patient record. It includes information such as medical history, previous and current diagnoses, treatment plans, medications, immunization dates, allergies and any laboratory results, X-rays and other medical imagery in real-time. The goal of utilizing the electronic health record is to aid in streamlining and automating services and provider workflow. It also gives providers access to evidence-based tools to make well-informed decisions about patient care. There are several benefits and impacts to care including increased patient participation, improved care coordination, improved diagnostics and patient outcomes, and cost savings.

Health system change – For the purposes of this FOA, Health systems change involves institutionalizing tobacco cessation interventions into routine clinical care in health care systems (e.g., clinics, hospitals, dental offices, pharmacies, emergency departments).1 The goals of health systems change with regard to tobacco cessation are to ensure that (1) every patient is screened for tobacco use and tobacco use status is documented, and (2) patients who use tobacco are advised to quit and provided with options for evidence-based treatments.2 Changes to the health systems to make tobacco cessation interventions more routine may include a variety of components, from creating decision support tools and developing clinical workflow to modifying electronic health records (EHRs) and generating routine feedback on performance.

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)

Meaningful use – Under the Health Information Technology for Economic and Clinical Health (HITECH Act), which was enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act), incentive payments are available to eligible professionals (EPs) who successfully demonstrate meaningful use of certified EHR technology. The Recovery Act specifies three main components of meaningful use: The use of a certified EHR in a meaningful manner, the use of certified EHR technology for electronic exchange of health information to improve quality of health care and the use of certified EHR technology to submit clinical quality and other measures.

Patient navigator – is a health professional that focuses on the patient's needs. The navigator helps guide the patient through the healthcare system and works to overcome obstacles that are in the way of the patient receiving the care and treatment they require.

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

ATTACHMENTS

Attachment 1: Work Plan

Attachment 2: Budget Justification & Budget

Attachment 3: Mandatory Assurances and Certifications

APPENDIX A – SUPPORTING BEST PRACTICE REFERENCES

APPENDIX B – DC QUITLINE INDIVIDUALIZED SERVICES

APPDENDIX C – REQUIRED INSURANCE COVERAGE

ATTACHMENT 1 – Work Plan

Grantee Work Plan

Agency/Organization Name:	
Program/ Grant Name:	
Project Title:	
Total Request:	
Primary Target Population:	
Estimated Reach:	
Programmatic Contact Person:	
Telephone:	
Email:	

Guidance:

Using the following instructions please complete the chart below:

Goal: Make sure your goals are clear and reachable, each one should be:

- Specific (simple, sensible, significant)
- Measurable (meaningful, motivating)
- Achievable (agreed, attainable)
- Relevant (reasonable, realistic and resourced, results-based)
- Time bound (time-based, time limited, time/cost limited, timely, time-sensitive)

- Objective (SMART): Measurable steps your organization would take to achieve the goal
- Key Indicator: A measurable value that effectively demonstrates how you will achieve your objective(s)
- Key External Partner: Who you work with outside of your organization to achieve the goal
- Key Activity: Actions you plan carry out in order to fulfill the associated objective
- Start Date and Completion Date: The dates you plan to complete the associated activity
- Actual Start Date and Completion Date: The dates you actually started and completed the activity
  - Note: These columns should be entered by you and submitted to your project officer at the end of the budget period
- Key Personnel: Title of individuals from your organization who will work on the activity

GOAL 1:					
Measurable Objectives/Activities:					
Objective #1:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
Objective #2:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
Objective #3:					
Key Indicator(s):					
Key External Partner(s):					

Key Activities to Meet this Objective:	Start Date:	Completion Date:	Actual Start Date:	Actual Completion Date:	Key Personnel (Title)
A.					
B.					

GOAL 2:					
Measurable Objectives/Activities:					
Objective #1:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #2:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					

B.					
C.					
Objective #3:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
GOAL 3:					
Measurable Objectives/Activities:					
Objective #1:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #2:					

Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #3:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					

GOAL 4:					
Measurable Objectives/Activities:					
Objective #1:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #2:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #3:					
Key Indicator(s):					
Key External Partner(s):					

Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Budget/Budget Justification Instructions

Provide 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. This document should be submitted with the Excel budget template that was provided to you.

A. **Personnel:** Personnel costs should be explained by listing each staff member who will **(1)** be supported from funds and **(2)** in-kind contributions. If personnel costs are supported by in-kind contributions, please indicate the source of funds. Please include the full name of each staff member (or indicate a vacancy), position title, percentage of full-time equivalency, and annual salary. Personnel includes, at a minimum, the program director responsible for the oversight and day-to-day management of the proposed program, staff responsible for quality improvement activities, staff responsible for monitoring programmatic activities and use of funds, and staff responsible for data collection, quality and reporting. **Note:** Final personnel charges must be based on actual, not budgeted labor. **Fringe Benefits:** Fringe Benefits change yearly, and should be confirmed before submitting your budget. List all components that make up the fringe benefits rate.

B. **Consultants/Contractual:** Grantees 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. Grantees must provide the following information in the budget justification:

1. **Name of Contractor/Consultant: Who is the contractor/consultant?**

   Include the name of the qualified contractor and indicate whether the contract is with an institution or organization if applicable. Identify the principle supervisor of the contract.

2. **Method of Selection: How was the contractor/consultant selected?**

   If an institution is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract services. If the contract is with an institution or organization, include the contract supervisor's qualifications.

3. **Period of Performance: How long is the contract period?**

   Include the complete length of contract. If the contract involves a number of tasks, include the performance period for each task.

4. **Scope of Work: What will the contractor/consultant do?**

   List and describe the specific tasks the contractor is to perform.

5. **Criteria for Measuring Contractor/Consultant Accountability: How will contractor/consultant use the funds?**

   Include an itemized line item breakdown as well as total contract amount. If applicable, include any indirect costs paid under the contract and the indirect cost rate used.

   Grantees must have a written plan in place for contractor/consultant monitoring and must actively monitor contractor/consultant.

C. **Occupancy/Rent:** This cost includes rent, utilities, insurance for the building, repairs and maintenance, depreciation, etc. Include in your description the cost allocation method used to allocate this line item.

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

E. **Supplies:** Provide justification of the supply items and relate them to specific program objectives. It is recommended that when training materials are kept on hand as a supply item, that it be included in the "supplies" category. **When training materials (pamphlets, notebooks, videos, and other various handouts) are ordered for specific training activities, these items should be itemized and shown in the "Other Direct Costs" category.** If appropriate, general office supplies may be shown by an estimated amount per month multiplied by the number of months in the budget period. If total supplies is over $10,000 it must be itemized.

F. **Equipment:** Provide itemized costs, specifications, quantity, unit, unit cost, and basis for cost estimate (actual cost or price quotation).

G. **Client / Participant Costs:** Includes client travel. Client/Participant costs are costs paid to (or on behalf of) participants or trainees (not employees) for participation in meetings, conferences, symposia, and workshops or other training projects, when there is a category for participant support costs in the project.

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

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

Agency/Organization Name Budget Period __								
Personnel								
Name of Staff	**Position Title**	**Percent Charge to Grant**	**Annual Salary**	**Salary Charged**	**Fringe Benefits Rates**	**Fringe Benefits Cost**	**Total Salary and Benefits**	**In-kind Contributions (Yes/No)**
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
		0%	$ -	$ -	0%	$ -	$ -	
Total Personnel			**$ -**	**$ -**		**$ -**	**$ -**	

Non-Personnel Costs				
Consultants/Contractual				**Total**
Occupancy (List the location of each service below)		**Cost**	**Monthly**	**Total**
		$ -	0	
		$ -	0	
		$ -	0	
		$ -	0	
Travel (List each travelers name below)	**Travel Destination**	**Time (Dates of Travel)**		**Total**
Supplies			**Quantity**	**Total**
			0	
			0	
			0	
Equipment			**Quantity**	**Total**
			0	
			0	
			0	
Client Costs				**Total**
Communication				**Total**
Total Non-Personnel Cost				**$ -**

Other Direct Costs	
Type of Service	**Total**
Total Other Direct Cost	**$ -**

Total Direct and Indirect Costs	
Direct Cost (Personnel + Non-Personnel + Other Direct)	**$ -**
Indirect Cost (10%)	**$ -**
Total Project Cost	**$ -**

ATTACHMENT 3 – Mandatory Assurances and Certifications

APPLICANT / GRANTEE ASSURANCES, CERTIFICATIONS & DISCLOSURES

This section includes certifications, assurances and disclosures made by the authorized representative of the Applicant/Grantee organization. These assurances and certifications reflect requirements for recipients of local and pass-through federal funding.

A. Applicant/Grantee Representations

1. The Applicant/Grantee has provided the individuals, by name, title, address, and phone number who are authorized to negotiate with the Department of Health on behalf of the organization;
2. The Applicant/Grantee is able to maintain adequate files and records and can and will meet all reporting requirements;
3. All fiscal records are kept in accordance with Generally Accepted Accounting Principles (GAAP) and account for all funds, tangible assets, revenue, and expenditures whatsoever; all fiscal records are accurate, complete and current at all times; and these records will be made available for audit and inspection as required;
4. The Applicant/Grantee is current on payment of all federal and District taxes, including Unemployment Insurance taxes and Workers' Compensation premiums. This statement of certification shall be accompanied by a certificate from the District of Columbia OTR stating that the entity has complied with the filing requirements of District of Columbia tax laws and is current on all payment obligations to the District of Columbia, or is in compliance with any payment agreement with the Office of Tax and Revenue; (attach)
5. The Applicant/Grantee has the administrative and financial capability to provide and manage the proposed services and ensure an adequate administrative, performance and audit trail;
6. If required by DC Health, the Applicant/Grantee is able to secure a bond, in an amount not less than the total amount of the funds awarded, against losses of money and other property caused by a fraudulent or dishonest act committed by Applicant/Grantee or any of its employees, board members, officers, partners, shareholders, or trainees;
7. The Applicant/Grantee is not proposed for debarment or presently debarred, suspended, or declared ineligible, as required by Executive Order 12549, "Debarment and Suspension," and implemented by 2 CFR 180, for prospective participants in primary covered transactions and is not proposed for debarment or presently debarred as a result of any actions by the District of Columbia Contract Appeals Board, the Office of Contracting and Procurement, or any other District contract regulating Agency;
8. The Applicant/Grantee either has the financial resources and technical expertise necessary for the production, construction, equipment and facilities adequate to perform the grant or subgrant, or the ability to obtain them;
9. The Applicant/Grantee has the ability to comply with the required or proposed delivery or performance schedule, taking into consideration all existing and reasonably expected commercial and governmental business commitments;

10. The Applicant/Grantee has a satisfactory record of performing similar activities as detailed in the award or, if the grant award is intended to encourage the development and support of organizations without significant previous experience, has otherwise established that it has the skills and resources necessary to perform the services required by this Grant.
11. The Applicant/Grantee has a satisfactory record of integrity and business ethics;
12. The Applicant/Grantee either has the necessary organization, experience, accounting and operational controls, and technical skills to implement the grant, or the ability to obtain them;
13. The Applicant/Grantee is in compliance with the applicable District licensing and tax laws and regulations;
14. The Applicant/Grantee is in compliance with the Drug-Free Workplace Act and any regulations promulgated thereunder; and
15. The Applicant/Grantee meets all other qualifications and eligibility criteria necessary to receive an award; and
16. The Applicant/Grantee agrees to indemnify, defend and hold harmless the Government of the District of Columbia and its authorized officers, employees, agents and volunteers from any and all claims, actions, losses, damages, and/or liability arising out of or related to this grant including the acts, errors or omissions of any person and for any costs or expenses incurred by the District on account of any claim therefrom, except where such indemnification is prohibited by law.

B. Federal Assurances and Certifications

The Applicant/Grantee shall comply with all applicable District and federal statutes and regulations, including, but not limited to, the following:

1. The Americans with Disabilities Act of 1990, Pub. L. 101-336, July 26, 1990; 104 Stat. 327 (42 U.S.C. 12101 et seq.);
2. Rehabilitation Act of 1973, Pub. L. 93-112, Sept. 26, 1973; 87 Stat. 355 (29 U.S.C. 701 et seq.);
3. The Hatch Act, ch. 314, 24 Stat. 440 (7 U.S.C. 361a et seq.);
4. The Fair Labor Standards Act, ch. 676, 52 Stat. 1060 (29 U.S.C.201 et seq.);
5. The Clean Air Act (Subgrants over $100,000), Pub. L. 108-201, February 24, 2004; 42 USC ch. 85 et.seq.);
6. The Occupational Safety and Health Act of 1970, Pub. L. 91-596, Dec. 29, 1970; 84 Stat. 1590 (26 U.S.C. 651 et.seq.);
7. The Hobbs Act (Anti-Corruption), ch. 537, 60 Stat. 420 (see 18 U.S.C. § 1951);
8. Equal Pay Act of 1963, Pub. L. 88-38, June 10, 1963; 77 Stat.56 (29 U.S.C. 201);
9. Age Discrimination Act of 1975, Pub. L. 94-135, Nov. 28, 1975; 89 Stat. 728 (42 U.S.C. 6101 et. seq.)

10. Age Discrimination in Employment Act, Pub. L. 90-202, Dec. 15, 1967; 81 Stat. 602 (29 U.S.C. 621 et. seq.);
11. Military Selective Service Act of 1973;
12. Title IX of the Education Amendments of 1972, Pub. L. 92-318, June 23, 1972; 86 Stat. 235, (20 U.S.C. 1001);
13. Immigration Reform and Control Act of 1986, Pub. L. 99-603, Nov 6, 1986; 100 Stat. 3359, (8 U.S.C. 1101);
14. Executive Order 12459 (Debarment, Suspension and Exclusion);
15. Medical Leave Act of 1993, Pub. L. 103-3, Feb. 5, 1993, 107 Stat. 6 (5 U.S.C. 6381 et seq.);
16. Drug Free Workplace Act of 1988, Pub. L. 100-690, 102 Stat. 4304 (41 U.S.C.) to include the following requirements:
    1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Applicant/Grantee's workplace and specifying the actions that will be taken against employees for violations of such prohibition;
    2) Establish a drug-free awareness program to inform employees about:
        a. The dangers of drug abuse in the workplace;
        b. The Applicant/Grantee's policy of maintaining a drug-free workplace;
        c. Any available drug counseling, rehabilitation, and employee assistance programs; and
        d. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace; and
    3) Provide all employees engaged in performance of the grant with a copy of the statement required by the law;
17. Assurance of Nondiscrimination and Equal Opportunity, found in 29 CFR 34.20;
18. District of Columbia Human Rights Act of 1977 (D.C. Official Code § 2-1401.01 et seq.);
19. Title VI of the Civil Rights Act of 1964;
20. District of Columbia Language Access Act of 2004, DC Law 15 - 414 (D.C. Official Code § 2-1931 et seq.);
21. Lobbying Disclosure Act of 1995, Pub. L. 104-65, Dec 19, 1995; 109 Stat. 693, (31 U.S.C. 1352); and
22. Child and Youth, Safety and Health Omnibus Amendment Act of 2004, effective April 13, 2005 (D.C. Law §15-353; D.C. Official Code § 4-1501.01 et seq.)(CYSHA). In accordance with the CYSHA any person who may, pursuant to the grant, potentially work directly with any child (meaning a person younger than age thirteen (13)), or any youth (meaning a person between the ages of thirteen (13) and seventeen (17) years, inclusive) shall complete a background check that meets the requirements of the District's Department of Human Resources and HIPAA.

C. Mandatory Disclosures

1. The Applicant/Grantee certifies that the information disclosed in the table below is true at the time of submission of the application for funding and at the time of award if funded. If the information changes, the Grantee shall notify the Grant Administrator within 24 hours of the change in status. A duly authorized representative must sign the disclosure certification

2. **Applicant/Grantee Mandatory Disclosures**

A. Per OMB 2 CFR §200.501– any recipient that expends $750,000 or more in federal funds within the recipient's last fiscal, must have an annual audit conducted by a third – party. In the Applicant/Grantee's last fiscal year, were you required to conduct a third-party audit?	☐ **YES** ☐ **NO**
B. Covered Entity Disclosure During the two-year period preceding the execution of the attached Agreement, were any principals or key personnel of the Applicant/Grantee / Recipient organization or any of its agents who will participate directly, extensively and substantially in the request for funding (i.e. application), pre-award negotiation or the administration or management of the funding, nor any agent of the above, is or will be a candidate for public office or a contributor to a campaign of a person who is a candidate for public office, as prohibited by local law.	☐ **YES** ☐ **NO**
C. Executive Compensation: For an award issued at $25,000 or above, do Applicant/Grantee's top five executives do not receive more than 80% of their annual gross revenues from the federal government, Applicant/Grantee's revenues are greater than $25 million dollars annually AND compensation information is not already available through reporting to the Security and Exchange Commission.	☐ **YES** ☐ **NO**
D. The Applicant/Grantee organization has a federally-negotiated Indirect Cost Rate Agreement. If yes, insert issue date for the IDCR:_____If yes, insert the name of the cognizant federal agency? _____	☐ **YES** ☐ **NO**
E. No key personnel or agent of the Applicant/Grantee organization who will participate directly, extensively and substantially in the request for funding (i.e. application), pre-award negotiation or the administration or management of the funding is currently in violation of federal and local criminal laws involving fraud, bribery or gratuity violations potentially affecting the DC Health award.	☐ **YES** ☐ **NO**

ACCEPTANCE OF ASSURANCES, CERTIFICATIONS AND DISCLOSURES

I am authorized to submit this application for funding and if considered for funding by DC Health, to negotiate and accept terms of Agreement on behalf of the Applicant/Grantee organization; and

I have read and accept the terms, requirements and conditions outlined in all sections of the RFA, and understand that the acceptance will be incorporated by reference into any agreements with the Department of Health, if funded; and I, as the authorized representative of the Grantee organization, certify that to the best of my knowledge the information disclosed in the Table: Mandatory Disclosures is accurate and true as of the date of the submission of the application for funding or at the time of issuance of award, whichever is the latter.

Date:

Sign:

NAME: INSERT NAME TITLE: INSERT TITLE

AGENCY NAME:

APPENDIX A – SUPPORTING BEST PRACTICE REFERENCES

Centers for Disease Control and Prevention. Cessation in Tobacco Prevention and Control
https://www.cdc.gov/tobacco/stateandcommunity/best-practices-cessation/pdfs/best-practices-cessation-user-guide-508c.pdf

Centers for Disease Control and Prevention – Health Systems Change FAQ
https://www.cdc.gov/tobacco/quit_smoking/cessation/pdfs/using-health-systems-change508.pdf

Centers for Disease Control and Prevention. Identifying and Treating Patients Who Use Tobacco: Action Steps for Clinicians. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2016
https://millionhearts.hhs.gov/files/Tobacco-Cessation-Action-Guide.pdf

Centers for Disease Control and Prevention. Protocol for Identifying and Treating Patients Who Use Tobacco. Atlanta, Georgia. 2016
https://millionhearts.hhs.gov/files/Tobacco-Cessation-Protocol.pdf

Health Equity in Tobacco Prevention and Control
https://www.cdc.gov/tobacco/stateandcommunity/best-practices-health-equity/pdfs/bp-health-equity.pdf

Million Hearts®: Meaningful Progress 2012-2016—A Final Report
https://millionhearts.hhs.gov/files/MH-meaningful-progress.pdf

Million Hearts®: Tobacco Cessation Change Package
https://millionhearts.hhs.gov/files/tobacco_cessation_change_pkg.pdf

The Community Guide - The Guide to Community Preventive Services
https://www.thecommunityguide.org/topic/tobacco

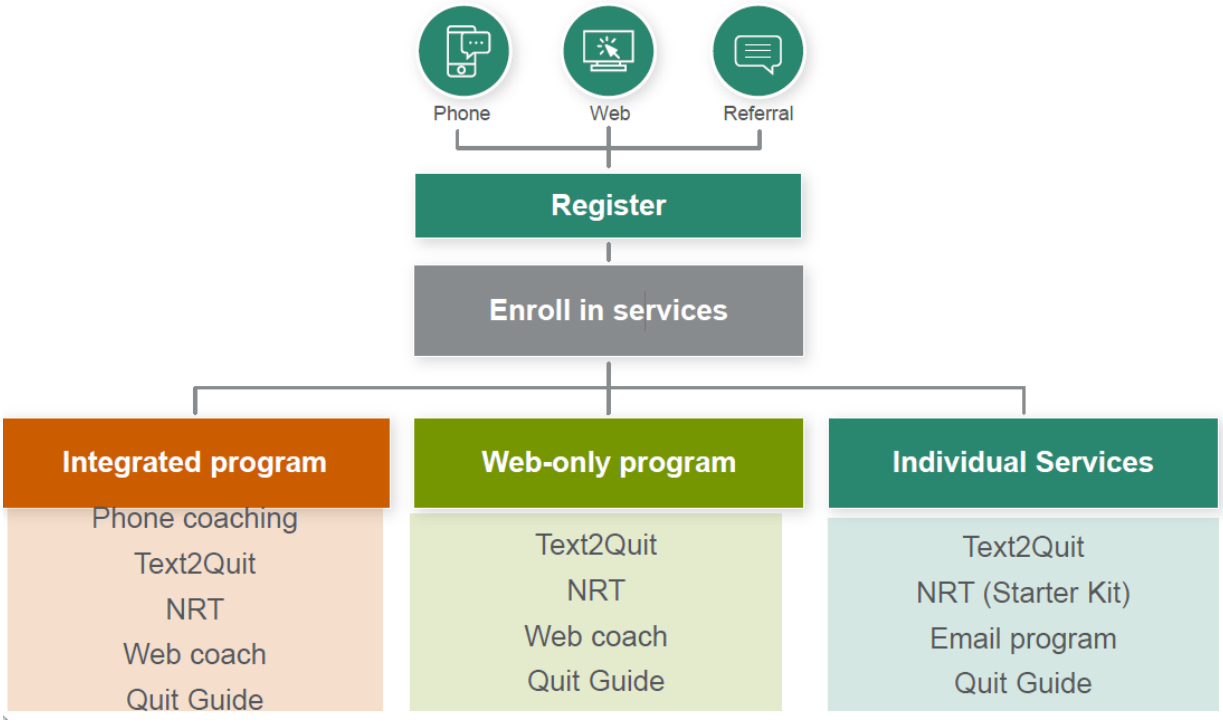
U.S. Preventive Services Task Force (USPSTF)
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening

U.S. Public Health Service Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update. https://www.ahrq.gov/prevention/guidelines/tobacco/index.html

APPENDIX B – DC QUITLINE INDIVIDUALIZED SERVICES

DC Quitline Services

Integrated program ENROLLMENT: PHONE OR WEB	Web-only program ENROLLMENT: PHONE OR WEB	Individuals Services ENROLLMENT: PHONE OR WEB
Materials Mailed letters and printed quit guide	**NRT**	**Materials** Mailed letters and printed quit guide
NRT	**Program emails** Custom messages coincide with quit date	**Options emails** General resource emails
Proactive phone coaching Unlimited inbound ad hoc calls	**Text2Quit** Custom messages coincide with quit date	**Options NRT** NRT starter kit and one follow-up call
Program e-mails Custom messages coincide with quit date	**Web coach** Trackers, community forums, e-lessons, videos, articles and quit plans	**Text2Quit** Custom messages coincide with quit date
Text2Quit Custom messages coincide with quit date		**Web dashboard**
Web coach Trackers, community forums, e-lessons, videos, articles and quit plans		



APPENDIX C: MINUMUM 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 award. 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 Contractor decide to engage a subcontractor for segments of the work under this contract, then, prior to commencement of work by the subcontractor, the Contractor 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 subcontractor and promptly deliver such requirements in writing to the Grantee and the PM. 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 Grantee.

   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 contract, 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's 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 Contractor 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 Grantee, 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 Grantee, with minimum per accident limits equal to the greater of (i) the limits set forth in the Grantee'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 contract 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, Grantee hereby agrees that prior to the expiration date of Grantee's current insurance coverage, Grantee shall purchase, at Grantee's 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 award. 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 contract 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 grantee's liability under this award.

E. CONTRACTOR'S PROPERTY. Grantee 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 contract 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 CO with an updated Certificate of Insurance should its insurance coverages renew during the award.

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 PM 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 PM 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.