

September 9, 2026

Maryland Department of Planning

State Clearinghouse for Intergovernmental Assistance
120 E. Baltimore Street, Suite 2000
Baltimore, MD 21202

RE: Executive Order 12372 Intergovernmental Review

Applicant: Owensville Primary Care, Inc. dba Bay Community Health

Funding Opportunity: HRSA-27-099 - Fiscal Year 2027 Expanding Nutrition Services

Federal Agency: Health Resources and Services Administration (HRSA)

Assistance Listing: 93.224 - Health Center Program

Federal Funding Request: \$350,000

Dear State Clearinghouse:

Owensville Primary Care, Inc., dba Bay Community Health (BCH), respectfully submits the enclosed application materials to the Maryland State Clearinghouse for Intergovernmental Assistance for review in accordance with Executive Order 12372.

BCH is applying to the Health Resources and Services Administration under HRSA-27-099, Fiscal Year 2027 Expanding Nutrition Services, to expand access to nutrition services for patients in Anne Arundel County, Maryland.

The proposed project will be implemented at BCH locations in West River, Shady Side, and Lothian, Maryland, within Anne Arundel County.

Enclosed for review are the relevant application materials, including the SF-424, project narrative, project/performance site information, and project budget.

Please contact Dr. Erica Johnson, Chief Executive Officer, at 443-223-6845 or ejohnson@baycommunityhealth.org if additional information is required.

Thank you for your review and consideration.

Sincerely,

Dr. Erica Johnson

Chief Executive Officer
Owensville Primary Care, Inc.
dba Bay Community Health
134 Owensville Road
West River, MD 20778-9702

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:

H80CS26633

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*** a. Legal Name:** Owensville Primary Care Inc.

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

52-1020937

*** c. UEI:**

NHXWPVMFKMF5

d. Address:

*** Street1:** 134 Owensville Road

Street2:

*** City:** West River

County/Parish: Anne Arundel

*** State:** MD: Maryland

Province:

*** Country:** USA: UNITED STATES

*** Zip / Postal Code:** 20778-9702

e. Organizational Unit:

Department Name:

Division Name:

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

Prefix:

Dr.

*** First Name:**

Erica

Middle Name:

*** Last Name:**

Johnson

Suffix:

Title: Chief Executive Officer

Organizational Affiliation:

*** Telephone Number:**

443-223-6845

Fax Number:

*** Email:** ejohnson@baycommunityhealth.org

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:

Owensville Primary Care Inc.- Expanding Access to Nutrition Services to Improve Health Outcomes in Anne Arundel County

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	MD-005	* b. Program/Project	MD-005
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	5,701.00		
* g. TOTAL	355,701.00		
* 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:	Dr.	* First Name:	Erica
Middle Name:			
* Last Name:	Johnson		
Suffix:			
* Title:	Chief Executive Officer		
* Telephone Number:	443-223-6845	Fax Number:	
* Email:	ejohnson@baycommunityhealth.org		
* 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:	Owensville Primary Care Inc		
UEI:	NHXWPVMFKMF5		
* Street1:	134 Owensville Rd		
Street2:			
* City:	West River	County:	Anne Arundel
* State:	MD: Maryland		
Province:			
* Country:	USA: UNITED STATES		
* ZIP / Postal Code:	20778-9702	* Project/ Performance Site Congressional District:	MD-005

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:	OPC Shady Side V1		
UEI:			
* Street1:	6131 Shady Side Rd		
Street2:			
* City:	Shady Side	County:	Anne Arundel
* State:	MD: Maryland		
Province:			
* Country:	USA: UNITED STATES		
* ZIP / Postal Code:	20764-9504	* Project/ Performance Site Congressional District:	MD-005

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:	Bay Community Health- Lothian		
UEI:			
* Street1:	5408 Southern Maryland Blvd		
Street2:			
* City:	Lothian	County:	Anne Arundel
* State:	MD: Maryland		
Province:			
* Country:	USA: UNITED STATES		
* ZIP / Postal Code:	20711-2601	* Project/ Performance Site Congressional District:	MD-005

Additional Location(s)

Add Attachment

Delete Attachment

View Attachment

Owensville Primary Care, Inc. dba Bay Community Health
Fiscal Year 2027 Expanding Nutrition Services -HRSA-27-099

Project Narrative

INTRODUCTION

Owensville Primary Care, dba Bay Community Health (BCH), seeks Fiscal Year (FY) 2027 Expanding Nutrition Services (ENS) funding to establish a formal nutrition service line for pediatric and adult patients in rural southern Anne Arundel County, Maryland. Within the primary care setting most South County residents use as their medical home, the project will provide structured nutrition assessment, counseling, and food-based interventions. The approach will be integrated with the health center's robust behavioral health program (without providing direct financial support). This approach directly supports the Make America Healthy Again (MAHA) priorities related to nutrition, chronic disease prevention, and reduction of chronic disease burden.

BCH is a Federally Qualified Health Center (FQHC) with more than 50 years of service to South County. During 2025, its three service sites provided care to 4,288 patients, including 330 individuals younger than age 18. A rural area south of Baltimore, "South County" lacks a hospital, has no fixed-route public transportation, and most of it is technically designated urban even though the residents pride themselves on their rural way of life. BCH is the only comprehensive primary care organization within the service area that offers a sliding fee schedule. Moreover, its status as an urban area makes the South County area ineligible for important organizational and rural development opportunities.

BCH does not currently provide nutrition services so this will be a new service line for BCH. The proposed project includes around four integrated components:

- Automatic referrals inside eClinicalWorks (eCW). BCH will combine defined clinical criteria with PRAPARE, a tool to screen for social drivers of health, to generate an electronic alert recommending a nutrition referral. The automated process integrates screening and provider decision support.
- Dedicated nutrition visits. BCH uses two strategies to deliver nutrition visits. Three positions will be added: a full time Nutritionist, a part time Registered Nurse Certified Diabetes Educator, and a Community Health Worker serving as Nutrition Coach. In addition, an existing Nurse Practitioner with an undergraduate degree in dietetics will expand her duties to include dedicated nutrition appointments. Nutrition encounters will have specific appointment slots, will be scheduled separately from primary care visits, and may be delivered in person or by telehealth.
- ProduceRx, delivered through an existing food distribution partner. Patients with a positive screen for food insecurity or limited access to healthy foods will receive a monthly produce prescription filled by the Anne Arundel County Food Bank. BCH and the Food Bank already work together to bring food into South County, and this project converts that established relationship into a clinical service. The Food Bank has agreed to

the project. Because the logistics of supporting South County are significant, the two organizations conduct a strategic planning session after award, including a pilot or soft launch, to ensure a smooth implementation. The budget funds both the produce and its delivery. BCH plans to issue 1,000 prescriptions in Year 1 and 1,200 in Year 2.

- Wraparound support. The Community Health Worker, care management, and outreach staff will coordinate scheduling, transportation, food resource linkages, and ProduceRx delivery and receipt. These functions place clinical and social barrier resolution within the same coordinated care process.

BCH's Year 1 target is 300 patient referrals and 600 completed nutrition visits, growing to 600 referrals and 1,000 visits in Year 2. BCH also maintains an established behavioral health program. When depression, anxiety, or disordered eating contributes to a patient's eating pattern, those conditions will be managed through existing, separately funded behavioral health services while nutrition treatment continues. The ENS budget contains no behavioral health personnel line and no behavioral health service costs.

NEED

1. Describe the need to start or expand your nutrition services to help prevent and manage chronic conditions in your service area. Include the following data to demonstrate unmet need:

BCH proposes to start nutrition services. Nutrition is not currently a service on BCH's Form 5A, BCH employs no health education specialists and 0.14 FTE of outreach workers in its 2025 Uniform Data System (UDS) report. Nutrition guidance today is delivered informally inside 15 minute and 30 minute primary care visits, which the ENS NOFO expressly distinguishes from nutrition services.

The consequence is visible in BCH's own quality data. Roughly 38% of both pediatric and adult patients lack complete weight assessment and follow up documentation, more than a quarter of hypertensive patients are uncontrolled, and 1,914 patients carried an overweight or obesity diagnosis across 4,968 visits in 2025. The sections below present the required UDS measures, additional UDS Table 6B measures, and service area data.

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

Table 1: UDS Table 6B, Line 12, Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents ¹				
Measure	Total Patients Aged 3 through 17	Number of Records Reviewed	Number of Patients with Counseling and BMI Documented	Rate
Percentage of patients 3 to 17 years of age with a BMI	256	256	159	62.1%

¹ BCH 2025 UDS report.

Table 1: UDS Table 6B, Line 12, Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents ¹				
percentile and counseling on nutrition and physical activity documented				

BCH reviewed records for all 256 patients aged 3 through 17. Only 159, or 62.1%, had both a documented BMI percentile and counseling on nutrition and physical activity. **Ninety seven children and adolescents, 37.9% of the pediatric measure population, did not receive or were not documented as receiving this preventive service.**

This gap is the single clearest argument for pediatric inclusion in BCH's ENS target population:

- Children and adolescents are 330 of BCH's 4,288 patients, so the measure captures nearly the entire pediatric panel rather than a small subgroup.
- Childhood weight status is the strongest modifiable predictor of adult type 2 diabetes, hypertension, and cardiovascular disease, which are the same conditions driving BCH's adult chronic disease burden.
- BCH has no staff position responsible for delivering or documenting the counseling half of this measure, so the gap is structural and does not close through provider reminders alone.
- 42% of Anne Arundel County students qualify for free or reduced price lunch,² which indicates that a substantial share of BCH's pediatric families face food cost pressure that shapes what children eat.

Expanding nutrition services allows BCH to convert this documentation and counseling gap into scheduled pediatric nutrition visits, with the family present, before diabetes or hypertension develops.

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

Table 2: UDS Table 6B, Line 13, Preventive Care and Screening, Body Mass Index (BMI) Screening and Follow Up Plan ³				
Measure	Total Patients Aged 18 and Older	Number of Records Reviewed	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate	Rate
Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan	3,740	3,740	2,308	61.7%

² County Health Rankings & Roadmaps, 2024. Retrieved June 11, 2026, from <https://www.countyhealthrankings.org/>

³ BCH 2025 UDS report.

documented if BMI is outside normal parameters				
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BCH reviewed records for all 3,740 adult patients. Only 2,308, or 61.7%, had both a BMI charted and an appropriate follow up plan documented. **A follow up plan was missing for 1,432 adults, 38.3% of the adult measure population.**

The adult and pediatric measures fail at almost the same rate, 37.9% and 38.3%, which points to a common cause. BCH captures weight reliably because vitals are a rostered rooming task. BCH does not capture the intervention that is supposed to follow an abnormal weight, because no role owns it and no workflow triggers it. A measure that requires a plan cannot be met by a health center with no one assigned to build the plan.

c. Additional UDS Table 6B Quality of Care Measures, as appropriate.

Three additional 2025 UDS Table 6B measures define the clinical population that expanded nutrition services reaches.

Table 3: Additional UDS Table 6B Quality of Care Measures ⁴					
Line	Measure	Denominator	Numerator	Rate	Patients in the Gap
17a	Statin therapy for the prevention and treatment of cardiovascular disease	1,128	934	82.8%	194
18	Ischemic vascular disease, use of aspirin or another antiplatelet	323	203	62.8%	120
21	Screening for depression and follow-up plan	3,774	3,560	94.3%	214

Statin therapy (Line 17a). BCH identifies 1,128 patients at high risk of cardiovascular events, and 194 of them are not on statin therapy. Statin benefit is amplified or blunted by diet, weight, and glycemic control. A high risk population of this size, in a panel of 4,288 patients, establishes that cardiovascular risk at BCH is broad rather than concentrated, and that a nutrition intervention reaches a large share of the adult panel.

Ischemic vascular disease (Line 18). Of 323 patients with established ischemic vascular disease or a prior AMI, CABG, or PCI procedure, 120 lack documented antiplatelet therapy. These patients have already had a cardiovascular event. Intensive dietary intervention, particularly sodium and saturated fat reduction, is secondary prevention for them, not general wellness advice.

Depression screening (Line 21). BCH screened and documented follow up for 94.3% of patients aged 12 and older, one of BCH's strongest measures. This matters to ENS for a specific reason. BCH already identifies, at scale, the depression and anxiety that drive emotional eating, loss of appetite, and abandonment of self-management routines. BCH can therefore route a

⁴ BCH 2025 UDS report.

nutrition patient whose barrier is behavioral into an existing behavioral health appointment on the same day, rather than losing the patient to a referral that never closes. Only 1 of 61 patients with major depression or dysthymia reached remission at twelve months in 2025, which underscores how persistent these barriers are for BCH patients attempting sustained dietary change. **BCH funds those behavioral health encounters through its existing behavioral health resources and charges no behavioral health service delivery to this award.**

d. Other relevant data specific to your service area.

Service area profile and geography. BCH's service area contains 64,925 residents across thirteen ZIP codes in southern Anne Arundel County. Of 7,015 low income residents, health centers reach 54.0%, leaving **3,228 low income residents unserved by any health center.**⁵ The area is rural, has no hospital, and has no fixed route public transportation. The nearest hospital is roughly a 30 minute drive.

Aggregate affluence masks concentrated need. At the service area level, low income (10.8%) and poverty (4.8%) rates fall below Maryland and national rates.

Table 4: Comparative Low Income and Poverty Rates ⁶		
Location	Low Income	Poverty
Service Area	10.8%	4.8%
Maryland	20.9%	9.2%
U.S.	29.2%	12.6%
*Rates in bold are worse than state/national values.		

These aggregates conceal the communities BCH actually serves. Analysis by ZIP code shows an eight fold spread in low income rate across a service area of fewer than 65,000 people.

Table 5: Need Indicators by ZIP Code, BCH Service Delivery Sites ⁷					
ZIP Code	Community	Low Income	Poverty	Population per Square Mile	Share of BCH Patients
20711	Lothian	25%	13.0%	219	28.1%
20764	Shady Side	12%	7%	1,077	17.8%
20778	West River	3%	1.0%	246	5.6%
Service Area		10.8%	4.8%		

Lothian (20711), on the southwestern edge of the service area, carries a low income rate of 25%, more than double the service area rate, and a poverty rate of 13.0%, nearly three times the service area rate. Lothian is also where **28.1% of BCH's patients live**, the largest share of any ZIP code. At 219 people per square mile, it is genuinely rural, and low density compounds every access barrier that low income creates. North Beach (20714), just across the Calvert County line

⁵ HRSA Health Center Program GeoCare Navigator. Retrieved July 21, 2026, from <https://geocarenavigator.hrsa.gov/>

⁶ HRSA Health Center Program GeoCare Navigator.⁶

⁷ HRSA Health Center Program GeoCare Navigator and GreatData.⁷

and inside BCH's patient draw area, also reports a 25% low income rate and accounts for 1.6% of BCH's patients. When service area data are aggregated, the needs of Lothian and North Beach disappear into the affluence of West River.

Food insecurity extends well beyond the SNAP population. Anne Arundel County has a lower Supplemental Nutrition Assistance Program (SNAP) participation rate than Maryland or the nation, but that reflects lower enrollment rather than lower need.

Table 6: SNAP Participation and Coverage ⁸					
Location	SNAP Rate	Coverage of Below Poverty Households	Coverage Gap	Senior Households	Disability Households
Anne Arundel	6.5%	30.6%	69.4%	39.6%	48.0%
Maryland	11.0%	33.8%	66.2%	40.3%	45.7%
U.S.	11.8%	42.9%	57.1%	38.5%	47.5%
*Rates in bold are worse than state/national values.					

Only 30.6% of below poverty households in Anne Arundel County receive SNAP, compared with 33.8% statewide and 42.9% nationally. **The 69.4% coverage gap is worse than the state and national gaps.** Roughly seven in ten households already living below poverty in the county are not connected to federal food assistance.

Table 7: Food Insecurity Indicators ⁹				
Location	Food Insecurity Rate, Overall	Food Insecurity Rate, Children	Share Below SNAP Threshold	Average Meal Cost
Anne Arundel	11.2%	11.0%	40%	\$3.89
Maryland	13.3%	16.1%	54%	\$3.71
U.S.	14.3%	19.2%	63%	\$3.58
*Rates in bold are worse than state/national values.				

Only 40% of food insecure county residents fall below the SNAP eligibility threshold, compared with 54% statewide and 63% nationally. **The remaining 60% of food insecure residents earn too much to qualify for SNAP and still cannot reliably afford adequate food.** They face the county's meal cost of \$3.89, higher than both the Maryland (\$3.71) and national (\$3.58) averages, with no federal food benefit behind them. This population is invisible to every food assistance program that uses SNAP eligibility as its gate, and it is reachable only through the health center. It is the population ProduceRx is designed to serve.

Chronic disease burden. Hypertension prevalence in the service area exceeds both state and national rates, and obesity matches them.

⁸ PantryPath analysis of U.S. Census Bureau, American Community Survey 5 Year Estimates.⁸

⁹ Feeding America, Map the Meal Gap, using U.S. Census Bureau American Community Survey 2019 to 2023.⁹

Table 8: Chronic Disease Prevalence ¹⁰			
Location	Diabetes	Hypertension	Obesity
Service Area	10.9%	36.8%	33.9%
Maryland	11.1%	34.5%	33.9%
U.S.	10.9%	32.4%	33.9%
*Rates in bold are worse than state/national values.			

The elevated hypertension burden carries through to mortality. The service area's age adjusted death rate from cerebrovascular disease is 57.5 per 100,000, above Maryland (52.7) and the United States (48.0). The diabetes mellitus death rate, 28.9 per 100,000, also exceeds the state rate of 27.5.¹¹ Nutrition is the primary modifiable factor in blood pressure control, which makes this mortality pattern directly actionable.

Chronic disease inside BCH's panel. BCH's 2025 UDS Table 6A quantifies the population a nutrition service line would serve on day one.

Table 9: BCH Patients and Visits by Diagnostic Category, 2025 ¹²		
Diagnostic Category	Patients with Diagnosis	Visits by Diagnosis
Overweight and obesity	1,914	4,968
Hypertension	1,800	3,636
Diabetes mellitus	677	1,859
Heart disease (selected)	418	730

Nearly 45% of BCH's total patient population carries an overweight or obesity diagnosis. These patients generated 4,968 visits in 2025, and not one of those visits was a nutrition visit.

Outcome data show where that absence costs patients:

- **Hypertension control.** Of 1,767 patients aged 18 through 85 with hypertension, 1,292 (73.1%) had controlled blood pressure. **475 patients, 26.9%, remain uncontrolled**, a condition highly responsive to sodium reduction and the DASH eating pattern.
- **Glycemic status.** Of 576 patients aged 18 through 75 with diabetes, 95 (16.5%) had a glycemic status assessment above 9%, missing, or not performed during the year. This is BCH's UDS poor control measure, and reducing it is a direct nutrition target.

Summary of need. BCH serves a rural population with urban center cost of living and challenges layered on. The service area has above average hypertension prevalence and above average stroke mortality, concentrated in ZIP codes where one in four residents is low income, inside a county where 69.4% of below poverty households receive no SNAP support and 60% of food insecure residents cannot qualify for it. Against that need, BCH currently provides zero dedicated nutrition service capacity.

¹⁰ HRSA Health Center Program GeoCare Navigator.¹⁰

¹¹ Centers for Disease Control and Prevention, National Center for Health Statistics. CDC WONDER, 2018 to 2024. Retrieved June 11, 2026, from <https://wonder.cdc.gov/>

¹² BCH 2025 UDS report, Table 6A.

2. Describe any challenges with your current health center workforce that impact your capacity to start or expand nutrition services. Workforce challenges may include personnel, training, roles, or workflows.

BCH's workforce constraints are specific, documented in its 2025 UDS staffing profile, and each is addressed by a defined element of this project.

Table 10: Workforce Challenges	
Challenge	Evidence
No personnel dedicated to nutrition	0.00 FTE health education specialists reported in 2025 UDS Table 5, and no BCH position carries nutrition responsibility
Nutrition guidance compressed into primary care visits	Nutrition counseling occurs inside 15 minute and 30 minute medical visits and is not separately scheduled or captured
Care management is at capacity	4.03 FTE case managers and 1.80 FTE nurses support 4,123 medical patients, and both nurse care managers are fully committed to existing programs
No credentialed diabetes education capability	BCH refers newly diagnosed and uncontrolled diabetic patients to care management, but holds no diabetes education credential
No staff to move food between a food distribution partner and patients	0.00 FTE community health workers reported in 2025 UDS Table 5, and no position currently handles food logistics
PRAPARE is not administered consistently	PRAPARE is embedded in eCW but is not completed at every chronic disease visit, so food insecurity is captured only when a Z code is entered
eCW decision support is not yet configured for nutrition	BCH is building a clinical rule engine on the PRAPARE form now, but no nutrition specific rule exists
Outreach capacity is thin	0.14 FTE outreach workers reported in 2025 UDS Table 5

Moreover, two workforce realities shape BCH's options for implementing a realistic, sustainable nutrition program.

First, **rural recruitment and retention ongoing constraint.** South County is remote from the region's clinical labor markets, and has no hospital to anchor or support a provider community. However, the most difficult challenge is that in rural South County, BCH competes against Annapolis, Baltimore, and Washington employers. Competing with urban health care facilities means trying to match their wages, benefits, and workplace accessibility. Local searches prove lengthy enough to depress appointment availability for a full year for new providers, but unfortunately the same can be true for support positions because younger people especially

prefer to work in the urban centers where the wages are higher. A nutrition program that depends on hiring several new staff before it can see a patient would not launch on time in this market nor would it maintain consistent availability.

A new part-time posting draws almost no qualified applicants because typically those positions are filled by staff moonlighting from larger employers like hospitals. Since there are no larger health care employers in South County, this is not a realistic option. A full time position carries benefits, qualifies for National Health Service Corps loan repayment in BCH's designated Medically Underserved Population.

RESPONSE

1. Describe how you will:

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

BCH increases nutrition services patients and visits by:

- 1) **Refer all new chronic disease diagnosis and all pediatric wellness visits.** Medical assistants and care management staff complete the PRAPARE screening at for adults who present with chronic diseases and pediatric patients having well-child visits. The Director of Nursing trains medical support staff on administration and timing and monitors completion rates as a quality measure.
- 2) **Trigger the referral in eCW.** BCH is already building a clinical rule engine on the PRAPARE form that sends a pop up alert to the provider and generates a care management referral when defined conditions are identified. That build is underway now and goes live later this year, ahead of this period of performance. On award, BCH reviews and adjusts the existing rule engine so that it also fires a nutrition services referral. BCH is therefore extending decision support it is already constructing rather than building it from nothing. The alert fires when a patient meets at least one clinical criterion and at least one social criterion.

Table 11: eCW Nutrition Referral Triggers	
Clinical Criteria (one or more required)	Social Criteria, from PRAPARE (one or more required)
Newly diagnosed type 2 diabetes (ICD-10 E11.x, within 12 months)	Food insecurity
Prediabetes	Limited access to healthy foods
Newly diagnosed hypertension (ICD-10 I10, within 12 months)	Transportation barriers
BMI at or above 30 in adults	Financial instability
BMI percentile above 95% in patients aged 3 through 17	Housing instability
Glycemic status assessment above 8%	
Blood pressure above 140/90	

The provider can automatically generate a nutrition services referral directly from the alert. Therefore, referral no longer depends on a provider remembering to raise nutrition in a compressed visit. BCH will prioritize newly diagnosed patients because receptivity to dietary change is highest in the weeks following a new diagnosis.

- 3) **Convert referrals into scheduled visits.** Outreach and care management staff work the referral queue daily. They contact referred patients, book them into nutrition specific appointment slots, confirm by call and text, arrange transportation where PRAPARE flagged it, and enroll eligible patients in ProduceRx. Nutrition visits are scheduled and documented separately from primary care visits, so each one is countable as a nutrition services visit.

Table 12: Nutrition Services Utilization Targets			
Measure	Baseline, 2025	Year 1 Target	Year 2 Target
Nutrition services in scope on Form 5A	No	Yes, within 120 days of award	Yes
Nutrition referrals generated	0	300	600
Nutrition visits delivered	0	600	1,000
Unique patients receiving nutrition services	0	240	480
Visits per enrolled patient	0	2.5	2.1
Produce prescriptions filled and delivered	0	1,000	1,200

BCH targets an 80% conversion from referral to a completed nutrition visit in both years, which is the process measure connecting referrals to patients above. The doubling of unique nutrition patients between Year 1 and Year 2, from 240 to 480, is the change HRSA measures, because the ENS objective is determined by the difference between BCH's 2027 and 2028 UDS nutrition services data.

- 4) **Leverage existing assets.** BCH expands the duties of an existing nurse practitioner who has specialized nutrition training. The Nurse Practitioner is scheduled 4 hours per week for nutrition visits. This expansion of her duties addresses the difficulty of recruiting specialized nutrition staff and leverages relationships she already holds with patients. Every existing BCH position on this project is funded as an expansion of current duties, and BCH adjusts its Health Center Program allocations so that no portion of any salary is charged to two awards for the same work.
- 5) **5. Build the return visit.** A single nutrition visit does not change a chronic condition. BCH schedules nutrition follow up monthly, and continued produce prescriptions require at least one completed follow up nutrition visit, so the food and the clinical contact reinforce one another. Year 1 concentrates on establishing that return pattern within a smaller enrolled cohort, averaging 2.5 visits per patient. Year 2 doubles the number of patients reached while holding comparable engagement at 2.1 visits per patient. BCH targets three consecutive

monthly visits for enrolled patients by the end of Year 2, which is the point at which A1c, blood pressure, and weight changes become measurable.

b. Help prevent and manage chronic conditions through expanded nutrition services.

BCH's nutrition services operate across the full disease trajectory, from children who have no diagnosis to adults with established cardiovascular disease. BCH has adopted the Dietary Guidelines for Americans, 2025-2030¹³ as the clinical standard for all nutrition counseling delivered under this project, and aligns its patient education materials, provider guidance, and ProduceRx box specifications to that edition. For hypertension, counseling also follows the DASH eating plan.¹⁴ Both are federally issued, evidence based standards.

Table 13: Nutrition Intervention by Target Population			
Target Population	Prevention Tier	Nutrition Intervention	Clinical Goal
Patients aged 3 through 17 with BMI percentile above 95%	Primary prevention	Family included nutrition visit, age appropriate food literacy, label reading, activity counseling, documented follow up plan	Establish healthy patterns before diabetes or hypertension develops, and close the Table 6B Line 12 gap
Adults with prediabetes	Primary prevention	Individual counseling on carbohydrate quality and portion, ProduceRx where indicated	Prevent progression to type 2 diabetes
Newly diagnosed type 2 diabetes	Secondary prevention	30 minute initial nutrition consultation, monthly follow up, ProduceRx	Reduce A1c by 1% within 6 months
Newly diagnosed hypertension	Secondary prevention	DASH education, sodium reduction counseling, grocery shopping education, ProduceRx	Achieve blood pressure below 140/90
Adults with BMI at or above 30	Secondary prevention	Individual counseling, portion control, activity counseling adapted to mobility, including seated exercise options	5% weight reduction within 6 months
Uncontrolled diabetes or hypertension	Disease management	Monthly nutrition visits coordinated with medical management, repeat PRAPARE	Move patients out of the UDS poor control and uncontrolled categories

¹³ U.S. Department of Agriculture and U.S. Department of Health and Human Services. Dietary Guidelines for Americans, 2025-2030. Retrieved September 3, 2026, from <https://www.dietaryguidelines.gov/>

¹⁴ National Heart, Lung, and Blood Institute, National Institutes of Health. DASH Eating Plan. Retrieved August 25, 2026, from <https://www.nhlbi.nih.gov/education/dash-eating-plan>

Table 13: Nutrition Intervention by Target Population

Patients at high cardiovascular risk or with ischemic vascular disease	Disease management	Saturated fat and sodium reduction counseling alongside statin and antiplatelet management	Reduce risk of a first or repeat cardiovascular event
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ProduceRx. A monthly produce prescription, valued at \$25 and filled with fresh fruits and vegetables, gives the patient foods the Dietary Guidelines prioritize. Counseling addresses what to limit, including added sugars, sodium, and highly processed foods, while ProduceRx supplies positive choices. Patients who cannot afford produce do not benefit from being told to eat it. The Anne Arundel County Food Bank assembles each box against the clinical specification written for that patient’s condition, which is what separates a produce prescription from a general food referral.

Monthly visit. BCH will schedule nutrition follow up monthly rather than quarterly. Monthly contact matches the prescription cycle, catches weight and blood pressure drift early, and reduces the attrition that quarterly intervals produce in a rural population with transportation barriers. Visits may be delivered in person or by telehealth, which matters in a service area with no fixed route public transportation.

Behavioral barriers. When a nutrition visit surfaces depression, anxiety, or disordered eating as the reason a care plan is not working, BCH connects the patient to its existing behavioral health team, most often on the same day and in the same building. The Nurse Practitioner leading nutrition care holds dual preparation in psychiatric mental health and family practice and applies motivational interviewing methods that BCH already uses in tobacco cessation.

The relationship also runs in the other direction. BCH’s behavioral health department screens for social drivers of health at every intake, for both prescriber and counseling intakes, and its Certified Application Counselor identifies food, housing, and utility needs while assisting patients with coverage enrollment. A behavioral health provider who identifies nutrition risk can enter a nutrition services referral, and that referral counts toward the targets in this application. Behavioral health is therefore a referral source for the nutrition program as well as a support for it. **Behavioral health encounters are billed and funded through BCH’s existing behavioral health resources. No ENS funds pay for behavioral health service delivery.**

Alignment with MAHA and HRSA priorities. This project advances each priority named in this funding opportunity:

- **Nutrition.** ProduceRx delivers the whole, nutrient dense foods the 2025-2030 Guidelines prioritize, including vegetables, fruits, legumes, nuts, and whole grains. Counseling addresses what those Guidelines direct patients to limit, including added sugars, refined grains, saturated fat, and sodium.
- **Disease prevention.** Pediatric patients with an elevated BMI percentile and adults with prediabetes are reached as primary prevention populations, before a chronic diagnosis exists.

- **Fighting the chronic disease epidemic.** Newly diagnosed diabetes and hypertension patients are prioritized for early engagement, and patients with uncontrolled disease receive monthly nutrition contact coordinated with their medical management.
- **Personal responsibility.** Care plans are built on goals the patient sets, and continued produce prescriptions require the patient to return for follow up.
- **Strong families and communities.** Pediatric visits include the family, because a child's diet is a household decision, and food reaches patients through a community partner already operating in South County.
- **Gold standard science.** Counseling follows federally issued standards, and outcomes are tracked against UDS clinical quality measures rather than measures BCH defines for itself.
- **Access to high quality care.** Nutrition services enter BCH's Form 5A scope, are delivered on a sliding fee schedule, and are offered in person or by telehealth.

c. Coordinate care for patients with inconsistent access to adequate nutritious food.

BCH does not have to build a food distribution channel for this project. It already has one. BCH and the Anne Arundel County Food Bank coordinate food into South County today, including a mobile food pantry that BCH arranges into a single fixed location where patients and community members come to receive food, and a monthly pantry operated across from BCH's Lothian site, the ZIP code where 28.1% of BCH's patients live. The two organizations build the clinical prescription model on top of that working relationship.

Coordination begins with a positive PRAPARE screen or a nutrition provider's ProduceRx order. The Care Manager and Outreach position and the Community Health Worker together ensure that patients follow through on securing food consistent with their clinical treatment plan.

- **Positive PRAPARE Screen.** PRAPARE results in eCW identify patients experiencing food insecurity, limited access to healthy foods, transportation barriers, financial instability, or housing instability. The care manager will be able to meet with the patient to set up ProduceRX distributions and also connect them with other partners in the community.
- **Prescribe.** The nutrition provider issues a ProduceRx prescription written to the patient's condition. The Anne Arundel County Food Bank fills the prescription, and BCH budgets \$25 per box. The initial prescription is issued at the nutrition visit where the patient enrolls, and continued monthly prescriptions require at least one completed follow up nutrition visit, so food support and clinical contact stay linked. Prescriptions are fulfilled as produce, not as gift cards or cash equivalents, and cannot be redeemed for any other product. BCH issues 1,000 prescriptions in Year 1 and 1,200 in Year 2. Nationally, Feeding America is directing its affiliates to fill clinical produce prescriptions on health center specifications, and that guidance frames the model BCH and the Food Bank are developing together.
- **Deliver.** Distance is the operational risk, because the Food Bank's main site is roughly two hours round trip from South County. The budget reserves a delivery allowance of \$10 per box, \$10,000 in Year 1 and \$12,000 in Year 2, so funding is in place for whichever routing the two organizations select. Options include scheduled drops into

South County, distribution at BCH sites alongside the mobile pantry the Food Bank already brings down, and direct delivery to patients without transportation. The strategic planning session sets the model, the pilot tests it, and BCH adjusts before scaling. BCH staff do not purchase, store, refrigerate, or handle the food.

- **Remove barriers.** The Community Health Worker and outreach team coordinate pickup and delivery logistics with the Food Bank, arrange transportation through South County Call N' Ride and Anne Arundel County Department of Aging transportation for eligible patients, and connect patients to additional food resources for needs beyond what the prescription covers. Where patients are eligible for SNAP or WIC, BCH's Certified Application Counselors provide enrollment assistance under BCH's existing Eligibility Assistance service. **Consistent with the ENS NOFO, BCH records that enrollment assistance as eligibility assistance and does not count it as a nutrition services visit.**
- **Monitor.** Care management tracks prescription issuance, fulfillment and receipt rates, and each patient's weight, A1c, and blood pressure trend on the same monthly cycle as the prescription. Patients who do not receive or collect a box receive outreach contact to identify the obstacle, which is most often transportation, delivery timing, or a missed return visit.
- **Re-screen.** PRAPARE is repeated for enrolled patients so that change in food insecurity status is measurable rather than assumed.

d. Advance the skills and knowledge of your workforce to support expanded nutrition services.

BCH builds nutrition competency across the whole care team rather than concentrating it in one position, which protects the program against turnover in a rural labor market.

Table 14: Role Specific Nutrition Responsibilities			
Role	Year 1 FTE	Year 2 FTE	Nutrition Responsibilities
Nutritionist (new hire)	1.00	1.00	Comprehensive nutrition assessment, individualized care plans, individual and family counseling, ProduceRx prescribing, documentation for the UDS nutrition measure
Registered Nurse Certified Diabetes Educator (new hire)	0.50	0.50	Structured diabetes and chronic disease nutrition education, care plan follow up, registry and PRAPARE review, adherence monitoring, groundwork for Diabetes Self-Management Training
Community Health Worker, Nutrition Coach (new hire)	0.60	1.00	ProduceRx delivery coordination and patient receipt, nutrition coaching, food resource navigation, transportation support
Chief Medical Officer	0.15	0.12	Project oversight and clinical champion, referral criteria design, interdisciplinary

Table 14: Role Specific Nutrition Responsibilities			
Role	Year 1 FTE	Year 2 FTE	Nutrition Responsibilities
			case review, nutrition visits if hiring is delayed
Nurse Practitioner	0.10	0.10	Dedicated nutrition visits, motivational interviewing framework, integration of behavioral barriers into nutrition care plans
Care Manager and Outreach	0.20	0.20	Patient facing outreach, referral follow up, ProduceRx enrollment and receipt support, food resource navigation
Director of Strategic Initiatives and Communication	0.20	0.10	Food Bank agreement management, organizational outreach, program marketing to the community
Director of Nursing (in kind, not charged to this award)	0.00	0.00	Coordinates quality assurance and quality improvement functions for the project, workflow design, PRAPARE training and competency, ENS reporting

Table 15: Funded Training and Certification		
Training	Staff	Purpose
Certified Diabetes Care and Education Specialist (CDCES)	Registered Nurse Certified Diabetes Educator	Credentialed diabetes self management education, and a required step toward Medicare Diabetes Self-Management Training accreditation
Nutrition coach training	Community Health Worker	Nutrition specific coaching technique, stigma reduction in weight conversations, food resource navigation
American College of Lifestyle Medicine and American Board of Lifestyle Medicine certification	Nurse Practitioner and Chief Medical Officer in Year 1, one additional provider in Year 2	Structured, evidence based competency in nutrition and lifestyle intervention for chronic disease
Food and Nutrition Conference and Expo (FNCE)	4 staff	Current nutrition science and practice, applicable to a low resource delivery setting
PriMed, Washington, DC	Up to 3 staff, Years 1 and 2	Primary care continuing education with chronic disease and nutrition content

BCH supplements paid certification with no cost curricula and patient materials from the American Diabetes Association and the American Heart Association, which the care team uses for label reading, healthy grocery shopping, meal planning, and DASH education. BCH accesses additional training through its Learning Management System, operated in partnership with the Mid-Atlantic Association of Community Health Centers (MACHC). Outreach and care management staff receive internal training from the Nutritionist and the Registered Nurse on

nutrition specific counseling technique, stigma reduction in weight conversations, and food resource navigation.

The CDCES credential carries a strategic purpose beyond the period of performance. Diabetes Self-Management Training is a Medicare billable service. Building the credential inside BCH creates a revenue path that sustains diabetes nutrition education after ENS funding ends, and the award funds the certification directly so the credential does not have to be present at hire.

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

BCH does not intend to build a separate quality structure for this project. Nutrition measures will be added to the Quality Improvement (QI) Committee, and be monitored by PDSA improvement cycles and the Key Performance Indicator (KPI) reports that the Board of Directors already reviews monthly.

Table 16: Nutrition Quality Improvement Measures			
Domain	Measure	Review Cycle	Owner
Process	PRAPARE completion rate at chronic disease and well child visits	Monthly	Director of Nursing
Process	Referral completion rate, referral to scheduled visit	Monthly	Care management
Utilization	Unique nutrition patients and nutrition visits	Monthly	Director of Nursing
Utilization	ProduceRx prescriptions issued, filled, and received by the patient	Monthly	Community Health Worker
Diabetes	Percentage of patients with glycemic status assessment above 9%, missing, or not tested, the UDS poor control measure, with the goal of reducing this percentage	Quarterly	Registered Nurse and Nurse Practitioner
Hypertension	Percentage of patients aged 18 through 85 with blood pressure controlled below 140/90	Quarterly	Nurse Practitioner
Weight	Percentage of enrolled adults achieving 5% weight reduction, and BMI percentile change in enrolled pediatric patients	Quarterly	Nutritionist
Documentation	UDS Table 6B, Line 12 and Line 13 rates	Quarterly	QI Coordinator
Food security	Change in PRAPARE food insecurity status among ProduceRx participants	Semiannually	Care management

The Director of Nursing coordinates the quality assurance and quality improvement functions for this project, including workflow design, PRAPARE training and competency, measure reporting, and ENS reporting. She carries these responsibilities within her existing duties, and no portion of her salary is charged to this award. BCH expects the day to day quality reporting role to be staffed by a nurse, consistent with how BCH staffs quality functions today. The Chief Medical

Officer holds overall project oversight and serves as clinical champion, and BCH's staffing plan funds that oversight time directly.

BCH earned HRSA's Advancing Health Information Technology badge and its National Quality Leader badge for Behavioral Health in its most recent UDS reporting. The first reflects the EHR driven, data informed practice this project's eCW referral engine depends on. The second reflects the behavioral health performance that supports patients whose barriers to dietary change are behavioral.

3. Explain how any proposed equipment and/or minor A/R costs are necessary for your project. Describe how you will complete all equipment purchases and/or minor A/R within 12 months of award.

BCH requests no funding for equipment or minor alteration and renovation.

COLLABORATION

1. Describe how you will work with organizations in your service area that improve patient health through better nutrition. If applicable, include how you will leverage expertise of Health Center Technical Assistance Programs, such as Primary Care Associations (PCAs), Health Center Controlled Networks (HCCNs), or National Technical Assistance Program (NTAPs).

BCH has a robust network of partners that are leveraged through this program.

Primary Care Association. BCH is a member of the Mid-Atlantic Association of Community Health Centers (MACHC), Maryland's Primary Care Association. BCH already partners with MACHC on staff training through a shared Learning Management System and participates in MACHC's monthly emergency preparedness meetings. BCH uses these established relationships to access nutrition program design assistance, peer learning from Mid-Atlantic health centers operating produce prescription and nutrition programs, and training content for the care team. BCH is also a subrecipient of a Centers for Disease Control and Prevention award made to MACHC that focuses on diabetes and hypertension, now in its third year, under which BCH has implemented data interfaces supporting chronic disease management. MACHC delivered a Maryland specific briefing on produce prescription program design in July 2026, and BCH is applying that guidance to this project's Food Bank contract.

Health Center Controlled Network. BCH partners with HealthEfficient, a HRSA funded HCCN operated jointly with MACHC and the DC Primary Care Association, for health information technology support, training, and technical assistance. BCH engages HealthEfficient specifically on the technical build this project depends on:

- Configuring the eCW Best Practice Alert logic that combines diagnosis codes, laboratory and vital sign thresholds, and PRAPARE responses.
- Building reports that isolate nutrition visits from medical visits, so BCH can report the nutrition services measure HRSA adds to UDS Table 5 in 2027.

- Constructing a patient registry that care management uses to track enrolled patients and ProduceRx participants.

National Training and Technical Assistance Partner. BCH is a member of the National Association of Community Health Centers (NACHC). BCH uses the Health Center Resource Clearinghouse, the joint HRSA and NACHC repository of technical assistance tools and promising practices, for program design, staff training, and evaluation. BCH also draws on the American Diabetes Association and American Heart Association for evidence based patient education content and no cost staff training.

Local health and social service partners. BCH's collaboration with the Anne Arundel County Department of Health covers cancer screening, tobacco cessation, and sexually transmitted infection services, and gives BCH a working channel into county chronic disease and nutrition programming. BCH co-hosts community outreach forums with the Anne Arundel County Department of Aging, whose nutrition site is located directly across the street from BCH's Owensville location.

2. Describe how you will link patients to partners that support access to healthy food, such as food banks, mobile markets, or community-supported agriculture.

Every linkage runs through the same referral pathway, so a patient identified once reaches the right partner without a second screening.

Table 17: Food Access Partners and Linkage Pathway			
Partner	Patient Need Addressed	Linkage Mechanism	Status
Anne Arundel County Food Bank, ProduceRx	Condition specific produce for patients with a nutrition prescription	ProduceRx order placed at the nutrition visit and filled by the Food Bank, with routing into South County set through joint planning and a pilot, supported by a funded delivery allowance	Established partner, agreed to participate
Anne Arundel County Food Bank, mobile food pantry	Broad food insecurity beyond the produce prescription	BCH coordinates the mobile pantry into a fixed South County location and refers patients from the PRAPARE food insecurity flag	Established partner
Monthly food pantry operated across from BCH's Lothian site	Immediate food need at the site where 28.1% of BCH patients live	Direct on site connection by outreach staff and the Community Health Worker	Established partner
Anne Arundel County Department of Aging Nutrition Site	Congregate and home delivered meals for older adults	Warm referral, site located directly across from BCH's Owensville location	Established partner

Table 17: Food Access Partners and Linkage Pathway			
Partner	Patient Need Addressed	Linkage Mechanism	Status
South County Baby Pantry	Infant and young child food and supply needs	Care management referral	Established partner
County administered WIC program	Nutrition support for pregnant and postpartum patients, infants, and children through age 5	Eligibility assistance and referral by Certified Application Counselors	Established referral relationship
SNAP	Federal food benefit for eligible households	Certified Application Counselor enrollment assistance under BCH's Eligibility Assistance service	Established capability
South County Call N' Ride and Department of Aging transportation	Transportation to nutrition visits and to redemption locations	Coordinated by outreach staff when PRAPARE flags a transportation barrier	Established partner

BCH concentrates ProduceRx fulfillment with the Anne Arundel County Food Bank rather than distributing it across farms, markets, and retail grocers. That decision is deliberate. A redemption model that sends patients to a storefront fails where there is no fixed route public transportation, and it puts the burden of assembling a clinically specified box on vendors not equipped to do it. A single partner that already moves food into South County addresses both problems. The Anne Arundel County Food Bank has agreed to the project. Because the logistics of supporting South County are significant, the two organizations conduct a strategic planning session after award, including a pilot or soft launch, to ensure a smooth implementation. That session sets box composition, delivery routing, and tracking. BCH's Director of Strategic Initiatives and Communication owns the Food Bank relationship, and the Community Health Worker monitors delivery and receipt so that fulfillment problems surface within the month they occur.

- 3. Explain how your project aligns with and does not duplicate existing federal programs that may be operating in your service area, like those proposed or currently funded by MAHA ELEVATE, National Diabetes Prevention Program, IHS Produce Prescription Pilot Program, USDA Food and Nutrition Service Programs, Healthy Start, Maternal Child Health Nutrition Training Program, or Gus Schumacher Nutrition Incentive Program (GusNIP). If there are no other federal programs operating in your service area, state this in your narrative.**

BCH reviewed each federal program named in the NOFO against its service area.

Table 18: Federal Program Alignment and Non Duplication Analysis

Federal Program	Operating in BCH's Service Area	Basis for Non-Duplication
USDA Food and Nutrition Service, WIC	Yes, county administered, in proximity to the service area	WIC serves pregnant and postpartum patients, infants, and children through age 5 with a defined food package. ENS serves patients of any age with a qualifying chronic condition or elevated risk plus a positive social screen. BCH refers eligible patients to WIC and does not replicate its benefit.
USDA Food and Nutrition Service, SNAP	Yes	SNAP is an income based federal benefit. ENS reaches the 60% of food insecure county residents who exceed the SNAP threshold and the 69.4% of below poverty households not enrolled. BCH's Certified Application Counselors enroll eligible patients in SNAP as eligibility assistance, separate from nutrition services.
MAHA ELEVATE	No awards announced as of this application	BCH monitors CMS awardee announcements throughout the period of performance and coordinates with any awardee operating in its service area to ensure complementary service delivery.
National Diabetes Prevention Program	No	No National DPP site operates in BCH's service area.
IHS Produce Prescription Pilot Program	No	No IHS supported clinics operate in Maryland or in BCH's service area.
Healthy Start	No	HRSA's Healthy Start Initiative operates in Maryland solely through Baltimore City Healthy Start, Inc., serving Baltimore City. Anne Arundel County's home visiting program of the same name is not the federal HRSA grantee.
Maternal Child Health Nutrition Training Program	No	No program site operates in BCH's service area.
GusNIP	Not in BCH's service area	A GusNIP funded produce prescription project operates in Maryland through the University of Maryland, College Park, serving Montgomery and Prince George's Counties. It does not extend to Anne Arundel County.

One state funded program warrants coordination. The Maryland Department of Health funds a Diabetes Prevention Program administered by the Healthy Anne Arundel Coalition within Anne Arundel County. It is not federally funded. BCH coordinates with this program for patients at risk of, but not yet diagnosed with, diabetes so that referrals are complementary rather than duplicative.

Across every program reviewed, BCH's ENS project remains distinct in target population, service delivery mechanism, or both. BCH continues to verify non-duplication as new federal and state programs emerge in its service area throughout the period of performance.

IMPACT

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

BCH measures impact using its existing electronic health record reporting, UDS submission, and QI infrastructure. Because BCH has no nutrition services today, every baseline in this section is zero, and every measure is a measure of new capacity actually delivered.

a. Number of nutrition services patients and/or visits. HRSA plans to add a nutrition services measure to 2027 UDS.

BCH tracks unique patients receiving nutrition services and total nutrition visits monthly. Two conditions make this measurable rather than aspirational:

- **Nutrition is a distinct scheduled visit type.** Nutrition visits occupy dedicated appointment slots and carry their own visit type in eCW. They are not nutrition advice delivered inside a medical visit, which the ENS NOFO excludes from the definition of nutrition services.
- **Reporting is built with the HCCN.** BCH works with HealthEfficient to build the report that isolates nutrition visits and unique nutrition patients, so BCH can populate the UDS Table 5 nutrition services measure directly from eCW rather than by manual count.

Measure	2025 Baseline	Year 1	Year 2	Two Year Change
Unique patients receiving nutrition services	0	240	480	+480
Nutrition visits delivered	0	600	1,000	+1,000
Nutrition referrals generated	0	300	600	+600
Produce prescriptions filled and delivered	0	1,000	1,200	+1,200

HRSA determines whether BCH meets the ENS objective using the difference between BCH's 2027 and 2028 UDS data for the new nutrition services measure. BCH's plan doubles unique nutrition patients and increases nutrition visits by two thirds between Year 1 and Year 2 for exactly this reason, and the Director of Nursing owns ENS reporting and reconciliation of program counts to the UDS submission.

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

BCH tracks clinical measures already embedded in its UDS reporting and QI infrastructure, so nutrition impact is visible in the same measures HRSA already uses to evaluate BCH.

One measure requires a note on ambition. BCH has placed in the national top quartile on the diabetes poor control measure for five consecutive years. Moving that measure 0.3% in the most recent year required identifying and re-engaging 50 to 60 individual patients, and the remaining variance is largely patient behavior. A panel wide target on an already strong measure would not be credible. BCH therefore commits to a defined subset, patients newly diagnosed with diabetes during the period of performance, who are the patients this project reaches first and where nutrition intervention is most likely to change the trajectory. BCH does not license a third party population health platform, and builds this registry from eCW data elements directly.

Table 20: Clinical Outcome Measures and Two Year Targets		
Measure	2025 Baseline	Two Year Target
Patients aged 18 through 85 with hypertension controlled below 140/90	73.1% (1,292 of 1,767)	Increase control rate, with priority on the 475 currently uncontrolled patients
Patients aged 18 through 75 with diabetes with glycemic status assessment above 9%, missing, or no test	16.5% (95 of 576)	Hold below 16% among patients newly diagnosed during the period of performance, a subset registry BCH builds in eCW
Mean A1c change among enrolled patients with diabetes	Not measured	Reduction of 0.5% to 1.0%
Enrolled adults with obesity achieving 5% weight reduction	Not measured	5% average weight reduction among enrolled patients
Patients at high cardiovascular risk prescribed or on statin therapy	82.8% (934 of 1,128)	Increase, with nutrition counseling complementing pharmacologic management
ProduceRx participants reporting food insecurity on repeat PRAPARE	Not measured	Measurable reduction from enrollment screen to follow up screen
ProduceRx prescription redemption rate	Not measured	70% or higher

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

BCH measures long term impact through UDS reporting, which continues regardless of grant status, and through the QI Committee review cycle. The Board of Directors reviews these measures as part of the KPI report it already receives monthly.

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

BCH tracks year over year improvement in the percentage of patients aged 3 through 17 with both a documented BMI percentile and counseling on nutrition and physical activity, against a 2025 baseline of 62.1% (159 of 256). Because nutrition visits produce documented counseling

and a documented follow up plan as a byproduct of the visit itself, improvement on this measure is a direct function of pediatric nutrition volume rather than a separate documentation initiative. BCH sets incremental annual improvement targets through the QI Committee and reports the measure through UDS every year, including after the period of performance ends.

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

BCH tracks the same way for adults, against a 2025 baseline of 61.7% (2,308 of 3,740). A nutrition referral and completed nutrition visit constitute the follow up plan this measure requires, so adult nutrition volume converts directly into measure performance. BCH already participates in national quality improvement work on related measures through the UDS Controlling High Blood Pressure Cohort in the RAPID Series, and folds nutrition performance into that improvement work.

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

Beyond the period of performance, BCH continues to monitor:

- **Hypertension control**, against the 2025 baseline of 73.1%, with attention to whether gains among nutrition enrolled patients persist.
- **Glycemic status assessment above 9%, missing, or no test**, against the 2025 baseline of 16.5%.
- **Cardiovascular risk management**, including statin therapy for high risk patients (82.8% baseline) and antiplatelet therapy for patients with ischemic vascular disease (62.8% baseline).
- **Overweight and obesity diagnosis volume**, against the 2025 baseline of 1,914 patients and 4,968 visits, as an indicator of whether earlier intervention slows growth in this population.
- **Patient reported food insecurity**, captured through PRAPARE, tracked at the panel level and among ProduceRx participants.
- **Pediatric BMI percentile trajectory** among patients enrolled in nutrition services as children, which is the measure that shows whether primary prevention worked.

Sustainability supports continued measurement. BCH pursues Medicare Diabetes Self-Management Training accreditation on the strength of the CDCES credential funded by this award and held by a full time Registered Nurse, which creates billable revenue for diabetes nutrition education. Nutrition visits delivered by billable providers generate program income under BCH's FQHC prospective payment rates. Nutrition remains in BCH's Form 5A scope after the period of performance, which preserves both the service and the reporting obligation.

CAPACITY

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

BCH brings more than 50 years of operating history, an established team based care model, and a staffing plan built for a rural labor market.

Organizational capacity. BCH has held Patient Centered Medical Home recognition from the National Committee for Quality Assurance since 2015, operates three service delivery sites, and maintains a dedicated Chief Information Officer position responsible for electronic health record configuration, data analytics, and health information exchange. BCH participates in CRISP, Maryland's health information exchange, and receives daily Encounter Notification System reports. BCH's Chief Executive Officer holds a Doctor of Strategic Leadership in Healthcare Administration and a Master of Business and Healthcare Administration, is a registered nurse, and has led NCQA, Joint Commission, 340B, Federal Tort Claims Act, and HRSA Operational Site Visit reviews, implemented a 340B program, and directed health education and dietitian services at a prior FQHC. This is a leadership team that has stood up new service lines before.

Recognized quality performance. BCH has earned HRSA quality recognition in consecutive Uniform Data System reporting years, including the Advancing Health Information Technology badge, which reflects the electronic health record driven practice this project's referral engine depends on, and the National Quality Leader badge for Behavioral Health, which reflects the performance that supports patients whose barriers to dietary change are behavioral.

Demonstrated performance on chronic disease grant work. BCH is in the third year of a subaward under a Centers for Disease Control and Prevention award to the Mid-Atlantic Association of Community Health Centers focused on diabetes and hypertension. Under that award BCH implemented data interfaces supporting chronic disease management, which is directly relevant experience for the electronic health record build and the patient registry this project requires. BCH also participates in the UDS Controlling High Blood Pressure Cohort in the RAPID Series.

An established food distribution relationship. BCH does not have to create a food channel for this project. BCH and the Anne Arundel County Food Bank already coordinate food into South County together, as described in the Response section, and the Food Bank has agreed to this project. BCH's Director of Strategic Initiatives and Communication manages that relationship today and manages ProduceRx fulfillment under this award. The question that determines whether a produce prescription program works, who fills a clinically specified box and how it reaches a patient in a service area with no public transportation, is therefore worked out with a partner BCH already knows rather than with a vendor BCH would have to find.

Project team. The staffing plan totals 2.75 FTE in Year 1 and 3.02 FTE in Year 2. Dedicated nutrition staff account for 1.50 FTE, and the Community Health Worker steps from 0.60 FTE to 1.00 FTE as ProduceRx volume grows.

Table 21: ENS Project Staffing Plan				
Position	Year 1 FTE	Year 2 FTE	Status	Role on Project
Nutritionist	1.00	1.00	New hire	Nutrition assessment, counseling, care plans, ProduceRx orders
Registered Nurse Certified Diabetes Educator	0.50	0.50	New hire	Diabetes and chronic disease nutrition education, care plan follow up, adherence monitoring
Community Health Worker, Nutrition Coach	0.60	1.00	New hire	ProduceRx delivery coordination and patient receipt, nutrition coaching, transportation support
Chief Medical Officer	0.15	0.12	Existing staff	Project oversight and clinical champion, referral criteria, case review
Nurse Practitioner	0.10	0.10	Existing staff	Dedicated nutrition visits, motivational interviewing framework
Care Manager and Outreach	0.20	0.20	Existing staff	Patient outreach, ProduceRx enrollment and receipt support
Director of Strategic Initiatives and Communication	0.20	0.10	Existing staff	Food Bank agreement management, organizational outreach, marketing
Director of Nursing	0.00	0.00	Existing staff, in kind	Coordinates quality assurance and quality improvement functions, workflow, training, ENS reporting
Total funded	2.75	3.02		

The Chief Medical Officer holds project oversight and serves as clinical champion, and that time is funded. The Director of Nursing coordinates the project's quality assurance and quality improvement functions, including workflow design, staff training and competency, measure reporting, and ENS reporting, within her existing duties and at no cost to this award. Every existing BCH position on this project is funded as an expansion of current duties, and BCH adjusts its Health Center Program allocations accordingly so that no salary is charged twice.

Nutrition specific expertise already in place. The Nurse Practitioner leading nutrition care holds a Doctor of Nursing Practice with dual preparation in psychiatric mental health and family practice, and an undergraduate degree in dietetics. She has asked to lead this program. That combination is unusual and directly matched to the project. She brings formal nutrition training, the clinical authority to write nutrition and ProduceRx orders, and the behavioral health preparation to recognize when a patient's obstacle is depression or anxiety rather than knowledge. She has already built a motivational interviewing framework for BCH's tobacco cessation work and adapts that framework to nutrition counseling.

A staffing plan designed around recruitment risk. Five of the eight roles on this project are BCH staff already on payroll whose duties are expanded to include nutrition. Three are new hires, and BCH sized each one to the work and to the local labor market:

- **The anchor position is full time.** The Nutritionist carries the bulk of the nutrition program and is posted as a full time, benefited, career position. A part time clinical posting in South County draws almost no qualified applicants, because part time clinical roles here are normally filled by staff moonlighting from a larger employer, and South County has none.
- **The Registered Nurse role is sized to its patient population.** Diabetes education serves a defined subset of the panel, and the Nutritionist covers general nutrition counseling, so this position is funded at 0.50 FTE rather than full time. It requires an RN license rather than a scarce dietitian credential, and BCH funds CDCES certification after hire rather than requiring it at hire, which both widens the applicant pool and makes the position more attractive.
- **The Community Health Worker phases in.** The position is funded at 0.60 FTE in Year 1 to account for recruitment lead time and lower first year prescription volume, and steps to 1.00 FTE in Year 2. Maryland maintains a state certification pathway for community health workers, and BCH can alternatively fill the role with a certified peer specialist, a workforce that is more available locally, using the same funded nutrition coach training.
- **BCH's service area is a designated Medically Underserved Population,** which supports National Health Service Corps loan repayment and placement, a channel BCH has used before.
- **The program launches without waiting on recruitment.** The Chief Medical Officer and Nurse Practitioner hold dedicated nutrition slots from month one, and the Care Manager and Outreach and Director of Strategic Initiatives positions begin screening, referral follow up, and Food Bank contracting immediately. That 0.65 FTE of existing staff runs the program's first quarter on its own.

If recruitment extends beyond the first quarter, nutrition visits shift to the Nurse Practitioner and Chief Medical Officer, initial education shifts to existing care management nurses, and Food Bank coordination stays with the Care Manager and Outreach position. Recruitment delay slows the ramp, and it does not stop the program.

Behavioral health capacity as a program asset. BCH employs 6.11 FTE of behavioral health providers, including licensed clinical social workers, licensed clinical professional counselors, and a psychiatric nurse practitioner, and served 482 behavioral health patients in 2025 out of a total panel of 4,288. Behavioral health has operated at BCH since 2014, with dedicated space and telehealth capability since 2018. The department screens for social drivers of health at every intake, which makes it a referral source into the nutrition program as well as a support for patients already enrolled. For nutrition care, this means a patient whose care plan is failing because of depression, anxiety, or disordered eating can be seen by a behavioral health clinician in the same building, often the same day. That is the difference between a nutrition plan that a patient can follow and one they cannot. **The ENS budget contains no behavioral health personnel line and no behavioral health service costs. BCH funds all behavioral health service delivery through its existing behavioral health resources, and no ENS funds pay for behavioral health services.**

2. Describe your use of screening tools to assess nutritional status of your patients. If you do not currently use screening tools for this purpose, describe your use of other risk identification screening tools to inform program development.

BCH does not currently use a nutrition specific screening tool. BCH uses three established screening and risk identification instruments, all embedded in eCW, and this project connects them into a nutrition risk pathway.

Table 22: Current Screening Tools and Nutrition Application		
Tool	Current Use	Application to Nutrition Services
PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences)	Standardized social risk screening being embedded in eCW, administered on inconsistent basis	Becomes standard at chronic disease, established care, and follow up visits. Food insecurity, limited food access, transportation, financial, and housing responses form the social half of the nutrition referral; one basis for ProduceRx eligibility
BMI and BMI percentile	Captured as a rostered rooming task at every visit for all ages	Clinical referral trigger at BMI at or above 30 in adults and above the 95th percentile in pediatrics
PHQ-9 and depression screening	Administered to patients aged 12 and older, with 94.3% screening and follow up documentation in 2025	Identifies behavioral barriers to dietary adherence, routing patients to existing behavioral health services alongside nutrition care

BCH also performs point of care A1c testing, which allows glycemic status to be known during the visit rather than after it. This means a patient can be identified as meeting nutrition referral criteria and referred in the same encounter.

The gap this project closes is not the absence of screening. BCH screens. The gap is that a positive screen does not currently produce a nutrition action. Food insecurity is captured only when a provider enters a Z code, PRAPARE is not administered at every chronic disease visit, and no rule in eCW converts a positive screen into a referral. This project builds that conversion, and adds a nutrition assessment at the visit itself, including a 24 hour dietary recall, a food frequency questionnaire, review of food access and preparation, and review of A1c, BMI, weight history, blood pressure, lipid profile, and medications.

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

BCH implements this project through governance and quality structures that already exist and already function.

Governance and oversight. BCH's Board of Directors, a majority patient board of 13 members, holds full authority for BCH operations, approves the annual Quality Improvement Plan, and

reviews the KPI report monthly. The QI Committee, comprised of clinical and administrative leadership and management staff, meets at least monthly alongside General Staff, Provider, Leadership, and Peer Review meetings. The Chief Medical Officer and QI Coordinator jointly prepare the Quality Improvement Plan. This project's measures enter that structure rather than sitting outside it, which gives the program governance level accountability from the first month.

Implementation sequence.

Table 23: Implementation Timeline	
Period	Milestone
Months 1 to 3	Submit Form 5A change in scope to add Nutrition. Post the Nutritionist, Registered Nurse Certified Diabetes Educator, and Community Health Worker positions, including National Health Service Corps listing. Convene the joint strategic planning session with the Anne Arundel County Food Bank to design box composition, delivery routing, and tracking, and execute the resulting agreement. Extend the eCW clinical rule engine already in development to fire nutrition referrals, and build the nutrition visit type. Train medical support staff on PRAPARE administration. Open nutrition slots on Chief Medical Officer and Nurse Practitioner schedules.
Months 4 to 6	Activate the nutrition alert. Begin ProduceRx with a pilot, or soft launch, to test the delivery model at limited volume before scaling. Onboard new hires and issue laptops and EHR licenses. Complete nutrition coach training for the Community Health Worker. First quarterly QI review of process measures.
Months 7 to 12	Scale to full referral and visit volume. Complete CDCES and lifestyle medicine certification coursework. Stand up the newly diagnosed diabetes subset registry in eCW. First full year UDS reporting including nutrition measures.
Year 2	Increase referrals to 600 and visits to 1,000, and step the Community Health Worker to full time. Build toward three consecutive monthly visits for enrolled patients. Pursue Medicare Diabetes Self-Management Training accreditation on the strength of the CDCES credential. Report the UDS Table 5 nutrition services measure for both 2027 and 2028.

Monitoring. Process and utilization measures report monthly to the Board KPI document. Clinical outcomes report quarterly to the QI Committee. BCH's routine chart audit process extends to nutrition documentation and referral completeness. The Director of Nursing owns ENS reporting and reconciles internal program counts to the UDS submission.

Adaptation. BCH applies the Focus-PDSA methodology it already uses across clinical quality measures. The program has three defined adaptation levers, each with a trigger:

- **Referral volume below target.** Broaden the alert criteria, increase PRAPARE screening frequency, or extend the newly diagnosed window beyond 12 months.
- **Referrals not converting to visits.** Adjust outreach contact timing and scripts, expand transportation coordination, or add evening and Saturday nutrition slots at the West River site, which already operates extended hours.

- **Prescriptions issued but not received.** Adjust the Food Bank delivery schedule and drop location, shift more volume to direct delivery for patients without transportation, or move prescription issuance to coincide with the return visit so the box and the appointment travel together.

BCH has managed adaptation of this kind before. It stood up telehealth within weeks at the onset of the COVID-19 public health emergency, added a service site through a formal change in scope, and built point of care A1c testing into the visit workflow to close a documented testing gap.

Bay Community Health			Year 1		Year 1 Total	Year 2		Year 2 Total
	Rate	Quantity	Federal Grant Request	Non Federal Resources		Federal Grant Request	Non Federal Resources	
REVENUE								
Funding			350,000		350,000	350,000		350,000
Program Income				5,701	5,701		4,560	4,560
TOTAL REVENUE			350,000	5,701	355,701	350,000	4,560	354,560
EXPENSES								
PERSONNEL								
Medical Staff			43,212	4,800	48,012	36,372	3,840	40,212
Enabling Staff			60,219	-	60,219	70,219	-	70,219
Nutrition Staff			120,760	-	120,760	120,760	-	120,760
TOTAL PERSONNEL			224,191	4,800	228,991	227,351	3,840	231,191
FRINGE BENEFITS								
FICA	0.765%		1,715	37	1,752	1,739	29	1,768
Health Insurance	16.00%		35,871	768	36,639	36,376	614	36,990
Unemployment & Workers Compensation	2.00%		4,484	96	4,580	4,547	77	4,624
TOTAL FRINGE	18.77%		42,070	901	42,971	42,662	720	43,382
TRAVEL								
Local Mileage for staff travel (\$0.76/mile) - 5 nutrition staff X 100 miles per month = 500 miles per month during Year 1 and Year 2. Conduct home visits, outreach events, visit partner food bank sites, etc.	0.76	6,000	4,560		4,560	4,560	-	4,560
PrilMed Conference-Washington DC - cost includes mileage only (160.5 miles round trip at 0.76/mile=\$122). Meals are covered by conference registration, and no hotel stay is required. Annual attendance for 3 staff during Year 1 and Year 2.	122	3	366		366	366	-	366
Food Nutrition Conference & Expo (FNCE) in Washington DC in Oct 2027- cost includes per diem (\$92/day x 4 days= \$368) hotel (\$225 * 3 nights) and mileage (160.5 miles round trip x 0.76/mile= \$122). Annual attendance for 4 staff during Year 1 and a 3% increase in year 2.	1,165	4	4,660		4,660	4,800	-	4,800
TOTAL TRAVEL			9,586	-	9,586	9,726	-	9,726
EQUIPMENT								
TOTAL EQUIPMENT			-	-	-	-	-	-
SUPPLIES								
Outreach Supplies - \$450 per month in Years 1 and 2.	450	12	5,400		5,400	5,400	-	5,400
Programmatic Supplies (educational materials-\$1,000, reference materials for care team-\$1,000 and monthly supplies of \$100 X 12 months).	3,200	1	3,200		3,200	3,200	-	3,200
Laptops for 3 new staff purchased during Year 1	2,000	3	6,000		6,000	-	-	-
TOTAL SUPPLIES			14,600	-	14,600	8,600	-	8,600

Bay Community Health			Year 1		Year 1 Total	Year 2		Year 2 Total
	Rate	Quantity	Federal Grant Request	Non Federal Resources		Federal Grant Request	Non Federal Resources	
CONTRACTUAL								
Anne Arundel County Food Bank. Prescription Rx \$25 per month per prescription box X 1,279 Rx's in Year 1 and 1,366 in Year 2.	25.00	1,279	31,975		31,975	34,150	-	34,150
Anne Arundel County Food Bank Delivery Fees (\$10 per box to bring ProducesRX basets to South County from main site in Baltimore)	10.00	1,279	12,790		12,790	13,660	-	13,660
TOTAL CONTRACTUAL			44,765	-	44,765	47,810	-	47,810
CONSTRUCTION								
TOTAL CONSTRUCTION			-	-	-	-	-	-
OTHER								
Certified Diabetes Care and Education Specialist training (CDCES) - RN; Nutrition Coach training for CHW \$275 each	275	2	550		550		-	-
EHR licenses (1 new licensed, independent provider) during Year 1 and Year 2	5,680	1	5,680		5,680	5,680	-	5,680
ACLM/ABLM Lifestyle Medicine Certification: Year 1 covers Exam & Preparation for 2 staff (Nurse Practitioner, Chief Medical Officer) at \$2,219 each (\$4,438 total). Year 2 covers a renewal exam fee for 1 continuing provider (\$2,219) plus a reduced, prep-only fee for 1 additional provider (\$1,832), totaling \$4,051.	2,219	2	4,438		4,438	4,051	-	4,051
Conference Registration - PriMed-Washington DC (\$500 fee x 2 staff). Attendance during Year 1 and Year 2	500	2	1,000		1,000	1,000	-	1,000
Conference Registration-Food Nutrition Conference & Expo (FNCE) in Washington DC in 2027 (\$780 registration fee x 4 staff). Attendance during Year 1 and Year 2	780	4	3,120		3,120	3,120	-	3,120
TOTAL OTHER			14,788	-	14,788	13,851	-	13,851
TOTAL DIRECT CHARGES			350,000	5,701	355,701	350,000	4,560	354,560
INDIRECT CHARGES								
0% indirect cost rate								
TOTALS			350,000	5,701	355,701	350,000	4,560	354,560

ENS Year 1 Staff Profile		
Full name	Position	Full-time / Part-time
TBD	Registered Nurse - Certified Diabetic Educator	50%
Nyediang Ateghang	Nurse Practitioner	10%
Catherine Njiru-Sewer	Chief Medical Officer	15%
Rayniece Anderson	Care Manager and Outreach	20%
Leslie DeJesus	Director of Strategic Initiatives and Communication	20%
Savannah Jones	Director of Nursing	0%
TBD	Community Health Worker - Nutrition Coach	60%
TBD	Nutritionist	100%
		2.75

ENS Year 2 Staff Profile		
Full name	Position	Full-time / Part-time
TBD	Registered Nurse - Certified Diabetic Educator	50%
Nyediang Ateghang	Nurse Practitioner	10%
Catherine Njiru-Sewer	Chief Medical Officer	12%
Rayniece Anderson	Care Manager and Outreach	20%
Leslie DeJesus	Director of Strategic Initiatives and Communication	10%
Savannah Jones	Director of Nursing	0%
TBD	Community Health Worker - Nutrition Coach	100%
TBD	Nutritionist	100%
		3.02