

ELAINE ELLIS CENTER OF HEALTH, INC.

Executive Order 12372 - Maryland Intergovernmental Review Submission

September 9, 2026

Maryland State Clearinghouse for Intergovernmental Assistance
Maryland Department of Planning

RE: FY 2027 Expanding Nutrition Services (HRSA-27-099) - E.O. 12372 Review

To the Maryland State Clearinghouse:

Elaine Ellis Center of Health, Inc. (EECH) respectfully submits its application materials for intergovernmental review under Executive Order 12372. EECH is applying to the Health Resources and Services Administration (HRSA) for FY 2027 Expanding Nutrition Services funding under opportunity HRSA-27-099. The proposed project includes nutrition services in Prince George's County, Maryland, including activities associated with the College Park site and the EECH mobile unit in Lanham.

Applicant	Elaine Ellis Center of Health, Inc.
Federal Agency	Health Resources and Services Administration (HRSA)
Funding Opportunity	HRSA-27-099 - FY 2027 Expanding Nutrition Services
Assistance Listing	93.224 - Health Center Program
Federal Funds Requested	\$350,000
Maryland Project Area	Prince George's County, Maryland
Maryland Project Sites	College Park and Lanham
Applicant Contact	Timothy Walker, Chief Operations Officer
Telephone	202-803-2340
Email	tw@eechealth.com

Enclosures:

- SF-424 Application for Federal Assistance
- Project Abstract
- Budget
- Project/Performance Site Location(s)

Thank you for your review of this application. Please contact Timothy Walker at 202-803-2340 or tw@eechealth.com regarding any questions concerning this submission.

Sincerely,
Timothy Walker
Chief Operations Officer
Elaine Ellis Center of Health, Inc.

Application for Federal Assistance SF-424

*** 1. Type of Submission:**

- ☐ Preapplication
☒ Application
☐ Changed/Corrected Application

*** 2. Type of Application:**

- ☐ New
☐ Continuation
☒ Revision

*** If Revision, select appropriate letter(s):**

E: Other (specify)

*** Other (Specify):**

Competing Supplement

*** 3. Date Received:**

Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

H80CS22679

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*** a. Legal Name:**

Elaine Ellis Center of Health, Inc.

*** b. Employer/Taxpayer Identification Number (EIN/TIN):**

273048576

*** c. UEI:**

RFJKYDWW7NJ3

d. Address:

*** Street1:**

1627 Kenilworth Ave. NE

Street2:

*** City:**

Washington

County/Parish:

DC

*** State:**

DC: District of Columbia

Province:

*** Country:**

USA: UNITED STATES

*** Zip / Postal Code:**

20019-2010

e. Organizational Unit:

Department Name:

Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:

Mr.

*** First Name:**

Timothy

Middle Name:

*** Last Name:**

Walker

Suffix:

Title:

Organizational Affiliation:

*** Telephone Number:**

202-803-2340

Fax Number:

*** Email:**

tw@eechealth.com

Application for Federal Assistance SF-424

* 9. Type of Applicant 1: Select Applicant Type:

M: Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

* 10. Name of Federal Agency:

Health Resources and Services Administration

11. Assistance Listing Number:

93.224

Assistance Listing Title:

Health Center Program

* 12. Funding Opportunity Number:

HRSA-27-099

* Title:

Fiscal Year 2027 Expanding Nutrition Services

13. Competition Identification Number:

HRSA-27-099

Title:

Fiscal Year 2027 Expanding Nutrition Services

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment

Delete Attachment

View Attachment

* 15. Descriptive Title of Applicant's Project:

Elaine Ellis Center of Health - Expanding Nutrition Services

Attach supporting documents as specified in agency instructions.

Add Attachments

Delete Attachments

View Attachments

Application for Federal Assistance SF-424			
16. Congressional Districts Of:			
* a. Applicant	DC - All	* b. Program/Project	DC - All
Attach an additional list of Program/Project Congressional Districts if needed.			
	Add Attachment	Delete Attachment	View Attachment
17. Proposed Project:			
* a. Start Date:	12/01/2026	* b. End Date:	11/30/2028
18. Estimated Funding (\$):			
* a. Federal	350,000.00		
* b. Applicant	0.00		
* c. State	0.00		
* d. Local	0.00		
* e. Other	0.00		
* f. Program Income	0.00		
* g. TOTAL	350,000.00		
* 19. Is Application Subject to Review By State Under Executive Order 12372 Process?			
☒ a. This application was made available to the State under the Executive Order 12372 Process for review on		09/09/2026	
☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.			
☐ c. Program is not covered by E.O. 12372.			
* 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)			
☐ Yes ☒ No			
If "Yes", provide explanation and attach			
	Add Attachment	Delete Attachment	View Attachment
21. *By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)			
☒ ** I AGREE			
** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.			
Authorized Representative:			
Prefix:	Mr.	* First Name:	Timothy
Middle Name:			
* Last Name:	Walker		
Suffix:			
* Title:	Chief Operations Officer		
* Telephone Number:	202-803-2340	Fax Number:	
* Email:	tw@eechealth.com		
* Signature of Authorized Representative:	Completed by Grants.gov upon submission.	* Date Signed:	Completed by Grants.gov upon submission.

Project/Performance Site Location(s)

Project/Performance Site Primary Location

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:	Elaine Ellis Center of Health - Kenilworth		
UEI:			
* Street1:	1627 Kenilworth Ave NE		
Street2:			
* City:	Washington	County:	District of Columbia
* State:	DC: District of Columbia		
Province:			
* Country:	USA: UNITED STATES		
* ZIP / Postal Code:	20019 - 2010	* Project/ Performance Site Congressional District:	DC - ALL

Project/Performance Site Location 1

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:	Elaine Ellis Center of Health - College Park		
UEI:			
* Street1:	10001 Rhode Island Ave		
Street2:			
* City:	College Park	County:	Prince Georges
* State:	MD: Maryland		
Province:			
* Country:	USA: UNITED STATES		
* ZIP / Postal Code:	207401141	* Project/ Performance Site Congressional District:	MD - 004

Project/Performance Site Location 2

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:	EECH Mobile - 1		
UEI:			
* Street1:	10101 Martin Luther King Junior Highway		
Street2:			
* City:	Lanham	County:	Prince George's
* State:	MD: Maryland		
Province:			
* Country:	USA: UNITED STATES		
* ZIP / Postal Code:	20706 - 4316	* Project/ Performance Site Congressional District:	MD - 004

Additional Location(s)

Add Attachment

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INTRODUCTION

Prince George's County, Maryland and the Kenilworth neighborhood of Washington, DC are adjacent communities sharing similar profiles of unmet health need. Chronic diseases driven by poor nutrition, obesity, diabetes, hypertension, affect residents at rates that exceed state and national averages, yet the community resources needed to address these conditions at their root causes remain scarce. Nearly one in five children in Prince George's County experiences food insecurity, nearly one in three adults in the Kenilworth ZIP code reports food insecurity, and more than 40% of service area residents live with obesity. The area children struggle with both malnutrition and obesity. Diabetes mortality in the service area outpaces both state and national rates.¹ And for many patients, the path between a clinical diagnosis and a healthy meal is blocked by transportation gaps, food costs, and a shortage of dedicated nutrition support.

Elaine Ellis Center of Health, Inc. (EECH) is a Federally Qualified Health Center providing comprehensive, integrated, patient centered healthcare services throughout Prince George's County, Maryland and Washington, DC. Through its integrated care model, EECH delivers primary care, behavioral health services, chronic disease management, preventive health education, case management, enabling services, and community outreach designed to improve health outcomes for populations with limited access to health care. EECH serves patients at two fixed sites, in College Park, Maryland and Kenilworth, DC, and through a school-based mobile unit serving Maryland families, placing it at the intersection of two communities where the consequences of poor nutrition are most acute and where clinical intervention is most needed.

The patients EECH serves reflect the full weight of these conditions. Per the 2025 UDS, the Center currently cares for 481 patients with diabetes ($A1C \geq 6.5\%$), 168 patients with pre-diabetes ($A1C 5.7-6.4\%$), and 696 patients with elevated blood pressure or diagnosed hypertension. Many of these patients are also experiencing food insecurity, live in households below 200% of the federal poverty level, and lack reliable access to affordable, nutritious food. These are not independent problems; they are compounding ones. A patient who cannot afford fresh produce cannot fully act on nutrition counseling. A child whose family relies on corner stores cannot benefit from a BMI screening without broader support. The clinical encounter is necessary but not sufficient.

EECH has worked to address malnutrition through summer backpack distributions with food and other food programs, and its school-based mobile unit delivers health screenings to children and families in Prince George's County Public Schools, supported since the 2024-2025 school year by a full-time Outreach Coordinator, funded under EECH's Behavioral Health Service Expansion award, who works with the district and other agencies on linkage to social needs resources including food banks. That relationship gives the Center a standing presence in the schools where children at nutritional risk are found. EECH's proposed Expanding Nutrition Services (ENS) project builds on these programs, leverages community resources, and addresses continued gaps through four components:

- Dedicated nutrition staff: a Registered Nutritionist and a Community Health Worker (CHW)/Project Coordinator, each at 0.75 FTE in Year 1 and 1.0 FTE in Year 2, with 0.1

¹ Centers for Disease Control and Prevention, National Center for Health Statistics. *CDC Wonders, 2018-2024*. Retrieved May 21, 2026, from: <https://wonder.cdc.gov/>

FTE of Chief Medical Officer time for medical direction and a driver for the refrigerated food delivery vehicle;

- Maryland: participation in the Maryland Market Money Rx (MMM Rx) pediatric produce prescription pilot administered by the Maryland Department of Agriculture, enrolling 75 families with children experiencing or at risk of obesity through the College Park site and school-based mobile unit in a structured prescription and nutrition education program;
- Washington, DC: targeted nutrition counseling for patients with pre-diabetes, diabetes, and hypertension at the Kenilworth site, and EECH-purchased food distributed directly to 50 food-insecure families in Year 1 and 75 in Year 2 through the prescription food pantry and a new refrigerated delivery vehicle, supplemented by referrals to So Others Might Eat (SOME) under a working agreement and to local food banks; and
- Both service areas: group nutrition education, quarterly cooking demonstrations hosted with community centers and churches, and telehealth nutrition counseling for Maryland patients who face transportation barriers.

Across both geographies, the ENS project targets three patient populations with measurable outcomes:

- Pre-diabetes: reverse pre-diabetes in at least 33 of the 168 patients currently identified with A1C levels in the pre-diabetic range, a 20% reduction;
- Diabetes: reduce the share of the 481 patients with diabetes whose A1C is above 9% from 35.0% to 30.0% or lower; and
- Children and adolescents: refer every patient aged 3 to 17 with an out-of-range BMI percentile to nutrition services, with at least 75% completing a nutrition education encounter.

Patients with hypertension will receive coordinated nutrition counseling and food access support designed to reduce cardiovascular risk, and children and families will gain lasting connections to local food systems, healthy eating education, and community-based wellness resources. This project is a targeted, data-driven response to the most pressing nutritional health challenges facing EECH's communities.

NEED

1. Describe the need to start or expand nutrition services to help prevent and manage chronic conditions in your service area.

The clearest evidence of unmet need in EECH's service area is an outcome gap, not a screening gap. EECH screens nearly every patient for weight and nutrition risk, yet per the 2025 UDS, 168 of the 480 patients assessed for glycemic status (35.0%) had an A1C above 9%, indicating poor glycemic control, and 242 of the 847 patients assessed for blood pressure (28.6%) did not have their hypertension controlled. The Center currently cares for 481 patients with diabetes, 168 with pre-diabetes, 696 with elevated blood pressure or hypertension, and 791 with overweight or obesity, and it employs no dedicated nutrition staff to treat any of them. Across Prince George's County and Washington, DC's Kenilworth community, rates of obesity, diabetes, and hypertension exceed state and national benchmarks, diabetes mortality exceeds both Maryland and the nation, and adult food insecurity in the Kenilworth ZIP code (32.3%) is more than double

the District rate. These conditions are compounded by poverty, transportation limitations, a Ward 7 grocery gap of three full-service stores, and the absence of dedicated nutrition support within primary care. Table 1 summarizes the clinical burden that expanded nutrition services must address.

Table 1: Nutrition-Related Chronic Disease Burden and Outcome Gaps Among EECH Patients (2025 UDS)	
Indicator	2025 UDS Value
Patients with diabetes (A1C 6.5% or higher)	481 patients
Patients with pre-diabetes (A1C 5.7% to 6.4%)	168 patients
Patients with elevated blood pressure or diagnosed hypertension	696 patients
Patients with overweight or obesity diagnoses	791 patients
Patients with diabetes with poor glycemic control (A1C above 9%)	168 of 480 assessed (35.0%)
Patients with hypertension without blood pressure control	242 of 847 assessed (28.6%)
Dedicated nutrition services staff (Registered Nutritionist, CHW)	0 FTE; not in scope of project
*Values in bold are the outcome gaps the ENS project targets.	

The subsections below present the UDS Table 6B measures this notice of funding opportunity requires, which show EECH performing near the ceiling on identification, followed by the UDS Table 7 outcome measures and the service area data that show where the unmet need lies: in treatment, follow-up, and food access after the screening is complete.

a. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (UDS Table 6B, Line 12)

EECH currently achieves strong performance on pediatric weight assessment measures. According to 2025 UDS data, 688 of 725 pediatric and adolescent patients (94.9%) received Weight Assessment and Counseling for Nutrition and Physical Activity during the reporting period. A substantial share of these children are reached through the school-based mobile unit's health screenings in Prince George's County Public Schools, and those screenings have already identified 53 children with overweight or obesity whose families meet the MMM Rx eligibility criteria. This performance reflects the Center's commitment to early intervention and preventive care and leaves little room for improvement on the screening measure itself. It also isolates the gap: even with near-universal screening and counseling at the visit, childhood obesity, poor nutrition, and food insecurity remain pervasive in the service area, because a documented counseling encounter is not a treatment plan, a produce prescription, or a follow-up visit.

Table 2: UDS Table 6B, Line 12 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
Measure	Total Patients Aged 3 through 17	Number of Records Reviewed	Number of Patients with Counseling and BMI Documented

Percentage of patients 3-17 years of age with a BMI percentile and counseling on nutrition and physical activity documented	725	725	688
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High screening rates confirm that children are being seen and measured. They do not confirm that children are eating well, that families have access to affordable produce, or that clinical guidance is being reinforced at home. The problem is not identification; it is what happens after the visit. EECH's service area obesity rate of 41.1% exceeds both the Maryland rate of 33.9% and the national rate of 33.9%, indicating that clinical encounters alone are insufficient to drive population-level change. ²

The ENS project will extend EECH's reach beyond the clinic through the MMM Rx produce prescription pilot, school-based mobile unit outreach, cooking demonstrations, and family-centered nutrition education designed to reinforce counseling and build healthy habits in the communities where children live.

b. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (UDS Table 6B, Line 13)

EECH's adult BMI screening performance is similarly strong. According to 2025 UDS data, 4,125 of 4,369 adult patients (94.4%) received BMI screening and an appropriate follow-up plan during the reporting period. The Center's QA/QI infrastructure, including Athenahealth EHR dashboards and integrated PRAPARE screening protocols, supports systematic identification and documentation of patients with elevated BMI.

Despite this performance, EECH currently serves 791 patients diagnosed with overweight or obesity, 481 patients with diabetes, and 168 patients with pre-diabetes. Of the 480 patients assessed for glycemic status, 168 (35%) had A1C levels greater than 9%, indicating poor glycemic control. Of 847 patients assessed for blood pressure, 242 (28.6%) did not have their hypertension controlled. These outcomes reflect the gap between identifying a problem and having the staff, tools, and food access infrastructure to address it. ENS funding will allow EECH to provide the intensive follow-up, individualized nutrition counseling, and food access support that high-risk patients require to improve their clinical outcomes.

c. Additional UDS Table 6B Quality of Care Measures

Beyond the Table 6B screening measures, EECH tracks the UDS Table 7 health outcome measures for diabetes and hypertension through its Athenahealth EHR system and QA/QI program, and these are the measures that define the unmet need. As shown in Table 1, 35.0% of patients assessed for glycemic status had an A1C above 9%, and 28.6% of hypertensive patients did not achieve blood pressure control. Near-universal screening and one-in-three poor glycemic control coexist in the same patient population because identification is followed by brief, provider-delivered dietary advice rather than structured nutrition assessment, individualized counseling, food prescription, and scheduled follow-up. Closing that gap, not raising screening

² Health Center Program GeoCare Navigator. Retrieved May 21, 2026, from: <https://geocarenavigator.hrsa.gov/>

rates, is the objective of the ENS project, and it requires dedicated nutrition intervention, chronic disease education, and food access support that EECH's primary care providers cannot deliver within existing visit time. The project therefore sets its outcome targets directly against these measures: reducing poor glycemic control among patients with diabetes from 35.0% to 30.0% or lower, reversing pre-diabetes in 20% of the 168 patients identified, and moving children with out-of-range BMI percentiles from a documented screening to a completed nutrition education encounter.

d. Other relevant data specific to your service area

Community-level data from Prince George's County confirms that the chronic disease burden seen in EECH's patient population reflects broader patterns of nutritional disadvantage, economic hardship, and limited food access across the service area.

The following table illustrates how the service area compares to state and national benchmarks on key nutrition-related health indicators:

Table 3: Service Area Health Disparities ³			
Location	Diabetes	Hypertension	Obesity
Service Area	13.5%	37.0%	41.1%
District of Columbia	7.7%	27.9%	24.7%
Maryland	11.1%	34.5%	33.9%
U.S.	10.9%	32.4%	33.9%
*Values in bold are worse than state and/or national values.			

Diabetes mortality in the service area stands at 31.7 deaths per 100,000 population, higher than both Maryland (27.5) and the nation (28.8). Cerebrovascular disease mortality is also elevated at 48.5 per 100,000, compared to 48.0 nationally. These mortality indicators reflect the downstream consequences of unmanaged nutrition-related chronic disease and reinforce the urgency of earlier, more intensive nutrition intervention.

Food insecurity compounds these health risks, particularly for children and families. The following table presents food insecurity data for Prince George's County:

Table 4: Food Insecurity ⁴				
Location	Food Insecurity Rate (Overall)	Food Insecurity Rate (Children)	Below SNAP Threshold	Average Meal Cost
Prince George's County	12.1%	19.8%	55%	\$3.95
District of Columbia	15.2%	21.8%	59%	\$4.53
Maryland	13.3%	16.1%	54%	\$3.71
U.S.	14.3%	19.2%	63%	\$3.58

³ Health Center Program GeoCare Navigator. Retrieved May 21, 2026, from: <https://geocarenavigator.hrsa.gov/>

⁴ Feeding America, Map the Meal Gap. *Census Bureau, American Community Survey (ACS, 2018-2022)*. Retrieved May 21, 2026, from: <https://map.feedingamerica.org/>

***Values in bold are worse than state and/or national values.**

While the overall food insecurity rate in Prince George's County is comparable to state and national levels, the rate for children stands at 19.8%, meaning nearly one in five children in the county does not have reliable access to adequate food. This rate exceeds both the Maryland average of 16.1% and the national average of 19.2%. The average meal cost of \$3.95 also exceeds both state and national averages, placing additional strain on low-income households trying to maintain nutritious diets.

The Kenilworth site sits in one of the District's most food-insecure neighborhoods. Ward 7 has three full-service grocery stores for its residents, compared with 17 in Ward 3, and Wards 7 and 8 together contain more than three-quarters of the District's food deserts, 31% in Ward 7 alone.⁵ Table 5 compares the Kenilworth ZIP code with Prince George's County and the District on the health-related social needs and chronic conditions that drive nutrition-related disease.

Table 5: Kenilworth Service Area (ZIP Code 20019) Compared to Prince George's County and the District of Columbia⁶			
Indicator (Adults, 2023)	ZIP 20019 (Kenilworth)	Prince George's County	District of Columbia
Food insecurity in the past 12 months	32.3%	22.1%	13.9%
Received SNAP benefits in the past 12 months	35.2%	15.7%	13.0%
Lack of reliable transportation in the past 12 months	16.4%	10.3%	8.0%
Housing insecurity in the past 12 months	25.6%	19.5%	12.2%
High blood pressure	41.5%	40.0%	28.5%
Diagnosed diabetes	14.0%	15.2%	7.8%
Obesity	34.6%	42.2%	24.7%
*Values in bold are worse than the District of Columbia value. Crude prevalence, model-based estimates.			

Food insecurity in the Kenilworth ZIP code is more than double the District rate: 32.3% of adults in ZIP code 20019 reported food insecurity in the past 12 months, compared with 13.9% across the District and 22.1% in Prince George's County, and 35.2% received SNAP benefits, compared with 13.0% District-wide. One in six Kenilworth adults (16.4%) lacked reliable transportation, twice the District rate, and 26.2% of District households have no vehicle available (Table 7), so a grocery store outside the neighborhood is not a practical source of fresh food for many of EECH's DC patients. The chronic disease consequences are visible in the same data: high blood

⁵ D.C. Hunger Solutions. (2025, November 19). Minding the grocery gap in D.C.: A 2025 update [Press release]; Smith, R. (2017, March 13). Food access in D.C. is deeply connected to poverty and transportation. D.C. Policy Center. Retrieved September 8, 2026, from: <https://www.dchunger.org/> & <https://www.dcpolicycenter.org/>

⁶ Centers for Disease Control and Prevention. (2025). PLACES: Local Data for Better Health, ZCTA Data and County Data, 2025 release (BRFSS 2023, crude prevalence). Retrieved September 8, 2026, from: <https://data.cdc.gov/>

pressure (41.5%), diagnosed diabetes (14.0%), and obesity (34.6%) in ZIP code 20019 all exceed the District rates of 28.5%, 7.8%, and 24.7%. These figures are the reason the DC arm of the ENS project delivers prescribed food directly to patients by refrigerated vehicle rather than relying on referrals to retail food access that does not exist in the neighborhood.

Economic hardship drives these food access challenges. The following tables illustrate the financial and poverty context facing Prince George's County residents:

Table 6: Financial Hardships ⁷				
Indicator	Prince George's County	District of Columbia	Maryland	U.S.
Median Household Income	\$99,180	\$109,707	\$102,905	\$81,604
Per Capita Income	\$45,863	\$76,604	\$53,199	\$45,256
Children in Poverty	14%	28%	11%	16%
Children on Free/Reduced Lunch	72%	Not Available	50%	56%
Severe Housing Cost Burden	18%	17%	15%	15%
*Values in bold are worse than state and/or national values.				

Despite a median household income above the national average, Prince George's County residents experience per capita income and child poverty rates that exceed state benchmarks. **72% of children in the county qualify for free or reduced-price lunch, far above both the Maryland rate of 50% and the national rate of 56%.** 18% of households face severe housing cost burden, leaving less disposable income for food and healthcare.

Transportation limitations further restrict food access for many residents. Prince George's County has a vehicle unavailability rate of 5.3%, exceeding both the Maryland rate of 4.2% and the national rate of 4.4%. For patients without reliable transportation, accessing grocery stores, farmers markets, and health center appointments requires significant additional effort and cost. These barriers directly limit the effectiveness of nutrition counseling delivered in isolation from food access support.

Table 7: No Vehicles Available ⁸	
Location	Rate
Prince George's County	5.3%
District of Columbia	26.2%
Maryland	4.2%
U.S.	4.4%
*Values in bold are worse than state and/or national values.	

⁷ Census Reporter, ACS 2022; County Health Rankings & Roadmaps, 2024. Retrieved May 21, 2026, from: <https://censusreporter.org/> & <https://www.countyhealthrankings.org/>

⁸ Data USA. Retrieved May 21, 2026, from: <https://datausa.io/>

Across the service area, 109,023 residents participate in SNAP monthly. Prince George's County WIC enrollment includes 39,499 participants, 5,536 infants, 22,175 children ages 1–5, and 11,788 women.⁹ The high enrollment in these programs reflects the depth of food and nutrition insecurity in the community, and the importance of connecting EECH's clinical nutrition services to the broader food access ecosystem.

2. Describe any challenges with your current health center workforce that impact your capacity to start or expand nutrition services.

EECH currently integrates nutrition education into primary care and chronic disease management visits as part of its standard workflow. However, the Center does not have dedicated nutrition staff or a structured, standalone nutrition services program. This gap significantly limits EECH's ability to provide the intensive, individualized nutrition interventions its patient population requires.

EECH currently cares for 481 patients with diabetes, 168 with pre-diabetes, 696 with elevated blood pressure or active hypertension, and 791 with overweight or obesity diagnoses. Providers and clinical staff incorporate nutritional guidance into routine visits, but competing clinical demands limit the time available for individualized counseling, ongoing follow-up, produce prescription coordination, and chronic disease education. The result is a patient population with significant nutritional health needs and limited access to the sustained support needed to address them.

Current workforce challenges limiting nutrition service capacity include:

- No dedicated Registered Nutritionist on staff to provide individualized assessments, counseling, and follow-up;
- No Community Health Worker or enabling staff focused on food insecurity navigation, food prescription fulfillment, and patient outreach;
- Growing demand for chronic disease prevention and management services among pre-diabetic and hypertensive patients;
- Competing provider priorities during medical visits that limit time for nutrition-specific counseling;
- Limited staff capacity for food insecurity navigation, food prescription fulfillment and delivery, and community nutrition education; and
- Need for expanded outreach and patient engagement activities to connect families to food access resources.

The addition of dedicated nutrition-focused staff will directly address these gaps. The Registered Nutritionist will provide individualized counseling, assessments, and chronic disease education for high-risk patients. The Community Health Worker/Project Coordinator will handle patient navigation, outreach, food insecurity follow-up, food prescription fulfillment and delivery, and MMM Rx pilot administration. Together, these positions will allow EECH's primary care providers to focus on clinical care while nutrition services are delivered with the depth and frequency that patients with pre-diabetes, diabetes, and hypertension require. ENS funding will

⁹ Feeding America, Map the Meal Gap. Census Bureau, American Community Survey (ACS, 2018-2022). Retrieved May 21, 2026, from: <https://map.feedingamerica.org/>

also support staff training in motivational interviewing, food insecurity intervention, safe food handling, and nutrition counseling tailored to individual patients' needs.

RESPONSE

1. Describe how you will

a. Increase the number of patients receiving nutrition services and/or the number of nutrition-related visits.

EECH currently provides limited nutrition education as part of routine medical care but does not have dedicated nutrition staff or a structured nutrition services program. The addition of a Registered Nutritionist and a CHW/Project Coordinator, each at 0.75 FTE in Year 1 and 1.0 FTE in Year 2, will allow EECH to launch a formal, structured nutrition services program and substantially increase both the number of patients receiving nutrition services and the number of nutrition-related visits across its Maryland and DC service areas. These nutrition services will be delivered and documented as discrete encounters that are separate and distinct from the basic dietary guidance given during general primary care visits, so that each encounter is countable under the nutrition services measure HRSA will add to UDS Table 5 in 2027.

The Registered Nutritionist will provide individualized nutrition assessments, counseling visits, meal planning support, chronic disease education, and nutrition-focused follow-up for patients diagnosed with obesity, diabetes, pre-diabetes, hypertension, and related chronic conditions. The CHW/Project Coordinator will increase patient participation in nutrition services by conducting outreach, coordinating care, screening for food insecurity, fulfilling and delivering food prescriptions, and providing ongoing support to help patients sustain healthy lifestyle changes. A 0.1 FTE Chief Medical Officer will provide program oversight, directing the nutrition services program, reviewing implementation progress and quality indicators, and holding accountability for the project's performance against its stated objectives. A driver, at 0.2 FTE in Year 1 and 0.4 FTE in Year 2, will operate a refrigerated food delivery vehicle. Together, this team of 1.8 FTE in Year 1, scaling to 2.5 FTE in Year 2, will allow EECH to serve substantially more patients with more intensive and sustained nutrition support than is currently possible.

Patients will be referred for nutrition services as a result of:

- BMI screening results identifying overweight or obesity;
- A1C results in the pre-diabetic (5.7–6.4%) or diabetic ($\geq 6.5\%$) range;
- Blood pressure readings indicating elevated, Stage 1, or Stage 2 hypertension;
- PRAPARE assessments identifying food insecurity or non-medical factors affecting health;
- Chronic disease management visits for diabetes, hypertension, or obesity; and
- Pediatric wellness visits and provider referrals from the College Park site and school-based mobile unit.

In **Maryland**, the ENS project will enroll 75 families with children experiencing or at risk of obesity through the College Park site and school-based mobile unit. The mobile unit already conducts health screenings, including height, weight, and BMI percentile, for students in Prince

George's County Public Schools under EECH's established relationship with the district, coordinated by EECH's Outreach Coordinator, who serves as the Center's liaison to the district. The ENS project dovetails with that program rather than building a new one: a BMI percentile at or above the 85th percentile recorded at a school screening will generate an internal referral to the CHW/Project Coordinator, who will complete the PRAPARE food insecurity screen with the family, enroll eligible families in MMM Rx, and schedule the child for nutrition counseling at the College Park site, on the mobile unit, or by telehealth. Some of the families EECH serves through the schools are hesitant to visit a clinic, so the first nutrition contact will occur where the family already is, at the school. These families will participate in the MMM Rx pediatric produce prescription pilot administered by the Maryland Department of Agriculture (MDA). This is a grant funded trial program in which EECH has been invited to participate. Under that state-administered program, MDA supplies the voucher instruments and the redemption infrastructure at no cost to this award; EECH's role is clinical, issuing produce prescriptions, delivering nutrition counseling, and tracking participation and outcomes. No ENS federal funds will be used to purchase vouchers, gift cards, or any other cash equivalent. ENS funded nutrition counseling, cooking demonstrations, food literacy education, and family-centered healthy eating programming will reinforce the produce prescription benefit and build lasting healthy behaviors.

The MMM Rx pilot routes nutrition investment directly to Maryland farmers. Each produce prescription EECH issues is exchanged at a participating farmers market or farm stand for MMM Rx market currency; families use that currency to buy fresh fruits and vegetables from direct-marketing farmers; and participating farmers redeem the vouchers through market management for reimbursement coordinated by MDA. Across the projected 75 participants at approximately \$200 in benefit each (covered by the MMM Rx grant), the pilot channels roughly \$15,000 of produce purchasing into local agricultural operations during the July through October peak season, and one identified participating market operates year-round, rain or shine, allowing purchasing relationships to continue during winter months. This structure matters for three reasons. First, it makes the intervention economically self-reinforcing: dollars that would otherwise leave the county as retail margin instead support the regional growers who supply the produce EECH's patients are being counseled to eat, strengthening the local food economy the pilot depends on. Second, produce bought at market is typically harvested closer to peak ripeness than produce moving through long retail supply chains, supporting the freshness and nutrient density that make the clinical recommendation worth issuing. Third, and most consequential for long-term outcomes, the transaction is itself part of the intervention: families meet the person who grew their food, ask preparation questions, learn what is in season, and return week after week, building the purchasing routines and food literacy that persist after the prescription period ends. EECH will reinforce those connections through market tours, farmer engagement activities, and seasonal eating education delivered alongside its nutrition counseling, and will contribute prescription issuance and participant feedback data to MDA's evaluation so the pilot can demonstrate the role of local agriculture in preventive health and support replication across Prince George's County and, eventually, statewide.

Nutrition counseling visits will also be available by telehealth for Maryland patients who face transportation barriers, ensuring that distance and lack of a vehicle do not prevent a patient from completing a nutrition visit. MMM Rx enrollment is capped at 75 families. Patients who screen positive for food insecurity once those slots are filled will not be turned away: they will receive

food purchased and distributed directly by EECH and delivered by the refrigerated food delivery vehicle, so that overflow demand is met by EECH's own food prescription program rather than deferred to the next pilot cycle.

In **Washington, DC**, the ENS project will deliver individualized nutrition counseling to patients with pre-diabetes and hypertension at the Kenilworth site and will provide prescribed food directly to 50 food insecure families in Year 1, and 75 in Year 2. Rather than relying primarily on referral arrangements, EECH will purchase prescription foods that align with the USDA Dietary Guidelines with ENS funds and distribute it to patients through its on-site prescription food pantry and a new refrigerated food delivery vehicle, so that the food-as-medicine intervention is delivered directly by the health center as part of the patient's nutrition care plan. Patients whose needs exceed the scope of their food prescription will be referred to So Others Might Eat (SOME) under EECH's working agreement with SOME, and to local food banks. The CHW/Project Coordinator will manage food prescription fulfillment, delivery scheduling, and nutrition follow-up.

EECH will also expand group-based nutrition education, outreach events, and chronic disease prevention workshops at both sites and through the school-based mobile unit. EECH will also partner with local community centers and churches to host quarterly cooking demonstrations for patients that are referred for food prescriptions. The demonstrations will rotate between the Maryland and DC locations and will host up to 15 patients. The patients will be shown proper food handling techniques, methods for cooking seasonal vegetables, and recipes to replicate the meal at home. These activities will increase the reach of nutrition services for patients and community members who may not yet be engaged in clinical care.

b. Describe how you will help prevent and manage chronic conditions through expanded nutrition services.

Expanded nutrition services will address the key risk factors associated with EECH's most prevalent nutrition-related chronic conditions: obesity, pre-diabetes, diabetes, and hypertension. Services will focus on patients identified through BMI screenings, A1C testing, blood pressure monitoring, PRAPARE assessments, and provider referrals, providing a structured pathway from clinical identification to individualized nutrition support.

Individualized nutrition counseling delivered by the Registered Nutritionist will support patients in improving healthy eating behaviors, meal planning, portion control, weight management, blood sugar regulation, and blood pressure management. For the 168 patients currently identified with pre-diabetes, the project aims to achieve a 20% reduction, at least 33 patients reversing to normal A1C levels, through a combination of intensive nutrition counseling, dietary behavior change education, and improved access to healthy foods. For the 481 patients with diabetes, the project targets a reduction in the share with poor glycemic control (A1C above 9%) from 35.0% to 30.0% or lower by the end of Year 2, with every patient with an A1C above 9% referred to the Registered Nutritionist for medical nutrition therapy and re-tested quarterly. For children and adolescents, every patient aged 3 to 17 whose BMI percentile is out of range (at or above the 85th percentile, or below the 5th percentile) will be referred to nutrition services, with a target that at least 75% complete a nutrition education encounter, individual or family-based, by the

end of Year 2; the 75 MMM Rx families are drawn from this group. For patients with hypertension, nutrition counseling will emphasize sodium reduction, DASH diet principles, weight management, and food preparation strategies aligned with their clinical care plans.

Preventive nutrition education and family-centered counseling will support pediatric and adolescent patients at increased risk for obesity. The MMM Rx produce prescription pilot will connect Maryland families with fresh local produce while building food literacy, positive food purchasing routines, and ongoing relationships with local food systems, outcomes that extend well beyond the clinical visit.

For patients in DC, the Registered Nutritionist will deliver targeted chronic disease nutrition education integrated into existing primary care and chronic disease management workflows at the Kenilworth site. Patients with diabetes will receive guidance on carbohydrate management, glycemic control, and meal planning. Patients with hypertension will receive DASH aligned nutrition counseling and sodium reduction education. All high-risk patients will be screened for food insecurity through PRAPARE assessments and connected to food access resources when identified.

All patient education materials are aligned with the 2025-2030 Dietary Guidelines for Americans and the Make America Healthy Again initiative: materials use the updated federal food guidance graphic, emphasize vegetables, fruits, lean protein, whole grains, and dairy, limit added sugars, sodium, and ultra-processed foods, translate the guidance into low-cost meals built from prescription pantry and farmers market items, and are written at appropriate health literacy levels. Expanded nutrition services will be embedded within EECH's existing integrated care infrastructure, ensuring that nutrition counseling, chronic disease management, behavioral health support, and food access navigation are coordinated within a unified patient care plan. The Registered Nutritionist and CHW/Project Coordinator will work collaboratively with primary care providers to ensure all patients identified through BMI screenings, A1C results, and blood pressure monitoring receive appropriate follow-up nutrition interventions and ongoing support.

c. Describe how you will coordinate care for patients with inconsistent access to adequate nutritious food.

EECH currently screens patients for food insecurity and non-medical factors affecting health using PRAPARE assessments integrated within the Athenahealth EHR at all EECH sites: the College Park and Kenilworth sites and the school-based mobile unit. Patients identified as food insecure, overweight, obese, diabetic, pre-diabetic, or experiencing risk factors for nutrition-related chronic conditions are referred to nutrition services and community food access supports as part of routine clinical workflows.

The ENS project will strengthen and systematize this process through the addition of a dedicated CHW/Project Coordinator responsible for ensuring that patients identified with food insecurity receive timely, sustained nutrition support and prescribed food. In Maryland, eligible families will receive MMM Rx produce prescriptions redeemable through MDA's voucher system at participating farmers markets and farm stands, reinforcing clinical nutrition counseling with direct access to fresh fruits and vegetables. In Washington, DC, patients will receive healthy

food purchased and distributed directly by EECH. The CHW/Project Coordinator will administer food prescription fulfillment and delivery, track participation, coordinate with MDA and participating vendors, and ensure enrolled families receive follow-up support throughout the project period.

In Washington, DC, patients at the Kenilworth site identified with food insecurity will receive prescribed food directly from EECH through the prescription food pantry and the refrigerated delivery vehicle. Where a patient's needs exceed what the food prescription covers, EECH staff will refer the patient to So Others Might Eat (SOME) under a working agreement, and to local food banks. SOME provides emergency food services, transitional housing support, and community meals across the DC area, offering a trusted and accessible supplemental resource for EECH's DC patient population. The working agreement with SOME is a referral arrangement, not a contract; no ENS funds will flow to SOME or to any food bank.

Care coordination for food insecure patients will center on nutrition services delivered by EECH: individualized nutrition counseling, food prescription fulfillment and delivery, group nutrition education, and clinical follow-up. Where patients need food assistance beyond the food prescription, EECH staff refer patients to SOME under the working agreement and connect them to local food banks and community food distribution events. EECH separately assists patients with SNAP and WIC applications as an enabling service; consistent with this notice of funding opportunity, that eligibility assistance is recorded under Eligibility Assistance, is not counted as a nutrition service, and is not charged to this award. Transportation assistance and appointment reminder calls will be provided by the CHW/Project Coordinator to reduce the obstacles patients face in obtaining nutrition care. Priority populations across both geographies will include children and adolescents with out-of-range BMI percentiles and their families, patients with diabetes whose A1C is above 9%, patients with pre-diabetes, patients with hypertension, and low-income households identified through PRAPARE screening as food insecure.

Integrated care coordination, consistent patient follow-up, and collaboration with community food partners will improve patient access to healthy foods while supporting chronic disease prevention, healthier lifestyle behaviors, and sustained patient engagement in nutrition services.

d. Describe how you will advance the skills and knowledge of your workforce to support expanded nutrition services.

ENS funding will support staff training and workforce development to strengthen EECH's capacity to deliver high-quality, effective nutrition services. The Registered Nutritionist and CHW/Project Coordinator will receive training in motivational interviewing, behavioral modification, chronic disease nutrition counseling, food insecurity intervention, DASH diet education, produce prescription program administration, and nutrition education tailored to each patient's individual needs and health literacy.

Existing primary care providers and clinical staff will also receive interdisciplinary training related to nutrition services workflows, referral protocols, and coordination with the new nutrition team. This training will allow providers to focus on clinical care while ensuring direct hand-offs to the Registered Nutritionist for intensive nutrition counseling and to the

CHW/Project Coordinator for food insecurity navigation and community resource referrals. The addition of dedicated nutrition-focused staff will free providers from nutrition coordination tasks that currently compete with clinical priorities, improving both care quality and provider capacity.

2. Describe your quality improvement plan to improve patient health outcomes related to nutrition services.

A comprehensive Quality Assurance and Quality Improvement (QA/QI) Program will support implementation and ongoing evaluation of the ENS project. Nutrition services will be integrated into EECH's existing QA/QI infrastructure, leveraging Athenahealth EHR dashboards and PRAPARE screening data to monitor patient outcomes, service utilization, care coordination activities, and chronic disease prevention efforts on a quarterly basis.

Quality improvement activities will include:

- Monitoring the number of patients enrolled in nutrition counseling at both the College Park and Kenilworth sites and through the school-based mobile unit;
- Tracking A1C levels for pre-diabetic patients quarterly, with a target of reducing A1C to below 5.7% in at least 33 of 168 pre-diabetic patients (20% reversal) by the end of Year 2;
- Tracking the proportion of patients with diabetes with A1C above 9% quarterly, with a target of reducing poor glycemic control from 35.0% to 30.0% or lower by the end of Year 2;
- Tracking the proportion of pediatric patients with an out-of-range BMI percentile who complete a nutrition education encounter, with a target of at least 75% by the end of Year 2;
- Monitoring blood pressure outcomes for patients with elevated, Stage 1, and Stage 2 hypertension enrolled in nutrition counseling;
- Tracking BMI screening completion and follow-up rates for pediatric and adult patients;
- Monitoring food insecurity screening rates and referral completion through PRAPARE assessment data;
- Tracking MMM Rx produce voucher distribution, utilization, and family participation in Maryland;
- Monitoring food prescription fulfillment and delivery completion rates in DC, and the volume of informal food bank referrals made;
- Reviewing patient satisfaction data and retention in nutrition services; and
- Utilizing Plan-Do-Study-Act (PDSA) quality improvement cycles to strengthen workflows, referral processes, and patient engagement strategies based on ongoing evaluation findings.

Performance data will be reviewed quarterly by EECH's leadership, providers, Registered Nutritionist, and QA/QI staff. When data indicates gaps in referral completion, patient engagement, or clinical outcomes, PDSA cycles will be initiated to identify root causes and test workflow modifications. The CHW/Project Coordinator will provide regular progress reports on food access referral outcomes, voucher utilization, and patient follow-up engagement to inform ongoing program adaptation.

3. Explain how any proposed equipment and/or minor A/R costs are necessary for your project.

EECH proposes one one-time equipment purchase under this funding opportunity: a refrigerated food delivery vehicle, budgeted at \$65,666 in Year 1. No minor alteration or renovation costs are proposed, and no equipment or A/R funds are requested in Year 2.

The vehicle is necessary because EECH's food-as-medicine intervention depends on moving perishable food safely between two service areas and out to the communities where patients live. EECH will purchase healthy food, including fresh produce, dairy, and lean protein, and distribute it directly to patients as prescribed food at the College Park and Kenilworth sites, through the school-based mobile unit, and by delivery. Prince George's County has a vehicle unavailability rate of 5.3%, above both the Maryland rate of 4.2% and the national rate of 4.4%,¹⁰ and many EECH patients cannot travel to a clinic site to collect perishable food. Without refrigerated transport EECH cannot maintain the cold chain that safe distribution of produce, dairy, and protein requires, which would confine the food prescription program to shelf-stable items and to the subset of patients able to travel. The vehicle allows EECH to deliver prescribed food to homebound and transportation-limited patients, move food between the two sites and the school-based mobile unit, and transport ingredients for cooking demonstrations and group nutrition education sessions.

The item to be purchased is a motor vehicle with an integrated refrigeration unit that meets the requirements of the ENS Notice of Funding Opportunity. Total federal equipment cost is \$65,666, within the \$150,000 limit on Year 1 one-time costs, and because no minor A/R is proposed the combined one-time total remains \$65,666.

EECH will complete the purchase within 12 months of award on the following schedule: specification development and internal approval in months one and two; competitive solicitation and bid evaluation under EECH's written procurement policy and the procurement standards at 2 CFR Part 200 in months three and four; award and order placement in month five; chassis delivery and refrigeration outfitting in months six through eight; and inspection, titling, insurance, and placement in service by month nine. This schedule leaves three months of contingency within the twelve-month window. The vehicle will be titled to EECH, used only at and in support of in-scope service delivery sites, and maintained, tracked, and disposed of in accordance with 2 CFR Part 200. Operating costs are budgeted alongside it: a driver at 0.2 FTE in Year 1 and 0.4 FTE in Year 2, commercial auto insurance, registration and commercial tags, fuel, and cold-chain supplies including insulated carriers, digital thermometers, and a platform scale.

Aside from the vehicle, EECH's College Park and Kenilworth sites are fully equipped to support the proposed nutrition services' expansion. Both sites have functional clinical examination rooms, EHR infrastructure, patient education spaces, and administrative support systems in place, and the school-based mobile unit is equipped for patient screenings, PRAPARE assessments, and community outreach. No facility improvement or additional major equipment investment is required to implement the ENS project as proposed.

¹⁰ Data USA. Retrieved May 21, 2026, from: <https://datausa.io/>

COLLABORATION

1. Describe how you will work with organizations in your service area that improve patient health through better nutrition.

EECH maintains strong partnerships with healthcare providers, community organizations, social service agencies, schools, food assistance programs, and public health entities throughout Prince George's County and Washington, DC. The proposed ENS project will deepen and formalize these collaborations to deliver coordinated nutrition education, food access support, and chronic disease prevention services across both geographies. The graphic below shows a high-level overview of the collaborative initiative.

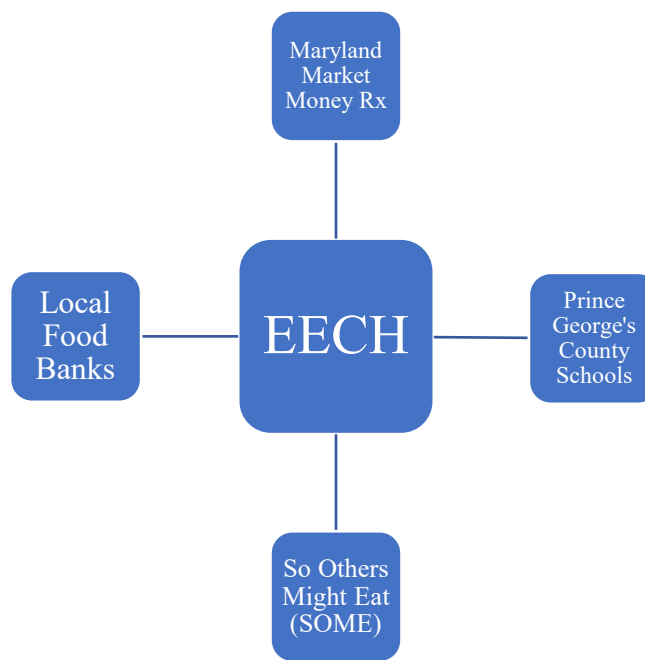


Table 8 identifies each partner, its role in the project, the current status and documentation of the relationship, and the EECH staff member accountable for it.

Table 8: ENS Partners, Roles, Relationship Status, and Accountable EECH Staff			
Partner	Role in the ENS Project	Relationship and Documentation	EECH Lead
Maryland Department of Agriculture (MDA), in partnership with the Prince George's County Office of Food Insecurity	Administers the MMM Rx pediatric produce prescription pilot; supplies voucher instruments, participant identification numbers, prescription stamps, tracking logs, redemption guidance,	EECH is a named clinical partner in the pilot; participation documented in EECH's signed pilot participation agreement with MDA (2026); planning calls under way since May 2026; no ENS funds flow to MDA	COO; CHW/Project Coordinator

	and market reimbursement		
Participating Maryland Market Money farmers markets and farm stands	Exchange produce prescriptions for MMM Rx market currency; sell fresh fruits and vegetables; reimburse farmers; report redemption data to MDA	Existing MMM access points coordinated by MDA; one identified market operates year-round	CHW/Project Coordinator
Prince George's County Public Schools	Host sites for the school-based mobile unit; identification of children with elevated BMI and food insecurity; family outreach for MMM Rx enrollment	Established school-based health screening relationship through the mobile unit; EECH Outreach Coordinator assigned as district liaison since 2024; 53 eligible children already identified	Director of Administrative Services
So Others Might Eat (SOME)	Supplemental emergency food, community meals, and pantry access for DC patients whose needs exceed their EECH food prescription	Existing working relationship through SOME's externship program; SOME leadership confirmed acceptance of ENS referrals in July 2026; working agreement defines the referral pathway and follow-up; no funds exchanged	CHW/Project Coordinator
Capital Area Food Bank and local food pantries (DC and Maryland)	Supplemental food access referrals, including winter months when farmers market activity is lowest	Informal point-of-care referral; referrals entered and closed in Athenahealth	CHW/Project Coordinator
Community centers and churches in both service areas	Host sites for quarterly cooking demonstrations for patients referred for food prescriptions	Host site scheduling completed after award; no ENS funds flow to hosts	Registered Nutritionist
Mid-Atlantic Association of Community Health Centers; DC Primary Care Association; HCCN; NTAPs	Nutrition workflow design, peer learning, Athenahealth configuration for nutrition visits and the 2027 UDS measure, produce prescription and cold-chain guidance	Existing PCA membership and HCCN participation; technical assistance at no cost to the award	CMO; Director of Quality and Compliance

In Maryland, EECH's primary nutrition partnership is with the Maryland Department of Agriculture (MDA), in partnership with the Prince George's County Office of Food Insecurity,

through the Maryland Market Money Rx (MMM Rx) pediatric produce prescription pilot. This initiative, designed specifically to connect pediatric patients experiencing or at risk of diet-related chronic disease and food insecurity with fresh fruits and vegetables from local farmers, represents a natural extension of EECH's clinical nutrition counseling into community food systems. Under this partnership, EECH's College Park site and school-based mobile unit will identify eligible pediatric patients and families, issue MMM Rx produce prescriptions, and coordinate with MDA and participating farmers markets and farm stands to facilitate voucher redemption. Participating markets will exchange prescriptions for vouchers redeemable for fresh fruits and vegetables. EECH will provide patient referrals, follow-up visits, and clinical nutrition counseling to reinforce the produce prescription benefit. The MDA provides voucher materials, tracking systems, participant identification numbers, and program administration support at no cost to this award, and no ENS funds are used to purchase MMM Rx vouchers or any other cash-equivalent instrument. EECH's participation is documented in a signed pilot participation agreement with MDA, and EECH has been in planning calls with MDA since May 2026 on eligibility criteria, workflows, and evaluation measures. EECH has already identified 53 pediatric patients with overweight or obesity who meet the pilot's eligibility criteria, so enrollment can begin in the first season after award.

This collaboration aligns with goals established under Maryland's ENOUGH Act, supporting nutrition security for children and families, strengthening clinical-community food access partnerships, and supporting local farmers and regional food systems. By embedding a produce prescription pilot within EECH's existing clinical workflows, the partnership creates a sustainable, replicable model for food-as-medicine programming in Prince George's County.

In Washington, DC, EECH's supplemental food access partner is So Others Might Eat (SOME), a trusted community organization providing food services, transitional housing, and supportive care to low-income DC residents. EECH already works with SOME through SOME's externship program, which places program participants at EECH, and in July 2026 EECH's COO met with SOME leadership, which confirmed SOME's willingness to accept referrals of EECH patients under this project; the two organizations have established a working agreement that defines the referral pathway described below. The referral protocol is defined: when a Kenilworth patient's need exceeds the food prescription EECH provides directly, the CHW/Project Coordinator enters a referral to SOME's food programs in the Athenahealth referral module, gives the patient SOME's location, hours, and intake requirements, and closes the referral through a follow-up call within two weeks to confirm the patient was served. The working agreement is a referral arrangement, not a contract: no ENS funds flow to SOME, SOME performs no service on EECH's behalf, and SOME does not form part of EECH's scope of project.

EECH's relationship with Prince George's County Public Schools is the project's pediatric identification engine. EECH's school-based mobile unit delivers health screenings to students at district schools; since the 2024-2025 school year a full-time EECH Outreach Coordinator, funded under the Center's Behavioral Health Service Expansion award, has worked directly with the district on outreach and on linking families to social needs resources including food banks; and EECH's annual back-to-school event distributes 500 backpacks to district families. Under the ENS project the same screening days will add nutrition education, BMI percentile referral to the CHW/Project Coordinator, PRAPARE food insecurity screening, and MMM Rx enrollment, and

the mobile unit will host family nutrition education sessions and produce prescription follow-up visits on school grounds. This partnership extends EECH's clinical reach into the community, identifying children at nutritional risk earlier and connecting families to food resources and nutrition support without requiring a separate clinic visit; it is the reason EECH can commit to enrolling 75 MMM Rx families in the pilot's first season.

Additional collaborations supporting the ENS project include referral relationships with Capital Area Food Bank, the regional food bank serving both the District and Prince George's County, and with local food pantries and emergency food distribution programs in both Maryland and DC, community-based organizations providing social services and health education, and health fairs and outreach events that provide opportunities for community nutrition education and patient engagement.

EECH will also leverage Health Center Program technical assistance resources to strengthen implementation. EECH will work with its Primary Care Associations, the Mid-Atlantic Association of Community Health Centers in Maryland and the DC Primary Care Association, on nutrition workflow design, peer learning, and food-as-medicine program models; with its Health Center Controlled Network on Athenahealth configuration for nutrition visit documentation, food prescription tracking, and reporting of the new UDS nutrition services measure; and with National Training and Technical Assistance Partners for guidance on produce prescription program design, written food distribution policy, and cold-chain compliance. This technical assistance is available at no cost to the award and will shorten the start-up period for both the nutrition services program and the food delivery operation.

2. Describe how you will link patients to partners that support access to healthy food.

Patients at both the College Park and Kenilworth sites and through the school-based mobile unit are screened for food insecurity and non-medical factors affecting health during routine medical visits using PRAPARE assessments integrated within the Athenahealth EHR. Patients identified as food insecure, overweight, obese, diabetic, pre-diabetic, or experiencing risk factors for nutrition-related chronic conditions are referred to nutrition services and community food access supports as part of standard clinical workflows.

The ENS project will strengthen and expand these pathways through dedicated CHW/Project Coordinator support and formalized food prescription protocols. In Maryland, pediatric patients and families identified through BMI screenings, wellness visits, PRAPARE assessments, and provider referrals at the College Park site and school-based mobile unit will be enrolled in the MMM Rx produce prescription pilot. Enrolled families will receive produce prescriptions exchangeable for MMM Rx vouchers issued by MDA at participating farmers markets and farm stands, providing direct access to fresh fruits and vegetables while building familiarity with local food systems and healthy food purchasing habits. ENS funds support EECH's clinical role in this pathway; they do not purchase the voucher instruments.

In DC, patients at the Kenilworth site identified with food insecurity will receive prescribed food purchased and distributed directly by EECH, provided at the site or delivered into the patient's community by refrigerated vehicle. Where a patient's needs exceed the food prescription, EECH

staff refer patients to SOME under the working agreement and to local food banks, which provide emergency meals and pantry access that complement EECH's clinical nutrition counseling. The CHW/Project Coordinator will manage food prescription fulfillment and delivery, provide transportation assistance when needed, and conduct follow-up to confirm that patients are receiving and benefiting from the food prescribed.

Across both geographies, patients will be connected to food resources based on their individual needs, household situation, and geographic location. The primary connection is the food EECH provides directly: prescribed food distributed from the Kenilworth and College Park sites and by refrigerated delivery vehicle, and MMM Rx produce prescriptions redeemable at participating Maryland farmers markets and farm stands. Supplemental connections include SOME's food programs in DC under the working agreement and, informally at the point of care, local food banks and produce distribution programs, farmers markets and community-supported agriculture, and school and community nutrition education resources. SNAP and WIC application assistance remains available to patients as an enabling service recorded under Eligibility Assistance, separate from the nutrition services delivered under this award. The CHW/Project Coordinator will provide food prescription fulfillment, patient navigation, and ongoing follow-up to reduce the obstacles patients face in obtaining food and to ensure these connections are sustained over time.

3. Explain how your project aligns with and does not duplicate existing federal programs that may be operating in your service area.

EECH's proposed ENS project is specifically designed to complement, rather than duplicate, the federal and state nutrition and food assistance programs operating within its service area and actively leverages existing programs in both Maryland and DC.

Washington, DC's Kenilworth community is served by SOME and local food banks. Rather than replicating these programs, EECH's ENS project integrates this program through referrals and care coordination and then supplements it with clinical nutrition intervention and home delivered prescription food.

The MMM Rx produce prescription pilot represents a complementary partnership with MDA, not a duplication of existing USDA programs. Maryland Market Money operates in part with support from USDA's Gus Schumacher Nutrition Incentive Program (GusNIP), and EECH has structured its participation specifically to avoid duplicating GusNIP-funded costs. MDA and its market partners bear all voucher, incentive, and redemption costs under the state-administered program; ENS funds support only EECH's clinical activity, nutrition counseling, food prescription issuance, patient follow-up, and outcome tracking, together with the staff who deliver it and the food EECH purchases for its own DC food prescription program. No cost is charged both to this award and to GusNIP, and EECH will document that delineation in its accounting records. Where SNAP provides broad food purchasing support, MMM Rx targets pediatric patients with specific nutritional health needs and connects them to local farmers and farmers markets; EECH's participation strengthens an emerging pilot that does not yet have established clinical partners in the College Park area.

SNAP, WIC, and food bank programs provide critical food access, but they do not provide individualized nutrition counseling, chronic disease education, A1C monitoring, blood pressure management, or the clinical follow-up needed to translate food access into measurable health outcomes. EECH's ENS project fills this gap by embedding a Registered Nutritionist and CHW/Project Coordinator within the clinical care team, connecting food access to health goals, and monitoring patient outcomes through existing EHR and QA/QI infrastructure.

EECH has reviewed the other federal programs identified in this Notice of Funding Opportunity for activity in its service area. EECH is not a recipient of, and its service area is not served by a program operating under MAHA ELEVATE, the IHS Produce Prescription Pilot Program, or the Maternal Child Health Nutrition Training Program. EECH does not operate a Healthy Start program, and it does not deliver a CDC-recognized National Diabetes Prevention Program lifestyle change program; where a patient is eligible for a community-based National DPP program, EECH will make an informal referral rather than duplicate that curriculum. USDA Food and Nutrition Service programs operating in the service area, principally SNAP and WIC, are addressed above. No cost proposed under this application is charged to any other federal award.

The ENS project also aligns with the Make America Healthy Again (MAHA) initiative's focus on chronic disease prevention, proper nutrition, and evidence-based health interventions delivered through trusted primary care settings. By targeting patients with pre-diabetes, diabetes, hypertension, and childhood obesity, and by connecting clinical nutrition services to community food resources, EECH's project directly advances MAHA's priorities of fighting the chronic disease epidemic through individualized, community-anchored, nutrition-focused interventions. No other federally funded program currently operating in EECH's service area provides this combination of clinical nutrition counseling, produce prescription coordination, and chronic disease outcome monitoring for the populations EECH serves.

IMPACT

1. Describe how you will measure the impact of your project by the end of the two-year period of performance.

By the end of the two-year project period, EECH will measure the impact of the ENS project against specific, data-grounded targets tied to the health needs of its Maryland and DC patient populations. Evaluation activities will focus on service utilization, food access outcomes, and measurable improvements in nutrition-related chronic disease indicators.

a. Number of nutrition services patients and/or visits

EECH will track the following service utilization measures throughout the two-year project period using Athenahealth EHR reporting functions and program-specific tracking tools:

EECH's core objective under this award is to increase the number of nutrition services patients and nutrition-related visits from a baseline of zero, since EECH does not currently operate a distinct nutrition services program, to 600 unduplicated nutrition services patients and 1,500

nutrition-related visits in Year 1, rising to 850 unduplicated patients and 2,400 visits in Year 2. These targets derive from staffing capacity: a 0.75 FTE Registered Nutritionist delivering an average of six counseling visits per clinical day in Year 1, scaling to 1.0 FTE in Year 2, supplemented by group nutrition education sessions and food prescription encounters documented by the CHW/Project Coordinator under the Registered Nutritionist's direction. Because EECH's baseline for the new UDS nutrition services measure will be established during calendar year 2027, the increase from 2027 to 2028 is the figure HRSA will use to determine whether EECH met the ENS objective, and EECH's Year 2 targets are set to demonstrate that increase.

- Number of patients receiving individualized nutrition counseling from the Registered Nutritionist at the College Park and Kenilworth sites;
- Number of patients with diabetes and an A1C above 9% who complete a medical nutrition therapy visit with the Registered Nutritionist, and the proportion of all such patients reached, tracked quarterly;
- Number of children and adolescents aged 3 to 17 with an out-of-range BMI percentile who are referred to nutrition services and who complete at least one individual or family-based nutrition education encounter, tracked quarterly with a target of 100% referred and at least 75% completing by the end of Year 2;
- Number of nutrition-related visits completed, tracked monthly and reported annually in alignment with the UDS nutrition services measure HRSA will add to 2027 UDS reporting;
- Number of group nutrition education sessions conducted, including cooking demonstrations, chronic disease education workshops, and family-centered nutrition programs;
- Number of Maryland families enrolled in the MMM Rx pediatric produce prescription pilot, with a Year 1 target of 75 families served through the College Park site and school-based mobile unit;
- Number of DC families receiving prescribed food directly from EECH through the prescription food pantry and refrigerated delivery vehicle, with a Year 1 target of 50 families; and Year 2 Target of 75 families.
- Number of patients receiving food insecurity screenings through PRAPARE assessments and the proportion successfully connected to food access resources.

Referral completion rates, follow-up engagement, and participation trends among high-risk patients identified through BMI screenings, A1C results, and blood pressure monitoring will also be tracked quarterly to evaluate the effectiveness of referral and coordination workflows.

b. Other measures to demonstrate that your project has helped prevent and manage chronic conditions

EECH will monitor the following outcome measures to evaluate the effectiveness of expanded nutrition services in improving chronic disease prevention and management:

- A1C reversal among pre-diabetic patients: EECH will track quarterly A1C values for all 168 patients currently identified with pre-diabetes (A1C 5.7–6.4%). The project target is

a 20% reduction, at least 33 patients achieving A1C levels below 5.7% by the end of Year 2;

- Glycemic control among patients with diabetes: EECH will track the proportion of the 481 patients with diabetes whose most recent A1C is above 9%, with a target of reducing poor control from 35.0% to 30.0% or lower by the end of Year 2;
- Pediatric nutrition education reach: EECH will track the number and proportion of patients aged 3 to 17 with an out-of-range BMI percentile who are referred to and complete a nutrition education encounter, with a target of 100% referred and at least 75% completing by the end of Year 2;
- Blood pressure outcomes for hypertensive patients: EECH will monitor blood pressure readings at each visit for patients with Stage 1 and Stage 2 hypertension enrolled in nutrition counseling, tracking the proportion achieving blood pressure control (below 130/80 mmHg) over the project period;
- BMI and weight management outcomes: BMI trends will be tracked for patients enrolled in obesity-related nutrition counseling, with a focus on pediatric patients in the MMM Rx pilot and adults with obesity diagnoses;
- Food insecurity screening and intervention completion rates: EECH will track the proportion of patients screened for food insecurity through PRAPARE assessments and the proportion successfully connected to food access resources;
- MMM Rx voucher utilization: Voucher distribution, redemption rates, and family retention in the produce prescription pilot will be tracked through MDA's voucher tracking system; and
- Patient engagement and retention in nutrition services: EECH will monitor appointment completion rates, return visit frequency, and participation in group nutrition education to assess ongoing engagement.

All outcome measures will be reviewed quarterly by EECH's leadership, providers, and QA/QI staff. Athenahealth EHR reporting tools, PRAPARE screening data, and MMM Rx program tracking will support ongoing data collection and analysis. Findings will be used to adapt interventions, strengthen referral workflows, and ensure the project is achieving meaningful improvements in the health outcomes of the populations it serves.

2. Describe how you will measure the impact of your program beyond the two-year period of performance.

EECH intends to sustain expanded nutrition services beyond the initial two-year project period by integrating the Registered Nutritionist and CHW/Project Coordinator positions into the organization's long-term clinical staffing model. As nutrition services become embedded within primary care, chronic disease management, and enabling services workflows, EECH will continue tracking long-term outcome measures that reflect the sustained impact of nutrition intervention on population health.

a. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (UDS Table 6B, Line 12)

EECH's current 94.9% performance rate for pediatric weight assessment and counseling reflects strong screening infrastructure. EECH intends to increase this goal to 97%. Beyond the two-year project period, EECH will track whether expanded nutrition programming, including MMM Rx participation, family-centered nutrition education, and school-based mobile unit outreach, translates into measurable improvements in pediatric BMI trends and obesity prevalence among the children served. Specifically, EECH will follow the cohort of children with out-of-range BMI percentiles who completed a nutrition education encounter during the project period, tracking the proportion whose BMI percentile moves toward the healthy range at 12 and 24 months and the proportion who remain engaged in nutrition services or MMM Rx. The goal is to demonstrate that the counseling delivered is producing behavioral and health outcome changes among children and families over time, not only to maintain high screening rates.

b. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (UDS Table 6B, Line 13)

EECH will continue monitoring adult BMI screening and follow-up rates beyond the project period, with a particular focus on whether patients identified as overweight or obese are receiving sustained nutrition follow-up and demonstrating improved weight management outcomes. The long-term target is to increase the proportion of patients with obesity achieving clinically meaningful BMI reductions through sustained nutrition counseling and food access support.

c. Targeted patient health outcomes identified in the Need and Response sections

EECH will track the following long-term outcomes beyond the two-year period of performance:

- Sustained A1C improvement among pre-diabetic patients who reversed to normal A1C during the project period, monitoring whether reversal is maintained at 12 and 24 months post-project;
- Sustained glycemic control among patients with diabetes whose A1C fell to 9% or below during the project period, with the proportion of all patients with diabetes with an A1C above 9% tracked annually through UDS Table 7 against the 30.0% project target;
- BMI percentile trajectories at 12 and 24 months for children with out-of-range BMI percentiles who completed nutrition education during the project period, and continued participation of their families in nutrition services;
- Long-term blood pressure control rates among patients with Stage 1 and Stage 2 hypertension who received nutrition counseling during the project period;
- Continued participation in MMM Rx and other food access programs by enrolled families beyond the pilot period;
- Reduction in food insecurity rates among patients screened through PRAPARE assessments over successive UDS reporting periods; and
- Integration of billable nutrition counseling services within EECH's clinical care model to support long-term financial sustainability.

EECH anticipates that demonstrated outcomes during the two-year project period will position the organization to pursue future funding from HRSA, state health agencies, private foundations, and other sources to sustain nutrition services. Continued partnerships with MDA, SOME, Prince

George's County Public Schools, and community food organizations will further strengthen EECH's role as a hub for nutrition-centered primary care in its service communities. Evaluation findings, quality improvement data, and patient outcome measures will be shared with partners and used to support future grant applications, program replication, and advocacy for expanded nutrition services funding across the region.

CAPACITY

1. Describe your skills, expertise, and organizational capacity to start or expand your nutrition services.

As an established FQHC operating across two states, EECH has navigated the compliance, reporting, financial oversight, and programmatic demands of federal grant funding under 2 CFR 200 Uniform Guidance and Health Center Program requirements since its founding in 2010. This institutional experience ensures that ENS funds will be administered with accountability, transparency, and sound fiscal stewardship.

Accountability for this award rests with a leadership team that has been in place since EECH's founding in 2010. Jacquelyn Walker, Chief Executive Officer, has led EECH since its inception; before founding the Center she spent 28 years as Director of Patient Billing at Southern Maryland Hospital Center, where she built the hospital's charity care and financial assistance programs. Timothy Walker, Founder and Chief Operating Officer, has served as COO since inception, oversees information technology, human resources, and business office functions, secured both the Kenilworth and College Park facilities, and represents EECH in MMM Rx pilot planning with MDA and in the SOME partnership. The Chief Medical Officer position, which chairs EECH's QA/QI Committee and directs all clinical protocols, is under active recruitment; the 0.1 FTE of CMO time charged to this award funds direct medical supervision of the nutrition services program by the incoming CMO, and until the position is filled the CEO has designated EECH's senior medical provider as interim clinical lead for the project, consistent with EECH's QA/QI plan, under which the CMO or designee chairs the committee. John Toshum, PhD, MPA, Controller, manages EECH's Blackbaud accounting system, which tracks each federal award separately, and reports revenue, expenses, and accounts receivable to the Board of Directors monthly. Mary K. Milone-Wilkerson, MS, Director of Quality and Compliance, a Certified Accreditation Health Care Professional and Certified Healthcare Emergency Professional, maintains the QA/QI, risk management, and compliance programs and prepares the UDS and quality reports the Board reviews quarterly. Raelene Muhammad, Director of Administrative Services, with more than 20 years in health care operations, supervises medical assistants and support staff and manages the school-based data collection that feeds MMM Rx enrollment. Table 9 summarizes each leader's role in ENS oversight and the qualifications of the two positions this award creates.

Table 9: Key Personnel and ENS Oversight Responsibilities			
Name and Title	Credentials and Tenure	Role in ENS Oversight	ENS FTE

Jacquelyn Walker, Chief Executive Officer	Founding CEO, 2010 to present; 28 years of hospital revenue cycle leadership	Executive accountability for the award; monthly reporting to the Board of Directors; approval of the written food distribution policy	Not charged
Timothy Walker, Founder and Chief Operating Officer	COO, 2010 to present; oversees IT, human resources, facilities, and business office	Project executive: recruitment of the two new positions, refrigerated vehicle procurement under 2 CFR Part 200, partner relationships with MDA, SOME, and schools	Not charged
Chief Medical Officer (position under recruitment)	Board-certified physician with a current DC and Maryland license required; chairs QA/QI Committee; interim clinical lead designated by the CEO until filled	Medical direction of nutrition services; referral criteria; clinical supervision of the Registered Nutritionist; quarterly outcome review	0.1 FTE
John Toshum, PhD, MPA, Controller	More than a decade of finance experience; Blackbaud federal award accounting	Separate ENS cost center; drawdowns and Federal Financial Reports; annual independent audit; GusNIP cost delineation	Not charged
Mary K. Milone-Wilkerson, MS, CAHP, CHEP, Director of Quality and Compliance	More than 10 years as a quality improvement and risk management director	PDSA cycles; UDS Table 5 nutrition measure and Table 6B and Table 7 reporting; compliance monitoring of the food distribution policy	Not charged
Raelene Muhammad, Director of Administrative Services	More than 20 years in health care operations	Supervision of support staff and the driver; school-based mobile unit data; scheduling and registration	Not charged
Registered Nutritionist (to be hired)	Registered Nutritionist credentialed to practice in Maryland and DC	Nutrition assessment, individualized counseling, group education, cooking demonstrations	0.75 FTE Year 1; 1.0 FTE Year 2
CHW/Project Coordinator (to be hired)	Community health worker training	Patient navigation, food prescription fulfillment and delivery, MMM Rx administration, referral tracking, progress reporting	0.75 FTE Year 1; 1.0 FTE Year 2

EECH's financial management systems have supported multiple concurrent HRSA awards, including its H80 Health Center Program award, Public Housing Primary Care funding, expanded services and behavioral health supplements, and a 2021 Primary Care HIV Prevention award, as well as a contract 340B pharmacy program. Board-approved financial policies are reviewed annually; the Controller reports revenue, expenses, and accounts receivable at the Board's monthly meeting; costs are tested for allowability under 2 CFR Part 200 Subpart E through an annual internal expense review; and an external certified public accounting firm conducts an independent audit every year, with results reported to the Board. The Blackbaud system will carry ENS as a separate cost center so that the GusNIP delineation described in the Collaboration section, the equipment purchase, and the federal share of each position can be traced from source document to Federal Financial Report. The Board of Directors meets monthly, approves the QA/QI plan annually, and receives quarterly quality reports; ENS performance will be a standing item on those reports.

Both project positions are vacant by design: they are new positions that this award creates, not backfills. EECH will post both positions within 30 days of the Notice of Award, using the recruitment funds budgeted in Year 1, and targets start dates within 90 days; the 0.75 FTE Year 1 budget for each position reflects that ramp. Until the Registered Nutritionist is on board, the interim clinical lead will direct nutrition counseling workflows, and the Director of Administrative Services' team will cover MMM Rx enrollment so that the pilot's July through October season is not missed.

EECH operates as a Patient-Centered Medical Home (PCMH), delivering integrated primary care, behavioral health, dental services, case management, enabling services, transportation assistance, and health education through multidisciplinary care teams at both the College Park and Kenilworth sites and through the school-based mobile unit. The organization uses the Athenahealth EHR system for clinical documentation, referral tracking, chronic disease monitoring, and performance reporting. PRAPARE screenings for non-medical factors influencing health outcomes are integrated into clinical workflows, enabling the systematic identification of patients with food insecurity, transportation limitations, housing instability, and other social determinants affecting nutrition and health.

Additionally, EECH has historically supported food access throughout its communities. For example, in 2012, the Center began providing turkeys and other food to complete Thanksgiving meals at its annual "Thanksgiving Turkey Giveaway," held every Saturday before Thanksgiving. The Center has served up to 700 families during the holiday season, providing canned goods, fresh produce, and baked goods. EECH's planning, storage, and distribution over the last 13 years have become extremely productive and quite efficient. EECH also brings an operating school-based mobile unit and an established health screening relationship with Prince George's County Public Schools, together with a full-time Outreach Coordinator already assigned as the Center's liaison to the district, so the pediatric identification and family outreach workflows the Maryland arm of this project depends on are already in place and staffed; ENS adds the nutrition intervention that follows the screening.

EECH's current patient data demonstrates both the scope of need and the breadth of existing clinical infrastructure to address it. The Center already tracks 481 patients with diabetes, 168 with pre-diabetes, 696 with hypertension or elevated blood pressure, and 791 with overweight or obesity diagnoses, populations who are primed to benefit from dedicated nutrition services and

for whom the clinical foundation for intervention is already in place. What is needed is the dedicated staffing and food access infrastructure that ENS funding will provide.

To support the ENS expansion, EECH will hire a Registered Nutritionist and a CHW/Project Coordinator. These positions will increase EECH's capacity for individualized nutrition counseling, patient outreach, care coordination, food insecurity screening, food prescription fulfillment and delivery, grant reporting, and ongoing quality improvement activities throughout the project period. In Year 1 both positions will be funded at 0.75 FTE while onboarding, training, and program infrastructure are established; in Year 2 both expand to 1.0 FTE as program operations reach full capacity. The project also supports 0.1 FTE of Chief Medical Officer time in both years for program oversight, including direction of the nutrition services program, review of implementation progress and quality indicators, and accountability for project performance and reporting, and a driver at 0.2 FTE in Year 1 and 0.4 FTE in Year 2 to operate the refrigerated food delivery vehicle. Total ENS-supported staffing is 1.8 FTE in Year 1 and 2.5 FTE in Year 2. All salaries charged to this award comply with the \$228,000 Executive Level II salary limitation in effect for this program.

Year 2 differs from Year 1 in four respects. The Registered Nutritionist and CHW/Project Coordinator increase from 0.75 to 1.0 FTE and the driver from 0.2 to 0.4 FTE as the program reaches full operating capacity and to allow time for recruitment. One-time costs do not recur: the refrigerated food delivery vehicle, staff laptops, and recruitment expense are Year 1 only. Food purchased for patient food prescriptions increases as enrollment grows across both service areas. Vehicle operating costs continue at a full-year level. There are no other substantive changes between the two budget years.

Nutrition services are not currently included in EECH's approved scope of project. EECH will submit a change in scope request to add nutrition services to Form 5A as a service provided directly by the health center within 120 days of award, as this notice of funding opportunity requires, and will maintain its H80 Health Center Program award status throughout the ENS period of performance. EECH will also adopt a written internal food distribution policy governing eligibility, food safety, cold-chain handling, storage, documentation, and inventory control before the first food prescription is filled.

2. Describe your use of screening tools to assess nutritional status of your patients.

EECH uses multiple integrated screening tools and clinical assessment processes to identify patients with risk factors for nutrition-related chronic disease and food insecurity. These tools are embedded within routine clinical workflows at all EECH sites and through the school-based mobile unit, enabling systematic identification of patients requiring nutrition counseling, food insecurity intervention, and community resource referrals.

EECH's current screening infrastructure includes BMI screening and follow-up assessments conducted during all adult and pediatric clinical visits, with Athenahealth EHR workflows supporting automatic flagging of patients with BMI values outside normal parameters and documentation of follow-up plans; A1C testing and monitoring for patients with diabetes and pre-diabetes, enabling tracking of glycemic status and identification of patients who would

benefit from intensive nutrition counseling; blood pressure monitoring at every clinical encounter, with documentation of hypertension stage and care planning for patients with elevated readings; PRAPARE assessments for non-medical factors that influence health outcomes, administered at all EECH sites, including the College Park and Kenilworth sites and the school-based mobile unit, to identify food insecurity, transportation limitations, housing instability, and other social factors affecting nutrition and health; and food insecurity screening tools integrated within the PRAPARE protocol, enabling providers and care teams to identify patients requiring referrals to food access resources, produce voucher programs, and community nutrition supports.

These screening activities enable EECH's providers and care teams to identify patients requiring nutrition counseling and food insecurity intervention in real time. When the Registered Nutritionist and CHW/Project Coordinator are on staff, flagged patients will be immediately referred into the nutrition services pathway, receiving individualized assessments, counseling appointments, and food access referrals tailored to their clinical needs and household situation.

3. Describe your capability to implement, monitor, and adapt the project throughout the period of performance.

EECH has strong organizational capability to implement, monitor, and adapt the proposed ENS project throughout the two-year period of performance. The Center's existing infrastructure, including its QA/QI program, Athenahealth EHR, multidisciplinary care teams, financial management systems, and community partnerships, provides a sound foundation for successful project implementation.

Table 10 sets out the implementation milestones for the 24-month period of performance and the staff accountable for each. The schedule front-loads recruitment, policy adoption, the change in scope request, and vehicle procurement so that all one-time purchases are complete within 12 months and both service arms are operating before the end of Year 1.

Table 10: 24-Month Implementation Milestones		
Period	Milestones	Accountable Staff
Months 1 to 3	Notice of Award received; Registered Nutritionist and CHW/Project Coordinator positions posted within 30 days; written food distribution policy adopted; refrigerated vehicle specifications approved; Athenahealth nutrition visit templates and referral pathways configured with HCCN support; MMM Rx workflows, eligibility criteria, and evaluation measures finalized with MDA; interim clinical lead directs referral protocol design	CEO; COO; Controller; Director of Quality and Compliance
Months 4 to 6	Both positions filled (target day 90) and staff trained in motivational interviewing, food insecurity intervention, and safe food handling; change in scope request submitted to add nutrition services to Form 5A (within 120 days	COO; CMO or interim clinical lead; Registered Nutritionist; CHW/Project Coordinator

	of award); competitive solicitation and award for the vehicle; refrigerator/freezer installed at Kenilworth; DC food prescription program launched from the on-site pantry; MMM Rx enrollment begins from the 53 children already identified; first quarterly cooking demonstration	
Months 7 to 9	Vehicle delivered, outfitted, titled, insured, and placed in service (month 9); driver hired; refrigerated deliveries begin for transportation-limited DC patients; school-year screening days resume with Prince George's County Public Schools with BMI percentile referrals to the CHW/Project Coordinator; first quarterly QA/QI review of A1C, blood pressure, and pediatric referral data; first PDSA cycle	COO; Registered Nutritionist; Director of Quality and Compliance
Months 10 to 12	Year 1 targets assessed: 600 nutrition services patients and 1,500 visits; 75 MMM Rx families enrolled; 50 DC families receiving prescribed food; SOME referral completion reviewed; Year 1 progress report to HRSA and the Board of Directors; Year 2 workflow adjustments from PDSA findings	CEO; CMO or interim clinical lead; Director of Quality and Compliance
Months 13 to 18	Registered Nutritionist and CHW/Project Coordinator to 1.0 FTE and driver to 0.4 FTE; DC food prescription enrollment expanded to 75 families; second MMM Rx season enrollment; calendar-year UDS reporting of the new nutrition services measure and Table 6B and Table 7 outcomes; mid-project review of A1C reversal, glycemic control, and pediatric education completion against targets	COO; Registered Nutritionist; Director of Quality and Compliance
Months 19 to 24	Year 2 targets assessed: 850 patients and 2,400 visits; 33 pre-diabetic patients reversed; poor glycemic control at or below 30.0%; at least 75% of referred children completing nutrition education; billing pathway for nutrition counseling operational; sustainability plan approved by the Board; final performance report; 12-month post-project follow-up cohorts defined	CEO; CMO; Controller; Director of Quality and Compliance

EECH's QA/QI Program will monitor project implementation, patient outcomes, workflow effectiveness, and quality indicators on a quarterly basis. The QA/QI team uses Plan-Do-Study-Act (PDSA) quality improvement cycles to test workflow changes, evaluate interventions, and adapt strategies based on real-time performance data. When quarterly reviews identify gaps in referral completion, patient engagement, voucher utilization, or clinical outcomes, PDSA cycles will be initiated to diagnose root causes and implement targeted improvements. This adaptive

management approach ensures that the project responds to emerging challenges quickly rather than waiting for end-of-year evaluations.

The CHW/Project Coordinator will provide regular progress reports on food prescription fulfillment and delivery completion, MMM Rx voucher utilization in Maryland, SOME and food bank referral volume in DC, and patient follow-up engagement, and the Registered Nutritionist will report quarterly on the three target populations: pre-diabetic patients tracked for A1C reversal, patients with diabetes and an A1C above 9% receiving medical nutrition therapy, and children with out-of-range BMI percentiles referred to and completing nutrition education. These reports will be reviewed alongside Athenahealth EHR data and PRAPARE screening outcomes at quarterly leadership meetings to ensure project activities are on track and producing the intended patient outcomes.

Through established integrated care coordination, data-driven quality improvement, and strong community partnerships across Prince George's County and Washington, DC, EECH is well positioned to implement the proposed ENS project with the clinical depth, community reach, and institutional accountability needed to produce lasting improvements in nutrition health outcomes for populations with limited access to care.

Elaine Ellis Center of Health			Year 1 Total	Year 2 Total
	Rate	Quantity		
REVENUE				
Funding			350,000	350,000
TOTAL REVENUE			350,000	350,000
EXPENSES				
PERSONNEL				
Medical Staff			22,800	22,800
Enabling Staff			62,500	99,000
Nutrition Staff			60,000	84,919
TOTAL PERSONNEL			145,300	206,719
FRINGE BENEFITS				
FICA	7.65%		11,115	15,817
Health Insurance	7.70%		11,188	15,917
Unemployment & Workers Compensation	2.63%		3,821	5,437
TOTAL FRINGE	17.98%		26,124	37,171
TRAVEL				
Local mileage for staff travel (\$0.76/mile)	0.76	1000	760	760
TOTAL TRAVEL			760	760
EQUIPMENT				
Refrigerated Unit for Mobile Delivery	65666		65,666	-
TOTAL EQUIPMENT			65,666	-

Elaine Ellis Center of Health			Year 1 Total	Year 2 Total
	Rate	Quantity		
SUPPLIES				
Outreach Supplies	250.00	12	3,000	3,000
Programmatic Supplies	250.00	12	3,000	3,000
Educational Supplies	250.00	12	3,000	3,000
Food for Quarterly Cooking Demonstrations	500.00	4	2,000	2,000
Portion Demonstration Kits to show patients portion size for different food groups. 2 for each location (DC, Kenilworth, and the mobile unit)	75.00	6	450	450
Laptops For New Staff (\$1,500 per laptop per staff) - Year 1 purchase only	1500.00	2	3,000	
Dual Temperature Refrigerator Freezer Combo - Year 1 purchase only	8400	1	8,400	
Prescription Pantry Food Supplies - serving 50 patients per month in Year 1 and 75 patients per month in Year 2	5500	12	66,000	86,200
Food-safe transport containers, insulated carriers, digital thermometers & platform scale (12 sets Yr 1 @ \$100; 6 replacement sets Yr 2)	100	12	1,200	600
TOTAL SUPPLIES			90,050	98,250

Elaine Ellis Center of Health			Year 1 Total	Year 2 Total
	Rate	Quantity		
CONTRACTUAL				
TOTAL CONTRACTUAL			-	-
CONSTRUCTION				
TOTAL CONSTRUCTION			-	-
OTHER				
Workforce development training for CHW and Nutritionist	1,500.00	2	3,000	3,000
Recruitment costs for Year 1 for the registered nutritionist	15,000.00	1	15,000	-
Commercial auto insurance - food delivery vehicle (\$300/mo; 5 mos in Yr 1, held flat at the same level in Yr 2)	300.00	5	1,500	1,500
Vehicle registration, DC commercial tags & annual safety inspection	600.00	1	600	600
Vehicle fuel - food prescription delivery routes (\$400/mo; 5 mos in Yr 1, held flat at the same level in Yr 2)	400.00	5	2,000	2,000
TOTAL OTHER			22,100	7,100
TOTAL DIRECT CHARGES			350,000	350,000
INDIRECT CHARGES				
0% indirect cost rate				
TOTALS			350,000	350,000

ENS Year 1 Staff Profile		
Full name	Position	Full-time / Part-time
Vacant	CHW/Project Coordinator	75%
Vacant	Registered Nutritionist	75%
Need	Driver	20%
Need	CMO	10%
		1.80

ENS Year 2 Staff Profile		
Full name	Position	Full-time / Part-time
Vacant	CHW/Project Coordinator	100%
Vacant	Registered Nutritionist	100%
Need	Driver	40%
Need	CMO	10%
		2.50