MCHRC
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

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

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Edward J. Kasemeyer, Chair – Mark Luckner, Executive Director

February 8, 2022

Pathways to Health Equity Call for Proposals
Applicants Invited to Present on February 15, 2022

Horizon Goodwill Industries. This program would address health disparities in diabetes and mental health in the Hagerstown area (zip code 21740). The project will provide on-site access to dietary and diabetic educators, healthcare navigation, wrap-around case management, and job training services; walk-in testing for diabetes (HgA1c) and retinal neuropathy; and referrals to mental health services. The goal is to decrease the rate of ED utilization for ambulatory care sensitive conditions, improve management of diabetes, and help reduce the rate of new diabetes diagnoses.

Eastern Shore AHEC. This program would address disparities in diabetes for the African American population in Dorchester County (zip codes 21613, 21622, 21626, 21627, 21631, 21643, 21643, 21648, 21659, 21664, 21669, 21672, 21675, 21677, 21835, 21869). Key interventions include home health visits by the Mobile Wellness Team, diabetes prevention and self-management courses, screenings for pre-diabetes and depression, linkages to primary care, health literacy programs, and opportunities for healthy food and increased physical activity. Target outcomes include reduced hospitalizations for diabetes-related illness.

La Clinica del Pueblo. This program would address disparities in diabetes for the Hispanic population in areas of Montgomery and Prince George's Counties (zip codes 20703, 20706, 20710, 20712, 20722, 20737, 20740, 20770, 20781, 20782, 20783, 20784, 20785, 20901, 20903, and 20912). Interventions would include remote diabetes monitoring, peer-led diabetes self-management, health screenings via the Luminis mobile clinic, navigation to primary care services, addressing barriers to access such as lack of insurance and transportation, access to fresh produce, peer-led walking groups, legal services support, medical interpretation, and health navigation support.

Prince George's County Health Department. This program would address disparities in heart disease and diabetes in the Capitol Heights, Bladensburg, Hyattsville, and Riverdale areas (zip codes 20710, 20737, 20743, and 20785). Key interventions include Community Health Worker (CHW)-driven outreach and care coordination, bi-directional e-referrals among health and social service providers, and technical assistance to improve providers' ability to bill for care coordination. The project will promote delivery of culturally and linguistically sensitive services, and utilize EMR, CRISP, and telehealth services including through telehealth hubs. Targeted outcomes include reductions in disparities related to heart disease and diabetes, improved diabetic control as measured by A1c or blood glucose levels, and increased access to primary care.

Sinai Hospital of Baltimore. This program would address disparities in diabetes, hypertension, and heart disease in the Southern Park Heights and Pimlico/Arlington/Hilltop neighborhoods of northwest Baltimore (zip code 21225). This project seeks to utilize non-traditional "doors" such as barbershops and community centers to screen and treat individuals facing chronic diseases and lacking primary care. Key interventions include: screenings by CHWs, expanded use of the Sinai Mobile Health Unit, and creating wellness plans for individuals with poorly controlled chronic conditions. Target outcomes include a reduction in avoidable ED

use and hospital admissions, reduction in morbidity and mortality from chronic diseases, and increased access to primary care.

Greater Baltimore Medical Center. This program would address disparities in diabetes and hypertension among the African American population in the Greenmount East, Harbor East/Little Italy, Inner Harbor/Federal Hill, Midtown, Oldtown/Middle East, and Waverly areas of Baltimore (zip codes 21202 and 21218). Key interventions include an expansion of the number of patients treated at GBMC Jonestown Clinic, where patients will receive comprehensive primary and preventive care services including vaccinations and screenings; disease management and care coordination services; at-home care for elderly participants; and support to address Social Determinants of Health (SDOH) needs. The project will also conduct public screenings and education at community events, and healthy lifestyle interventions such as community walks/runs, education workshops, patient support groups, peer challenges to support water and protein intake goals, and healthy cooking demonstrations.

Tidal Health. This program would address disparities in diabetes experienced by the Black and Haitian population on the Lower Shore (zip codes 21801, 21804, 21822, 21853, 21851, and 21863). Key interventions identified include expansion of Mobile Integrated Health, connections with primary care, expansion of culturally linguistic and evidenced-based diabetes programming, and deployment of CHWs. Target outcomes include reduced rates of uncontrolled diabetes and hypertension among Black adults (18+) in the prioritized zip codes.

Charles County Health Department. This program would address disparities in heart disease and hypertension in the Indian Head, Bryans Road, Marbury, Nanjemoy, and White Plains areas (20695, 20616, 20640, 20658, and 20662). Key interventions include Community Blood Pressure Stations for screenings and follow up, transportation services, a Healthy Heart Ambassador, a dietitian referral program, educational opportunities to increase the number of individuals who are aware of their blood pressure readings and regularly check their blood pressure (BP) readings at home, and "sensory and story paths" at local recreation areas. The project seeks to help those with elevated blood pressures connect with a primary care provider and to improve the rate of ED utilization for hypertension.

University of Maryland School of Nursing. This program would address disparities in hypertension, mental health, and social isolation in West Baltimore (zip codes 21201, 21217, 21223, and 21229). Key interventions include: establishing a learning collaborative, using nurse-managed health centers, leveraging mobile health care, and enhancing care coordination through a community health worker model. Targeted outcomes include decreasing the number of patients with uncontrolled hypertension and increasing participation in social support groups.

Johns Hopkins School of Medicine. This program would address disparities associated with the high prevalence of sickle cell disease (SCD) in the Upper Marlboro, Laurel and Capital Heights areas of Prince George's County (zip codes 20773, 20707, and 20743) and lack of access to a local comprehensive sickle cell program. The comprehensive sickle cell program and clinic will be established at UM Capital Region Medical Center. The project aims to reduce the number of adults who present to UMCP hospital for acute pain requiring hospital admission, and to improve access to SCD modifying treatment and transition services for adolescents and young adults to reduce hospitalizations. CHWs will identify participants who lack resources to facilitate access, coordinate their care, and provide SCD education. A nurse navigator will facilitate interventions to address SDOH needs, and a nutritionist will develop a food plan for each participant.

Baltimore Healthy Start. This program would address disparities in hypertension, Substance Use Disorder (SUD), Low Birth Weight, and Severe Maternal Morbidity for pregnant and postpartum women and their infants in the Druid Heights and Walbrook areas of Baltimore (zip codes 21216 and 21217). The project will expand existing service coordination and home-visiting programs and facilitate access to primary care and substance use treatment through referrals. Interventions include hypertension education administered by trained CHWs, home BP monitoring and tracking, peer support groups, and care coordination addressing clients' acute stressors and SDOH needs.

HealthCare Access Maryland. This program would address disparities associated with poor maternal health outcomes in West/Central Baltimore (zip codes 21201, 21202, 21205, 21213, 21216, 21217, 21223, and 21229). CHWs will connect participants to a primary care medical home, services to address SDOH, and health insurance. Health education activities will include disease management, COVID-19 vaccination, at-home screening for blood pressure and blood glucose, nutrition and weight management, family planning, and breastfeeding. Targeted outcomes include reduced mortality/morbidity for women with hypertension, pre-eclampsia and/or diabetes and reduced hospitalizations/rehospitalizations within 90 days postpartum.

Care for Your Health. This program would address disparities in mental health for African American and Hispanic populations in the Silver Spring, Takoma Park, Gaithersburg, Montgomery Village, Germantown, and Rockville areas of Montgomery County (zip codes 20812, 20850, 20851, 20852, 20868, 20874, 20876, 20877, 20879, 20886, 20901, 20902, 20903, 20904, 20906, 20910, 20912). Key interventions include: integration of linguistically competent mental health services within the primary care setting at two partnering health clinics, establishment of a community mental health program, culturally competent mental health training for Health Promoters, and enhanced provider capacity to better serve non-English speakers and increase health literacy.

St. Mary's County Health Department. This program would address disparities in Behavioral Health (mental health and SUD) and heart disease in the Lexington Park area (zip codes 20634, 20653, 20667). Key interventions include the opening of a new facility to provide primary care, counseling, and other Behavioral Health services; law enforcement referrals and ED diversions; case management to connect clients to partner organizations addressing SDOH; and respite care post-hospital discharge. Target outcomes include a reduction in ED admissions for chronic conditions and mental health and substance use disorders, increased access to primary and preventative care, decreased recidivism in the criminal justice system, and a reduction in overdoses.

Primary Care Coalition. This project seeks to address complex intergenerational Social Determinants of Health needs in the northern Gaithersburg area of Montgomery County (zip codes 20877 and 20886). Key interventions include outreach and case management services provided by CHWs (called JEDIs), telehealth navigation support, food pantry assistance, kindergarten readiness programs, and entrepreneurship programs including training on the formation of childcare centers. Targeted outcomes include increased health screenings, health literacy, health navigation, and utilization of social supports.

Community Ministry of Prince George's County. This program would address disparities in the mortality rate for prostate cancer for African American men within the Capitol Heights area (zip code 20743). The project will provide educational workshop sessions for African American men to increase awareness of the disease and refer them to free and/or low-cost prostate cancer screenings at local churches, hospitals, and health centers. Men who receive a positive diagnosis will be offered one-on-one consultations with health professionals and prostate cancer survivors, as well as professional support services and counseling.