MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

ANNUAL REPORT

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MARCH 2021

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Abbreviations

CASBHC: Maryland Council on Advancement of School–Based Health Centers

CHRC: Community Health Resources Commission

CHW: Community Health Worker

CMMI: Center for Medicare and Medicaid Innovation

CRISP: Chesapeake Regional Information System for our Patients

DAP: Maryland Diabetes Action Plan (MDH population health initiative)

ED: Emergency Department

EHR: Electronic Health Record

FQHC: Federally Qualified Health Center

HEDIS: Health Effectiveness Data and Information Set

HIPAA: Health Insurance Portability and Accountability Act

LHD: Local Health Department

LHIC: Local Health Improvement Coalition

MAT: Medication Assisted Treatment

MCO: Managed Care Organization

MDH: Maryland Department of Health

MHBE: Maryland Health Benefit Exchange

MOU: Memorandum of Understanding

MASBHC: Maryland Assembly on School-Based Health Care

MRHA: Maryland Rural Health Association

MSDE: Maryland State Department of Education

PCP: Primary Care Provider

QBP: CASBHC's Quality and Best Practices Workgroup

RFP: Request for Proposals

SBHC: School-Based Health Center

SDOH: Social Determinants of Health

SHIP: State Health Improvement Process

I. Executive Summary

This report highlights the main activities and deliverables provided by the Maryland Community Health Resources Commission for CY2020. The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 with a mission to expand access to health care services in underserved communities in Maryland. The CHRC is an independent commission within the Maryland Department of Health, and its 11 members are appointed by the Governor. Since its inception, the CHRC has expanded access to health services in Maryland's underserved communities by awarding 312 grants totaling $79.2 million, supporting projects in all 24 jurisdictions. Of these 312 grants, 266 support projects that have delivered quality health care to 503,810 Marylanders resulting in 1,282,142 service encounters at health centers, clinics, and neighborhood locations across the State. Over this same period, the Commission has received 946 grant proposals for consideration, totaling more than $415 million in funding requests. The initial funding provided by the CHRC has also enabled its grantees to leverage $31.8 million in **additional** federal and private/non-profit resources of which $26.8 million is private or local funding to provide even more needed health care in vulnerable, underserved communities. The CHRC works with grantees to assist in post-grant sustainability, and more than 77% of the grants awarded in FY 2016 (the last year for which sustainability data is available) were sustained for a minimum of one year after grant funds were expended.

CHRC grants have supported the following population health priorities of the state: (1) Supporting the implementation of the Maryland Diabetes Action Plan; (2) Addressing the impact of COVID-19; (3) Promoting access to Medication Assisted Treatment and the state's response to the opioid epidemic; (4) Increased access to dental care in underserved communities; and (5) Expanded access to prenatal care and women's health services to reduce health disparities with infant and maternal health outcomes. CHRC programs have led to measurable improvements in health outcomes and have generated cost savings by reducing avoidable hospitalizations for vulnerable populations. The CHRC looks to support grant funded programs that are innovative, sustainable, and replicable, and prioritizes projects that use evidence-based intervention strategies to meet a specific community need and provide measurable improvements in health outcomes.

Annual Call for Proposals

To fulfill its statutory responsibility of expanding access to health care services for low-income Marylanders and to bolster the capacity of the health care safety net infrastructure to deliver high-quality health services in underserved communities, the CHRC issues an annual Call for Proposals and has focused its grant making activities to support the state's public health needs and priorities. The most recent CHRC Call For Proposals issued in November 2020, has two strategic priorities: (1) promoting health equity by addressing health disparities and the Social Determinants of Health (SDOH), in particular disparities that disproportionately impact racial and ethnic minorities and are now exacerbated by the COVID-19 pandemic; and (2) promoting the efficient, strategic delivery of

integrated population health interventions for vulnerable residents in underserved communities through the support of innovative, sustainable community partnerships such that the totality of needs for the targeted populations are addressed. Under these strategic priorities, the CHRC requested applications that address the following areas: (1) chronic disease prevention and disease management with a particular focus on the prevention and management of diabetes; (2) the health and social needs of vulnerable populations who are disproportionately impacted by the COVID-19 pandemic; and (3) the immediate and longer-term recovery needs of Maryland's safety net providers as they navigate the impact of the COVID-19 pandemic and work to restore their capacity to deliver essential health services and help support the basic needs of the disproportionately impacted vulnerable communities they serve.

CHRC Response to the COVID-19 Pandemic

Early in the COVID-19 virus pandemic, the CHRC recognized the unprecedented challenges facing Maryland's safety net service providers caused by this public health crisis. These providers faced dramatic reductions in revenue as operational costs increased and typical funding streams were disrupted, impacting their capacity to provide essential health and social services. To help ameliorate the impact of the COVID-19 pandemic on community health resources, the CHRC implemented a series of actions including authorization of a number of COVID-19 impact mitigation options for all current CHRC grantees, and issuing its first ever emergency funding Call for Proposals in April 2020, to provide safety net providers immediate relief and financial resources to support the continued delivery of much needed services to the most vulnerable populations. The CHRC awarded 46 grants totaling $1.5 million, funding supported by federal CARES Act and made available by the Maryland Department of Health.

CHRC Support of the Maryland Diabetes Action Plan

Improving the health of all Marylanders through local coalition action and partnerships with community health resources is a mutual, ongoing goal of the CHRC and the Maryland Department of Health. The Local Health Improvement Coalitions (LHICs) are locally driven population health system planning and delivery collaboratives which have been used by Local Health Departments (LHDs) as an important entity to engage key stakeholders, partners, and the community for almost a decade. The CHRC continued its commitment to the mission and success of the LHICs with the release of the FY2020 Local Health Improvement Coalition (LHIC) Call for Proposals. These grants are intended to support the LHICs' efforts to expand capacity and build on innovative partnerships with community stakeholders and health resources to advance the initiatives and strategies detailed in the Diabetes Action Plan and other local population health improvements.

In addition to grant making, the CHRC provides technical assistance to its grantees to increase their capacity to serve residents in vulnerable communities. These services include reporting and data analytics; supporting care coordination initiatives; and connecting grantees with other sectors of Maryland's health care community. The purpose of the technical assistance program is to bolster the capacity of Maryland safety-net providers, to assist CHRC grantees in documenting program impact, to support program evaluation, and to help promote program sustainability.

In 2017, the Maryland General Assembly approved legislation that transferred the staffing responsibilities of the Maryland Council on Advancement of School–Based Health Centers (CASBHC) from the Maryland State Department of Education (MSDE) to the Department of Health (MDH). Under the legislation, the CHRC provides day-to-day staffing support for the Council. The purpose of the Council is to improve the health and educational outcomes of students who receive services from a School-Based Health Center (SBHC). CASBHC is responsible for advancing the integration of SBHCs into (1) the health care system at the state and local levels and (2) the educational system at the state and local levels. The Council develops specified policy recommendations to improve the health and educational outcomes of students who receive services from SBHCs.

II. Background and Mission

The Maryland General Assembly created the Community Health Resources Commission in 2005 to expand access to affordable, high-quality health care services in the state's underserved communities; support the adoption of health information technology in community health resources; increase access to specialty health care services for uninsured and low-income individuals; promote interconnected systems of care and partnerships among community health resources and hospitals; and, help reduce preventable hospital emergency department visits. The CHRC is an independent commission within the Maryland Department of Health, and its 11 members are appointed by the Governor (Appendix A). The Commission is led by Chair Elizabeth Chung and Vice Chair J. Wayne Howard. The CHRC fulfills its statutory responsibilities through its grant making activities and technical assistance to community-based health care providers, and special projects aimed at bolstering the capacity of the Maryland health care safety net.

The CHRC consistently supports projects that meet the health needs of local communities and projects that tailor intervention strategies to bolster the capacity of safety net providers to serve more individuals. Health disparities related to gaps in access to care, the limited availability of providers and services, and other Social Determinants of Health (SDOH) such as lack of transportation persist in Maryland and throughout the country and contribute to poor health outcomes. These health disparities are found across rural, urban, and suburban communities. Racial and ethnic minorities, and those who are uninsured and underinsured, economically disadvantaged, elderly, homeless, immigrants, or have behavioral health disorders are less likely to have a usual source of care or to have received essential health or dental care in the previous year.[1] These groups also confront more barriers to care and are impacted by SDOH, leading to poorer quality care than higher-income individuals. For this reason, the CHRC continues to prioritize funding for projects that offer innovative ways to address health disparities and promote health equity. Given the ongoing effects of the COVID-19 virus pandemic on the delivery of health care services and the pandemic's disproportionate impact on Maryland's vulnerable populations, it is more critical than ever that Maryland supports and protects the integrity of the state's safety net

[1] http://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/

providers. These safety net providers have a historical mission of serving low-income individuals and have a demonstrated track record of implementing programs that serve vulnerable populations by offering innovative approaches to tackling the SDOH and helping to reduce health disparities.

III. CHRC Grant Making Activity

To fulfill its statutory responsibility of expanding access in underserved communities, the CHRC issues an annual Call for Proposals and focuses its grant making activities on supporting Maryland's public health needs and priorities. Since its inception, the CHRC has issued 15 Calls for Proposals and awarded 312 grants totaling $79.2 million, supporting programs in all 24 jurisdictions. Over the same period, the Commission has received 946 grant proposals for consideration, totaling more than $415 million in funding requests. Of these 312 grants awarded, 266 support projects that have to-date collectively provided essential health and social services to 503,810 Maryland residents, resulting in 1,282,142 service encounters at health centers, clinics, and neighborhood locations across the State. Commission funded projects have also achieved a demonstrable return on investment (ROI) by reducing avoidable hospital and 911 system utilization.

Investing limited public resources efficiently and strategically and achieving post-grant project sustainability are top priorities of the Commission. Initial funding provided by the CHRC has enabled its grantees to leverage $31.8 million in **additional** federal, local, and private resources, of which $26.8 million is private or local funding to continue and further expand access to health services for vulnerable, underserved communities. CHRC works with grantees to assist in post-grant sustainability, and more than 77% of the grants awarded in FY 2016 (the last year for which sustainability data is available) were sustained after grant funds had been expended. Table 1 summarizes the types of grants that have been awarded by the CHRC.

Table 1:

Maryland Community Health Resources Commission				
Focus Area	**# of Projects Funded**	**Total Award Provided**	**Cumulative Total**	
			Patients Seen/Enrolled	**Visits Provided**
Expanding access to primary care at Maryland's safety net providers	77	$19,479,428	99,765	302,544
Providing access to integrated behavioral health services	72	$19,481,102	92,276	340,690
Increasing access to dental care for low-income Marylanders	44	$8,750,606	71,434	161,127
Promoting women's health and addressing infant mortality	27	$5,658,294	19,814	66,321
Reducing obesity and promoting food security	32	$5,765,000	3,412	19,821
Supporting community health providers during COVID-19 pandemic	46	$1,445,932	(COVID Emergency Funding)	
Promoting health information technology at community health centers	9	$3,268,661	(Health Information Technology)	
Health Enterprise Zones	5	$15,335,997	217,109	391,639
Total Grant Funding Provided	**312**	**$79,185,020**	**503,810**	**1,282,142**
Total Funding Requested	**946**	**$415,084,177**		
Number of Patient/Clients Served		**503,810**		
Number of Patient/Client Encounters		**1,282,142**		
Additional federal and private resources leveraged		**$31,792,229**		

Increasing affordable and accessible primary and preventative medical, dental, and women's health services using multi-sectoral approaches are the bedrock goals of the CHRC. Of the 266 project grants awarded, 77 grants totaling $18.3 million were for primary care; 44 grants totaling $8.8 million were for dental care; and 27 grants totaling $5.7 million funded women's health care services.[2] These grants have: (1) increased access to primary care services and supported new health care access points in underserved communities; (2) supported interventions that address childhood and adult obesity, food security, diabetes and other chronic diseases; (3) provided preventative and restorative dental care and oral hygiene education to adults and children; (4) targeted "super-utilizers" of emergency care through hospital Emergency Department (ED) and emergency medical (EMS) diversion, and care coordination; and (5) provided prenatal and perinatal services for women who would otherwise lack access. These projects have in total served 194,000 Marylanders. In addition, the CHRC has awarded 72 grants totaling $19.5 million to support the integration of behavioral health and primary care services and expand access to substance use treatment in total serving over 92,000 individuals.

A. Current CHRC Call for Proposals (FY 2021)

The most recent CHRC Call For Proposals (FY 2021) issued in November 2020, has two strategic priorities: (1) promoting health equity by addressing health disparities and the Social Determinants of Health (SDOH), in particular disparities that disproportionately impact racial and ethnic minorities and are now exacerbated by the COVID-19 pandemic; and (2) promoting the efficient, strategic delivery of integrated population health interventions for vulnerable residents in underserved communities through the support of innovative, sustainable community partnerships such that the totality of needs for the targeted populations are addressed. Under these strategic priorities, the CHRC requested applications that address the following areas: (1) chronic disease prevention and disease management with a particular focus on the prevention and management of diabetes; (2) the health and social needs of vulnerable populations who are disproportionately impacted by the COVID-19 pandemic; and (3) the immediate and longer-term recovery needs of Maryland's safety net providers as they navigate the impact of the COVID-19 pandemic and work to restore their capacity to deliver essential health services and help support the basic needs of the disproportionately impacted vulnerable communities they serve. The FY2021 Call for Proposals generated 55 applications requesting $13.1 million in funding, and final award determinations will be made by the Commission in March 2021.

The CHRC continues to support grant funded projects that are innovative, sustainable, and replicable, and prioritizes projects that use evidence-based intervention strategies to meet a specific community need and provide measurable improvements in health outcomes. In addition, the Commission encourages grant applicants to use an integrated community-based outreach approach when designing their programs, for example, deploying Community Health Workers (CHWs) from the affected communities to engage vulnerable, hard to reach residents and provide vital health education and coordination to establish or restore access to needed health and social services.

[2] https://health.maryland.gov/mchrc/Pages/grantees-by-focus-area.aspx

CHRC FY 2021 Call for Proposals - Strategic Priority One:

Promoting health equity by addressing health disparities and Social Determinants of Health (SDOH), with a particular emphasis on addressing disparities that disproportionately impact racial and ethnic minorities and have been exacerbated by the COVID-19 pandemic.

Health equity is achieved when every individual has the ability to attain optimal health and wellness without being disadvantaged due to their race, ethnicity, age, gender, gender identity, sexual orientation, socioeconomic status or other factors such as geographic location and disability status.[3] When individuals are not provided equal opportunities or the resources to pursue optimal health and wellness, this creates health inequities which invariably result in health disparities. Health disparities are preventable differences in health outcomes and their causes (e.g., the burden of disease) observed between groups of people.[4] The burden of chronic disease and the preventable differences in health outcomes are significantly greater for racial and ethnic minorities in the U.S. compared to non-Hispanic whites.[5]

Despite decades of efforts to eliminate health disparities in Maryland, preventable differences in disease burden in disadvantaged populations continue to persist. Whilst some progress has been made in narrowing the health disparities gap, efforts to eliminate these disparities must continue in Maryland.[6] Elimination of, or improvement in these disparities is unlikely to be achieved without addressing the SDOH. According to Healthy People 2020, SDOH are conditions in the environments in which people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The forces that shape these conditions include economic policies and systems, social norms, social policies and stigma, and political systems. Addressing SDOH is one of the most effective ways to improve health and reduce health disparities.[7] Understanding the intersection between the SDOH and health outcomes is fundamental to advancing health equity. SDOH include the availability of health insurance coverage and access to providers; access to transportation, social support systems and community engagement; and access to healthy foods and food security.

For the FY2021 Call for Proposals, as in past years, the CHRC encouraged grant applicants to address one or more SDOH through the interventions of their programs. For example, some recent grantees have provided vouchers for transportation to health care appointments or counselling to link patients to education and employment opportunities. Applicants have also been encouraged to consider the full-range of factors contributing to health disparities including race, ethnicity and socioeconomic status taking into account the ongoing impact of the COVID-19 virus pandemic on

[3] https://www.cdc.gov/chronicdisease/healthequity/index.htm
[4] https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities
[5] https://www.cdc.gov/mmwr/pdf/other/su6203.pdf
[6] https://health.maryland.gov/mhhd/Documents/Maryland%20Chartbook%20of%20Minority%20Health%20and%20Minority%20Health%20Disparities%20Data,%20Third%20Edition%20(December%202012).pdf
[7] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

access to health care services and the added burdens this places on those at increased risk due to the impact of the pandemic.

The value of increasing the availability of population health interventions as one approach to reducing health disparities and addressing SDOH is widely recognized.[8] The CHRC places strategic importance on multi-sectoral, public and private partnerships that engage the participation of community stakeholders to develop and deliver effective project interventions through these partnerships that create or expand social, political, or economic support systems to address the SDOH for specific population(s).

CHRC grants have supported health population management activities in vulnerable underserved communities through programs that: increase access to affordable healthy food in underserved communities through the development of community gardens and local food pantries; increase the availability of healthy foods in local grocery stores in neighborhoods designated as healthy food priority areas ("food deserts"); promote access to effective screening and diagnostic testing for diabetes, high blood pressure, and high cholesterol; provide education on reducing health risk behaviors; foster healthy living across life stages among disadvantaged groups through nutrition and physical activity education and employer sponsored health promotion projects; and, target reductions in health risk behaviors such as tobacco use

A key area for applicant consideration under this strategic priority was **expanding access to essential health care services and health insurance coverage,** as one of the SDOH that contributes to health disparities. Following the passage of the Affordable Care Act, Maryland, like many states, achieved dramatic increases in health insurance coverage rates. There has been a dramatic drop in the uninsured rate for Marylanders between the ages of 18 and 64, from 11.3% in 2013 to 6% in 2019.[9] Despite these coverage gains, the uninsured rate remains high for certain racial and ethnic groups. For example, the uninsured rate for Hispanic/Latino individuals was 37.1% in 2019.[10] According to an analysis by the Maryland Health Benefit Exchange, as of October 2019, an estimated 252,011 exchange eligible individuals remain uninsured with or without a subsidy.

Another area applicants were to consider under this strategic priority is **workforce diversity**. A landmark study supported by the HHS Office of Minority Health and conducted by the Institute of Medicine, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," was published in 2003, and concluded that racial and ethnic minority groups tend to receive a lower quality of healthcare compared to non-minority groups despite efforts to address access issues such as health insurance coverage. The study recommended increasing the representation of racial and ethnic minorities in the healthcare workforce and providing patients with culturally appropriate health education as an effective way to improve the quality of healthcare provided to racial and

[8] https://www.cdc.gov/minorityhealth/strategies2016/index.html
[9] https://www.census.gov/library/publications/2020/demo/p60-271.html
[10] https://www.kff.org/uninsured/state-indicator/distribution-uninsured-nonelderly-race-ethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

ethnic minority populations.[11] Increasing racial and ethnic minority representation among healthcare professionals and the leaders of the organizations that provide health and social services proportionally to the communities they serve will help to improve the cultural competency of the healthcare workforce, and support improved health literacy and understanding to better meet the needs of these communities and help to reduce health disparities.

The CHRC also encouraged applicants to consider including measures that increase language access and the associated costs for language accommodation in their grant budget to support community outreach and the delivery of services to immigrant communities.

CHRC FY 2021 Call for Proposals - Strategic Priority Two:

Promoting the efficient and strategic delivery of integrated population health interventions for vulnerable residents through the support of innovative, sustainable community partnerships that focus on underserved communities, such that the totality of needs for the targeted populations are addressed.

The concept and process models for "integrated" care have generally focused on health care delivery systems and the provision of primary and behavioral healthcare services within one healthcare system or provider location, using a multidisciplinary care team to address the comprehensive health and social needs of each patient, as well as their families and caregivers. However, for individuals with multiple chronic diseases and complex social service needs, integrated health care systems and providers face challenges to effectively managing the totality of each patient's needs. This is especially true for vulnerable individuals in underserved rural and urban communities who have limited access to an integrated care provider or who rely on their local hospital and emergency departments for their essential healthcare needs. Approaches to integrated care continue to evolve to find more effective ways to improve the effectiveness and quality of care.

The CHRC has consistently supported innovative, sustainable, community-based partnerships that address the unmet medical and SDOH needs of Maryland's vulnerable, low-income, underserved communities. The current strategic priority further enhances this focus by increasing the opportunities to fund projects designed to identify more effective approaches to improving chronic disease management and addressing the social factors that will contribute to better health outcomes and increase the quality of life for residents of underserved communities.

B. Prior CHRC Calls for Proposals

Prior Calls for Proposals issued by the CHRC have addressed these strategic priorities: (1) preserving or enhancing the state's ability to serve vulnerable populations regardless of insurance status; (2) promoting health equity by reducing health disparities and addressing SDOH; and (3) supporting community-based programs that are innovative, sustainable, and replicable. Over the past few years, the CHRC has requested applications and strategically awarded grants in

[11] https://unequaltreatment.com/

areas that: (1) promote delivery of essential health services (primary care, dental, and women's health services); (2) address the heroin and opioid epidemic through behavioral health integration; and (3) promote food security and address childhood and family obesity.

Projects funded by the CHRC have included:

(1) **Access to integrated behavioral health services**, either by adding behavioral health in traditional primary care settings or adding primary care to existing behavioral health programs. Recent grants awarded in this category have included partnerships between behavioral health providers and federally qualified health centers to provide primary care services to behavioral health patients, or projects to implement Screening, Brief Intervention and Referral to Treatment (SBIRT) in community primary care settings.

(2) **Medication-assisted therapy** for those suffering from opioid addiction, including programs that involve supportive housing, peer recovery support specialists, and/or telehealth. The CHRC has funded projects to increase access to Medication-assisted treatment though telehealth services in rural underserved areas and projects to provide peer-to-peer recovery services to those presenting to the emergency department for addiction-related conditions.

(3**) Re-entry or justice system diversion programs** for those with behavioral health needs that need help in transitioning back to the community. The Commission has supported a program to provide wrap around services to incarcerated individuals and their families with substance use disorders facing adverse SDOH.

(4) **Mobile crisis intervention programs**, **stabilization centers, and walk-in crisis centers**. The CHRC has funded Mobile Integrated Health programs for those with serious mental health issues and programs to connect patients to needed treatment in the community. CHRC funds have also supported stabilization centers in Anne Arundel County and Baltimore City and a walk-in crisis center in Frederick County whose goal is to work with patients in crisis due to substance use or serious mental illness, connect them to needed services, and help keep them out of hospitals and the criminal justice system.

(5) **ED diversion programs that promote post-hospital care coordination** and facilitate access to ongoing primary and behavioral health services. CHRC-funded care coordinators work with individuals to connect those with serious mental illness to health care providers, social services, and other needed programs to help improve their mental and physical health status.

(6) **Efforts to promote food security in food deserts**. The Commission has funded projects to introduce healthy foods in corner stores in Baltimore City and projects to provide healthy foods to low-income families through food pantries and farmer's markets.

(7) **School-based interventions to identify children considered obese or at risk of obesity and provide nutritional counseling to their families**. These CHRC-funded projects have provided home visitation, nutrition education, and cooking classes to students and families facing childhood and family obesity.

(8) **Partnerships with private pediatrician offices** to provide assessment and culturally sensitive and appropriate treatment and/or resources for children who are overweight or obese. These programs have trained pediatricians to recognize children at risk of becoming obese and to provide treatment for both children and their families.

(9) **Interventions that enhance community access to physical activity opportunities** and also provide alternative fitness solutions in the absence of the built environment. The CHRC has supported projects that provide afterschool programs, fitness classes, and community soccer tournaments in areas lacking resources for safe physical fitness activities.

(10) **Programs to reduce the incidence premature, low-birth weight newborns and infant mortality**. The CHRC funds women's health programs that assist high-risk, racial/ethnic minority women who are pregnant or postpartum in accessing much needed care and social services, including women diagnosed with cardiovascular disease, diabetes or other chronic conditions. Interventions include direct community outreach by Community Health Workers (CHW) to engage hard-to-reach women, link them to appropriate care, provide health education and address social determinants of health to achieve better health outcomes.

C. CHRC Project Design Priorities and Objectives

The CHRC has and will continue to support projects that are innovative, sustainable, and replicable, and prioritizes projects that use evidence-based intervention strategies to meet a specific community need and provide measurable improvements in health outcomes. The Commission serves as an incubator for innovative projects and supports the efforts of grantees to continue projects once initial CHRC grant funding has been expended.

Innovative:

The CHRC looks to fund projects that are **innovative**. According to the World Health Organization, a health care innovation responds to "unmet public health needs by creating new ways of thinking and working with a focus on the needs of vulnerable populations. It aims to add value in the form of improved efficiency, effectiveness, quality, sustainability, safety, and/or affordability."[12] Successful CHRC-funded projects are newly developed, evidence-based projects which improve health policies, systems, services or delivery methods, or those that have been successfully implemented in other states and planned for use in Maryland for the first time.

Sustainable:

Proposals that present a clear **sustainability** plan will be viewed favorably by the Commission. The Commission has funded projects with sustainability plans that have included increasing the ability of a safety net provider to bill for services or to receive financial support from local hospitals, private foundations, health insurers, or municipalities.

[12] http://www.who.int/topics/innovation/en/

Replicable:

The CHRC also supports projects that are **replicable**. Several projects that have been funded by the Commission in the past have led to statewide adoption of initiatives in behavioral health and care coordination services in many underserved communities in the state. For example, the CHRC funded the initial Behavioral Health Home pilot implemented by Way Station in FY 2012. The Maryland Department of Health has implemented the Medicaid Behavioral Health Home Initiative statewide, and there are now more than 80 Health Homes in the state.

Measurable Impact:

The CHRC prioritizes projects that use **evidence-based intervention strategies** to meet a specific community need and are designed to provide measurable improvements in health outcomes. To achieve this objective, applicants are strongly encouraged to identify discrete data variables that allow measurement of the intended impact of project interventions. Applicants are also encouraged to perform a "formal" cost-benefit analysis that compares the cost of implementing an innovative project intervention(s) against existing interventions and calculating the cost saving(s) that result from the project intervention(s).[13] This could apply to projects that address the SDOH, for example securing health insurance coverage for vulnerable populations that otherwise would not get routine health screenings and preventive care and are at greater risk for serious health problems and poor health outcomes.[14]

D. CHRC Emergency Relief Supporting Safety Net Providers During the COVID-19 Virus Pandemic

Early in the COVID-19 virus pandemic, the CHRC recognized the unprecedented challenges facing Maryland's safety net service providers caused by this public health crisis. Safety net service providers have faced dramatic reductions in revenue and increased operational costs, significantly impacting their capacity to provide essential health and social services. These challenges continue and only exacerbate the existing, persistent health disparities experienced by racial and ethnic minorities, and increasing the burden for those most susceptible to the immediate and longer-term consequences of the pandemic. To help ameliorate the impact of the COVID-19 pandemic on community health resources, the CHRC implemented a series of actions. First, the Commission authorized a number of COVID-19 impact mitigation options for all current CHRC grantees. These grant modification relief options included: 1) adjusting the grant reporting schedules and reporting requirements; 2) revising the original project service goals; 3) reallocating up to 25% (not to exceed $50,000) of unspent grant funds to cover increased or unanticipated costs related to COVID-19 pandemic response (e.g., telehealth capacity); and 4) extending the grant end date by up to 12 months.

[13] https://www.cdc.gov/policy/polaris/economics/cost-effectiveness.html
[14] https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/increase-proportion-people-health-insurance-ahs-01

Second, the CHRC issued its first ever emergency funding Call for Proposals to provide safety net providers immediate relief and financial resources to support the continued delivery of much needed services to the most vulnerable populations. Supported by federal CARES Act funding made available by the Maryland Department of Health, the CHRC awarded 46 grants totaling $1.5 million. The CHRC COVID-19 emergency funding grants have been used to support the delivery of services via telehealth (e.g., laptops, video capability), procurement of Personal Protective Equipment (PPE), and measures necessary to implement and maintain social distancing and follow enhanced infection control guidelines. An overview of these 46 grants is provided in Appendix B.

E. CHRC Support of Local Health Improvement Coalitions (LHICs) and the Maryland Diabetes Action Plan

Improving the health of all Marylanders through local coalition action and partnerships with community health resources is a mutual, ongoing goal of the CHRC and the Maryland Department of Health. The Local Health Improvement Coalitions (LHICs) are locally driven population health system planning and delivery collaboratives which have been used by Local Health Departments (LHDs) as an important entity to engage key stakeholders, partners, and the community for almost a decade.

The CHRC has previously supported Local Health Improvement Coalitions (LHICs) through its grant making, awarding $1.96 million in fiscal years 2012-2014. In FY 2012, the CHRC provided base funding grants to support LHIC capacity building and a variety of programs aligned with local health priorities followed by program continuation grants in FY2013-2014.

The CHRC continues its commitment to the mission and success of the LHICs with the release of the FY2020 Local Health Improvement Coalition (LHIC) Call for Proposals. In June 2020, the CHRC awarded grants to the LHICs representing all 24 county jurisdictions which are intended to support their efforts to expand capacity and build on innovative partnerships with community stakeholders and health resources to advance the initiatives and strategies detailed in the Diabetes Action Plan and other local population health improvements. The Diabetes Action Plan released by the Maryland Department of Health in January 2020, is used by the State to drive a significant population health agenda in the Maryland Waiver with the Center for Medicare and Medicaid Innovation (CMMI). The Diabetes Action Plan highlights initiatives and strategies to broaden and strengthen collaboration among communities, organizations, businesses, local governments, and individuals to improve diabetes prevention and the management of diabetes. Maryland's success in improving diabetes prevention and management rests in large part with intentional and informed local collaborative actions. Given the significant commitment by the State of Maryland to improving diabetes outcomes, LHICs will need to assume new roles and assure new deliverables to secure progress in this priority area.

Most LHICs received a grant of $41,666, while the LHIC on the Eastern Shore, which involves five jurisdictions (Caroline/Dorchester/Kent/Queen Anne's and Talbot Counties), received a grant of $208,330. Interim administrative and fiscal reports are due to the CHRC in April 2021, with

final reports due in October 2021. Major activities/expenses funded under the LHIC grants include strategies and programs that address diabetes, staffing and communication costs, and supplies.

The list with brief program summaries of the FY2020 LHIC grants is provide in Appendix C.

IV. Grantee Performance Monitoring

The CHRC takes its role as steward of public resources very seriously. The CHRC has developed and implements a robust system for grantee performance management that includes monitoring of programmatic performance and fiscal compliance as specified in each grant agreement. Grantees are required to periodically submit both programmatic and fiscal reports to the Commission. The grant monitoring system is designed to ensure that public resources are utilized efficiently and effectively and that program objectives are achieved. Grantees must meet CHRC reporting requirements as a condition of payment of Commission grant funds.

A. Programmatic Performance Monitoring

Prior to the distribution of any grant funds from the Commission, CHRC staff works with the grantee to develop a **Milestones and Deliverables Form (M&D)** that will be used to report the agreed program measures which are due bi-annually (Appendix D). The M&D Form includes a set of process data variables (e.g., the number of unduplicated program participants served, the number of participant encounters, and numeric counts of program services provided) and health outcome variables (e.g., Emergency Department and hospital utilization, improvements in clinical measures such as blood glucose, and cost savings realized through program interventions). Distribution of grant funds is contingent on this form being accepted by the grantee and CHRC.

To ensure that grant-funded programs are successfully launched, the CHRC also requires **60-90-day updates** that are due two-three months after a grant is awarded. If programs are not fully implemented at that time, additional updates are required until the program is operational and serving the target population. These updates not only keep the Commission informed about the early progress of a program, but they allow CHRC staff to assist grantees when problems arise. Grantees are held accountable for performance, and project delays are brought to the attention of CHRC Commissioners.

Every six months, grantees are required to complete and submit the M&D Form along with a **narrative report**. The narrative report follows a template containing a series of required questions that capture information about program status, including activities, results, successes, and challenges. Grantees are also asked to provide information on progress towards post-grant sustainability. If the program encounters implementation or other challenges, CHRC requires the grantee to define a plan to address and rectify the challenges. CHRC staff reviews the actual data reported by the grantees and compares these figures to the program goals. Grantees are held accountable for performance and progress towards meeting those goals. If grantees are experiencing difficulty in program implementation or progress towards achieving objectives, CHRC staff is available to provide technical assistance. If grantees are unable to improve performance, a Notice of Insufficient Progress is sent, which requires the grantee to develop a

corrective action plan to improve project implementation to achieve the project objectives. The grantee is required to present the plan to the Commission and, if it is deemed insufficient to overcome barriers to achieving the objectives, the Commission may withhold funding from the underperforming grantees and redirect grant funding to other grant programs.

B. Fiscal Monitoring

In addition to the agreed programmatic performance measures, CHRC grantees are required to meet fiscal reporting requirements by providing expense reports with supporting documentation to account for the grant funds expended. Every six months, grantees are required to submit an **expenditure report** which includes a summary of monies spent and the documentation to support the use of funds.

The expenditure report details how grant funds were utilized in the preceding reporting period and lists expenses by the budget line item. Grantees provide supporting documentation such as bills of sale, receipts for expenditures, invoices, and payroll records. CHRC staff examines these expenditures to ensure that public grant funds are spent in accordance with the original grant approved by the CHRC.

Distribution of the initial grant fund payment follows the approval of the M&D Form and full execution of the required grant agreement. Upon receipt of these two items, the Commission awards initial funding to the grantee, usually one-half of the year one grant award. Distribution of subsequent funding amounts requires a successful reconciliation of the supporting documentation to the amounts presented on the expenditure report and grantee fiscal performance in alignment with the original project budget approved by the CHRC. While funds are initially paid in advance of project activities, the Commission converts payments from scheduled amounts to a cost-reimbursement basis as the program progresses.

C. Audits of CHRC Grantees

In 2016, CHRC instituted the process of performing a documented review of self-reported grantee performance results for 25% of all current/active grants on an annual basis. The number of grantees randomly selected for audit has ranged from 10 grantees in CY 2017 to 14 grantees in CY 2019. For CY 2020, nine grantees will undergo a virtual site audit, to be completed by April/May 2021. The CHRC requires that each grantee selected for audit provides documentation to support the key process and outcome measures reported on their M&D Forms. When problems in documentation are encountered during the audit, CHRC staff provides technical assistance help the grantee improve reporting accuracy. A second audit is performed once the grantee verifies that all findings identified during the first audit are addressed. The results of the 2020 audits conducted in 2021 will be reported prior to the end of the current fiscal year.

D. Providing Technical Assistance to Build Capacity in the Maryland Safety Net Infrastructure

In addition to grant making, the CHRC provides technical assistance to its grantees to increase their capacity to serve residents in vulnerable communities. These services include reporting and data analytics; supporting care coordination initiatives; and connecting grantees with other sectors of Maryland's health care community. The purpose of the technical assistance program is to assist CHRC grantees in documenting program impact, to support program evaluation, and to help promote program sustainability.

V. Project Impact

Promoting sustainable, integrated systems of care in local communities to improve health outcomes for vulnerable residents and to facilitate long-term financial sustainability of CHRC funded programs are key priorities of the Commission. The Commission closely tracks the impacts in the areas of health outcomes, generating cost savings, leveraging grant funds and sustainability of programs after grant funds have been expended.

A. Improving Health Outcomes

The Commission measures not only the delivery of promised services by their grantees, but also the improvements in health outcomes resulting from each program. Grantees report on a number of health indicators which are program dependent but illustrate the effect of the services being provided to program participants. Examples of programs that have produced measurable improvements in health impacts include:

- **Shepherd's Clinic** received a two-year ($105,000) grant to support its diabetes self-management program, providing services to 390 pre-diabetic and diabetic patients in Baltimore City. Among patients who participated in diabetes self-management education, regular clinical measurements indicated that 66% lost weight and 70% had a reduced A1C. Among patients who participated in diabetes prevention counseling, just one patient converted to a diagnosis of diabetes.
- **Chinese Culture and Community Services Center** received a three-year ($200,000) grant to support the relocation and expansion of the clinic in Gaithersburg. The clinic provides primary care, case management, prescription assistance, lab testing, and free screening and vaccinations for Hepatitis B to individuals facing complex health and social needs. At the end of the second year of the grant, 35% of those diagnosed with diabetes had an A1C below 7, and 60% of individuals diagnosed with hypertension had a blood pressure of less than 140/90.
- **Mary's Center for Maternal and Child Care, Inc**. received a two-year ($300,000) grant to increase access to prenatal care and expand its women's health program in an effort to improve birth outcomes and reduce infant mortality in Prince George's County. The grant served 3,000 women, and the percentage of women in the program receiving prenatal care in

the first trimester increased from a baseline of 63.6% to 74%. Those in the program delivering low-birth weight babies (2,500 grams or less) was 5% (the rate in Prince George's County is 9.1%, and the state is 8.6%).

- **Helping Up Mission** received a three-year ($150,000) grant to provide emergency and comprehensive restorative dental care to 385 men in the Helping Up Mission's long-term residential recovery program for substance use disorders. The program, in partnership with the UM School of Dentistry, provided 1,153 dental service encounters. Beyond the significant improvement in oral and overall physical health, participants remained in residential program longer and a number of participants were able to secure stable employment. Although the cost benefit of the program was not quantified, the qualitative benefit is demonstrated by the reported improvement in health outcomes.

B. Generating cost savings

The CHRC prioritizes programs that yield reductions in avoidable hospital utilization and generate cost savings. Many grantees work specifically with individuals who are high hospital utilizers and provide wrap around services intended to connect these individuals to health care and social supports. In many cases, the shift in care from hospitals to community health care leads to cost savings for hospitals and the state's Medicaid system.

Programs that have generated significant cost savings include:

- **Charles County Health Department** received a three-year ($400,000) grant in 2016 to fund an innovative public health-EMS-hospital partnership to address over-utilization of EMS and emergency department (ED) services in Charles County by assisting frequent ED/EMS users in managing their chronic conditions in a primary care setting or at home. The funding supported a Mobile Integrated Healthcare team staffed by a paramedic, a nurse practitioner, and two community health workers. The grantee served 149 patients and completed 4242 encounters to manage care outside the hospital. A subset of 130 patients who participated in the program for at least three months was analyzed and revealed significant reductions in 9-1-1 calls, ED use and in-patient hospitalizations. The number of ED visits was reduced by 61%, inpatient admissions were reduced by 65%, the number of 30-day readmissions dropped 73%, and EMS utilization for non-emergency services was reduced by 47%. Patients received health education on disease prevention and management and home self-monitoring. The total cost savings was calculated at over $1.4 million.

  The program was a collaboration between the Charles County Health Department, Charles EMS, and Charles Regional Medical Center. Grant funding from CHRC was leveraged to obtain an additional $150,000 from the Charles Regional Medical Center**.**

- **Lower Shore Clinic,** an outpatient mental health clinic, received a 15-month grant in 2016 to implement the CareWrap program that targets individuals with behavioral health needs who present at the Peninsula Regional Medical Center (PRMC) ED in high volumes and provides intensive case management services for these individuals in a community setting post-hospital

discharge. The grant ended in June 2017 having served 63 individuals. Chesapeake Regional Information System for our Patients (CRISP) calculated a six-month pre vs. six-month post comparison for the patients in the program and concluded that the CareWrap program achieved $923,594 in cost avoidance. Considering the $120,000 grant investment, the program's return on investment (ROI) was 670%.

- **Calvert County Health Department** received a three-year grant in 2015 to support Project Phoenix, which provides substance use treatment services, including medications, and addresses the SDOH impacting individuals with substance use disorders. Over the duration of the grant, the program served a total of 1,220 individuals. A reduction in ED use by program participants was the key outcome measure to demonstrate program impact. From April 2016 (year one) to April 2017 (year two), the average number of ED visits dropped 60%, from 1.57 visits per participant to 0.63 visits per participant. In light of the reductions in avoidable hospital costs, Calvert Memorial Hospital is providing financial support to continue implementing the program once the initial CHRC grant funds are expended.
- **Esperanza Center**, a free clinic in Baltimore City, received a two-year, $100,000 grant in 2015 to expand service capacity. The program reported serving more than 1,500 individuals through 2,941 patient visits. Using data collected in a patient survey, the grantee reported that 1,460 of the patient visits would have otherwise resulted in an ED visit. The reduction translates into total cost savings/avoided charges of $1.8 million since the start of the program.
- **Helping Up Mission** received an additional two-year ($385,000) grant in 2019, to support two new programs for vulnerable, low-income women experiencing homelessness and substance use disorder: (1) a 14-bed Joint Commission accredited transitional recovery housing program operated in partnership with Johns Hopkins Hospital Broadway Center for Addictions; and (2) a 16-bed long-term Spiritual Recovery Program that focuses on integrated modalities of care and other SDOH. Both programs are modeled after the successful Helping Up Mission program serving adult males. CHRC grant funding was leveraged to obtain $715,000 in funding from several organizations including the Helen Pumphrey Denit Charitable Trust; the Johns Hopkins Neighborhood Fund; the Greenberg Foundation; and Walmart Foundation.

C. Leveraging additional resources and supporting innovative public/private partnerships

The initial grant funding provided by the CHRC ($79.2 million) has enabled grantees to leverage approximately $31.8 million in additional federal, private/non-profit, and local resources. The Commission serves as an incubator for innovative programs and supports the efforts of grantees to continue programs once initial CHRC grant funding has been expended. The following are several recent examples of CHRC grantees utilizing Commission grant funding to leverage significant additional resources.

- **Family Services, Inc.** received a two-year, $250,000 grant from the CHRC in 2017 for the Thriving Germantown program, a multi-sector and multi-generational approach focused on

supporting family pathways for self- sufficiency: 1) early care and education; 2) health and wellness; 3) behavioral health; and 4) household stabilization (workforce, emergency assistance, resources). Family Services has leveraged Commission funds to receive $2,014,832 from private and local funders including: (1) Healthcare Initiative Foundation; (2) Mead Family Foundation; (3) Kaiser Permanente; (4) Cafritz Foundation; (5) Meyer Foundation; (6) Montgomery Coalition for the Advancement of English Learners; and (7) Montgomery County Council.

- **La Clinica del Pueblo** received a three-year, $300,000 grant from the CHRC in 2016 to open a new Federally Qualified Health Center site in Hyattsville, Prince George's County, which serves the Langley Park, Hyattsville, Riverdale, Mt. Rainer, and Bladensburg communities, providing access to medical, behavioral health, and other social support services. In the first 18 months of the program, La Clinica has leveraged Commission funds to receive an additional $514,000 from private and local funders including: (1) Cafritz Foundation; (2) Blaustein Foundation; (3) Morningstar Foundation; (4) Eugene & Agnes E. Meyer Foundation; (5) Quality Health Foundation; (6) Quality Healthcare Foundation; (7) Greater Washington Community Foundation; (8) Prince George's Executive Office; (9) Prince George's Community Partnership; and (10) Prince George's Council Members.

The distribution of CHRC grants supporting innovative public/private partnerships across Maryland is illustrated in Figure 1 below.

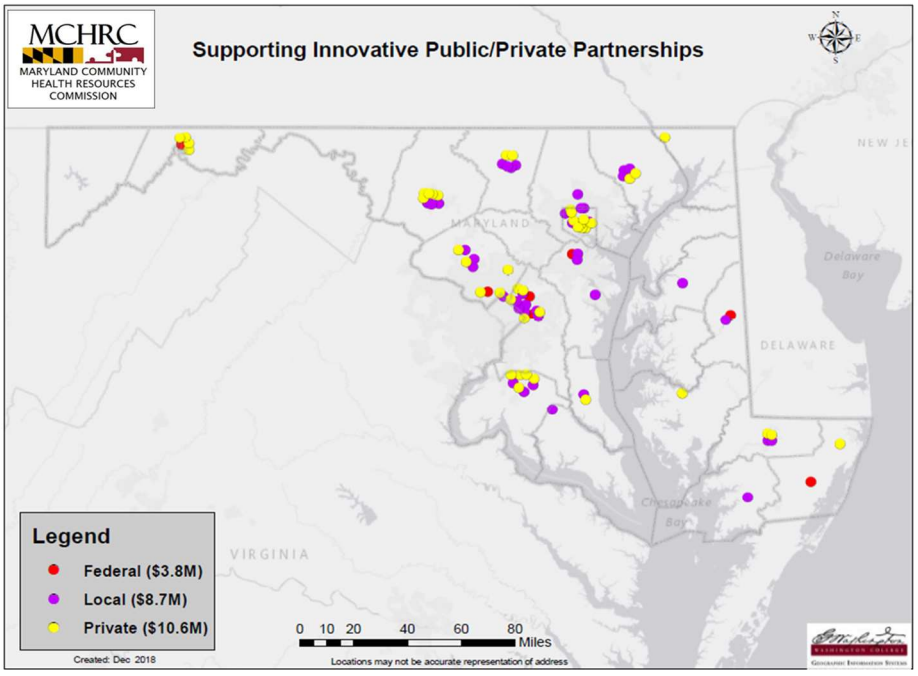

Figure 1

D. Sustainability of CHRC-funded programs

Promoting sustainable, integrated systems of care in local communities and facilitating long-term financial sustainability of grant programs are key priorities of the Commission. The CHRC

defines program sustainability as: the core services have been maintained for a minimum of one year after Commission funds have been expended.

The CHRC prioritizes programs that present a strong sustainability plan as part of their grant application when it considers its awards. After grant awards are made, grantees are asked to comment on the status and feasibility of achieving post-grant sustainability in each bi-annual narrative report. Upon completion of the grant, applicants are asked to submit a plan for continuing sustainability (i.e., long-term funding streams including billing for services, and funding from a private partnerships) in the final report. One year after the end of grant, CHRC staff verifies that the program continues to exist with other funding sources. CHRC queries public sources such as the grantee's website or annual report, or directly contacts the grantee to determine whether the grantee continues to provide the services previously supported by CHRC funds.

In January 2021, the Commission reviewed the FY 2016 grants to determine whether these programs were sustained for at least one year after CHRC funds were expended. Of the 15 grants awarded in FY 2016, one grant remains open and the other grant closed within past three months; both grants were excluded from the current assessment. Of the remaining 13 grants, 10 (77%) have been sustained, with one grant (8%) partially sustained (services are continuing but assumed by the grantee from the partner organization), and two (15%) have not been sustained. A summary of the three CHRC sustainability reviews completed in 2016, 2018 and 2021 are summarized in Table 2.

Table 2:

Post-Grant Sustainability of CHRC Grants				
Grant Cycle	**Date**	**# of Grants**	**# Sustained**	**% Sustained**
FY 2012	October 2016	13	11	84.6%
FY 2014	October 2018	19	14	73.7%
FY 2016	February 2021	13	10	76.9%
In FY 2012, a total of 15 grants were awarded. Of this total, two involved a one-time IT projects. Post-grant assessment of sustainability does not apply, and these grants were excluded.				
In FY 2014, a total of 15 grants were awarded. Of this total, two involved a one-time IT projects. Post-grant assessment of sustainability does not apply, and these grants were excluded.				
In FY2016, a total of 15 grants were awarded. Of this total, one grant remains open, and one other closed within the past 2 months - these grants were excluded from the review.				
The CHRC defines **program sustainability as the continuation of the core services supported by the grant for at least one year following total expenditure of grant funds**. A determination is made by: 1) review of the final grant narrative report submitted at the end of the grant; and 2) reviewing publicly available information (e.g., the grantee website or annual report); and 3) contacting the grantee directly, if necessary.				

The full results of these assessments can be found in Appendix E.

VI. Special Projects

A. Maryland Council on Advancement of School-Based Health Centers

The Maryland Council on Advancement of School-Based Health Centers was created in legislation approved by the Maryland General Assembly in 2015. The purpose of the Council is to improve

the health and educational outcomes of students who receive services from school-based health centers. The Council is responsible for advancing the integration of SBHCs into (1) the health care system at the state and local levels and (2) the educational system at the state and local levels. The Council develops specified policy recommendations to improve the health and educational outcomes of students who receive services from SBHCs.

In 2017, the Maryland General Assembly approved legislation that transferred the Council from the Maryland State Department of Education to the Department of Health. Under the legislation, the Maryland Community Health Resources Commission (CHRC) provides staffing support for the Council and is permitted to seek the assistance of organizations with expertise in school-based health care to support the work of the Council. Key activities of the Council in 2020 included:

- releasing comprehensive recommendations to position SBHCs to be utilized during the COVID-19 crisis and future public health emergencies;
- working to facilitate telehealth utilization by SBHC practitioners during the COVID-19 crisis and beyond;
- expanding the types of organizations that can sponsor SBHCs;
- developing a plan to make data gathered from the annual survey of SBHCs publicly available; and
- issuing recommendations to integrate SBHCs into the statewide Diabetes Action Plan.

The Council reports specified findings and recommendations to the Department of Health, the Department of Education, and the CHRC by December 31 of each year, and the 2020 Annual Report can be found in Appendix F.

B. Rural Health

Over the years, the Commission has placed special emphasis on supporting programs that address unmet health needs in rural areas. Of the 266 program grants awarded by the CHRC, more than half (138 of 266) have supported programs in rural areas (Appendix G). CHRC rural health grants, totaling approximately $35 million, have provided 120,459 rural residents access to primary care, behavioral health care, dental, women's health, and childhood obesity prevention services across the 18 rural jurisdictions of the state (Figure 2). CHRC grants have provided the start-up funding to enable safety net providers to increase their capacity and have supported innovative and replicable projects to address the SDOH and serve vulnerable populations.

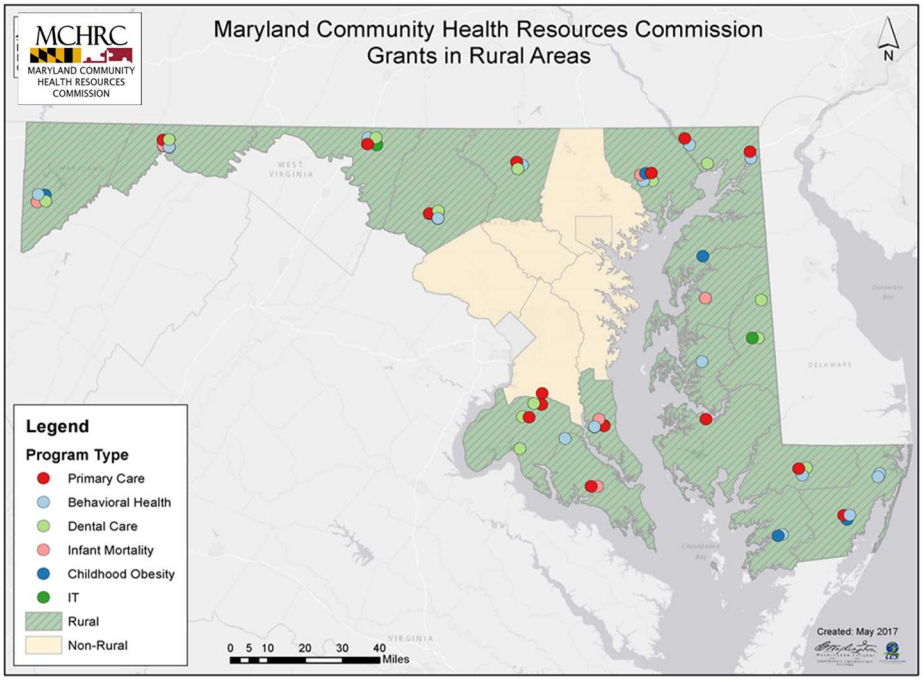

Figure 2

In 2020, the CHRC also awarded 16 COVID-19 virus pandemic emergency grants to rural community health organizations and 14 grants to Local Health Improvement Coalitions (LHICs) serving all 18 rural counties to expand operational capacity and support local community initiatives aligned with the Maryland Diabetes Action Plan to improve diabetes prevention and diabetes management.

A. CHRC Launch of the Maryland Rural Health Stories Project

The CHRC released a series of videos that highlight the human impact of CHRC grants in rural communities. These videos were produced as part of the Maryland Rural Health Stories project, a special collaboration with the Maryland Rural Health Association (MRHA). Under the project, six programs in rural communities that received grant funding from the CHRC are highlighted and residents who received services under these six programs agreed to go on camera to tell their story about how their lives were impacted by these programs.

The videos highlight programs in Calvert, Carroll, Cecil, Garrett, Wicomico, and Calvert Counties and present the stories of the six residents interviewed for the project, including one video that recounts the story of Calvert County resident Rachel who is overcoming addiction and changing her life's path, and another video that presents the story of Garrett County resident Jessica and her journey to recovery.

The videos can be viewed at:

https://health.maryland.gov/mchrc/Pages/RURAL-HEALTH.aspx

The projects highlighted as part of the CHRC Rural Health Stories project are listed below.

Access Carroll Integrated Healthcare, a community-based healthcare provider of somatic, dental, and behavioral health services, all provided in one location.

Calvert County Health Department's "Healthy Beginnings" Program, a project to reduce infant mortality rates by creating a "one-stop shop" of integrated behavioral health and social services for substance-using women and expectant mothers.

Garrett County Health Department's Tele-Buprenorphine Expansion Program, a program to use telehealth technology to increase access to Medication-assisted Therapy which responds to the recommendations of the Governor's Heroin and Opioid Emergency Task Force. The program involves a collaboration between the Garrett County Health Department and the University of Maryland School of Medicine's Department of Psychiatry.

Lower Shore Clinic's CareWrap Program, a program that targets individuals with behavioral health needs who visit Peninsula Regional Medical Center in high volumes and provides intensive case management services for these individuals post-hospital discharge.

West Cecil Health Center Smiles Program, an expanded dental program in Cecil County through a partnership with the University of Maryland Dental School. Under a cooperative agreement, West Cecil has agreed to take over operations of the Dental School's clinic and maintain its status as a clinical teaching site.

Wicomico County Health Department's Salisbury Wicomico Integrated Firstcare Team (SWIFT), a mobile-integrated health project aimed at reducing preventable 911 calls through a team consisting of an emergency medical technician and a registered nurse who identify frequent callers to 911 for non-emergent conditions and conduct welfare checks, case management, safety planning, and refer patients to primary care physicians, medical specialists, and, if necessary, in-home care providers.

The CHRC Rural Health Stories project was featured in a radio interview in December 2019. Mark Luckner, CHRC Executive Director and Lara Wilson, Executive Director of the MRHA, joined Sheilah Kast, host of the WYPR radio program ***On the Record*** to discuss the challenges residents of Maryland's 18 rural counties face in accessing primary, behavioral and dental care. The interview highlighted the innovative and collaborative ways that safety net providers and other community-based organizations stretch limited resources to provide quality healthcare and expand access to social supports closer to home. Mr. Luckner discussed how CHRC start-up grant funding has enabled safety net providers to increase their service capacity, and support new, innovative programs such as the Garrett County Health Department's telehealth program to increase access to Medication Assisted Therapy (MAT) in collaboration with the University of Maryland School of Medicine's Department of Psychiatry, and the Lower Shore Clinic

(Wicomico County) grant to fund the addition of primary care services to their existing behavioral care services. Ms. Wilson highlighted the dramatic impact that increased access to services has for many rural Maryland residents and described the Maryland Rural Health Stories project. A recording of the WYPR interview can be accessed at:

Accessing Healthcare In Rural Maryland | WYPR

APPENDIX A

Appendix A

CHRC Commissioner Listing March 5, 2021

Elizabeth Chung, Chair	Chairman, Executive Director, Asian American Center, Frederick
J. Wayne Howard, Vice Chair	Former President & CEO, Choptank Community Health System, Inc.
Scott T. Gibson	Chief Strategy Officer, Melwood Horticultural Training Center, Inc.
Celeste James	Executive Director of Community Health and Benefit, Kaiser Permanente of the Mid-Atlantic States
Maulik Joshi, DrPH	President & CEO, Meritus Health
Edward J. Kasemeyer	Former Chair, Maryland Senate Budget & Taxation Committee
Karen-Anne Lichtenstein	Former President & CEO, The Coordinating Center
Carol Masden, LCSW-C, MDPCP	Project Manager, Lois A. Narr, D.O., LLC
Destiny-Simone Ramjohn, PhD	Vice President, Community Health & Social Impact, CareFirst BlueCross Blue Shield
Erica I. Shelton, MD	Executive Director of Community Health and Benefit, Kaiser Permanente of the Mid-Atlantic States
Carol Ivy Simmons, PhD	Behavioral Health Operations Manager, Suburban Maryland, Kaiser Permanente

APPENDIX B

Appendix B

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

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Elizabeth Chung, Chair – Mark Luckner, Executive Director

August 27, 2020

CHRC COVID-19 Emergency Relief Call for Proposals
Summary of 46 Award Recipients

ARC of Southern Maryland (Southern Maryland; total award $8,600) -The ARC of Southern Maryland, based in Calvert County, operates 25 group homes which have remained open and fully staffed (in some cases 24/7) during the COVID-19 pandemic. All individuals served receive SSDI and are considered low income. CHRC funds will be used to purchase additional personal protective equipment for two of the ARC residences.

Asian Indian Community Services (Multiple Counties; total award $33,760) - Asian Indian Community Services provides access to social support and health-related services for vulnerable, low-income, underserved residents in the Asian, Latino and African immigrant communities. The organization provides multi-lingual, culturally competent programs that help to reduce access barriers to healthcare. CHRC funds will cover the cost of physical distancing partitions and furniture, pre-paid cell phones and laptops with software to facilitate telework and delivery of mental health counseling by Stanford certified counselors using telehealth technology. Funds will also provide for office sanitation, personal protective equipment for frontline staff, thermometers for COVID-19 client screening and multi-language COVID-19 educational materials.

Catholic Charities of Baltimore / Esperanza Center Health Services Clinic (Baltimore City; total award $16,500) - The Esperanza Health Center Clinic offers no-cost primary, preventive and dental care services to vulnerable, low-income uninsured immigrants in the Greater Baltimore area. CHRC funds will support the salary of an administrative assistant to continue the Center's COVID-19 Help Line for four months. Funds will also be used to purchase of additional PPE and disinfection supplies to comply with COVID safety protocols as the clinic restores in-person visits. The Esperanza Center recently completed a CHRC grant funded program awarded in FY2018, which helped to clinic expand primary care services.

Associated Charities of Cumberland (Allegany County; total award $27,464) - Associated Charities of Cumberland serves low income, vulnerable, underinsured and uninsured families in Western Maryland, providing emergency assistance programs, care coordination and wrap-around services that address a variety of social needs including housing, food, and short- and long-term prescription medication assistance. CHRC funds will support the short-term prescription medication assistance program and allow expansion of service capacity to supply vital medications in response to an increase in applications for assistance due to the impact of COVID-19 disease, and the financial and social consequences of the stay at home order.

Black Men's Xchange (Baltimore City; total award $27,893) - Black Men's Xchange provides culturally centered, preventive health campaigns and educational workshops focused on communicable disease prevention (e.g. HIV/STIs), mental health, substance use prevention and literacy support. The organization also sponsors peer and professionally led youth and adult empowerment groups regardless of insurance status. CHRC funds will be used to purchase disinfectants, wipes and personal protective equipment for staff and masks for clients that allow continued access to at the Xchange and other health care and service providers. Funds will also cover the cost of laptops and WiFi hotspots to increase telehealth capacity for remote COVID-19 education and updates, referrals and dissemination of information to help with access to essential health care.

Care 4 Your Health (Howard, Montgomery, and Prince George's Counties; total award $19,860) - Care 4 Your Health (C4YH) provides primary and geriatric clinic and home healthcare to low-income, underserved, uninsured and underinsured individuals from ethnic and racial minorities. In response to the pandemic C4YH has expanded their service area through new partnerships with the Germantown Hub and referrals from CRISP and the Montgomery County Mobile Unit. C4YH has transitioned to telehealth and telemedicine service delivery but continues to conduct home and in-office assessments. CHRC funds will cover the cost of personal protective equipment for clinical staff use during home visits, and computer equipment to increase telehealth and telemedicine capacity.

Casa de Maryland (Montgomery County; total award $37,300) - Casa de Maryland serves Latino immigrant residents, providing an array of social support, health insurance enrollment, health education, and other community support services. CHRC funds will help the organization bring "high-traffic" CASA sites into compliance with physical and social distancing guidelines. Funds will cover the costs of physical barriers, no-touch hand dryers, signaling equipment, temperature kiosks, and a remote Virtual Assistant to reduce exposure risk by asking screening questions of clients before visiting the sites. Funds for enhanced sanitation measures are also included.

Casa Ruben, Inc. (CRI) (South Baltimore and Langley Park; total award $42,709) - Casa Ruben offers a public health program, including general health and wellness promotion services. Case Ruben is partnering with a FQHC in South Baltimore, Casa de Maryland, Centro de Apoyo Familiar and its network of local churches, and the Baltimore City and Prince George's health departments to facilitate access to COVID-19 testing and contact tracing in Langley Park and South Baltimore, areas listed as COVID hot spots at the time of award. Casa Ruben will facilitate access to COVID-19 testing in partnership with the Prince George's and Baltimore City health departments and link individuals back to primary care using telehealth technology. CHRC funds will help expand telehealth capacity with three tablets with broadband access. Certified Medical Assistants will determine SDOH needs and administer a PHQ-9 to assess mental health using telehealth technology. Funds will also cover PCR testing kits.

Catholic Charities of Washington DC (Montgomery County; total award $24,924) - Catholic Charities of Washington strives to eliminate health disparities for low-income, uninsured, or underinsured individuals by offering high-quality, affordable health care, pharmacy, and urgent care services. CHRC funds will cover the cost of patient telehealth kits which include supplies that will allow patients to participate in care appointments using telehealth technology. The telehealth kits include tablet devices with cellular service capabilities and remote exam equipment (pulse oximeters and wrist BP

cuffs with Bluetooth capabilities). The kits are delivered by mail before appointments and then returned after appointments for disinfection using CDC guidelines or replacement if necessary. Funds will cover the shipping costs and disinfection of the returned equipment.

Center for Children (Southern Maryland; total award $45,475) - The Center for Children is the largest provider of outpatient mental health services to low-income children, youth, and families in Southern Maryland. Southern Maryland is a federally designated underserved area for mental health. With the emergence of COVID-19, the organization moved to provide telehealth services. CHRC funds will cover the costs for purchasing new computers which have the necessary hardware and software necessary to improve capability to deliver telehealth and teletherapy programs. Funds will also cover increased cleaning and sanitation measures, and personal protective equipment.

Center for Creative Values (Baltimore City and Baltimore County; total award $25,000) - The Center for Creative

Values is a for-profit outpatient mental health provider serving children and adolescents primarily in Baltimore City and Baltimore County. Services include a psychiatric rehabilitation program, outpatient mental health clinic, substance use treatment, and transportation to the office and community appointments for clients of limited or no financial means who often lack transportation. CHRC funds will be used for a teleconferencing platform and software for workstation screen sharing to enhance telehealth use during client sessions. Funds will also cover the expense of personal protective equipment for staff and interns, increased infection control and disinfection measures, physical barriers in the office, and telehealth training for staff.

Central Maryland AHEC (Multiple Counties; total award $22,339) - The Central Maryland AHEC works to increase health equity by educating and strengthening the healthcare workforce and improve health outcomes for residents in medically under-served communities. The organization provides interdisciplinary education and community based clinical practice experience programs for health professional students. CHRC funds will support the training of (10) new PEARLS counselors (a national, evidence-based program for seniors) who conduct screening and remote intervention for depression, anxiety and other secondary effects of social isolation due to the stay-at-home order. The counselors will help elderly and disabled individuals access care by instructing them on the use of telehealth apps and offering COVID-19 information. Funding will also cover the cost of COVID-19 related office supplies.

Charlotte Hall Veterans Home (St. Mary's County; total award $42,303) - Charlotte Hall Veterans Home is a skilled nursing facility providing a variety of services, including on-site primary care for veterans who are at highest risk for COVID-19 infection and serious disease. CHRC funds will support acquisition of two computer servers to support increased telework capacity and a Fit Tester Machine for evaluating N95 filtering facemask fit changes and adjustments.

City of Salisbury / SWIFT Program (Wicomico County; total award $24,799) - The Salisbury-Wicomico Integrated FirstCare Team (SWIFT) program is a Mobile Integrated Health/EMS diversion program in Salisbury, providing real time access to primary and preventive care, and in-home chronic disease management to vulnerable, low-income residents. CHRC funds will be used to establish a

telehealth program to facilitate primary care access and follow-up care for COVID-19 patients at home. Funds will supply iPads, tablets and mobile WiFi hotspots for telehealth services, and equipment to facilitate remote patient monitoring during the telehealth visits, as well as personal protective equipment for the SWIFT paramedics and CHWs. The SWIFT program was awarded a program grant by the Commission in April 2020, to support expansion of this program first funded by CHRC in FY2018.

Columbia Lighthouse (Montgomery & Prince George's Counties; total award $11,300) - Columbia Lighthouse serves low income, underinsured and uninsured residents and students at Title 1 schools, providing eye and vision screenings by operating a mobile eye care van. The organization offers case management services for seniors that includes teaching independent living skills, orientation and mobility training, assistive technology, and computer training. CHRC funds will be used to purchase personal protective equipment to continue existing visual and visual/hearing services for impaired seniors who are at higher risk from the virus, and to support volunteer transportation services for seniors unable to attend medical appointments, pharmacies or obtain groceries due to disruption of normal transportation services.

Community Clinic, Inc. (Montgomery and Prince George's Counties; total award $35,952) - Community Clinic, a Federally Qualified Health Center (FQHC) provides comprehensive medical, dental, prenatal and behavioral care to low-income, uninsured and underinsured individuals in underserved areas regardless of an individual's ability to pay. CHRC funds will cover the cost of 35 tablets for providers to perform video enabled telehealth assessments, and 29 mobile phones to connect providers with patients for telehealth while using language translation services. Funding for thermometers will facilitate enhanced patient screening upon arrival at the clinics.

Community Free Clinic (Washington County; total award $4,000) - Community Free Clinic provides free, accessible healthcare to uninsured and underserved residents of Washington County. The clinic has maintained limited in-person clinic services during the stay at home order, while responding to increased referrals for essential care for individuals impacted by COVID-19 related loss of insurance and employment. CHRC funds will be used for personal protective equipment, infection control supplies, thermometers for patient and visitor screening at the clinic, and continuation of teleconferencing service for teleworkers.

DXT Therapeutic Services (Prince George's County; total award $33,000) - DTX Therapeutic Services is a for-profit outpatient mental health clinic that provides an array of behavioral health services, including psychological evaluations, individual, family, group sessions, psychiatric rehabilitation services, DUI education, substance use assessments and treatments in school settings. CHRC funds will cover the purchase of cell phones and internet service for low-income children who otherwise are unable to afford access to services. Funds will also be used to purchase iPads and provide internet stipends for teleworking employees, personal protective equipment, and enhanced infection control and environmental cleaning.

Greater Baden Medical Services (Charles, Prince George's and St. Mary's Counties; total award $46,700) - Greater Baden Medical Services is a Federally Qualified Health Center (FQHC) based in Brandywine, providing comprehensive medical, dental and behavioral care to low-income individuals in

underserved areas regardless of the individual's ability to pay. CHRC funds will be used for personal protective equipment, laptops to improve provider and patient telehealth service and telework communications, and iPads with EHR integration software to reduce the time for patient intake assessments at clinic check-in and reduce patient density in the waiting areas to mitigate the COVID-19 exposure risk.

The Hearing and Speech Agency (HASA) (Baltimore City; total award $45,000) - HASA provides audiology services for vulnerable low-income children, families, and older adults who experience significant challenges with communication due to hearing loss. HASA also provides special education programs for children ages 2-15, speech language therapy and a centralized interpreter referral service. CHRC funds will be used to expand patient access to "charitable" telehealth services by covering the cost of additional laptops with headsets to maintain continuity of care. Funds will also be used for personal protective equipment, disinfection supplies, enhanced infection control cleaning of facilities, physical barriers, and travel costs for HASA audiologists when providing service to patients in assisted living and skilled nursing facilities.

HBI-DC (Washington DC Metro; total award $14,100) - HBI conducts a screening program for HBV, HCV, and HIV among low-income minority populations, as well as outreach and services for program participants. Since COVID19 restrictions were put in place, HBI has been unable to screen community members in person and has instead implemented a telehealth program to stay connected to prior clients to help with continued access to care and medication and provide COVID-19 education. CHRC funds will cover the cost of personal protective equipment for in-person visits, as well as HIPAA-compliant Zoom software and office supplies for telehealth.

Health Care Access Maryland (HCAM) (Baltimore City; total award $50,000) - Health Care Access Maryland (HCAM) provides health insurance enrollment and care coordination services to help clients with complex care and social needs. HCAM offers Care Coordination, Foster Care, Behavioral Health, and Returning Citizens HealthLink programs to assist Medicaid recipients, as well as health education on the primary drivers of health care. HCAM is planning to safely reopen their offices using a return to work plan that complies with social distancing and infection control protocols. CHRC funds will cover the expense of installing plexiglass barriers, posting signage for social distancing in waiting areas and reconfiguration of common seating areas. Funds will also provide all employees with masks and will allow distribution of disposable masks to clients who are unable to obtain them.

House of Ruth Maryland (Baltimore City; Baltimore and Prince George's Counties; total award $47,192) - House of Ruth is the state's largest provider of counseling services, abuse intervention programming and community outreach for adults and children affected by intimate partner violence (IPV), their friends and family members, and the perpetrators of IPV. House of Ruth provided services to 9,000 individuals in FY2019, in areas of the state currently designated as COVID-19 'hot spots'. CHRC COVID funds will cover enhanced cleaning and disinfection services, the purchase of supplies and physical barriers for infection control, and staff training on the use of telehealth technology to maintain service delivery.

La Clínica del Pueblo (Prince George's County; total award $42,138) - La Clínica del Pueblo is a Federally Qualified Health Center (FQHC) providing primary medical, behavioral health and substance use treatment, and wrap around services to low-income, uninsured and underinsured individuals regardless of their ability to pay. CHRC funds will help the clinic purchase video enabled laptops and peripherals to build telehealth capability, as well as remote home monitoring equipment (e.g., blood pressure cuffs, thermometers, glucometers) for patients to support telehealth service delivery, particularly for patients with COVID-19 infections not requiring hospitalization. Funds will also cover installation of physical barriers for social distancing and other infection control measures.

Life Energy Wellness Center (Caroline, Talbot, Dorchester, Wicomico, and Somerset Counties; total award $42,359) - The Life Energy Wellness Center, based in Easton, MD, is a licensed behavioral health and substance use treatment provider that serves the Eastern Shore. CHRC funds will provide resources to support the Center's telehealth program through acquisition of computer equipment and a telehealth software platform with the necessary system security, and telehealth stations for patients in the outpatient clinics. Funds will also be used to purchase personal protective equipment for outpatient clinic staff and clients accessing the office telehealth set up.

Life Renewal Services, Inc. (Multiple Counties; total award $35,430) - Life Renewal Services is a for-profit outpatient mental health center that serves low-income, unemployed, Medicaid enrolled adults and children, primarily from Baltimore City. CHRC funds will be used to purchase personal protective equipment, telehealth equipment and supplies, physical barriers in the Carroll and Baltimore County offices, and enhanced environmental cleaning for infection control.

Loyola Clinical Centers (Loyola University) (Baltimore City; total award $18,376) - The Loyola Clinical Center is a student training clinic that provides mental health and/or speech and language support services to vulnerable and low-income residents of the York Road, an economically distressed area of Baltimore. The clinic served 3,500 individuals in the 2018-2019 academic year. CHRC funds will be used to ensure a safe clinic environment for individuals unable to participate in telehealth services by covering the expense of personal protective equipment, protective barriers and additional sanitation and cleaning services.

Mary's Center (Montgomery, Prince George's Counties; total award $46,450) - Mary's Center is a Federally Qualified Health Center (FQHC) which provides comprehensive medical, dental, behavioral and social services, regardless of the individual's ability to pay. CHRC funds will help the center fully transition to a prenatal telehealth service model to meet increased service demands. Funds will support the purchase of Prenatal Self-monitoring kits for expectant mothers to measure weight, fundal height, temperature and BP at home, and additional telehealth equipment for remote delivery of routine prenatal care to reduce the risk of COVID-19 exposure during in-person clinic visits in areas of the state with the highest rate of COVID-19 infections at the time of award.

Maryland Foundation for Dentistry (Statewide; total award $24,000) - Maryland Foundation for Dentistry has provided low or no cost dental services to approximately 12,000 mentally, physically, and intellectually challenged individuals across Maryland since 1989. CHRC funds will cover the cost of laptops for staff telework using HIPAA compliant software. The laptops will allow remote triage and

continued coordination of dental care with partner dentists and cover higher dental lab fees resulting from increased COVID-19 related service demands. Funds also cover the cost of office equipment to facilitate telework and the provision of remote services.

Mercy Health Clinic (Montgomery County; total award $17,184) - Mercy Health Clinic provides free primary care, medications, and health education to low-income, uninsured adult residents, primarily in Gaithersburg and Germantown. A large percentage of Mercy Health patients are managing a chronic condition who are at higher risk for more severe COVID-19 disease. CHRC funds will help the clinic transition from telephonic services to video enabled telemedicine services through their purchase of video enabled laptops for clinical staff, and remote patient monitoring equipment (e.g., pulse oximeters, blood pressure cuffs, oral thermometers) that will greatly enhance telemedicine capabilities. Funds will also cover personal protective equipment and sanitizing supplies necessary to comply with enhanced CDC guidelines for prevention of COVID-19 transmission, and other measures to implement physical distancing protocols in the clinic.

Maryland State Dental Association Foundation (Multiple Counties; total award $49,400) - The Maryland State Dental Association Foundation (MSDA) provides no-cost dental services to low-income, underserved, and vulnerable populations from their mobile clinics which operate across the state. MSDA will use CHRC funds to resume essential dental services through the acquisition of equipment necessary to adapt the mobile clinics for enhanced infection control to minimize aerosol transmission of the COVID-19 virus to staff and patients. Enhanced infection and environmental controls will include installation of air purifiers, suction systems and low aerosol handpieces.

University of Maryland National Center for School Based Mental Health (Prince George's County; total award $43,083) - The National Center for School-based Mental Health at the University of Maryland provides comprehensive behavioral health services to low-income, underserved children in the Prince George's County school system, many of whom have disabilities. Clinicians and case managers address health and social support needs and help link students and their families to services that address SDOH. CHRC funds will cover the cost of video enabled laptops and peripherals for staff, and chrome books and WiFi access for students to provide telehealth capability. Funds will also supply students with mental health tool kits to help monitor their mental health needs remotely. The technologies and equipment will help the program reach students who are currently unable to access care due to the stay at home order or lack access to remote technology.

Partnership Development Group (Baltimore City, Anne Arundel, Montgomery and Howard Counties; total award $45,247) - The Partnership Development Group is a for-profit behavioral health provider offering psychiatric rehabilitation programs to vulnerable, low-income individuals who are court-involved and/or held in detention centers. CHRC funds will support telehealth services through acquisition of smart phones with voice and data plans (for clients) and tablets with voice and data plans for staff. Funds will also cover the costs of personal protective equipment, disinfection supplies, furniture and partitions to facilitate physical distancing, and thermometers for COVID-19 screening as the offices reopen.

Planned Parenthood of MD (Multiple Counties; total award $50,000) - Planned Parenthood of MD provides women's health (including urgent reproductive care) and family planning services to low-income, vulnerable patients at seven centers across the state. Many of these patients do not have access to other healthcare services and are affected by SDOH and health disparities. The centers continue to provide in-person care but have adopted telehealth technology for non-urgent services. CHRC funds will be used for laptops, telehealth software, setup fees and language link for translations to conduct non-urgent care remotely and allow the centers to focus in-person care resources on urgent needs, which helps reduce demand on emergency departments.

Planned Parenthood of Washington DC. (Montgomery and Prince George's Counties; total award $26,895) - Planned Parenthood of Washington DC provides high quality, affordable primary care and reproductive health care to low income, uninsured or underinsured adolescents and adults, regardless of gender, sexual, or racial identity, age, immigration, ethnic or socioeconomic status. The clinics have remained open during the pandemic to provide essential care and patient pre-screenings are performed before arrival. Patients have their temperatures taken on arrival and are provided masks. CHRC funds will cover the cost of personal protective equipment for staff and distribution to patients who attend the clinic and are unable to obtain masks. Funds will also be used for no-contact thermometers, disposable stethoscopes, and blood pressure cuffs, and "deep cleaning" at both clinics according to CDC guidelines.

Potomac Case Management (Washington County; total award $48,660) - Potomac Case Management serves low-income, underserved individuals by providing a range of case management and care coordination services to children and adults, primarily Medicaid enrollees. The agency works collaboratively with the Washington County DSS to provide in-home parenting skills support and post-incarceration case management. CHRC funds will cover acquisition of webcam-enabled laptops, webcam equipment, and Zoom web conferencing to support telehealth technology. Funds will also cover the cost of personal protective equipment and physical barriers to mitigate the risk of transmission during in-person visits and enhanced disinfection measures at their office location.

Prince George's Community College Wellness Center (Prince George's County; total award $50,000) - The Prince George's Community College Wellness Center is a school-based health center that provides health and wellness, and mental health counseling. The Center provided services to 2,000 students in FY2019. The Center has been closed due to the stay at home order and does not have telehealth capability. CHRC funds will support the initiation of a Remote Patient Monitoring program to provide clinical care to 50 at-risk students who agree to participate for six months. Each student receives a PPE kit and home monitoring equipment (e.g., blood pressure machines, glucometers) which automatically transmits data to the monitoring physician for review. The monitoring physician will also work with the Wellness Center to provide medication adjustments, counseling, and COVID education to students in an area of the state with the highest rate of COVID-19 infection at the time of award.

Southern MD Community Network (Charles County; total award $23,000) - Southern Maryland Community Network provides a range of behavioral health services to low-income adults and children with persistent and serious mental illness in southern Maryland, including psychiatric and residential rehabilitation programs. Approximately 10% of their service population is homeless. CHRC funds will

support delivery of services via telehealth through acquisition of laptops, mobile phones and car chargers for direct care and residential staff.

Tuerk House (Baltimore City; total award $5,000) - Tuerk House provides both inpatient and outpatient behavioral health services low-income, medically indigent individuals experiencing addiction to alcohol or other substances who often have chronic medical and other mental health conditions and face multiple SDOH. Tuerk House received a FY2020 CHRC grant award to support opening of an urgent care behavioral health clinic. CHRC COVID funds will allow acquisition of personal protective equipment and supplies to implement enhanced infection control measures in Baltimore City, an area designated as a COVID-19 infection hot-spot.

United Way of Central MD (Multiple Counties; total award $25,500) - United Way of Central Maryland, based in Baltimore, provides grant funding to more than 100 central Maryland nonprofits and manages initiatives aimed at advancing education, housing, employment and health for low-income, underserved individuals. Calls to the United Way 211 hot-line have increased dramatically since the emergence of COVID-19, particularly for mental health issues. In response, United Way has expanded their network of behavioral health providers to accept 211 help-line referrals. CHRC funds will enable the United Way to provide laptops, peripherals and a secure teletherapy platform to Pro Bono (a behavioral health provider partner providing free services) and 211 referral coordinators to telework effectively.

Upper Shore Aging (Caroline, Kent, and Talbot Counties; total award $17,310) - Upper Shore Aging develops and manages a coordinated program of services that help elderly residents remain and live well in the community as long as possible. Services include nutrition and meal services for home bound seniors and senior health and wellness programs at their centers. CHRC funds will support installation of temperature kiosks at their senior centers, primarily to screen staff and volunteers to reduce risk of COVID-19 virus transmission for this high-risk population. Funding will cover the expense of a laptop and WiFi hotspot for remote telework. Upper Shore Aging also received a CHRC FY2020 program grant in April 2020.

Urban Behavioral Associates (Prince George's County; total award $34,600) - Urban Behavioral Associates is a minority-owned for-profit outpatient mental health clinic that serves low-income Medicaid enrollees in Prince George's County, an area with the highest rate of COVID-19 infections in Maryland. CHRC funds will support increased access to mental health services through telehealth technology with the purchase of laptops, tablets, remote phone access and a televideo platform. Funds will also be used for personal protective equipment, physical space enhancements for social distancing, and enhanced cleaning and disinfection.

Urban Counseling (Prince George's County; total award $23,000) - Urban Counseling is a for profit outpatient substance use counseling service to highly diverse, low-income population, including individuals who are 'reentering' society from incarceration. Urban Counseling has been conducting on-line counseling via Zoom, but clients are hesitant to use this method or do not have equipment to access. CHRC funds are provided for office supplies and new counselors to respond to increased demand for therapy and treatment services.

Vietnamese American Services, Inc. (Montgomery County; total award $7,220) - Vietnamese American Services, Inc. (VAS) partners with business, schools, faith communities and local organizations to improve the quality of life for the Vietnamese community. VAS serves low-income and vulnerable Vietnamese residents through delivery of essential social support services. CHRC funds will cover the cost of delivery of food and essential items to senior citizens, personal protective equipment and supplies for enhanced infection control. VAS received a program grant from the CHRC in April 2020.

Way Station (Frederick, Washington, Howard, Allegany, and Carroll Counties; total award $31,200) – Way Station is a behavioral health provider headquartered in Frederick offering a range of behavioral health services to over 3,000 individuals, which includes clients with serious mental illness, SUD and individuals with differing abilities. CHRC funds will cover the cost of personal protective equipment for residential program clients. Way Station has implemented and completed several grants programs funded by the CHRC.

Westminster Rescue Mission (Carroll County; total award $50,000) - Westminster Rescue Mission provides faith-based residential substance use treatment program and community outreach program and manages an onsite food pantry and thrift store operation dedicated to redirecting donated food and recycled goods to those in the community in need. The population served by the organization is generally low-income, underinsured, or uninsured, and underemployed individuals and families primarily from minority communities. With the emergence of COVID-19, the organization temporarily halted new admissions to its residential treatment program. CHRC funds will support the salaries of three new (to be hired) full-time clinic coordinators to process new patients when the residences re-open to admissions. The new staff will oversee clients who test positive for the COVID-19 virus and need to quarantine upon admission to the residences.

APPENDIX C

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

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Elizabeth Chung, Chair – Mark Luckner, Executive Director

January 21, 2021

SUMMARY OF LOCAL HEALTH IMPROVEMENT COALITION (LHIC) GRANT AWARDS TO SUPPORT MARYLAND DIABETES ACTION PLAN

Background

The Maryland Community Health Resources Commission (CHRC) issued a Call for Proposals to support the activities of Local Health Improvement Coalitions (LHICs) and to build capacity in local communities to help implement the recommendations of the Maryland Diabetes Action Plan. The LHIC RFP was developed in close consultation with the Maryland Department of Health. In October 2020, the CHRC awarded $1 million to twenty LHICs, supporting one-year planning grants. Most LHICs received grants of $41,666 while the LHIC on the Eastern Shore, which involves five jurisdictions, received a grant of $208,330. Interim reports are due to the CHRC in April 2021 and final reports are due October 2021. Major activities/expenses funded under the LHIC grants include staffing costs, communication costs, and supplies.

Allegany County

Allegany County is utilizing its LHIC grant to hire a short-term consultant to serve as the Diabetes Coordinator. The Diabetes Coordinator will be responsible for bringing partners together to create the Local Diabetes Action Plan for Allegany County and begin implementation of the plan. The Local Diabetes Action Plan will include actionable strategies, well-defined goals, measurable outcomes, and clear division of responsibilities among partners.

Anne Arundel County

Anne Arundel County is utilizing its LHIC grant to hire a lead staffer and a strategic facilitator to support its LHIC. The Coalition intends to address barriers to participation in lifestyle programs and to promote knowledge and awareness of healthy eating, with social determinants of health and health equity as overarching themes.

Baltimore County

Baltimore County plans to host a virtual Diabetes Prevention seminar for program managers, diabetes educators, and National Diabetes Prevention Program providers. Training will be provided on the American Diabetes Association's Pre-Diabetes Risk Test. Funding will also be used for incentives/promotional items, prediabetes risk tests, MyPlate brochures, and advertising.

Baltimore City

Baltimore City is utilizing its LHIC grant to hire an LHIC coordinator who will work with a small planning team within the Baltimore City Health Department to identify 3-5 LHIC priorities and target

outcomes, one of which will be related to diabetes. This planning team will identify LHIC subcommittees, key stakeholders and share LHIC priorities once established to engage community input.

Calvert County

Calvert County is utilizing its LHIC grant to support salary costs of a physician liaison, epidemiologist, and program administrator. Calvert County will focus on strategies to address diabetes include supporting primary care providers, increasing the capacity of county-wide diabetes management and prevention programs, offering physical activity opportunities and healthy eating information, and partnering with food pantries to provide healthy menus and recipes.

Caroline/Dorchester/Kent/Queen Anne's/Talbot Counties

This LHIC involves five jurisdictions on the Eastern Shore; each jurisdiction will receive $41,600. Each jurisdiction will utilize about half of its grant award to support DAP implementation activities including stakeholder recruitment; participation in continuing education on diabetes/pre-diabetes, health literacy, and health equity; assistance with focus groups; workgroup facilitation; and data compilation on available local resources. Additional grant funds will be used to develop a public website, a contact list, video conferencing platform, develop social media, print, and video advertising, and support development of the Mid-Shore Diabetes Action Plan.

Carroll County

Carroll County is utilizing its LHIC grant to support the salary costs of a Health Planner, Health Educator, and Epidemiologist. Funding will also support virtual wellness program materials; incentives for program completion or goal achievement; and subsidies/scholarships for wellness programs. The Carroll LHIC will build organizational capacity, including creating a charter, expanding the roster, and increasing the LHIC's visibility and communications.

Cecil County

Cecil County is utilizing its LHIC grant to hire a consultant that will advise the jurisdiction on the creation of a new 501(c)(3) entity and cultivating public-private partnerships to support this new nonprofit entity. The consultant will also assist in preparing articles of incorporation, bylaws, a conflict of interest policy and all necessary application documents for the new 501(c)(3) entity. The consultant would also make recommendations on best practices and strategies to engage local businesses in investing in public health activities centered on diabetes prevention. In addition, Cecil County will utilize the LHIC grant to support a health literacy needs assessment with a focus on chronic disease and diabetes.

Charles County

Charles County is utilizing its LHIC grant to cover costs to advertise diabetes programs and purchase educational materials. Charles County plans to focus on the following strategies related to the Diabetes Action Plan: (1) expanding healthy cooking and healthy eating education for children and their families; (2) partnering with Charles County Parks & Recreation to provide enhanced community physical activity opportunities; (3) developing a media campaign to promote the replacement of screen time with increased physical activity; (4) addressing social determinants of health through vouchers for

transportation and farmers markets; (5) increasing the capacity of diabetes management programs; and (6) advertising to increase participation in the Diabetes Prevention Program.

Frederick County

Frederick County is utilizing its LHIC grant to hire a Coordinator of Special Programs, who will gather information and facilitate the advancement of the LHIC's strategic plan to strengthen coalition engagement and involvement. The Coordinator will also support virtual "Living Well" classes, an evidence-based program for those with chronic health conditions including diabetes.

Garrett County

Garrett County is utilizing its LHIC grant to support staff salaries, supplies, audience development, and audience development and marketing activities. Funds will also be used for a farmer cooperative to distribute fresh produce boxes and vouchers to local restaurants, grocers, and the community through subscriptions to encourage healthier foods as a preferred option. Funding will support the County's new population-based well-being initiative, a program that educates about existing resources and optimal practices and allows participants the opportunity to earn points toward prizes that support local businesses.

Harford County

Harford County is utilizing its LHIC grant to hire an LHIC Coordinator to support capacity building, including developing a charter, redesigning the website, creating monthly newsletters and social media posts, and developing a plan for robust community engagement. The LHIC Coordinator will work with partners at the University of Maryland Upper Chesapeake Health (UMUCH) to implement diabetes prevention strategies that focus on increasing physical activity and improving diets, as well as strategies to help individuals with diabetes adopt the necessary skills and behaviors for self-care.

Howard County

Howard County is utilizing its LHIC grant to hire a consultant to design messaging and visuals, expand advertising of diabetes programs on digital media, newspaper, and television, and produce and distribute educational materials. Howard County will engage LHIC member organizations in a health promotion campaign to combat obesity through evidence-based messaging and best practices which can be adapted for existing health programming. A social marketing campaign will encourage daily health habits through a simple, consistent message representing four recommendations for healthy eating and physical activity.

Montgomery County

Montgomery County is utilizing its LHIC grant to hire a contractual Human Services Specialist who will: (1) provide planning, implementation, and evaluation support to the "Predict – Link – Control T2D" project (CHRC Grant 20-020) which contributes to the county's diabetes initiative; and (2) provide administrative support to establish a Chronic Disease Coalition. Additionally, the funding will be used for LHIC staff to complete DECIDE (Decision-making Education for Choices in Diabetes Everyday) Facilitator training.

Prince George's County

Prince George's County is utilizing its LHIC grant to support the salary of a coordinator to plan, implement, and evaluate a food-as-medicine model, Produce Rx, intended to promote healthy eating strategies and address food insecurity. Funds also would be used to provide $7,500 in stipends ($2,500 x3) to three local grocers for shelving and/or refrigeration units, and $7,500 in stipends ($2,500 x3) to three local grocers for the purchase of healthy food as part of the Healthy Corner Store Initiative. Finally, funds would support a research assistant to engage community stakeholders in an in-depth assessment of the food landscape, including in-store assessments of healthy food availability.

St. Mary's County

St. Mary's is utilizing its LHIC grant to support the salary of LHIC Coordinator. Funding will also support an outreach table at the county fair, speaker fees, and a communications campaign to include digital advertisements, PSAs, and printed outreach materials. St. Mary's LHIC intends to implement a virtual healthy eating and active living series to include exercise classes, healthy cooking classes, and speakers targeting both adults and children.

Somerset County

Somerset County is utilizing its LHIC grant to hire a new Diabetes Coordinator who will support the development of a local Diabetes Initiative and implement several components of the state's Diabetes Action Plan in a coordinated effort with community partners in healthcare, recreation, and higher education.

Washington County

Washington County is utilizing its LHIC grant to hire a consultant for strategic planning and program evaluation and provide primary care providers and endocrinologists with stipends to incorporate a county-wide referral system. The LHIC is supporting the "Go for Bold" initiative through advertising, redesigning, and updating the website, hiring a consultant for strategic planning. "Go for Bold" is a new community-wide initiative aimed at promoting healthy lifestyles with a bold goal of losing 1 million community pounds by 2030. The initiative will promote healthy eating, increased physical activity, and mindfulness techniques.

Wicomico County

Wicomico County is utilizing its LHIC grant to cover salary costs for a Management Associate and a Prevention and Health Communications Clerk, to provide staff training, and to enhance the role of the LHIC coordinator. In addition, funds will allow for the purchase of computer equipment and office supplies, printing materials, program advertising, and promotion of the "Walk Wicomico" program with participant and PCP incentives. Funds are also supporting the contractual costs of consultants who will complete Academic Detailing services, which will provide education (virtual if necessary) to health care providers to improve pre-diabetes identification and referral.

Worcester County

Worcester County is utilizing its LHIC grant to provide grants to create policies and programs to improve physical activity, encourage healthy eating and develop diabetes prevention and management.

Appendix C

Worcester County will work collaboratively to engage all community residents in physical activity and healthy eating where they live, work, worship, and play; connect residents with programs designed to improve physical activity participation, healthy eating, and weight loss/management; and implement the social marketing campaign, “Eat Healthy. Be Active. Prevent Diabetes Today.” The plan also includes the following strategies for employers: supporting physical activity and healthy eating in the worksite, offering weight management programs at work, and expanding healthy cooking and healthy eating education.

APPENDIX D

Appendix D

CHRC Grantee Monitoring Report

Grantee Name:	**Moveable Feast**		
Grantee Contact Information:	Sara Ziscow-McClean, Project Director; 310-327-3420 ext. 13 - smcclean@mfeast.org Marty Stanley, Director of Finance, 410-327-3420 ext. 22 - mstanley@mfeast.org		
Grantee #:	20-019		
Grant Period:	May 1, 2020 - April 30, 2022		
Date of this Report:			
Total Grant Award:	$170,000		
Amount Paid to Date:	$75,000		**Program goal** (target # unduplicated individuals): **65**
Outstanding Grant Balance:	$95,000		**Progress to goal** (current # unduplicated individuals):
Expenditure to Date:			

MCHRC
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Grantee Payout and Report Schedule

Reporting Period	Due Date	Status	Proposed Fund Distribution	Actual Fund Distribution	Actual Expenditures	Required Items
N/A		Complete	$75,000	$75,000	n/a	Signed grant agreement, approved performance measures and invoice
Project Update 1 (90 days post award)	August 31, 2020	Received	n/a	n/a	n/a	Project Update Narrative
Report Period One May 1, 2020 - October 31, 2020	November 30, 2020		$25,000			**Report 1**: narrative, signed M&D report, expenditure report, supporting fiscal documentation and invoice
Report Period Two November 1, 2020 - April 30, 2021	May 31, 2021		$25,000			**Report 2**: narrative, signed M&D report, expenditure report, supporting fiscal documentation and invoice
Report Period Three May 1, 2021 - October 31, 2021	November 30, 2021		$25,000			**Report 3**: narrative, signed M&D report, expenditure report, supporting fiscal documentation and invoice
Report Period Four November 1, 2021 - April 30, 2022	May 31, 2022		$20,000			**Final Report**: narrative, signed M&D report, expenditure report, supporting fiscal documentation and invoice
		TOTALS:	$170,000	$75,000	$0	

Appendix D

CHRC Grantee Monitoring Report		SHIP Focus Area(s) & Measure(s):
Grantee Name:	Moveable Feast	
Grant #:	20-019	
Attestation:	I attest that, to the best of my knowledge and belief, all the information contained in this report is accurate and complete. I attest that, to the best of my knowledge and belief, that the information reported by any subcontractors is accurate and complete, and that my organization has in place policies and procedures to monitor and ensure the accuracy of this information. Documentation to support the data will be kept for 5 years and provided to CHRC upon request. Signed_____Date:_____	

NOTE #1: Any measurement counting "UNDUPLICATED" patients **CANNOT** include the same patients over different reporting periods. The "Totals" column for these measures should sum only unique individuals. For example, if an individual is counted in reporting period 1, then that person should **not** be counted again in reporting period 2.

NOTE #2: The program data with its associated data source reported by the grantee on this M&D report is subject to audit by the CHRC.

NOTE #3: The CHRC will utilize output **1a** for its "**Total patients/clients seen**" measure, and output **1b** for its "**Total patient/client encounters**" measure.

NOTE #4: "Patient/Client Encounters" is defined as any face-to-face visit to a clinician in a clinical setting or a face-to-face meeting with a care manager in a care coordination program.

Process Metrics (Do NOT alter shaded cells)

Key Project Milestones	Output	Data Source	Reporting Period #1 (MAY 1 - OCT 31, 2020)	Reporting Period #2 (NOV 1, 2020 - APR 30, 2021)	Totals	Goal
Improve access to diabetes appropriate food.	1a) # of unduplicated people living w/diabetes served.	Grantee Database			**0**	65
	1b) # of client interactions with Movable Feast staff.	Grantee Database			**0**	2,600
Increase access to healthy nutrition education.	1c) # of medically tailored meals served to program clients.	Grantee Database			**0**	36,720
	1d) # of MNT sessions provided to clients.	Grantee Database			**0**	85

Outcome Metrics

Key Project Milestones	Output	Data Source	Reporting Period #1 (MAY 1 - OCT 31, 2020)	Reporting Period #2 (NOV 1, 2020 - APR 30, 2021)	Totals	Goal
Clients report improved QOL.	2a) % of clients who report that services have improved the QOL	Client Survey				[80%]
	2b) % of clients who report reduced anxiety related to access and preparation of medically appropriate food.	Client Survey				[65%]
	2c) % of clients who report reduced financial strain related to food purchase.	Client Survey				[50%]

APPENDIX E

Appendix E

STATE OF MARYLAND

Community Health Resources Commission

45 Calvert Street, Room 336 • Annapolis, Maryland 21401

Larry Hogan, Governor – Boyd Rutherford, Lt. Governor
Allan Anderson, M.D., Chair – Mark Luckner, Executive Director

TO: CHRC Commissioners

FROM: Mark Luckner, Executive Director, CHRC
Michael Fay, Program Manager, CHRC

DATE: February 12, 2021

RE: Post-Grant Sustainability of CHRC Programs Awarded in FY2016

The following memo summarizes recent analysis performed by CHRC staff of the post-grant sustainability of CHRC-funded projects. Post-grant sustainability is determined by CHRC staff as to whether the core services of the grant have been maintained one year after Commission funds have been fully expended. This determination is made by: (1) reviewing the final grantee narrative report submitted to the Commission upon the close of the grant; (2) querying of publicly available information (*i.e.,* grantee website or annual report), and (3) contacting the grantee, if necessary.

The post-grant sustainability of CHRC grants is a key accountability measure that the Department of Budget and Management (DBM) and Maryland Department of Health (MDH) consider when evaluating the CHRC's annual budget allowance. CHRC staff has performed three determinations of post-grant sustainability; in October 2016, which evaluated grants awarded in FY 2012; in October 2018, which evaluated grants awarded in FY 2014; and, in February 2021, which evaluated grants awarded in 2016. The table below summarizes these findings. A more detailed, per project assessment of the 2016 grant is presented later in this briefing memo.

Post-Grant Sustainability of CHRC Grants				
Grant Cycle	**Date**	**# of Grants**	**# Sustained**	**% Sustained**
FY 2012	October 2016	13	11	84.6%
FY 2014	October 2018	19	14	73.7%
FY 2016	February 2021	13	10	76.9%
In FY 2012, a total of 15 grants were awarded. Of this total, two involved a one-time IT projects. Post-grant assessment of sustainability does not apply, and these grants were excluded.				
In FY 2014, a total of 15 grants were awarded. Of this total, two involved a one-time IT projects. Post-grant assessment of sustainability does not apply, and these grants were excluded.				
In FY2016, a total of 15 grants were awarded. Of this total, one grant remains open, and one other closed within the past 2 months - these grants were excluded from the review.				
The CHRC defines **program sustainability as the continuation of the core services supported by the grant for at least one year following total expenditure of grant funds**. A determination is made by: 1) review of the final grant narrative report submitted at the end of the grant; and 2) reviewing publicly available information (e.g., the grantee website or annual report); and 3) contacting the grantee directly, if necessary.				

Appendix E

BACHGROUND

In response to a special review of the three regulatory commissions performed by the Department of Legislative Services several years ago, CHRC staff has adopted a process for periodically determining the sustainability of its grants which have been closed for at least a year at the time of review. The current review includes 15 grants awarded during FY 2016 and is the third periodic review to be completed. This review includes 13 of the 15 grants awarded in FY 2016 and is summarized in the table below. Two of these fifteen grants have been excluded from review as one remains open and the other closed two months ago. Of the remaining 13 grants, 11 were found to have been sustained.

Post-Grant Sustainability of CHRC Grants Awarded in FY2016-2017		
Grantee / Number	**Sustained?**	**Notes / Assessment**
AHEC West (Washington Co.) 16-001	Sustained; awarded a subsequent CHRC grant	The grantee continues to provide free restorative dental care (Final report and website)
Catholic Charities DC (Prince George's County) 16-002	Sustained	The grantee continues to provide dental care (Final report and website)
Carroll County HD 16-003	Sustained	The grantee continues to provide dental care (Final report and website)
Mountain Laurel Medical Ctr. (Garrett Co.) 16-004	Not Sustained	The grant provided integrated dental with primary care services (Final report and website)
Garrett County HD 16-005	Sustained (qualified)	The grantee transitioned the tele-buprenorphine services to onsite delivery by a qualified MAT prescriber at the HD (Website)
Potomac Healthcare Foundation (Baltimore) 16-007	Sustained and awarded a subsequent CHRC grant	The grantee continues to provide residential substance use recovery services (Final Report and Website)
Bon Secours Medical System (Baltimore) 16-008	Not Sustained	The grantee no longer provides services through the Forensic Diversion Program (Website)
Shepherd's Clinic (Baltimore) 16-010	Sustained	The grantee continues to provide DSME incorporated within primary care (Final Report and Website)
La Clinica del Pueblo (Prince George's Co.) 16-011	Sustained	The grantee opened a new primary care clinic in Hyattsville (Final Report and Website)
Lower Shore Clinic (Eastern Shore) 16-012	Not Sustained	The grantee continues to provide care wrap services (Website)
Charles Co HD Mobile Integrated Health 16-013	Sustained	The grantee continues to provide integrated mobile care (Final Report and Website)
Chinese Community and Community Services Center (Gaithersburg) 16-014	Sustained	The grant supported the opening of the Pan Asian Volunteer Clinic for primary care.
Baltimore City HD 16-015	Sustained; awarded a subsequent CHRC grant	The grant supported implementation of an operational central intake system to engage hard to reach pregnant women in prenatal care to reduce low birth weights and racial disparities in infant mortality.

Appendix E

DESCRIPTION OF FY 2016 CHRC GRANTS

Allegany Health Right (AHEC West) (16-001): This two-year grant expanded the existing Dental Access Program serving low-income seniors and disabled adults. The program relied on Allegany Health Right's existing model of community outreach and the program engaged private dentists to provide dental services at a discounted rate of 50%-80%. CHRC grant funding supported the salaries of a Community Health Worker (CHW) and dental case manager and the discounted costs for dental services to program participants. The grantee received a second CHRC grant in FY 2019 to provide continued program funding support.

Catholic Charities, Archdiocese of Washington D.C. (16-002): This two-year grant supported the opening of a new, comprehensive, four-chair dental clinic in Temple Hills (Prince George's Co.) to provide dental services to low-income residents. At the time of award, the grantee was operating two other dental clinics in the region. The new (third) clinic was opened to focus exclusively on serving low-income and un/underinsured residents in Prince George's County. CHRC grant funding was used to support the salary costs of the practitioners for the first two years after clinic opening.

Carroll County Health Department (16-003): This two-year grant provided funding to expand access to pediatric dental services in Carroll County by improving the administrative efficiency of the existing Carroll County Health Department Pediatric Dental Program. Grant funds were used to support non-personnel costs, including dental equipment, staff training, and software/EMR costs to modernize the outdated equipment in use by the dental program at the time of award. Grant funds helped to increase the administrative efficiency of the program and enabled the program to upgrade the practice management system.

Mountain Laurel Medical Center (16-004): This two-year grant supported a program that provided dental screenings and referrals to discounted dental care to patients of Mountain Laurel with chronic diseases such as diabetes, hypertension, and cardiovascular disease. Grant funds were used to support the salary of program dental staff and the cost of dental supplies. Garrett County is one of the most dentally underserved areas in the state, and this program expanded access to dental services and promoted the integration of medical and dental care services in a primary care setting.

Garrett County Health Department (16-005): This three-year grant supported the use of tele-health technology to increase access to Medication Assisted Therapy (MAT) in response to recommendations made by the Governor's Heroin and Opioid Emergency Task Force. The program involved a collaboration between the Garrett County Health Department and the University of Maryland School of Medicine's Department of Psychiatry. Grant funds supported the salary costs of program staff and the contracting of an outside evaluator.

Potomac Healthcare Foundation (16-007): This thee-year grant provided funding to establish a 50-bed residential Recovery Support Center in West Baltimore. The project addressed three of the seven goals of the Governor's Heroin and Opioid Emergency Task Force by: (1) expanding access to treatment by removing housing as a barrier to accessing care; (2) enhancing the quality of treatment by through an evidence-based approach using residential recovery housing; and (3) boosting overdose prevention efforts through stable housing and quality treatment as bulwarks against overdose. Grant funds

supported the salary costs of case managers at the program. The grantee received a second CHRC grant in FY 2018 to provide continued program funding support.

Bon Secours Baltimore Health System (16-008): This three-year grant supported the creation of a new Forensic Diversion Program (FDP) for inmate pre-trial mental health stabilization prior to competency determination from the courts. The goal of the Bon Secours FDP program was to enable court-involved individuals with serious mental illness awaiting trial to receive services at Bon Secours in lieu of another placement in the state hospital system. Grant funds were used to support staff salaries and training.

Lower Shore Clinic (16-012): This two-year grant provided funding to support the "CareWrap" program targeting individuals with behavioral health needs who presented at the Peninsula Regional Medical Center (PRMC) ED in high volumes. The program provided intensive case management services for these individuals in a community setting post-hospital discharge. The program involved a partnership with PRMC designed to help reduce 30-day readmission rates for individuals participating in the program. CHRC grant funds supported the salaries of program staff.

Shepherd's Clinic (16-010): This two-year grant funded a diabetes prevention and control initiative, which sought to improve the care of pre-diabetic and diabetic patients by: 1) reducing barriers to accessing affordable diabetes care, 2) providing comprehensive diabetes self-management education to patients with pre-diabetes and diabetes, 3) encouraging and promoting healthier behaviors, and 4) improving the medication adherence. Patient referrals to the program came from within Shepherd's Clinic, from a MedStar-operated clinic as well as from the community at large in the NE Baltimore region. CHRC grant funds will be used to hire a part-time certified diabetes educator.

La Clinica del Pueblo (16-011): This two-year grant helped support the opening of a new health center site in Hyattsville (Prince George's Co.) to serve low-income, un/underinsured individuals in the Langley Park, Hyattsville, Riverdale, Mt. Rainer, and Bladensburg communities. The new clinic continues to provide access to medical, behavioral health, and other social support services. The grantee leveraged the CHRC grant to secure an additional $250k in funding from private foundations. CHRC grant funds supported the salary costs of the new health center site.

Charles County Health Department (16-013): This three-year grant supported an innovative public health-EMS-hospital partnership to reduce utilization of EMS and ED services in Charles County by assisting frequent ED/EMS users manage their chronic conditions in a primary care setting or at home. This ongoing program is a collaboration among the Charles County Health Department, Charles County EMS, and Charles Regional Hospital. Grant funding was used to support the Mobile Integrated Healthcare team comprised of a paramedic, a nurse practitioner, and two community health workers.

Chinese Culture and Community Service Center (16-014): This three-year grant supported the relocation and expansion of the Pan Asian Volunteer Health Clinic, which serves the low-income Asian American population in Montgomery County. The clinic continues to provide primary care, case management, prescription assistance, lab testing, and free screening and vaccinations (e.g., Hepatitis B). The Clinic is staffed by volunteer physicians and part-time administrative staff. Grant funding was used to support the salary costs of program staff.

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Baltimore City Health Department (16-015): This two-year grant provided funding to support the continued implementation of the B'More for Healthy Babies (BHB) Initiative. Grant funds were used to support the salaries of two new public health investigators who used aggressive, trauma-informed strategies to outreach pregnant women who could not be located though traditional outreach methods or refused to talk to care coordinators. The investigators used cutting-edge strategies to direct vulnerable pregnant women and newborns into appropriate obstetric and pediatric homes. The grantee received a second CHRC grant in FY 2018 to provide continued program funding support.

APPENDIX F

Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Acting Secretary

Council on Advancement of School-Based Health Centers

Annual Report
Health – General § 19-22A-05
HB 221, Ch. 199 (2017)

December 2020

Larry Hogan
Governor

Boyd K. Rutherford
Lieutenant Governor

Dennis R. Schrader
Acting Secretary of Health

Elizabeth Chung, Chair
Community Health Resources Commission

Dr. Katherine Connor, Chair
Dr. Patryce Toye, Vice-Chair
Council on Advancement of
School-Based Health Centers

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Council on Advancement of School-Based Health Centers
Table of Contents

Abbreviations

Blueprint: Blueprint for Maryland's Future (legislation to implement Kirwan recommendations)

CRISP: Chesapeake Regional Information System for our Patients

CHRC: Community Health Resources Commission

Council: Council on Advancement of School-Based Health Centers

DAP: Maryland Diabetes Action Plan (MDH population health initiative)

EHR: Electronic Health Record

FERPA: Family Educational Rights and Privacy Act

FQHC: Federally Qualified Health Center

HEDIS: Health Effectiveness Data and Information Set

HIPAA: Health Insurance Portability and Accountability Act

Kirwan Commission: Kirwan Commission on Innovation and Excellence in Education

LHIC: Local Health Improvement Coalition

MASBHC: Maryland Assembly on School-Based Health Care

MHBE: Maryland Health Benefit Exchange

MCO: Managed Care Organization

MDH: Maryland Department of Health

MOU: Memorandum of Understanding

MRHA: Maryland Rural Health Association

MSDE: Maryland State Department of Education

PCP: Primary Care Provider

QBP: CASBHC's Quality and Best Practices Workgroup

SBHA: School-Based Health Alliance

SBHC: School-Based Health Center

SHIP: State Health Improvement Process

SIF: CASBHC's Systems Integration and Funding Workgroup

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Executive Summary

The Council on Advancement of School-Based Health Centers works to improve the health and educational outcomes of students who receive School-Based Health Center (SBHC) services by advancing the integration of SBHCs into the health care and education systems at the State and local levels. The Council is staffed by the Community Health Resources Commission, an independent commission operating within the Maryland Department of Health (MDH).

There are currently 84 SBHCs across 12 jurisdictions in Maryland. A portion of these SBHCs receive funding from MSDE from the general fund allocation of $2.5M annually. These monies are administered through grant funding. Diagram 1 illustrates the distribution of SBHCs across Maryland. Jurisdictions indicated in green are where SBHCs are located.

Diagram 1: SBHC distribution across Maryland

The Council made important progress on its mission in 2020. Key accomplishments are outlined below.

1. **The Council publicly released comprehensive recommendations to position School-Based Health Centers to be utilized during the COVID-19 crisis and future public health emergencies.** In response to the COVID-19 crisis, the Council convened an ad-hoc workgroup and conducted a survey of SBHCs. These efforts resulted in comprehensive recommendations to: actively promote continuity of care for vulnerable students, develop clear processes and lines of authority to provide SBHC flexibility, support remote care by SBHC practitioners, enhance central agency resources for the SBHC program, and consider access to closed school buildings for certain SBHC activities. Recommendations were approved by the full Council, shared with a wide range of stakeholders, and presented at the Maryland Rural Health Association's virtual conference in October 2020. A copy of the recommendations is provided in Appendix 2.

2. **The Council worked to facilitate telehealth utilization by SBHC practitioners during the COVID-19 crisis and beyond.** In response to issues identified in the SBHC administrator survey conducted through the Council's ad hoc pandemic work group, the QBP workgroup conducted a comprehensive review of Maryland regulations relevant to telehealth and school-based healthcare, including policy guidance and recommendations from the Maryland

Assembly on School Based Healthcare (MASBHC). QBP and Council leadership then engaged with MSDE and MDH to clarify telehealth models and the telehealth authorization process, clarify billing requirements, and address concerns regarding liability and oversight. MDH/Maryland Medicaid secured a Federal waiver to allow for Medicaid reimbursement for certain telehealth encounters not previously approved by SBHCs, and updated the SBHC billing manual, which MSDE circulated to SBHC administrators. A vision statement related to the Workgroup's efforts is provided in Appendix 3. Additional work remains to be done to make sure all Maryland SBHCs are able to easily implement telehealth, and this issue is likely to continue to be a priority for the Council during 2021.

3. **The Council informed legislation to expand the types of organizations that can sponsor SBHCs.** Until recently, Maryland's SBHCs have been sponsored overwhelmingly by Local Health Departments, a different and potentially more limited model than other states with SBHC programs. The Harbage Report, commissioned by the Council in 2018, recommended expanding the types of organizations that can sponsor SBHCs in Maryland, and the Council has advocated for this policy change for several years. Legislation passed during the 2020 General Assembly session (HB 409), with input from the Council, expands the types of SBHC sponsorship organizations that can receive Medicaid reimbursement – effectively opening the door for hospitals, physician or nurse practitioner groups, and other organizations to sponsor SBHCs. A copy of the Council leadership letter regarding HB 409 can be found in Appendix 4.

4. **With MSDE releasing its redesigned annual survey of SBHCs during the fall of 2020, the Council developed a plan to make data gathered from the survey publicly available**. The Council previously collaborated with MSDE to modernize data collected in the annual SBHC survey. That survey was released to SBHC administrators during fall 2020. Also during 2020, the Council's Data Workgroup worked with MSDE and the Maryland Department of Information Technology (DoIT) to develop a proposed strategy for making SBHC data collected through the survey publicly available on the State's Open Data Portal. These recommendations can be found in Appendix 5.

5. **The Council developed recommendations to integrate SBHCs into the statewide Diabetes Action Plan.** The Council's SIF Workgroup prepared these recommendations as an example of how SBHCs can be integrated into the State's larger public health infrastructure. Recommendations related to SBHCs and the Diabetes Action Plan are included in Appendix 6.

The Council on Advancement of School-Based Health Centers looks forward to a successful 2021. For more information about the Council, please contact Lorianne Moss, staff to the Council, at (410) 456-6525 or Mark Luckner, Executive Director of the Community Health Resources Commission, at (410) 260-6290.

Council on Advancement of School-Based Health Centers
Health – General § 19-22A-05 2020 Annual Report

I. Council Activities in 2020

The Council was established in 2015 to improve the health and educational outcomes of students who receive services from School-Based Health Centers (SBHCs) by advancing the integration of SBHCs into the health care and education systems at the State and local levels (Health – General § 19–22A–02(b)). It is comprised of 15 members appointed by the Governor and six ex-officio members from across state government. The Council is chaired by Dr. Katherine Connor, who serves as the Medical Director of the Johns Hopkins Rales Health Center at KIPP Baltimore. Dr. Patryce Toye, Chief Medical Officer, MedStar Health Plans, serves as Vice Chair. The full Council met five times during 2020.

Appointments. 14 of the Council's 15 appointed seats currently are filled. The Council is recruiting a representative of a Federally Qualified Health Center (FQHC) to fill the open slot.

During 2020, two previously vacant positions were filled: a representative of the Maryland Assembly on School-Based Health Care, and a principal of a secondary school with a school-based health center. A roster of Council members is included at the end of this report.

Council Meetings. The Council met five times during 2020. One meeting in January was held in-person, while the others were held via Google Meet due to the COVID-19 pandemic.

At its January meeting, the Council set priorities for 2020 based on its evaluation of recommendations stemming from the 2019 Harbage Report commissioned by the Council. The Council also received updates on the Blueprint for Maryland's Future education reform legislation.

At its April and July meetings, the Council discussed legislative developments, agency implementation of Council recommendations including the revision of SBHC standards and the annual SBHC survey, and the Council's role in responding to the COVID-19 pandemic. Council recommendations regarding SBHCs and the COVID-19 pandemic were approved by electronic vote on July 27, 2020.

At its October meeting, the Council voted to approve recommendations related to: (1) SBHCs and the State's Diabetes Action Plan and (2) a public-facing platform for SBHC data. The Council also discussed issues related to telehealth utilization by SBHCs.

At its December meeting, the Council reviewed the 2020 Annual Report and recommendations related to building access for SBHCs. Meeting minutes from each of the Council meetings are included in Appendix 8.

Workgroups. Much of the Council's work is conducted by its three workgroups, which meet approximately every 2 months. The workgroups began the year by prioritizing areas of focus related to recommendations stemming from the Harbage Report. Later in the year, two workgroups took up issues related to SBHCs and the COVID-19 pandemic.

Data Collection and Reporting (Data) Workgroup. The Data Collection and Reporting Workgroup was chaired by Joy Twesigye, representative of the Maryland Assembly on School-Based Health Care and Director of Health Program Planning and Evaluation for School Health at the Baltimore City Health Department. During 2020, the Data workgroup built upon its previous efforts with MSDE to redesign the annual survey of SBHCs. Specifically, the Data workgroup focused on next steps for the collected data, including a platform to host the data and a strategy to make data publicly available.

The Data workgroup held webinars with data experts from the School-Based Health Alliance (the national organization for SBHCs) and Maryland's Department of Information Technology (DoIT). Consensus emerged among Council members that the State of Maryland's Open Data Portal (ODP), managed by DoIT, would be a cost-effective means for hosting SBHC data. The Data workgroup had some reservations about using ODP, specifically noting that more technologically advanced solutions may be available. However, because this platform already is available and in use, the workgroup advised moving ahead to test this option.

ODP is split between public and private data. The workgroup recommended utilizing ODP's private capabilities as a repository for annual survey data. Then, the workgroup recommended a phased approach to begin making selected SBHC data available on the public side, beginning with data that is already publicly available, but not easily accessible. The workgroup developed a list of sample data points that could be included during this first phase and mapped these to annual survey questions. Continued commitment as well as designated time and resources will be needed at the Department level in order to move ahead with making SBHC data publicly available.

Systems Integration and Funding (SIF) Workgroup. The Systems Integration and Funding Workgroup is chaired by Dr. Maura Rossman, representative of the Maryland Association of County and Health Officers and Local Health Officer for the Howard County Health Department. Because of Dr. Rossman's increased workload around the COVID-19 pandemic, Council Chair Kate Connor filled in as SIF workgroup chair during much of 2020.

The SIF workgroup began the year by looking at ways to better integrate SBHCs into the State's population health goals, a priority that had been identified through the Council's recommendations related to the Harbage Report. The workgroup decided to focus on the State's Diabetes Action Plan (DAP), an MDH population health initiative. This effort resulted in the development of recommendations that were approved by the full Council in October.

As the COVID-19 crisis began spreading through Maryland communities during the spring, the SIF workgroup began an effort to identify SBHC assets that could be used during a public health emergency, as well as barriers to their utilization. The workgroup then began to develop recommendations around the role of SBHCs during COVID-19 and future emergencies. Due to the high level of interest among Council members and the complexity of the topic, this work was moved to an ad-hoc Pandemic workgroup.

Following Council adoption of recommendations produced by the ad-hoc Pandemic workgroup, the SIF workgroup continued to look into issues around the use of closed school buildings by SBHCs. The workgroup developed recommendations to facilitate the use of closed

school buildings by SBHCs. These recommendations were approved by the Council by electronic vote in December.

Quality and Best Practices (QBP) Workgroup. The Quality and Best Practices Workgroup is co–chaired by Jean-Marie Kelly, Maryland Hospital Association representative and Senior Program Manager for Population Health at Christiana Care, and Dr. Patryce Toye, Maryland Assembly on School-Based Health Care representative and Chief Medical Officer, MedStar Health Plans.

Having previously developed a matrix of recommendations to support changes to the SBHC standards, the QBP workgroup continued to prioritize completion of these revisions. MSDE accepted the Council's previous recommendation to hire a contractor to update the standards. In December, MSDE selected Ms. Samantha Neilson, who will work through June 2021 to update the standards document. Representatives of the QBP workgroup met with Ms. Nielson in December to discuss the Council's work related to the standards and to share with her the workgroup's recommendations matrix.

Next, the workgroup began to move forward on ways to collect and ultimately utilize SBHC quality data, a priority that had been identified through the Council's recommendations related to the Harbage Report. The workgroup initiated a survey of SBHC Administrators to determine readiness to collect and share quality data through Electronic Medical Records (EMR), Chesapeake Regional Information System for our Patients (CRISP), and other means. Preliminary results indicated a wide variety of EMR systems as well as other barriers to efficient, consistent reporting of SBHC quality data. The workgroup intends to use survey results to inform future recommendations.

After the COVID-19 recommendations were approved by the Council, the QBP workgroup was tasked with continuing to work on barriers to telehealth faced by SBHCs. The workgroup met with MDH and MSDE to clarify the different models of telehealth utilized in SBHCs before, during, and after the COVID-19 crisis, and to identify concerns related to each model. The workgroup continued to meet with MDH and MSDE to recommend ways to streamline the telehealth authorization process, ensure reimbursement and appropriate parental consent, and promote telehealth utilization in the future. QBP recommendations regarding utilization of telehealth by SBHCs in Maryland cannot be finalized until clarification of legal requirements on place of service is obtained from MDH and MSDE Assistant Attorneys General. In the interim, the workgroup produced a "vision document" to communicate the status and overall direction of their efforts to date and to guide the development of specific recommendations once clarification on legal aspects is obtained. Work around telehealth is likely to continue during 2021.

Ad-Hoc Pandemic Workgroup. Statewide school closures in March 2020 related to the COVID-19 pandemic resulted in the closure of SBHCs as well. This jeopardized continuity of care for vulnerable children, exacerbated health disparities, and left SBHC assets underutilized. In response, the Council's SIF workgroup worked to identify ways SBHCs could continue to be used during such emergencies.

Due to the high level of Council interest and expertise, as well as the complexity of the topic, the effort initiated by SIF was shifted to an ad-hoc Pandemic workgroup, on which a majority of Council members served. The workgroup engaged a medical student to conduct a survey of

SBHCs to understand their capabilities and challenges. The workgroup met several times to discuss the appropriate role of SBHCs during a public health emergency and/or long-term school closure. This effort resulted in comprehensive recommendations through three phases: during school closures, preparation for re-entry, and planning for future emergencies. Five core recommendations apply to all three phases: actively promoting continuity of care for vulnerable students, developing clear processes and lines of authority to provide SBHC flexibility, supporting remote care by SBHC practitioners, enhancing central agency resources for the SBHC program, and considering access to closed school buildings for certain SBHC activities. The full Council approved these recommendations on July 27, 2020, while requesting that work continue around the issues of telehealth and building access.

II. Council Recommendations and Planning for 2021

The Council began 2020 by continuing work prioritized through strategic recommendations developed by an independent consultant, Harbage Consulting, which had been released by the Council in 2019. During 2020 and continuing into 2021, the Council continues to prioritize implementation of the following recommendations:

1. Revising SBHC standards;
2. Moving forward to share SBHC data, including on a public-facing platform (see Appendix 5);
3. Enhancing central agency resources for the SBHC program, including through additional staffing at MSDE and MDH, as well as increased grant funding; and,
4. Integrating SBHCs into Maryland population health initiatives such as the Diabetes Action Plan (see Appendix 6).

While this work continues, the Council also took up new and urgent priorities related to the role of SBHCs during the COVID-19 pandemic and future school closures. Core recommendations approved by the Council relating to the COVID-19 pandemic align with previous Council recommendations and are summarized below:

Recommendation #1: Promote continuity of care for vulnerable students. The Council recommends that MSDE and MDH offer guidance to clarify that SBHC practitioners are permitted and encouraged to continue offering clinical care to their patients even if their physical building is closed, provided that such care can be provided in ways that are consistent with other guidelines. Each SBHC sponsor should determine the best way to ensure continuity of care for its patients during current and future school closures. Approaches should be aligned with approved/acceptable practices of that sponsor. If permitted, some SBHCs could consider reopening, potentially with limited staff. Some SBHCs may offer video telemedicine or telephonic care. Some may encourage visits to partner organizations such as affiliated clinics. All SBHCs should encourage patient outreach to primary care providers. SBHCs should communicate these plans with MSDE and local education agencies.

Recommendation #2: Develop clear processes and lines of authority for flexibility in SBHC services. Acknowledging that authority may at times reside with MSDE, local superintendents, MDH, or other entities, the Council recommends that MSDE, as the lead oversight agency for SBHCs, create a document that clarifies lines of authority and processes for SBHCs to gain

approval for changes to their emergency operations including: telemedicine (see next section), hours/months of operation, staffing changes, expanding service population, changes to services provided, grant modifications, operations during school closures, etc. The Council urges that SBHC sponsors be given maximum authority to make such changes.

Recommendation #3: Support remote care (telehealth) by SBHC practitioners. The Council supports the guidance and flexibility for emergency telehealth provided by MDH and Maryland Medicaid and recommends that this flexibility remain in place. The Council appreciates efforts by Maryland Medicaid to ensure reimbursement for telehealth, both video and audio-only, and urges that this reimbursement remain in place. The Council recommends that additional clarity on telehealth authorization be communicated to SBHC Administrators and sponsors, and that any unnecessary barriers be eliminated.

Recommendation #4: Enhancing central agency resources for the SBHC program. Independent consultants have noted that Maryland's SBHC program has less central agency support than other states', both in terms of grant funding and SBHC-dedicated staffing. The Council is deeply appreciative of the high level of commitment to SBHCs of staff at both MSDE and MDH and acknowledges that these staff members have other responsibilities and are constrained in their capacity. Additional central resources for SBHCs are also warranted due to the complexities of inter-agency cooperation. Such resources would expand oversight of and support for SBHCs during crisis periods, as well as periods of normal operation. Measures to increase central agency resources for SBHCs which were passed by the Maryland General Assembly as part of the Blueprint for Maryland's Future legislation, which was subsequently vetoed by the governor, include: providing new "primary contact employee" positions in MSDE and MDH to focus exclusively on SBHCs; and increasing SBHC grant funding by $6.5 million annually.

Recommendation #5: Considering access to closed school buildings for certain SBHC activities. During current and future times of school closure, the Council recommends policymakers plan for occasional building access to SBHCs for the purpose of obtaining supplies, health records, data files, and other materials necessary for continuity of care, coordinated through local schools and school districts. The Council further urges policymakers to support the provision of care in SBHCs' brick and mortar location during times of school closure, particularly in facilities that have separate entrances and/or barriers between the centers and the rest of the school. Such in-person care may be particularly warranted for high needs, large schools, or those also serving community members, and should include safeguards identified in State guidance for the reopening of ambulatory practices.

The full text of the Council's recommendations related to the COVID-19 pandemic is included as Appendix 1.

The 2020-2021 school year began with many school districts continuing to restrict access to school buildings. Some SBHCs were able to resume services through telehealth or in-person care. Other SBHCs have remained unable to see patients. The Council will continue to support efforts to restore and expand access to health care for vulnerable children.

In November, the Council approved additional recommendations related to building access for SBHCs (see Attachment 7). These recommendations acknowledge the role of local Superintendents in making decisions about school building use, except for extraordinary

circumstances when the State Superintendent may close all school buildings. The Council recommends that local Superintendents be given information about the value of SBHCs in their communities, the ability of SBHCs to safely re-open for in-person services, and a process to permit SBHCs to have access to school buildings even when these buildings may be closed to students. This process should include a letter signed by the Superintendent clarifying the terms under which an SBHC may operate. The signed letter should be emailed to MSDE along with a description of changes to the SBHC's services facilitated by the letter.

During 2021, the Council will work to develop a vision statement articulating the Council's vision for school-based health care in Maryland. The Council anticipates that this vision statement will help to prioritize Council efforts moving forward. Key elements of this vision include support for vulnerable children and communities, as well as the equitable distribution of health care resources.

The Council will continue its efforts related to the role of SBHCs during the COVID-19 pandemic. A top priority is the role SBHCs could play in the COVID-19 vaccine effort, as well as routine childhood vaccinations.

In a related effort, the Council will continue to focus on facilitating the use of telehealth by SBHCs. Telehealth is transforming the health care landscape and will continue to be an invaluable tool for SBHCs during and after the COVID-19 pandemic. The Council seeks to address remaining obstacles to telehealth faced by SBHC administrators, and to expand the use of telehealth by SBHCs. Promotion of tele-mental health will be explored.

The Council will investigate opportunities to support funding from a variety of sources and other resources for SBHCs. This includes funding for new SBHCs as well as the operation of existing SBHCs. Funding is also needed for vaccine distribution efforts. Expanded central agency resources for SBHCs also will continue to be a priority, including additional staff and grant dollars. The Council may work on recommendations to define the scope of work of any additional staff and to redesign the grant program.

Finally, existing efforts to support the revision of SBHC standards, the analysis and sharing of SBHC data, and the collection of SBHC quality data will remain on the Council's agenda for 2021.

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The Council is confident its recommendations will support school health advancement in Maryland.

The Council will continue to offer its expertise and guidance during the 2021 General Assembly session as it relates to SBHC use of telehealth, SBHC central agency resources, systems integration, data priorities, and quality and best practices. The Council will continue to partner with the Maryland Assembly on School-Based Health Care through the provision of subject matter expertise and leadership to support their advocacy efforts for school health advancement.

The Council on Advancement of School-Based Health Centers looks forward to a successful 2021. For more information about the Council, please contact Lorianne Moss, staff to the Council, at (410) 456-6525 or Mark Luckner, Executive Director of the Community Health Resources Commission, at (410) 260-6290.

III. Roster of Council Members

Appointed by the Governor

Dr. Katherine Connor, Chair School-Based Health Center
(The Johns Hopkins Rales Health Center, KIPP Baltimore)

Dr. Patryce Toye, Vice Chair
Maryland Assembly on School-Based Health Care (MedStar Health Plans)

Joy Twesigye
Maryland Assembly on School-Based Health Care (Baltimore City Health Department)

Jean-Marie Kelly
Maryland Hospital Association (ChristianaCare)

Joan Glick
Maryland Assembly on School-Based Health Care (Montgomery County Dept. of Health and Human Services)

Dr. Arethusa Kirk
Managed Care Organization
(United Health Care)

Cathy Allen
Maryland Association of Boards of Education
(St. Mary's County Board of Education)

Rick Robb
Secondary School Principal of a School with an SBHC (Patuxent Valley Middle School)

Sean Bulson, Ed.D.
Public Schools Superintendents Assn. of Md.
(Harford County)

Meredith McNerney
Md. Assn. of Elementary School Principals
(Gaithersburg Elementary School)

Jennifer Dahl
Commercial Health Insurance Carrier (CareFirst)

Dr. Maura Rossman
Md. Association of County Health Officers
(Howard County Health Department)

Dr. Diana Fertsch
Md. Chapter of American Academy of Pediatrics (Dundalk Pediatric Associates)

Kelly Kesler
Parent/guardian of a student who receives services from SBHC (Howard County Health Department)

Ex Officio Members

Senator Clarence Lam Maryland State Senate

Delegate Bonnie Cullison
Maryland House of Delegates

Dr. Cheryl De Pinto
Designee of the Secretary of Health
Director, Office of Population Health Improvement

Mary L. Gable
Designee of the State Supt. of Schools
Assistant State Supt., Student, Family, and School Support

Andrew Ratner
Chief of Staff, Maryland Health Benefit Exchange

Mark Luckner
Executive Director, Maryland Community Health Resources Commission

Appendix 1.

Council on Advancement of School-Based Health Centers
School-Based Health Center Data

Chapter 417 of the Acts of 2015 requires the Council to report data on Maryland school-based health centers. This data is provided by the Maryland State Department of Education (MSDE). With input from the Council and support from the Maryland Department of Information Technology (DoIT), MSDE recently revised its annual survey of SBHCs. The new survey will be a powerful tool to collect and ultimately analyze SBHC data. Unfortunately, complete SBHC data for the 2018-2019 and 2019-2020 school years are not yet available, due to delays associated with the survey redesign. The Council hopes to provide information related to SBHC utilization, including enrollment and visits for mental health, somatic, and dental, as a mid-year addendum to the 2020 report.

Table 1. SBHC Programs by Jurisdiction, Level of Service, and Telehealth 2019-2020

Jurisdiction	SBHC Programs	Level 1	Level 2	Level 3	Utilizes Telehealth
Baltimore City	17	11	6	-	10
Baltimore County	13	13	-	-	-
Caroline	9	8	1	-	-
Dorchester	4	-	4	-	-
Frederick	1	1	-	-	-
Harford	5	5	-	-	-
Howard	10	8	2	-	7
Montgomery	13	-	13	-	-
Prince George's	4	-	-	4	-
Talbot	3	3	-	-	-
Washington	3	3	-	-	-
Wicomico	2	-	2	-	-
TOTALS	84	52	28	4	17

Source: Maryland State Department of Education

Definitions (from the Maryland School-Based Health Center Standards)

Level I: Core School-Based Health Center
A Level I SBHC site must have hours that are at a minimum eight hours per week with a licensed medical clinician present and are open a minimum of two days per week when school is open. Level I SBHC staff must include, at a

minimum, a licensed medical clinician and administrative support staff. There may be additional clinical support staff such as a RN, LPN, or CNA. Note: the licensed medical clinician cannot replace the school nurse.

Level II: Expanded School-Based Health Center
The SBHC site must be operational (with an advance practice provider on site) a minimum of twelve hours per week, three to five days for medical care when school is in session. Mental health services must be available on site for a minimum of three days and a minimum of twelve hours per week. The SBHC staff must include at a minimum: A licensed medical clinician; Mental health professional; Clinical support staff (RN, LPN, or CNA); and Administrative support staff.

Level III: Comprehensive School-Based Health Center
Medical services must be available a minimum of five days and twenty hours per week. The availability of fulltime services needs to be commensurate with the number of students enrolled in the school. The SBHC may rely on other community healthcare providers for 24-hour coverage. Level III or Comprehensive SBHC is available limited hours for defined services for enrolled students during the summer hours. The SBHC is open before, during, and after school hours. The SBHC staff must include at a minimum: A licensed medical clinician; Clinical support staff (RN, LPN, or CNA); Administrative support staff; Mental health professional; and at least one additional service provider such as a general or pediatric dentist, dental hygienist, nutritionist, or health educator for a minimum of four hours per month.

Appendix 2.

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

Larry Hogan, Governor – Boyd Rutherford, Lt. Governor
Elizabeth Chung, Chair – Mark Luckner, Executive Director

July 23, 2020

Recommendations Regarding School-Based Health Centers and Public Health Emergencies and/or Long-Term School Closures

Summary: When Maryland school buildings were closed in March 2020 in accordance with Phase 1 of the Governor's Plan to address the coronavirus pandemic, all school-based health centers (SBHCs) statewide were closed as well. In keeping with its legislative mandate to provide recommendations to improve the health and educational outcomes of students who receive services from SBHCs, the Maryland Council on the Advancement of School-Based Health Centers (the Council) generated the following recommendations that would allow SBHCs to most effectively fulfill their critical role as public health and educational resources during public health emergencies and/or extended school closures.

These recommendations are grounded in three core principles: (1) continuity of care consistent with MDH guidance for the re-opening of ambulatory practices and other guidance from the Governor, (2) working collaboratively to support readiness for school reentry, and (3) deepened integration of SBHCs as public health resources. The Council's comprehensive recommendations span three phases: (1) current summer school closures, (2) re-entry, and (3) future closures. While these recommendations have been generated in response to the current coronavirus pandemic, they may be applied more broadly to other public health emergencies, natural disasters, or other causes of emergency school closure.

Five overarching recommendations emerge that support these principles throughout all phases:

1. Actively promoting continuity of care for vulnerable students
2. Developing clear processes and lines of authority to provide SBHC flexibility
3. Supporting remote care (telehealth) by SBHC practitioners
4. Enhancing central agency resources for the SBHC program
5. Considering access to closed school buildings for certain SBHC activities

Background: School-based health centers (SBHC) play a critical role in preventive care, chronic disease management, and acute care for some of the most vulnerable students in Maryland schools. SBHCs can continue to serve these functions during school closures and can serve as public health resources during the current COVID-19 crisis and in future planning around long-term school closures. SBHCs have existing medical facilities, equipment, and supplies – as well as skilled clinicians with existing patient relationships.

The closure of Maryland school buildings and SBHCs due to the COVID-19 pandemic left many SBHC assets underutilized, and jeopardized continuity of care for many SBHC patients. A small number of SBHCs made requests to transition to remote services and were permitted to do so. Many other SBHCs, however, were unable to provide care for their patients. A number of factors contributed to this, including questions about how and whether SBHCs could pivot operations, obstacles to communication with patients, reduced staffing and supplies due to redeployment, and other barriers. Because SBHCs are safety net providers and in some cases the child's only source of primary care, this reduction in services may have put at risk the health of some of Maryland's most vulnerable children, potentially exacerbating health disparities. In preparation for another emergency, the Council, in collaboration with MSDE and MDH, is reviewing the needs and desires of SBHCs to provide services. At a time when primary care capacity is being strained, SBHCs must be considered as an additional source of high-quality primary and preventive care.

During school closures, SBHC practitioners could provide many services to patients remotely or through partner organizations, thus helping to keep children out of urgent care and emergency rooms. Other services that require face-to-face interaction could be conducted in other settings or in limited SBHC sites that remain open and serve additional schools, in coordination with the Governor and State Superintendent's policy guidelines. Besides ensuring continuity of care for existing SBHC patients, an alternative scenario could involve integrating SBHC personnel and assets into county- and state-wide responses to COVID-19.

As we emerge from this crisis, SBHCs could serve a critical role in addressing gaps in care (eg. routine immunizations, school physicals, etc.) that will allow students to return quickly to school and could have a role in population-wide vaccination programs and other public health functions specific to COVID-19.

Because of their unique nature, authority for SBHCs spans across diverse agencies and levels of government, including the State Department of Education (MSDE), Health Department (MDH), local education agencies, and others. The Council recognizes that this governance structure means progress on many of the following recommendations will require significant collaboration across diverse government entities.

The Council further recognizes that every school and school district is different, and every SBHC and SBHC sponsor is different. Therefore, many of these topics do not have a one-size-fits-all solution.

Moreover, the Council recognizes that while some of these recommendations could be implemented fairly easily, others may require legislation, regulatory change, revision of emergency orders, or other action.

The Council applauds actions already taken by policymakers, administrators, practitioners, and others in the face of this unprecedented challenge. In particular, the Council is grateful for expanded authorities related to telehealth, steps to ensure reimbursement for remote services including well child visits, large-scale distribution of meals to families, the deploying of countless health professionals to testing and other sites, outreach to children with behavioral health and other needs, the release of Maryland Together: Maryland's Recovery Plan for Education, and many others.

Above all, the Council acknowledges the extraordinary efforts of countless agencies, organizations, and individuals dedicated to the health and well-being of Maryland communities. The following recommendations are offered in the spirit of building upon our shared commitment to the health of Maryland children.

About the Council: The Council on Advancement of School-Based Health Centers was created by the Maryland General Assembly in 2015 to issue policy recommendations to promote the advancement of school-based health centers in Maryland, and to offer recommendations to improve the health and educational outcomes of students who receive services from SBHCs. It is comprised of 15 members appointed by the Governor representing a range of providers, educators, administrators, and other experts from across the health care and education sectors, as well as six exofficio members from across state government. Since 2017, the Community Health Resources Commission has provided staffing support for the Council. More information about the Council can be found at: https://health.maryland.gov/mchrc/Pages/Maryland-Council-on-Advancement-ofSchool–Based-Health-Centers.aspx

RECOMMENDATIONS

The following recommendations are grounded in rigorous research that supports the efficacy of SBHCs in improving health and educational outcomes, particularly for marginalized and vulnerable students and communities. They are based on expert consensus among Council members informed by the organizations they represent, a survey of Maryland SBHCs conducted by the Council, and best practices identified through the Maryland Assembly on School-Based Health Centers (MASBHC). Recommendations align with previously issued Council recommendations on the need for integration of SBHCs into public health, educational, and healthcare networks and systems.

Listed first are core recommendations, which apply to all three phases of the pandemic. These are followed by additional recommendations specific to each phase. Decision-makers are indicated in brackets following each recommendation.

Appendix 1 organizes these recommendations by implementing agency, and attempts to rank them by degree of feasibility.

Appendix 2 organizes these recommendations by core principle, recommendation for practice, implementor, corresponding policy action, and funding considerations.

CORE RECOMMENDATIONS

1. Promote continuity of care for vulnerable students

SBHCs are a safety net provider to vulnerable populations, and continuity of care during current and future extended school closures is critical. The Council appreciates the highlighting of SBHC continuity of care capacities in MSDE's planning document, Maryland Together: Maryland's Recovery Plan for Education, and supports cooperation between local schools and SBHCs to reach out to provide behavioral health supports, especially to at-risk children.

The Council recommends that MSDE and MDH offer guidance to clarify that SBHC practitioners are permitted and encouraged to continue offering clinical care to their patients even if their physical

building is closed, provided that such care can be provided in ways that are consistent with other guidelines. [MSDE and MDH]

Each SBHC sponsor should determine the best way to ensure continuity of care for its patients during current and future school closures. Approaches should be aligned with approved/acceptable practices of that sponsor. If permitted by the Governor and State Superintendent, some SBHCs could consider reopening, potentially with limited staff. [Governor, MSDE, LEAs, SBHCs] Some SBHCs may offer video telemedicine or telephonic care. [SBHCs and sponsors] Some may encourage visits to partner organizations such as affiliated clinics. [SBHCs and sponsors, LEAs] All SBHCs should encourage patient outreach to primary care providers. [SBHCs, PCPs] SBHCs should communicate these plans with MSDE and local education agencies.

Other recommendations to promote continuity of care include:

- with appropriate permissions (see next section), allowing patients from a closed SBHC to receive services from an open SBHC [SBHCs and sponsors, LEAs]
- with appropriate permissions, implementing brief, low-contact services, including in an outdoor setting if appropriate, for such needs as injections, medications, and vaccines [SBHCs and sponsors]
- conducting outreach to students to inform them of continued SBHC operations, including through contact databases, social media, and at food distribution sites [SBHCs, local schools and school districts]

2. Develop clear processes and lines of authority for flexibility in SBHC services

Because of the unexpected, rapid changes in the educational and public health landscape due to COVID-19, schools and other institutions have had to make changes in the way they deliver services. Likewise, many SBHCs have had to be flexible, and would like additional flexibility. The Council's survey of SBHC administrators identified confusion regarding how to make changes to operations such as service delivery, particularly during State emergencies. Surveyed administrators expressed uncertainty about which of the SBHC governing authorities to approach, and in what manner, in order to make needed changes (e.g., implementation of remote service delivery approaches such as telemedicine).

Acknowledging that authority may at times reside with MSDE, local superintendents, MDH, or other entities, the Council recommends that MSDE, as the lead oversight agency for SBHCs, create a document that clarifies lines of authority and processes for SBHCs to gain approval for changes to their emergency operations including: telemedicine (see next section), hours/months of operation, staffing changes, expanding service population, changes to services provided, grant modifications, operations during school closures, etc. [MSDE] The Council urges that SBHC sponsors be given maximum authority to make such changes.

Other recommendations to provide flexibility to SBHCs include:

- Permitting the carryover of FY 2020 funds to FY 2021 [Governor, policymakers]
- Allowing reporting and other flexibility for SBHC grantees [MSDE, Budget Agency]

3. Supporting remote care (telehealth) by SBHC practitioners

Social distancing requirements have led some SBHC practitioners, like other healthcare providers, to utilize telehealth, both video and audio-only. Such remote services are likely to become part of the "new normal" even after the immediate crisis passes, particularly if schools reopen with staggered schedules. As such, the Council appreciates the discussion of SBHC telehealth capacity in MSDE's planning document, Maryland Together: Maryland's Recovery Plan for Education, while urging additional measures.

The Council supports the guidance and flexibility for emergency telehealth provided by MDH and Maryland Medicaid, including the expanded definition of a telehealth originating site, and recommends that this flexibility remain in place. [Maryland Medicaid] The Council appreciates efforts by Maryland Medicaid to ensure reimbursement for telehealth, both video and audio-only, and urges that this reimbursement remain in place.

The Council is concerned about difficulties some SBHCs have faced in trying to transition to telehealth. SBHC Administrators surveyed by the Council cited a lack of clarity on steps required to gain authorization for telehealth during the COVID-19 pandemic. Council discussions with MSDE and MDH have shed light on different approval processes required for different circumstances (emergency vs non-emergency), different sponsor types (e.g. general clinics, Local Health Departments, Federally Qualified Health Centers), and different types of telehealth (e.g. originating site at the school vs the patient's home, telehealth requiring specialized equipment vs no specialized equipment, etc.). Some scenarios may require a checklist and site visit to authorize telehealth, while many others, particularly during an emergency, do not and should not. The Council recommends that additional clarity on telehealth authorization during different scenarios be communicated to SBHC Administrators and sponsors, and that any unnecessary barriers be eliminated. [MSDE and MDH]

Anticipating that remote services are likely to become part of the "new normal," the Council recommends that MDH develop a process to ensure that real or perceived barriers to reimbursement identified by SBHC administrators or sponsors be efficiently communicated to MDH/Medicaid, that Agency responses be collated and shared with sponsors, and that technical assistance be provided as needed. Agencies may wish to utilize contractors including but not limited to MASBHC. [MDH] Other measures to support remote care include:

- Providing equipment, technical assistance, and training to SBHCs related to telemedical and telephonic care [SBHC sponsors, Policymakers, MDH, and MSDE and/or their partners or contractors]
- Utilizing school and/or community hot spots for video telehealth visits, particularly in communities lacking broadband access [SBHCs, MSDE, LEAs]
- Expanding affordable high-speed internet/broadband services to underserved parts of the state [Governor, policymakers]

4. Enhancing central agency resources for the SBHC program

Independent consultants have noted that Maryland's SBHC program has less central agency support than other states', both in terms of grant funding and SBHC-dedicated staffing. The Council is deeply appreciative of the high level of commitment to SBHCs of staff at both MSDE and MDH, and

acknowledges that these staff members have other responsibilities and are constrained in their capacity. Additional central resources for SBHCs are also warranted due to the complexities of interagency cooperation. Such resources would expand oversight of and support for SBHCs during crisis periods, as well as periods of normal operation. [Policymakers]

The Council further recognizes that additional financial resources may be required to support funding for technical assistance, training, supplies, and other recommendations of this report. [Policymakers]

Other measures to increase central agency resources for SBHCs, both of which were passed by the Maryland General Assembly as part of the Blueprint for Maryland's Future legislation, which was subsequently vetoed by the governor, include:

- Providing new "primary contact employee" positions in MSDE and MDH, to focus exclusively on SBHCs [Policymakers, General Assembly]
- Increasing SBHC grant funding by $6.5 million annually [Policymakers, General Assembly]

5. Considering access to closed school buildings for certain SBHC activities

The Council observes that some SBHCs regularly operate in school buildings when buildings are open to staff but school is not in session, and recommends that this be considered a possible model for the consideration of SBHC use when school buildings are closed. The Council further observes that some closed school buildings are being used in a limited capacity during COVID-19 closures, including for food preparation and, during Phase 2, for special education purposes. Accordingly, during current and future times of school closure, the Council recommends policymakers plan for occasional building access to SBHCs for the purpose of obtaining supplies, health records, data files, and other materials necessary for continuity of care, coordinated through local schools and school districts. [Policymakers, State Superintendent, LEAs]

The Council further urges policymakers to consider allowing the provision of care in SBHCs' brick and mortar location during times of school closure, particularly in facilities that have separate entrances and/or barriers between the centers and the rest of the school. [State Superintendent, Policymakers, LEAs, SBHCs] Such in-person care may be particularly warranted for high needs, large schools, or those also serving community members, and should include safeguards identified in State guidance for the reopening of ambulatory practices.

Other recommendations related to building access:

- Using available SBHC facilities for public health purposes during future emergencies, including for vaccines, screenings, non-pandemic-related services, continuity of care, or other purposes [Policymakers, MDH, MSDE]
- Studying whether concerns about HVAC systems should be an obstacle to SBHC operations in the event of school closures. [MSDE or MDH]

ADDITIONAL RECOMMENDATIONS, BY PHASE

Phase One: Short-Term Recommendations Related to Current School Closures

During the current phase, continuity of care should be a top focus. As stated above, a clear process to allow flexibility to SBHCs is needed, as are policies to promote remote care and permit some

building access. Additional central agency resources would help to coordinate such efforts. Also during phase one:

- At a minimum, continuation of existing funding for SBHCs should be prioritized, to allow SBHCs to maintain staff and supplies for essential functions. [Governor, Budget Agency, policymakers]
- Given the disruptions of this school year and strains on primary care capacity, some SBHCs may wish to continue or resume SBHC services during the summer, with appropriate permissions and safeguards. [State Superintendent, SBHCs, Sponsors, MSDE, LEAs]

Phase Two: Preparing for Reentry

As schools reopen, SBHCs should be utilized in protocols developed by MSDE and LEAs to monitor and address COVID-19 cases in schools. This may include collaboration with school health services on school-wide screenings for fever or other symptoms, isolation areas and barriers inside the existing SBHC and potentially in other areas of the school, and possibly COVID-19 testing. Technical assistance and training should be provided as needed, as well as funding for isolation areas, supplies and other materials. [Policymakers, MSDE, LEAs] Telehealth capacities should be retained in order to ensure continuity of care, and flexibility should be facilitated. Also during phase two:

- In preparation for the reopening of schools, SBHCs and school health services should make plans for increased staffing and PPE replenishment. SBHCs that offer behavioral health services may require additional behavioral health staffing. SBHCs that offer dental care may require additional resources for deferred dental services. The Council recommends that MSDE provide support for such replenishment and staffing needs. [SBHCs, sponsors, MSDE, local schools, Policymakers]
- SBHCs should coordinate with PCPs to provide medical services such as well-child visits, sports physicals, medical forms, and vaccines that have been deferred due to the current crisis. Some may be able to work with patients remotely to begin health history and other parts of visits that do not require in-person encounters. When in-person encounters are permitted, these appointments may be shortened. This process could be started in the summer months to spread out the volume. [SBHCs, PCPs]
- SBHCs should be considered a public health resource and therefore utilized in any COVID-19 mass-vaccination campaign, including to populations beyond SBHC patients, such as school staff, families, and potentially the broader community. [Governor, Policymakers, MDH]

Phase Three: Preparation for future school closures or public health emergencies

Spring 2020 school closures are unlikely to be the last time Maryland schools are required to close, whether for another wave of COVID-19 or a future public health emergency. SBHCs should be incorporated into public health efforts to prepare for both events. While continuity of care for SBHC patients should continue to be prioritized, including through remote care, SBHCs should have the flexibility to serve the broader community. [SBHCs, MSDE, LEAs] Also during phase three:

- SBHCs and sponsors should determine which assets (facilities, staff, supplies, etc) are needed for a continuity of care plan during a long-term school closure, then work collaboratively to determine how additional SBHC assets (if any) could be shared or utilized by Local Health

Departments and/or sponsoring agencies in such an event. The Council recommends the development of MOUs between SBHCs and Local Health Departments to clarify roles to this end. [LHDs, SBHCs]

- The Council urges MSDE to continue to prioritize completion of comprehensive SBHCs standards revision, which has not occurred since 2006. In addition to other recommendations the Council has provided to MSDE relative to the standards, the Council recommends that revised standards require SBHCs to develop plans for continuity of care during long-term school closures, promote separate SBHC entrances and/or barriers between the SBHC and the rest of the school, and encourage elements to minimize transmission risk and maximize SBHC effectiveness during a public health crisis. Standards also should clarify lines of authority and processes required to make changes to SBHC operations in response to a changing landscape. [MSDE]
- The Council recommends that any revision of the MSDE grant process include provisions to reflect SBHC continuity of care planning, assistance in COVID-19 recovery efforts, and public health resource capacity during future emergencies, including through barriers or separate entrances for SBHCs. [MSDE]
- The Council recommends the development of template language for SBHC consent forms to support continuity of care during long-term school closures, including consent for remote services, services by affiliated providers, and patient outreach by SBHCs. [MSDE and contractors, SBHC Administrators and sponsors]

Annual Report Appendix 2.

Appendix 1

Summary recommendations sorted by implementing agency and ranked by estimated degree of feasibility.

Governor/Budget Agencies/State Superintendent/Policymakers

1. Permit intermittent building access to SBHC staff during school closures to obtain needed supplies, files, and other materials
2. Consider allowing SBHC operations in closed school buildings, including during the summer and during future school closures
3. Budget flexibility for FY 20/21
4. Utilize SBHC facilities in planning around future school closures
5. Utilize SBHCs in mass vaccination campaigns for children and other community members
6. Fund new SBHC Ombudsmen positions
7. Robust/increased FY 21 funding for SBHCs
8. Funding to support SBHCs including PPE, supplies, isolation areas, technical assistance, telehealth promotion, central agency infrastructure
9. Expand broadband internet access to underserved parts of the state
10. Increase annual grant dollars for SBHCs by $6.5 million

MSDE

1. Timely completion of SBHC standards revision, incorporating COVID-19 factors and other recommendations
2. Clarify lines of authority for approval of other changes to SBHC operations, particularly during health emergencies
3. With LEAs, incorporate SBHCs into future COVID-19 protocols for reentry with appropriate training and supplies
4. If/when SBHC grant process is revamped, incorporate COVID-19 factors
5. Flexibility on grant reporting requirements
6. Develop template SBHC consent form language to prepare for future closures with SBHC sponsors and Administrators
7. Financial support for replenishment of supplies if funding is available
8. Support telehealth and telephonic care through funding, equipment, TA, and training if funding is provided

MDH and Maryland Medicaid

1. Maintain site origination flexibility regarding telehealth
2. Maintain Medicaid reimbursement for telehealth including audio-only
3. Clarify and streamline authorization processes for telehealth by SBHCs
4. Develop process to help SBHCs overcome barriers to reimbursement
5. Utilize SBHCs in any mass-vaccination program
6. Consider SBHCs as public health resource in future health emergency planning

7. Support remote care through grant funding, equipment, TA, and training

MSDE and MDH Collaboratively

1. Provide uniform guidance and approval process regarding changes to SBHC operations to insure continuity of care, telehealth, and remote care
2. Study HVAC concerns
3. Provide TA to SBHCs regarding billing during school closures
4. Provide equipment, TA, grants, and training to SBHCs to support telehealth and other remote care, as well as IT infrastructure, if funding is provided

SBHCs and Sponsors, in coordination with LEAs and principals

1. Determine best way to provide continuity of care currently, and communicate to patients, MSDE, and LEAs
2. As appropriate, permit patients from closed facilities to visit open ones
3. Encourage patients to utilize "hot spots" in order access telehealth
4. Consider brief, low-contact services, including in an outdoor setting, for injections, etc.
5. Reach out to Primary Care Providers regarding care coordination during COVID-19 closures and after reopening when a surge in deferred appointments may occur
6. Continue to utilize telehealth and other remote services, even when in-person visits are again permitted
7. Sponsoring agencies should provide equipment, TA, and training to SBHCs to support telehealth and other remote care
8. Reevaluate summer plans, to support continuity of care and readiness for school reentry
9. Begin to conduct physicals and other visits in a two-step process, beginning with medical history and other parts that could be done remotely
10. With school health services, plan for increased PPE and staffing requirements when schools reopen

Local Education Agencies

1. Partner with SBHCs on communications and outreach, including contact databases, social media, and food distribution sites, as permissible within HIPAA and FERPA protections
2. Provide building access if approved by Governor and/or State Superintendent
3. Utilize SBHCs in reentry planning

Several Agencies Must Coordinate

1. Consider offering SBHC services to families and broader community
2. MOUs between Local Health Departments and SBHCs to plan roles for future emergencies

Appendix 2

Principle	Recommendation for practice	Policy requirement for recommendation	Decision-maker	Funding considerations	Notes
Continuity of care	Maximize existing funding streams for SBHCs (1)	At a minimum, maintain existing SBHC funding	Governor/ Budget agency, Policymakers	No additional funds needed	
	Maximize existing funding streams for SBHCs (2)	Permit flexibility with existing funds and reporting requirements, including carryover	Governor/ Budget agency, Policymakers MSDE	Flexibility with existing funding	
	Facilitate SBHC flexibility	Articulate clear process for approving changes to SBHC operations, including clear lines of authority	MSDE	No additional funds needed	High Priority
	Encourage continuity of care (1)	Issue guidance to clarify that SBHCs are permitted and encouraged to provide continuity of care	MSDE and MDH	No additional funds needed	
	Encourage continuity of care (2)	Each SBHC determines best way to provide continuity of care, and communicates to patients, MSDE, and LEAs	SBHCs and Sponsors, MSDE, LEAs	No additional funds needed	
	Encourage continuity of care (3)	Allow SBHC staff occasional building access for medical records and supplies, etc.	Governor, State Superintendent LEAs	No additional funds needed	
	Encourage telehealth and telephonic health (1)	Clarify and streamline authorization processes for telehealth by SBHCs	MSDE, MDH	No additional funds needed	High priority

Appendix 2

Principle	Recommendation for practice	Policy requirement for recommendation	Decision-maker	Funding considerations	Notes
	Encourage telehealth and telephonic health (2)	Maintain expanded TH reimbursement policies and site origination flexibility	MD Medicaid	No additional funds needed	
	Encourage telehealth and telephonic health (3)	Develop process to address real and perceived barriers to reimbursement	MDH	No additional funds needed	
	Encourage telehealth and telephonic health (4)	Provide TA for remote services and billing	MSDE and MDH, sponsors	No/minimal additional funds needed	
	Encourage telehealth and telephonic health (5)	Provide funding for TH equipment and software	MSDE and MDH, Governor/ budget agency, sponsors	Additional funds or funding flexibility needed	
	Encourage telehealth and telephonic health (6)	Encourage utilization of hot spots for TH	MSDE, LEAs, SBHCs	No additional funds needed	Rural areas and others lacking broadband
	Encourage telehealth and telephonic health (7)	Expand broadband to underserved areas	Governor/ budget agency, Policymakers	Additional funds needed	Rural areas and others lacking broadband
	Permit in-person care with appropriate permissions, PPE, etc. (1)	Allow certain SBHCs to reopen for in-person care	Governor, State Superintendent, LEAs, SBHCs and sponsors	No additional funds needed	Consider offering services during summer

Appendix 2

Principle	Recommendation for practice	Policy requirement for recommendation	Decision-maker	Funding considerations	Notes
	Permit in-person care with appropriate permissions, PPE, etc. (2)	Provide PPE, barriers, etc. to reduce transmission	Sponsors, MSDE, MDH Governor/ Budget agency	Additional funds or funding flexibility needed	
	Permit in-person care with appropriate permissions, PPE, etc. (3)	Permit care at affiliated non-school clinics, or selected open SBHCs	SBHC Sponsors, MSDE, LEAs	No additional funds needed	
	Permit in-person care with appropriate permissions, PPE, etc. (4)	Study concerns about transmission via HVAC systems	MSDE or MDH	No/minimal additional funds needed	
	Permit in-person care with appropriate permissions, PPE, etc. (5)	Offer brief, low-contact services, including in an outdoor setting	Sponsors, SBHCs	No/minimal additional funds needed	
	Outreach to inform patients of continuity of care plans	1. SBHCs work with schools, LEAs, and insurers 2. Share/utilize databases and social media 3. SBHC presence at food distribution sites	SBHCs, LEAs	No additional funds needed	Respecting HIPAA and FERPA protections
	Care coordination	SBHCs coordinate with PCPs to provide care to shared patients	SBHCs and PCPs	No additional funds needed	

Appendix 2

Principle	Recommendation for practice	Policy requirement for recommendation	Decision-maker	Funding considerations	Notes
	"Catch up" on deferred services	SBHCs ramp up services during summer as permitted	Governor, State Superintendent, Sponsors, LEAs, SBHCs	Flexibility with existing funding	
Supporting readiness for school reentry	Identify and fund increased staffing, PPE replenishment, barriers, and other supplies for safe reopening of schools and SBHCs (1)	Support through unspent grant dollars and other funding sources	SBHCs and Sponsors, MSDE, Policymakers	Flexibility with existing funding and/or additional funds	Including isolation areas inside the SBHC and potentially in other areas of the school
	Identify and fund increased staffing, PPE replenishment, barriers, and other supplies for safe reopening of schools and SBHCs (2)	Provide full funding for SBHC grant program, as well as proposed $6.5 million annual increase	Governor and State Superintendent, General Assembly	Additional funds may be needed	
	Expedite routine back-to-school visits	Partial remote visits in summer to expedite sports physicals and other visits that will require in-person attention	SBHCs and Sponsors	No additional funds needed	Coordinate with PCPs
	Reducing COVID-19 transmission in reopened schools	Utilize SBHCs in schoolwide screenings and potentially COVID-19 testing and contact tracing	MSDE, MDH, Policymakers, LEAs	Additional funds may be needed	Provide training and supplies as needed

Appendix 2

Principle	Recommendation for practice	Policy requirement for recommendation	Decision-maker	Funding considerations	Notes
	Enhance Central agency oversight and support of SBHCs	Provide additional positions and resources at MSDE and MDH focused exclusively on SBHCs	Governor/ Budget agency, General Assembly	Additional funds needed	Additional $6.5 million in SBHC grant funding and 2 new ombudsmen positions
	Modernize SBHC standards	Update SBHC standards to take into account public health emergencies and other priorities	MSDE	No additional funds needed	High Priority
	Promote continuity of care during future school closures (1)	Plan in advance to allow certain SBHCs to remain open during future school closures	Governor and State Superintendent, Sponsors, LEAs	No additional funds needed	
	Promote continuity of care during future school closures (2)	Develop template language for SBHC consent forms	SBHC sponsors, LEAs	No/minimal additional funds needed	Consent for remote services, services by affiliated providers, contact information during closures
	Promote continuity of care during future school closures (3)	Promote continuity of care planning through grant process and standards revision	MSDE	No additional funds needed	
SBHCs as integrated public health resources	COVID-19 Vaccine	Utilize SBHCs in mass vaccinations, including school staff and community members	MDH, Governor, Policymakers	No additional funds needed	

Appendix 2

Principle	Recommendation for practice	Policy requirement for recommendation	Decision-maker	Funding considerations	Notes
	Potentially provide care to community members, particularly during crisis periods	Clear process to permit flexibility to change SBHC operations	Sponsors, LEAs, MSDE	No/minimal additional funds needed	
	Integrate SBHCs into future health emergency planning (1)	Develop MOUs with Local Health Departments to clarify roles	MDH, Local Health Departments	No/minimal additional funds needed	
	Integrate SBHCs into future health emergency planning (2)	Plan in advance to allow certain SBHCs to remain open during future school closures	Governor, State Superintendent, Sponsors, LEAs	No additional funds needed	(also included in "Supporting readiness for school reentry")
	Integrate SBHCs into future health emergency planning (3)	Encourage separate entrances or barriers between such SBHCs and the rest of the school building so certain SBHCs can remain open	MSDE	No additional funds needed	Including through revised SBHC standards
	Integrate SBHCs into future health emergency planning (4)	Incorporate SBHC public health functions into MSDE grant process and revised standards	MSDE	No additional funds needed	

Appendix 3.

Quality and Best Practices Workgroup – Telehealth Vision and Update

As directed by the Council during its July 2020 meeting, the Quality and Best Practices Workgroup has held several meetings to build on the Council's July 2020 recommendations with regard to telehealth. The workgroup consulted numerous reference documents and met with MDH and MSDE staff.

1. Defining telehealth service delivery models

Telehealth exists in various service delivery models, and lack of clarity on these models has led to confusion. The Workgroup studied these models and summarized them in the following table:

	Already in use?	When appropriate	Originating site/patient's location	Staff/ telepresenters at originating site	Technology currently required	Rendering clinician and location	Current approval process
Model 1 (TH-only-SBHC)	Yes	Normal school operations	SBHC in school	RNs	Specialized equipment	Remote clinician in office, hospital, or another SBHC	TH service delivery plan, MDH checklist, site visit, MSDE application/update
Model 2 (Hub-and-Spoke)	Yes	Normal school operations	SBHC in school	RNs	HIPAA compliant video conferencing software	Remote clinician in a related SBHC	TH service delivery plan, MDH checklist, site visit, MSDE application/update
Model 3 (Home-to-Home)	Not currently permissible	During emergency situations	Student's home or other location (must be located in Maryland)	None (parents/ guardians)	HIPAA compliant video conferencing software	Remote clinician in home, office, or hospital	Not currently allowed, pending AG review
Model 4 (Home-to-School)	Yes	Normal school operations and during emergencies	Student's home or other location (must be located in Maryland)	None (parents/ guardians)	HIPAA compliant video conferencing software	Clinician in SBHC	TH service delivery plan, MDH checklist, site visit, MSDE application/update
Model 5 (Specialist)	No, but permissible	Normal school operations	SBHC in school	Physicians, NPs, or RNs	HIPAA compliant video conferencing software	Specialist in office or hospital	TH service delivery plan, MDH checklist, site visit, MSDE application/ update, documentation of care relationship with specialist

2. Vision for utilization of telehealth by SBHCs

- Telehealth will continue to be a widely accepted clinical practice even after the end of the COVID-19 public health emergency.

- School-based health center services can be delivered via telehealth.

- During times of school closure and other times, SBHC services provided through telehealth can promote continuity of care.
- Each of the five above models will continue to have utility in the future as telehealth becomes even more standard across the health care system.
- Legislation passed by the Maryland General Assembly in 2020 (SB 402) is intended to standardize telehealth across health occupations and ensure the same standards of practice for telehealth compared to in-person care. This framework should apply to SBHCs.
- As a general principle, all physicians and Nurse Practitioners (NPs) should have the capability to transition quickly to telehealth as circumstances dictate. In most cases, the workgroup does not believe additional agency approvals should be required.
- Additional clarity is needed on the steps required, if any, for an SBHC to adopt telehealth according to Model 3, above. Modified consent forms may be required.
- Revised telehealth consent forms, with input from agency attorneys, may help provide a level of comfort for agencies and school principals, particularly for telehealth originating in a student's home (Models 3 and possibly 4, above). While signed, hard-copy consent forms are preferred, verbal parental consent should be deemed sufficient for a one-time visit in the event that a signature cannot be obtained.
- Parents/guardians must provide active consent for telehealth services, including for SBHC services provided when students are not in the school building.
- School principals, MSDE, and MDH should be notified when an SBHC begins to offer new or expanded telehealth services.
- Efforts to secure a Federal waiver for Medicaid reimbursement for SBHC telehealth, as well as the updating of the SBHC billing manual, have been helpful. Medicaid reimbursement flexibilities for telehealth should be maintained.
- Telehealth should be part of updated SBHC standards, but requirements for telehealth at SBHCs should not exceed telehealth requirements for other Maryland providers.
- Licensed physicians and NPs in SBHCs should not be required to demonstrate more proof of compliance than any other telehealth providers.

3. Next Steps

- Guidance from agency attorneys is being sought in order to address school and agency responsibility for SBHC telehealth services that do not originate in the school (Model 3 and possibly 4 above). New consent form language may resolve concerns.
- Guidance is also needed to determine whether SBHCs can bill for telehealth services as an SBHC if the clinician is not located in the SBHC at the time of the visit.
- More work needs to be done to develop consensus on recommendations for streamlining the agency approvals for each of the five models listed above.
- In the future, as the COVID-19 pandemic recedes and the Public Health Emergency ultimately expires, the workgroup intends to monitor developments such as the possible reimposition of telehealth restrictions, and may have further recommendations at that time.
- The workgroup is interested in learning more about whether telehealth could be used to provide services to students in schools that do not have a physical SBHC in their building as a means of

expanding the SBHC program. This potentially could represent a sixth model or an expansion of the first model.

Appendix 4.

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

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Allan Anderson, M.D., Chair – Mark Luckner, Executive Director

February 4, 2020

The Honorable Bonnie Cullison
House of Delegates
312 House Office Building
6 Bladen Street
Annapolis, MD 21401

Dear Delegate Cullison,

Thank you for sharing with the Council on Advancement of School-Based Health Centers (the Council) your legislation, HB 0409, regarding expanded sponsorship models for school-based health centers (SBHCs).

As you know, the Council has been interested in this topic and supportive of expanding SBHC sponsorship models. Last year's Blueprint for Maryland's Future legislation required the Council to consult with the Maryland Department of Health and the State Department of Education on a plan to build a sustainable sponsorship model by expanding the types of organizations that can sponsor SBHCs. The Council formed an ad-hoc workgroup to study the issue more closely.

In its letter to the Maryland Department of Health and State Department of Education pursuant to the legislative requirement of last year's Blueprint legislation, the Council advised:

> …the Council recommends considerations for modifying Maryland State Medicaid regulations to include hospitals, and additional Sponsoring entities beyond LHD, FQHC, and general clinic, endorsed by the Council …

The recommendations of the ad-hoc workgroup outlined above are based in part on the findings of an independent consultant commissioned by the Council, and are aligned with the Council's 2019 recommendations to the General Assembly.

The independent report commissioned by the Council included the following:

> We recommend that the Council further analyze opportunities for improving the SBHC model in Maryland, which differs from other states ... Currently, hospitals are not permitted to receive Medicaid reimbursement for SBHC services, but this is something that should be reviewed, leveraging experiences from other states.

The Council's 2019 Annual Report included the following recommendation:

> The Council recommends expanded sponsorship models to promote the advancement of school-based health center sustainability. The sponsoring agency types should not be restrictive if the standards of being a safety net provider are met.

By way of background, the Council was charged by the Maryland General Assembly in 2015 to issue policy recommendations to promote the advancement of SBHCs in Maryland, and to offer recommendations that would help improve the health and educational outcomes of students who receive services from SBHCs. As a rule, the Council does not take positions on legislation. The Council does, however, respond to requests for information and is poised to share with policymakers its views on whether policy proposals align with the Council's recommendations.

Sincerely,

Dr. Katherine Connor Dr. Patryce Toye Chair, Council Vice Chair, Council

cc: Webster Ye, Deputy Chief of Staff, Maryland Department of Health
Mark Luckner, Executive Director, Community Health Resources Commission
Lorianne Moss, Staff Consultant, Council on Advancement of School-Based Health Centers

Appendix 5.

Council on Advancement of School-Based Health Centers
2020 Data Workgroup Recommendations

The Maryland State Department of Educations (MSDE) has made commendable strides to update its annual survey of school-based health centers (SBHCs). This effort, to which the Council's Data group contributed its own expertise, will yield a great deal of data critical for analyzing Maryland's SBHC program and demonstrating the value of SBHCs. The Data workgroup thanks MSDE for investing in this time- and labor-intensive project, and looks forward to working together to build upon it.

With the revised survey now beginning to be completed by SBHC sponsors, the Data workgroup recommends that MSDE consider shifting its data-related focus to the development of a publicfacing platform to host selected survey data and permit its analysis. This may require a commitment from the highest levels at the Department, and the Council stands ready to reinforce with MSDE leadership the importance of this task.

Why focus on a data platform? Improving SBHC data collection and management has been a central part of the mandate given to the Council by the General Assembly. The Council's authorizing legislation requires the Council to "review the collection and analysis of school-based health center data collected by the State Department of Education to: (1) make recommendations on best practices for the collection and analysis of the data; and (2) provide guidance on the development of findings and recommendations based on the data."

Currently, very little data on the SBHC program is publicly available or easily accessible. The Council's annual report, which is public, is required to report some high-level data on SBHCs including: enrollment; total number of visits for mental, somatic, and oral care; level of service designated for each SBHC; and the number of SBHCs using telehealth. MSDE supplies this information to the Council upon request. (Delays related to the survey redesign have meant that the latest annual report data is for the 2017-2018 school year.) MSDE's SBHC website, while including a contact list of all SBHC locations, does not contain information such as SBHC enrollment and utilization, services provided, use of telehealth, poverty indicators such as free or reduced meals, health or education outcome data, etc. Right now, the only way to procure even very basic data to describe the SBHC program is to place a request with MSDE staff.

Data is essential for understanding how the needs of Maryland's children are being met by the current SBHC program, and in which areas improvement is needed. For example:

- Population data is needed to ensure that SBHC services are being matched with students who need them most.
- Health and educational outcome data is needed to evaluate SBHC effectiveness.
- Quality data is needed to measure the performance of individual SBHCs and demonstrate their value to insurers and others.
- Demographic data would help to ensure health equity goals are met.
- Data on the provision of vaccines and well-child visits by SBHCs would be important to understand in the context of current pediatric health care challenges.

With all this information now being collected in the annual survey, the workgroup recommends that the Department next consider which data sets should be made public, and how to present them in a way that best facilitates analysis. Such an approach also is consistent with Maryland open data laws.

Previous Council recommendations: For several years, the Council has discussed the importance of SBHC data sharing. These recommendations are included in the 2018 annual report, the 2019 annual report, and the Harbage Report commissioned by the Council.

- **From 2018 Annual Report**: With improved data collection, mechanisms should be developed to annually share the data with key stakeholders. Infrastructure support will be needed to ensure data sharing and analysis. Strategies should be shared with SBHC administrators on best practices for utilizing the data collected to enhance SBHC programming and development. These strategies should include analysis of the MSDE SBHC annual data and state and local population health data. Also, recommendations on needs assessment tools should be provided to SBHC administrators. If additional SBHC funding is available, a dedicated program administrator is needed at the state level to move forward the improved data collection system, dissemination, and analysis of SBHC data to support and advance SBHCs in Maryland.

- **From 2019 Annual Report**: **Recommendation 4.B.iv.** Develop public facing data portals for key SBHC measures. The reporting may be modeled after the MDH State Health Improvement Process (SHIP) and MHBE Data Reporting. Key considerations for a public facing portal include: (1) MSDE's SBHC Annual Report to stakeholders, (2) Capacity to respond to Public Information Act and Inter-Agency data requests, and (3) Technical portal capability and sophistication for public accessibility

  … The Council recommends resources be devoted to maintaining this new platform and to continually advance its capabilities in line with Council recommendations and SBHC Administrator needs …

- **From the Harbage Report**: The State of Maryland must be willing and able to take on a leadership role in developing a data reporting plan and obtaining buy-in from frontline staff and other stakeholders. The state will also need to dedicate additional resources and staff to strengthening the infrastructure for data collection, reporting, analysis, and dissemination.

2020 Activities: During 2020, the Data workgroup held several meetings with MSDE, the Maryland Department of Information Technology (DoIT), and the School-Based Health Alliance to explore options for such a platform. Consensus emerged among Council members that the State of Maryland's Open Data Portal (ODP), managed by DoIT, would be a cost-effective means for beginning to host SBHC data.

ODP and SBHC Data: ODP is a repository for large amounts of state data, using the Socrata software. MDH's SHIP operates from this platform, and MSDE already utilizes it.

ODP's purpose is to organize data and make it available to the public. It does NOT analyze data, but has some built-in capabilities to facilitate data analysis and even create basic data visualizations (graphs, etc.). Data can be entered in many ways, including from Excel spreadsheets, which MSDE currently uses for SBHC data. Data can be public or private.

The Data workgroup has some reservations about using ODP. Specifically, the Data workgroup believes more technologically advanced solutions may be available. However, because this platform is already available and in use, the workgroup advises moving ahead to test this option.

The Data workgroup is aware of concerns related to the privacy of SBHC data. The Data group believes these concerns should not prevent forward progress. Datasets already hosted on ODP include: kindergarten readiness, AP Exams taken, Free/Reduced Breakfast and Lunch Programs, teen pregnancies, child maltreatment, children with elevated blood lead levels, adolescents who use tobacco, children receiving dental care, children who received wellness checkups, children who received vaccines, adolescent obesity, etc. Furthermore, data can be suppressed or protected on ODP.

Two tracks: The Data workgroup recommends that MSDE move forward with posting SBHC data on ODP, taking advantage of ODP's private and public capabilities.

1. **Private Data**: The Data group recommends that MSDE work with DoIT to utilize ODP as a repository for annual survey data. DoIT designed the annual survey with MSDE, and may be able to integrate the data seamlessly. Any data initially should be posted to the private side of ODP. Sensitive data may remain on the private side, while less sensitive data should be made public.
2. **Public Data**: The Data workgroup proposes a phased approach for making SBHC data public.
    a. Begin with a small set of high-level information that is *already* publicly available (see below). This information may come from current SBHC annual surveys and/or prior years. This information should be posted on ODP's public-facing side.
    b. As comfort grows with this initial set of data, look at ways to expand, including data that is not currently public. CASBHC's Data workgroup may make recommendations on future data sets. Work through privacy issues as they arise.
    c. Initiate efforts to manipulate and analyze data. Display charts and graphs generated by the data on MSDE webpages and use them in MSDE's reports on the SBHC program.
    d. Investigate dashboards for displaying public data and/or graphs and maps generated from the data. This may include other software packages that integrate with Socrata.

Public Data Points: Below is a list of potential data points that the workgroup recommends MSDE consider for sharing publicly on ODP, as well as the question(s) in the annual survey to which each corresponds. This information would help to describe Maryland's SBHC program without getting into student health measures. Most of this is already public information. This list is not exclusive. Moreover, as the comfort level grows, the Data workgroup recommends that additional data sets be added.

- SBHC sponsor names and jurisdiction - already on MSDE's website - #5

- Total number of SBHCs in jurisdiction and state - already on MSDE's website - #36-40
- Number of students enrolled in each SBHC/jurisdiction/state - #67
- Number of non-students enrolled in each SBHC (faculty, parents, siblings, etc.) - #74-79

- Percentage of students receiving free or reduced meals in schools served by SBHCs already reported publicly in the school's Report Card - #45
- SBHC's level of services (Level I, II, or III) - CASBHC already includes this information in its annual report - #42
- SBHCs offering Behavioral Health services - CASBHC already includes this information in its annual report - #1-2
- SBHCs offering Oral Health services - CASBHC already includes this information in its annual report - #3-4
- SBHCs offering vaccines - CASBHC already includes this information in its annual report - #58
- SBHCs utilizing telehealth - CASBHC already includes this information in its annual report - #41, 80, 84, 85

Next Steps for the Short-Term: The Data group recommends that over the next 12 months, MSDE consider the following steps:

1. Secure Department-level commitment to the posting of public and private SBHC data on ODP. This may involve the crafting of a written implementation plan, and may require approval from the Department's Accountability Office and the State Superintendent's Office. The Council stands ready to reinforce with MSDE leadership the importance of this task. 2. Identify data sets that could be posted publicly in the short-term. (see above)
3. Identify thresholds and procedures to ensure the privacy of sensitive data.
4. Designate an MSDE staff member to obtain an ODP account and be responsible for SBHC data. Provide information to the Council about any additional resource requirements and constraints.
5. Finalize any required agreement with DoIT for this purpose.

Appendix 6.

Council on Advancement of School-Based Health Centers
2020 Recommendations Re: Diabetes Action Plan

School-based health centers (SBHCs) should be utilized as a resource in implementing the State's Diabetes Action Plan (DAP).[15] SBHC collaboration on this priority can serve as a model for SBHC integration into future statewide population health initiatives. One outcome of such

[15] In this document, Diabetes Action Plan (DAP) refers to the Maryland Department of Health's diabetes-related population health initiative found here: https://phpa.health.maryland.gov/CCDPC/Pages/diabetes-action-plan.aspx. The DAP is a collaborative effort between health care partners and community-based organizations to align efforts, resources, and funding to reduce the burden of diabetes in Maryland. For the purpose of the Council's recommendations, DAP does not refer to an individual's diabetes management plan.

collaboration would be a shift of SBHCs away from being isolated care providers toward becoming a state public health resource.

Recommendations for the Maryland State Department of Education (MSDE) and Maryland Department of Health (MDH):

- Encourage the involvement of SBHCs in their respective Local Health Improvement Coalitions (LHICs) by providing LHIC contact information to SBHCs, and vice versa. Hold these organizations accountable by following up with them and hosting a meeting with LHICs and SBHCs (and possibly others) around the DAP. [MDH]
- Distribute to all SBHCs an electronic copy of the DAP. [MSDE]
- Host a presentation on the DAP at an upcoming SBHC Administrators meeting. [MSDE/MDH].
- Provide technical and financial assistance to SBHCs to expand the reach of their DAP-related activities to include school staff and other community members. [MSDE/MDH]
- Provide professional development tailored to SBHCs on best practices for diabetes, as well as DAP implementation guidance issued by MDH. [MSDE/MDH].
- Integrate SBHCs into guidance related to the DAP, including guidance provided to primary care providers and others. [MSDE/MDH]
- Ensure SBHCs are considered for financial resources associated with DAP implementation. [MDH/Other state agencies and funders]
- Expand SBHC data collection to include diabetes measures, and share such data with other entities involved in DAP. [MSDE]
- Consider providing BMI screenings to all students, regardless of a student's enrollment status in a SBHC. Such screenings should correspond with a certain grade or grades, modeled after the periodic vision and hearing screenings currently conducted in schools. SBHCs should be a partner in this effort, and should receive appropriate funding to do so. SBHCs should help provide screenings and should encourage screened students to enroll in their SBHC. [MSDE/MDH]
- Create a document outlining clear lines of communication, processes, and lines of authority for SBHCs and their sponsors seeking to make changes to current SBHC service delivery models (eg. to expand diabetes-related services, to provide services to school staff and/or community members in addition to students, respond to changing circumstances, etc.). [MSDE/MDH]

Recommendations for individual SBHCs and sponsors:

- Become familiar with the DAP, as well as any additional guidance on DAP implementation to be provided by MDH.
- Become involved in their respective LHICs.
- With technical assistance from MSDE and MDH, be involved in implementing the DAP by providing:
    1. Screening and testing, including BMI testing, for diabetes and obesity;
    2. Lifestyle diabetes prevention strategies including nutrition and physical activity; and
    3. Managing diabetes, including performing A1C and other testing, for individuals diagnosed with diabetes.
- With technical assistance from MSDE and MDH, connect patients with diabetes and prediabetes, as well as at-risk individuals, to DAP resources.

- Coordinate DAP efforts with other medical providers, including information sharing through CRISP.
- Because the DAP will focus on adults in the near term, consider expanding diabetes-related services beyond students, including to school staff as well as other community members.
- Seek additional financial support from state agencies as well as other grant-making entities for expansion of diabetes-related services and other actions related to DAP implementation.
- Gain approval from MSDE and/or other agencies for any changes in services related to the DAP. (See approval process recommendation in previous section.)

Recommendations for LHIC*s*:

- Reach out to include SBHCs in their coalitions, and encourage SBHC participation and leadership roles within their organizations.
- Identify roles for SBHCs in their planning and implementation of DAP, as a model for addressing future population health topics.

Recommendations for policymakers:

- Ensure adequate funding to enable MDSE and MDH to: provide technical assistance and professional development to SBHCs for implementing the DAP; support expansion of SBHC services to school staff and other community members; foster cooperation between SBHCs and LHICs; expand the sharing of diabetes-related information; and implement other efforts related to the DAP.
- Increase funding for the SBHC program by $6.5 million annually, as envisioned in the Blueprint for Maryland's Future legislation, in order to support the expansion of SBHC services and support DAP goals.
- Add new staff at MSDE and MDH dedicated solely to the SBHC program, as envisioned in the Blueprint for Maryland's Future legislation, who will have a capacity to focus on these and other recommendations critical to the SBHC program.
- Where barriers to the sharing of diabetes-related information are identified, including HIPAA/FERPA barriers, lack of CRISP connectivity, etc., systems level solutions should be developed.

Appendix 7.

Council on Advancement of School-Based Health Centers
Recommendations for SBHC Access to School Buildings

As safety net providers for vulnerable Maryland children, school-based health centers (SBHCs) should be permitted access to school buildings, including schools that have opted for on-line or hybrid learning models.[16] Such access should be provided both for patient care and for support activities. Many jurisdictions, including Baltimore City, already have reached agreements to permit SBHCs to operate in buildings closed for students. This model should be expanded to jurisdictions where

[16] In July 2020, the Council issued comprehensive recommendations regarding the utilization of SBHCs during the COVID-19 pandemic and future school closures. Among these was a recommendation to consider expanding access to closed school buildings for certain SBHC activities. At the request of Council members, the Council's Systems and Integration Workgroup has continued to work on the topic of school building access for SBHCs.

building access currently is restricted. SBHCs should inform MSDE if approved by their superintendent to provide in-person care.

SBHC practitioners adhering to Maryland Department of Health (MDH) guidelines for ambulatory operations can safely provide much-needed health care services. Careful pre-screening of patients, specialized personal protective equipment (PPE), and adherence to other MDH guidelines will allow SBHCs to mitigate transmission to an even greater degree than programs currently permitted in many school buildings, such as daycare and special education programs. The safe reopening of SBHCs will not put other school staff or children at increased risk of COVID-19; to the contrary, the presence of on-site health care services will be an asset.

The Council supports the role of local Superintendents in making decisions about the use of school buildings, while acknowledging the authority of the State Superintendent to close schools during extraordinary circumstances. The Council recommends that local authorities be informed about the role SBHCs play in their communities, and the rationale and process for allowing SBHCs to resume in-person services.

The Council appreciates the discussion of SBHCs in the Maryland State Department of Education's (MSDE) planning document, *Maryland Together: Maryland's Recovery Plan for Education*, including a commitment to "provide leadership, guidance, and support for local school-based health center programs during and after the COVID-19 pandemic." One area in which MSDE and MDH have an opportunity to provide additional leadership and support is the issuance of guidance on how to provide SBHCs with operational access to school buildings.

Consistent with previous State actions to encourage local jurisdictions to permit daycare centers in otherwise closed school buildings, the Council recommends that local Superintendents be provided with information about:

1. the presence of SBHCs in their districts;
2. the role of SBHCs in advancing health and educational equity;
3. the ability of SBHCs to provide health care safely, consistent with State and local guidelines on ambulatory operations during the pandemic; and
4. the decision-making authority of local Superintendents regarding school building use for SBHCs.

[MSDE and MDH]

The Council recommends that SBHC sponsors and local Superintendents be given clarity about a process (see below) by which SBHCs could be permitted to provide in-person care in school buildings that are restricted due to the COVID-19 crisis. [MSDE]

The Council recommends that this process include a letter from the local Superintendent to the SBHC sponsor that articulates and acknowledges the following, and that the signed letter be emailed to MSDE:

1. The SBHC's existing/annual MOU which authorizes the SBHC's presence in the school building(s). This MOU differentiates the SBHC from many other community entities requesting the use of school buildings.
2. SBHC adherence to State and local health department guidance on ambulatory operations during the pandemic, and other measures the SBHC will implement in order to minimize transmission risk.
3. Terms under which the SBHC may operate in the school building(s), including: hours of operation, patient population, safety measures, contact personnel, etc.

4. Steps required to modify the above terms if necessary.
5. Consent of the individual school principal(s) to the SBHC's operation in the school building(s).

[MSDE, Local Education Agencies, SBHC sponsors]

This signed letter should be emailed to MSDE, along with a description of changes to the SBHC's services facilitated by the letter. [SBHC sponsors]

Background:

The blanket closure of school buildings mandated in spring 2020 by State Superintendent Salmon was lifted when the State moved to Stage Two of Governor Hogan's Roadmap for Recovery. With local jurisdictions once again the current decision-making authorities for their school buildings, it is an appropriate time to reconsider restrictions on the use of SBHC facilities.

Health requirements of children do not disappear when a school building is closed. For example, reports indicate Maryland students are falling behind on routine vaccines, including vaccines deemed mandatory for attending school. April 2020 saw a 46 percent reduction in childhood vaccines compared to April 2019. COVID-19 also has exacerbated mental health challenges. Additionally, many children rely on school health services to provide occupational therapy, physical therapy, and/or behavioral health services.

Many SBHC services can be offered remotely, and the Council strongly supports the expansion of telehealth capacities. However, many SBHCs have not been able to transition to telehealth for a variety of reasons. In fact, for some SBHCs, lack of practitioner access to school buildings has been a barrier to telehealth services. Moreover, other services such as vaccines, lead tests, injections, and certain examinations must be provided in person. In-person pediatric care remains vitally important, and SBHCs are crucial for meeting the needs of some of Maryland's most vulnerable children.

Appendix 8.

STATE OF MARYLAND

Community Health Resources Commission

45 Calvert Street, Room 336 • Annapolis, Maryland 21401

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Allan Anderson, M.D., Chair – Mark Luckner, Executive Director

Council on Advancement of School-Based Health Centers Teleconference: 605-475-4000 Passcode: 142685# MINUTES

Thursday, November 14, 2019
1:00PM-3:00PM

Attendees / Roll-Call

Appointee Membership

1. Dr. Katherine Connor, CASBHC Chair | Medical Director Johns Hopkins Rales SBHC | KIPP Baltimore
2. Cathy Allen, Maryland Association of Boards of Education | Vice Chair, St. Mary's County Board of Education
3. Dr. Patryce Toye, Maryland Assembly on School-Based Health Care | Medical Director, MedStar Family Choice
4. Dr. Arethusa Kirk, CASBHC Managed Care Organization Member | Chief Medical Officer United HealthCare Community Plan
5. Jennifer Dahl, Commercial Health Insurance Member | Credentialing Coordinator, CareFirst
6. Meredith McNerney, Maryland Association of Elementary School Principals | Gaithersburg Elementary School
7. Dr. Sean Bulson, Public Schools Superintendents Association of Maryland | Harford County Public Schools
8. Kelly Kesler, Parent/Guardian of student who receives SBHC services | Director, Howard County Local Health Improvement Coalition
9. Karen Williams, Federally Qualified Health Center | CEO, Mid-Atlantic Assoc. of Community Health Centers

Ex Officio

10. Delegate Cullison, Ex Officio Member | House of Delegates, District 19 (Montgomery County)
11. Senator Lam, Ex Officio Member | Maryland State Senate, District 12 (Howard & Baltimore City)
12. Mark Luckner, CASBHC Community Health Resource Commission (CHRC) Ex Officio Member | Executive Director CHRC
13. Dr. Cheryl De Pinto, CASBHC Maryland Department of Health (MDH) Ex Officio Member | Director, MDH Population Health
14. Andrew (Andy) Ratner, Ex Officio Maryland Health Benefit Exchange Member | Chief of Staff,

Maryland Health Benefit Exchange

Public

1. Jennifer Barnhart, CASBHC Staff Consultant | President LUMA Health Consulting
2. Rachael Faulkner, Public Policy Partners
3. Joy Twesigye, Public Member | Baltimore City Health Department
4. Pam Kasemeyer, Public Member | Schwartz, Metz, and Wise, PA
5. William (Mike) Shaw, Public Member | St. Mary's County Health Department

1:00PM Welcome (Chair: Dr. Kate Connor)

Dr. Connor welcomed Council members and the public, and thanked everyone for the hard work on finalizing the 2019 Council recommendations.

1:05PM Minutes from October 7, 2019

Dr. Toye moved to approve the meeting minutes. Ms. Dahl seconded the approval. There were no oppositions or abstentions. The meeting minutes were approved.

1:10PM Elections

Ms. Barnhart described that the term of the Chair and Vice Chair is limited to two years. There is no limit on the number of terms the Chair and Vice Chair can serve. The Chair and Vice Chair are nominated by appointed and ex officio Council members. Appointed members may nominate themselves or others on behalf of their nominating organization. The Chair and Vice Chair are elected by appointed members and may be re-elected into their respective positions after the conclusion of their terms. Members may recuse themselves from elections.

Ms. Barnhart described that a quorum of the Council shall consist of two-thirds (67%) of the appointed members, including the Chair and Vice Chair. A quorum shall be required for the affirmative transaction of official business of the Council, as deemed a priority of the Council Chair, including but not limited to the Annual Report, leadership elections, recommendations to the Governor's Office, and General Assembly

The Council shall elect the Chair and Vice Chair. Biographies have been distributed earlier today.

The Council had a single nomination for Chair, Dr. Kate Connor. There were no discussions requested before the vote. The motion to re-elect Dr. Connor was made and seconded, with no abstentions or oppositions. Dr. Connor was re-elected to another term (November 14, 2019 through November 14, 2021).

The Council had a single nomination for Vice Chair, Dr. Patryce Toye. There were no discussions requested before the vote. The motion to elect Dr. Toye was made and seconded, with no abstentions or oppositions. Dr. Toye was elected as Vice Chair for a two-year term (November 14, 2019 through November 14, 2021).

1:20PM 2019 Annual Report

Dr. Connor provided Council members with ten minutes during the meeting to read through the Annual Report. After ten minutes, Dr. Connor asked for Council members to provide substantive comments. The comments are outlined as follows:

Activity: The Council provided strategic guidance to Wicomico County School-Based Health Centers. The Council recommended strategies to improve enrollment by leveraging managed care organization capabilities.

Discussion: The Council asked to describe this activity. Mr. Luckner described that this activity was to advise a Community Health Resources Commission SBHC grantee's difficulty in achieving enrollment objectives. Council Managed Care Organization representatives advised the CHRC grantee about how to leverage MCO member outreach capabilities to engage parents and encourage them to enroll their students at the Wicomico County SBHC. The Council requested that 'text capabilities' language be removed from the strategies to improve enrollment.

Activity: The Quality & Best Practices Workgroup recommended changes to the SBHC Standards.

Discussion: The Standards are overseen by MSDE and not jointly by MSDE and MDH. The Annual Report was updated to reflect this.

Activity: SBHC Annual Survey

Discussion: The Council inquired about the status of the Annual Survey. MSDE stated that leadership will not allow any more changes at this point. The Survey is expected to be distributed to SBHC Administrators in winter 2020. The Council felt the Report captured the objectives and challenges of the survey very well.

Annual Report Content: Diagram 1 visual map of SBHCs across Maryland.

Discussion: Council requested it be updated to include Frederick and Howard counties. MSDE said they will fix the visual and send to Ms. Barnhart for inclusion in the final Report.

Annual Report Content: SBHC alignment with state population health priorities.

Discussion: The Council requested that managed care Performance Improvement Process be removed from this section of the Report. The Council requested the Report build upon the MDH diabetes population health goals.

Next Steps: Dr. Connor asked Council members to further review and provide feedback to Ms. Barnhart. Ms. Barnhart will share the Report back with the Council before Thanksgiving in a track-changes format. The Council members will vote by electronic poll to approve the final Report. The Report needs to be finalized by early December and distributed to the General Assembly, on or before December 31, 2019.

3:00PM Adjourn

Dr. Connor adjourned the meeting at 3:00PM.

STATE OF MARYLAND

MCHRC
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Community Health Resources Commission

45 Calvert Street, Room 336 • Annapolis, Maryland 21401

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Allan Anderson, M.D., Chair – Mark Luckner, Executive Director

Council on Advancement of School-Based Health Centers
House Office Building, 6 Bladen St, Room 170, Annapolis, MD 21401

MINUTES

Monday, January 29, 2020
1:00 PM-3:00 PM

Attendees / Roll-Call

In-Person Appointee Membership

1. Katherine Connor, CASBHC Chair | Medical Director, Johns Hopkins Rales SBHC, KIPP Baltimore
2. Patryce Toye, Maryland Assembly on School-Based Health Care | Medical Director, MedStar Family Choice
3. Joy Twesigye, Maryland Assembly on School-Based Health Care | Bureau of School Health, Baltimore City Health Department
4. Sean Bulson, Public Schools Superintendents Association of Maryland | Harford County Public Schools
5. Cathy Allen, Maryland Association of Boards of Education | Vice Chair, St. Mary's County Board of Education
6. Meredith McNerney, Maryland Association of Elementary School Principals | Gaithersburg Elementary School
7. Arethusa Kirk, Managed Care Organization | Chief Medical Officer, United HealthCare Community Plan
8. Jennifer Dahl, Commercial Health Insurance Carrier | Credentialing Coordinator, CareFirst

In-Person Ex Officio

9. Cheryl De Pinto, Ex Officio Member | Director, MDH Population Health
10. Mary Gable, Ex Officio Member | Assistant State Superintendent, MSDE
11. Andrew Ratner, Ex Officio Member | Chief of Staff, Maryland Health Benefits Exchange
12. Mark Luckner, Ex Officio Member | Executive Director, Maryland CHRC
13. Lorianne Moss | CASBHC Staff

In-Person Public

14. Rick Robb, Principal, Patuxent Valley Middle School
15. Joan Glick, Senior Administrator, Health Services, Montgomery County DHHS
16. Sharon Hobson, Howard County Health Department
17. Rachael Faulkner, Director, Public Policy Partners

18. Alicia Mezu, MSDE
19. Corey Carpenter, MDH
20. Hannah Gaskill, Maryland Matters

On the Phone Appointee

21. Kelly Kesler, Parent/Guardian of student who receives SBHC services | Director, Howard County Local Health Improvement Coalition
22. Diana Fertsch, Maryland Chapter of American Academy of Pediatrics | Pediatrician, Dundalk Pediatric Associates

On the Phone Ex Officio

23. Sen. Clarence Lam, Ex Officio Member | Maryland State Senate, District 12 (Howard and Baltimore County)
24. Del. Bonnie Cullison, Ex Officio Member | Maryland House of Delegates, District 19 (Montgomery County)

1:00 PM Roll-Call (Chair: Kate Connor)

Kate Connor introduced Rick Robb, nominee for the Council position of Secondary Principal of a school that has an SBHC; and Lorianne Moss, new staff consultant.

1:10 PM Minutes from November 14, 2019 meeting

Cathy Allen moved to approve the meeting minutes. Jennifer Dahl seconded the approval. There were no oppositions or abstentions. The meeting minutes were approved.

1:15 PM Kirwan Commission Update (Rachel Faulkner)

Rachael Faulkner described MASBHC's efforts to shape the work of the Kirwan Commission.

1. The bill passed last year, SB 1030, the Blueprint for Maryland's Future, provides for a full-time healthcare practitioner in every school with 80% poverty. The governor's budget proposes a fulltime healthcare practitioner for schools with 70% poverty, likely encompassing additional schools. These are purely state dollars, without cost sharing by counties.
2. MASBHC's primary focus this year is on the Commission's recommendation to provide an additional $6.5 million for SBHCs through the existing MDSE grant process. This represents full funding of a promise made in the 1990s, plus inflation. The goal is for this funding to be available in the FY 2022 budget.

Legislation to implement the Kirwan Commission recommendations is expected this week or next. It will be at least 200 pages long. It is unclear whether it will originate in the House or Senate.

Meredith McNerney asked whether the additional funding would support existing SBHCs or be dedicated to establishing new Centers. Rachael said it is unclear, and anticipates stakeholder input in reviewing the grant-making process. Kate Connor observed that this may be an opportunity for the Council to offer recommendations.

Kate Connor asked Council members to share information about the positions of their organizations on Kirwan legislation, in order to address any potential conflicts as the legislative process unfolds. Information provided in advance by Cathy Allen shows no current conflict with the positions of the Maryland Association of Boards of Education and the Council.

1:20 PM Legislative Update (Delegate Cullison and Senator Lam)

Delegate Cullison discussed two bills she is working on related to SBHCs.

1. She has proposed to create one staff position in MDH and one in MDSE whose sole responsibility would be oversight of SBHCs, in order to better coordinate agency efforts and activities. This was her ombudsmen's bill last year. She cited the Harbage Report as highlighting the need for such infrastructure to support SBHCs. She has spoken to the chairs of the Ways and Means and Appropriations Committees, as well as the respective Education Subcommittees, to encourage them to include this provision in their Kirwan legislation. If the bills do not contain her provision, she plans to introduce her legislation separately.
2. She has introduced legislation, HB 409, to require MDH to revise regulations to permit Medicaid reimbursement of SBHC providers beyond the provider types that currently may receive reimbursement for SBHC services. This legislation relates to the Council's work in providing recommendations on the Sustainable Sponsorship Model, as required by last year's Kirwan legislation, SB 1030. HB 409 will have a hearing on February 5th. Before that time, Cullison hopes to have the sustainable sponsorship report by MSDE and MDH that had been required by SB 1030.

Senator Lam agreed that the Kirwan legislation will be lengthy and will provide opportunities for Council input. He said upcoming legislation related to health data sharing and telehealth also could be opportunities for the Council to offer recommendations.

1:35 PM Discussion of Council's role (Kate Connor)

Kate Connor thanked both legislators and reiterated that the Council's role is to provide information and make recommendations on legislation, but not to lobby or advocate for bills. The Council should be poised to respond to requests, and to describe how legislation does or does not align with Council recommendations.

Kate Connor instructed Workgroups to develop plans for 2020 by prioritizing items from the Council's recommendations related to the Harbage Report.

1:45 PM Workgroups: Break-out

Workgroups broke out to discuss priorities for 2020.

2:15 PM Workgroups Report-out

Quality and Best Practices (QBP) Workgroup (Co-Chairs: Patryce Toye and Jean-Marie Kelly) The QBP Workgroup will focus on efforts to update SBHC standards (annual report recommendation 5A). Dr. Toye noted that MSDE has provided MASBHC a small grant to begin to look at the standards. This will be particularly important if the Kirwan legislation results in an expansion of the number of SBHCs in Maryland.

The QBP group had some concerns about annual report recommendation 5B related to performance measurement incentives, and favored aligning the goals of SBHCs with Medicaid and state goals.

The QBP group believes recommendation 5D, concerning site-specific identifiers for SBHCs, would be easy and inexpensive to accomplish. Cathy Allen suggested this could be part of telehealth legislation.

Data Workgroup (Chair: Joy Twesigye)

The Data Workgroup plans to focus on recommendation 4, regarding data planning, collection, analysis, reporting, and evaluation. The group will look in particular at recommendation 4Aii, relating to the development of a data collection platform. Such efforts go hand-in-hand with the development of MOUs on information sharing, as mentioned in recommendation 1A.

Kate Connor encouraged all Workgroups to enumerate the support needed to operationalize their recommendations.

Systems Integration and Funding (SIF) Workgroup (Chair: Maura Rossman; Kate Connor filled in) The SIF Workgroup proposed to focus on recommendation 2, regarding central infrastructure support and funding. They also will work on recommendation 1 as it involves data sharing, possibly using CRISP, for the purpose of coordination of care. They will not work on recommendation 3, regarding additional funding sources, pending the outcome of the Kirwan legislation. Additionally, they will work on recommendation 8, related to barriers to information sharing arising from FERPA and HIPAA.

2:45 PM Agency Update on Sustainable Sponsorship Model (Cheryl De Pinto and Mary Gable)

Agency representatives to the Council confirmed that the response to the Sustainable Sponsorship Model required by SB 1030 is awaiting final approval. Broad consensus exists among many stakeholders for the response they propose.

Kate Connor noted that Del. Cullison's bill causes some urgency for the agencies to complete their work. Rachael Faulkner noted that considerable delay can occur between a report's submission to DLS and its posting on-line, and asked that the report be shared as soon as possible.

2:50 PM Survey Update (Mary Gable and Alicia Mezu)

The updated SBHC survey is nearing completion. The MSDE technician will be attending the meeting of SBHC Administrators in February to demonstrate it and identify whether additional changes are needed.

Cathy Allen pointed out some minor corrections that the survey needs. Joanie Glick offered to review the survey. Mary Gable suggested that substantive changes to the survey be postponed until the latest version is completed.

3:00 PM Adjourn

Kate Connor adjourned the meeting at 3:00 PM.

STATE OF MARYLAND

Community Health Resources Commission

45 Calvert Street, Room 336 • Annapolis, Maryland 21401

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Elizabeth Chung Chair – Mark Luckner, Executive Director

Council on Advancement of School-Based Health Centers Telecon via Google HangOuts MINUTES

Tuesday, April 14, 2020
9:00 AM-11:30 AM

Attendees / Roll-Call

Appointee Membership

1. Katherine Connor, CASBHC Chair | Medical Director, Johns Hopkins Rales SBHC, KIPP Baltimore
2. Patryce Toye, Maryland Assembly on School-Based Health Care | Medical Director, MedStar Family Choice
3. Joy Twesigye, Maryland Assembly on School-Based Health Care | Bureau of School Health, Baltimore City Health Department
4. Sean Bulson, Public Schools Superintendents Association of Maryland | Harford County Public Schools
5. Cathy Allen, Maryland Association of Boards of Education | Vice Chair, St. Mary's County Board of Education
6. Jean-Marie Kelly, Maryland Hospital Association | Senior Program Manager, Population Health, Christiana Care Health System
7. Arethusa Kirk, Managed Care Organization | Chief Medical Officer, United HealthCare Community Plan
8. Rick Robb, Secondary School Principal with SBHC |Principal, Patuxent Valley Middle School
9. Jennifer Dahl, Commercial Health Insurance Carrier | Credentialing Coordinator, CareFirst
10. Kelly Kesler, Parent/Guardian of student who receives SBHC services | Director, Howard County Local Health Improvement Coalition

Ex Officio

1. Del. Bonnie Cullison, Ex Officio Member | Maryland House of Delegates, District 19 (Montgomery County)
2. Mary Gable, Ex Officio Member | Assistant State Superintendent, MSDE
3. Andrew Ratner, Ex Officio Member | Chief of Staff, Maryland Health Benefits Exchange
4. Mark Luckner, Ex Officio Member | Executive Director, Maryland CHRC
5. Lorianne Moss | CASBHC Staff

Public

1. Joan Glick, Senior Administrator, Health Services, Montgomery County DHHS
2. William "Mike" Shaw, St. Mary's County Health Department
3. Rachael Faulkner, Director, Public Policy Partners
4. Alicia Mezu, MSDE

5. Kristi Peters, MSDE
6. Lynne Muller, MSDE
7. Sharon Hobson, Howard County Health Department
8. Nicole Mair, University of Maryland Baltimore Medical School

9:00 AM Roll-Call (Lorianne Moss)

Kate Connor announced that CASBHC member Karen Williams has passed away.

9:15 AM Minutes from January 27, 2020 meeting

Patryce Toye moved to approve the January meeting minutes. Del. Cullison seconded the approval. There were no oppositions or abstentions. The meeting minutes were approved.

9:20 AM Legislative Update

Del. Cullison expressed thanks for the work of all in demonstrating the value of SBHCs, and shared relevant legislative victories for SBHCs.

1. Her provision to create positions dedicated to SBHCS at both MSDE and MDH was included in the final version of the Kirwan/Blueprint for Maryland's Future legislation as "primary contact employees." However, given the state budgetary crisis related to COVID-19, everything is now "in limbo," including the Kirwan bill, which passed both chambers but has not been signed into law by the governor. Del. Cullison was hopeful that pieces of the Blueprint bill will be funded, although likely not at the level she and others had hoped. She hoped SBHCs would be seen as an asset and a resource especially during times of need.
2. Her bill to expand MMAP reimbursement for different kinds of SBHC sponsors also passed and awaits action by the governor.

Rachael Faulkner described two additional elements of the Blueprint bill relevant for SBHCs. As above, uncertainties about the fate of the Blueprint bill make it difficult to project the outcome of these measures.

1. $6.5 million in additional grant funding per year through the existing MSDE grant program, which represents the first substantial increase for SBHC grants since the 1990s. This is supposed to take effect beginning in FY 2021.
2. Last year's Blueprint bill provides for a full-time healthcare practitioner in every school with 80% poverty. The Governor's budget brought that level to 75%, encompassing more schools. This year's Blueprint bill eventually would bring the number to 55%.

Rachael Faulkner explained that if the governor vetoes the Kirwan bill, the General Assembly would need to meet in a special session in order to override that veto. If a special session is not held, the SBHC grant funding could not be increased by July 1, the first day of FY 2021.

Del. Cullison explained that May 15 is the deadline for the governor to sign, veto, or allow the Blueprint to pass without his signature. One possibility is that the Blueprint bill could end up having a one-year delay. It is unclear whether a special session will be held.

Kate Connor stressed the importance of keeping SBHCs on the radar screen during the COVID-19 emergency in order to maintain the safety net for vulnerable children and families.

Mark Luckner briefed the Council on another provision included in the Blueprint bill: a 20-member

Consortium on Coordinated Community Supports. This Consortium will develop a framework for creating coordinated community supports to address behavioral health in schools. The Chair of CASBHC will appoint one consortium member, and CASBHC members are invited to get involved in the Consortium's work in other ways. Del. Cullison shared that during her visits to SBHCs and schools, she observed a strong desire to do more around the issue of behavioral health.

9:45 AM Agency Update: Primary Contact Employees and Grant Dollars (Mary Gable)

Kate Connor asked representatives from MSDE and MDH to update the Council on their planning related to the previously discussed Blueprint provisions.

Mary Gable explained that the "primary contact employee" language in the Blueprint bill requires MSDE to "designate" such employees, but doesn't necessarily provide funding for them. As such, MSDE may interpret this to relate to *existing* staff rather than the hiring of new staff.

As for the increased grant dollars, Mary said MSDE is "delighted." They hope to offer the grant funding to a larger number of SBHC, and would like to work with CASBHC on recommendations to this end.

Rachael Faulkner stressed the MASBHC's interpretation of the "primary contact employee" language was that new positions be funded out of the additional $6.5 million. Del. Cullison also emphasized that the legislative intent was for two additional positions, something she communicated clearly in her discussions with committee chairs. She offered her assistance to convey this message to relevant administration officials making determinations about the language. Kate Connor also suggested that CASBHC may weigh in on this.

Lynne Muller said that MSDE's regular annual grant application process was up and running, and said she plans to present it at the April 30 SBHC Administrators meeting. She noted that it is not an RFP process, but rather an "application," since the same group of sponsors are eligible year after year.

Kate Connor asked whether applicants and MSDE might begin to plan for an expanded process "just in case" the additional funding becomes available in July. Mary Gable responded that legally MSDE can only release an RFP if funding is secure.

Joy Twesigye asked whether the COVID-19 crisis presents an opportunity to rethink the SBHC grant model. Arethusa Kirk echoed that schools are already playing a new role in community food distribution and wondered whether SBHCs might pivot to a larger role in COVID-19 response such as in a future mass vaccination campaign.

Kate Connor suggested MSDE undertake a statewide needs assessment to inform its grant-making process, particularly as schools transition to a "new normal."

10:20 AM Agency Update: Survey and Standards Update (Mary Gable and Lynne Muller)

Lynne Muller said MSDE plans to release the new survey by early May. The release will include a webinar to help SBHCs complete the survey. Data from 2018-2019 will be collected to the best of SBHC abilities. Then, later in the year, the 2019-2020 survey would be distributed.

Mary Gable said MSDE is preparing a job description for someone to update the standards. In order to move expeditiously, this person would need to come from another agency. Del. Cullison asked about the work CASBHC's QBP workgroup began with the SBHC Administrators related to the Standards. Lynne said this information is helpful, but it is just one piece that needs to be considered in the new standards.

Joan Glick and Patryce Toye asked why MASBHC isn't eligible to do this work. Lynne said certain legal and procurement restrictions led to a determination that MASBHC could not work on this.

10:40 AM Break

10:45 AM Discussion re: SBHC role during pandemics (Kate Connor)

Kate Connor led a discussion about the role SBHCs are playing, and could play, during the COVID-19 crisis. She walked Council members through a table the SIF workgroup prepared that begins to catalogue the resources that SBHCs can bring to the crisis, both in terms of continuity of care and in direct response.

Alicia Mezu noted that MSDE has asked SBHCs to tell MSDE what they currently are doing.

Dorchester responded that they are doing mental and somatic health services via telehealth, but that they were challenged in providing contraceptive services. Baltimore County responded that all SBHC clinics closed, and providers are working with health department doing intake, clinic screenings, and potentially testing. Baltimore County also reported challenges in communicating with students privately regarding ongoing family planning and pending lab screening. Kate replied that KIPP in Baltimore is providing continuity of care via video and telephone, and that Joanie Glick would say the same for Montgomery County.

Kate Connor introduced medical student Nicole Mair, who is preparing a survey to SBHCs to find out what they currently as doing. This work will help to inform potential CASBHC recommendations related to COVID-19 and future public health emergencies. Lynne urged that this work be coordinated with the QBP workgroup's proposed EMR survey, so as to avoid survey fatigue.

Kate Connor said that pediatric practices are trying to restrict their offices only to patients under the age of two for vaccines.

Rick Robb noted that some SBHCs are doing a good job of reaching out to provide mental health services.

Due to the lack of time, Kate Connor proposed forming an ad-hoc workgroup on pandemic recommendations. Members are encouraged to reach out to Kate, Mark, and Lorianne if they are interested in being part of this.

11:25 AM Workgroups Update

Data Workgroup (Chair: Joy Twesigye). The Data workgroup is focused on big picture data infrastructure technology. This may influence the SBHC standards. This work may also dovetail with the behavioral health Consortium's mandate to develop and analyze metrics.

QBP Workgroup (Co-Chairs: Patryce Toye and Jean-Marie Kelly). The QBP workgroup's top priority is the standards revision. Next, the group wants to investigate measuring quality scores, and as such is working on the EMR survey.

SIF Workgroup (Chair: Maura Rossman is occupied with COVID; Kate Connor is filling in). The SIF workgroup put together recommendations related to the Diabetes Action Plan, but these are now low priority. The SIF group views the COVID-19 response as another opportunity to demonstrate the value of SBHC integration into the bigger state public health infrastructure, and will work with the ad-hoc group to continue to formulate SBHC pandemic recommendations. SIF will now place a priority on ensuring

the primary contact employee positions are new PINs, and that standards updates and a statewide needs assessment be conducted in concert with the increase in SBHC grant funding.

11:35 AM Adjourn

Kate Connor adjourned the meeting at 11:35 AM.

The Blueprint for Maryland's Future:

Key Provisions of Interest for CASBHC

1. SBHC Grant Funding. The legislation increases grant dollars for MSDE's existing school-based health center grant program. This funding will be available for both existing SBHCs and new SBHCs. Beginning in FY 2021, the total funding level will rise to $9 million per year from the current $2.5 million per year. MSDE retains discretion on how to award this money.

2. Agency Staffing. MSDE and MDH must each designate a "Primary Contact Employee" for SBHC matters. Contact employees are to provide technical assistance to new and existing SBHCs and to coordinate efforts with the other agency. The provision was added an amendment by Del Cullison, based on her SBHC Ombudsmen bill. The intent is to ensure additional staffing and better coordination between agencies.

3. Concentration of Poverty Grants. Under the legislation, high-poverty schools will receive special grant funding and become Community Schools. Community Schools must provide full-time coverage by at least one health care professional. Each Community School must conduct a needs assessment to determine the physical, behavioral, and mental health needs and wraparound service needs of students, families, and communities. Among the wraparound services a Community School may consider is the establishment or expansion of SBHCs. In other words, Concentration of Poverty Grants *may* be used to support SBHCs, but this depends on the school.

4. Behavioral Health Consortium. The legislation creates a new Consortium on Coordinated Community Supports, related to behavioral health. It has 20 members, representing a variety of organizations, one of whom would be a member of CASBHC appointed by the CASBHC Chair. Like CASBHC, it will be staffed by CHRC. Technical Assistance will be provided by the National Center for School Mental Health at UMB. The Consortium shall:

- develop a framework for the creation of Coordinated Community Supports Partnerships (CCSP) to provide services to meet students' behavioral health needs;
- design a model involving reimbursement, hospital community benefit, and other financial footing for such services;
- establish and implement a CCSP grant program to deliver services;
- develop best practices for a positive classroom environment;
- evaluate relevant regulations related to a positive classroom environment;
- develop accountability metrics coordinated through the Maryland Longitudinal Data Center; and
- use these metrics to guide the development of best practices for CCSPs.

CCSP grant program funding is: $25 million in FY 2022, $50 million in FY 2023, $75 million in FY 2024, $100 million in FY 2025, and $125 million in FY 2026 and beyond.

NOTE: In light of recent economic uncertainties, a provision was added to the bill stipulating that if state revenues drop by 7.5% in a given year, the bill's provisions would be put on hold and increases to education spending would be limited to the rate of inflation.

STATE OF MARYLAND

MCHRC
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Community Health Resources Commission
45 Calvert Street, Room 336 • Annapolis, Maryland 21401

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Elizabeth Chung Chair – Mark Luckner, Executive Director

Council on Advancement of School-Based Health Centers Telecon via Google HangOuts MINUTES

Monday, July 13, 2020
10:00 AM-1:00 AM

Attendees / Roll-Call

Appointee Membership

1. Katherine Connor, CASBHC Chair | Medical Director, Johns Hopkins Rales SBHC, KIPP Baltimore
2. Patryce Toye, CASBHC Vice Chair, Maryland Assembly on School-Based Health Care | Medical Director, MedStar Family Choice
3. Joy Twesigye, Maryland Assembly on School-Based Health Care | Bureau of School Health, Baltimore City Health Department
4. Joan Glick, Maryland Assembly on School-Based Health Care | Senior Administrator, Health Services, Montgomery County DHHS
5. Cathy Allen, Maryland Association of Boards of Education | Vice Chair, St. Mary's County Board of Education
6. Sean Bulson, Public Schools Superintendents Association of Maryland | Harford County Public Schools
7. Jennifer Dahl, Commercial Health Insurance Carrier | Credentialing Coordinator, CareFirst
8. Jean-Marie Kelly, Maryland Hospital Association | Senior Program Manager, Population Health, ChristianaCare
9. Kelly Kesler, Parent/Guardian of student who receives SBHC services | Director, Howard County Local Health Improvement Coalition
10. Arethusa Kirk, Managed Care Organization | Chief Medical Officer, United HealthCare Community Plan

Ex Officio

6. Del. Bonnie Cullison, Ex Officio Member | Maryland House of Delegates, District 19 (Montgomery County)
7. Sen. Clarence Lam, Ex Officio Member | Maryland State Senate, District 12 (Howard & Baltimore City)
8. Mary Gable, Ex Officio Member | Assistant State Superintendent, MSDE
9. Cheryl De Pinto, Ex Officio Member | Director, Population Health, MDH
10. Andrew Ratner, Ex Officio Member | Chief of Staff, Maryland Health Benefits Exchange

11. Mark Luckner, Ex Officio Member | Executive Director, Maryland CHRC
12. Lorianne Moss | CASBHC Staff

Public

1. Benjamin Wolff, Medicaid Provider Services, MDH
2. Alicia Mezu, MSDE
3. Kristi Peters, MSDE
4. Lynne Muller, MSDE
5. Scott Tiffin, Chief of Staff, Office of Sen. Lam
6. Pam Kasemeyer, Managing Partner, Schwartz, Metz, and Wise, PA
7. Rachael Faulkner, Director, Public Policy Partners
8. Nolan O'Dowd, MedStar Family Choice
9. Evie Frankl
10. Nicole Mair, University of Maryland Baltimore Medical School

10:00 AM Roll-Call (Lorianne Moss)

10:10 AM Minutes from April 14, 2020 meeting

Cathy Allen moved to approve the April meeting minutes. Jean-Marie Kelly seconded the approval. There were no oppositions or abstentions. The meeting minutes were approved.

10:15 AM Legislative Update

Del. Cullison stated that the legislature has been focused on the COVID-19 pandemic and the State budget. The Kirwan/Blueprint for Maryland's Future education reform legislation was vetoed by the Governor. A special session is unlikely. The legislature is not expected to reconvene until January.

Sen. Lam added that the outlook for reconvening in January is also uncertain. He is a member of the Joint COVID-19 Response Legislative Workgroup, which meets every other week.

The Council discussed the veto of the Kirwan/Blueprint legislation, which had contained several provisions important for the Council's work. Legislators restated their commitment to the bill, noting that it may be modified in any future iteration. Kate Connor observed that the COVID-19 pandemic highlights more than ever the need to bolster health care in schools, as the legislation aimed to do. Cheryl De Pinto suggested that future work on the Kirwan bill apply more of a public health perspective. Sen. Lam agreed that policies should seek to better integrate SBHCs into the work of Local Health Departments, including through information sharing. Kate Connor suggested that the draft Pandemic Recommendations being developed by CASBHC could help to focus this work.

10:30 AM Agency Updates: Annual Survey and Standards Revision (Mary Gable)

Mary Gable and Lynne Muller briefed the Council on MSDE's efforts to hire an outside contractor to revise the SBHC standards. The RFP has been approved and entered into the system. It now awaits action by MSDE's Procurement Office. MSDE staff will notify the Council when the procurement is posted. MSDE intends for a contractor to be hired and the work to begin in late August, with a goal of completing the work by December, at which point MSDE will review the contractor's proposal.

Del. Cullison urged MSDE to plan for on-going revisions after this effort is completed. Jean-Marie Kelly applauded MSDE's steps forward on the standards. Kate Connor thanked the QBP workgroup, led by Jean-Marie Kelly and Patryce Toye, for its efforts on the standards.

Mary Gable and Lynne Muller told the Council that the updated annual survey of SBHCs has been released to Administrators. Because it took two years to update and reformat the survey, this version requests data from the 2018-2019 school year. The deadline for completion of the survey has been extended to September or October, since school buildings are closed. After this survey has been completed, Administrators will be asked to fill out the survey for the 2019-2020 school year, which also will be completed in the fall.

Kate Connor commended MSDE for putting out the survey and asked about the plan for sharing results and data with stakeholders. Lynne Muller suggested MSDE may be prepared to share reports generated by the survey at the SBHC Administrators meeting in spring 2021. Del. Cullison suggested MSDE utilize the Department of Information Technology (DoIT) to streamline their data analysis.

10:40 AM Agency Updates: Financial Sponsorship regulatory change (Ben Wolff)

Ben Wolff briefed the Council on Maryland Medicaid's plans for updating Maryland regulations to permit Medicaid reimbursement for different kinds of SBHC sponsors, as required by HB 409. The plan is to add two additional provider types: Physician Groups and Nurse Practitioner Groups. The effect of this change would be to allow hospitals and others to be SBHC sponsors, as they would bill Medicaid through these kinds of groups. The draft regulations are being put together now, with a notice of proposed action in the next couple weeks. Maryland Medicaid also will need to modify its enrollment system.

Cheryl De Pinto said that MDH had recommended certain safety net criteria for SBHC sponsors. Ben Wolff responded that such criteria would be out of place in Medicaid regulations. Because there are no other COMAR regulations around SBHCs, Lynne Muller and Cheryl De Pinto discussed including these provisions in the SBHC standards. Ben Wolff suggested that SBHCs should have COMAR regulations apart from Medicaid. Del. Cullison said she may look into this, and Rachael Faulkner suggested the 2019 Kirwan bill as a possible statutory basis for such regulations. Kate Connor reminded participants that the Council submitted a letter last year with recommendations regarding SBHC sponsorship, and offered to provide additional feedback and assistance if needed.

11:00 AM Agency Updates: Telehealth (Cheryl De Pinto and Mary Gable)

Kate Connor asked Cheryl De Pinto and Mary Gable to discuss issues surrounding SBHCs transitioning to telehealth due to COVID-19 closures. Cheryl De Pinto said that expanded authorities and reimbursement for telehealth will continue until 30 days after the end of the Governor's State of Emergency.

Mary Gable said that in a non-COVID situation, authorization for telehealth for SBHCs requires a simple check list and a site visit. Lynne Muller said that MSDE did not deny any SBHC that wished to transition to telehealth authorization to do so. Cheryl De Pinto discussed different models for telehealth. Kate Connor observed that the different types of telehealth and different approval processes for different situations had led to some confusion among SBHC administrators and sponsors. Rachael Faulkner noted that FQHCs were able to switch to telehealth without additional hurdles, and that MDH has provided clear guidance on telehealth. Behavioral health services also were able to switch to telehealth with

relative ease. She said MSDE has not provided guidance on telehealth for SBHCs, and that many questions remain.

11:20 AM Discussion of Pandemic Recommendations (Kate Connor)

Kate Connor began a discussion of recommendations the Ad-Hoc Pandemic Workgroup has developed related to SBHCs and school closures/public health emergencies.

Cheryl De Pinto raised concerns about the document's recommendations related to continuity of care, noting that different sponsor types have different abilities. Joy Twesigye and Joanie Glick discussed some of the unused capabilities of their SBHCs potentially to provide care despite closures.

Mary Gable raised concerns about the document's recommendations related to allowing building access for SBHCs. Lynne Muller and Mary Gable raised concerned about the document's recommendations related to telehealth, particularly ambiguity about whether these recommendations intended to address telehealth authorization only during emergencies, or also during normal operations.

11:40 AM Break

11:45 AM Continued discussion of Pandemic Recommendations (Kate Connor)

Cathy Allen suggested modifications to the document's telehealth section to address some of the Agencies' concerns. Kate Connor and Cheryl De Pinto summarized some of the previous discussion about different kinds of telehealth requiring different steps for authorization. Del. Cullison and Patryce Toye suggested that this should be clarified for SBHCs. Sean Bulson observed that the issue may have been one of perceived rather than actual barriers to telehealth, and a lack of clarity as to when additional authorization is needed and when it is not.

Regarding building access, Cathy Allen suggested that SBHCs with external entrances might be more conceivable for use during school closures than those that do not have separate entrances. Patryce Toye stressed that, moving forward, there should be a plan in advance as to how school buildings could be accessed by SBHCs in the event of closures. Sean Bulson said that local superintendents will want to have a say regarding building access of SBHCs, and observed that SBHC operations may be a worthy exception to building closure rules, akin to kitchen use. Joanie Glick added that Special Education services also have been permitted in otherwise closed school buildings.

Kate Connor summarized the conversation and told Council members she will distribute a modified version of the Pandemic Recommendations document for electronic vote.

12:30 PM Workgroups Update

QBP Workgroup (Co-Chairs: Patryce Toye and Jean-Marie Kelly). The QBP Workgroup's top priority has been the standards revision, and the workgroup is delighted that MSDE is making progress on hiring a contractor. Now, the group is beginning to look to a future state when SBHCs will be able to provide electronic quality measures. The Workgroup has developed a brief questionnaire to assess readiness for such measures, focusing on electronic medical records. Lynne Muller said the questionnaire is short and focused and will not add to "survey fatigue" among SBHC administrators. Once the questionnaire is complete, the Workgroup intends to turn these findings into recommendations about infrastructure and communications related to quality measures.

Data Workgroup (Chair: Joy Twesigye). The Data Workgroup intends to build upon MSDE's updated SBHC survey by looking into platforms to host and ultimately analyze the data. After several webinars with experts, the Workgroup is considering the capabilities of Maryland's Open Data Portal, which many state agencies already use. The Workgroup needs to work through some details and hopes to have recommendations prepared for the full Council's next meeting. Cheryl De Pinto said MDH has worked with Open Data Portal. Del. Cullison said that DoIT is a valuable resource and should be utilized. She urged that cost not stand in the way. Lynne Muller agreed that cost should not be prohibitive.

SIF Workgroup (Chair: Maura Rossman is occupied with COVID; Kate Connor is filling in). Earlier this year, the SIF Workgroup put together recommendations related to the State's Diabetes Action Plan, as an example to shed light on the bigger issue of SBHC integration into public health systems. Kate Connor will circulate those recommendations for comments and an electronic vote after the meeting.

Having completed its work on the Pandemic Recommendations, the SIF Workgroup now is taking up the issue of information sharing, using COVID-19 test results as an example. The workgroup had a good discussion with Marc Rabner about CRISP capabilities to this end, and may reach out to other Workgroups to draw on their expertise as the work continues.

1:00 PM Adjourn

Kate Connor adjourned the meeting at 1:00 PM.

STATE OF MARYLAND

MCHRC
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Community Health Resources Commission

45 Calvert Street, Room 336 • Annapolis, Maryland 21401

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor

Elizabeth Chung, Chair – Mark Luckner, Executive Director

Council on Advancement of School-Based Health Centers Telecon via Google HangOuts MINUTES

Thursday, October 22, 2020
2:00 PM-5:00 PM

Attendees / Roll-Call

Appointee Membership

1. Katherine Connor, CASBHC Chair | Medical Director, Johns Hopkins Rales SBHC, KIPP Baltimore
2. Patryce Toye, CASBHC Vice Chair, Maryland Assembly on School-Based Health Care | Medical Director, MedStar Family Choice
3. Joy Twesigye, Maryland Assembly on School-Based Health Care | Bureau of School Health, Baltimore City Health Department
4. Joan Glick, Maryland Assembly on School-Based Health Care | Senior Administrator, Health Services, Montgomery County DHHS
5. Cathy Allen, Maryland Association of Boards of Education | Vice Chair, St. Mary's County Board of Education
6. Jennifer Dahl, Commercial Health Insurance Carrier | Credentialing Coordinator, CareFirst
7. Dr. Diana Fertsch, Maryland Chapter of American Academy of Pediatrics Member | Pediatrician, Dundalk Pediatric Associates
8. Jean-Marie Kelly, Maryland Hospital Association | Senior Program Manager, Population Health, ChristianaCare
15. Arethusa Kirk, Managed Care Organization | Chief Medical Officer, United HealthCare Community Plan
16. Rick Robb, Secondary School Principal with SBHC | Principal, Patuxent Valley Middle School
17. Maura Rossman, Maryland Association of County Health Officers Member | Local Health Officer, Howard County

Ex Officio

13. Del. Bonnie Cullison, Ex Officio Member | Maryland House of Delegates, District 19 (Montgomery County)
14. Sen. Clarence Lam, Ex Officio Member | Maryland State Senate, District 12 (Howard & Baltimore City)
15. Mary Gable, Ex Officio Member | Assistant State Superintendent, MSDE
16. Cheryl De Pinto, Ex Officio Member | Director, Population Health, MDH

17. Andrew Ratner, Ex Officio Member | Chief of Staff, Maryland Health Benefits Exchange
18. Mark Luckner, Ex Officio Member | Executive Director, Maryland CHRC
19. Lorianne Moss | CASBHC Staff

Public

20. Lynne Muller, MSDE
21. Alicia Mezu, MSDE
22. Kristi Peters, MSDE
23. Scott Tiffin, Chief of Staff, Office of Sen. Lam
24. Chris Daniels, Office of Sen. Lam
25. Pam Kasemeyer, Managing Partner, Schwartz, Metz, and Wise, PA

2:00 PM Roll-Call

2:05 PM Minutes from July 13, 2020 meeting (Kate Connor)

Cathy Allen requested page one of the minutes be corrected to say 1:00 PM rather than 1:00 AM. Cheryl De Pinto requested the spelling of her name be corrected throughout.

Cathy Allen moved to approve the July meeting minutes with those two changes. Jean-Marie Kelly seconded the approval. There were no oppositions or abstentions. The meeting minutes were approved.

2:10 PM Council Processes and Procedures (Kate Connor)

Kate Connor described new procedures to ensure review of documents prior to Committee meetings in order to make meetings more efficient.

1. Recommendations developed by workgroups will be circulated to Council members two weeks prior to Council meetings.
2. Council members are requested to provide written feedback within one week of receiving these materials.
3. Workgroup chairs and Council leadership will incorporate this feedback as appropriate.
4. Final recommendations will be circulated to Council members at least 48 hours prior to the meeting.
5. During Council meetings, voting and ex-officio members will have the opportunity to make comments for the record and raise concerns in order to inform the votes of Council members. Substantive changes beyond clarifications and factual corrections will not be permitted during Council meetings.
6. Pending a motion and second, a vote will be called. Recommendations that are voted down will return to workgroups.

2:15 PM Annual Report Update (Kate Connor and Lorianne Moss)

Kate Connor and Lorianne Moss discussed the Council's 2020 annual report. The report is due to the General Assembly by December 31, but must be approved by MDH first. The aim, then, is to complete the report around Thanksgiving time. The report will include an executive summary with a list of key Council deliverables, a summary of Council activities during 2020, recommendations and planning for

2021, a roster of Council members, Council meeting minutes, and approved recommendations. The annual report may be considered for a vote at a future Council meeting, or possibly considered by electronic vote.

The report also is required to include several data points about Maryland SBHCs to be provided by MSDE. Because of the survey redesign process, last year's report did not include this data. The goal is for this year's report to include data from the 2018-2019 school year; this will depend on MSDE's ability to complete the survey and extract the needed data. Data from the 2019-2020 survey may be submitted to the legislature as a mid-year addendum.

Delegate Cullison suggested that the annual report stress the Council's recommendations to add dedicated staff for SBHCs at MSDE and MDH, and to increase grant funding for the program.

2:25 PM Pandemic Recommendations Update (Kate Connor and Lorianne Moss)

Kate Connor and Lorianne Moss said that the Council's recommendations related to the role of SBHCs during COVID-19 and other public health emergencies were approved 13-0, as of July 24, by electronic vote. They have been disseminated to relevant agencies and to legislators, and posted on the Council's website. Two ex-officio members, Delegate Cullison and Senator Lam, also had recorded support for the recommendations. Several members, while voting in favor of the recommendations, also had requested that the Council continue to work on the issue of telehealth. The Council's Quality and Best Practices Workgroup is continuing this effort.

Delegate Cullison, Kate Connor, and Lorianne Moss presented the recommendations at the Maryland Rural Health Association's virtual conference on Monday, October 19. The conference was an opportunity to highlight both the recommendations and the Council's work. Delegate Cullison observed that the Council helps to demonstrate the value of SBHCs by participating in events which raise awareness of them.

2:30 PM Diabetes Actions Plan Recommendations (Kate Connor)

Kate Connor reminded Council members that the Systems Integration and Funding Workgroup had approved recommendations related to SBHCs and implementation of the State's Diabetes Action Plan prior to COVID-19, but held back in order to allow the Council to focus on activities related to the pandemic. These recommendations are intended to illustrate how SBHCs can be integrated into state level public health goals.

Diana Fertsch asked about the recommendations' omission of endocrinologists. Kate Connor and Patryce Toye responded that the document refers to the statewide Diabetes Action Plan public health initiative, not an individuals' diabetes action plan, which can lead to confusion. Cathy Allen moved that the recommendations be approved with a footnote to reference the State's plan and include the clarification. Patryce Toye seconded the motion. There were no oppositions or abstentions. Ex-officio members Delegate Cullison and Senator Lam also expressed support for the recommendations. The recommendations were approved. Approved recommendations will be circulated to Council members with the added footnote.

2:45 PM Data Platform Recommendations (Kate Connor and Joy Twesigye)

Joy Twesigye shared the Data Workgroup's recommendations for a public facing platform for SBHC data, building upon previous discussions and MSDE's revised survey. Lynne Muller thanked workgroup leadership for modifying its previous draft to emphasize the need for such a strategy to be approved through MSDE's approval processes. Mary Gable committed to moving forward on data, recognizing the hard work of MSDE staff to redesign the annual survey, and observing that it will be easier to talk with MSDE leadership about next steps once they have actual survey data. Rick Robb complimented the document's listing of specific data points that are already public. Delegate Cullison commended the effort to move toward analysis and harvesting of survey data. Kate Connor observed that SBHC administrators provide a lot of data, and will be gratified when they are able to see their data being used.

Cheryl De Pinto observed that the document should refer to the "Open Data Portal" rather than "Open Data Platform." Cathy Allen suggested that the document should spell out the acronym SHIP, which refers to the State Health Improvement Process. Cathy Allen moved that the recommendations be approved with technical corrections related to "Open Data Platform" and "State Health Improvement Process." Rick Robb seconded the motion. There were no oppositions or abstentions. The recommendations were approved. Approved recommendations will be circulated to Council members with the technical corrections.

3:00 MSDE Updates (Mary Gable and Lynne Muller)

Lynne Muller said that the redesigned annual survey for 2018-2019 has been sent to SBHC Administrators and will close on November 1. MSDE will review the data and the survey mechanics, adjusting as necessary, then aims to send the 2019-2020 survey to SBHC Administrators during December. MSDE will try to provide the 2018-2019 data needed for the Council's annual report.

Regarding the procurement of a contractor to work on revising the SBHC standards, Lynne Muller said a second solicitation has been posted, and will close on October 28. This contract would run from November 15 through June 30. Responding to a question from Delegate Cullison, Mary Gable explained that the previous solicitation had resulted in bids that were too high, and applauded the creativity of MSDE staff in modifying the solicitation and identifying other possible sources of funds.

Lynne Muller and Alicia Mezu noted that the SBHC Administrators met on Monday, October 19. News SBHCs may be opening soon, including in Worcester, Somerset, and St. Mary's. Cathy Allen discussed funding concerns surrounding the St. Mary's SBHC project. Mark Luckner observed that the Community Health Resources Commission's 2021 Request for Proposals could be a source of grant funding for SBHCs. Kate Connor said she was glad to see interest in opening additional SBHCs and would like to know what has prompted this interest. Delegate Cullison said these developments highlight the need for additional staff at MSDE and MDH dedicated exclusively to the SBHC program.

3:20 PM Legislative Update (Senator Lam and Delegate Cullison)

Senator Lam said the General Assembly may vote to override the Governor's veto of the Kirwan Blueprint for Maryland's Future education reform bill, which contains provisions to increase central agency staffing and funding for SBHCs. He said several legislators reached out to his office to support the Council's pandemic recommendations. During the upcoming session, he anticipates further legislation on telehealth, particularly regarding reimbursement. Due to COVID-19, the 2021 session

will look very different than previous years, with Committee work done mostly online, limits to the number of bills Senators can introduce, and socially distanced in-person floor sessions that would not occur every day.

Delegate Cullison said that while the House has not set bill limits yet, Delegates have been urged to focus on bills relevant to the COVID-19 pandemic. The House Health and Government Operations Subcommittee, on which she serves, will focus on telehealth. She will continue to advocate for the added staff and funding for SBHCs contained in the Kirwan bill, and will reference the apparently increasing demand for SBHCs. Kate Connor asked Council members to be sure to share the Council's pandemic recommendations with their member organizations in anticipation of the legislative session.

3:30 PM Discussion of Council Structure (Kate Connor and Patryce Toye)

Kate Connor and Patryce Toye said the Council may wish to reconsider the structure of its workgroups in light of several factors. New priorities have emerged for the Council, particularly due to the COVID19 crisis. Some issues do not fit neatly into a single workgroup. Some Council members have expertise needed for activities in more than one workgroup, which is time-consuming. Patryce Toye said the Council may wish to periodically brainstorm about its top priorities and rethink its structure accordingly. For example, in 2021, the Council may wish to prioritize helping the new SBHCs launch. Kate Connor suggested that another approach could involve the entire Council selecting a priority issue, then splitting it up among the three workgroups.

Cathy Allen said the guiding principles behind the Council's three workgroups are still applicable, and that breakout sessions during in-person meetings had been helpful. Delegate Cullison said that while self-evaluation is beneficial, she felt that the three workgroups still make sense, and wondered whether the issue was lack of time rather than inappropriate structure. Rick Robb suggested taking an inventory of each Council member's expertise. Kate Connor said a vision statement might help to clarify these issues, and that this conversation will continue.

3:55 PM Break

4:05 PM Telehealth Discussion (Kate Connor and Cheryl De Pinto)

Kate Connor reminded Council members that the Ad-Hoc Pandemic Workgroup had included specific recommendations related to telehealth in its earlier draft of the pandemic recommendations. Further discussion revealed that these recommendations needed to better align with existing practices. As a result, the telehealth recommendations ultimately approved in the Council's pandemic recommendations were broad. The Council's Quality and Best Practices Workgroup then began a more thorough effort to review documents, including MASBHC's policy statement, and to meet with stakeholders regarding telehealth use by SBHCs. The workgroup has prepared a document for this meeting to help Council members understand its thought process. Because legal and regulatory questions are still outstanding, this document will not be brought for a vote.

Cheryl De Pinto said that both agencies recognize the importance of telehealth for SBHCs. She explained the current telehealth approval process, which involves a checklist. While telehealth exists in various forms, involving different locations for originating (patient) and rendering (provider) sites, the model of home-to-home telehealth services presents the greatest concern, in part because of restrictions

related to Medicaid reimbursement. MDH and MSDE are working with their Attorneys General to address agency concerns about safety and liability.

Kate Connor noted that home-to-home telehealth was not envisioned when the SBHC telehealth checklist was developed. Diana Fertsch discussed her practice's positive experience with telehealth. She added that children are struggling because they are not in school due to the pandemic, and urged that progress be made to reach SBHC patients via telehealth. Cheryl De Pinto agreed with this concern for children, and said the agencies are moving quickly to approve telehealth that involves the school as either the originating or rendering site. She acknowledged a communication disconnect between the agencies and SBHC administrators regarding the steps needed to authorize telehealth. She said a recent test with Worcester County revealed their equipment was not functioning, and that this demonstrates the need for continued agency oversight.

Joanie Glick stressed that home-to-home telehealth is the central issue for Montgomery County, because neither children nor SBHC staff are permitted in school buildings. Medicaid reimbursement is not a primary concern because the highest need children are uninsured. SBHCs in Montgomery County have been able to call patients, but would like to use video technologies. She said Montgomery County uses models of telehealth not covered by the workgroup's vision document.

Patryce Toye urged that barriers to home-to-home telehealth be resolved expeditiously, because COVID-19 cases have been on the rise and schools may be closed again by January. Cheryl De Pinto responded that the agencies hope to have an answer from their AGs by early next week, which may entail simply some additional procedures and consent for home-to-home telehealth.

Delegate Cullison observed that the agencies seem to view their oversight as relating to the school building rather than to the practitioners or to the SBHC as a medical practice. She said telehealth will continue to be important after schools reopen due to student absences. Diana Fertsch observed that in her practice, all telehealth visits begin with an explanation of the visit and consent to telehealth services. Billing relates to the originating site, not the rendering site. Joanie Glick said telehealth should not be viewed as a programmatic change, like adding a different service such as dental services, but rather as the same services provided through a different process, and therefore should not require additional authorization. Telehealth involving specialized equipment may require additional oversight, she added. Rick Robb noted that in his school, telehealth is being used for mental health services but not for somatic. Kate Connor said that the rendering location should not matter, because regardless of whether she is working at home or in her school's SBHC, no state agency is directly observing her.

Patryce Toye asked Joanie Glick to share with the workgroup the additional models of telehealth utilized in her jurisdiction. Kate Connor said the Council looks forward to learning the response from the AGs.

5:00 PM Adjourn

Kate Connor adjourned the meeting at 5:00 PM.

Appendix G

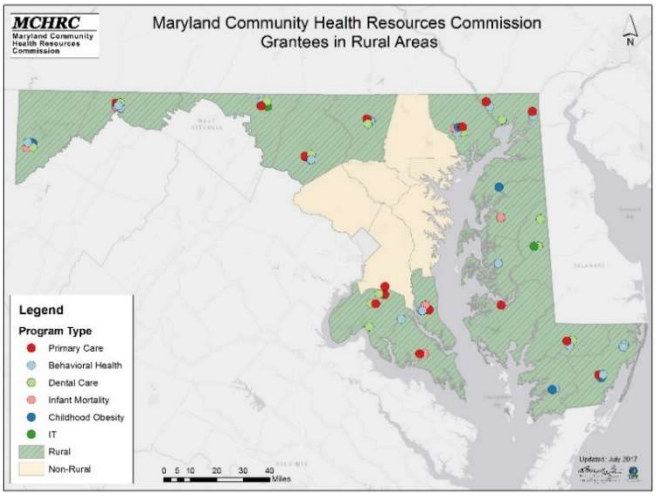
STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Room 336 • Annapolis, Maryland 21401

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Elizabeth Chung, Chair – Mark Luckner, Executive Director

January 29, 2021

Community Health Resources Commission: Grants Supporting Programs in Rural Communities

The CHRC has awarded 312 grants totaling $79.2 million. Of the 266 program grants, over half (138, $35.4 million) have supported programs that to-date have provided 120,459 residents access to primary care, behavioral health care, dental, women's health, childhood obesity and diabetes prevention and management services in the 18 rural jurisdictions of the state. These grants have provided start-up funding to enable safety net providers to increase their capacity and have supported innovative and replicable programs to address the social determinants of health for vulnerable rural populations. In FY2020, the CHRC also awarded 16 COVID-19 virus pandemic emergency grants to rural community health organizations and 14 grants to Local Health Improvement Coalitions (LHICs) serving all 18 rural counties to expand operational capacity and support local community initiatives aligned with the Maryland Diabetes Action Plan to improve diabetes prevention and diabetes management.



FY 2020 Grants (16)

The following 16 FY2020 grant programs are currently under implementation.

Salisbury-Wicomico Integrated First Care Team (SWIFT) City of Salisbury (20-001). This program supports expansion of the current CHRC funded Mobile Integrated Health/EMS diversion program in Salisbury, providing real time access to in-home primary and preventive care services and chronic disease management to Wicomico County residents outside the Salisbury City Fire District service area.

Frederick Health Hospital (20-002). This program supports and expands a care coordination service program for low-income seniors living in single-unit housing who present with complex health care and social service needs. The program will provide an array of services and care coordination to help these residents continue living at home and reduce avoidable hospitalizations through a partnership with the Frederick County Aging Department. This program could provide a useful blueprint for other jurisdictions to prepare for its aging population.

Somerset County Health Department (20-008). This program supports the opening a new School-based Wellness Center (SBWC) at Washington High School for students and staff. Many Washington High School students live in distressed neighborhoods and are at greater risk for negative outcomes including poor physical and mental health, delinquency, and high-risk sexual behavior. The SBWC will address several healthcare service delivery gaps, social determinants of health and health disparities. The CHRC has supported a number of SBHCs and currently staffs the Council on Advancement of SBHCs.

Corsica River Mental Health Services, Inc. (20-010). The Care Connections program supports a care transition team providing services to individuals following hospital discharge. The Care Connections Team conducts comprehensive health assessments and develops person-centered care plans within 2-3 days of discharge. The Team will use Motivational Interviewing, Illness Management Recovery, a Wellness Recovery Action Plan and Family Psychoeducation practices to initiate and maintain participant engagement. The program will use the GoMo Health Concierge mobile application to deliver personalized text messages about nutrition, health, exercise, and emotional support to encourage participants to proactively manage their care.

Choptank Community Health (20-011). This program funds the initiation of mental health services for vulnerable adults and children at the new Denton practice, in an underserved area for behavioral and substance use treatment. The new program will help promote integration of somatic and behavioral health services on-site rather than through a contractual partnership with an existing mental health provider. Choptank currently offers MAT at one other primary care practice and this grant will support future provision of SUD treatment at the Denton location.

Pressley Ridge (20-012). This program supports the HOMEBUILDERS model, which is an evidenced-based family preservation program serving families impacted by the opioid crisis who are referred by Child Protective Services and have infants and children at serious risk for removal from the home. The program provides intensive in-home services to vulnerable families with complex health and social service needs over a 28-day period, and referrals for specialized addiction services outside the home.

Worcester Youth & Family Counseling (20-013). This grant will expand existing service capacity and accelerate access to mental health services for vulnerable, at-risk low-income residents on the Eastern Shore by helping to reduce a current two-month waiting list. The program supports a licensed clinical supervisor and a master's level social work graduate during completion of their required 3,000 hours of supervised clinical social work required for LCSW licensure.

Garrett County Lighthouse (20-014). This program supports the initiation of an Adolescent Psychiatric Rehabilitation Program (PRP) to serve children and adolescents ages 10-17 years, who suffer with a chronic mental illness, with or without a co-occurring substance use disorder (SUD). Garrett County currently does not have an Adolescent Psychiatric Rehabilitation facility. The grantee is pursuing a partnership with the local Board of Education to attempt in-school client contact when on-site services or in-home visits are not feasible.

Meritus Medical Center (20-018). This program supports screenings for individuals with SUD treatment needs, providing crisis intervention and stabilization, care planning and care coordination, and ongoing support through recovery. The program will focus on care gaps following discharge. The program team will follow-up and maintain contact with SUD patients for 100 days post-discharge, institute a peer support program following crisis intervention/stabilization at the hospital and address social determinants of health and barriers to support services during recovery.

Moveable Feast (20-019). This grant expands the currently successful program delivering free medically tailored meals to vulnerable low income, home bound individuals who have prediabetes or diabetes and other chronic conditions, and who experience food insecurity and malnutrition. Clients are offered medical nutrition therapy courses and receive the added benefit of increased social contacts with Mobile Feast staff and volunteers.

Food and Friends (20-020). This Grant supports expansion of the current home-delivered medically tailored free meals program for individuals identified by MedStar Family Choice and MedStar Health with diabetes, food insecurity, malnutrition, and limitations of Activities of Daily Living. The program will continue building the case for coverage by public and private payors to address social determinates of health. The grantee also navigates clients to the Supplemental Nutrition Assistance Program (SNAP) and public health insurance. Transportation and nutrition education barriers are overcome through the delivery of meals.

Chesapeake Food Pantry (20-021). The grantee is the largest food pantry in Southern Maryland. Funding will support implement the Eat Smart, Move More Calvert! pilot program serving low income food pantry clients with diabetes and/or prediabetes. The program will hire a Food Ambassador to develop a team of volunteer health coaches and provide for cooking classes and food distribution costs. The program will leverage multiple health resources and community supports to address social determinant of health needs of participants.

Cecil County Health Department (20-023). Cecil County HD will implement the County Diabetes Action Plan Program to expand delivery of the evidence-based National Diabetes Prevention Program (NDPP) to under-served, vulnerable low-income individuals whilst addressing common barriers to program recruitment and retention including lack of transportation and high medical expenses. Childcare vouchers will be distributed to parents to encourage NDPP attendance. Cecil County HD will convene their Local Health Improvement Coalition (LHIC) as the coordinating body.

Mountain Laurel Medical Center (20-025). This program will expand access to chronic care management for uninsured/underinsured, low-income patients with uncontrolled diabetes at three primary care delivery locations, offering free diabetes self-management education classes to improve diabetes self-management and health outcomes. The program will employ a LPN Navigator to help patients secure their diabetes medication through assistance programs and two RNs to deliver the diabetes self-management education programs.

Lower Shore Clinic (20-027). This program aims to improve access to healthy food for vulnerable clients with serious mental illness (SMI) who have prediabetes and diabetes by hiring a Healthy Foods coordinator to develop sustainable relationships with farmers, food distribution companies and local supermarkets to obtain food that is about to expire and will otherwise be wasted, to improve food security, stretch food budgets and supplement SNAP. Clients will also receive nutrition education, training on food preservation techniques and safe food storage, and opportunities to engage in physical activity, following the evidence based Geisinger Health System "Farmacy" model.

Upper Shore Aging (20-030). This program aims to increase diabetes risk screening for all low-income seniors served by the grantee, including those attending their senior centers and home bound seniors. Home screenings are performed in partnership with Meals on Wheels (MoW). The program will also increase awareness of diabetes risk factors and provide risk prevention education. MoW will deliver fresh fruit and vegetables with home meals to address food insecurity. The grantee will work to increase collaboration among health care providers and the Kent County HD and DSS to increase no cost access to Diabetes Prevention Programs.

Open Grants (16 programs)

Open FY 2019 Grants

Harford County Health Department (19-001). The *Meaningful Environment to Gather and Nurture* (MEGAN's Place) program provides a supportive, non-judgmental, and restorative place to improve perinatal health outcomes and build family resiliency skills. The program serves at-risk pregnant and postpartum women and their families, with a specific emphasis on women with substance use disorders, employing evidence-based practices from existing programs, including Harford's current Healthy Families program and Helping Families Recover program.

Family Healthcare of Hagerstown (19-002). This program provides health care and care coordination services for complex patients who are chronically ill and/or discharged from the hospital. The program employs two LPNs to provide telephone and face-to-face support to individuals before their first provider visit to address applicant care barriers upon referral, perform medication reconciliations, and obtain medical histories. The program seeks to decrease patient no-show rates, thereby generating additional patient fee-for-service revenue.

Health Partners (19-005). This new care management program seeks to increase patient

participation in disease management, increase preventative screenings, and reduce avoidable hospital ED visits. The program will expand access to new services for underserved, vulnerable and isolated residents. The grantee is also supported by local partners including Charles County Commissioners and the University of Maryland Charles Regional Medical Center which provides the program with patient referrals.

MedStar St. Mary's Hospital (19-006). This grant supports the opening of a new dental practice, East Run Dental Services, in Lexington Park, which will prioritize serving Medicare and un/underinsured individuals living in the southern corridor of St. Mary's County. The dental clinic, located in the existing East Run Medical Center, currently provides primary and behavioral health services. The grant funds a new dentist and the costs of dental supplies, while the hospital is committed to contributing funding for the salaries of a dental hygienist, a dental assistant, and front desk staff.

Mosaic Community Services (19-007). This program expands access to dental services for the organization's highly vulnerable patients with mental illness and/or substance use disorders. These patients are also impacted by chronic diseases including diabetes and hypertension, have poor diets and have delayed seeking dental care. The program provides dental services from private providers who will serve Mosaic clients in the Psychiatric Rehabilitation Program and Health Home Program at six sites, including Harford and Carroll Counties.

Western Maryland AHEC (19-010). This program expands an existing dental program for low-income adults in western Maryland. The program will target individuals who are in recovery from opioids and other addictions and have delayed accessing dental services. A Community Health Worker works with program participants to overcome the social determinants of health that prevent accessing care. Participants will also be screened for somatic health and social support needs.

Cecil County Health Department (19-016). This program provides services to low-income pretrial detainees involved with the Office of the Public Defender on misdemeanor or nonviolent felony charges who have a substance use disorder and lack access to appropriate treatment services in the community. The program will screen detainees and connect/serve them with treatment, support with a peer recovery specialist, and referral to other services as needed.

Harford County Crisis Center/Upper Chesapeake Health (19-018). This grant supports the opening of a new 24-hour Walk-in/Urgent Care Center and an Assertive Care Treatment Program. The new Walk-in/Urgent Care Center provides 24-hour access to behavioral, mental, and addiction services. The program provides an array of services, including a 24-hour crisis hotline; outpatient mental health; SUD treatment and MAT services; residential crisis beds; a mobile crisis team; and an ACT team for individuals with serious mental illness, including referrals to community providers.

Queen Anne's County Health Department (19-019). This program promotes screening and access to behavioral health services for patients in the existing Mobile Integrated Health (MIH) program in Queen Anne's County. Individuals will be able to access a Peer Recovery Specialist who performs an in-person follow-up visit. The program also provides telehealth services, which provides Screening, Brief Intervention and Referral to Treatment (SBIRT) for disadvantaged populations.

Worcester County Health Department (19-021). This program addresses obesity prevalence among youth and adults in the jurisdiction through several intervention strategies that include online education learning modules; coaching and wearable technology; community gardening programs; linkages with local food pantries; virtual and in-person cooking demonstrations and grocery store tours. Program referrals will come from the Health Department and Chesapeake Health Care. The overall goals of the program are to promote healthier lifestyle choices (both exercise and nutrition) among the target population, weight loss, weight management, and improved food security.

Washington County Health Department (19-022). This program supports the use of a mobile farmer's market to get locally grown fresh fruits and vegetables into the city of Hagerstown where there

is no supermarket access for vulnerable populations. The vendor will sell the produce at Title I schools, low-income housing sites, the Commission on Aging, congregate meal sites, and the senior center. The mobile farmer's market will accept food stamps/EBT, WIC vouchers, and cash. In addition, the program involves providing nutrition education provided by Meritus Medical Center, the County Health Department, and a local dietician.

Somerset County Health Department (19-023). This grant supports implementation of the Sustainable Change and Lifestyle Enhancement (SCALE) for Families program, a comprehensive weight loss and health improvement plan for low-income and uninsured adults modeled after an evidenced-based program in West Virginia. The program targets women of childbearing age in Somerset and Wicomico Counties with reported BMI over 30, children under 18 at risk for obesity, and minority populations.

Open FY 2018 Grants

Western Maryland Area Health Education Center (18-016). This program expands an existing successful dental program that currently serves two jurisdictions (Allegany and Garrett Counties) into a third jurisdiction (Washington County). The program provides access to reduced price dentures for low-income residents of Washington County who face a number of barriers accessing health and dental care. A Community Health Worker works with vulnerable residents to overcome the social determinants of health which hinder access to care. Participants will also be screened for somatic health and social support needs.

Frederick Memorial Hospital (18-020). This program seeks to implement the evidence-based "5-2-1-0 Campaign", a nationally recognized childhood obesity prevention program. The program involves multiple intervention strategies to fight obesity through engagement of students and families through the Frederick County Public School System.

Open FY 2016 Grants

Wicomico County Health Department (16-009). This grant supported the opening of a new school-based health center (SBHC) in Salisbury. The SBHC is open to students and adult staff members of the school and will provide a new access point for both primary and behavioral health services.

Completed Grants (106 programs)

Lower Shore Clinic (19-003). This grant funded the expansion of the Lower Shore Clinic's existing Assertive Community Team (ACT) into Caroline, Dorchester, and Talbot Counties. Clients served by the ACT teams have serious and persistent mental illness and often have complex comorbid medical health conditions and are utilizers of high-cost services. The ACT team consisted of a Psychiatric Nurse Practitioner, Registered Nurse, Substance Use Counselor, and Vocational Counselor who provided behavioral health services to individuals with substance use treatment needs. The Team assisted clients in developing preventative health care skills and relationships with primary care providers and addressed social determinants of health.

Choptank Community Health System (18-001). This program addressed the dental workforce challenges in a rural area of the state by expanding access to pediatric dental services through a new dental practice in Denton, in partnership with the University of Maryland School of Dentistry. A Dental Fellow provided pediatric dental services at existing Choptank clinics in Federalsburg, Goldsboro, and Cambridge.

Talbot County Health Department (18-002). This program established a Rural Health Collaborative working across five counties (Queen Anne's, Kent, Talbot, Caroline, and Dorchester) to improve the integration of clinical, social, and preventative health systems. The Collaborative focused on improving health care for low-income residents and develop models for integration replicable in other rural areas.

Wicomico County Health Department/EMS (18-006). The SWIFT program reduced preventable 911 calls through a team consisting of an emergency medical technician and a registered nurse who identified frequent callers to 911 for non-emergent conditions, conducted welfare checks, case management, safety planning, and offered referrals to primary care physicians, medical specialists, and, if necessary, in-home care providers.

Wells House (18-010). This program provided somatic care services at two addiction treatment facilities in Western Maryland. Many of the patients at Wells House have complex medical needs and providing integrated behavioral and somatic care to reduce avoidable hospital utilization for this vulnerable population. The program utilized a nurse practitioner and medical assistant to perform health assessments, provide necessary health education, and address other somatic health issues.

Atlantic General Hospital (18-011). This program developed a new interdisciplinary chronic pain management center to provide access to somatic and behavioral health, and therapy services to help patients relieve chronic pain without the use of opioid medications. For those with Substance Use Disorders, the intervention offered a concentrated outpatient program using a multi-disciplinary approach to reduce or discontinue the use of opioids for pain management.

Upper Bay Counseling and Support Services (18-012). This program provided integration of behavioral health and somatic care by placing therapists in the offices of Union Primary Care, the largest primary care provider in Cecil County. The program implemented the Screenings, Brief Interventions, and Referrals to Treatment (SBIRT) Model for those with substance use issues. This program expanded access to integrated behavioral health services in this underserved area.

Worcester County Health Department (18-019). This program enhanced an existing Medication Assisted Therapy (MAT) program through the addition of Naltrexone. The target population included: (1) Individuals released from inpatient addictions treatment programs; (2) inmates leaving Worcester County Detention Center with opioid addiction; and (3) individuals involved in Drug Court.

Health Partners (17-002). This grant supported access to primary care services in two sites in Charles County, an existing site in Waldorf and a new site in Nanjemoy.

Way Station (17-004). This grant used "Care-at-Hand" technology by a network of community behavioral health providers (multiple jurisdictions) serving individuals with Serious Mental Illness. The program focused on clients who are high utilizers of hospital resources to help improve the quality of client care.

Worcester Youth & Family Counseling (17-005). This grant supported increasing access to behavioral health services in the community by expanding the capacity of the organization to hire additional clinical staff. The organization currently has a three-month waiting list for clients seeking services.

Cornerstone Montgomery (17-007). This grant supported the creation of a data warehouse developed by the Community Behavioral Health Association to assist community behavioral health providers across the state to collect patient clinical outcome data.

Calvert County Health Department (17-008). This grant supported an innovative re-entry program to address the social determinants of health impacting formerly incarcerated individuals and develop concrete measurable outcomes to track and demonstrate the performance of re-entry programs at the local level. The program was also supported financially by the Governor's Office of Crime Control and Prevention.

Somerset County Health Department (17-011). This grant supported a multi-disciplinary approach to combat child and family obesity and promote food security through a nutritional home visiting program. The program also provides nutrition education in the schools; garden fresh produce distribution; and transformation of abandoned asphalt slabs into "Fitness Towns."

West Cecil Health Center (17-013). This grant supported an expanded dental program in Cecil County through a partnership with the University of Maryland Dental School. Under a cooperative agreement, West Cecil agreed to take over operations of the Dental School's clinic and maintain its status as a clinical teaching site.

Allegany County Health Department (17-015). This grant supported the expansion of the capacity of the organization to provide dental services for adults and children and is designed to help reduce preventable dental-related visits to the hospital emergency department.

Health Partners (17-016). This grant supported the expansion of access to dental services in Charles County, a dentally underserved area of the state, by supporting Health Partners' expansion of dental services at a new site in Nanjemoy.

Youth Ranch (17-018). This planning grant enabled the organization to develop a business plan that identifies a model of care for substance use treatment programs that reflects clinical best practices and is financially sustainable. The planning grant is also designed to assist the grantee in leveraging additional capacity-building grants from local private foundations in Frederick.

Queen Anne's County (17-019). This planning grant enabled the organization to develop a dental care access program for vulnerable populations that is financially sustainable.

Pressley Ridge (17-020). This grant supported use of the evidence-based HOMEBUILDERS® model to increase family engagement in substance use treatment with a goal of family preservation by increasing access to behavioral health and wraparound services. HOMEBUILDERS® provides intensive, in-home crisis intervention, counseling, and life-skills education for families who have children at imminent risk of placement in state-funded care. The Center works closely with the Allegany County Department of Social Services to provide services for children who are removed from their parents due to substance use.

Allegany Health Right, Inc. (16-001). This grant supported expansion of the organization's existing Dental Access Program to serve low-income seniors and disabled adults. The program continued Allegany Health Right's model of community outreach and engaging private dentists to provide dental services at a discounted rate of 50%-80%.

Carroll County Health Department (16-003). This grant supported the expansion of access to pediatric dental services in Carroll County by modernizing the

outdated equipment of Carroll's existing dental program and enabling the grantee to upgrade the practice management system.

Mountain Laurel Medical Center (16-004). This grant supported a program to provide dental screenings and referrals to discounted dental care for patients of Mountain Laurel with chronic diseases such as diabetes, hypertension, and cardiovascular disease.

Garrett County Health Department (16-005). This grant supported the use of telehealth technology to increase access to Medication Assisted Therapy (MAT) and responds to the recommendations of the Governor's Heroin and Opioid Emergency Task Force. The program involves a collaboration between the Garrett County HD and the University of Maryland School of Medicine, Department of Psychiatry.

Lower Shore Clinic (16-012). This two-year grant supported implementation of the "CareLink" program that targets individuals with behavioral health needs who visit Peninsula Regional Medical Center in high volumes and provides intensive case management services for these individuals post-hospital discharge.

Charles County Health Department (16-013). This grant supported an innovative public health-EMS-hospital partnership that addresses overutilization of EMS and ED services by assisting frequent ED/EMS users to manage their chronic conditions in a primary care setting or at home. The program was a collaboration among the Health Department, Charles EMS, and Charles Regional Hospital.

Allegany Health Right, Inc. (15-002). This grant supported the expansion of the organization's existing Dental Access Program to serve Medicaid-covered adults. The program continued Allegany Health Right's model of community outreach and engaging private dentists to provide dental services at a discounted rate of 50%-80%.

Frederick Memorial Hospital (15-003). This grant supported a partnership between Frederick Memorial Hospital and the University of Maryland Dental School (UMD) to reduce dental-related ED visits. UMD used a clinic at the Frederick Memorial Hospital as a rotational practicum site to provide care to vulnerable patients.

Health Partners (15-005). This grant expanded the organization's existing Dental Access Program to serve adults covered by Medicaid. The grant built on a past CHRC award to assist the clinic in transitioning from a grant-based revenue model to billing third-party payers for primary care services provided.

Calvert County Health Department (15-007). This grant supported an acceleration of ongoing behavioral health integration efforts in Calvert County through the "Program Phoenix" program, which expands access to behavioral health and medication assisted addiction treatment to those suffering from Substance Use Disorder.

Harford County Health Department (15-008). This grant supported a partnership between Harford Health Department and Upper Chesapeake Health to identify and provide care coordination and disease management services to high-risk, high-cost individuals to reduce avoidable hospital utilization.

Calvert County Health Department (14-004). This grant supported a program to reduce infant mortality rates by creating a "one-stop shop" of integrated behavioral health and social services for substance-using women and expectant mothers.

Allegany Health Right, Inc. (14-005). This grant supported the expansion of the organization's existing Dental Access Program to serve disabled adults. The program continued Allegany Health Right's model of community outreach and engaging private dentists to provide dental services at a discounted rate of 50%-80%.

Charles County Health Department (14-006). This grant supported a school-based dental program that screened children in the Charles County public school system and provided access to fluoride, dental sealants, and clinical services in an area lacking in an oral health safety net infrastructure.

Frederick Community Action Agency (14-007). This grant supported the provision of oral health care services to disadvantaged and low-income children and adults in Frederick County. The program also provided oral health education to participants.

West Cecil Community Health Center (14-008). This

grant supported the opening of a new Federally Qualified Health Center (FQHC) site in Harford County. The new FQHC site offers primary care services in West Cecil in a Medically Underserved Area (MUA) between Aberdeen and Havre de Grace.

Mental Health Association of Frederick County (14-012). This grant supported the expansion of access to behavioral health services and reduction of behavioral-health related hospital emergency department visits at Frederick Memorial Hospital. The grantee expanded the hours of a new behavioral health urgent care/walk-in service, which is available to residents regardless of ability to pay.

Worcester County Health Department (14-014). This grant supported a program to improve access to somatic/primary care services for adults who have Serious Mental Illness and/or addictions illness.

Access Carroll (14-015). This grant supported the long-term financial sustainability as the grantee transitioned from a grant-based billing model to billing Medicaid and private payers. The grantee provides access to primary care, behavioral health, and dental services for low-income individuals.

Health Partners (14-016). This grant assisted this free clinic as it transitions from a grant-based billing model to billing both Medicaid and private payers.

Allegany County Health Department (14-017). This grant supported the provision of dental services to disabled adults in Allegany County. The grantee served as a referral and coordinating agency for underserved, uninsured adults in Allegany County.

Somerset Health Department (14-020). This grant supported a public outreach campaign to reduce rates of childhood obesity in Somerset County by: 1) creating after-school opportunities for physical activity; 2) expanding access to affordable healthy food; and 3) providing home visitation and health coaching for youth deemed at highest risk of obesity.

Dorchester County Health Department (HEZ-003). This multi-year grant supported a program which targeted primary care and behavioral health issues by employing health care services teams that included peer recovery support specialists, community health outreach workers, mobile health care crisis teams, and school-based wellness programs.

MedStar St. Mary's Hospital (HEZ-005). This multi-year supported a program to expand access to primary and behavioral health services to reduce emergency department and hospital admissions for behavioral health conditions, obesity, and key chronic conditions such as hypertension and diabetes.

Allegany County Health Department (LHIC13-001). This grant supported the use of Community Health Workers to link patients to community resources, create a community resource guide, support cultural competency provider training, and provide access to subsidized transportation services.

Tri-County/Lower Shore (LHIC13-003). This grant supported a program which targeted diabetes-related hospital ED visits through a comprehensive care coordination model to link frequent ED users with access to primary care in the community.

Cecil County Health Department (LHIC13-004). This grant supported the Cecil County Community Health Advisory Committee program aimed at the reduction of behavioral health-related ED visits.

Charles County Health Department (LHIC13-005). This grant supported expanding access to primary care services through the establishment of a Patient Centered Medical Home in Nanjemoy (Western County Family Medical Center).

Harford County Health Department (LHIC13-007). This grant supported a comprehensive coordinated care and preventative mental health program to improve overall health outcomes for high-risk residents to decrease ED utilization and to expand the grantee's Comprehensive Women's Health Program care coordination model.

Kent County Health Department/Mid-Shore (LHIC12-001). This grant supported a program to address obesity among African American adults and children residing in the mid-shore region through a nutritional intervention targeting African American churches.

Tri-County/Lower Shore (LHIC12-002). This grant supported a program aimed at the prevention and

management of diabetes in Somerset, Wicomico, and Worcester Counties. The program used the National Diabetes Prevention Program (NDPP) that promotes healthy eating, physical activity, and weight loss to prevent and delay diabetes.

Allegany County Health Department (LHIC12-003). This grant supported a program to reduce tobacco use and address alcohol and substance use in Allegany County.

Calvert Memorial Hospital (LHIC12-006). This grant supported a program to reduce ED utilization for diabetes related conditions in Calvert County through patient education.

Carroll County Health Department (LHIC12-007). This grant supported a program to increase the urgent care capacity of an existing Outpatient Mental Health Center to provide an alternative to the use of the Emergency Department for individuals seeking care for a behavioral health condition.

Cecil County Health Department (LHIC12-008). This grant supported the implementation of a needs assessment and evaluation of Cecil County's substance use continuum in order to provide the county's local health improvement coalition with a blueprint to guide its work.

Charles County Health Department (LHIC12-009). This grant supported the Partnerships for a Healthier Charles County's Chronic Disease Prevention Team efforts to implement chronic disease and obesity prevention programs identified in the Charles County Health Improvement Plan.

Frederick County Health Department (LHIC12-010). This grant supported programs to address six priorities identified by the Frederick County Health Care Coalition's Local Health Improvement Plan: 1) mental health, 2) affordable dental care, 3) access to care, 4) wellness and prevention, 5) health inequities, and 6) early childhood growth and development.

Garrett County Health Department (LHIC12-011). This grant supported a program to increase access to healthy foods and reduce obesity in adults and teens.

Harford County Health Department (LHIC12-012). This grant supported the development and implementation of a marketing campaign to promote healthy eating, active living, and tobacco cessation designed to reach minority populations.

St. Mary's County Health Department (LHIC12-016). This grant supported the implementation of a smoking cessation social marketing campaign in the low-income population of St. Mary's County and to recruit and assist local employers with the adoption of tobacco-free workplace policies.

Washington County Health Department (LHIC12-017). This grant supported the implementation of a county health needs assessment to identify issues for which changes in the health care system can improve both patient care and preventive services.

Harford County Health Department (12-001). This grant supported the addition of comprehensive care coordination and community outreach to existing family planning/reproductive health services. The comprehensive program targeted low-income, minority women and health services and interventions to reduce infant mortality rates.

Tri-State Community Health Center (12-002). This grant supported a collaborative program to provide OB/GYN and postnatal care services through Tri-State providers and home visiting services through the Allegany County Health Department staff.

Walnut Street Community Health Center (12-004). This grant supported the expansion of the Healthy Smiles in Motion, a mobile dental van program, in Hagerstown.

Bel Alton (12-005). This grant supported a program which provided comprehensive dental screenings and oral health education to children in eight elementary schools in Charles, St. Mary's, and Calvert Counties.

Lower Shore Clinic (12-007). This grant supported a program to add primary care services to an existing behavioral health care clinic. The program provided regular physicals, preventative services, and chronic disease management for individuals with existing mental health or substance use disorders.

Walden Sierra, Inc. (12-013). This grant enabled Walden Sierra to co-locate behavioral health services with primary care providers and serve low-income

and uninsured individuals with behavioral health disorders. Walden partnered with Greater Baden Medical Services and Medstar St. Mary's Hospital to provide primary care and clinical space for Walden Sierra outpatient services.

St. Mary's County Health Department (11-001). This grant supported a program which provided individual and group reproductive health and family planning counseling and multi-vitamins with folic acid to women of child-bearing age, as well as pregnancy tests and up to three months of birth control.

Allegany County Health Department (11-003). This grant supported a program that provided post-partum case management services to women who use substances during pregnancy. Services included drug/alcohol rehabilitation and instruction for providing care to substance affected newborns.

Choptank Community Health System (11-004). This grant supported a partnership between CCHS and the Chester River Hospital Center to provide pediatric dental surgery services in Kent County, a Medically and Dentally Underserved Area (MUA).

Health Partners (11-005). This grant supported a dental program and transportable dental unit to serve the uninsured and underinsured residents of Charles County.

Access Carroll (11-006). This grant supported a new full-time family dental clinic as part of the Access Carroll integrated care model.

West Cecil Community Health Center (11-007). This grant supported the addition of behavioral health services at the FQHC's site in Conowingo.

Greater Baden Medical Services (11-012). This grant supported the opening of a new FQHC site in Waldorf that provided access to primary care services for low-income individuals.

Calvert Healthcare Solutions (11-014). This grant expanded the grantee's capacity to provide primary health care services and linkage to service supports in Calvert County. The grant supported an increase in service hours for primary care and mental health services, the creation of a formal referral consortium with community agencies, and an increase in access to prescription assistance programs.

Garrett County Health Department (10-004). This grant supported the expansion of the health department's Nurse-Family home visiting program, which provided services throughout pregnancy and through the first two years of the child's life.

Dorchester County Health Department (09-005). This grant supported the operations of a SBHC in Dorchester County.

Frederick County Health Department (09-006). This grant supported the opening of a new SBHC at Hillcrest Elementary. This grant supported primary care services, links for students and families to medical homes, oral health screenings, and dental fluoride varnishes.

Harford County Health Department (09-007). This grant supported a SBHC program at four elementary schools in the county. The CHRC's grant supported expansion of primary care and mental health services at the SBHCs for students and their families, particularly those lacking access to care.

Washington County Health Department (09-009). This grant supported the expansion of mental health services at the health department's three SBHCs. The grant also helped to support the evaluation and implementation of a software system to improve student/patient tracking and improve billing and collections for services.

Carroll County Health Department (09-011). This grant funded the Best Beginnings Program, an interagency prenatal care program that targets women who are low-income, uninsured, and underserved residents of Carroll County.

Mid-Shore Health System (09-014). This grant supported a telemedicine initiative for youth enrolled in the 60-day inpatient substance use treatment at the Jackson Unit in Allegany County. The program enabled families to participate in treatment by addressing transportation barriers.

Somerset County Health Department (09-017). This grant provided support for a program providing assessment and counseling services to individuals with addiction and mental health related issues. The

program involved a collaboration between Eastern Shore Psychological, Maple Shade, and Lower Counties Community Services.

Upper Chesapeake Healthlink (09-018). This grant supported the integration of on-site mental health services and medication management in a primary care setting.

Allegany County Health Department (08-001). This grant supported expansion of the existing dental program capacity, improving access to preventative health services and oral health education for low-income children and their families.

Carroll County Health Department (08-003). This grant funded a program that supported two pediatric dental programs. The first program expanded access to pediatric dental care by extending the dental clinic hours. The second program piloted an off-site Fluoride Varnish Program for children enrolled in the county Head Start program.

Choptank Community Health System (08-004). This grant provided support to expand the Choptank dental program. Funds were used to enhance a new seven-chair dental facility in Goldsboro.

Garrett County Health Department (08-005). This grant supported the Program Smiles program, which provided dental care to low-income and uninsured adults at community-based dentists who provided/donated care at the health department dental clinic or pro bono care.

Harford County Health Department (08-006). This grant supported Harford's efforts to provide dental services to low-income and underinsured/uninsured children.

Wicomico County Health Department (08-007). This grant supported the relocation and expansion of the WCHD Village Dental clinic to improve access and increase its capacity to serve county residents.

Allegany County Health Department (08-008). This grant enabled the Allegany County Health Department to purchase and implement a system which helped to improve the efficiency of the department's patient records and administration while maintaining compliance to HIPAA standards.

Choptank Community Health System (08-010). This grant supported the Choptank electronic health record system deployment to all the health center sites and locations, including final planning, testing and infrastructure building. Grant funds were utilized to provide software and staff IT training.

Walnut Street Community Health Center (08-012). This grant supported implementation of an integrated practice management, electronic dental records, and electronic medical records system.

Junction, Inc. (08-014). This grant supported psychiatric services for adolescents and young adults with co-occurring mental health and substance use disorders. Services provided included psychiatric mental health and medication management services.

Harford County Health Department (08-015). This grant supported the Hope Program, a re-entry program which provided free drug treatment, counseling, medical, and mental health care to those incarcerated at the Harford County Detention Center and continued those services after release.

Way Station (08-016). This grant supported the implementation of Integrated Dual Disorders Treatment (IDDT) and the development of Dual-Diagnosis Capability to better serve individuals with co-occurring substance addictions.

Allegany Health Right, Inc. (08-017). This grant supported a program to provide dental services for low-income residents with an urgent or developing dental problem.

Atlantic General Hospital (08-021). This grant enabled Atlantic General Hospital to open a behavioral health center to deliver services in an ambulatory care setting, targeting individuals using the hospital's emergency department for behavioral health issues.

Upper Chesapeake Health (08-024). This grant supported the development of a comprehensive ED diversion program to redirect uninsured patients away from using emergency rooms for non-emergent visits towards a medical home for primary and preventative care, as well as linking them to a comprehensive community-based continuum of care.

Queen Anne's Health Department (08-027). This grant supported a program to provide the resources for prenatal care for uninsured and undocumented foreign-born women and provide transportation to and from medical appointments, as well as linkages to other resources in the community.

Access Carroll (07-001). This grant supported an expansion of care coordination to ensure timely referrals for specialty care services and improve the organization's overall efficiency.

Calvert Memorial Hospital (07-004). This grant supported improving access to health care services for low-income and uninsured residents of Calvert County by increasing the capacity of the Twin Beaches Community Health Center, increasing access to the case management, and providing supplemental payments to specialists and an area pharmacy to cover the gap between patients' sliding fee scale payments and actual costs.

Frederick Community Action Agency (07-006). This grant supported the Access to Care Program, which provided primary health care services to low-income, uninsured adults and children in Frederick County.

Health Partners (07-007). This grant supported expanding the grantee's capacity to serve low-income un/underinsured residents in Charles County.

Tri-State Community Health Center (07-010). This grant supported a collaborative program between the grantee, Allegany Health Right, and Western Maryland Health System to integrate community-based mental health and substance use services with somatic services for uninsured adults.

Walnut Street Community Health Center (07-012). This grant supported the Improving Patient Care Program at WSCHC health facility. The program incorporated behavioral health services within the Center's established family practice.