

“Reducing Health Disparities in Baltimore County”
Health Enterprise Zone Grant Application

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“Reducing Health Disparities in Baltimore County”
Health Enterprise Zones Grant Application

3. Program Summary

This project proposes to address the persistently elevated rates of low birth weight and infant mortality among minority populations in Eastern Baltimore County by implementing an intensive case management component to the Baltimore County Department of Health’s current intervention efforts in the proposed Health Enterprise Zone (HEZ) region.

The proposed HEZ in Eastern Baltimore County, MD has a combined population of 216,332, generates 2,437 births per year, and meets the four criteria of the HEZ Call for Proposals. The contiguous area demonstrates economic disadvantage by exceeding Medicaid enrollment (210.68/1,000) and WIC participation (38.43/1,000) rates. The HEZ has demonstrated poor health outcomes including higher rates of newborn low birth weight (7.88%) and lowered life expectancies (75.2 years). A higher poverty rate, diverse ethnic population, a large number of women with Medical Assistance during their pregnancy, and a preponderance of first time mothers in the Baltimore metropolitan area (Vital Statistics, DHMH, 2010) render the geographic area a primary site for the HEZ where disparities in infant mortality and child health and development can be addressed and improved.

The Baltimore County Department of Health (BCDH) has a history of addressing women’s health needs among those with economic, social or health literacy barriers that are known to reduce access to care. BCDH developed several successful community outreach efforts to improve pregnancy outcomes for the target population funded by DHMH’s Office of Minority Health and Health Disparities. Family planning and women’s health services are offered at three health centers in the east side of the County. In addition, the Special Supplemental Nutrition Program for Women, Infants, and Children services are provided at two locations within the HEZ in order to improve the nutritional status of low income pregnant women, infants and young children. In 2009, using County funds supplemented with funding from the State of Maryland Community Health Resources Commission, BCDH created the Prenatal Enrichment Program (PEP) to establish a minimum level of in-home public health nursing support and case management to high-risk pregnant women without access to other resources. Within PEP, clients receive at least one home visit every three months and monthly telephone contact ending with a final home visit scheduled six weeks after the baby is born. Under this program, progress has been made with the approximately 500 women served per year, but it has become clear that a subset, especially first time mothers, need a more intensive intervention during their pregnancy and after the baby’s birth to enable her to provide better care for her infant and educate her about strategies to foster optimal development in her child.

Baltimore County has selected the evidence-based Nurse-Family Partnership (NFP) program to deliver this intensive support for high-risk mothers and their newborns in the designated HEZ area because of the strength of evidence supporting its use to meet the specific objectives of this project – improving pregnancy outcomes, decreasing infant mortality, and improving developmental outcomes for the babies born to first time mothers with limited resources. Additional goals include reducing emergency room visits and hospitalizations for accidents and ingestions, increasing rate and duration of breast feeding, and improving immunization rates.

4. Program Purpose

This project is designed to improve the health and overall well-being of high risk, first time pregnant women within the HEZ zone by providing a dedicated nurse case management to serve 100 women with the goal of improving pregnancy outcomes, reducing infant mortality, and improving health literacy and parenting skills to improve long-term safety and development of infants born to these high risk families. It is anticipated that 200 families will receive services over the four year duration of the grant.

Baltimore County has experienced widening racial gaps in infant mortality over the past five years. High infant mortality rates within the zip codes included in this HEZ have contributed substantially to this increasing disparity. Despite the existence of several programs targeted to Black women to help address low birth weight, premature birth, and infant mortality, the gaps in these outcomes persist. Current intervention efforts by BCDH are limited in support and terminate at six weeks. The staff assigned to work with high risk, pregnant women has been especially concerned about the first time mothers with whom they work and feel that an intensive program targeted to first time mothers within the HEZ area is crucial to begin to address this striking health disparity. In addition, the State Legislature has recently passed legislation mandating that evidence-based programs with proven track records be the primary method by which the problem of infant mortality is addressed at the local level. Baltimore County's current model of service delivery is limited and lacks the funding to provide the labor-intensive provision of care coordination and neonatal assistance that are fundamental to existing evidence-based models. BCDH believes that the Nurse-Family Partnership (NFP) Program represents the best evidence-based program targeted to first time mothers from economically disadvantaged backgrounds. It is this group that BCDH will target with the NFP program and outreach and engagement efforts will be concentrated on families within the proposed HEZ.

There are multiple factors that influence infant mortality. Data supplied by the Department of Health and Mental Hygiene (DHMH) Office of Maternal and Child Health (MCH) indicate that low birth weight accounts for 26% of infant deaths. Maternal complications of pregnancy account for 10% and Sudden Infant Death (largely attributable to unsafe sleep practices) accounts for another 10% of the infant deaths. MCH has determined that maternal chronic disease, smoking, obesity, maternal age and unintended pregnancy are the key risk factors in Maryland for low birth weight.

In addition, MCH states that hypertension and diabetes during pregnancy pose particular risks for the black population. Black mothers who had hypertension prior to getting pregnant were more than two and a half times more likely to have a very low birth weight baby than black mothers without hypertension prior to getting pregnant, and their hypertension was much more likely to be a factor contributing to the low birth weight of the baby. Developing hypertension during pregnancy was also much more likely to occur for black women and to be associated with low birth weight. Similarly, black women were more likely than white women to have diabetes, both before and developing during pregnancy and their diabetes was more likely to contribute to a premature birth and very low birth weight in their baby than with white pregnancies. While early prenatal care is one important step to address these risk factors during pregnancy,

continued counseling and support in addressing chronic illness and health issues during pregnancy is crucial to improved pregnancy outcomes.

From one month to twelve months of age, SIDS and other sleep related deaths become the leading cause of infant deaths. Counseling about safe sleep and continued monitoring regarding safe sleep practices are key to addressing this concern. Data clearly shows that, while white, Hispanic and Asian women in the U.S. follow safe sleep practices 75-80% of the time, black women only follow safe sleep practices 50% of the time. Likely related to this, SIDS and other sleep related deaths occur almost twice as often for black babies than they do for white or Hispanic infants according to NICHD/NIH data (2010).

Obesity is also of increasing concern – both for pregnant women and for young children. Obesity is linked with poor pregnancy outcomes. Obesity plays a role in the incidence of diabetes and hypertension for the mother and can lead to premature delivery of her baby and/or increased infant mortality. Obesity is especially prevalent among Blacks. In reviewing the 52 cases of fetal death (prior to 28 days of age) among black women in Baltimore County in 2011, 83% of cases were from mothers diagnosed as overweight or obese prior to conception. Of that 83%, 30% occurred in mothers who were “morbidly obese (BMI equal to or greater than 35%). In addition, health professionals now recognize that excessive weight gain in infancy and certain parenting practices of infants and toddlers (feeding practices, excessive exposure to TV, limited physical activity) set the stage for development of obesity in children that is very difficult to reverse once it occurs per the Chair, Task Force on Childhood Obesity and Director, President’s Domestic Policy Council in May, 2010.

To address these disparities, BCDH requests funding to develop and implement a Nurse-Family Partnership (NFP) Program in order to educate and support high risk, first-time mothers and their babies living in the proposed HEZ. The Nurse-Family Partnership Program has received national recognition because of its well-substantiated impact on pregnancy outcomes and on the welfare of the young mother and her baby. Using the NFP model, 200 families will be continuously enrolled over a 2-year period, for the purpose of reducing health disparities among this select population. This model, outlined in following sections, includes intensive education and support, by a nurse case manager, during the pregnancy and continuing until the child turns two years of age.

It is anticipated that participant mothers from the HEZ will have improved health outcomes during pregnancy (including lower rates of tobacco use, improved weight status, decreased hypertension and diabetes), better health outcomes at delivery (as measured by rates of low birth weight), improved rates of infant mortality including lower rates of infant death from sleep related deaths, higher rates of initial and sustained breastfeeding, improved childhood immunization rates, lower accident rates requiring emergency room visits and hospitalization, and improved child development. In addition, mothers involved in the project will set life goals and implement steps to achieve these goals with the expected result of achieving long-term and sustained self sufficiency.

5. HEZ Geographic Description

The proposed HEZ community is located in Eastern Baltimore County and encompasses five (5) contiguous zip codes:

- 21220 – Middle River, MD
- 21221 – Essex, MD
- 21222 – Dundalk, MD
- 21224 – Baltimore, MD (Eastpoint, Colgate, & Eastwood communities)
- 21237 – Rosedale, MD

Eastern Baltimore County is the area extending from the City-County line eastward to Ebenezer Road and bounded by Philadelphia Road and the White Marsh Business Community to the north and the Chesapeake Bay to the south.

Attachment Item 5-1 is a map of the proposed HEZ.

Communities within the proposed HEZ continue to experience economic loss including recent job loss resulting from closures of an automobile plant on Broening Highway, Bethlehem Steel in Sparrows Point, and reductions to the Martin Marietta plant in Middle River. These changes are in addition to the de-industrialization of other blue-collar manufacturing jobs in adjoining communities in Baltimore City. Once a successful commercial, manufacturing and transportation center, the region has declined as a result of these closures and changes to the local economy. Because its economic fortunes have shifted, Eastern Baltimore County now has a poverty rate 20% higher than that of Baltimore County as a whole, along with a large aging workforce without the education or skills appropriate to emerging industries. Generations of its residents are observing a rapid decline in opportunities that, combined with an increase in poverty levels, produce increases in violence, drug activity, and declines in neighborhood stability. The largest employer in the area is Medstar Health Franklin Square Hospital Center. However, an increasing number of families and individuals either have no health insurance or severely reduced health insurance.

This area is identified as having disparities in many other health indicators in comparison to the rest of Baltimore County and across the State of Maryland. Eastern Baltimore County's infant mortality rate and teen birth rate are higher than the County's and climbing consistently. The rate of infants born to mothers without a high school education is significantly higher than the County's rate. As a result, infants born in Eastern Baltimore County face substantial health risks, more so than do infants in Baltimore County as a whole. Area babies are more likely to be born underweight, to teen mothers and/or to mothers who did not finish high school. These factors put infants at increased risk for poor health outcomes, including death in the first year.

6. Community Needs Assessment

Baltimore County has experienced dramatic widening of the gaps between white and black infant mortality over the past ten years. Maryland Vital Statistics Annual reports indicate that, in 2002, low birth weight rates were 8.0% for whites and 13.1% for blacks. Infant mortality rates

in 2002 per 1,000 live births were 7.3 for white and 10.2 for blacks. In 2011, low birth weight rates had improved to 7.1% for whites while they had stayed the same at 13.1% for blacks. However, in 2011, infant mortality rates for white babies had dropped per 1,000 live births to 3.6 while the rate for black babies had increased to 12.7.

The Southeast Area Community Network, with funding from Medstar Health Franklin Square Hospital Center, did a community needs assessment in 2007 and published the results in 2008. This needs assessment identified three main goals as pertains to children: (1) children safe in their families and communities, (2) children successful in school, and (3) children born healthy. In terms of the last goal, they specifically identified premature births, low birth weight and infant mortality as indicators with higher than average incidence in their community that needed to be addressed. In terms of the goal of children safe in their families, they felt it was important to increase awareness of “positive parenting” which is a central objective of the Nurse Family Partnership intervention as well.

Medstar Health Franklin Square Hospital Center’s recent (2012) community survey identified obesity as the number one health concern of respondents. Infant mortality was considered of lesser concern but that may partially result from fewer people and that over one-third of the respondents to this community survey were over age 65. However, obesity as a major concern is important in that maternal obesity increasingly is linked to poor birth outcomes including premature birth and infant mortality. Establishment of good parenting practices helps prevent the onset of obesity as well since it leads to healthier diets, less TV watching, and more physical activity. This same survey identified adequate access to jobs as a major concern. This is not surprising given the recent closure of the major steel plant in this area and the likelihood that it will not reopen. This produces direct loss of good paying jobs but also affects a wide range of other goods and services in the area that were purchased by employees and their families of this plant.

Other factors which have been linked to higher rates of infant mortality and less than optimal child development include poverty and low levels of educational attainment. While pockets of poverty occur throughout Baltimore County’s older communities, the greatest concentration of areas with less than the County’s median household income and 10-20% poverty rates is in Eastern Baltimore County. The educational level of attainment in Eastern Baltimore County also is lower than that of the County, the region, and nation. For example, only 65% of residents in eastern Baltimore County are graduates from high school. Similarly, the percentage of Eastern Baltimore County residents with college or advanced degrees is one-third of that in the County, region, and nation.

7. Core Disease Targets and Conditions

This proposal is specifically designed to address the problems of low birth weight, high infant mortality, and less than optimal child development among low income, first time mothers and their children. This will be accomplished by provision of in-home public health nursing services using the Nurse-Family Partnership model to first time, low income pregnant women. Key during pregnancy will be to help these first time mothers address health issues including obesity, hypertension, diabetes, asthma, and dental caries. In addition to monitoring and providing

nursing interventions for these medical problems, the nurse home visitor also will focus on encouraging the mothers to develop healthy habits during pregnancy and to set goals and develop a plan for reaching her goals. All of the pregnant women will be screened for mental health problems and substance abuse including tobacco, misuse of legal drugs, and use of illegal drugs and then will be assisted in obtaining intervention for these problems as well.

The nurse home visitor will continue to work with the mother and her child until the child reaches the age of two. This portion of the intervention will emphasize helping these mothers develop strong parenting skills including implementing safety practices, ensuring good preventive health measures for their baby, and fostering their child's growth and development. The nurse home visitor will work with the family to improve child health through better understanding of safety practices, better compliance with immunization schedules, and improved care of young infants and toddlers. Child development will be fostered through instruction and modeling about strategies to promote development and to enhance the parenting skills of the mother and all other adults in the household. The program will address childhood obesity through the promotion of breastfeeding and good parenting skills. Enhanced parenting skills are expected to result in decreased "screen time", increased appropriate physical activity, and improved rates of healthy eating. The project is intended to augment the currently existing programs to decrease infant mortality and enhance child development, not to replace them. Our intervention teams have increasingly felt that first time mothers, especially in the Eastern Baltimore County area, desperately need intervention on a more intensive level than could be supplied by current programs being offered by BCDH or in the community.

8. Goals

The specific targeted goals for this grant application are as follows:

- (1) Develop intervention to address health disparities among low-income first time mothers
 - a. Recruit and train five public health nurses and a supervisor specifically to provide intensive home visiting services to first-time pregnant women within Baltimore County's proposed HEZ. This will increase the number of public health nurses and public health nurse supervisors devoted to working with high risk pregnant women in Baltimore County from the current 4 FTE to 9 FTE with 5 FTE devoted specifically to the HEZ.
 - b. Provide services to 100 first time mothers at any point in time and 200 over the four year course of the grant period. Note: Most families will be enrolled for a period of 2.5 years.
 - c. Have 70% of the enrollees complete the program.
- (2) Improve the health measures for first time, low income pregnant women and their child who participate in this project in the following areas:
 - a. Improve pregnancy outcomes
Decrease the low birth weight rate (<2500 gm) of participants to below the current Maryland overall low birth weight rate of 9.2%.

b. Improve the weight status of enrolled mothers

Decrease the average Basal Metabolic Index (BMI) of enrolled mothers by 1.0 over their pre-pregnancy average BMI.

c. Increase rates of breast feeding

Rates of initiating breast feeding among enrollees will increase by 10% from 62.5% to 68.8% and rates of still breast feeding at 6 months of age will increase by 10% from 25.2% to 27.7% (baseline based on Baltimore County WIC data from July of 2011 – June of 2012).

d. Improve developmental outcome of the children

At least 85% of enrolled children will have developmental skills on target indicating that they are on track to be ready to learn on entry to kindergarten. (Based on the Maryland State Health Improvement Plan (SHIP) goal).

(3) Increase resources for health

Greater than 95% of program participants will be linked with an on-going source of health care for themselves and for their child.

(4) Reduce preventable emergency department visits and hospitalizations

Infants and toddlers in this program will have lower rates of ER visits and hospitalizations for accidents and ingestions compared to other Maryland Medical Assistance covered children under age 2.

(5) Reduce unnecessary costs in health care

Children in this program will meet the Maryland target of at least 80% of their immunizations being up to date by age 2. (Based on the Maryland SHIP goal)

9. Strategies

Baltimore County will implement a Nurse-Family Partnership (NFP) program in accordance with the standards and guidelines established by NFP. NFP is a well-documented, evidence-based program that has been endorsed by the Coalition for Evidence-Based Policy for its effectiveness in improving pregnancy outcomes, child health and development, and self-sufficiency for eligible first-time parents.

Nurse-Family Partnership was developed thirty years ago and has been tested in multiple communities with excellent outcomes for low income, first time mothers and their children. The program involves intensive (at least every other week), in home services by a public health nurse who has been extensively trained in providing education and support to first time mothers and then in guiding them to set life goals and plans as well as provide physical and developmentally optimal care for their newborn through age 2.

Steps to implement include the following:

- a. Sign a proprietary protection letter and/or contract with NFP.
- b. Formalize membership in a community board to serve as the Advisory Board for the grant. Membership in this board will include current participants in the subcommittee devoted to reducing minority low birth weight of Baltimore County's Health Coalition with addition of representatives from the three main providers of obstetric care to Medicaid participants in the HEZ (Medstar Health Franklin Square Hospital Center, Johns Hopkins Bayview Hospital and Baltimore Medical Systems) as well as a representative from each of the major community associations in the HEZ and a representative from County Council for the HEZ area served.
- c. Recruit a nursing supervisor with home visiting experience either with pregnant women and/or young children to serve as the supervisor for the program. This person will devote 25 hours per week to the project as per NFP guidelines of 5 hours of time per nurse being supervised. This person's duties will include oversight of recruitment of participants for the program, in person and overall supervision of each of the nurses providing services, planning of group supervision sessions and didactic instruction at a local level, and oversight of the data management component of the program.
- d. Hire an office assistant to manage communications, prepare information packets, and record and manage the data files required under the NFP program and to allow for reporting of results to the granting agency.
- e. Recruit and hire 5 bachelor's prepared public health nurses (PHN), each to work 32 hours per week carrying a case load of 20 cases as per NFP guidelines. Preference will be given for candidates who are Spanish speaking or who are of African-American or Latino backgrounds in order to facilitate comfort of the client participants in the program when possible.
- f. Implement training for the PHN and the supervisor, both at the local level and by participation in national training by the NFP program to prepare them to implement the NFP Program in a reliable and consistent fashion, to maintain records in accordance with the NFP guidelines and to meet the reporting requirements for this grant.
- g. Develop a new module specific for the necessary documentation of each NFP client visit in Visual Health Net, the electronic medical record currently being used by BCDH.

It is anticipated that steps 'a' through 'g' will take the first 6 months of the grant period.

- h. Recruit participants in the program. This will be accomplished in several ways. Our partners in our Community Advisory Board who are the main providers of Medicaid services will play a key role in identifying potential participants and helping inform them of the value of the program. Additional potential participants will be identified through the Administrative Care Coordination Unit at BCDH which is responsible for linking newly pregnant women with services to address their needs. BCDH Health Centers in Essex and Dundalk will be asked to determine interest in the program among women who have a positive pregnancy test at the

Health Center, live in the HEZ, and would be a first time mother. One of the PHN will be paired with each of these referral sources in order to facilitate communication about potential new participants.

i. Implement in-home interventions using Nurse-Family Partnership. NFP is based upon specific model elements which must be incorporated into the organization's program. These are described below along with a rationale:

Model Elements	Rationale
<ul style="list-style-type: none"> (1) Client participates voluntarily in the program (2) Client is a first-time mother (3) Client meets low-income criteria at intake (4) Client is enrolled in the program early in her pregnancy and receives her first home visit by no later than the end of the 28th week of pregnancy (5) Client is visited one-to-one (6) Client is visited in her home (7) Client is visited throughout her pregnancy and the first 2 years of child's life (8) Nurse home visitors are registered nurses with a BS degree (9) Nurse home visitors complete core educational sessions required by NFP and deliver intervention with fidelity to the program (10) Nurse home visitors apply NFP visit-to-visit guidelines and individualize them to the family (personal health, environmental health, life course, maternal role, friends & family, and health & human services referrals (11) Self-efficacy, human ecology and attachment theories and clinical methodology employed (12) Each nurse home visitor carries caseload of 23-25 active clients/40 hour work week (13) Full-time nurse supervisor will supervise up to 8 nurse home visitors (14) Reflection, integration of theories, plus one-to-one supervision, case conferences, team meetings and field supervision (15) Data collection supervised by NFP Nat'l Office and their reports (incl. program fidelity) (16) Implementing agency is located by local organization known as provider of prevention services to low-income families 	<ul style="list-style-type: none"> Demonstrates motivation will learn best practices Meets criteria of grant Insures early adoption of best practices Fosters client connection Invites full participation Insures continuity as well as developmental improvement Provides professional approach Covers full array of needed education & insures program success Provides customized approach to each family Assures reasonable caseload Provides appropriate supervision to insure program fidelity Ensures educational & clinical topics are taught Ensures assessment is valid Helps integrate program into the community

(17) Agency convenes a LT Community Advisory Board quarterly to promote community support	Generates community system support
(18) Support & structure in place to implement and enter data in a timely manner	Permits careful evaluation of results

Each of these steps is considered a crucial component of the NFP program. Fidelity to the program enables NFP Headquarters to measure progress against goals, make adjustments if needed, and to eventually report on positive outcomes for the program. All of these elements are designed to: (1) improve the health outcomes of the target population through the use of community based health workers (Nurse Home Visitors and Nurse Supervisor), (2) engage underserved racial and ethnic minority persons in the Health Enterprise Zone, (3) enhance provider capacity to serve non-English speakers in an HEZ, and (4) improve the quality of service delivery as dictated by HEDIS measures.

j. Carry out regular trainings (at least twice a year) in cultural competency and family-centered interventions in order to ensure that families are true partners in the plans and care they receive.

k. Use good working relationships with the Bureau of Behavioral Health at BCDH to facilitate linkages for services to access mental health and substance abuse treatment services in a timely fashion.

l. Collaborate with the Bureau of Healthcare Access to locate resources for healthcare for those who do not qualify for medical assistance, with the Department of Human Services to make sure specific needs are addressed, and with WIC for additional nutritional counseling and food supplementation.

m. Take advantage of the multiple modalities of intervention within BCDH to access and implement the best tobacco cessation program for a given client's needs. This might involve individual counseling, group support, medication, etc. depending on the specific client's needs.

n. Collect data on a regular basis as required by the NFP as well as any additional data required for the grant. This will be collected by the PHN and entered into one of two data management systems by the office assistant – the NFP one whenever possible since they will generate regular reports for us and a BCDH one for any additional data needed for this grant.

o. Provide on-going education for staff and monitoring of quality of services using NFP model for quality control.

p. Implement plans for sustaining the program including necessary additional financing as well as conversion of staff positions to County positions.

10. Use of Incentives and Benefits

Baltimore County is asking for funds to develop a module in an electronic health record for recording the client interactions within this program. Currently the BCDH uses Visual Health

Net for its electronic medical record but there is no module that is appropriate for this program at present so funds have been allocated to develop this module.

Baltimore County will assist health care providers hired under this grant in applying for any loan repayment assistance that may be available on either a State or a Federal level if requested by the employee.

Baltimore County will explore further with the Commission about whether any of the employees hired under this grant might be eligible for tax credits against State Income Tax.

11. Cultural, linguistic, and health literacy competency

Research has demonstrated that an individual's culture has substantial impact on his or her health beliefs and behaviors. Furthermore, culture has been shown also to influence the level of importance that a person will place upon changing his or her health-related behavior. Success of a health care program takes place only if the program is developed and implemented to be sensitive to and consistent with the individual and family's culture. Care must be taken not to assume that all individuals with a given race or ethnicity share the same cultural values. Rather, each individual's cultural values and beliefs should be respected by those providing care and the interventions should be based on the values and priorities of the individual.

One central part of the group training and individual supervision in this project is helping the nurse home visitors learn how to ask about a person's values and beliefs, respect those beliefs, and help develop a plan with the individual client that is compatible with his or her cultural values and beliefs. The NFP model stresses this as a core element of the program and additional training will be provided in collaboration with other programs within BCDH. There are numerous resources we can draw on for this training including materials developed by the Georgetown Center for Cultural Competence, web-based materials through the federal Health Resources Services Administration (HRSA), the BCDH On-Site Translator hired to work specifically with the Latino populations regarding service delivery, Dr. Grossman who has led workshops at national meetings regarding cultural competence (the Pediatric Academic Societies' Annual Meetings), etc.

Every effort will be made to hire public health nurses for this project who strongly believe in families as partners in care and understand the importance of care being delivered in a culturally competent fashion. Efforts will be made to give priority to hiring staff that represent the ethnic and racial backgrounds of the clients to be served and efforts will especially be made to hire one nurse who is fluent in Spanish. When possible, staff will be assigned to serve clients from similar racial and ethnic backgrounds. When a Spanish speaking staff member is not available, either an interpreter from BCDH will go along on the visit or the language line will be used for interpretation.

All print materials distributed through this program have been extensively tested for cultural, linguistic and health competency. Reading levels of the materials to be used range from 3rd to 7th grade with none higher than 7th grade. All materials (NFP, Ages and Stages, and other materials provided) are available in both English and Spanish.

12. Applicant Organization and Key Personnel

Applicant Organization

The mission of the Baltimore County Department of Health (BCDH) is to promote health and prevent disease through education, advocacy, and linkage to resources and treatment in order to improve the quality of life for Baltimore County residents. BCDH is comprised of five organizational components or Bureaus: Behavioral Health; Clinical Services; Community Health Services; Healthcare Access; and Prevention, Protection, and Preparedness (Attachment 12-1). Baltimore County Department of Health is part of a combined Department of Health and Human Services (Attachment 12-2). This combination facilitates linkages to extensive social services supports when necessary as well as the relevant programs of the Department of Health.

The HEZ initiative will be managed within the Bureau of Clinical Services. Clinical Services provides services in four divisions: Center-Based Services; Pregnancy and Early Childhood Program; Women's, Infants', and Children's Supplemental Nutrition Services (WIC); and School and Adolescent Health Services. Center-Based Services, Pregnancy and Early Childhood Program, and WIC are all directly relevant to this grant and will be partners in the activities under this grant. Center-based Services encompasses family planning, dentistry, immunizations, sexually transmitted disease diagnosis and treatment, and limited well child care. Pregnancy and Early Childhood Program includes a wide range of services from the Prenatal Enrichment Program for high risk pregnant women, the Lead Program to provide case management of childhood cases of elevated lead levels, Bright Beginnings for high risk infants, early intervention services through Infants and Toddlers Program, audiology services, and case management services for children with disabilities and their families. The Bureau of Clinical Services has a close working relationship with Behavioral Health to facilitate access to mental health and substance abuse treatment as well a good working relationship with Healthcare Access thus making it easier to access assistance in signing up clients for Medicaid for the pregnant woman and Medicaid or MCHIP for the new baby. These close relationships will be key to the success of this project as well.

Key Personnel

Program Director: Overall leadership of the project will be provided by Linda Grossman, M.D., Bureau Director of Clinical Services. She is Board-Certified in Pediatrics and in Developmental-Behavioral Pediatrics. Dr. Grossman will play a major role in the planning of the initiative and will take responsibility for working with the Advisory Board, communicating with high-ranking officials within the community, and forging links with community organizations that will serve as referral sources for the program as well as collaborators with the program. No funding is requested for Dr. Grossman.

Program Administrator: Colleen Freeman, RN, the Division Chief for Pregnancy and Early Childhood Programs, will provide administrative leadership of the program including day-to-day management of the program as well as addressing issues that arise and coordinating activities of the program. Both she and Dr. Grossman will provide subject-matter consultation and advice throughout the program. The nursing supervisor hired under this program will report directly to Ms. Freeman. No funding is requested for Ms. Freeman.

Nursing Supervisor: A nursing supervisor will be hired 25 hours per week to supervise the day to day activities of the five public health nurses who will serve as home nurse visitors under this new Nurse Family Partnership project. Ideally her background will include home visiting with pregnant women and/or families with young children. She will provide one-to-one supervision of the public health nurses who provide the in-home services, organize and lead group supervision and education sessions, and perform other administrative tasks. She will be responsible for fidelity to the program's requirements. She also will supervise the office assistant.

Public Health Nurses (5): Five part-time (32 hour per week) public health nurses (PHN) will be hired to serve as the nurse home visitors. They will be responsible for direct delivery of services primarily in the client's home. All will be registered nurses with a Maryland license to practice nursing. A minimum of a baccalaureate degree in nursing is required for each of these positions as per the NFP requirements. All will complete core educational sessions required by the Nurse-Family Partnership National Service Office (NSO) as their first activity in the project. They will be responsible for working with our community partners to get referrals that meet program requirements and enrolling clients in the program. Then they will deliver the intervention services according to the NFP model. Each will carry a caseload of 20 families as per NFP caseload requirements.

Office Assistant: A part-time (34 hour per week) office assistant will be responsible for recording data, photocopying forms as necessary, preparing binders for program participants, and managing telephone communications of the program. He or she will report directly to the nursing supervisor.

Contractual Personnel: Nurse Family Partnership personnel will be provided under contractual services to administer training as well as providing on-going advice and consultation regarding the planning, implementation of the program, data collection and analysis to help ensure that program fidelity is maintained and program requirements are met. They also will be responsible for generating reports based on the data submitted at regular intervals.

Attachment Items 12-3 and 12-4 are Curriculum Vitae of critical positions for this project.

13. Coalition Governance and Participating Partners

The HEZ Advisory Board will be based on the current membership of the subcommittee of the Local Health Coalition dedicated to addressing minority low birth weight. Additional invitations to participate in the Advisory Board will be extended to partners especially key to the southeast area of Baltimore County including Medstar Franklin Square Hospital and Johns Hopkins Bayview Hospital as well as membership from the community organizations active in the southeast area.

The names of the proposed HEZ Advisory Board are reflected in Attachment Item 13-1.

14. Work-Plan

Appendix D is the proposed Work Plan for the initiative. It describes the key strategies, activities, and evaluation measures with linkages to the overall goals of the HEZ. It also includes the key actions, implementation timelines, and parties responsible for implementation.

15. Evaluation Plan

A key component of the Nurse Family Partnership is routine collection of data, both to document the services provided and to document outcome measures. The required data collection elements will permit BCDH to assess the effectiveness of this intervention as an additional component of its efforts to address minority infant mortality in Baltimore County as well as its on-going efforts to improve developmental outcomes for infants and toddlers.

The NFP data collection system is designed to record and report participating family characteristics, needs, services provided, risk and outcome characteristics and progress toward accomplishing program goals. The information is collected during home visits by the PHN home visitors. The NFP central office uses the data generated to evaluate the effectiveness of the program and generates reports for the individual programs based on this data. The BCDH will use the reports to assist in quality improvement, program management, and demonstration of program services and outcomes. The BCDH will also collect data on health indicators and progress of mothers and children in the program.

Risk and outcome indicators collected by NFP programs are as follows:

Pregnancy Health

- Gestational age at which prenatal care began
- Weight gain during pregnancy
- Substance use (cigarette, alcohol, marijuana, cocaine, other substances) during pregnancy
- Any experiences of intimate partner violence during pregnancy
- Government assistance use during pregnancy

Birth Outcomes

- Gestational age at birth
- Birth weight
- Need for intensive care following delivery for the baby

Child Health and Development

- Breast feeding initiation and duration
- Immunizations number and timeliness
- Developmental progress and occurrences of developmental delay
- Language development
- Doctor/ER visits and hospitalizations for injury and ingestion

Maternal Life Course

- Subsequent pregnancies
- Participation in education
- Educational attainment
- Work force participation

- Marital status
- Government assistance use

In addition, the project will collect data regarding on-going source of health care for both the mother and baby and the mother's post pregnancy weight for the duration of the project in order to provide the additional necessary data regarding project goals.

The budget worksheet reflects the costs from the NFP central office for data analysis. The office assistant is responsible for entering data collected by the public health nurses into the NFP data management system.

16. Sustainability

This is an expensive program to initiate due to substantial start-up costs and on-going training and oversight costs. Without funding such as this, it is unlikely that BCDH would be able to initiate this important program.

However, sustaining it is somewhat easier. We anticipate that full implementation of Health Care Reform over the next four to five years will result in a decrease in demand for both family planning and women's health services through BCDH as more young adults have health insurance to cover the costs of preventative care. As a result, we anticipate being able to reassign existing nursing positions to this important outreach effort within several years as our need for staffing in family planning decreases. Currently the vast majority of our staffing for family planning services is County full time staff. We do not anticipate transferring existing nurses into NFP program positions as the skill set required is quite different. However, as staff in family planning retire or leave to take other positions, we will be in a position to reassign the position to this program. Staff hired under this grant then can apply for those full time County positions preserving our well trained staff acquired under this grant.

The ongoing costs of NFP oversight of the program and training any new employees hired will be a persistent issue. However, Federal funds to the Maryland State Department of Health and Human Hygiene's Division of Maternal and Child Health may be available to support this part of the program costs once we are reliably in operation. In the past, MCH has said that they appreciate our needs but could not allocate full start up costs to us. However, they likely will be willing to help support a modest expansion and/or some of the on-going costs, especially in the projected range of \$25,000-\$50,000 per year, if we are able to cover the costs of personnel salaries and fringe benefits. The other potential source of funds to pay for the costs mentioned above are our partners on the Coalition, especially since the services provided are likely to reduce their costs by reducing ER use and NICU stays.

17. Program Budget and Justification

Appendix F reflects the Global Budget Form and Appendix H reflect the BCDH program budget under this application. The program budget is all inclusive of personnel costs, administrative costs, contractual services, equipment costs, travel costs, and miscellaneous costs. For the four (4) year period of the grant, the estimated budget is \$ 2,527,122.

The budget narrative is as follows:

Benefits and Expenses

Electronic Medical Records Conversion

Cost to convert manual paper documents to an electronic records system for data reported by Nurse Home Visitors and Nurse Supervisor when visiting with families is estimated to cost approximately \$ 20,000 for a one time expense.

Personnel

Nurse Supervisor – part time(1)

Year 1:

- Annual salary of \$ 59,637
- 25 hours of 35 hour work week (71%) = \$ 59,637 X (.71) = \$ 42,342
- Employee will work only 11 months for the first year (.92) = \$ 42,342 X (.92) = **\$ 38,954**
- An employee working less than 30 hours per week is not entitled to health benefits; thus the fringe benefit rate drops from 39% to 18% = \$ 38,954 X (.18) = **\$ 7,012.**
- Total = \$ 45,966

Year 2:

- Annual salary of \$ 59,637
- Employee will earn a 5% salary increase \$59,637 X (.015) = \$ 62,619
- 25 hours of 35 hour work week (71%) = \$ 62,619 X (.71) = \$ 44,459
- Employee will work 12 months for the second year (1.00) = **\$ 44,459**
- An employee working less than 30 hours per week is not entitled to health benefits; thus the fringe benefit rate drops from 39% to 18% = \$ 44,459 X (.18) = **\$ 8,003**
- Total = \$ 52,462

Year 3:

- Annual salary of \$ 62,619
- Employee will earn a 5% salary increase \$ 62,619 X (.015) = \$ 65,750
- 25 hours of 35 hour work week (71%) = \$ 65,750 X (.71) = \$ 46,683
- Employee will work 12 months for the third year (1.00) = **\$ 46,683**
- An employee working less than 30 hours per week is not entitled to health benefits; thus the fringe benefit rate drops from 39% to 18%. = \$ 46,683 X (.18) = **\$ 8,403**
- Total = \$ 55,086

Year 4:

- Annual salary of \$ 65,750
- Employee will earn a 5% salary increase \$ 65,750 X (.015) = \$ 69,038
- 25 hours of 35 hour work week (71%) = \$ 69,038 X (.71) = \$ 49,017
- Employee will work 12 months for the second year (1.00) = **\$ 49,017**
- An employee working less than 30 hours per week is not entitled to health benefits; thus the fringe benefit rate drops from 39% to 18% = \$ 49.017 X (.18) = **\$ 8,823**
- Total = \$ 57,840

Public Health Nurses – part-time (5)

Year 1:

- Annual salary of \$ 56,836
- 32 hours of 35 hour work week (91%) = \$ 56,836 X (.91) = \$ 51,721
- Employee will work only 9 months for the first year (.75) = \$ 51,721 X (.75) = **\$ 38,791**
- An employee working 30 hours or more per week is entitled to health benefits at a rate of 39% = \$ 38,791 X (.39) = \$ 15,128
- Total = \$ 53,919
- Five (5) Nurse Home Visitors = 5 X \$ 53,919 = \$ 269,595

Year 2:

- Annual salary of \$ 56,836
- Employee will earn a 5% salary increase \$56,836 X (.015) = \$ 59,678
- 32 hours of 35 hour work week (91%) = \$ 59,678 X (.91) = \$ 54,307
- Employee will work 12 months for the second year (1.00) = **\$ 54,307**
- An employee working 30 hours or more per week is entitled to health benefits at a rate of 39% = \$ 54,307 X (.39) = **\$ 21,180**
- Total = \$ 75,487
- Five (5) Nurse Home Visitors = 5 X \$ 75,487 = \$ 377,435

Year 3:

- Annual salary of \$ 59,678
- Employee will earn a 5% salary increase \$ 59,678 X (.015) = \$ 62,662
- 32 hours of 35 hour work week (91%) = \$ 62,662 X (.91) = \$ 57,022
- Employee will work 12 months for the third year (1.00) = **\$ 57,022**
- An employee working 30 hours or more per week is entitled to health benefits at a rate of 39% = \$ 57,022 X (.39) = **\$ 22,239**
- Total = \$ 79,261
- Five (5) Nurse Home Visitors = 5 X \$ 79,261 = \$ 396,305

Year 4:

- Annual salary of \$ 62,662
- Employee will earn a 5% salary increase \$ 62,662 X (.015) = \$ 65,795
- 32 hours of 35 hour work week (91%) = \$ 65,795 X (.91) = \$ 59,874
- Employee will work 12 months for the second year (1.00) = **\$ 59,874**
- An employee working 30 hours or more per week is entitled to health benefits at a rate of 39% = \$ 59,874 X (.39) = **\$ 23,351**
- Total = \$ 83,225
- Five (5) Nurse Home Visitors = 5 X \$ 83,225 = \$ 416,125

Administrative Assistant – part time for Data Entry/Administrative Support (1)

Year 1:

- Annual salary of \$ 31,262
- 34 hours of 35 hour work week (97%) = $\$ 31,262 \times (.97) = \$ 30,324$
- Employee will work only 10 months (83%) for the first = $\$ 30,324 \times (.83) =$
\$ 25,169
- An employee working 30 hours or more per week is entitled to health benefits at a rate of 39% = $\$ 25,169 \times (.39) =$ **\$ 9,816**
- Total = \$ 34,985

Year 2:

- Annual salary of \$ 31,262
- Employee will earn a 5% salary increase $\$ 31,262 \times (.015) = \$ 32,825$
- 34 hours of 35 hour work week (97%) = $\$ 32,825 \times (.97) = \$ 31,840$
- Employee will work 12 months for the second year (1.00) = **\$ 31,840**
- An employee working 30 hours or more per week is entitled to health benefits at a rate of 39% = $\$ 31,840 \times (.39) =$ **\$ 12,418**
- Total = \$ 44,258

Year 3:

- Annual salary of \$ 32,825
- Employee will earn a 5% salary increase $\$ 32,825 \times (.015) = \$ 34,466$
- 34 hours of 35 hour work week (97%) = $\$ 34,466 \times (.97) = \$ 33,432$
- Employee will work 12 months for the third year (1.00) = **\$33,432**
- An employee working 30 hours or more per week is entitled to health benefits at a rate of 39% = $\$ 33,432 \times (.39) =$ **\$ 13,039**
- Total = \$ 46,471

Year 4:

- Annual salary of \$ 34,466
- Employee will earn a 5% salary increase $\$ 34,466 \times (.015) = \$ 36,189$
- 34 hours of 35 hour work week (97%) = $\$ 36,189 \times (.97) = \$ 35,103$
- Employee will work 12 months for the third year (1.00) = **\$35,103**
- An employee working 30 hours or more per week is entitled to health benefits at a rate of 39% = $\$ 35,103 \times (.39) =$ **\$ 13,690**
- Total = \$ 48,793

Grand total of personnel costs inclusive of salary and benefits for the four (4) year term of the project is \$ 1,845,321.

Equipment/Furniture/Laptops

Equipment and Laptops

- Light weight laptops (\$ 1,810) with software (\$ 320) and printer (\$ 400) totaling \$ 2,530 each for one (1) Nurse Supervisor and five (5) Nurse Home Visitors for a total of 6 units = \$ 15,180 for one time expense
- Desktop computer (\$ 770), software (\$320), and printer (\$ 400) for one (1) Data Entry/Support Person = \$ 1,490 for one time expense
- Cellular phones for \$ 1.00 per Nurse times 6 nurses = \$ 6.00 for one time expense

Furniture

- Desks (7), Chairs (7) and bookcases (7) at a cost of \$ 2000 per unit X 7 = \$ 14,000 for a one-time expense

Supplies

One time expenses

- NCAST materials at \$ 1,138 for one time expense
- PIPE materials of \$ 2,695 for one time expense
- HOME IT Assessment materials of \$ 75 for one time expense
- ASQ-Social Emotional in English and Spanish (\$ 400)

Total: \$ 4,308

Recurring expenses

- Medical & Program Supplies of \$ 412 per Nurse Home Visitors X 5 = \$ 2,060 in Year 1 and one-half that in future years with a 5% increase in costs
Year 1: \$ 2,060
Year 2: \$ 1,082
Year 3: \$ 1,136
Year 4: \$ 1,193
- Office supplies are estimated to cost \$ 371 per Nurse for Year 1. For the 6 nurses including the Nurse Supervisor, the estimated cost would be \$ 2,226 for Year 1 with a 5% increase in cost per year.
Year 1: \$ 2,226
Year 2: \$ 2,337
Year 3: \$ 2,454
Year 4: \$ 2,577
- Client Support Materials of \$ 52 per family per year for 100 families totals \$ 5,200 per year
- Copy of forms/facilitators of \$ 68 per family per year for 100 families total \$ 6,800 per year

Training

- Dyadic Measurement Training of \$ 5,870 for one time expense

Travel/Mileage/Parking

- Travel of Administrator to attend NFP Education course of \$ 1,100 for one time expense
- Travel for five (5) Nurse Home Visitors to education Unit 2 per NHV and one (1) Supervisor of \$ 1,550 each totals \$ 9,300 for one time expense

- Travel of Nurse Supervisor to Education Unit 4 for \$ 1,050 for one time expense
Total one time expenses: \$ 11,450

- Travel of Nurse Supervisor to Annual Education Seminar for \$ 1,050 per year
- Mileage (20 trips/family/year) at .55/mile at 10 miles per trip for six (6) nurses each year totals \$ 11,000 per year for mileage expense
Recurring expenses: \$ 12,050

Contractual Services

NFP charges a number of fees to establish the NFP program in a jurisdiction. These fees have been approved by the NFP Board of Directors, will remain constant for the duration of the grant and are considered contractual services consistent with the contract between the Baltimore County Department of Health and Nurse Family Partnership and include:

One-time fees

- Start-up fee of \$ 25,391
- Nurse Home Visitors Initial Education Tuition of \$ 4,069 each for a total of \$ 20,345 for a one-time expense.
- Supervisor Initial Education Tuition of \$ 4,803 for a one-time expense.
- Administrator Initial Education Tuition of \$ 480 for a one-time expense.
- Nurse Education materials of \$ 517 including Supervisor equals 6 X \$ 517 for a one time expense of \$ 3,102.

Total: \$ 54,121

Recurring expenses

- Professional development of \$ 515 per Nurse per year totals \$ 3,090 per year.
- Program Support Fee of \$ 7,046 per year.
- Nurse Consultation Fee of \$ 8,447 per year.

Other

Postage of \$ 6.00 per family per year totals \$ 600 per year with a 5% increase per year

Year 1: \$ 600
Year 2: \$ 630
Year 3: \$ 662
Year 4: \$ 695

Computer wireless network fees of \$ 43 per month for one (1) Nurse Supervisor and five (5) Nurse Home Visitors for a total of six monthly network fees = \$ 3,096 per year

Year 1: \$ 3,096
Year 2: \$ 3,251
Year 3: \$ 3,413
Year 4: \$ 3,585

Cellular usage fees of \$ 75 per month for six (6) nurses for a total monthly fee of \$ 450 X 12 months per year = \$ 5,400 annual expense

Year 1: \$ 5,400

Year 2: \$ 5,670
Year 3: \$ 5,954
Year 4: \$ 6,252

18. Financial audits

N/A due to the Coordinating Organization being a local government entity

Appendix Item A

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION
Health Enterprise Zone – Eligibility Worksheet

All Health Enterprise Zone (HEZ) applicants must complete this Eligibility Worksheet as part of the Letter of Interest process (due October 19, 2012). The CHRC staff will certify proposed HEZ community eligibility, and eligible applicants will be invited to submit an HEZ proposal to the CHRC.

All proposed HEZs must meet the following Community Eligibility Criteria (see page 4 in the Call for Proposals):

- The area proposed is contiguous geographically;
- The population in the proposed area is at least 5,000;
- An HEZ must demonstrate economic disadvantage by having either a Medicaid enrollment rate above 109 per 1,000 residents or a WIC participation rate of 17.9 per 1,000 residents.
- An HEZ must demonstrate poor health outcomes by having either a life expectancy below 79.2 years, or a percentage of low birth weight infants above 6.3%.

1: Attach a map of the proposed HEZ area that clearly identifies the zip code or sub-zip codes that are part of the proposed HEZ. Applicants must include the specific HEZ area (if using sub-zip code level) as part of this map.

2: Complete Table 1 by providing the population for each zip code or sub-zip code areas that are part of the proposed HEZ.

Table 1. (add or remove lines as needed)

Zip Code(s)/Other Geographic Boundary	Population
<i>e.g., 21218</i>	<i>49,796</i>
Total Population	<i>49,796</i>

3: Complete Table 2 by providing the data for each zip code that is part of the proposed HEZ (add or remove lines as needed). If the proposed HEZ area uses a sub-zip code geographic boundary (i.e., Census Tracts), provide the data for the zip code(s) where the HEZ will be located. The zip code(s) included in the proposed HEZ designated area must meet each of the Community Eligibility Criteria, even if a sub-zip code area is used (e.g., A proposed HEZ includes Census Tract 902.00. C.T. 902.00 is located in zip code 21218. Data for zip code 21218 should be provided in Table 2)

Table 2. (add or remove lines as needed)

Zip Code(s)	Economic Disadvantage Criteria		Poor Health Outcome Criteria	
	Medicaid Enrollment Rate (per 1,000 residents)	WIC Enrollment Rate (per 1,000 residents)	Life Expectancy	Percentage Low Birth Weight
<i>e.g. 21218</i>	<i>268.27/1,000</i>	<i>29.98/1,000</i>	<i>73.6 years</i>	<i>12.4%</i>

Data: Resident Population data by zip code can be found using the 2010 U.S. Decennial Census available at <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>.

Economic Disadvantage and Poor Health Outcome Criteria data can be found at the Maryland HEZ Viewer Data available at <http://eh.dhmdh.md.gov/hez/index.html>.

Review by CHRC Staff (Applicant does not complete)

	Medicaid Enrollment Rate	WIC Enrollment Rate	Life Expectancy	Percentage Low Birth Weight
Maryland Median	Above 109/1,000	Above 17.9/1,000	Less than 79.2 years	Above 6.3%
Does each of the zip codes in the proposed HEZ exceed the Maryland median?				
Is the proposed HEZ eligible to submit full proposal?	YES		NO	

APPENDIX ITEM B



STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Annapolis, MD 21401, Room 336

Martin O'Malley, Governor - Anthony G. Brown, Lt. Governor
John A. Hurson, Chairman - Mark Luckner, Executive Director

**Health Enterprise Zones
Call for Proposals
Cover Sheet FY2013**

Applicant Organization:

Name: Baltimore County Department of Health

Federal Identification Number (EIN): 52-6000-889

Street Address: 6401 York Road

City: Baltimore State: MD Zip Code: 21212 County: Baltimore

Official Authorized to Execute Contracts:

Name: Fred Homan E-mail: fhoman@baltimorecountymd.gov

Title: Administrative Officer, Baltimore County, MD

Phone: 410-887-2460 Fax: 410-887-5781

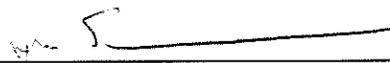
Signature:  Date: 11/14/12

Project Director (if different than Authorized Official):

Name: Dr. Linda Grossman E-mail: lgrossman@baltimorecountymd.gov

Title: Director, Bureau of Clinical Services, Baltimore County Department of Health

Phone: 410-887-3422 Fax: 410-377-9646

Signature:  Date: 11/15/12

Alternate Contact Person:

Name: Douglas Zinn E-mail: dzinn@dhr.state.md.us

Title: Grants Specialist

Phone: 410-853-3207 Fax: 410-853-3225

HEZ Project Name: Reducing Health Disparities in Baltimore County

Appendix Item C - Assurances

STATEMENT OF OBLIGATIONS, ASSURANCES, AND CONDITIONS

In submitting its grant application to the Maryland Community Health Resources Commission (“Commission”) and by executing this Statement of Obligations, Assurances, and Conditions, the applicant agrees to and affirms the following:

1. All application materials, once submitted, become the property of the Maryland Community Health Resources Commission.
2. All information contained within the application submitted to the Commission is true and correct and, if true and correct, not reasonably likely to mislead or deceive.
3. The applicant, if awarded a grant, will execute and abide by the terms and conditions of the Standard Grant Agreement (attached).
4. The applicant affirms that in relation to employment and personnel practices, it does not and shall not discriminate on the basis of race, creed, color, sex or country of national origin.
5. The applicant agrees to comply with the requirements of the Americans with Disabilities Act of 1990, where applicable.
6. The applicant agrees to complete and submit the Certification Regarding Environmental Tobacco Smoke, P.L. 103-227, also known as the Pro-Children Act of 1994.
7. The applicant agrees that grant funds shall be used only in accordance with applicable state and federal law, regulations and policies, the Commission’s Call

for Proposals, and the final proposal as accepted by the Commission, including Commission-agreed modifications (if any).

8. If the applicant is an entity organization under the laws of Maryland or any other state, that is in good standing and has compiled with all requirements applicable to entities organized under that law.

9.

AGREED TO ON BEHALF OF Baltimore County on behalf of the Department of Health
(Applicant name)

BY:

Fred Homan, County Administrator
Legally Authorized Representative Name (Please PRINT Name) Title


Legally Authorized Representative Name (Signature) Title

11/14/12

APPENDIX ITEM E - Work-plan Chart, Sample

**MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION
Health Enterprise Zones - Work-plan Chart, Sample**

Organization Name: Community Organization Y

HEZ Project Name: Underserved Community X

Grant Program Name: Reducing cancer disparities and improving health outcomes for Hispanic/Latina women

PROJECT PURPOSE: To improve health outcomes and reduce health disparities for Hispanic/Latina women at risk for or with cancer.

Goal #1 : Increase the number of Hispanic/Latina women 40 years and older screened for breast cancer.

Measure of Success: Five thousand Hispanic/Latina women 40 years and older women will be screened for breast cancer, an increase of 1,000 over last year

Objective	Program Activities/Action Steps	Expected Outcome	Data and Evaluation Measures	Organization/Person Responsible	Timeframe
<p>1. Within 12 months, through teaming with the community-based providers, the public education coordinator and outreach workers will recruit at least 500 women to enroll in breast cancer screening in the HEZ-Underserved Community X.</p>	<p>1a. Develop and pilot test public education materials to be available at area stores and service locations (i.e. Beauty Salons).</p>	<p>Increase awareness of breast cancer screening program among target population.</p>	<p># of stores and service locations with public education materials; # of women who enroll in breast cancer screening program who reference public education materials; # the enrolled women referred by public education materials; who actually get screened.</p>	<p>Community Organization Y- Public Education Coordinator</p>	<p>March 2013 - Develop education materials; June 2013 - test and Refine Materials; June 2013 - Ongoing, distribute public education materials to stores and shops.</p>
	<p>1b. Provide training for peer recruitment at a local community-based organizations and faith community coalition members.</p>	<p>Improve knowledge of breast cancer screening program and peer recruitment techniques among target population.</p>	<p># of local community-based organizations and faith community coalition members participating in peer recruitment training; # of peer recruitment trainings; # of women trained in peer recruitment; # of women who enroll in breast cancer screening program referred by a peer recruiter; Total # the enrolled women referred by a peer recruiter who actually get screened.</p>	<p>Community Organization Y- Outreach Coordinator, community based and faith based coalition members</p>	<p>March 2013 - Develop peer recruitment presentation and materials; March 2013 - Ongoing - Conduct peer recruitment sessions.</p>

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION
Health Enterprise Zones - Global Budget Form Template (Blank)

Coordinating Organization Name: Baltimore County Department of Health

HEZ Project Name: Reducing Health Disparities in Eastern Baltimore County

Directions: All applicants must complete the Global Budget Template which provides the annual and total budget request by program benefit and incentive requested. Applicants should choose from the listed benefits and incentives (items 1-8). Applicants are not required to request funding in each benefit or incentives area. Applicants requesting CHRC Grant Funding for health programs are required to list each partnering organization and grant request amount under item 8. CHRC Grant Funding and complete the Program Budget Form for each organization. Add or remove lines for CHRC Grant Funding as needed.

Budget Request for Benefits and Incentives Applicants should choose from the listed benefits and incentives (items 1-8) and do not need to request funding from each benefit or incentives	Year 1 (January - December 2013)	Year 2 (January - December 2014)	Year 3 (January - December 2015)	Year 4 (January - December 2016)	Total HEZ Request
1. State Tax Credits					
2. Hiring Tax Credits					
3. Loan Repayment Assistance					
4. Participation in the Patient Centered Medical Home Program					
5. Electronic Health Records	20,000	\$0	\$0	\$0	\$20,000
6. Capital or Leasehold Improvements					
7. Medical or Dental Equipment					
8. CHRC Grant Funding*					
8a. Baltimore County Dept. of Health	512986	\$529,758	\$554,283	\$580,470	\$2,177,497
8b. Insert Organization 2					
8c. Insert Organization 3					
8d. Insert Organization 4					
Subtotal for Benefits and Incentives	532986	529758	554283	580470	2197497
9. Data Collection and Evaluation**	26649	\$26,488	\$27,714	\$29,024	\$109,875
10. Indirect Costs***	53299	\$52,976	\$55,428	\$58,047	\$219,750
Totals	612934	609222	637425	667541	2527122

* Applicants requesting CHRC Grant Funding must also complete Program Budget Form

** Data collection and evaluation should be between 5-10% of the subtotal for benefits and incentives.

*** Indirect Costs may be no more than 10% of the subtotal for benefits and incentives.

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION
Health Enterprise Zones - Global Budget Form, Sample

Coordinating Organization Name: Local Community Nonprofit X

Coordinating Organization

HEZ Project Name: Underserved Community X

Community name of the proposed HEZ

Directions: All applicants must complete the Global Budget Template which provides the annual and total budget request by program benefit and incentive requested. Applicants should choose from the listed benefits and incentives (items 1-8). Applicants are not required to request funding in each benefit or incentives area. Applicants requesting CHRC Grant Funding for health programs are required to list each partnering organization and grant request amount under item 8. CHRC Grant Funding and complete the Program Budget Form for each organization. Add or remove lines for CHRC Grant Funding as needed.

Budget Request for Benefits and Incentives	Year 1 (January - December 2013)	Year 2 (January - December 2014)	Year 3 (January - December 2015)	Year 4 (January - December 2016)	Total HEZ Request
1. State Tax Credits	\$100,000	\$100,000	\$100,000	\$100,000	\$400,000
2. Hiring Tax Credits	\$0	\$0	\$0	\$0	\$0
3. Loan Repayment Assistance	\$70,000	\$145,000	\$145,000	\$125,000	\$485,000
4. Participation in the Patient Centered Medical Home Program	\$0	\$0	\$0	\$0	\$0
5. Electronic Health Records	\$100,000	\$100,000	\$100,000	\$100,000	\$400,000
6. Capital or Leasehold Improvements	\$150,000	\$75,000	\$75,000	\$75,000	\$375,000
7. Medical or Dental Equipment	\$20,000	\$20,000	\$20,000	\$20,000	\$80,000
8. CHRC Grant Funding*	\$352,500	\$350,912	\$362,212	\$345,675	\$1,411,300
8a. Local Health Department	\$77,500	\$75,250	\$75,500	\$75,000	\$303,250
8b. Community Organization Y	\$125,000	\$125,012	\$124,957	\$128,603	\$503,573
8c. Community Organization Z	\$50,000	\$55,000	\$65,000	\$75,000	\$245,000
8d. Community Clinic X	\$100,000	\$95,650	\$96,755	\$93,745	\$386,150
Subtotal for Benefits and Incentives	\$1,145,000	\$1,141,825	\$1,164,425	\$1,138,023	\$4,589,272
9. Data Collection and Evaluation**	\$114,500	\$114,182	\$116,442	\$113,802	\$458,927
10. Indirect Costs***	\$114,500	\$114,182	\$116,442	\$113,802	\$458,927
Totals	\$1,259,500	\$1,256,007	\$1,280,867	\$1,251,825	\$5,048,200

Line 8. CHRC Grant Funding is the subtotal of the Organization requests (lines 8a-8d) below.

The sum of the request for benefits and incentives (items 1-8).

The annual total is the sum of the subtotal for benefits and incentives (lines 1-8), data collection (line 9), and indirect costs

* Applicants requesting CHRC Grant Funding must also complete Program Budget Form
 ** Data collection and evaluation should be between 5-10% of the subtotal for benefits and incentives.
 *** Indirect Costs may be no more than 10% of the subtotal for benefits and incentives.

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION
Health Enterprise Zones - Program Budget Template (Blank)

Organization Name: Baltimore County Department of Health
HEZ Project Name: Reducing Health Disparities in Eastern Baltimore County
Grant Program Name: Nurse-Family Partnership Program

Directions: HEZ application that include requests for CHRC Grant Funds (Line item 8 in the Global Budget Form) for health programs must complete this budget form for each organization requesting funds. Use the line-items below to provide the annual budget (Years 1 - 3) and the total organization's program budget request for the three-year program duration. Attached to this Program Grant Budget Template, submit a concise budget justification. In the budget justification, detail what is included in each line-item and describe how each item will support the achievement of program's goals and objectives.

Budget Request for CHRC Grant Funding <small>(remove lines as needed)</small>	Year 1 (January - December 2013)	Year 2 (January - December 2014)	Year 3 (January - December 2015)	Year 4 (January - December 2016)	Total Organization Request
Personnel Salary					
71% FTE/Nurse Supervisor	\$38,954	\$44,459	\$46,683	\$49,017	\$179,113
91% FTE/Nurse Home Visitor	\$38,791	\$54,307	\$57,022	\$59,874	\$209,994
91% FTE/Nurse Home Visitor	\$38,791	\$54,307	\$57,022	\$59,874	\$209,994
91% FTE/Nurse Home Visitor	\$38,791	\$54,307	\$57,022	\$59,874	\$209,994
91% FTE/Nurse Home Visitor	\$38,791	\$54,307	\$57,022	\$59,874	\$209,994
91% FTE/Nurse Home Visitor	\$38,791	\$54,307	\$57,022	\$59,874	\$209,994
97% FTE/Data Entry/Support	\$25,169	\$31,840	\$33,432	\$35,103	\$125,544
1. Personnel Subtotal	\$258,078	\$347,834	\$365,225	\$383,490	\$1,354,627
2. Personnel Fringe/39% (see narrative)	\$92,468	\$126,321	\$132,637	\$139,268	\$490,694
3. Equipment/Furniture/Laptops (6)	\$30,676	\$0	\$0	\$0	\$30,676
4. Supplies/see Narrative	\$20,594	\$15,419	\$15,759	\$16,547	\$68,319
5. Travel/Mileage/Parking	\$23,500	\$12,050	\$12,050	\$12,050	\$59,650
6. Staff Trainings/Development	\$5,870	\$0	\$0	\$0	\$5,870
7. Contractual	\$72,704	\$18,583	\$18,583	\$18,583	\$128,453
8. Other Expenses	\$9,096	\$9,551	\$10,029	\$10,532	\$39,208
Direct Costs Subtotal (lines 1-8)	\$512,986	\$529,758	\$554,283	\$580,470	\$2,177,497
Indirect Costs (no more than 10% of direct costs)	\$51,299	\$52,975	\$55,428	\$58,047	\$217,750
Totals	\$564,285	\$582,733	\$609,711	\$638,517	\$2,395,247

APPENDIX ITEM I - Program Budget Form, Sample

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION
Health Enterprise Zones - Program Budget, Sample

Partnering organization receiving grant funds to implement a health program.

Organization Name: Community Organization Y

HEZ Project Name: Underserved Community X

Community name of the proposed HEZ.

Grant Program Name: Reducing cancer disparities and improving health outcomes for Hispanic/Latina women

Directions: HEZ application that include requests for CHRC Grant Funds (Line item 8 in the Global Budget Form) for health programs must complete this budget form for each organization requesting funds. Use the line-items below to provide the annual budget (Years 1 - 3) and the total organization's program budget request for the three-year program duration. Attached to this Program Grant Budget Template, submit a concise budget justification. In the budget justification, detail what is included in each line-item and describe how each item will support the achievement of program's goals and objectives.

Budget Request for CHRC Grant Funding <small>Add or remove lines as needed</small>	Year 1 (January - December 2013)	Year 2 (January - December 2014)	Year 3 (January - December 2015)	Year 4 (January - December 2016)	Total Organization Request
Personnel Salary					
1a. 100% FTE - Jane Smith, RN	\$55,000	\$57,000	\$59,000	\$61,000	\$232,000
1b. 25% FTE - John Smith, Case Manager	\$13,750	\$14,500	\$15,250	\$15,500	\$59,000
1c. 10% FTE - Joe Smith, Supervisor	\$9,847	\$10,150	\$10,400	\$10,750	\$41,147
1. Personnel Subtotal	\$78,597	\$81,650	\$84,650	\$87,750	\$244,897
2. Personnel Fringe (15% - Rate)	\$11,790	\$12,248	\$12,698	\$13,163	\$36,735
3. Equipment/Furniture	\$7,500	\$0	\$0	\$0	\$7,500
4. Supplies	\$10,000	\$10,000	\$10,000	\$10,000	\$40,000
5. Travel/Mileage/Parking	\$750	\$750	\$750	\$750	\$3,000
6. Staff Trainings/Development	\$2,500	\$2,500	\$2,500	\$2,500	\$10,000
7. Contractual	\$0	\$0	\$0	\$0	\$0
8. Other Expenses	\$2,500	\$6,500	\$3,000	\$2,750	\$14,750
Direct Costs Subtotal (lines 1-8)	\$113,637	\$113,648	\$113,398	\$116,913	\$457,795
Indirect Costs (no more than 10% of direct costs)	\$11,364	\$11,365	\$11,360	\$11,690	\$45,778
Totals	\$125,000	\$125,012	\$124,957	\$128,603	\$503,573

Personnel Subtotal is the sum of all personnel salary costs (1a - 1c).

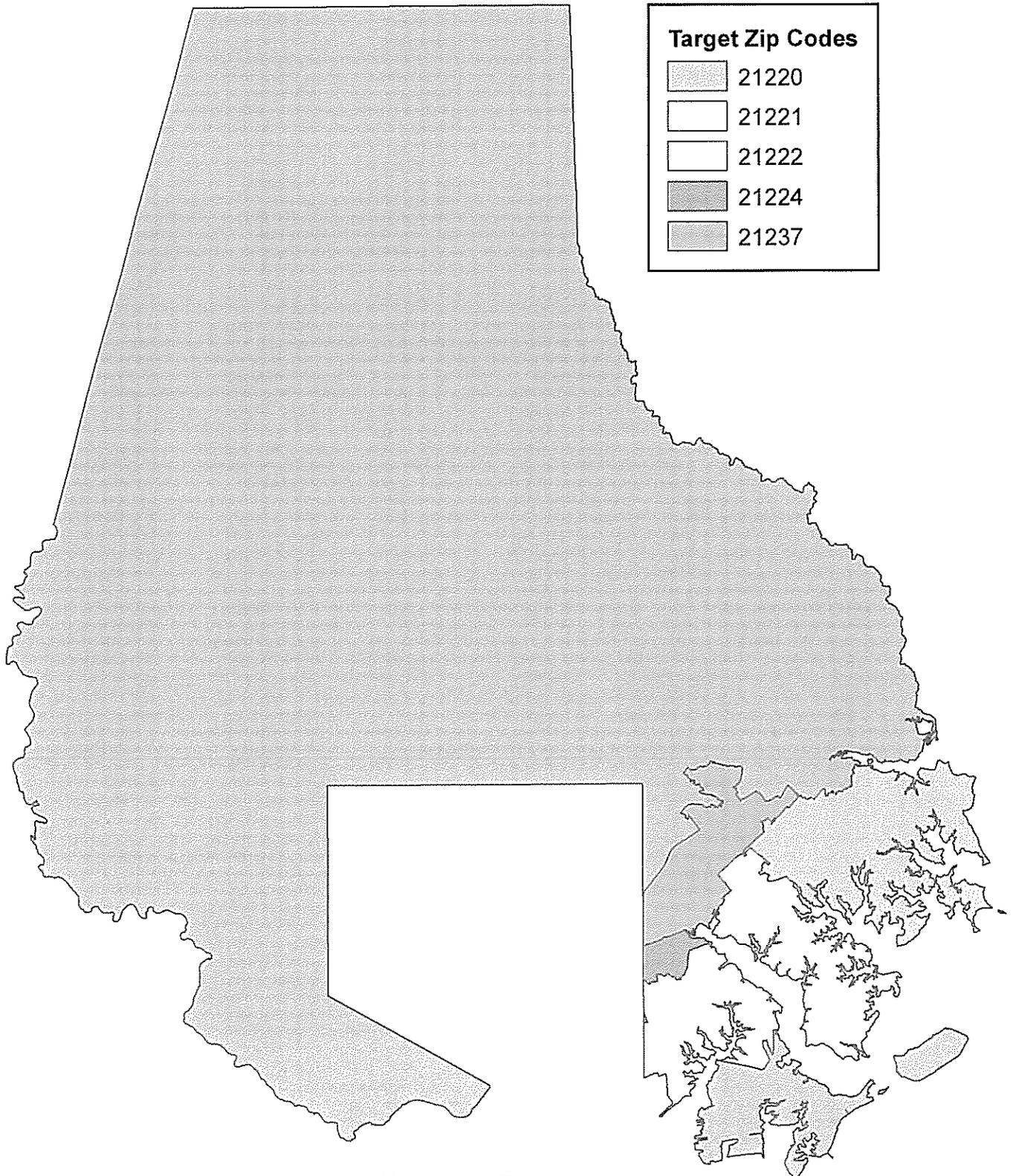
Multiply the Personnel Subtotal by the organization's % Personnel Fringe Rate.

Direct Costs are the sum of line items 1-8.

The annual total is the sum of Direct Costs and Indirect Costs.

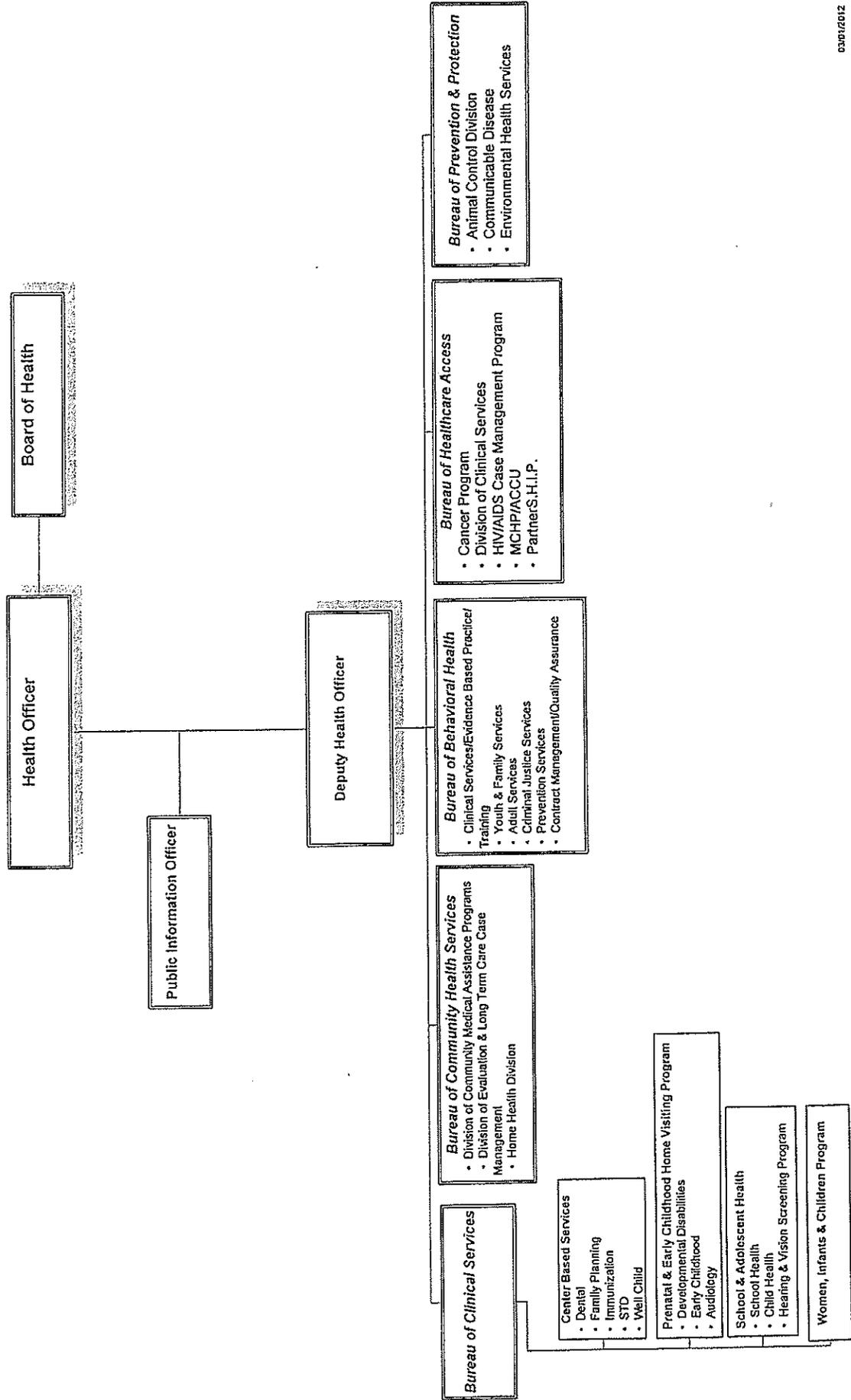
This is the total request for all line items (1-8) for the four-year program period.

Baltimore County HEZ Proposed Target Communities



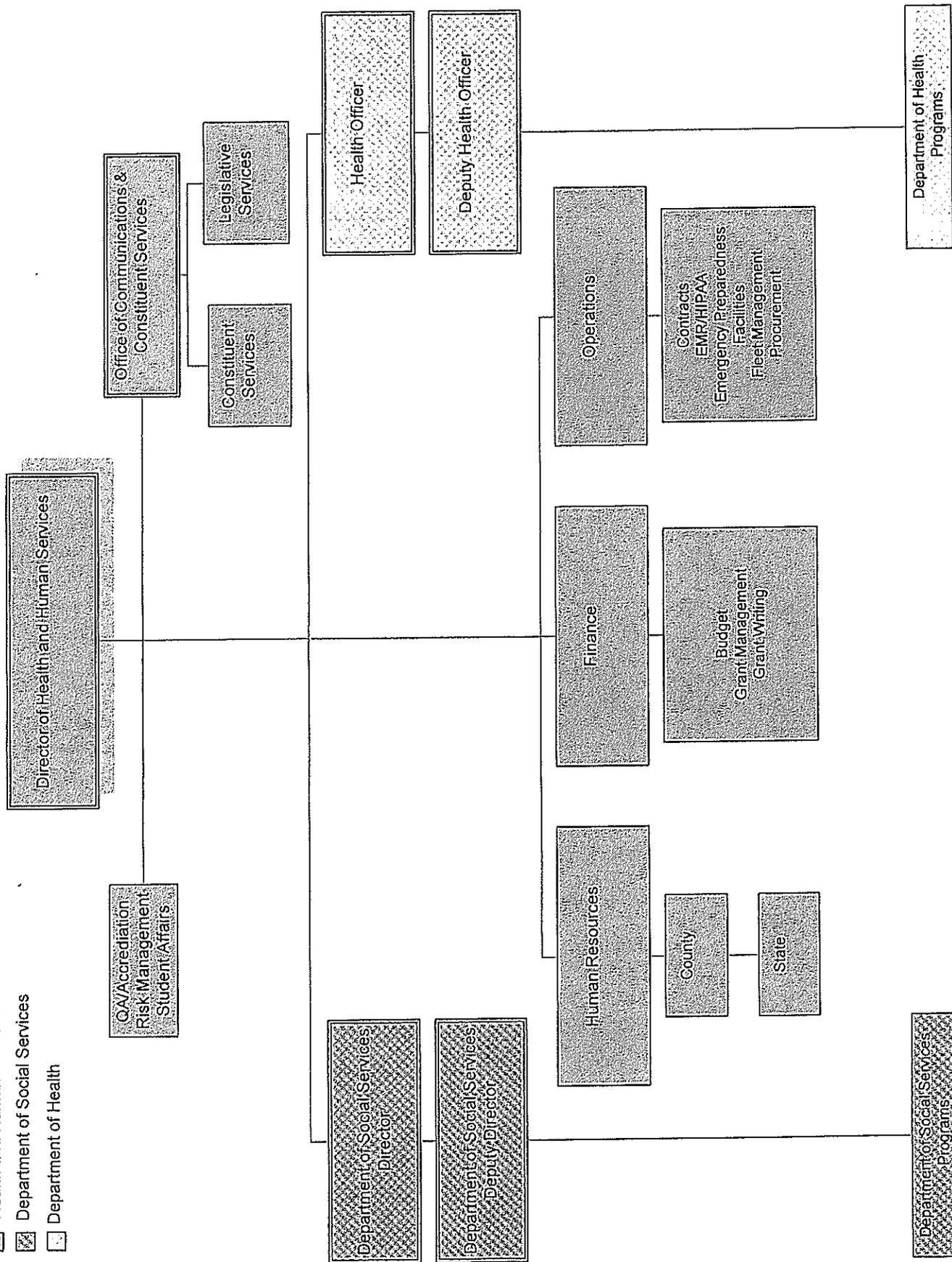
Map created by the Baltimore County Local Management Board
for the exclusive use of the Baltimore County Department of Health.

Baltimore County Department of Health Organization Chart



Health and Human Services Table of Organization

- Health and Human Services
- Department of Social Services
- Department of Health



CURRICULUM VITAE**Linda Elizabeth Sullivan Grossman, M.D.**

TITLE AND ADDRESS: Director, Bureau of Clinical Services
Baltimore County Department of Health
6401 York Road, 3rd Floor
Baltimore, MD 21212

TELEPHONE: 410-887-3422 (office)
410-296-7131 (home)

EDUCATION: A.B., Radcliffe College, 1969
M.D., University of Rochester School of Medicine, 1973

POSTGRADUATE TRAINING:
Fellow in Behavioral Pediatrics
University of Maryland School of Medicine
July, 1979 - June, 1982

Residency - Combined Medicine and Pediatrics
University of Rochester, Rochester, New York
July, 1973 - June, 1976

BOARD CERTIFICATION: Pediatrics (April, 1979)
Developmental-Behavioral Pediatrics (November, 2002)

MEMBERSHIPS IN PROFESSIONAL ASSOCIATIONS:
Society for Developmental and Behavioral Pediatrics, 1983 - present
Nominating Committee (elected position) , 1994-95, 2007-08
Program Director, 1997 – 2003
Education Committee, 2002 - present
Liaison to Ambulatory Pediatric Association, 1997 – 2004
American Academy of Pediatrics – 2007- present
Maryland Chapter of the American Academy of Pediatrics –
Emotional Health Committee, 1993 – present
School Health Committee, 1997- present

WORK EXPERIENCE:
Director, Bureau of Clinical Services
Baltimore County Department of Health
July 2009 – present

Director, Bureau of Child, Adolescent and Reproductive Health
Baltimore County Department of Health
March 2008 – June 2009

Clinical Associate Professor of Pediatrics
University of Maryland School of Medicine
Baltimore, MD
March 2008 - present

Head, Division of Behavioral and Developmental Pediatrics
Department of Pediatrics, University of Maryland
November 2003 – March 2008

Interim Head, Division of Behavioral and Developmental Pediatrics
Department of Pediatrics, University of Maryland
June 2002 – November 2003

Interim Co-Head, Division of Behavioral and Developmental Pediatrics,
Department of Pediatrics, University of Maryland
April 2000 – June 2002

Director, Behavioral and Developmental Pediatrics Fellowship Program
Division of Behavioral & Developmental Pediatrics, University of Maryland
2000 –2008

Associate Professor of Pediatrics
University of Maryland School of Medicine
1999 – 2008

Clinical Associate Professor of Pediatrics
University of Maryland School of Medicine
1997-99

Co-Director, Behavioral and Developmental Pediatrics Fellowship Program
Division of Behavioral & Developmental Pediatrics, University of Maryland
1988 - 2000

Associate Director, Behavioral Pediatrics Fellowship Program
Division of Behavioral & Developmental Pediatrics, University of Maryland
1986 - 1988

Director, School Health and Community Consultation Program
Division of Behavioral & Developmental Pediatrics, University of Maryland
1985 - 2008

Clinical Assistant Professor of Pediatrics
University of Maryland School of Medicine
1982 – 1997

Practicing Pediatrician
Greenwood Clinic
Greenwood, Wisconsin
1976 - 1979

SELECTED NATIONAL AND STATE PROFESSIONAL RESPONSIBILITIES:

Editorial Board, *American Family Physician*, 1993 - 2010

Reviewer:

Journal of Developmental and Behavioral Pediatrics, 1993 - present

American Journal Diseases of Children/ Archives of Pediatric and Adolescent Medicine, 1993 – present

Ambulatory Pediatrics, 1999 – present.

Pediatrics, 2007- present

Journal of Pediatrics – 2010 - present

National Trainer for DSM-PC, American Academy of Pediatrics, 1996 - 1998

Co-Chair, School Health and Mental Health Services Committee of the Health, Mental Health and Safety in Schools Project of the American Academy of Pediatrics, 1999 - 2002.

Member, Planning Committee for American Academy of Pediatrics DB-PREP Intensive Review of Developmental-Behavioral Pediatrics, August 2004, August 2006, and December 2008

Member, Review Panel for HRSA Grants for Leadership Education in Developmental-Behavioral Pediatrics, February 2008.

Member, Sub-Board in Developmental and Behavioral Pediatrics, American Board of Pediatrics, 2010 - 2015

PUBLICATIONS:

Selected Peer Reviewed Papers:

Kenny T, Gaes G, Saylor W, **Grossman L**, Kappelman M, Chernoff R, Toler S, and Majer L: The Pediatric Early Elementary Examination: Sensitivity and specificity. *Journal of Pediatric Psychology*, Vol. 15, No. 1, 1990, pp. 21-26.

Joost JC, **Grossman LS**, McCarter RJ, Verhulst SJ, Winstead-Hall D, and Mehl R: Predictors of frequent middle school health room use. *J Devel Beh Pediatr*, 14:259-263, 1993.

Tellerman K, Chernoff R, **Grossman LS**, Adams P. When a parent dies. *Contemporary Pediatrics*, 15 (9): 145-153, 1998.

Allen EC, McCarter R and **Grossman LS**: Depressive symptoms in school age children entering foster care. *International Journal of Ambulatory Pediatrics*, 2000.

Tellerman K, Band S, Bromberg D, Chernoff R, **Grossman L**, et al. D-TECKT, A template for you to assess and address behavioral problems, *Contemporary Pediatrics*, August, 2005.

Tellerman, **Grossman**, et al. D-TECKT, A template for you to assess and address behavioral problems, *Skyscape Electronic Journal*, article 174261, 2006.

Wilms Floet A, Scheiner C, **Grossman L**. Attention Deficit Hyperactivity Disorder. *Pediatr Rev*. 2010 Feb;31(2):56-69. *Pediatrics In Review*, February, 2010.

Selected Invited Papers:

Grossman L and Chernoff R. Small Group Report: Nursing and Behavioral Pediatrics. Proceedings of National Conference on Behavioral Pediatrics. *J Devel Beh Pediatr*, 6: 1985

Grossman, LS: Working cooperatively with schools. In Olsen, A. (Ed.), *Management of Chronic Illness and Disability in the Primary-Care Setting*, Report on the Twenty-Sixth Ross Roundtable on Critical Approaches to Common Pediatric Problems. Columbus, Ohio: Ross Products Division, Abbott laboratories, 1995, p.31-36.

Grossman, LS: Commentary on "Asthmatic school children, self-reported asthma prevalence and lifestyles", *Ambulatory Child Health, the Journal of General and Community Pediatrics*, in press.

Grossman, LS: Attention Deficit /Hyperactivity Disorder – Diagnostic Criteria and Process. *E-Learning@AAP.org*, July 2008.

Grossman, LS: Attention Deficit /Hyperactivity Disorder – Differential Diagnosis. *E-Learning@AAP.org*, July 2008.

Book Chapters:

Soares, N and **Grossman L**. "Somatoform Disorders: Conversion Disorder" www.emedicine.com, Emedicine Journal September 2001, Volume 2, Number 9, revised Spring 2006

Grossman LS and Beale DA. "Bioethics in Pediatric Practice". www.emedicine.com/ped/topic/2769.htm, Emedicine Journal, August 2006

Grossman LS "Child Development" in Elzouki AY (ed.) Textbook of Clinical Pediatrics, 2nd Edition, Springer, in press.

Colleen Callahan Freeman

TITLE AND CONTACT INFORMATION

Public Health Nurse Administrator, Division of Prenatal and Early Childhood Services
Baltimore County Department of Health
6401 York Road, 3rd Floor
Baltimore, Maryland 21212
410-887-3725 (Work)
cfreeman@baltimorecountymd.gov

EDUCATION

Johns Hopkins University, Baltimore Maryland
Master of Science, Applied Behavioral Science, 2000

College of Notre Dame of Maryland, Baltimore, Maryland
Bachelor of Science in Nursing, Magna Cum Laude, 1995

Essex Community College, Baltimore Maryland
Associate of Arts Degree in Nursing, Honors Graduate, 1978

PROFESSIONAL EXPERIENCE

Baltimore County Department of Health, Baltimore Maryland (1985-Present)

*Public Health Nurse Administrator/ Prenatal and Early Childhood Division Services
(July 2011-Present)*

*Public Health Nurse Supervisor/ Early Childhood and School Health Programs
(July 2006-July 2011)*

Duties and Responsibilities:

- Supervise professional and support staff providing a variety of public health and health care services. Conduct performance evaluations and field supervision of staff.
- Evaluate the effectiveness of programs as necessary. Monitor staff and programs for compliance with State and Federal regulations.
- Coordinate and supervise the preparation of records, reports and data collection.
- Establish and maintain interagency collaboration with representatives from other departments and agencies.
- Provide technical assistance to child care providers related to general health and safety issues and for the prevention and control of infectious disease transmission. Coordinate disease control efforts during outbreaks affecting child care programs.
- Provide nursing care and coordinate services for the provision of medical examinations for child victims of sexual abuse/assault for the Baltimore County Child Advocacy Center.

Colleen Callahan Freeman

Public Health Nurse/Bureau of Child, Adolescent and Reproductive Health (March 1985-July 2006)

Served in a variety of classifications performing services as a public health nurse. Past duties have included: Performing licensing inspections of child care centers and providing health consultation for child care operators and staff; planning, implementing and monitoring a compliance program related to laboratory practice standards for the Baltimore County School-Based Wellness Program; conducting home-based nursing visits for high-risk infants; and providing nursing care and coordinating services for the medical program of the Child Advocacy Center.

PREVIOUS EMPLOYMENT

Surgical Supply Service, Baltimore, Maryland

Durable Medical Equipment Sales Specialist, 1984-1985

Manor Care Nursing Center, Towson, Maryland

Nursing Supervisor, 1982-1983

Citizens Nursing Center, Havre de Grace, Maryland

Nursing Supervisor, 1980-1982

Staff Builders, Inc., Baltimore, Maryland

Nursing Supervisor for Harford County Chapter of Home Health Agency, 1979-1980

Fallston General Hospital, Fallston, Maryland

Staff Nurse for medical-surgical unit, 1978-1979

HONORS AND MEMBERSHIPS

Sigma Theta Tau International, Honor Society of Nursing, 1995-Present

Member, Baltimore County Child Fatality Review Team, 2002-Present (Coordinator for Team since July 2010)

Member, Maryland State School Health Council, 2010-Present

LICENSES AND CERTIFICATION

Maryland State Board of Examiners of Nurses, Registered Nurse, Current Maryland License

Attachment Item 13-1

Proposed Advisory Board Eastern Baltimore County HEZ

Chair: Dr. Grossman

Administrative support: office assistant to be hired under grant

Membership: Representatives from each of the following organizations or groups

Healthcare system representatives:

Baltimore Medical Systems (the Federally Qualified Health Center Serving the HEZ area) *

Johns Hopkins Bayview Medical Center *

Medstar Health Franklin Square Hospital Center*

United Health Care – Erin Anderson **

Community representatives:

Representative designated by Baltimore County Councilman Olszewski

Two Representatives from the community associations within the HEZ (such as Colgate Improvement Association, Greater Dundalk Community Association, etc.

Representative from the area churches (Currently St. Stephen's Church is represented on the Health Council – could be this person or someone from the Dundalk area churches)

Representatives from related services:

Bureau of Behavioral Health, BCDH*

Bureau of Healthcare Access, BCDH*

Women's, Infants' and Children's Supplemental Nutrition Services (WIC)

Baltimore County Emergency Medical Technicians – Christian Griffin**

Baltimore County Department of Social Services

NFP Program Representatives:

Program Administrator (Colleen Freeman)

Nursing Supervisor (to be hired)

* Organization already represented on the Baltimore County Health Coalition but a different person from the organization may be the representative on this advisory group

** This person already serves on the Health Coalition and likely would be the representative on this advisory group