

**The Family League of Baltimore City, Inc.  
Strategy to Improve Birth Outcomes (SIBO)  
Community-Based Services DRAFT RFP**

**February 25, 2010  
2305 N. Charles Street, Suite 200 Baltimore, MD 21218**

**Community Forum Comments, Questions & Answers**

Thank you for attending the Community Forum and for submitting comments and questions for the RFP. As was shared at the forum, all questions and answers are public information. Below we have outlined the answers to the most common questions received since release of the draft RFP.

**Existing home visiting funds:**

Funds available through this RFP are in addition to and separate from the current funding for home visiting programs through the Family League. Current FLBC home visiting contracts run through June 30, 2010 and later this spring programs will have a chance to apply for renewal funding to begin on July 1. Details on this round of funding will be released later this spring.

The current SIBO RFP will allow for three awards in the range of \$400,000 - \$600,000 each for the 21 month period April 1, 2010 – December 31, 2011.

**Data support available:**

The data and information released with the RFP, and posted on the FLBC website, should be sufficient for RFP application purposes. Baltimore City Health Department epidemiologists cannot offer more data support before applications are due, but will serve as a resource to successful applicants once they are selected. The SIBO document and resources posted with the RFP reflect 2005-2007 data. If more recent data (2008) becomes available it will be posted on the FLBC website with the RFP.

**Innovative approach:**

The innovative idea here is that community based organizations will work together to deliver better results than currently exist on a critical public health issue in Baltimore. While individual efforts have perhaps been successful, it is clear that delivering results on a community wide scale have failed thus far. Further, there are multiple "silos" of efforts with little seamless integration and accountability. This is not a service delivery project. The primary objective is creative partnership within a community and among its existing and new partners. Successful applications will show evidence of inclusive and collaborative leadership in forming community collaboratives and creative ideas to mobilize community members to improve birth outcomes. (Please reference support continuum found on FLBC website.)

**Lead agency requirements:**

The RFP requires that a lead agency is named as the applicant. The lead agency is accountable for the money and for results, but is not necessarily responsible for implementing all content. The lead applicant will represent, and will serve as fiscal agent for, a collaborative

of community partners who will complement each others' strengths and services. The lead applicant is not required to be a home visiting program or prenatal care provider (though it can be) but must partner with entities that fit this description. The lead applicant must maintain a presence within the geographic boundaries of the neighborhood. The strength of applications is partly based on how well lead applicants define their presence in the community (strongest applicants will demonstrate being well known and well connected in their community).

**Public agency support:**

Public agencies will serve as non-exclusive partners to communities in the SIBO initiative. We are adding a component to the Definition of Need section of the RFP Program Narrative to allow for a report of more general community needs that will help inform FLBC discussions and actions with agencies like BSAS, BHCA, BMHS, BCDSS, and Housing. All of these agencies are currently represented on the Steering Committee for the SIBO initiative. Applicants are not expected to negotiate their own MOUs with these public agencies; rather applicants must help define the needs, and FLBC will create agreements for public agency support of the RFP communities.

\*\*\*\*\*

**Listed below are more specific comments, questions and answers that were raised during the February 25, 2010 Community Forum and during the online public response period.**

**Q/C 1: What happens to applicants who apply for the same neighborhood? Will both those applicants be disqualified?**

**A 1:** Applicants for the same neighborhood will be evaluated on their own merit. There will be three successful applicants in total, with only one coming from any given neighborhood. The strongest applications will show evidence of "real-time" partnership with a number of entities with a record of accomplishment of results, not those forged in the act of grant submission.

**Q/C 2: What is the new "citywide triage system"? Please describe.**

**A 2:** A revised citywide triage system will be released during the second week of March. In broad strokes, this system 1) maintains Baltimore Health Care Access as the central point of referral for all women in need of home visiting services, and 2) clarifies and slightly modifies which women need to be seen by professional (RN or SW) home visiting programs and which can be seen by a paraprofessional. Currently, it is not uncommon for individuals to go unseen or "fall through the cracks."

**Q/C 3: What is the expected balance between coordination/collaboration of existing services and new service development, in provision of access to the 11 high impact areas?**

**A 3:** This project is meant to enhance coordination among existing services and improve their collaboration. We are looking for creative ideas for how to coordinate services and residents in the interest of improving birth outcomes within a community.

**Q/C 4: In the list of high impact service areas there is not mention of responsible fatherhood, housing, education (school system/ rate of teen pregnancy in Baltimore) or workforce development. Why is that?**

**A 4:** The strategy is targeting evidence-based service areas most proximal to infant mortality. While social causes like housing and workforce development are critical to sustained maternal, infant, and family health, they are not proximal causes of infant mortality. In order to most effectively adhere to the mission of SIBO (mortality reduction) with the available resources, the service areas of focus for this strategy will be those with the potential to have the greatest impact on infant mortality in the community. That stated, please refer to the following excerpt from the SIBO document (p. 4) that explains how the strategy envisions addressing underlying factors of poor birth outcomes. To support this in a practical way, the Steering Committee is made up of members across city agencies, including housing and education. This committee meets on a quarterly basis and makes recommendations to ensure the strategy is on track, and as such is an opportunity to advocate for change in these agencies that can support improved birth outcomes.

(SIBO document, p.4) Underlying Factors of Poor Birth Outcomes Need Attention

To improve poor birth outcomes in Baltimore City, this strategy will target the eleven high-impact health service areas. We cannot ignore, however, the underlying factors of poor birth outcomes, including poverty, inadequate and unstable housing, racism, unemployment, environmental exposures, genetic factors, and low levels of education<sup>[i],[ii],[iii]</sup> While the strategy will not directly fund efforts in these areas, it will be aligned with citywide efforts addressing these issues and will provide a mechanism for coordination and advocacy on social issues.

For example, if community-based programs engaged in this strategy identify a housing policy that is detrimental to health, the network of partners supporting the plan can make this information available and advocate for change. Conversely, as new programs are developed, such as for housing or job training, information can be disseminated through the community programs.

Because birth outcomes reflect deep social and health disparities, a resolution of the birth outcomes crisis in Baltimore will be intertwined with improvements in the social and economic conditions of the city. Better organized and coordinated public health services are important elements in a holistic approach to achieving improvements in the health and wellbeing of all city residents.

---

[i]. Lane, Sandra. *Why are Our Babies Dying*. Boulder, USA, Paradigm Publishers, 2008.

[ii]. Nuru-Jeter A, Dominguez TP, Hammond WP, Leu J, Skaff M, Egerter S, Jones CP, Braveman P. It's the Skin You're In: African-American Women Talk About Their Experiences of Racism. An Exploratory Study to Develop Measures of Racism for Birth Outcome Studies. *Maternal Child Health J*. 2008 May 8.

[iii]. Chomitz Virginia Rall, Cheung Lilian WY, Lieberman Ellice. *The Role of Lifestyle in Preventing Low Birth Weight*. *The Future of Children* 5, no. 1 (1995):

**Q/C 5: If you reside in a neighborhood where there are no prenatal care facilities, how is it possible to propose a plan for their development?**

**A 5:** If there are no prenatal care facilities, partner with those that are close by. Suggestion is to find out where neighborhood women currently receive prenatal care and work with those groups, regardless of their location. This is not about dictating where a woman receives services, but making sure she is connected to appropriate ones.

**Q/C 6: Identify all pregnant women within their geographic area -**

- (a) How will this be measured and benchmarked?**
- (b) Would this mean that we would need to have agreements with all of the community providers of care, not just our traditional referrals?**
- (c) Would the city offer assistance with this – access to PRAs, for example?**
- (d) What are the HIPAA implications of this? How do we legally “identify” pregnant women in the care of providers who are not part of agreement/collaboration?**
- (e) It seems that this would be difficult criteria to measure and to meet. Would not a more realistic criteria be something along the lines of “Outreach to all pregnant women in their geographic community in order to connect them with appropriate care and services”?**

**A 6 (a-e):** SIBO wants applicants to describe the ongoing process they would use to identify pregnant women in the community at the outset of the intervention and to identify women as they become pregnant during the course of the intervention, so that these women can be properly referred to the services they need. This process might include developing agreements with existing providers in the community, as well as other innovative processes or collaborations that will help to reduce the number of women who are missed by existing screening and referral programs.

The City will assist implementing partners in any way possible within legal limits.

The suggested rewording will be adopted --“Outreach to all pregnant women in their geographic community in order to connect them with appropriate care and services”. SIBO is looking to applicants to suggest innovative approaches to the challenge of reaching all women who are in need of services.

**Q/C 7: Each of the high impact services is very important; however, except for home visiting, most of the services involve coordination of services rather than actual field work. However, it appears that no specific amount or percentage of the funding is designated for home visiting.**

**A 7:** Correct, there is no specified amount designated for home visiting. Neither is there a required number of clients that must be served.

**Q/C 8: It is unclear whether or not a home visiting program can work in more than one of the targeted SIBO funded areas.**

**A 8:** Yes, a home visiting program can work in more than one of the targeted neighborhoods.

**Q/C 9: Can an organization who is a not for profit, that does home visiting services apply as lead agency for this application?**

**A 9:** Yes.

**Q/C 10:** Final selection criteria refers to “additional funding sources to support at least one-third of the total budget for the management and operations of the community collaborative.”

(a) Where is the required budget form on the FLBC website?

(b) Is this a formal matching requirement?

(c) If we are asking for \$600,000, we’d have to identify another \$200,000 in support of the program? If so, must that support be in hand, or pending?

**A 10(a):** The budget form can be found by clicking the hyperlink within the RFP document or by downloading it from the SIBO RFP page.

**A 10 (b):** Yes, it is critical that the funds made available through this process are not solely responsible for the ongoing operations of the community collaborative.

**A 10 (c):** If additional funding is pending, there must be a clear delineation of the source of the funds, expected timelines for the funds to be “in hand”, and, if applicable, documentation from the source confirming the intent to make those funds available.

**Q/C 11:** What does leveraging money mean? Does that mean grant money that you are already getting for a service area, hard cash, etc?

**A11:** See A(10) – leveraging money is a mechanism to utilize one source of money to draw down other sources so that operations and services can be sustained and expanded. For example, a private grant can be used to leverage federal funding to operate a program.

**Q/C 12:** Under organizational capacity (under #3) there is the requirement to submit information on previously awarded grants for “similar or related programs over the last three years.” What is your definition of “similar” here?

**A 12:** Similar programs may include any of the 11 high-impact services, collaborative work involving multiple partners and organizations, or other such programs or projects that demonstrate your past experiences and successes in managing complex work.

**Q/C 13:** On page 22 of the RFP, is there a requirement to report the ethnicity of the board?

**A 13:** Yes, applicants are asked to provide all required data listed on the form. If the information is not available, please explain why.

**Q/C 14:** Provide clarification of what it means to have delivered culturally sensitive services in a specific targeted area.

**A 14:** How a successful organization serves their clients matters. For example, if a growing number of women in a specific neighborhood speak a language other than English, how did the organization’s staff and services meet this challenge? Were appropriately skilled staff able to communicate directly with the client? Demonstrated skills, knowledge and ability to meet the needs of a community matter.

**Q/C 15: How might we be connected with other interested organizations in these communities for a Community Collaborative? We welcome the opportunity to partner on this project.**

**A 15:** The Family League is completely willing to post interested partners on the SIBO web page. In the interest of seeking the most qualified collaboratives, we will post a listing of all those who attend the Community Forum so that all can see who has expressed interest.

**Q/C 16: Please provide a clearer description of what it means that the lead applicant must have had a physical presence in the target community that they propose to serve; and the number of years that an organization must have provided.**

**A 16:** See response in introductory section “lead applicant requirements.”

**Q/C 17: The document does not address whether or not a home visiting program that is currently funded by FLBC and currently supporting families in one of the targeted community which is selected for SIBO funding would be allowed to continue to utilize that funding to support families + to get additional funding.**

**A 17:** See response in introductory section “existing home visiting funds.”

**Q/C 18: The actual plan, in terms of identifying adequate funding to support every family in targeted communities, is not clear.**

**A 18:** See A (3).

**Q/C 19: How is this RFP different from the Success By 6® Project?**

**A 19:** See response in introductory section “innovative approach.”

**Q/C 20: On page 3 you talk about data that says poor birth outcomes are associated with factors preventable through preconception healthcare, however the impact service areas do not speak to preconception health unless primary health care and a medical home are a proxy for preconception care. Is this your meaning? Since most clients are Medicaid eligible, are MCOs going to pay for preconception health?**

**A 20:** Most of the high impact areas also relate to preconception care; primary care in a medical home is certainly preconception health. Please refer to p. 5 of the SIBO strategy document and the chart that shows the modifiable determinants of poor birth outcomes by stage (preconception, pregnancy, postpartum).

**Q/C 21: Is there an existing document describing the new citywide triage system for pregnant women into home visiting programs? Could you also provide a more detailed description of the nature of the desired participation in this system, so we know how to integrate this into our proposal?**

**A 21:** See A (2).

**Q/C 22: Would you comment on the sustainability plans for this proposal? The granting cycle is from April 2010 to December 31, 2011, 21 months. However, the BCHD SIBO document has specific goals to be achieved within a three-year timeframe. Will there be**

**a plan to re-evaluate and refund programs to give time to document the stated outcomes?**

**A 22:** The eighteen month period for the community programs represents the timeframe that CareFirst has currently allocated funds to this project. The Steering Committee and Core Implementation team are developing a resource generating strategy to secure future funds. The strategy is looking for a population-based change and, therefore, has an overall timeframe of 10-20 years. There will be continual monitoring and evaluation and search for funds to ensure that there is time to achieve the desired outcomes. We would also look to community programs to partner in the effort to generate new resources.

**Q/C 23: Do you have an estimate of what the required training and staff development time commitments will be? This will allow us to ensure that we have appropriately allocated estimated FTE's to the project – especially for those individuals who may have other grant funding sources and/or are clinicians with specific committed time to clinical service.**

**A 23:** Training and staff development sessions will include community mobilization/planning, Baby Basics curriculum orientation, and leadership training. Estimated time allocation is up to 12 days in year one and 6 days in year two.

**Q/C 24: Can an organization be apart of more than one community collaborative, in more than one community?**

**A 24:** Yes.

**Q/C 25: Can we have the sign in sheet to see other organizations for current or future partnership efforts?**

**A 25:** Yes, the sign in sheet was copied and distributed to everyone present at the community forum. It will also be posted on the FLBC website.