DEPARTMENT OF HEALTH

COMMUNITY HEALTH ADMINISTRATION

Youth Engagement in Tobacco Control Initiatives

REQUEST FOR APPLICATIONS

FO# CHA-PG-00179-012

RFA# CHA_YETC_07.08.2022

SUBMISSION DEADLINE:

AUGUST 10, 2022 BY 6:00 PM

The Department of Health (DC Health) reserves the right without prior notice, to reduce or cancel one or more programs listed in this Request for Applications (RFA). DC Health reserves the right to reject all applications, adjust the total available funds or cancel the RFA in part or whole. Funding levels for the total program and budget amounts of individual awards shall be contingent upon continued receipt of funding by DC Health, as well as any reduction, elimination or reallocation of funds by a federal grantor, the Executive Office of the Mayor (EOM) and/or DC Health. Any adjustments shall be in accordance with authorizing legislation for the use of funds, all DC municipal regulations for grant-making and the applicable federal and DC Health terms of agreement.

DC DEPARTMENT OF HEALTH

Community Health Administration

NOTICE OF FUNDING AVAILABILITY (NOFA)

FO# CHA-PG-00179-012
RFA# CHA_YETC_07.08.2022

Youth Engagement in Tobacco Control Initiatives

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

Funding Opportunity Title:	Youth Engagement in Tobacco Control Initiatives
Funding Opportunity Number:	CHA-PG-00179-012
Program RFA ID#:	CHA_YETC_07.08.2022
DC Health Administrative Unit:	Community Health Administration
DC Health Program Bureau	Cancer and Chronic Disease Prevention Bureau
Program Contact:	Carrie Dahlquist, MPH Manager, Tobacco Control Programs tobaccocontrol@dc.gov
Program Description:	DC Health seeks proposals to lead a comprehensive, District-wide initiative that encourages and supports youth and young adults to make behavior choices consistent with tobacco-free norms. This funding opportunity will support the implementation of policy, systems, and environmental change strategies and activities that allow all DC residents to live a healthy, tobacco-free life. The evidence-informed effort will elevate the youth voice and engage youth and young adults as essential partners to change the social norms of tobacco use and reduce initiation of and dependence on tobacco products, including e-cigarettes and other emerging tobacco products.
Eligible Applicants	Community-based or national nonprofit or for-profit organizations; local, public, private, or charter school

	systems; institutions of higher education, research centers, or healthcare organizations.
Anticipated # of Awards:	1
Anticipated Amount Available:	$300,000
Annual Floor Award Amount:	$200,000
Annual Ceiling Award Amount:	$300,000
Legislative Authorization	FY23 Budget Support Act of 2022
Associated CFDA#	Not applicable
Associated Federal Award ID#	Not applicable
Cost Sharing/Match Required?	No
RFA Release Date:	July 8, 2022
Letter of Intent Due date:	Not applicable
Application Deadline Date:	August 10, 2022
Application Deadline Time:	6:00 p.m.
Links to Additional Information about this Funding Opportunity	DC Grants Clearinghouse https://communityaffairs.dc.gov/content/community-grant-program#4 DC Health EGMS https://dcDC Health.force.com/GO__ApplicantLogin2

Notes:

1. DC Health reserves the right to issue addenda and/or amendments subsequent to the issuance of the NOFA or RFA, or to rescind the NOFA or RFA.
2. Awards are contingent upon the availability of funds.
3. Individuals are not eligible for DC Health grant funding.
4. Applicants must have a DUNS #, Tax ID#, and be registered in the federal Systems for Award Management (SAM) with an active UEI# to be registered in DC Health's Enterprise Grants Management System.

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RFA TERMS AND CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

K. DC Health reserves the right to require registry into local and federal systems for award management at any point prior to or during the Project Period (i.e., the total number of years for which funding has been approved). This includes DC Health Electronic Grants Management System (EGMS), for which the awardee will be required to register and maintain registration of the organization and all users.

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

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

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

O. DC Health shall provide the citations to the local or federal statute/s and implementing regulations that authorize the award; all applicable District of Columbia and Federal regulations, including 2 CFR 200 and Department of Health and Services (HHS) published 45 CFR Part 75, payment provisions identifying how the awardee will be paid for performing under the award; reporting requirements, including programmatic, financial and any special reports required by the funding agency; and compliance conditions that must be met by the awardee.

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

Additional information about grants management policy and procedures may be obtained at the following site: https://oca.dc.gov/page/division-grants-management or click here: Citywide Grants Manual and Sourcebook.

If your organization would like to obtain a copy of the **DC Health RFA Dispute Resolution Policy,** please visit the DC Health Office of Grants Management webpage, here. Any additional questions regarding the RFA Dispute Resolution Policy may be directed to the Office of Grants Management (OGM) at doh.grants@dc.gov. Your request for this document will not be shared with DC Health program staff or reviewers.

CHECKLIST FOR APPLICATIONS

- ☐ Applicants must be registered in the federal Systems for Award Management (SAM) and the DC Health Enterprise Grants Management System (EGMS).
- ☐ Complete your EGMS registration at least **two weeks** prior to the application deadline.
- ☐ Start constructing and uploading your application components into EGMS at least a week prior to the application deadline.

  The complete **Application Package** should include the following:

  - ☐ Certificate of Clean Hands dated within 60 days of the application deadline
  - ☐ Current business license or certificate of licensure or proof to transact business in local jurisdiction
  - ☐ Current certificate of insurance
  - ☐ Copy of cyber liability policy
  - ☐ IRS tax-exempt determination letter (for nonprofits only)
  - ☐ IRS 990 form from most recent tax year (for nonprofits only)
  - ☐ Current list of Board of Directors, on letterhead, signed and dated by a certified official from the Board (this cannot be the executive director)
  - ☐ Assurances, certifications and disclosures
  - ☐ Proposal abstract
  - ☐ Project narrative
  - ☐ Budget table
  - ☐ Budget justification
  - ☐ Staffing plan
  - ☐ Organization chart
  - ☐ Work plan
  - ☐ Letters of commitment (minimum of 2)
- ☐ Documents requiring signature have been signed by an organization head or authorized representative of the applicant organization.
- ☐ The applicant needs a Unique Entity Identifier number (UEI#) and an active registration in the System for Award Management to be awarded funds.
- ☐ The 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 one-inch margins.
- ☐ The application proposal format conforms to the "Proposal Components" (See section 5.2) listed in the RFA.
- ☐ The proposed budget is complete and complies with the budget forms provided in the RFA. The budget narrative is complete and describes the categories of items proposed.
- ☐ The proposed work plan and other attachments are complete and comply with the forms and format provided in the RFA.

☐ Submit your application via EGMS by the application due date and time**. Late applications will not be accepted.**

1. GENERAL INFORMATION

1.1 Key Dates

- Notice of Funding Announcement Date: **June 24, 2022**
- Request for Application Release Date: **July 8, 2022**
- Pre-Application Meeting Date: **visit https://OGMDCHealth.eventbrite.com**
- Application Submission Deadline: **August 10, 2022**
- Anticipated Award Start Date: **October 1, 2022**

1.2 Overview

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

The Community Health Administration (CHA) within DC Health promotes healthy behaviors and healthy environments to improve health outcomes and reduce disparities in the leading causes of mortality and morbidity in the District. CHA focuses on population health strategies to prevent and control cancer, chronic disease, and vaccine preventable diseases; promote nutrition and physical fitness; ensure access to quality health care services; and support the health and well-being of families across the lifespan. CHA's approach targets the behavioral, clinical, and social determinants of health through evidence-based programs, policy, and systems change.

Within CHA, the Cancer and Chronic Disease Prevention Bureau (CCDPB) works closely with health systems, community-based organizations, governmental agencies, and other key partners to improve cancer and chronic disease health outcomes among District residents. Activities within CCDPB are designed to close the chasm between clinical medicine and public health, strengthen public-private partnerships, and implement outcomes-oriented public health interventions.

DC Health's Tobacco Control Program (TCP) applies evidence-based approaches to reduce disease, disability, and death related to tobacco use. TCP works closely with government, community, and clinical partners to ensure that residents of all ages can pursue a healthy life by preventing the initiation of tobacco use, promoting tobacco cessation, eliminating exposure to secondhand smoke (SHS), and identifying and eliminating tobacco-related health disparities.

Funding under this RFA will support the implementation of policy, systems, and environmental change strategies and activities that allow every DC resident to live a healthy, tobacco-free life. The recipient will lead a comprehensive, District-wide initiative that encourages and supports youth and young adults to make behavior choices consistent with tobacco-free norms. The evidence-based effort will elevate the youth voice and engage youth as essential partners to change the social norms of tobacco use and reduce initiation of and dependence on tobacco

products, including e-cigarettes and other emerging tobacco products. The recipient will utilize a community-based policy, systems, and environmental (PSE) change approach in collaboration with key stakeholders and guided by the latest data, best practices, and partner feedback. Strategies, objectives, and activities related to this initiative shall include but are not limited to:

- Development of advocacy and engagement skills in youth and young adults
- Evaluation and analysis of progress
- Increased capacity and sustainability through partnership development and collaboration
- Alignment with DC Health's youth-focused tobacco control campaigns

1.3 Purpose

The purpose of this funding is to demonstrate improved health outcomes among youth and young adults in the District of Columbia through engagement, education, communication and messaging, and advocacy. DC Health aims to identify a qualified organization that will support and implement programs and policies to reduce tobacco product use and dependence among youth and young adults, prioritizing the health of all children and the community overall by engaging with organizations, health care systems, and networks.

1.4 Source of Grant Funding

Funding is anticipated to be available using the District of Columbia FY23 Budget Support Act of 2022.

1.5 Award Information

1.5.1 Amount of Funding Available

The total funding amount of $300,000 is anticipated for one (1) award to implement sustainable youth-based initiatives for the first budget period.

1.5.2 Period of Performance and Funding Availability

The first budget period of this award is anticipated to begin on October 1, 2022 and continue through September 30, 2023. After the first budget period, there will be up to two (2) additional 12-month budget periods for a total project period of October 1, 2022–September 30, 2025. The number of awards, budget periods, and award amounts are contingent upon the continued availability of funds and grantee performance and compliance.

1.5.3 Eligible Organizations/Entities

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

- Community-based or national nonprofit or for-profit organizations
- Local, public, private, or charter school systems
- Institutions of higher education

- Research centers
- Healthcare organizations

Considered for funding shall be organizations meeting the above eligibility criteria and having documentation of providing services (health and social services) to the target populations. Priority will be given to those organizations with a demonstrated track record of successfully working with the priority populations.

1.5.4 Non-Supplantation

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

2. BACKGROUND

2.1 Demographic Overview

Tobacco use is the leading cause of preventable death and disease in the U.S. Each year, approximately 480,000 people die from smoking, including more than 40,000 from secondhand smoke (SHS) exposure.[1] Tobacco use causes cardiovascular disease, multiple types of cancer, pulmonary disease, diabetes, and adverse reproductive outcomes; exacerbates conditions such as asthma; and is associated with the development of dementia.[1] Smoking causes more deaths each year than human immunodeficiency virus (HIV), illegal drug use, alcohol use, motor vehicle injuries, and firearm-related incidents combined.[2] Economically, the total cost of smoking in the US is estimated at more than $225 billion a year and $180 billion in lost productivity due to secondhand smoke exposure.[3]

Engaging in tobacco use is a habit that starts early: nearly all tobacco experimentation and initiation begin in youth and young adulthood. Youth exposed to nicotine are at a higher risk for addiction than adults because developing brains are much more susceptible to long-lasting change.[4] Among U.S. adults who currently use tobacco, 9 out of 10 first tried tobacco by the age of 18. Each day, about 1,600 youth in the U.S. smoke their first cigarettes, and almost 200 begin

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[1] Centers for Disease Control and Prevention. (2014) The health consequences of smoking – 50 years of progress. A report of the Surgeon General. *U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health*. https://www.ncbi.nlm.nih.gov/books/NBK179276/pdf/Bookshelf_NBK179276.pdf

[2] Centers for Disease Control and Prevention. (2021, June 2). Fast Facts. *U. S. Department of Health and Human Services, Centers for Disease Control and Prevention.* https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm#:~:text=For%20every%20person%20who%20dies,includes%20emphysema%20and%20chronic%20bronchitis

[3] Centers for Disease Control and Prevention. (2021, May 25). Smoking & Tobacco Use. Economic Trends in Tobacco. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/economics/econ_facts/index.htm

[4] Ren, M., & Lotfipour, S. (2019). Nicotine gateway effects on adolescent substance use. *The Western Journal of Emergency Medicine*, 20(5), 696–709. https://doi.org/10.5811/westjem.2019.7.41661

smoking every day.[1,5] This early initiation has significant consequences on both individual and population health. If the current rates of youth tobacco use remain unchanged, an estimated 5.6 million of today's U.S. youth will die prematurely from a smoking-related illness.[3] As a result, smoking has been labeled a "pediatric epidemic" and remains an ongoing public health concern among youth populations.[6]

Tobacco use among youth has been declining over the past few decades, but the introduction and marketing of e-cigarettes and vaping products has reversed the trend. In the District of Columbia, 17.2% of high school students and 7.8% of middle school students reported using combustible (cigarettes, cigars, cigarillos, little cigars), smokeless, and/or noncombustible (e-cigarettes, vapes) tobacco products in 2020.[7] In young adults aged 18-24, 5.7% reported using any tobacco products, while 41.5% reported using an e-cigarette or other electronic vaping product at least once in their lifetime.[8] Figures 1 and 2 reflect trends of use among youth by product type since 2015.

Figure 1: Trends in Tobacco Product Use among High School Students

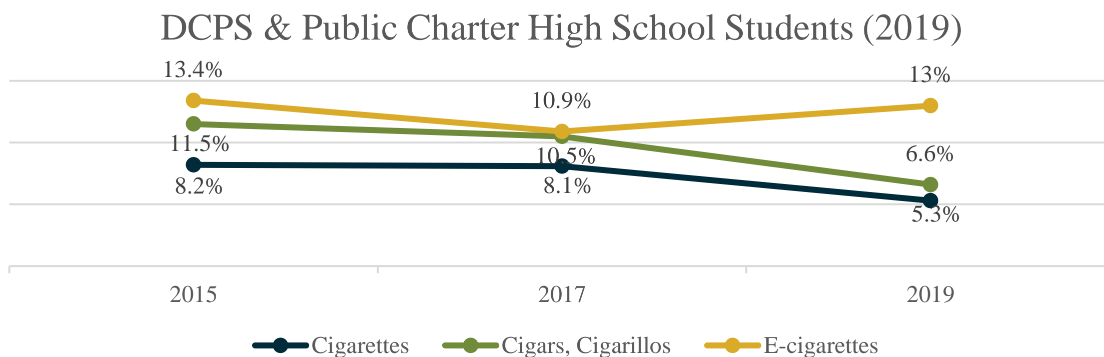

Figure 2: Trends in Tobacco Product Use among Middle School Students

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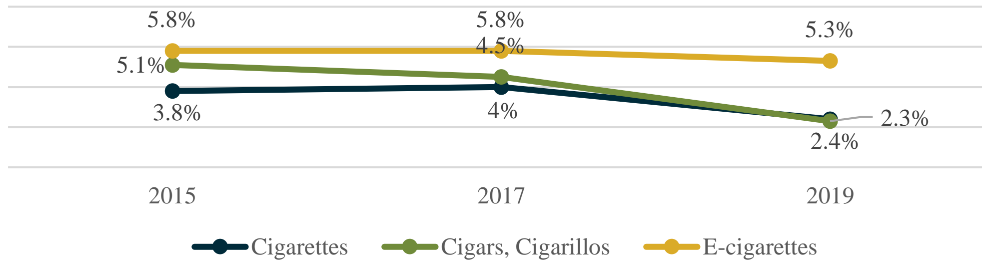
[5] Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health. *U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration*. https://store.samhsa.gov/product/key-substance-use-and-mental-health-indicators-in-the-united-states-results-from-the-2019-national-survey-on-Drug-Use-and-Health/PEP20-07-01-001?referer=from_search_result

[6] Centers for Disease Control and Prevention. (2012). Preventing tobacco use among youth and young adults: A report of the Surgeon General. *U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health*. https://www.hhs.gov/sites/default/files/preventing-youth-tobacco-use-exec-summary.pdf

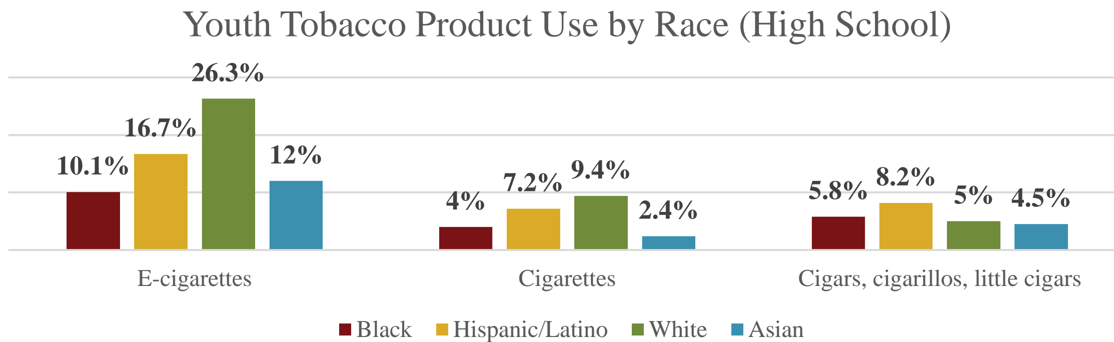
[7] Office of State Superintendent of Schools of the District of Columbia (OSSE). DC Youth Risk Behavior Survey (YRBS), 2019. https://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/2019%20DC%20YRBS%20Report.pdf

[8] Centers for Disease Control and Prevention BRFSS Prevalence & Trends Data 2020. *U.S. Department of Health and Human Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health*. Retrieved on February 17, 2022, from https://www.cdc.gov/brfss/brfssprevalence/index.html



Youth tobacco use overall is not more prevalent in one racial/ethnic group compared to another. There are, however, differences in the types of products used by racial ethnic groups. While e-cigarettes are the tobacco product favored across most racial/ethnic groups, the proportion of White youth using e-cigarettes is highest. Black/African American youth tend to use tobacco products at lower rates even though tobacco use among Black/African American adults in the District is higher than tobacco use among White adults (18% vs 5.7%).[8] This could be related to higher rates of mentholated tobacco use in African American communities stemming from decades of industry targeting.[9]

Figure 3: DC Youth Tobacco Product Use by Racial/Ethnic Group



Data Source: DC Youth Behavioral Risk Survey (2019). Data represented is exclusive of private schools.

Figure 4: DC Youth Tobacco Product Use by Racial/Ethnic Group

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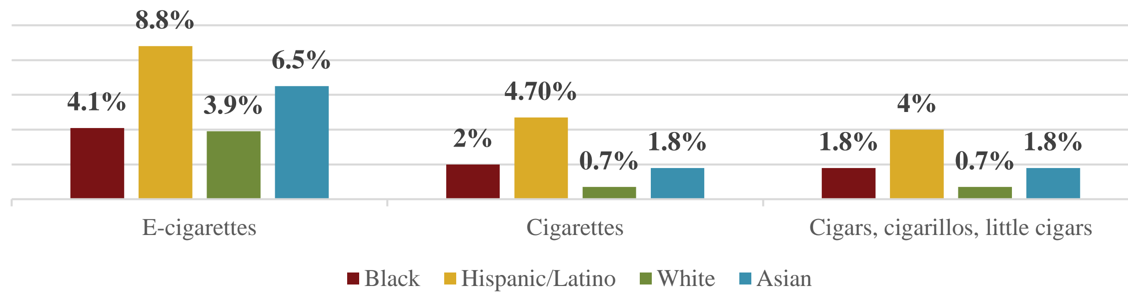
[9] Dauphinee, A. L., Doxey, J. R., Schleicher, N. C., Fortmann, S. P., & Henriksen, L. (2013). Racial differences in cigarette brand recognition and impact on youth smoking. BMC public health, 13, 170. https://doi.org/10.1186/1471-2458-13-170



Data Source: DC Youth Behavioral Risk Survey (2019). Data represented is exclusive of private schools.

While the prevalence of use among youth in DC overall is not restricted to one geographic area or racial/ethnic minority group, tobacco product use is prominent within other sub-populations – youth with mental/behavioral health or substance use disorders and youth who identify as lesbian, gay, or bisexual (LGB). (The Youth Behavior Risk Survey administered by the Office of Superintendent of Schools does not collect data specifically for youth who identify as transgender). Across the U.S., youth with a mental/behavioral health diagnosis or substance use disorder are more likely to smoke compared to individuals without those health conditions.[10] They are also more likely to become lifetime smokers, with 35% of adult cigarette smokers having a behavioral health disorder and smoking 38% of all cigarettes produced in the U.S.[11] The higher rate of tobacco use within this population of youth in DC impacts their health as adults.

The lesbian, gay, bisexual, and transgender (LGBT) community across all age groups is disproportionately impacted by tobacco product use, influenced by various psychological and environmental risk factors. LGBT individuals experience internalized homophobia, stress due to societal stigma, and negative reactions to their disclosure of sexual orientation or "coming out" that contribute to increased smoking rates.[12,13] More specifically, LGB youth in DC are much more likely to use tobacco than their straight peers, as illustrated in Figure 5.[7] Compared to heterosexual youth, LGB youth are more than twice as likely as straight youth to report experiencing feelings of sadness or hopelessness.[14] Overall, there is a significant overlap

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[10] Lipari, R. & Van Horn, Struther. (2017). Smoking and Mental Illness Among Adults in the United States. https://www.samhsa.gov/data/sites/default/files/report_2738/ShortReport-2738.html

[11] Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2017. Analysis performed by the American Lung Association Epidemiology and Statistics Unit using SPSS software

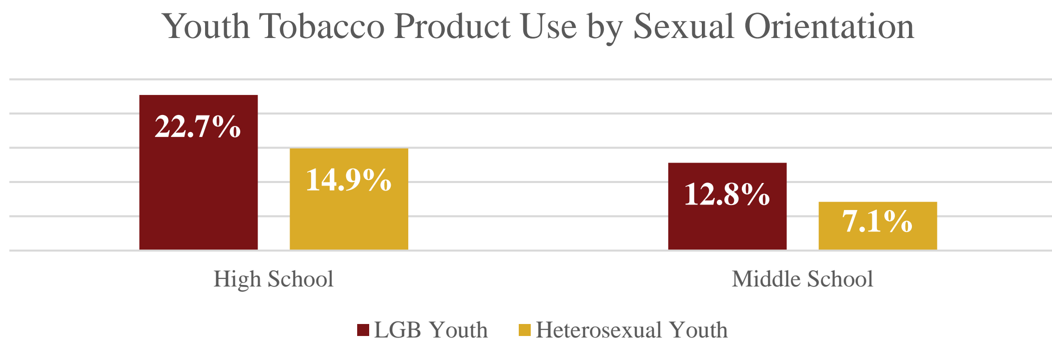
[12] Blosnich J, Lee JGL, Horn K. (2013). A systematic review of the aetiology of tobacco disparities for sexual minorities. *Tobacco Control*. 22(2): 66-73.

[13] Centers for Disease Control and Prevention. (2022, January). Smoking & Tobacco Use: Lesbian, Gay, Bisexual, and Transgender Persons and Tobacco Use. *U. S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.* https://www.cdc.gov/tobacco/disparities/lgbt/index.htm.

[14] National Alliance on Mental Illness. (2022). LGBTQIA. Retrieved from https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/LGBTQI

between LGB and transgender youth regarding certain mental/behavioral health challenges putting them at higher risk for tobacco use.

Figure 5: DC Youth All Tobacco Product Use by Sexual Orientation



Data Source: DC Youth Behavioral Risk Survey (2019). Data represented is exclusive of private schools

2.2 The Effects of Tobacco Use on Teens

With nearly 86,000 new underage daily smokers in the country each year, the toll of tobacco use has heightened the health and economic consequences faced by the U.S.[15]

Tobacco use and nicotine addiction in youth has significant effects on emotional wellbeing, behavior, and educational success. Emotional and/or behavioral problems can result in depression and are further exacerbated by negative life events in youth and young adults.[16] Events associated with increased tobacco use include major personal illness or injury, conflict at home, and parental separation.

There is also a significant association between tobacco use and academic performance. Nicotine exposure interferes with adolescent cognitive development, executive functioning, and inhibitory control.[16] District youth who smoke are more likely to report making mostly Ds/Fs than students who do not, as shown in Figure 6.[7] Other risks of nicotine dependence include impairments to overall mood, and health concerns such as nausea, lightheadedness, difficulty concentrating, insomnia, and increased cravings for tobacco/nicotine.[17]

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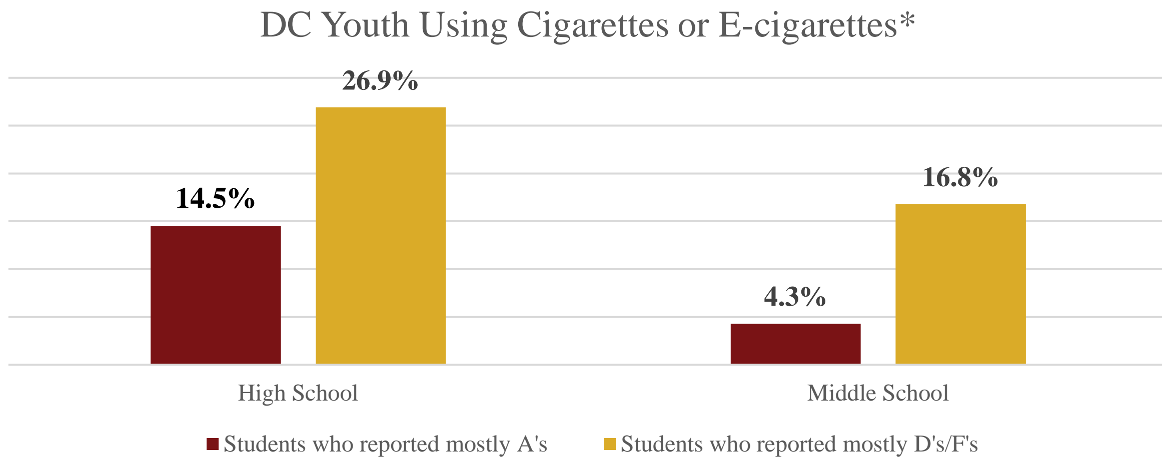
[15] Substance Abuse and Mental Health Services Administration. (2019). National Survey on Drug Use and Health, NSDUH: Detailed Tables. *U.S. Department of Health and Human Service Substance Abuse and Mental Health Services Administration*. https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables

[16] National Institute on Drug Abuse. (2020, January). How many adolescents use tobacco? *National Institutes of Health, National Institute on Drug Use*. https://nida.nih.gov/publications/research-reports/tobacco-nicotine-e-cigarettes/how-many-adolescents-use-tobacco

[17] National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General. *U. S. Department of Health and Human Services, Centers for Disease Control and Prevention.* https://www.ncbi.nlm.nih.gov/books/NBK99242/ -

Figure 6: DC Youth Tobacco Product Use by Academic Performance



Data Source: DC Youth Behavioral Risk Survey (2019). Data represented is exclusive of private schools
**Tobacco use includes cigarettes and e-cigarettes*

The COVID-19 pandemic highlighted the health risks of smoking. In 2020, e-cigarettes were the tobacco product of choice for youth. More than 2 million U.S. middle and high school students reported e-cigarette use, with 8 in 10 favoring flavored e-cigarettes.[18] Both cigarette and e-cigarette use damage the respiratory system, potentially increasing the risk of experiencing COVID-19–related symptoms and exacerbated health outcomes.[18] Among young adults aged 13-24 years, COVID-19 testing and diagnosis were more likely among ever-users of e-cigarettes and dual e-cigarette/cigarette users. This could be related to reduced lung function associated with tobacco use making a person more susceptible to infection.[19]

Prior to the pandemic, a lung injury condition emerged among youth and young adults who used e-cigarettes or other vaping products. This sometimes-fatal lung illness, EVALI (e-cigarette or vaping use-associated lung injury), resulted in young people being admitted to intensive care units with a pneumonia-like lung condition with respiratory symptoms including shortness of breath, cough, and chest pain as well as gastrointestinal symptoms (nausea, vomiting, diarrhea), fever, chills, and weight loss.[20] Across the United States, 2,807 people were hospitalized and 68

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[18] Park-Lee, E., Ren, C., Sawdey, C, et al. (2021). E-cigarette use among middle and high school students – National Youth Tobacco Survey, United States, *Morbidity and Mortality Weekly Report (MMWR)*, 70(39): 1387-1389. Centers for Disease Control and Prevention. http://dx.doi.org/10.15585/mmwr.mm7039a4

[19] Gaiha, S. M., Cheng, J., & Halpern-Felsher, B. (2020). Association between youth moking, electronic cigarette use, and COVID-19. *The Journal of Adolescent Health*, 67(4), 519–523. https://doi.org/10.1016/j.jadohealth.2020.07.002

[20] Centers for Disease Control and Prevention. (2020, December). *Smoking & Tobacco Use*. Frequently Asked Questions. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease/faq/index.html

people died as a result of EVALI.[21] Both COVID-19 and EVALI have been shown to cause significant harm to youth populations, specifically related to tobacco product use.

2.3 Factors Influencing Tobacco Product Use among Youth and Young Adults

Youth and young adults living in the District are exposed to tobacco products at varying levels due to certain influencing factors that worsen tobacco use outcomes. These biological, psychosocial, and environmental factors interact with each other and negatively impact health behaviors among youth populations. The decision to initiate use and continue to use a tobacco product depends on factors such as self-image, ease of access and peer influence in addition to the environments in which a person lives, learns, plays, and works.[22]

Peer Behavior Peer behaviors are particularly influential during adolescence as the overall lack of mature cognitive control in adolescents makes them more susceptible to social pressure.[23] In youth under the age of 18, those whose peers smoke are 4.3 times more likely to pick up smoking compared to those who have no peers smoking.[24] The adolescent brain is still maturing and developing, making youth more susceptible to peer influence and nicotine addiction.

Targeted Marketing by Tobacco Companies Tobacco company marketing has targeted specific populations over the years to encourage experimentation with tobacco. The tobacco industry strategically advertises tobacco use as a "normal" part of LGBT life, in addition to advertising at "gay pride" festivals and several community events.[13] Adolescents exposed to cigarette advertising often find the ads appealing, which leads to increased desires to smoke.[25] The bright, colorful packages of flavored tobacco products are appealing to youth, with the majority of high school and middle school students who smoke using flavored tobacco products.[26] While laws and regulations have been implemented to limit youth access to tobacco products, tobacco companies

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[21] Centers for Disease Control and Prevention. (2022). Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products. *U.S. Department of Health and Human Service, Centers for Disease Control and Prevention.* https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html

[22] National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health. (2012). Preventing tobacco use among youth and young adults: A report of the Surgeon General. *U. S. Department of Health and Human Services, Centers for Disease Control and Prevention*. https://www.ncbi.nlm.nih.gov/books/NBK99237/

[23] Goriounova, N. A., & Mansvelder, H. D. (2012). Short- and long-term consequences of nicotine exposure during adolescence for prefrontal cortex neuronal network function. *Cold Spring Harbor Perspectives in Medicine*, 2(12), a012120. https://doi.org/10.1101/cshperspect.a012120

[24] Lydon, D. M., Wilson, S. J., Child, A., & Geier, C. F. (2014). Adolescent brain maturation and smoking: what we know and where we're headed. *Neuroscience and biobehavioral reviews*, 45, 323–342. https://doi.org/10.1016/j.neubiorev.2014.07.003

[25] Centers for Disease Control and Prevention. (2022). Smoking & tobacco use: Tobacco industry marketing. *U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health*. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/marketing/index.htm

continue to introduce new products, such as disposable, single use cartridges and dissolvable nicotine, that bypass flavor restrictions.[26]

Trauma & Adverse Childhood Events Studies have shown that early initiation of tobacco use, adult tobacco use, duration and intensity of use, and increased risk of smoking in adulthood are highly correlated to past trauma experienced by individuals, including post-traumatic stress disorder (PTSD) and adverse childhood experiences or events (ACEs).[27] ACEs could potentially include certain events such as experiencing violence in the home, having a family member attempt or die by suicide, and abuse or neglect.[28] Childhood trauma has been linked to increased risks of nicotine dependence and e-cigarette use in adolescent populations, influenced by chronic exposure to childhood adversity; this exposure affects brain development, learning capacities, adaptive behaviors, and health.[29] Among youth who identify as homeless, approximately 70% smoke tobacco products.[30]

3. PURPOSE

The DC Health Community Health Administration (CHA) is requesting applications from qualified applicants to reduce initiation of and dependence on tobacco products, including e-cigarettes and other emerging tobacco products, among youth and young adults in the District of Columbia, with an emphasis on priority populations that are disproportionately affected by tobacco use. DC Health aims to identify a qualified organization that will work collaboratively with community organizations and stakeholders, focusing on youth engagement to enact change. The lead organization and community partners will implement policy, systems, and environmental change (PSEC) interventions to engage youth as essential partners and build the capacity of community organizations, schools, worksites, and colleges and universities that serve youth to promote tobacco prevention and cessation.

3.1 APPROACH

To reduce the burden of tobacco on youth and young adults living in the District, applicants will implement evidence-informed, youth-based tobacco use prevention and cessation programs and

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[26] U.S. Food and Drug Administration. (2021). FDA commits to evidence-based actions aimed at saving lives and preventing future generations of smokers. *U.S. Department of Health and Human Service, U.S. Food and Drug Administration*. https://www.fda.gov/news-events/press-announcements/fda-commits-evidence-based-actions-aimed-saving-lives-and-preventing-future-generations-smokers

[27] Roberts, M. E., Fuemmeler, B. F., McClernon, F. J., & Beckham, J. C. (2008). Association between trauma exposure and smoking in a population-based sample of young adults. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, 42(3), 266–274. https://doi.org/10.1016/j.jadohealth.2007.08.029

[28] Centers for Disease Control and Prevention. (2022). *Violence Prevention*: Fast Facts: Preventing Adverse Childhood Experiences. Retrieved from https://www.cdc.gov/violenceprevention/aces/fastfact.html

[29] Shin, S. (2020). Preventing E-cigarette use among high-risk adolescents: A trauma-informed prevention approach. *Addictive Behaviors*, 115. https://www.sciencedirect.com/science/article/abs/pii/S0306460320309242?via%3Dihub

[30] Glasser, A. M., Macisco, J. M., Miller, L. M., Garbsch, E. M., Wermert, A., & Nemeth, J. M. (2020). Smoking cessation methods among homeless youth in a Midwestern city. *Addictive Behaviors Reports*, 11, 100276. https://doi.org/10.1016/j.abrep.2020.100276

policies in collaborate with key stakeholders to strengthen youth engagement efforts. Strategies and activities should engage youth and incorporate proven public health initiatives and best practices through a policy-systems-environmental change (PSEC) approach.

PSEC interventions support sustainable, comprehensive action to improve community health by addressing social determinants that encourage and reinforce positive lifestyle choices. This approach shifts away from merely educating the community about the health impact of tobacco to reducing access, opportunity, and acceptability of tobacco use while providing support to youth and young adults to reduce smoking initiation. Activities proposed should build the foundation for sustainable interventions and change that support living smoke-free with minimal resources beyond the life of the grant.

Policy, systems, and environmental change activities that can be considered for this project are detailed in ***Section 4.4: Allowable Activities***.

Outcomes

To improve tobacco initiation and cessation, reduce tobacco use disparities, and decrease tobacco-related mortality among youth and young adults, applicants will employ strategies and activities to develop sustainable programming within various communities and youth-focused settings.

Strategies and Activities	Short-Term Outcomes (1 – 2 years)	Intermediate Outcomes (2 – 4 years)	Long-Term Outcomes (5 years)
• Engage youth and young adults to serve as ambassadors and peer leaders to drive tobacco control initiatives • Collaborate with CBOs, national organizations, and school administrators to identify, engage, and guide youth leaders in tobacco control initiatives • Engage community to support awareness campaigns and policies that restrict youth access to tobacco products	• Increased number of youth and young adults participating in tobacco use prevention programs • Increased number of universities with smoke-free campus policies • Increased number of schools adopting non-punitive measures addressing tobacco use on campus • Increased number of healthcare providers, including school nurses, referring youth to tobacco cessation programs • Increased implementation & enforcement of strategies to support quitting, and reduce	• Decreased tobacco use and dependence among youth and young adults in the District • Decreased access to tobacco products by minors	• Decreased tobacco use among youth, young adults, and adults • Decreased exposure to secondhand smoke (SHS) • Reduction in tobacco related illnesses in the District

	SHS exposure & access to tobacco products among youth and young adults		

Applicants shall demonstrate how the proposed project plan will measure the impact of the following key outcome areas.

<u>Outcome Area 1</u>: Youth Engagement and Advocacy
Increased engagement with youth ambassadors to educate other youth and communities on tobacco use and tobacco-related disparities
Performance Indicators

- Number of youth and young adults trained as ambassadors and peer leaders
- Number of training modules, toolkits, and guides developed for youth and young adult peer leaders
- Number of events and activities developed and led by youth and young adults
- Reach and engagement of social media campaigns and messages developed and led by youth and young adults

<u>Outcome Area 2</u>: Mobilize Community and Stakeholder Support
Increased partnerships with community organizations and partners to reach and engage youth and young adults
Performance Indicators

- Number of adult advisors engaged to support and guide youth leaders
- Number of multi-sector partnerships developed to implement PSE change activities supporting tobacco control efforts
- Number of community organizations newly engaged in tobacco control efforts because of this grant

<u>Outcome Area 3</u>: Improve Tobacco Use Assessment and Cessation Support among Youth and Young Adults
Increased provider tobacco screening and cessation referrals
Performance Indicators

- Number of youth and young adult tobacco users who are referred to cessation resources such as *This Is Quitting* and DCQuitNow
- Number of youth and young adults referred to *This Is Quitting* or DCQuitNow
- Number of youth and young adults referred to *This Is Quitting* or DCQuitNow with a successful cessation attempt

<u>Outcome Area 4</u>: Facilitate Health Environments through PSE Change
Increased implementation and enforcement of strategies to support quitting, reduce SHS exposure and access to tobacco products among youth and young adults.
Performance Indicators

- Number of smoke-free policies adopted by community organizations, schools and campuses, places of worship, and businesses

- Number of tobacco control initiatives adopted by community organizations, schools and campuses, places of worship, and businesses

4. PERFORMANCE REQUIREMENTS

Applicants should propose projects that meet the criteria listed below.

4.1 Target Population

Grantees shall provide services to middle and high school aged youth (12-18 years of age) and young adults (18-24 years of age) in the District of Columbia, including those at higher risk of tobacco use (e.g., youth and young adults identifying as LGBTQ, youth with mental and/or behavioral health challenges).

4.2 Location of Services

Grantees must be licensed to work within the District of Columbia. Services must be delivered in the following settings: community settings in the District of Columbia, which could include but are not limited to faith-based communities; service and social organizations; schools, health clinics, and healthcare systems serving residents of DC. Organizations should demonstrate a track record of successfully working with youth and/or young adults.

4.3 Scope of Services

The applicant shall implement a targeted youth development approach engaging the priority population that seeks to build relationships and leverage resources among multiple sectors of the community. Tobacco-free focused youth development strategies are defined as intentional, prosocial approaches that engage youth within their communities, schools, organizations, peer groups, and families in a manner that is productive and constructive; recognizes, utilizes, and enhances young people's strengths; and promotes positive outcomes for young people by providing opportunities, fostering positive relationships, and furnishing the support needed to build on their leadership strengths.

Applicants must identify strategies to enhance and elevate youth voices and describe how they will coordinate this work with other funded entities to ensure a strategic approach, while also identifying strategies to promote trusting, authentic relationships with youth and young adults. To accomplish this, the overarching goal is to develop an innovative youth engagement initiative that focuses on youth-led commercial tobacco prevention strategies.

All strategies for the selected components are required and must be youth-driven and adult-guided, building the foundation for sustainable interventions within the community that can be shared, duplicated, and/or expanded with minimal resources beyond the life of the grant.

4.4 Allowable Activities

Policy, systems, and environmental (PSE) change approaches are designed to affect the social acceptability of smoking and limit access to tobacco products while supporting those who wish

to quit. Activities proposed within the PSE change context should build the foundation for sustainable interventions and create an environment that supports smoke-free living with minimal resources beyond the life of the grant.

Policy Change Interventions that create resolutions, mandates, regulations, or rules.

Examples of policy change activities that could be included in the proposal:

- Collaborate with school systems to adopt policies that promote cessation support rather than penalty for youth and young adults using tobacco products on campus
- Collaborate with School Wellness Committees to develop written policies that create supportive school environments and promote tobacco cessation by including the following elements:
  - A requirement that all students receive instruction on avoiding tobacco use
  - Provisions for students and all school staff to have access to programs to help them quit using tobacco
  - Prohibitions against tobacco advertising in school buildings, at school functions, and in school publications
- Provide technical assistance to businesses and organizations to develop and implement comprehensive tobacco control policies that include smoke-free campuses
- Work with DC Health and other governmental agencies to ensure Tobacco 21, smoke-free workplace, and flavors ban policies are enforced

This initiative should promote non-legislative policies, such as smoke-free multi-unit housing and smoke-free public spaces, that drive systems and environmental change. ***Lobbying and development of state or federal legislation is prohibited through this funding.***

Systems Change Interventions that impact all elements of an organization, institution, or system.

Examples of systems change activities that could be included in the proposal:

- Recruit and engage partners to reach at-risk youth and young adults impacted by tobacco-related disparities in communities, schools, worksites, and colleges and universities
- Recruit, train, and support youth to serve as youth leaders that:
  - Create leadership councils or chapters engaging youth in schools, faith communities, organizations, and other social settings
  - Advocate for public health initiatives and policies that limit access to tobacco among youth and young adults
  - Implement tobacco control activities
  - Raise awareness of the dangers of combustible and non-combustible tobacco use and the benefits of living a smoke-free life
- Provide technical assistance and training to adults working with youth on tobacco prevention and cessation

- Collaborate with partners and organizations (e.g., school nurses, parents, community-based organizations, etc.) to develop a coordinated response to the rapidly increasing use of and dependence on traditional and emerging tobacco products by youth and young adults
- Work with DC Health and other governmental agencies to institutionalize processes and procedures within systems under their purview that are supportive of youth tobacco cessation and healthy living goals
- Develop content for website and messaging for social media that promotes youth engagement activities and tobacco control

Environmental Change Interventions that involve material or structural changes to economic, social, or physical settings.

Examples of environmental change activities that could be included in the proposal:

- Promote smoke-free public places
- Support DC Health Tobacco Control Programs media and outreach campaigns such as #DontBeOne
- Work closely with the DC Health Tobacco Control Programs media team align activities with campaign messaging
- Collaborate with government agencies and CBOs to address tobacco product waste
- Collaborate with the Department of Energy and Environment to implement effective strategies that address appropriately disposing of confiscated tobacco products on campus grounds

4.5 Program Strategies

The applicant shall propose activities to support the following strategies as aligned with anticipated outcomes of the project:

- Innovative and coordinated District-wide youth engagement initiative
- Increased multi-sector partnerships to implement youth and young adult activities supporting tobacco control efforts
- Increased engagement of community stakeholders in tobacco control efforts

The following strategy areas for implementation are required:

Strategy 1: Community Partnerships and Engagement

Applicants shall collaborate and partner with key stakeholders, including schools and CBOs, to involve youth and young adults in the development and implementation of tobacco control interventions.

The following activities are required *but additional activities may be proposed:*

A. Recruit community groups, school wellness committees, student groups, school nurses, college sororities and fraternities, and student councils/governments to serve as sponsors of youth cohorts/chapters for the initiative and recruit youth members
B. Provide training and technical assistance for stakeholders on:

   a. Recommended evidence-based cessation and prevention interventions targeted to youth and young adults
   b. Culturally competent and responsive messaging to various youth populations

C. Collaborate with partners to facilitate youth/young adult involvement in community coalitions and initiatives and in the development and implementation of policy interventions

Strategy 2: Youth Development and Engagement

Applicants shall develop strategies and implement activities to engage and support youth in tobacco control efforts.
The following activities are required *but additional activities may be proposed:*

A. Recruit youth to serve as ambassadors and peer leaders in cohorts or chapters sponsored by CBOs or schools
   a. Prioritize engagement of youth and young adults from populations at higher risk of tobacco use (individuals who identify as LGBT and those with mental and/or behavioral health conditions)

B. Conduct youth ambassador and leadership training on topics such as the health and environmental consequences of tobacco use, evidence-based tobacco control strategies, public speaking, advocacy, effective teamwork, action planning, and media literacy

C. Include students in anti-tobacco efforts as leaders with active roles and experiential participation in tobacco-use prevention

D. Engage where possible with organizations such as Truth Initiative and Campaign for Tobacco Free Kids to enhance youth engagement efforts

Strategy 3: Adult Engagement

Applicants shall engage and involve parents and families in addressing tobacco control efforts through education and prevention.
Suggestions for activities that would support this strategy include:

A. Provide and facilitate forum(s) for youth and young adults to interact with community leaders, policymakers, and business leaders on tobacco control initiatives (e.g., website, conference calls, blogs, townhall meetings, focus groups, etc.)

B. Engage parents, community leaders, and other youth mentors to support the implementation and enforcement of smoke-free policies and restrictions on youth access to tobacco

C. Provide available contextual and culturally responsive tools and resources to adults to engage youth

Strategy 4: Monitoring and Evaluation

Applicants shall monitor project progress and conduct program evaluation to inform the creation of best practices and disseminate results to community stakeholders.
The following activities are required:

A. Develop and implement a written evaluation plan to identify successes as well as barriers to meeting project goals and outcome objectives (*detailed on pages 21-22*)

B. Implement formative, process, and outcome evaluation
C. Conduct evaluation activities:
    a. Utilize CDC's Framework for Evaluation as the guide for evaluation activities
    b. Conduct listening sessions with various youth populations to assess their perspectives on the program
D. Develop and implement plan to disseminate evaluation report on activities, strategies, findings, and lessons learned to key stakeholders and community partners
E. Collect quantitative and qualitative data to develop one success story each project year that conveys program impact at the organizational, community, or policy level and submit to DC Health

Strategy 5: Project Management
Applicant shall maintain appropriate program management practices in support of the project.

A. Participate in project orientation session with TCP project officer
B. Designate point-of-contact to participate in monthly and ad-hoc meetings with the TCP Project Officer
C. Submit required monthly invoices and monthly/annual reports.
D. Attend webinars and training sessions to augment and complement technical assistance support
E. Prepare a succession plan including the transfer of knowledge as staff turnover occurs
F. Become an active member of the District of Columbia Tobacco Free Coalition

4.6 Resources

Campaign for Tobacco Free Kids Youth Initiatives: https://www.tobaccofreekids.org/what-we-do/youth-programs

Campaign for Tobacco Free Kids Resources for Parents: https://www.tobaccofreekids.org/protectkids/resources-for-parents/?utm_medium=ads&utm_source=Google&utm_content=Search&utm_campaign=AlwaysOnSearch&sl_tc=AO-Search&gclid=Cj0KCQjwpImTBhCmARIsAKr58cx3A8aP7h5kgnCRx-jmcM_JcTNYd-WyxcIn6ORiOtJBDUgdTWJ2NPMaAh3yEALw_wcB

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

CDC Best Practices User Guides: Youth Engagement in Tobacco Prevention and Control: https://www.cdc.gov/tobacco/stateandcommunity/best-practices-youth-engagement/pdfs/best-practices-youth-engagement-user-guide.pdf

CDC Framework for Program Evaluation: https://www.cdc.gov/evaluation/framework/index.htm

Counter Tobacco Resources and Tools: https://countertobacco.org/resources-tools/

Live Vape Free Vape Resource: https://livevapefree.org/

Louisiana Campaign for Tobacco-Free Living Resources: https://tobaccofreeliving.org/education

Massachusetts Youth Tobacco Cessation and Prevention Program: https://the84.org/

National LGBT Cancer Network: https://cancer-network.org/

Not-on-Tobacco Teen Smoking and Vaping Cessation Resource: https://www.lung.org/quit-smoking/helping-teens-quit/not-on-tobacco

Policy, Systems, and Environmental Change Resource Guide: https://smhs.gwu.edu/cancercontroltap/sites/cancercontroltap/files/PSE_Resource_Guide_FINAL_05.15.15.pdf

Public Health Law Center: Tobacco Product Waste, A Public Health and Environmental Toolkit: https://www.publichealthlawcenter.org/sites/default/files/resources/Tobacco-Product-Waste-Toolkit.pdf?utm_source=Public+Health+Law+Center&utm_campaign=621362c742-EMAIL_CAMPAIGN_2017_12_13_COPY_01&utm_medium=email&utm_term=0_59c1ffe67d-621362c742-43107225

Stanford Medicine Tobacco Prevention Toolkit https://med.stanford.edu/tobaccopreventiontoolkit.html

The American Heart Association Tobacco-Free Schools Toolkit: https://www2.heart.org/site/DocServer/AHA_Tobacco-Free_Schools_Toolkit.pdf

Truth Initiative: https://truthinitiative.org

Truth Initiative *This is Quitting*: https://truthinitiative.org/thisisquitting

Virginia Foundation for Healthy Youth Tobacco Free Generation Community Innovation Toolkit: https://www.vfhy.org/wp-content/uploads/2021/07/Tobacco-Free-Generation-Community-Innovation-Toolkit.pdf

5. APPLICATION REQUIREMENTS

5.1 Eligibility Documents

Certificate of Clean Hands

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

Current Business License

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

Current Certificate of Insurance

This document must be issued by your insurance company. All DC Health grantees must meet the minimum insurance requirements as outlined in Appendix A: Minimum Insurance Requirements. Should an applicant be awarded the grant, the Office of Risk Management will

conduct a review of exposures of the grantee organization based off the final approved workplan and may make changes to the insurance requirements.

Copy of Cyber Liability Policy

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

IRS Tax-Exempt Determination Letter

This applies to nonprofits only.

IRS 990 Form

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

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

This CANNOT be signed by the executive director.

Assurances, Certifications and Disclosures

This document must be signed by an authorized representative of the applicant organization. (Attachment 1).

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

5.2 Proposal Components

Project Abstract

A one-page project abstract is required. Please provide a one-page abstract that is clear, accurate, concise, and without reference to other parts of the Project Narrative. The project abstract must be **single-spaced, limited to one page in length**, and include the following sections:

- **Overview:** Provide a three-to-five-sentence description of your project that identifies the population and/or community needs that are addressed.
- **Problem:** Describe the principal needs and problems addressed by the project.
- **Purpose:** State the purpose of the project.
- **Goal(s) And Objectives:** Identify the major goal(s) and objectives for the project. Typically, the goal(s) are stated in a sentence, and the objectives are presented in a numbered list.
- **Methodology:** Briefly list the major activities used to attain the goal(s) and objectives

Project Narrative (10-page maximum)

The narrative section should describe the applicant's approach of relevant background information that includes the context of the problem.

The narrative should include the following sections:

Overview

This section should briefly describe the purpose of the proposed project and how the application aligns with the RFA. It should also summarize the overarching problem to be addressed and the contributing factors. Applicant must clearly identify the goal(s) of this project.

Project or population need

Applicants should provide an overview of their constituent population as relevant to the project. Applicants should be able to demonstrate the ability to reach the youth and young adults and how they will be served through this project.

Project Description

Applicants must demonstrate how their proposed strategies and activities will engage the priority population around tobacco prevention efforts and improve health outcomes in the District of Columbia through engagement, education, communication and messaging, and advocacy. This section should provide a clear and concise description of strategies and activities they will use to achieve the project outcomes and should detail how the program will be implemented. Applicants must base their strategies and activities on those described in Sections 3.1 Approach, 4.3 Scope of Services, and 4.4 Program Strategies, above. Describe activities for each strategy, how they will be implemented, and how they will be operationalized to achieve program goals, objectives, and outcomes

- Describe activities for each strategy, how they will be implemented, and how they will be operationalized to achieve program goals, objectives, and outcomes.
- Describe how the proposed project meets the requirements in the Scope of Services section (please see Performance Requirements Section for more details).
- Outline the rationale for selecting the proposed activities and objective, including an assessment of the current needs and assets in the community. Describe how strategies are based upon evidence-based, evidenced-informed or promising practices/programs.
- Describe how participants will be recruited, enrolled, and retained in the program initiatives and activities.
- Describe how objectives will maximize public health impact, building, sustaining and operationalizing enhanced community capacity.
- Indicate plans for sustainability of the initiative beyond the projected funding period.

Performance Monitoring

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:

- How the applicant will measure community engagement and its impact

- How the applicant will ensure activities reduce social acceptance and use of tobacco products in youth and young adult populations, including youth and young adults identifying as LGBT, or those with a mental/behavioral health diagnosis
- How activities will be monitored and adapted to improve program success

ORGANIZATIONAL CAPACITY

This section should provide an overview of the organizational infrastructure, mission, and vision. Applicants should demonstrate capacity and infrastructure to implement evidence-based or promising practices when engaging communities and youth and young adults in comprehensive tobacco control efforts. The applicant should describe the scope of current community engagement and empowerment activities with youth and young adults and demonstrate staff capacity to conduct activities as required by this RFA.

Applicants should demonstrate ability to meet performance requirements, collect data, follow project deadlines for deliverables, and provide timely and accurate reporting and invoicing regarding all financial transactions related to this program. Lastly, applicants should affirm organizational leadership commitment to complete the project as proposed in the work plan.

Applicants should demonstrate achievements from current or prior project efforts, with a demonstrated track record of successfully engaging youth and young adults in the District of Columbia, and illustrate experience in and/or capacity to conduct the following activities:

- Mobilize or contribute to the mobilization of a community regarding a specific youth-focused public health issue or community concern
- Maintain or participate in a community partnership implemented to advocate for or change a specific youth-focused public health issue or community concern
- Identify and implement tobacco or other public health program messaging, best practices, and marketing tactics appropriate for youth and young adults
- Advocate for or change a specific public health issue or community concern with a significant impact on youth and young adults
- Implement policy, systems, and environmental change activities to improve a public health issue or community concern in youth and young adults
- Develop youth programs in community-level youth commercial tobacco prevention work or other public health-related community-level change efforts
- Establish authentic, trusted relationships with youth and young adults working in shared leadership models
- Engage diverse community partners and stakeholders

WORK PLAN

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

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

The work plan should include process objectives and measures. Objectives should be SMART. The attributes of a SMART objective are as follows:

- Specific: includes the "who," "what," and "where." Use only one action verb to avoid issues with measuring success.
- Measurable: focuses on "how much" change is expected.
- Achievable: realistic given program resources and planned implementation.
- Relevant: relates directly to program/activity goals.
- Time-bound: focuses on "when" the objective will be achieved.

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

BUDGET TABLE

The application should include a project budget worksheet using the excel spreadsheet in District Grants Clearinghouse as noted in form provided (Attachment 3). The project budget and budget justification should be directly aligned with the work plan and project description. All expenses should relate directly to achieving the key grant outcomes. Budget should reflect the budget period, as outlined below (Key Budget Requirements).

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

Key Budget Requirements

The budget should reflect a 12-month period of October 1, 2022 – September 30, 2023.

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

Include the following in the budget justification narrative:

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

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

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

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

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

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

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

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

ORGANIZATIONAL CHART

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

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 may also be submitted.

Letters of Support

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

6. EVALUATION CRITERIA

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

Criterion 1: Need

(10 points) – Corresponds to Sections: Introduction and Target Population

The extent to which the applicant:

- Demonstrates an understanding of the benefits of addressing tobacco use in youth and young adults by engaging them in community-driven tobacco control initiatives (5 points)
- Demonstrates an understanding of factors influencing tobacco use initiation and dependence (5 points)

Criterion 2: Implementation Framework

(35 points) – Corresponds to Sections: Project Description and Work Plan

The extent to which the applicant:

- Demonstrates that the proposed plan provides a foundation for sustainability of efforts beyond the projected funding period (10 points)
- Presents a work plan with realistic/feasible approaches built on evidence-informed interventions and best practices to address tobacco use and initiation in youth and young adults (5 points)
- Demonstrates how proposed activities will engage and mobilize youth, young adults, and community stakeholders to reduce tobacco initiation and tobacco use (10 points)
- Provides a clear description of proposed project objectives and activities that are tied strategies required in the RFA (10 points)

Criterion 3: Evaluative Measures

(30 points) – Corresponds to Sections: Performance Monitoring and Evaluation

The extent to which the applicant:

- Identifies measurable indicators to monitor the project's success (5 points)
- Describes how the project will be monitored to ensure reach and engagement of the youth and young adults (5 points)
- Describes how youth and young adults will be engaged in evaluation of the project (5 points)

- Describes processes to collect qualitative and quantitative data related to project goals (5 points)
- Identifies skilled staff to analyze data aligned to the project's goals (5 points)
- Specifies a process to monitor progress and adapt strategies and objectives to improve outcomes (5 points)

CRITERION 4: CAPACITY AND RESOURCES

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

The extent to which the applicant:

- Describes an organizational structure that can support management of the grant and implementation of proposed strategies (5 points)
- Demonstrates that project personnel have demonstrated qualifications (by training and/or experience) to implement the project (5 points)
- Demonstrates experience and past successes working collaboratively with government agencies and/or public health initiatives aimed to advance a public health goal and/or address youth-focused tobacco control and prevention (5 points)
- Describes established partnerships with key community stakeholders working with youth and young adults and identifies opportunities for collaboration (5 points)
- Explains how they currently serve the priority population – youth and young adults – or other vulnerable populations described in this RFA – by addressing youth engagement, advocacy, and leadership (5 points)

CRITERION 5: SUPPORT REQUESTED

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

The extent to which the applicant:

- Presents a reasonable budget for the project period in relation to the objectives, the complexity of the activities, and the anticipated results
- Outlines costs and required resources that are reasonable given the scope of work
- Demonstrates key personnel have adequate time devoted to the project to achieve project objectives

7. REVIEW AND SCORING OF APPLICATION

7.1 ELIGIBILITY AND COMPLETENESS REVIEW

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

7.2 External Review

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

7.3 Internal Review

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

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

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

8. POST AWARD ASSURANCES & CERTIFICATIONS

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

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

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

9. APPLICATION SUBMISSION

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

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

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

9.1 Register in EGMS

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

1. **Access EGMS**: The user must access the login page by entering the following URL: https://dcdoh.force.com/GO ApplicantLogin2. Click the button REGISTER and following the instructions. You can also refer to the EGMS External User Guide.
2. Determine the agency's Primary User (i.e. authorized to accept terms of agreement, certify and submit documents, request and accept modifications). The Primary User will determine a Secondary User and send a notification via EGMS for him/her to set-up an account.
3. Your EGMS registration will require your legal organization name, your **DUNS#, UEI# and Tax ID#** in order to complete the registration. Your EGMS registration will also require your SAM (System for Award Management) expiration date to be entered into your agency profile. Please ensure that you have an active SAM registration (www.sam.gov).
4. When your Primary Account User request is submitted in EGMS, the Office of Grants Management will review the request. If the requester is NOT the identified Executive Director, DC Health Office of Grants Management will make an additional request for the Executive Director to send an email to DC Health to confirm that the requester is the authorized representative for EGMS. When requested, your authorized representative should send to doh.grants@dc.gov the name, title, telephone number and email address of the desired Primary User for the account. Note: The email will help to support the validation of authorized users for EGMS. DC Health official grant records will also be used. Please reply ASAP to any requests from Office of Grants Management to provide additional information, if needed.

EGMS User Registration Assistance:

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

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

9.2 Uploading the Application

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

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

- ***Proposal Documents***
  - Proposal Abstract
  - Project Narrative (10-page maximum)
  - Budget Table
  - Budget Justification
  - Organization Chart
  - Work Plan
  - Staffing Plan
  - Two (2) Letters of Support

9.3 Deadline

Submit your application via EGMS by 6:00 p.m., on the deadline date of August 10, 2022. Applications will **not** be accepted after the deadline.

10. PRE-APPLICATION MEETING

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

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

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

Note that questions will only be accepted in writing. Answers to all questions submitted will be published on a Frequently Asked Questions (FAQ) document onto the District Grants Clearinghouse every three business days.

11. GRANTEE REQUIREMENTS

If the applicant is considered for funding based on the results of the completion and receives a Notice of Intent to Fund and subsequently accepts grants award, the following requirements are in effect:

11.1 Grant Terms & Conditions

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

11.2 Grant Uses

The grant awarded under this RFA shall be used exclusively to pay costs associated with the implementation of the grant. Payment requests will be monitored by DC Health to ensure compliance with the approved budget and work plan.

11.3 Conditions of Award

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

1. Revise and resubmit a work plan and budget with justification in accordance with the approved scope of work and assignments prescribed by a DC Health Notice of Intent to Fund and any pre-award negotiations with assigned DC Health project and grants management personnel.
2. Meet pre-award requirements, including submission and approval of required assurances and certification documents, documentation of non-disbarment or suspension (current or pending) of eligibility to receive local or federal funds.

3. Adhere to mutually agreed upon terms and conditions of a grant agreement and Notice of Grant Award issued by the Department of Health and accepted by the grantee organization. The NOGA shall outline the scope of work, standards, reporting requirements, fund distribution terms and any special provisions required by federal agreements.
4. Utilize performance monitoring and reporting tools developed and approved by DC Health.

11.4 Indirect Cost

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

11.5 Insurance

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

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

11.6 COVID-19 Grantee Requirement

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

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

11.7 Audits

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

11.8 Nondiscrimination in the Delivery of Services

In accordance with Title VI of the Civil Rights Act of 1964 (Public Law 88-352), as amended, no person shall, on the grounds of race, color, religion, nationality, sex, or political opinion, be denied the benefits of, or be subjected to discrimination under, any program activity receiving funds under this RFA.

11.9 Quality Assurance

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

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

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

12. GLOSSARY OF TERMS

Adult Tobacco Survey – Created to assess the prevalence of tobacco use, as well as the factors promoting and impeding tobacco use among adults. The National Adult Tobacco Survey also establishes a comprehensive framework for evaluating both the national and state-specific tobacco control programs. The survey questionnaire is built around key outcome indicators from each of the following four goal areas: (1) Preventing initiation of tobacco use among young people; (2) Eliminating nonsmokers' exposure to secondhand smoke; (3) Promoting quitting among adults and young people, and (4) Identifying and eliminating tobacco-related disparities.

"National Adult Tobacco Survey (NATS)." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, December 18, 2018. https://www.cdc.gov/tobacco/data_statistics/surveys/nats/index.htm#:~:text=The%20National%20Adult%20Tobacco%20Survey,state%2Dspecific%20tobacco%20control%20programs.

Adverse Childhood Experiences (ACEs) – ACEs are potentially traumatic events that occur in childhood (0-17 years) that are linked to chronic health problems, mental illness, and substance use problems in adolescence and adulthood. ACEs can also negatively impact education, job opportunities, and earning potential. However, ACEs can be prevented.

Centers for Disease Control and Prevention. (2022). Violence Prevention: Fast Facts. Retrieved from https://www.cdc.gov/violenceprevention/aces/fastfact.html

Behavioral Risk Factor Surveillance System – BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world.

"CDC - BRFSS - BRFSS Frequently Asked Questions (FAQs)." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, January 2, 2018. https://www.cdc.gov/brfss/about/brfss_faq.htm.

National Youth Tobacco Survey (NYTS) – The NYTS was designed to provide national data on long-term, intermediate, and short-term indicators key to the design, implementation, and evaluation of comprehensive youth tobacco use prevention and control programs. NYTS is the only nationally representative survey of U.S. middle and high school students that focuses exclusively on tobacco use patterns and associated factors.

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

Social Determinants of Health – Social determinants of health are the conditions in which people are born, live, work, play and age that influence health. The public health community has long understood that there is a link between an individual's health and the social environmental and economic conditions within which an individual resides and interacts. Social determinants of health include access to healthy foods, housing, economic and social relationships, transportation, education, employment and access to health. The higher the quality of these resources and supports, and the more open the access for all community members, the more community outcomes will be tipped toward positive health outcomes. Thus, improving conditions at the individual and community level involve improving societal

conditions, Page 36 of 36 including social and economic conditions (freedom from racism and discrimination, job opportunities and food security), the physical environment (housing, safety, access to health care), the psycho-social conditions (social network and civic engagement), and psychological conditions (positive self-concept, resourcefulness and hopefulness).

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

Youth Risk Behavior Surveillance System – The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults, including— (1) Behaviors that contribute to unintentional injuries and violence, (2) Sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection, (3) Alcohol and other drug use, (4) Tobacco use, (5) Unhealthy dietary behaviors, and (6) Inadequate physical activity. YRBSS also measures the prevalence of obesity and asthma and other health-related behaviors plus sexual identity and sex of sexual contacts. This data only includes public and charter schools, and is exclusive of students within private school settings.

Trauma – Trauma is an emotional response to a terrible event like an accident, rape, or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like headaches or nausea.

13. ATTACHMENTS

Attachment 1: Assurances and Certifications

Attachment 2: Work Plan

Attachment 3: Budget Table

Attachment 4: Budget Justification

Appendix A: Minimum Insurance Requirements

APPENDIX A: MINIMUM INSURANCE REQUIREMENTS

INSURANCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. <u>Commercial Umbrella or Excess Liability</u> - 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. **<u>All</u>** liability coverages must be scheduled under the umbrella and/or excess policy. The insurance required under this paragraph shall be written in a form that annually reinstates all required limits. Coverage shall be primary to any insurance, self-insurance or reinsurance maintained by the District and the “other insurance” provision must be amended in accordance with this requirement and principles of vertical exhaustion.

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

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

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

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

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

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

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

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

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

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