SLFRF COVID-19 Public Health Response – Louisville Metro

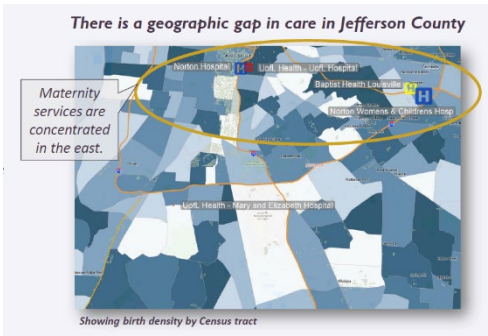
Mary & Elizabeth Hospital Birthing Center - Obstetrical and Women's Services

Summary of Project Eligibility and Need (Harm/Solution/Proportionality/Alternatives)

Project Request	$10M in ARPA SLFRF funds for UofL Health-Louisville, Inc. d/b/a UofL Health – Mary & Elizabeth Hospital, a 501(c)(3) non-profit, to support the capital expenses (~20M) required to bring a complete obstetrical and women's health service line back to South Louisville and surrounding communities.

Treasury Guidance on Allowable Use of Funds	Project Alignment
Disproportionately Impacted Households Disproportionately impacted households are those that experienced a disproportionate, or meaningfully more severe, impact from the pandemic. As discussed in the interim final rule, **pre-existing disparities in health and economic outcomes magnified the impact of the COVID-19 public health emergency** on certain households and communities. (Page 38-46)	This project has without a doubt demonstrated eligibility for Disproportionately Impacts Households based on both quantitative and qualitative data, including qualified census tracts, incomes, and research/data on health care outcome and access disparities.
Medical Facilities Given the central role of access to high-quality medical care in reducing health disparities and addressing the root causes that led to disproportionate impact COVID-19 health impacts in certain communities, **the final rule recognizes that medical equipment and facilities designed to address disparities in public health outcomes are eligible capital expenditures**. This includes primary care clinics, hospitals, or integrations of health services into other settings. (Page 126-127)	As *enumerated* within the final rule, this project requests funding to support the development of a medical facility to support health services designed to address the root cause of health disparities, exacerbated by the pandemic, for maternal care within South Louisville.

Description of Harm
(see Capital Expense Justification Form)



- Approximately 11,000 annual births occur within a 30-minute drive time of M&E Hospital. **To date under the pandemic this is ~27,500 women, their newborns, and their families that suffer disproportionately from pre-existing inequalities in access and outcomes, worsened by COVID-19, that this project will address.**
- In the United States, Kentucky, and South Louisville, racial and economic disparities in maternal morbidity and mortality are pronounced and persistent.
- Racial, ethnic, and income disparities in severe maternal morbidity and outcomes persist and are exacerbated by obstetrical unit closures and existing maternity care "deserts", which is true for M&E's service area.
- Research documents pre-pandemic health inequities have been exacerbated by the public health emergency, including among low-income, Hispanic, and Black pregnant women and newborns.

Appropriate & Proportional Response
(see Capital Expense Justification Form)

- The gap in care for women West of I-65 is glaringly blatant. M&E does not currently offer obstetrics (OB) services yet it is the only hospital west of I-65 that could potentially fill this much needed gap in care for the communities we serve. Our patient population is diverse, in an underserved area and the birth rate is one of the highest in Jefferson County.
- **Capital expenditures are essential to open the Birthing Center; we must have medically sound facilities and equipment to safely serve patients.** This will require renovations to retrofit

existing facilities, including moving current services, and occur over three phases of construction.

- Conservatively, this will serve:
  - Year 1: 300 births + 1500 gynecological care encounters
  - Year 2: 375 births + 1800 gynecological care encounters
  - Year 3: 575 births + 2700 gynecological care encounters
  - Year 4: 850 births + 4000 gynecological care encounters
  - Year 5: 1,000 births + 5900 gynecological care encounters
- **The facility will enable the implementation of an integrated care model, providing pregnancy, wellness, and preparation for parenthood services to address the root causes of the disproportionate harm the South Louisville community has suffered**, and will continue to suffer absent investment, due to the lack of dedicated maternity care facilities and programs within M&E, its community hospital.

Alternative Comparison
(see Capital Expense Justification Form)

1. **Alternate #1**: Developing an Obstetrics ED would require minimal construction capital outlay of less than $1M but would require a multimillion-dollar annual investment to support a program without general obstetrical care. While the OBED would make an impact, it would not address the fundamental problems that lead to poor outcomes and would be prohibitively expensive.

2. **Alternate #2**: Initiate a full-service OB program by retrofitting a portion of the second floor to accommodate OBED, L&D, OB Surgery, and nursery services. Estimated costs were $17M. The existing space currently supports patient services including patient care rooms, GI labs, and other patient care services. With this approach, the space and flexibility of program design was limited to the existing floorplan within the hospital interior.

3. Selected Option: The selected approach is to build a separate building and annex to the hospital. Estimated costs of $20M. This approach offers significant positive attributes, including:
   - Minimal disruption to the existing services within M&E
   - Provides for the immediate need in the underserved community, while setting M&E up for future growth.
   - Separate entrance and dedicated OB/ED providing advanced 24/7 coverage for OB patients and decreased cOVID-19 exposures.
   - Modern floorplan would be accessible to both women's floor and existing ED, allowing clinical staff crossover, and dramatically lowering overall operating costs.
   - Outpatient clinic within the building outside of the hospital license for a lower cost, convenient, and integrated experience for the patient.
   - Ability to offer other integrated women's services that will improve access, convenience, and patient care.

Table on Contents for Additional Project Materials:

1. *Completed Capital Expenditure Written Justification Form*
2. *Letter of Request / Letter of Support*
3. *Detailed Budget*
4. *M&E PowerPoint Materials with Project & Service Lines Overview*
5. *Research supporting the project rationale and need.*
6. *501(c)(3) IRS Approval Letter*

#1
Capital Expenditure
Written Justification Form

Louisville Metro Government
American Rescue Plan Capital Expense Justification

Project Name	Mary & Elizabeth Hospital Birthing Center – Meeting a Critical Need
ARP Funds Amount Requested	$10 million
Requested By	Melisa Adkins, CEO, UofL Health-Louisville, Inc. d/b/a UofL Health – Mary & Elizabeth Hospital
Date Requested	3/30/2022

1. **Description of the Harm or Need to be Addressed** (should be the same for all expenses in project, based on project proposal problem statement) SEE JUSTIFICATION GUIDANCE BELOW

Research regarding the pandemic, and echoed by the SLFRF funds intended use, documents that the COVID-19 pandemic has had disproportionally negative impacts on many households and communities that were already experiencing inequality in public health outcomes related to race, gender, age, or income before the pandemic. As reported by the Urban Institute:

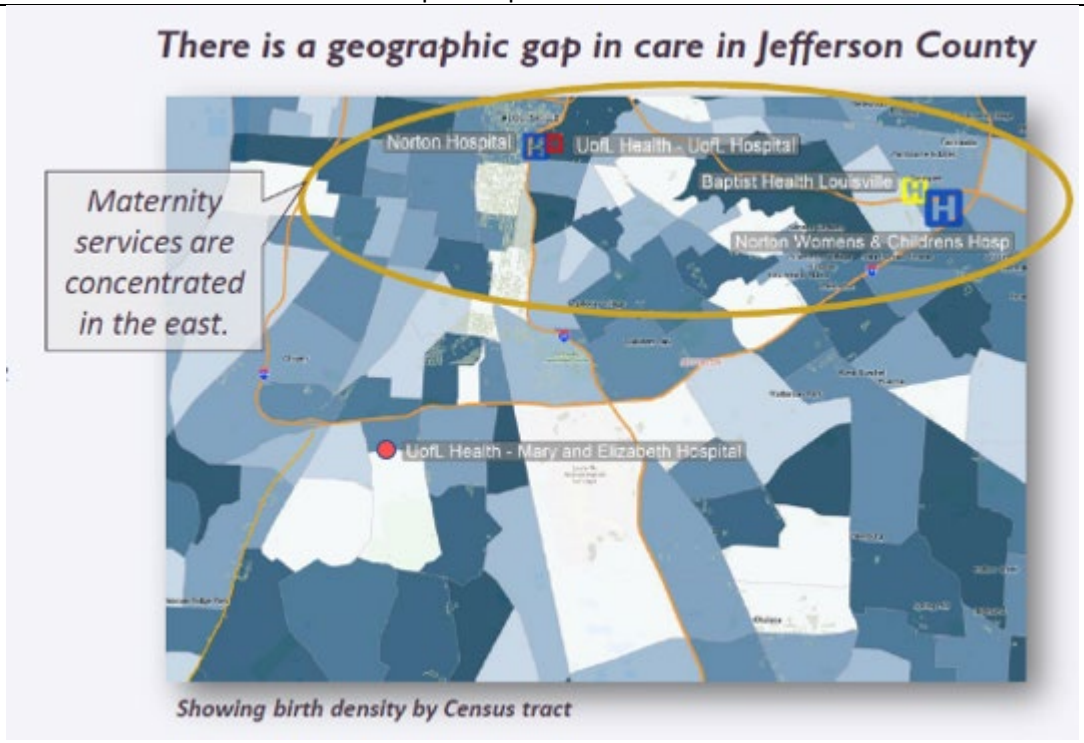
> The public health crisis has also highlighted preexisting deficiencies in our health care system. Most notably, long-standing racial inequities in health care access and health outcomes have been amplified by the disproportionate toll the pandemic has taken on communities of color (Artiga, Corallo, and Pham 2020). The pandemic has also raised new challenges, increasing both medical and social needs while isolating people from community and family supports… Systemic disparities affect access to care for women of color, as manifested in relatively low insurance coverage rates, **geographic availability of care**, and access to transportation (Haley and Benatar 2020; Johnston et al. 2019). *Maternal Health Inequities during the COVID-19 Pandemic (May 2021).*

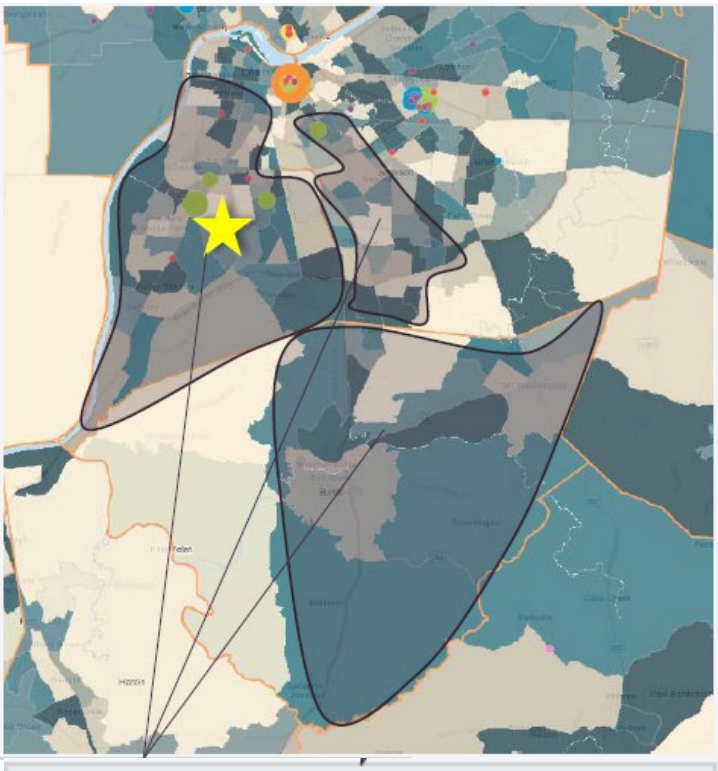
Due to the unprecedented and harmful effects of the COVID-19 pandemic, our original 2020 Birthing Center plan for Mary & Elizabeth Hospital (M&E) was delayed. Our resources were diverted to combat the virus instead of investing in other areas of need for our community. Because of this, the pre-existing, ongoing harm for pregnant women in the communities M&E serves has only continued to negatively and disproportionately impact the South Louisville community. Our communities are comprised of diverse and underserved populations in Louisville that have been overlooked when it comes to equitable and accessible healthcare when compared to the East End communities.

Mary & Elizabeth Hospital is located at 1850 Bluegrass Ave, Louisville, Ky 40215, which is within both the HUD 2022 Qualified Census Tract and Difficult Development Area. The hospital is in and near a population with high infant mortality rates yet physically located in a maternity care desert where community members must travel to downtown Louisville (with a similar birth density) for the nearest maternity hospital (March of Dimes, Nowhere To Go, 2018).

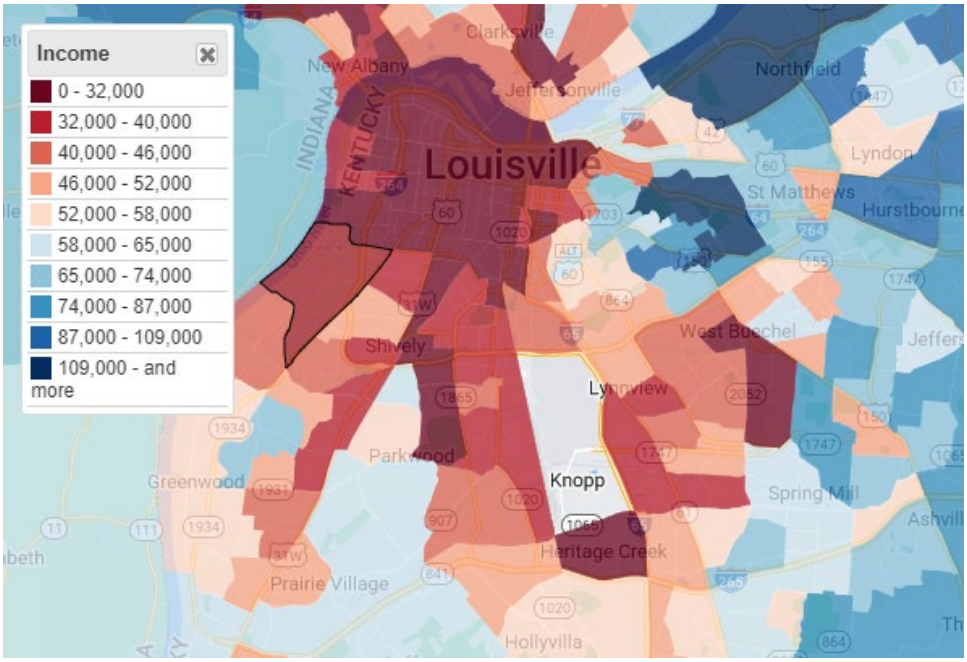
Approximately 11,000 annual births occur within a 30-minute drive time of M&E. This puts babies and mothers at unnecessary risk and delay for receiving the quality medical attention they need. Additionally, if complications arise and the baby and mother need to stay longer than average at the hospital, this could be difficult for families to afford the travel back and forth between their home and the hospital, afford lodging, transportation, and childcare for additional children. In the community where M&E is located, the median annual household income is $31,132 and nearly 83% of public-school students in the community are eligible for free or reduced lunch (Zip Data Maps, 40215, March 2022). Any additional costs, especially those that could have been avoided if a mother and child received the care they needed, close to home and in a timely manner, can be devastating to families.

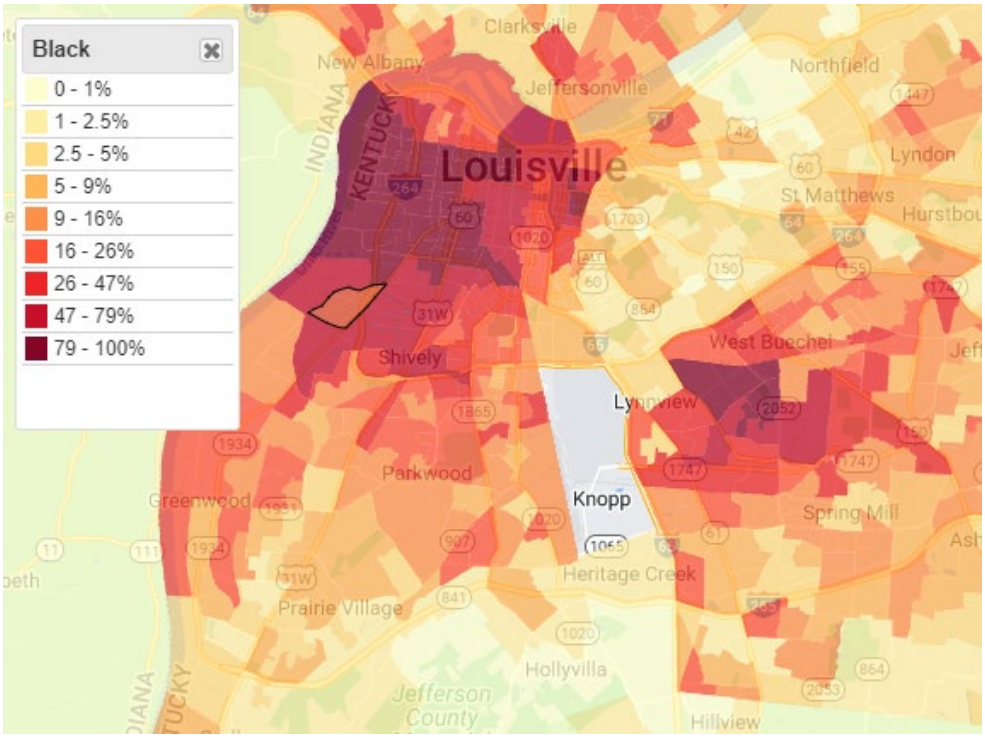
A series of maps below help visualize this access and outcome divide geographically based on current facilities, income, and race:

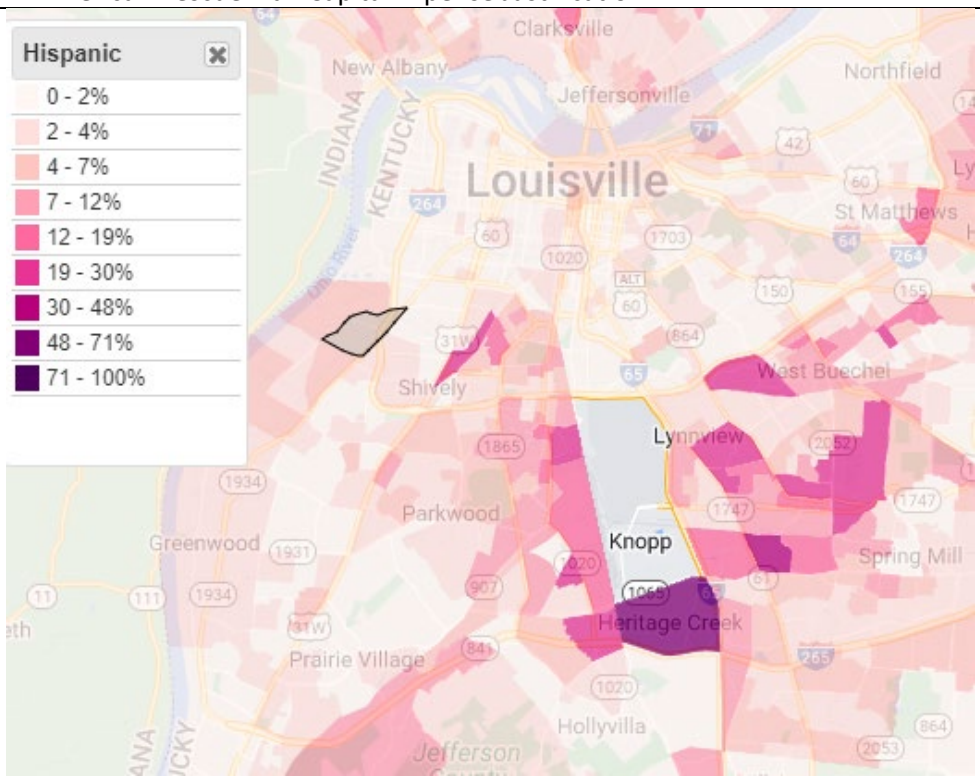




We anticipate serving families from the I-65 Corridor and Bullitt County in addition to Mary & Elizabeth's primary service area.


Income
0 - 32,000
32,000 - 40,000
40,000 - 46,000
46,000 - 52,000
52,000 - 58,000
58,000 - 65,000
65,000 - 74,000
74,000 - 87,000
87,000 - 109,000
109,000 - and more
Louisville
Clarksville
New Albany
Jeffersonville
Northfield
Lyndon
St Matthews
Hurstbourne
West Buechel
Shively
Lynnview
Parkwood
Knopp
Spring Mill
Heritage Creek
Prairie Village
Hollyvilla
Greenwood
INDIANA
KENTUCKY


Black
0 - 1%
1 - 2.5%
2.5 - 5%
5 - 9%
9 - 16%
16 - 26%
26 - 47%
47 - 79%
79 - 100%
Louisville
Clarksville
New Albany
Jeffersonville
Northfield
Lyndon
St Matthews
West Buechel
Shively
Lynnview
Parkwood
Knopp
Spring Mill
Heritage Creek
Prairie Village
Hollyvilla
Jefferson County
Hillview
INDIANA
KENTUCKY



We must do a better job as a community and provide access to those most vulnerable in our city. Not everyone has the means or the wherewithal to make it downtown or to the East End should an emergency occur during pregnancy.

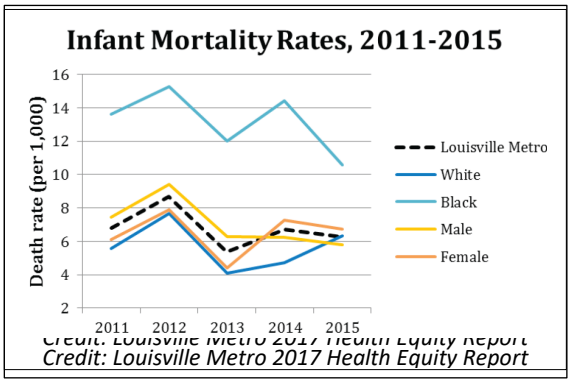
When a pregnant woman presents to the Emergency Department with an issue related or unrelated to COVID-19 it can be very serious. Pregnant women are more likely to get very sick from COVID-19 compared to people who are not pregnant. Additionally, if a woman does contract COVID-19 during pregnancy, she is at an increased risk of preterm birth and stillbirth and might be at risk for other pregnancy related complications that can affect the pregnancy and the developing baby.

A study published in November 2020 compared pregnant women admitted in Philadelphia for severe or critical coronavirus disease to reproductive-aged nonpregnant women admitted for severe or critical coronavirus disease. It found that pregnant participants were more likely to be admitted to the ICU, to be intubated, to require mechanical ventilation, and were at increased risk of composite morbidity. Similarly, an analysis of 400,000 women in the United States between 15 and 44 years of age with symptomatic COVID-19 published in October 2020 found that pregnant women were more likely to experience ICU admission, intubation, mechanical ventilation, and death. Publications including data from a variety of contexts and designs found that the most reported adverse outcome was preterm delivery. Additionally, an increased prevalence of low birthweight and Cesarean-section (C-section) delivery were also observed. As previously stated, other obstetric complications and outcomes including maternal death, stillbirth, miscarriage, preeclampsia, fetal growth restriction, coagulopathy, and premature rupture of membranes were rare, but apparent (“The impact of the COVID-19 pandemic on maternal and perinatal health: a scoping review”, Reproductive Health Journal, 2021).

If provided this financial support, M&E would be able to build a space designed to prevent transmission of the virus that causes COVID-19 in pregnant women. The design would include appropriate isolation of pregnant patients who have suspected or confirmed COVID-19; basic and refresher training for all healthcare personnel on the OB unit (related specifically to pregnancy) to include correct adherence to infection control practices and personal protective equipment (PPE) use and handling; and sufficient and appropriate PPE supplies positioned at all points of care.

M&E would be bringing access to prenatal care close to home for so many who may not seek maternity care because of the inequities that exist in our area. This would include women's clinics, educational classes, birthing unit, and emergency care for pregnant women that does not require adding additional minutes into already critical situations that present because access is so limited. Time can make all the difference if a mother and/or baby are in trouble. (CDC, Considerations for Inpatient Obstetric Healthcare Settings, 2021).

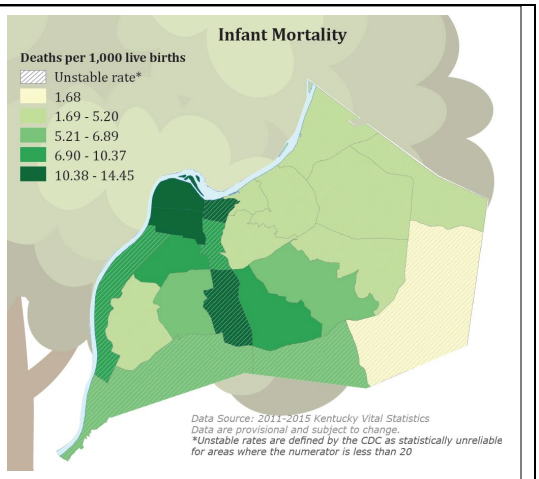
Kentucky has some of the worst health outcomes in the country and ranks 44th as the least-healthy state, according to America's Health Rankings 2020 Annual Report. This has significant impacts on maternal and infant health and mortality. Lack of access to prenatal care, increased rates of smoking among women of childbearing age and the use of opiates and other substances contribute to premature and late preterm births in Kentucky.



Credit: Louisville Metro 2017 Health Equity Report

Kentucky's preterm birth rate is one of the highest in the U.S., 11.3% in 2019, which ranked the state 9th in the nation. Additionally, the state's low birthweight rate was 8.8%, ranking the state 16th (CDC National Center for Health Statistics, Key Health Indicators 2019). According to Louisville Metro's most recent 2017 Health Equity Report, "preterm birth can present a serious risk of disability and/or shortened life expectancy for the baby because there is so much development that occurs in the third trimester of pregnancy, including the brain, lungs, and liver." Currently, there are no maternal healthcare services at M&E despite serving zip codes with the highest birthrates and projected births.

Furthermore, Kentucky has a 50% rate of pregnancy-related maternal deaths, 46% involving substance abuse and 78% of these were preventable (Maternal Mortality Review, 2020 Annual Report). Without access to immediate, quality care, preterm births can lead to lifelong impacts on social and physical development, such as learning disabilities and mobility issues. Having access to a Birthing Center and trained medical providers in one's local community can also make the difference between life and death for a preterm baby and mother (Louisville Metro Health Equity Report, 2017).

	Every year, almost 700 U.S. women die due to pregnancy or delivery complications. Racial disparities are evident in Louisville Metro. The maternal mortality rate is disproportionately higher for Black women (Maternal Mortality Review, 2020 Annual Report). In addition, more Black babies than white babies experience preterm births, low birth weights and infant mortality (Louisville Metro Health Equity Report, 2017). In the U.S., Black women are nearly 4 times more likely to die from complications than non-Hispanic White women (Centers for Disease Control and Prevention, 2019). In Kentucky, the maternal mortality rate is 2.5 times higher for Black/African American women than White women (Maternal Mortality Review, 2020 Annual Report), even though Black/African Americans make up only 8.5% of Kentucky's population (U.S. Census, 2021).  *Credit: Louisville Metro 2017 Health Equity Report* M&E's service area includes 22.4% Black/African American. However, a recent snapshot of the past 24 months showed that 27% of M&E patients identified as Black/African American. Overall, the UofL Health system's newborn patient demographics was even higher – 31% Black/African American. Please note that UofL Health and M&E serve other races and ethnicities, but the data presented here is focused on Black/African American demographics due to the alarmingly high mortality rates for this population in Kentucky. There is a lack of maternal healthcare services for the population served by M&E, many of whom have limited access to healthcare and late or no prenatal care. Because of the socio-economic challenges faced by patients, their babies are frequently born prematurely, with low birth rates and other complicating medical conditions. Importantly, over 60% of pregnancy-related deaths can be prevented (Maternal Mortality Review, 2020 Annual Report). The last birth at M&E was in 1974. Now, nearly 50 years later, we have the opportunity to not only return this program but also offer novel, holistic care and midwifery services (currently not offered in any other hospital in Kentucky). Establishing a Birthing Center at M&E will offer local specialized care for babies, improving treatment while reducing burdens on parents and families. Maternal healthcare services and an experienced team will give infants a chance at life, as well as interventions that reduce long-term trauma to the child and support for the mother during a time of tremendous need.
2. **Explanation of Why a Capital Expenditure is Appropriate** (explain why project cannot use existing Metro property or other methods besides new capital expense) SEE JUSTIFICATION GUIDANCE BELOW	This is a $20 Million project, which we are requesting ARP funding of $10 Million to cover the first two (of three) phases of necessary renovations to create the Birthing Center. The remaining $10 Million needed will be provided through operating capital investment from UofL Health, additional community partnerships and philanthropy. Capital expenditures are essential to open the Birthing Center; we must have medically sound facilities and equipment to safely serve patients. This will require renovations to retrofit existing facilities, including moving current services, and occur over three phases of construction. With $20 Million in start-up costs, the project is expected not to break even for five years. However, with $10 Million in support from ARP funding, the Birthing Center could break even in year three,

which will be well-timed with reinvestments that will then be needed in equipment and facilities for ongoing updates.

UofL Health is committed to serving medically underserved communities, and *even with the availability of the American Cares Act to support citizens, in Fiscal Year 2021, it incurred over $51 Million in charity care.* Given the ongoing financial consequences of the pandemic, our ongoing support for charity care, and the numerous needs of our facilities that the system is facing, without this capital support, the Birthing Center is not feasible. It would be extremely difficult for UofL Health to be financially responsible for all of the $20Million in start-up funds without becoming financially viable for five years.

M&E does not currently offer obstetrics (OB) services yet it is the only hospital west of I-65 that could potentially fill this much needed gap in care for the communities we serve. The gap in care for women West of I-65 is glaringly blatant. Our patient population is diverse, in an underserved area and the birth rate is one of the highest in Jefferson County. The internal structure of M&E would not meet compliance to provide these services without a major capital expenditure to meet code and bring the hospital into compliance. Just because we do not offer OB services does not mean we should not.

Per an Urban Institute report on the topic:

> Legislators, payers, and health systems could expand access to services and alternative care models that promote equitable outcomes. Legislators could increase funding for services that may be more culturally and linguistically effective, such as telehealth, midwifery, doula support, prenatal risk assessments, screening for postpartum depression and social determinants of health, substance use treatment services, home visiting, and alternative care models like birth centers and group prenatal care.
> *Maternal Health Inequities during the COVID-19 Pandemic (May 2021).*

This project encompasses nearly all the above solutions as part of the service lines delivered through the capital investment in the Birthing Center - all designed to respond to the pandemic and its exacerbation of pre-existing health inequities disproportionally impacting South Louisville mothers, babies, and families.

Building an integrated women's service line that includes labor and delivery, an OB Emergency Department (OBED), and other integrated services to benefit our community is a priority. Without OB services in M&E, mothers will have to drive further for care (both prenatally and during labor), leading to more mothers forgoing prenatal care and poorer perinatal outcomes (including higher C-section rates and higher maternal mortality rates). Adding OB services with a 24/7 hospitalist program and OBED will lead to a reduction in "serious harm" incidents during perinatal episodes, lower claim frequency, and lower cost per birth. For example, Ascension Health saw a 31% decrease in "serious harm incidents" after implementing an OBED. Offering a high-touch, low-intervention option, led by midwives, leads to even better-quality outcomes such as lower pre-term birth rates, lower C-section rates, and higher VBAC (vaginal birth after cesarean) rates (Cochrane review; CMS Strong Start).

The proposed Birthing Center will offer 12 beds, including triage, and offer a space that feels more like a home environment than an institution, to invite families to be present together. It will also have a space to isolate COVID-19-positive mothers. Delivering mothers who are COVID-19 positive must be isolated from other patients and these services require additional space

	considerations. Maternity care and birthing are health and community services and programs that require both specialized equipment and space to offer the safe delivery of services. When a woman is in labor, time is of the essence when it comes to the health and wellbeing of the mother and child. A lot of birth-related issues are unknown until the birth process begins. Increased time to reach a healthcare facility can cause an increase in harm and the difference between life and death/disability for both mother and child. Without the requested capital expenditure, M&E will not be able to meet this critical and growing need and bring services back to the community in which it serves. Approximately 11,000 annual births occur within a 30-minute drive time of M&E. Below are the annual projected numbers of patients to benefit from our maternal care and birthing services in the next five years. The first number is projected births and the second number is the anticipated non-obstetrics related visits including well women and gynecological care: • Year 1: 300 births + 1500 gynecological care encounters • Year 2: 375 births + 1800 gynecological care encounters • Year 3: 575 births + 2700 gynecological care encounters • Year 4: 850 births + 4000 gynecological care encounters • Year 5: 1,000 births + 5900 gynecological care encounters
3. **Comparison of the proposed capital expenditure against alternative capital expenditures** (list alternative products/vendors and procurement process used to select this product) SEE USTIFICATION GUIDANCE BELOW	When comparing whether to retrofit the Obstetrical unit into an already existing area of the hospital ($17M) or analyzing the prospect of constructing a new building to fit the program ($20M), the answer is clear. Retrofitting takes a lot of construction and redefining of an already existing space, which may not be the best and most efficient way to start a new program. Furthermore, it will disrupt day-to-day care in an already busy facility. This would also take away from much needed non-OB related clinical beds needed in an acute care situation. Constructing a new building will allow the facility to build an OB that is designed to be efficient for patients and staff alike versus taking the already existing space and trying to make it work (which is not always the most efficient because we must work within the original 1950's footprint). The new build will take into consideration the latest designs, regulations and codes needed to move this project forward and deliver the best product for the community we serve. The total operating costs, including staffing, supplies, and overhead per year, is expected to be approximately $9.7M. This is not something M&E or UofL Health is taking lightly as evidenced by the willingness of the UofL Health CEO to agree to match the requested funding of $10 Million dollar for dollar. This program requires UofL Health to continue investing in the women of this community for many years to come. Although an OB unit is not the most profitable program to open and maintain, it is one that shapes the future of our community. We have recognized the need and the harm that can come to those most innocent should we not be allowed to move forward in this endeavor. The remaining alternative would be to choose to do nothing in the face of this critical need. As stated previously, this would endanger the lives of mothers and children when true emergencies occur without access to the care they need close to home. Details of UofL Health's considerations related to the three options verses the status quo include: 4. Development of an OBED program. Developing an Obstetrics ED would require minimal construction capital outlay of less than $1M but would require a multimillion-dollar annual investment to support a program without general obstetrical care. While the

	OBED would make an impact, it would not address the fundamental problems that lead to poor outcomes and would be prohibitively expensive. 5. Initiate a full-service OB program by retrofitting a portion of the second floor to accommodate OBED, L&D, OB Surgery, and nursery services. Estimated costs were $17M. The existing space currently supports patient services including patient care rooms, GI labs, and other patient care services. With this approach, the space and flexibility of program design was limited to the existing floorplan within the hospital interior. 6. Build a separate building and annex to the hospital. Estimated costs of $20M. The additional $3M offers significant positive attributes over the retrofit option (#2 above): • Minimal disruption to the existing services within M&E • The entirety of funds utilized for women's health. A larger infrastructure would provide for the immediate need in the underserved community, while setting M&E up for future growth. • Separate entrance and dedicated OB/ED providing advanced 24/7 coverage for OB patients. Modern floorplan would be accessible to both women's floor and existing ED. Clinical team staffing the OB/ED can crossover with Labor & Delivery dramatically lowering overall cost to provide both services. • Provides a floorplan with maximum versatility to accommodate programing designed for efficiency, quality outcomes, an enhanced patient experience, and future growth. • Outpatient clinic within the building outside of the hospital license for a lower cost, convenient, and integrated experience for the patient. The proximity of a clinic within the building enhances the efficiency for the clinical team. • Ability to offer other integrated women's services that will improve access, convenience, and patient care. Within the building infrastructure, M&E will have space designed to support and build community within the women's care programming.
Prepared by	Name: Melisa Adkins; Bryn Cowgill Bidwell — Department: CEO, Mary & Elizabeth Hospital; Executive Director, Philanthropy

This form is designed to meet a U.S. Treasury requirement in 31 CFR Part 35, the SLFRP Final Rule:
https://home.treasury.gov/system/files/136/SLFRF-Final-Rule.pdf#page=194

This form, with appropriate approval, is required for capital expenditures (spending on equipment, property, and facilities) on ARP projects over $1 million.

See guidance on following page.

Justification Guidance (excerpted from the SLFRF Final Rule linked on page 1)

The Written Justification should (1) describe the harm or need to be addressed; (2) explain why a capital expenditure is appropriate to address the harm or need; and (3) compare the proposed capital expenditure against alternative capital expenditures that could be made. The information required for the Written Justification reflects the framework applicable to all uses under the public health and negative economic impacts eligible use category, providing justification for the reasonable design, relatedness, and reasonable proportionality of the capital expenditure in response to the harm or impact identified.

1. Description of harm or need to be addressed: Recipients should provide a description of the specific harm or need to be addressed, and why the harm was exacerbated or caused by the public health emergency. When appropriate, recipients may provide quantitative information on the extent and type of the harm, such as the number of individuals or entities affected.

2. *Explanation of why a capital expenditure is appropriate:* Recipients should provide an independent assessment demonstrating why a capital expenditure is appropriate to address the specified harm or need. This should include an explanation of why existing capital equipment, property, or facilities would be inadequate to addressing the harm or need and why policy changes or additional funding to pertinent programs or services would be insufficient without the corresponding capital expenditures. Recipients are not required to demonstrate that the harm or need would be irremediable but for the additional capital expenditure; rather, they may show that other interventions would be inefficient, costly, or otherwise not reasonably designed to remedy the harm without additional capital expenditure.

3. *Comparison of the proposed capital expenditure against alternative capital expenditures:* Recipients should provide an objective comparison of the proposed capital expenditure against at least two alternative capital expenditures and demonstrate why their proposed capital expenditure is superior to alternative capital expenditures that could be made. Specifically, recipients should assess the proposed capital expenditure against at least two alternative types or sizes of capital expenditures that are potentially effective and reasonably feasible. Where relevant, recipients should compare the proposal against the alternative of improving existing capital assets already owned or leasing other capital assets. Recipients should use quantitative data when available, although they are encouraged to supplement with qualitative information and narrative description.

Recipients that complete analyses with minimal or no quantitative data should provide an explanation for doing so.

a. *A comparison of the effectiveness of the capital expenditures in addressing the harm identified.* Recipients should generally consider the effectiveness of the capital expenditures in addressing the harm over the useful life of the capital asset and may consider metrics such as the number of impacted or disproportionately impacted individuals or entities served, when such individuals or entities are estimated to be served, the relative time horizons of the project, and consideration of any uncertainties or risks involved with the capital expenditure.

b. *A comparison of the expected total cost of the capital expenditures.* Recipients should consider the expected total cost of the capital expenditure required to construct, purchase, install, or improve the capital assets intended to address the public health or negative economic impact of the public health emergency. Recipients should include pre-development costs in their calculation and may choose to include information on ongoing operational costs, although this information is not required.

In determining whether their proposed capital expenditure is superior to alternative capital expenditures, recipients should consider the following factors against each selected alternative.

Recipients should balance the effectiveness and costs of the proposed capital expenditure against alternatives and demonstrate that their proposed capital expenditure is superior. Further, recipients should choose the most cost-effective option unless it substantively reduces the effectiveness of the capital investment in addressing the harm identified.

#2
Letter of Request / Letter of Support

#3
Detailed Budget

#4
M&E PowerPoint Materials w/ Project & Service Lines Overview

#5
Research Articles

#5
IRS 501(c)(3) Approval