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

Wes Moore, Governor – Aruna Miller, Lt. Governor
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Maryland Health Equity Resource Act

Addressing health disparities, improving health outcomes, and reducing health care costs

Health Equity Resource Communities

Call for Proposals

October 4, 2023

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1. Background on the CHRC

The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly through the Community Health Care Access and Safety Net Act of 2005 to expand access to health care for low-income individuals and underserved communities in Maryland and bolster the capacity of health care safety net infrastructure to deliver affordable, high-quality health services to those populations. The CHRC is an independent commission within the Maryland Department of Health (MDH) that has 11 members appointed by the Governor. In creating the Commission, the Maryland General Assembly recognized the need to have an independent commission to support projects that serve the unique health needs of vulnerable populations; strengthen the state's network of community health resources; and address service delivery gaps in Maryland's dynamic health care marketplace. Thus, the fundamental policy objective of the CHRC authorizing statute is to expand access to community health providers since health insurance coverage alone is not always sufficient to enable at-risk communities and vulnerable populations to receive affordable, high-quality health care services.

The CHRC has, through its strategic grant funding priorities, focused on health disparities when supporting innovative programs administered by public health agencies, safety net healthcare providers and community-based organizations that are designed to reduce health disparities and improve health outcomes by achieving equitable access to health care and support services and addressing social determinants of health (SDoH).

Since its inception, the CHRC has issued 17 Calls for Proposals and awarded 695 grants totaling $126 million to support projects in each of Maryland's 24 jurisdictions. To date, these grants have provided essential health and social services to more than 525,000 residents, resulting in 1,409,703 service encounters.

Investing limited public resources efficiently and strategically to achieve post-grant project sustainability are some of the Commission's top priorities. To that end, CHRC grantees have used initial grant funds to leverage $42.5 million in additional federal, private/non-profit, and local funding. CHRC-funded projects have achieved a demonstrable return on investment (ROI) by reducing avoidable hospital and 911 system utilization.

The Health Equity Resource Communities Call for Proposals (RFP) is structured around the Maryland Health Equity Resource Act of 2021 (Resource Act) that was approved by the General Assembly and created the Health Equity Resource Communities (HERC) and Pathways to Health Equity Program (Pathways Program) to provide targeted State resources to reduce health disparities; improve health outcomes; increase access to primary care; promote primary and secondary prevention services; and reduce health costs and hospital admissions and readmissions in specific areas of Maryland.

The Pathways Program is built on the prior success(es) of the Maryland Health Enterprise Zone (HEZ) initiative that was created by the Maryland Health Improvement and Disparities Reduction Act of 2012. The HEZ's goals were to reduce health disparities and improve health outcomes. This HEZ pilot program (2013-2017) was jointly administered by the Maryland Department of Health and Mental Hygiene and the CHRC. The HEZ designation provided each HEZ access to a range of incentives and

grant funding to address health disparities, expand access, and attract health care practitioners to the HEZ area. The HEZ program had a positive impact on health outcomes by using a variety of innovative community-based solutions.[1]

2. Health Equity Resource Communities Call for Proposals

The most recent annual report from the MDH Office of Minority Health and Health Disparities (MHHD) indicates that, while progress has been made in reducing some health disparities, it remains essential to the overall health of Marylanders that persistent, ongoing health disparities, particularly those affecting minorities, be further reduced, or eliminated. Factors that contribute to higher incidences of chronic disease, comorbidities, and poorer health outcomes include disparities in community conditions, the availability of prevention and screening services, access to health care, and the quality of patient care.[2]

One health disparity that must be addressed is the higher incidence of chronic diseases among Black residents. This community experiences a disproportionately high age-adjusted rate of death caused by conditions such as heart disease, cancer, stroke, diabetes, HIV/AIDS, and infant mortality compared to their White counterparts. Other health disparities, such as the higher rate of preventable utilization of emergency department services for ambulatory care sensitive conditions for Black residents, have been improving although large disparities remain.

The Health Equity Resource Communities Program and Pathways to Health Equity Program are designed to address these persistent health disparities. The following subsections will discuss the Pathways Program's purpose as well as its strategic approach to accomplishing its mission.

2.1 Purpose

The purpose of this RFP is to solicit proposals that present comprehensive, effective, and sustainable plans to achieve the Resource Act's legislative intent and strategic goals. An applicant's proposal must demonstrate how their project will measurably impact each of the Recovery Act's strategic goals to 1) reduce health disparities; 2) improve health outcomes; 3) improve access to primary care; 4) promote primary and secondary prevention services; and 5) reduce health care costs and hospital admissions and readmissions. Additionally, the Health Equity Resource Communities (HERC) grants will emphasize long-term interventions to address SDOH such as housing, transportation, employment, and food security.

2.2 Pathways Program Concept

In its first RFP, the Pathways Program adopted a phased approach to addressing health disparities and increasing access to health care. The Pathways Program provided the opportunity for the nine Pathways grantees to demonstrate the efficiency and effectiveness of their project design or model, organizational structures and processes, and selected project activities and interventions in achieving

[1] https://healthcareforall.com/wp-content/uploads/2020/09/HEZ-White-Paper_2020.09.10_Final-1.pdf
[2] https://health.maryland.gov/mhhd/Documents/2018%20Minority%20Health%20and%20Health%20Disparities%20Annual%20Report%20.pdf

the Resource Act's strategic goals, including an assessment of what worked well and what needs to be improved or changed in preparation for a potential HERC designation and grant. The Pathways Program also offered its grantees the opportunity to build capacity in data collection and requirements and in key strategic areas such as community leadership development and engagement, coalition building and governance, and local data collection and integration.

Current Pathways grantees are eligible to submit applications under this HERC RFP.

3. HERC Advisory Committee

The HERC Advisory Committee was established under the Resource Act. The duties of the HERC Advisory Committee are to provide initial and ongoing assistance and guidance on program evaluation and data collection services for the Pathways program and a future HERC program.

The 11 members of the Committee are appointed by the Governor, the President of the Senate, and the Speaker of the House and include the CHRC Chair; the Director of the MHHD; experts in health equity and public health; and one member of the public residing in an area that has been, or may be, designated as a HERC. The collective qualifications of Advisory Committee members and their respective terms of service are provided in Maryland Code Annotated, Health-General, § 20-1403. A list of Advisory Committee members is provided in Appendix I.

4. Strategic Goals of the Health Equity Resource Communities Program

Health Equity Resource Communities applicants must develop strategies and interventions that will address each of the Resource Act's strategic goals. These strategic goals are:

(A) Reduce health disparities

The Resource Act defines a health disparity as a particular type of health difference, such as a difference in the rates of disease occurrence, that is closely linked to social, economic, or environmental disadvantage and adversely affects groups of individuals who have systematically experienced greater obstacles to health care based on their:

a) Race or ethnicity;

b) Religion;

c) Socioeconomic status;

d) Gender, gender identity, or sexual orientation;

e) Age;

f) Mental health status;

g) Cognitive, sensory, or physical disability;

h) Geographic location; or

i) Other historic characteristic(s) linked to exclusion or discrimination.

(B) Improve health outcomes

The World Health Organization defines health outcomes as a "change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status".[3] Improvement in health outcomes can be achieved through a variety of interventions, including those that focus on the leading causes of premature deaths within a target population (e.g. reducing risk factors for premature deaths), health disparities that contribute to poor health outcomes, and interventions that aim to improve the overall health status or physical and mental well-being of individuals and communities.

(C) Improve access to primary care

Improving access to primary care services and establishing a familiar and reliable source of primary care contribute to better health in a variety of ways (e.g., regular health screenings), particularly for individuals who have chronic, untreated conditions. Interventions intended to address this strategic goal may include measures to reduce barriers to care such as helping uninsured individuals gain health insurance coverage and increasing primary care service capacity in medically underserved areas.

(D) Promote primary and secondary prevention services

From a population health management perspective, prevention services are essential to efforts to reduce the incidence and prevalence of illness and disease and promote optimal health for those who have an illness or chronic disease. Primary interventions are intended to prevent illness or disease by identifying and reducing potential health risks (e.g., immunizations, cancer screenings, and health education). Secondary interventions are intended to detect illnesses or diseases before the conditions worsen or cause other health issues (e.g., screenings for high blood pressure and mammograms to detect breast cancer). Tertiary prevention involves managing diseases to prevent progression or deterioration in health status (e.g., integrated care management and comprehensive care coordination).

(E) Reduce health care costs and hospital admissions and readmissions

There are numerous benefits associated with reducing health care costs and reducing the potentially avoidable utilization of hospital services, particularly for ambulatory care sensitive conditions (e.g., congestive heart failure or diabetes) through improvements in care management and care coordination.

Successful or competitive applicants must address each of the Resource Act's strategic goals in their proposals. The proposals will need to be specific in describing how the applicant plans to address and demonstrate progress toward achieving each of these strategic goals within the HERC program.

[3] https://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf

HERC applicants will need to focus on **at least two health disparities,** which could include a focus on one or more chronic diseases as well as other health disparities, and **at least three social determinants of health** (e.g., affordable housing, economic stability, access to health care, transportation, food insecurity, education, etc.) that drive disparities and affect the target population in the applicant's proposed geographic area. **However, applicants may tailor their focus to address the identified needs of the proposed geographic area and target population.** In addition, the proposal should describe how the program will integrate and align with the State Health Improvement Process (SHIP) and the goals defined in the strategic plan(s) of the Local Health Improvement Coalition(s) (LHIC) for the proposed geographic area.

NOTE: Applicants may wish to consider the HI-5 Initiative sponsored by the Centers for Disease Control and Prevention (CDC) when developing their project strategies. The HI-5 initiative highlights non-clinical, evidence-based community-wide approaches and interventions that can have a positive impact on health outcomes over a five-year period.[4]

5. Health Equity and Social Determinants of Health

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.[5] When individuals are not provided equal opportunities or resources to pursue optimal health and wellness, the result is health inequities and health disparities.

Despite decades of efforts to eliminate health disparities, preventable differences in disease burdens within disadvantaged populations continue to persist in Maryland. Whilst some progress has been made in narrowing the health disparities gap, efforts to eliminate these disparities must continue if we hope to impact change.[6] Elimination or improvement in these disparities is unlikely to be achieved without addressing SDOH. According to Healthy People 2030, conditions in the environments in which people live, work, play, worship, and age affect a wide range of health, functioning, and quality-of-life outcomes and risks.[7] The factors that shape these conditions include economic policies and systems; social norms; social policies and stigma; and political systems.

Addressing this is one of the most effective ways to improve health outcomes and reduce health disparities that contribute to wide health inequities.[8] Therefore, increasing the availability of population health interventions is a widely recognized approach to reducing and addressing health disparities.[9]

Understanding the intersection between SDOH, health disparities, and health outcomes is fundamental to advancing health equity. Therefore, all applicants will clearly outline how they will

[4] https://www.cdc.gov/policy/hst/hi5/interventions/index.html
[5] https://www.cdc.gov/chronicdisease/healthequity/index.htm
[6] Maryland Chartbook of Minority Health and Minority Health Disparities Data, Third Edition (December 2012).pdf
[7] https://health.gov/healthypeople/objectives-and-data/social-determinants-health
[8] https://health.gov/healthypeople/objectives-and-data/social-determinants-health
[9] https://www.cdc.gov/minorityhealth/strategies2016/index.html

describe policies, scalable approaches, and interventions that will address each of those factors to best meet the health and nonmedical needs of the target population they seek to serve. Some examples of acceptable approaches include the following:

a) Access to health care services, insurance coverage, and increased provider availability
b) Social support systems and community engagement
c) Affordable housing and safe neighborhoods
d) Access to healthy food and opportunities for physical activity
e) Educational, economic, and job opportunities
f) Access to transportation
g) Safe environment (e.g., less violence or reduced exposure to toxins or air and water pollution)
h) Language and health literacy skills

Applicants are encouraged to consider the full range of factors contributing to health disparities including race, ethnicity, and socioeconomic status, as well as added burdens the COVID-19 pandemic has placed on those who are most vulnerable.

6. Key Dates to Remember

Proposed Key Dates for the Health Equity Resource Communities Call for Proposals

October 3, 2023	**Release of the Call for Proposals**
October 16, 2023 at 9:30 am	**Frequently Asked Questions Call (all potential applicants)** • Zoom meeting link: https://us06web.zoom.us/j/87589188280?pwd=jaaQaX8QThHtVTQK5KusLtjNgU3OWK.1 • Meeting ID: 875 8918 8280 // Passcode: 389211 // Dial-in: (301) 715-8592
December 5, 2023 at 12 noon	**Deadline for email receipt of full applications**
January 2024	**Select number of applicants notified to present to the CHRC**
February 2024	**Applicant presentations to the CHRC, with award decisions immediately following the presentations**

7. Requirements for All HERC Proposals

Applicants must present a comprehensive, effective, and sustainable plan that describes how their proposed HERC project will address **each** of the strategic goals defined in the Resource Act during the five-year grant period and demonstrate their project's self-sustainability as a HERC.

All applicants will be required to declare any potential barriers to launching the project (See Risk Assessment section 8.2.4).

7.1 Entities Eligible to Apply

To be eligible to receive a HERC Designation and Program grant, applicants must meet certain requirements as set forth in the Resource Act and defined by this HERC RFP. The following types of organizations are eligible and may apply as the lead or coordinating organization applicant on behalf of the proposed geographic area:

a) Nonprofit community-based organizations;

b) Nonprofit hospitals;

c) Institutions of higher education;

d) Federally Qualified Health Centers (FQHC); or

e) Local government agencies.

Proposals must be submitted by **one** lead or coordinating organization of the type listed above. The applicant will need to demonstrate that it has the capability and capacity to serve as the lead or coordinating (i.e., "backbone") organization on behalf of a coalition of key community stakeholders, community-based organizations, and residents of the proposed geographic area and intended target population. Applicants are **strongly encouraged** to form a broad coalition of health and community partners which could include community-based organizations, non-profit social service agencies, faith-based institutions, charities, schools, local businesses, or municipal and local government entities with demonstrated experience working with the target population/communities in the defined geographic area. The proposal must **clearly define** the roles and responsibilities of the lead or coordinating organization, each coalition or participating partner organization, and other groups participating in the proposed HERC project.

The lead or coordinating organization applying for this grant will be required to provide evidence to demonstrate that efforts were made to solicit input from residents of the proposed geographic area or target population and communities, including racial and ethnic minority groups, when developing their proposal. In addition, applicants should describe how this community involvement will be incorporated in their coalition governance structure to ensure public input will be solicited during their HERC project (e.g., through community advisory boards).

7.2 HERC Geographic Area

Geographic Area Eligibility Requirements: The proposal must designate a contiguous geographic area that demonstrates measurable and documented health disparities and poor health outcomes (e.g., the percentage of low-birth weight infants above the median value for all Maryland zip codes, etc.).

The proposed geographic area must have a minimum of at least 5,000 residents. At the same time, the proposed geographic area must be compact enough to allow the proposed resources permitted under the Resource Act to have a significant impact on improving health outcomes and reducing health disparities, including racial, ethnic, geographic, and disability-related health disparities.

If the above geographic and population requirements are met, applicants ***are permitted to further define geographic eligibility.*** This may include:

a) A sub-ZIP code geographic area (e.g., US Census Tract or Public Use Microdata Areas) or

b) A community, or cluster of contiguous communities, that are defined by one or more ZIP code boundaries.

HERC applicants seeking eligibility based on a sub-ZIP code or community-based boundary will be required to reference the health disparities and poor health outcome data that supports the selection of the proposed geographic area or target communities.

HERC applicants that plan to work across multiple ZIP codes or larger jurisdictional boundaries must demonstrate that the above eligibility requirements have been met in **each** zip code.

Geographic Diversity: The CHRC must consider geographic diversity when considering proposals for the HERC Program. As noted in Section 5, the CHRC and HERC Advisory Subcommittee on Consumer Engagement and Community Outreach will conduct outreach efforts to facilitate a geographically diverse pool of applicants, including efforts to facilitate submission of proposals from rural areas.

7.3 HERC Application Requirements

The HERC proposal **must** include:

a) A description of how federally qualified health centers or other community-based organizations provide health or wraparound support services within the Health Equity Resource Community.

b) An effective and sustainable plan to reduce health disparities, reduce costs or produce savings to the healthcare system, provide health and wraparound supports, and improve health outcomes; and

c) A description of how the funding available under this RFP will be used to address health disparities and improve health outcomes through evidence-based, cross-sector interventions that achieve the following goals:

- Build health care provider capacity;
- Improve the delivery of health services;

- Effectuate community improvements;
- Conduct outreach and education efforts;
- Implement systemic strategies to improve coordination and communication across organizations that provide health care services;
- Support community leadership and development efforts; and
- Facilitate policy interventions to address upstream SDoH.

c) Implementing scalable approaches to meet the non-medical social needs of the populations identified in the most recent Community Health Needs Assessment (e.g., unstable housing, inadequate food, lack of transportation or job development);

d) Presenting a plan to hire or contract an evaluator during the five-year HERC grant period to evaluate the operation, impact, and effectiveness of the project. The proposed HERC grant budget will allocate funds to cover the salary and benefit costs for one evaluator or cover the fees for one contract evaluator (refer to Section 8.2.7.).

7.3.1 Incentives

Health care practitioners and community health workers that practice in a HERC may receive incentives. Proposals **may** include the following:

a) Proposing to use available funding to provide loan repayment incentives to induce health care practitioners to practice in the proposed area.

b) A plan to use available tax credits and other resources to encourage health care practitioners to establish or expand health care practices in the proposed area;

c) A proposal to use innovative public health strategies to reduce health disparities in the proposed area that may be supported by grant awards, such as the use of community health workers, community health centers, FQHCs, institutions of higher education, and/or community-based disease management activities; or

d) A proposal to use other incentives or mechanisms to address health disparities that focus on ways to expand access to care, expand access to non-medical interventions that promote improved health outcomes, promote hiring, and reduce costs to the health care system.

7.4 Special Review Considerations for a Prior HEZ

The Pathways Program, as it applies to the HERC program, directs the CHRC to give "special consideration" to proposals from areas previously designated as a Health Enterprise Zone (HEZ) and funded through grants issued by the CHRC. The five previously funded HEZs were:

a) The Annapolis Community Health Partnership at the Morris Blum Senior Citizen Public Housing in Anne Arundel County (zip code 21401).

b) Capital Heights in Prince George's County (zip code 20743).

c) Competent Care Connections in Caroline and Dorchester Counties (zip codes 21613, 21631, 21632, 21643, 21659, 21664, and 21835).

d) The Greater Lexington Park area of St. Mary's County (zip codes 20634, 20653, 20667).

e) The West Baltimore Primary Care Collaborative in Baltimore City (zip codes 21216, 21217, 21223, and 21229).

NOTE: Proposals submitted by prior HEZs and Pathways must meet all requirements set forth in this RFP.

8. Project Proposal Requirements

The CHRC review of HERC proposals will focus on each of the proposal requirements and elements listed in this section. The CHRC will evaluate each of the required proposal elements for completeness and quality.

8.1 General Requirements

The proposal must demonstrate:

a) How the applicant will address each of the Resource Act's five strategic goals;

b) How the applicant will demonstrate self-sustainability as a future HERC; and

c) How the applicant will meet data evaluation and program reporting requirements.

The CHRC review will place a significant emphasis on the Project Plan, in particular the Work Plan, Logic Model and Data Collection and Evaluation Plan. These components must be clearly defined, achievable, demonstrate quantifiable goals, and clearly identify the activities and interventions designed to achieve the intended results for each of the Resource Act's strategic goals. The plan should also explain how each project activity and intervention will be measured to evaluate their effectiveness and impact.

Applicants will need to provide an estimate of the potential cost reductions or savings that project interventions may achieve, with a description of the methodology used to calculate those estimates. It is strongly encouraged to plan for data sharing across partner organizations and include clear strategies.

Additionally, applicants must demonstrate how members of the target population the project intends to serve have been engaged in the development of the proposal and how members of that population will be involved in the governance structure of their HERC project if funding is awarded.

8.2 Proposal Requirements

This section provides guidance on the structure each HERC RFP proposal should use. Each proposal submitted to this HERC RFP must include all the sections and information listed below. The CHRC may disqualify any proposal that fails to satisfy any of the following requirements.

8.2.1 Project Title Page and Executive Summary

Provide a clear, concise overview of the proposed HERC project. The executive summary must state the purpose of the proposed project, give a clear description of what the project seeks to achieve, and outline how it will be achieved.

The executive summary should not be more than 2 pages in length and must provide all of the following:

a) The project title;

b) A description of the proposed geographic area and target population to be served, including the baseline number of the **new** individuals to be served and the expected number of **new** individuals to be served by the end of the five-year project;

c) An overview of the proposed project, including a statement that describes the project's intended impact and outcome(s);

d) A brief description of the health disparities that the applicant plans to address;

e) A brief explanation of how the applicant will demonstrate progress toward achieving each of the Resource Act's five strategic goals;

f) The name of the lead or coordinating applicant organization, the type of organization it is as defined by the Resource Act, and its organizational structure, current service population, and services it typically provides;

g) The names of proposed and/or existing community stakeholders and participating partner organizations in the Pathways partnership or coalition, including a brief description of what each will contribute to the five-year project;

h) The total funding amount requested for **each** of the five project years;

i) A brief but specific description of how CHRC funds will be utilized; and

j) A brief statement describing the project's long-term funding and sustainability.

8.2.2 Background and Justification

This section of the proposal should:

(A) Describe the proposed HERC geographic area. Provide a detailed description of the proposed geographic area where your target population lives and where grant-funded services will be provided. Explain how the proposed geographic area was determined and what criteria were used. Applicants must demonstrate that the proposed geographic area complies with the legislative requirements listed in Section 7.3 of this RFP. Service maps, data, and other statistics on the target population may be provided as an attachment to the proposal.

(B) Describe how the project will address the Resource Act's strategic goals. Discuss the extent to which the project will address the Resource Act's strategic goals listed in Section 4 of this RFP. The proposal should also discuss other public or population health management and health care delivery

initiatives such as alignment with the State Health Improvement Process (SHIP), strategic plan(s) of LHIC(s) within the proposed geographic area, or the Total Cost of Care Model.

(C) Describe the proposed target population. Identify the target population to be served (i.e., demographics, insurance coverage, income levels, and other distinguishing characteristics). Include a projected total number of individuals to be served by the end of the five-year project. Provide a brief explanation of how the projected number of individuals to be served was calculated.

(D) Describe the needs of the proposed target population. Clearly identify and describe the health and social needs of the target population to be served. What gaps in the healthcare delivery system impact the target population? What specific barriers obstruct access to health care and social services in the proposed geographic area? Discuss the community conditions affecting the target population's health risk behaviors (e.g., smoking, alcohol consumption, level of physical activity) and health outcomes.

Provide sufficient data to justify or validate the selection of that population and clearly identify the target population within the proposed geographic area using quantitative data that includes demographics, rates of insurance coverage, and service utilization statistics. What are the health and social needs of the target population identified within the proposed geographic area? How do these needs exceed the existing health and nonmedical resources that are available and accessible to the target population?

Identify and describe the socioeconomic factors that impact the health of the target population, such as income, poverty rate, education attainment, employment, housing, physical environment, etc.

(E) Describe the health disparities the project will address in the target population. Discuss the specific health disparities the project is intended to address and how the project will address these disparities. The proposal must demonstrate **measurable** health disparities, poor health outcomes, and other nonmedical needs by ZIP code or other jurisdictional designation and present a comprehensive, effective, and sustainable plan to address these needs (see Work Plan section below). If ZIP code or census tract data does not adequately describe the health disparities of the proposed geographic area and target population, population-level data will be accepted.

(F) Define strategies to address the targeted health disparities. Describe how funding available under this grant will be used to address health disparities through evidence-based, cross-sector, or, when not available, practice-based, strategies and interventions. Refer to Section 7.3 of this RFP for more guidance.

(G) Describe community buy-in for the project. Describe the process used to identify and engage stakeholders and community members to solicit community buy-in for the project. Describe how community stakeholders influenced the design of the project being proposed. Will community stakeholders be consulted or involved during project implementation?

8.2.3 Project Plan

The Project Plan defines the project scope and explains how all project services and activities will be initiated, executed, and completed on time while meeting the approved budget. The Project Plan should comprehensively detail the strategies, activities, interventions, and measures required to achieve the project's target goals and objectives, meet the specific needs of the target population, and provide measurable improvements in health disparities.

The Project Plan must clearly state an achievable plan to demonstrate progress toward meeting the Resource Act's strategic goals, listed in Section 4 of this RFP, and describe the specific actions and/or steps necessary to achieve timely implementation of all project components and delivery of all services described in the proposal.

The Project Plan must present a clear set of project goals and objectives with a well-considered rationale for each goal selected (refer to the section below on the Work Plan and Logic Model). The proposed project goals and objectives should align with **each** of the Resource Act's strategic goals.

The project goals and objectives must be measurable and directly correlate key project activities and interventions with the intended impact and outcomes proposed. Each goal should be reflected in the Data Collection and Evaluation Plan (see Section 8.2.5 below).

The applicant will select the best available **evidence-based, cross-sector** or, when not available, practice-based activities and interventions necessary to achieve the project goals with a rationale for their selection. The effectiveness and impact of the selected strategies, activities, and interventions designed to achieve longer-term outcomes should be measurable over the duration of the five-year HERC Program. It is understood that this may involve a combination of project activities and interventions that demonstrate short-term outcomes (e.g., the number of individuals who establish and maintain a usual source of primary care) as well as activities and interventions that are designed to demonstrate longer-term outcomes.

The Plan should describe the major steps or actions necessary to carry out the project and define who will be responsible for initiating, implementing, and completing all project processes and activities (e.g., key project staff, coalition or participating partners, subcontractors). Once the project achieves full implementation, (meaning all project components are operational and all interventions and services have been initiated) the CHRC will request that each grantee reassess their project plan and update it as needed based on lessons learned or other factors identified during the implementation period.

8.2.4 The Project Plans' Required Components

The Project Plan is essential to the HERC application and must include the following components:

1. A community outreach and engagement strategies (target population);
2. A participant recruitment and retention strategies (all project service components);
3. A hiring plan or strategy (key project personnel to include credentialing);

4. A data management and evaluation plan;
5. A work plan;
6. A logic model;
7. An operating budget (requests and allocates sufficient funds to fully execute the project over the entire five-year CHRC grant period); and
8. A risk assessment for **each** of the above plan components.

Community Outreach and Engagement Strategies

The community outreach and engagement strategy should be a targeted approach that uses a combination of methods designed to establish and/or expand existing relationships with members of your target community or population while also building interest in the project. The strategies should include ways to maintain these relationships over the course of the HERC project. Applicants are **strongly encouraged** to formulate a targeted outreach campaign and/or a strategic marketing plan with culturally sensitive messaging and materials to raise awareness of the project.

For example, one strategy is to conduct community focus groups that assess the needs and preferred services of the target community or population and encourage participation. Engaging an existing community advisory board that has broad community member representation and engaging with the participation of service providers, community organizations, and other community stakeholders (e.g., through an LHIC) is another method to consider.

The CHRC will consider reasonable costs for developing and implementing outreach strategies or a marketing plan that is included in the proposed budget. Applicants should also determine staffing requirements and, if applicable, any training that is required to support outreach and engagement activities.

Recruitment and Retention Strategies

The recruitment and retention strategy should be a targeted approach that uses a combination of methods, activities, and resources to engage the target community or population and recruit the planned number of unduplicated individuals and other project participants. Applicants should consider a variety of recruitment approaches and tactics that address the unique needs of your target community or population. The recruitment strategies should align with your projections for the number of unduplicated individuals to be enrolled and the rate of enrollment over the course of the project. Applicants should explore all potential barriers to participation in all project service components and determine what actions can be taken to either eliminate or reduce those barriers. Applicants should also consider building new and/or leveraging current referral relationships with service providers and community-based organizations, as well as determining what agreements are required with these potential referral sources.

Hiring Plan or Strategy

The hiring plan or strategy will define the staffing requirements for the entire five-year period of the CHRC HERC grant period. List the current staff and new staff hiring requirements and, if applicable,

contract positions necessary to conduct the project with your anticipated staffing levels. The structure and content of the plan is left to the applicant's discretion based on their organizational policies and procedures. Key project positions must be defined by role, project responsibilities, and qualifications. Their corresponding salaries and/or contractual costs should be documented in the CHRC grant budget template (see Appendix IV) as well as the budget narrative that is submitted with the HERC application.

Applicants should consider current hiring trends, particularly for health care professionals and paraprofessionals in your area and determine if potential delays in hiring these key positions should be anticipated. Identify contingencies that will be adopted to reduce the impact of potential hiring delays and/or a lack of qualified candidates on project implementation. Other factors to consider are the length of time required to hire and onboard new staff, the rate of staff turnover, and when relevant contractual agreements with staffing agencies or other personnel sources may be executed.

For Clinical Services and Providers:

Anticipate credentialing provider requirements for your project as well as delays in the credentialing process. Plan to utilize all current credentialed providers, if needed, during the credentialing process of newly hired providers.

Risk Assessment

A risk assessment is considered an essential process in the development of the Project Plan. Applicants are expected to consider all foreseeable operational factors that could delay implementation of the project, negatively impact participant recruitment and enrollment, and/or result in an unexpected, undesired change to the project plan. While some risks may be unforeseen or unavoidable, other risks can be anticipated. Applicants should be prepared to take steps to avoid or reduce the risk of potential problems, barriers, or delays. The goal is to proactively consider what can go wrong during project planning and implementation and come up with ways to avoid the risk, minimize the negative impact, and problem solve.

Are you aware of anything that would prevent the launch of this project? Applicants should include any potential barriers to launching this project. Some examples of potential barriers include construction delays, partnership agreements, hiring delays, licensing and credentialing. As noted above, risk assessment should be undertaken for each key component of the Project Plan.

The Work Plan and Logic Model

The Work Plan must provide a clear description of all strategies and interventions that will be used to achieve the project's intended goals and objectives, including the key project activities, or steps, necessary to fully implement each of the project's service components effectively within the corresponding timeframes for completion. The Work Plan will define the tasks, roles, and responsibilities of the lead organization, each community coalition or network, and all participating partner organizations that assist in the execution and implementation of the proposed strategies and interventions designed to achieve the project's intended impact and outcomes. ***The proposed***

strategies and interventions should be balanced between non-medical community-based interventions and primary-care-provider-based approaches.

The Work Plan should demonstrate a clear understanding of how the project will be implemented, including any foreseeable challenges that will need to be proactively addressed to prevent project implementation delays.

The Work Plan will document how the project will achieve each of the Resource Act's strategic goals, with corresponding objectives and measures of success and the planned key activities and steps the applicant will take to achieve each objective. Applicants are **strongly encouraged** to use SMART (Specific, Measurable, Achievable, Realistic, and Time Frame) methodology to develop their project goals and objectives.

A Work Plan **must** be submitted with the application. An image of the Work Plan template is provided in Appendix III. The Excel file of the Work Plan template is available on the CHRC Call for Proposals website.

The CHRC encourages applicants to include a Gantt chart, or similar project management tool, that maps key project milestones, actions, tasks, sub-tasks, and deliverables with their corresponding timeframes for initiation and completion dates.

All proposals **must** also include a Logic Model that fully defines specific project goals and objectives, the milestones and deliverables, and the activities or interventions to be implemented, with timelines, in each of the five project years. The Logic Model will illustrate the activities (inputs) defined in the Work Plan that, when accomplished, will produce the evidence or service delivery (outputs) that demonstrate the intended short- and longer-term outcomes and impacts of the project. An image of the Logic Model template is provided in Appendix II. The Word file of the Logic Model template is available on the CHRC Call for Proposals website. In addition, a link is provided below to the Kellogg Foundation guide.[10]

8.2.5 Data Management and Evaluation Plan

The Data Management and Evaluation Plan should describe the project deliverables. What specific deliverables will be reported to the CHRC as evidence of completion of project milestones? How and when will these deliverables be produced? What quantifiable or qualitative outcome measures are associated with these deliverables and the overall project goals? All data collection tools, and the methodology should be defined, developed and ready to implement at the onset of your project (e.g., data collection tools, questionnaires, and/or digital collection tools such as EMRs).

The Data Management and Evaluation Plan **must** include the following components:

[10] https://www.wkkf.org/resource-directory/resources/2004/01/logic-model-development-guide

Roles and Responsibilities: Who is responsible for collecting the data? Who will have access to and use the data? Who will process the data for reporting to the CHRC? Who ensures the integrity of the data? Who holds, secures, and archives the data for future access?

a) **Data to be Collected**: What data will be collected and used to monitor the progress of project implementation and the initiation of all grant funded services? What data will be collected and used to evaluate project impact and demonstrate outcomes? This should also be captured in the Work Plan and Logic Model. **NOTE: CHRC and the HERC Advisory Committee have defined a set of minimum data elements (MDEs) that are required for the HERC program.**

b) **Data Sources**: Who generates and provides the data to be used (e.g., the lead grantee, partnering service providers and community-based organizations, or other sources such as government agencies)?

c) **Data Collection Process**: How will the data be collected? What processes and methods will be used to collect, transmit, and share the data?

d) **Timeframes for Data Collection and Processing**: When will the data be collected (i.e., the frequency and interval of assessments and measures)?

e) **Data Systems**: Will data management involve an integration of systems and/or use of platforms or dashboards that will need to be created or modified, particularly if PHI or PII are involved?

f) **Data Sharing**: What agreements are currently in place, or planned, to allow sharing of data? If this involves sharing protected data (PII or PHI), are the necessary data use agreements, or other agreements, in place or planned at the time of application? Will the sharing of protected data require institutional reviews (e.g., from the IRB)? What is the anticipated timeline for executing data use agreements?

Discuss what data will be collected, the method(s) of collection, and how frequently and when data will be collected. When evaluating the needs of the target community or population, describe the quantitative data (e.g., Community Health Assessment) and, when available, reliable qualitative data (e.g., focus groups and surveys) and other data sources that can be used to determine and document the needs of the target population. Examples of data sources that could be used to describe the health needs of the target population include, but are not limited to, indicators of health status (e.g., life expectancy and maternal and infant mortality), risk factor prevalence, health insurance status, and access to primary and specialist care.

For data generated during the project, the plan must identify the discrete data variables to be collected and evaluated, the data sources, and the methods used to generate and collect the data. For example, indicate if this will be done through validated assessment tools, clinical observation, participant surveys, clinical and biometric measures, etc.

NOTE: The CHRC **strongly recommends** that the applicant develop a data flow chart or diagram to help identify any gaps in the data collection process and submit this with the application.

Where relevant, proposals should document the use of a functional EMR system; use of the CRISP ENS system; planned or existing data-sharing agreements with hospitals, community partners and/or

service providers; the use of Medicaid claims data; or other applicable data tools and resources. Applicants are encouraged to include the projected costs of IT and data collection in their line-item budget and budget narrative with the expected costs for evaluation in the overall grant budget request.

Project monitoring and the capacity to collect/report data. The plan must describe and demonstrate the applicant's capacity and ability to measure and report progress in achieving the project's goals and objectives using both qualitative and quantitative data.

The proposal must describe how the lead or coordinating organization and participating partners will systematically collect and evaluate data during the project. It should also define the roles and responsibilities of the lead or coordinating organization and coalition or participating partner organizations (or sub-grantees) in the data collection and reporting process.

There are two main categories of project data:

a) Project Performance: Data that will be used to evaluate project performance in meeting key implementation and other project milestones. This data will also inform evaluation of project design, the Logic Model, and the Work Plan. The data will serve to answer other process-related questions. For example, was the project initiated, conducted, and completed on time and on budget according to the original Project Plan? If not, what could be improved, changed, or replaced during the project to contribute to the HERC program beyond the five-year CHRC grant? Are there other aspects of the project or plan execution that could be improved? The CHRC suggests taking a "Plan-Do-Study-Act" approach as a planned reset mechanism during periodic reviews or evaluation of the project during execution.[11]

b) Project Impact and Outcomes: Data that will be used to evaluate the effectiveness of the selected project strategies, activities, and interventions in achieving the intended impact and their efficacy in helping to reduce health disparities, improve health outcomes, and accomplish the other strategic goals of the Resource Act.

Applicants will need to plan for a regular CHRC reporting schedule regarding progress and challenges related to implementation of the Project Plan. The exact process and outcome metrics to be reported to the CHRC will be jointly determined between the CHRC and each HERC grantee following the grant award.

Data Evaluation

The proposal should describe what internal data analytic tools and methodologies will be used to perform quantitative and qualitative analysis. The analytic tools and methods selected must be appropriate to the data that will be available to demonstrate project performance and progress in meeting the key deliverables as defined in the Work Plan and Logic Model. The evaluation will also need to determine the effectiveness and impact of these project activities and interventions in achieving the stated project outcomes **and** in demonstrating progress toward achieving the strategic

[11] https://www.ahrq.gov/health-literacy/improve/precautions/tool2b.html

goals of the Resource Act (i.e., what does success look like?). The evaluation methods must align with the Work Plan and the Logic Model.

Beyond the minimum data elements (MDEs) required by the CHRC and HERC Advisory Committee, applicants will need to select process and outcome measures (data elements) that are reasonable and achievable within the program's five-year CHRC grant period. These measures must be adequate to support an analysis of the effectiveness of the project in achieving the desired impact and outcomes. The Data Collection and Evaluation Plan must also align with the Work Plan and Logic Model.

It is expected that an interim project evaluation will be requested at a time to be determined during the HERC project, with a final project evaluation at the completion of the project's five-year CHRC grant period. HERC grantees may elect to perform additional periodic evaluations to assess project strategies, activities, and interventions during project execution– this could be a data driven review or an operational evaluation by the grantee with all stakeholders, coalition, and/or participating partner organizations.

Whereas the Work Plan and Logic Model can be presented in chart format, this Data Collection and Evaluation Plan should be presented in narrative form. The CHRC will give priority to applications that provide an evaluation plan that demonstrates the impact of project strategies and interventions.

The applicant could also perform a cost-benefit analysis that compares the cost of implementing innovative project interventions against existing interventions and calculating the cost savings that result.[12]

8.2.6 Definition of Unduplicated Individuals Served

Describe your understanding of Unduplicated Individuals Served as it relates to your proposed service target goals and program evaluation.

The CHRC requires that all grant funded projects track and report the number of **unduplicated individuals served towards your service target goal.** HERC grantees must follow a clearly defined intake process that facilitates collection of required standardized data measures and uses a standard/universal definition of individuals being "served." The criteria (below) are designed to reflect the variety of community outreach, interventions, and activities.

To be counted as an **unduplicated individual served,** the following criteria must be met:

1) The grantee and/or partnering organization must establish a relationship with the individual that results in documented delivery of clinical services and/or non-medical services that address the identified health and social service needs of the individual. Engagement in ongoing documented services (when indicated) is preferred but not required to meet the definition.

2) The grantee and/or partnering organization must ensure that delivery of services (clinical and non-medical) to the individual can be confirmed and documented.

[12] https://www.cdc.gov/policy/polaris/economics/cost-effectiveness.html

3) All individuals recorded under the number of unduplicated individuals served who receive grant funded services (all project components) are included in the panels uploaded to CRISP.

4) If an individual is screened or assessed and health and/or social needs are identified, the individual must receive documented services that address one or more of these needs to be counted as unduplicated. If an individual is offered a referral for services to address one or more of these needs, the grantee or partner organization must have the ability to track and close the referral to document that the intended services were received for this individual to be counted as unduplicated. The process for obtaining this information from non-participating organizations or service providers should be identified.

The **unduplicated individuals served** should only represent **newly** enrolled patients/participants receiving grant funded services under the Health Equity Resource Communities Program.

The proposal should clearly state your understanding of the definition of "*u*nduplicated individuals served."

Delivery of **all** CHRC grant-funded services will be captured in the data and reflected in reporting to the CHRC. This includes both unduplicated individuals served and other individuals who receive grant-funded services but do not meet the definition of "unduplicated individuals served." For example, individuals who have a one-off health education encounter in the community without further engagement in documented project services should be tracked.

An unduplicated individual will be a participant or patient (as identified through use of a standardized intake assessment form or other reliable data collection and documentation method) that receives documented ongoing services, such as clinical health services and/or services that include, but are not limited to:

- Health Care Access
- Transportation
- Addressing food insecurity
- Legal services
- Stable housing
- Education and Literacy
- Safety
- Social support network

8.2.7 Project Evaluator

Present a plan to hire or contract an evaluator during the five-year HERC grant period to evaluate the operation, impact, and effectiveness of the project. The proposed HERC grant budget will allocate funds to cover the salary and benefit costs for one evaluator or cover the fees for one contract evaluator. The CHRC must be notified immediately if the project evaluator requires replacement. A nonprofit community-based organization, a nonprofit hospital, an institution of higher education, an FQHC, or a local government agency may contract with a predominantly black institution, historically black college or university in Maryland to provide evaluator services.

The evaluator must have demonstrated experience in the methods of qualitative and quantitative analysis. The applicant should define the activities and responsibilities to be assigned to the evaluator, which shall include:

- Providing data, statistical, and other analyses or reports necessary to comply with CHRC reporting requirements; and
- Ensuring that the CHRC is provided with timely data and other information necessary to meet its reporting requirements to the Governor and General Assembly as defined in Maryland Code Annotated, Health-General, § 20-1408.

NOTE: Notwithstanding the above requirement to hire (or formulate a plan to hire) a full-time employee, applicants are encouraged to contract with a predominantly black institution, historically black college or university (HBCU) in Maryland to provide these evaluation services.

8.2.8 Sustainability

The sustainability section of the proposal should describe a feasible plan and strategies for long-term sustainability that includes acquisition of resources beyond State funding, including generating fee-for-service revenue or in-kind contributions from local community partners and stakeholders as part of a strategic resource mix. Discuss strategies (e.g., integrating efforts into other initiatives, promoting policy change, identifying champions, or securing additional funding) to ensure the program, processes, and mechanisms/structures the applicant is proposing will be sustained beyond the five-year grant period. The proposal should identify potential sources of future revenue and describe efforts to achieve long-term financial sustainability, including matching fund commitments or leveraging additional resources. Letters of commitment that demonstrate financial support at the beginning, middle, or end of the project grant period are also strongly encouraged. Proposals that present clear long-term funding and sustainability plans will be viewed favorably by the CHRC.

8.2.9 Lead or Coordinating Organizational Capacity

Describe the Organization's mission, structure, governance, facilities, and staffing. Describe the mission of the lead or coordinating organization (the organization submitting the HERC proposal and the entity ultimately responsible for managing the project and complying with CHRC reporting requirements), current projects, and service area. Discuss organizational strengths and any foreseeable challenges with implementing the project if a Health Equity Resource Community grant is

awarded. Describe the type of organization (e.g., nonprofit community-based organization; FQHC; nonprofit hospital; institution of higher education; or local government agency).

Specify the governance structure of the lead or coordinating organization. In an attachment to the proposal, provide a list of the senior officers and board of directors or other governing body. Describe current and proposed project staffing levels and provide an organizational chart for project staffing as an attachment to the proposal. Describe the facilities owned and/or operated by the organization.

The lead or coordinating organization should state how it plans to monitor the completion of project processes and activities assigned, including those assigned to coalition or participating partners or sub-grantees, to ensure timely project implementation and completion according to the Work Plan. This should include any information or data sharing the lead or coordinating organization will require from their coalition, participating partners, or sub-grantees to ensure internal performance monitoring and for progress reports to the CHRC. The information gathered by the lead or coordinating organization should reflect the specific project milestones, data, and/or other measures that will be used to evaluate progress in completing project implementation activities and progress toward achieving project goals (include a description of the data and/or measures in the Data Collection and Evaluation Plan below).

The proposal should describe what mechanisms will be put in place to address missed deadlines, delayed project deliverables, or other performance issues on the part of the accountable partner(s) or sub-grantee(s), and how this information will be reported to the CHRC.

Describe organizational capacity, the roles and responsibilities of key project personnel and planned project staffing: Describe the organization's capacity to implement and lead a HERC project and demonstrate self-sustainability as a HERC. This could include any relevant experience in leading a coalition of organizations, community-based work, and the implementation of multi-year projects. Identify the Project Director or other project leader, their role in the lead or coordinating organization, their qualifications to lead the project, and their responsibilities in carrying out the project. Also, identify other key staff, their roles in the project, and their relevant qualifications. Résumés for all key personnel should be included with the full grant proposal. The proposal should describe the project positions that the organization will need to fill.

Describe the organization's history of working with the target population in the proposed geographic area and their partnerships in that community. The proposal must be specific in describing the lead or coordinating organization's history of service, work, or presence in the target population and/or their work alongside partner organizations with close ties to the target population described above. This information should also be provided for coalition and participating partner organizations where applicable.

Describe organizational commitment and financial viability: The lead or coordinating applicant organization must provide evidence that the organization is in sound financial standing, has adequate financial management systems, can manage grant funds, and presents the strong likelihood of achieving the overall objective(s) defined in the grant proposal.

8.2.10 Partnerships

Identify the participating partners and/or community-based organizations (including any community advisory groups) that will be involved in the project. Name the participating partner organizations, community groups, service providers and/or other organization(s) that will play a defined role in the project. During the CHRC proposal review process, priority will be given to proposals that demonstrate support from key stakeholders and partner organizations (CBOs) in the public and private sectors, especially the support and engagement of residents from the proposed geographic area and local government entities (e.g., LHICs). The full proposal should provide a list of all HERC coalition and participating partner organizations (include commitment letters, MOUs, or contract agreements) and designate whether these partnerships are funded or unfunded.

For a proposed or existing HERC coalition, describe the coalition governance structure.
A potential or existing Pathways coalition led by a lead or coordinating organization includes participating partner organizations, other community-based organizations, or health care and other service providers that are delivering services for the HERC project. Describe the coalition and participating partner organizations, capabilities, experience, knowledge, and other resources to be contributed to the project. There should be a clear governance structure for the coalition with a point of accountability for the lead or coordinating organization and each coalition or participating partner organization.

Discuss the ways a HERC coalition and participating partners will contribute to the project. Clearly define the role of an existing or proposed HERC coalition and each participating partner organization in the project. Include a description of the added resource capacity that the partners bring to the project. Include letter(s) of intent, commitment, and/or Memoranda of Understanding (MOUs) with the proposal (see the "How to Apply" section below). Include a description of the specific role each participating partner organization agrees to play. Only organizations that have submitted a letter of intent, commitment, MOU, or other binding agreement will be considered participating partners in the project.

Discuss how the relationships within a HERC coalition and with participating partner organizations will be managed. Describe the management processes and organizational structures that exist or will be put in place to ensure that the coalition and/or participating partners will effectively work together to implement the project. Alternatively, this can be covered under the Work Plan if specifically identified as project management.

Also, describe how members of the target populations and minority groups will be included to provide input on project planning and ongoing oversight of the project. Applicants are encouraged to seek advice, input, and support from an existing community advisory board (CAB) at any stage of project development and execution. The CAB will often be a collective group composed of members from community-based organizations, neighborhood associations, and residents of the proposed geographic area. The CAB may also serve in an oversight role in the coalition. The CAB should have experience in serving minority communities or populations.

9. Selection Criteria

The CHRC will evaluate proposals based on the proposal requirements in Section 8, and the selection criteria listed below. **All** proposals will be reviewed using these selection criteria. Based on this review, the CHRC Commissioners will select applicants to present their proposals before the full CHRC. Details on the dates, location, and presentation requirements will be announced following applicant selection. Applicants not selected for HERC funding will be contacted and offered the opportunity to receive feedback on their proposals from CHRC staff.

The CHRC will use the following criteria to assess, prioritize, and select proposals based on a scoring system that assigns a numeric value range to each requirement of the proposal. The selection criteria are divided into four categories:

1) The responsiveness to the strategic goals of the Resource Act (refer to section 9.1);

2) How effectively the proposal addresses the legislative requirements as a HERC (refer to section 9.2);

3) The quality, completeness, and effectiveness of the overall project plan in addressing the strategic priorities and achieving the intended impact (refer to section 9.3); and

4) Additional selection criteria based on CHRC priorities (refer to section 9.4).

In addition, proposals offered from geographic areas previously designated as Health Enterprise Zones (HEZs) will receive special consideration.

9.1 Responsiveness to the Strategic Goals of the Resource Act (30 points)

The selection criteria that the CHRC will use during its review of the HERC applications will focus on the plan presented for achieving each of the strategic goals of the Resource Act listed below.

(A) Reduce health disparities: Does the proposal clearly identify at least one health disparity that will be addressed through project strategies, activities, and interventions that are designed to achieve or demonstrate progress toward achieving a quantifiable impact in reducing health disparities?

(B) Improve health outcomes: Does the proposal clearly target one or more health outcomes to address? Does the proposal describe how the proposed evidence-based, cross-sector (or, when not available, practice-based) strategies, activities and interventions will result in measurable changes in health outcomes, health status and/or physical and mental well-being? What health indicators will be selected to demonstrate measurable changes that are attributable to the effect of the project strategies, activities or interventions used? Will the effect be measured at an individual, group or population level? Will the effectiveness and impact of the selected strategies, activities, and interventions be achievable and measurable by the end of the five-year HERC Program? Refer to Section 8.2 above.

(C) Improving access to primary care services: Does the proposal explain how increased access to primary care services will be defined, calculated, and achieved within the five-year grant period? Does the proposal define evidence-based, cross-sector (or when not available, practice-based) multidisciplinary strategies, activities, and interventions that improve access and demonstrate understanding of the various factors that impact access? Have these factors been considered in the selection of measurements necessary to demonstrate measurable improvements in access to primary care? What access measurements will be used? Will the strategies and interventions focus on barriers or other factors that affect individuals (e.g., lack of insurance) or factors that limit the ability of primary care providers to meet the demand for health services within the proposed geographic area (e.g., limited primary care provider capacity, needed improvements in appointment scheduling and tracking)?

(D) Primary and secondary prevention services: Does the proposal clearly identify the primary and secondary prevention services that will be implemented, improved, or expanded? Does the proposal explain how improved or expanded access will help reduce health disparities in the target population? Does the proposal define achievable and measurable strategies and interventions to increase access/reduce barriers, expand service capacity, and/or improve the availability of primary and secondary prevention services? Do these strategies and interventions help to support the broader efforts within the proposed geographic area to reduce the incidence and prevalence of illness and disease and promote optimal health for those who have an illness or chronic disease? Does the proposal provide a sufficient explanation for how the selected strategies and interventions will achieve the intended impact on services and health benefits?

(E) Reduce health care costs and hospital admissions and readmissions: Does the proposal offer quantifiable cost savings goals and clearly state what data will be collected to determine these cost savings and measure reductions in hospital admissions and readmissions? Does the proposal provide an estimate of the potential cost reductions or savings that project strategies and interventions may achieve, with a description of the methodology used to calculate the savings? For example, does the proposal clearly define what data will be used to establish a baseline cost figure from which a reduction in costs over time will be calculated (i.e., what data will be used)? Does the proposal offer strategies and measurable interventions to reduce potentially avoidable utilization of hospital services, particularly for ambulatory care sensitive conditions (e.g., congestive heart disease or diabetes) through improvements in care management and care coordination?

9.2 Addressing the HERC Legislative Requirements (30 points)

HERC requirements: Applicants will need to define how the HERC requirements defined in Section 7 of this RFP are addressed in their project plan and how the associated activities and interventions to meet these requirements will be developed, implemented, and measured during, and at the conclusion of, the five-year project. Compliance with the following requirements is necessary to evaluate the ability of a HERC project to become a self-sustaining HERC.

(A) The proposal provides a description of how the project will expand the capacity of FQHCs or other community-based organizations to provide health care services or wraparound health and support

services to address non-medical SDOH. The proposal must also define how expanded capacity in these areas will be measured.

(B) The proposal provides a detailed description of how the project will have the full operational capacity to sustain program elements and interventions after the conclusion of the five-year grant period.

(C) The proposal clearly describes how the funding available under this RFP will be used to address health disparities and improve health outcomes through evidence-based, cross-sector (or, when not available, practice-based) strategies that achieve one or more of the following:

a) Build health care provider capacity;

b) Improve the delivery of health services;

c) Effectuate community improvements;

d) Conduct outreach and education efforts;

e) Implement systematic strategies to improve coordination and communication across organizations that provide health care services;

f) Support community leadership and development efforts;

g) Facilitate policy interventions to address upstream SDOH; and

h) Implement scalable approaches to meet the non-medical social needs of the populations identified in the most recent Community Health Needs Assessment (e.g., unstable housing, inadequate food, lack of transportation).

(D) The applicant presents a plan to hire or contract an evaluator during the five-year HERC grant period to evaluate the operation, impact, and effectiveness of the project. The proposed grant budget also should allocate funds to cover the salary and benefit costs for one evaluator or cover the fees for one contract evaluator (refer to Section 8.2.7).

(E) Priority will be given to applications that demonstrate:

a) Support from, and participation of, key stakeholders in the public and private sector, including residents of the area and local government;
b) A plan for long-term funding and sustainability;
c) Inclusion of supporting funds from the private sector; and
d) A plan for evaluating the impact of designating the proposed area a HERC and strategies for quality improvement.

9.3 Project Plan Components (25 points)

Quality, completeness, and effectiveness of the overall project plan in addressing the Resource Act's strategic priorities and achieving the intended impact (15 points): Does the Work Plan provide a clear, achievable, and effective plan that demonstrates how the proposed project will achieve, or show progress toward achieving, each of the strategic goals of the Resource Act as listed in Section 4 of this RFP? Does the proposed project demonstrate a high likelihood of achieving its overall project

goals and a reasonable prospect for success? Does the proposal clearly define the intended impact and outcomes that will be achieved? Is the Logic Model clear; effective at summarizing the project; and able to link project strategies, activities, and interventions with the expected impact and intended outcomes? Does the application reflect careful attention to detail, completeness, and editorial quality? Does the application include letters of commitment, MOUs, or other contractual agreements (e.g., Data Use Agreements) from key project partners (e.g., community-based organizations, service providers, or institutional partners such as hospitals or universities)? If these agreements are not currently in place, does the application provide a realistic timeframe for when all agreements will be executed so as not to delay project implementation? Does the proposal include responses to the risk assessment as outlined in section 8.2.4.

Project monitoring, and the capacity to collect, evaluate and report data (10 points): Does the proposal demonstrate the capacity and capability of the lead or coordinating organization and coalition or participating partners to collect and report the data necessary to demonstrate that the project is being implemented effectively? Does the project incorporate the best available evidence-based (or, when not available, practice-based) activities and interventions to demonstrate impact and achieve the defined project objectives? Does the proposal clearly identify what data source(s) will be utilized to document overall project impact? Does the proposal identify the methodology or established tools to be used for quantitative and qualitative evaluation of the data collected? Does the proposal demonstrate the ability of the applicant to comply with the periodic monitoring requirements that will be required by the CHRC?

9.4 Other Selection Criteria Based on CHRC Priorities and Experience (15 points)

Community involvement in the development and implementation of the HERC project (10 points). Does the proposal identify support from, and participation of, key community stakeholders in the public and private sectors, area residents, community partners, local government agencies (e.g., LHICs), and community groups or organizations who were actively engaged and participated in the preparation of the proposal? Does the proposal enlist the partnership of community-based organizations currently doing the work? Does the proposal describe if/how these entities will be involved in the planning and implementation of the HERC project? Does the proposal clearly identify how the support of, and input from, members of the communities represented in the target population in the proposed geographic area were solicited and incorporated in the proposal? Has the applicant documented how the advice, input, and support of an existing community advisory board, similar community-based organizations, and neighborhood associations of the proposed geographic area and target population were solicited, particularly those serving minority communities? Does the selection of HERC coalitions and/or participating partners from the public and private sectors represent a broad cross-section of entities that serve the target population (i.e. health and community partners which could include community-based organizations, non-profit social service agencies, faith-based institutions, charities, schools, local businesses, and municipal and local government entities) with demonstrated experience working in the defined geographic area with the target population/communities? Does the applicant propose the creation of a sustainable community network or coalition of local leaders, residents, businesses, nonprofits, and other community service organizations to support the ongoing work of the HERC? Does the proposal include letters of commitment and clearly define the roles and responsibilities of the lead or coordinating organization,

each coalition or participating partner organization, and other groups participating in the proposed HERC project? Applicants are strongly encouraged to demonstrate community engagement and outline how budget resources will support tasks and activities. As a legislative requirement, the CHRC will give priority to proposals that demonstrate geographical diversity.

Cultural, linguistic and health literacy competency (5 points). Applicants are encouraged to present strategies for working with the target population/community in a culturally sensitive and linguistically competent manner. Explain what strategies the project may consider addressing low health literacy in the target population or community. Other strategies could include the following:

- Managing translation and interpretation issues for non-English speakers;
- Making efforts to enhance recruitment of a racially, ethnically, and linguistically diverse project and/or healthcare workforce; and
- Expanding the cultural and interpretation capacity and health literacy competencies of the professional and paraprofessional health care workforce.

9.5 Special Considerations for Prior Health Enterprise Zones (HEZs)

The CHRC will give "special consideration" to proposals from areas previously designated as a Health Enterprise Zone (HEZ) that continue the activities or support the work of the prior HEZs. To address the legislative requirement, the CHRC will consider allocating up to **five additional points** for proposals submitted from the geographic areas previously designated as HEZs.

- Prior Health Enterprise Zones:
  - Annapolis (21401)
  - Capital Heights (20743)
  - Caroline / Dorchester Counties (21613, 21631, 21632, 21643, 21659, 21664, and 21835)
  - Lexington Park (20634, 20653, 20667)
  - West Baltimore (21216, 21217, 21223, and 21229)

10. Data and Technical Support

As part of the HERC Call for Proposals, the CHRC and CRISP will provide potential HERC applicants with data files to help support the preparation of HERC proposals. Applicants can use these public health and data files to identify health disparities in their communities and highlight areas of need. The data files will be posted on the CHRC website following the release of this RFP. CRISP will also provide links to state, federal, and other relevant data sources; however, applicants may also use additional verifiable data sources with supplementary information on health disparities in their communities. A description of the data in the health and data files with links to other potential data sources is provided in Appendix V.

CRISP will provide technical assistance on the provided public use files to HERC applicants during proposal preparation, and the CHRC will host a series of in-person and virtual regional forums and technical assistance calls prior to the application submission deadline on December 5, 2023. The dates and details for these in-person and virtual calls will be posted on the CHRC website.

In addition, the CHRC has provided a list of useful links to information, guidance, resources, reports, and other materials in Appendix VI that applicants may wish to consult.

11. CHRC Monitoring of Projects

As a condition of receiving grant funds, grantees must agree to participate in an ongoing CHRC evaluation of the project. Grantees will be required to submit regular project progress, fiscal and expenditure reports, and deliverables produced under the grant as a condition for payment of Commission grant funds. To facilitate project monitoring, grantees will be required to articulate and report clearly defined data metrics, quantifiable outcomes, and progress towards achieving the overall goals of the project. CHRC grantees will also be required to participate in ongoing grant monitoring and technical assistance provided by the CHRC.

The project team may be asked to attend regular virtual or in-person meetings, participate in site visits, and give reports on progress and accomplishments to the CHRC, its staff and technical advisors, and other grantees. At the conclusion of the project, the grantee will be required to provide a final written report on the project.

In addition, all CHRC grants are subject to periodic programmatic audits with grantees randomly selected annually.

11.1 Grantee Performance Requirements

The programmatic performance of all HERC grantees will be assessed by the CHRC and HERC Advisory Committee on an ongoing basis. These assessments will be based on specific performance criteria related to the timeliness of the initiation of project services, full implementation of all project activities and interventions, and the rate at which unduplicated individuals served are enrolled. **Grantees will be held accountable to meet these performance milestones and thresholds.**

The CHRC will establish a target date for these milestones once the HERC grants are awarded. Generally, we expect the initiation of key services and full implementation of the project to occur within the first three to six months following the execution of grant agreements, unforeseen circumstances notwithstanding.

Emphasis will be placed on the rate at which unduplicated individuals served are enrolled in the project. The rate of enrollment needs to be at a rate adequate to meet the service targets approved by the CHRC at the time of the award. The estimated annual percentage enrollment targets for unduplicated individuals served is presented below.

Target Enrollment Thresholds for Unduplicated Individuals Served (per Target Service Goal):

Grant Year	End of Year 1	End of Year 2	End of Year 3	End of Year 4	End of Year 5
Service Goal	15%	30%	50%	75%	75-100%

12. Use of Grant Funds

Grant funds may be used for project staff salaries and fringe benefits (note: fringe benefits are limited to 25% of total salaries), consultant fees, data collection and analysis, project-related travel, conference calls and meetings, and office supplies and expenses. If the grantee requests more than 25% in fringe benefits, the applicant will be required to provide a compelling rationale for exceeding this amount. Requests exceeding 25% will be considered on a case-by-case basis.

Applicants are encouraged to be efficient in their use of public resources. **Proposals that reflect moderation in budget requests will be viewed favorably by the Commission**. Indirect costs are limited to 10% of the total grant funds requested. However, in light of legislation approved by the Maryland General Assembly which requires the State to honor certain rates for indirect costs on certain State-funded grants and contracts with nonprofit organizations that involve federally approved rates, the CHRC will consider, on a case-by-case basis, permitting indirect cost rates above 10% if the applicant can demonstrate that a higher rate has been approved by the federal government.

Grant funds may also be expended for a limited amount of essential equipment and minor infrastructure improvements required by the project. Grantees may subcontract with other organizations as appropriate to accomplish the goals of the project, and the role of the subcontractor organization in achieving the fundamental goals and objectives of the project should be explicitly explained in the proposal in terms of achieving. Grant funds may not be used for depreciation expenses, major equipment, new construction projects, clinical trials, lobbying or political activity. Grant funds may be used for those renovations necessary to carry out the proposed project. Grant funds may also be utilized to:

a) Defray the costs of capital or leasehold improvements or medical or dental equipment to be used in a HERC;
b) Defray the costs of medical or dental equipment not to exceed $25,000 or 50% of the cost of the equipment; or
c) Provision for capital or leasehold improvements for the purposes of improving or expanding the delivery of health care in the HERC.

If the services proposed by the project are to be delivered by a subcontractor organization and not directly by the lead applicant, the applicant may not take a fee for passing through the funds to the contractor agency. Subcontractors must meet CHRC policies and procedures. Applications should include a clear description indicating how CHRC funding made available under the HERC RFP would leverage, without duplicating, current initiatives, and resources from the Maryland Department of Health, federal or state agencies, and/or private foundation funding sources that serve the strategic goals under this RFP.

13. How to Apply

The application process begins with submission of the full grant proposal by **12:00 p.m. (noon) on December 5, 2023.** CHRC staff will review these materials to ensure the proposal is complete with all required attachments as described below.

Applicants will be notified about the status of their grant proposals in January 2024. **A select number of well-reviewed grant proposals will then be considered for grant awards at the Commission's meeting in February 2024.** The CHRC will make grant awards following this meeting and applicants will be notified shortly after the meeting.

STEP 1:

Submission of the full grant proposals (see components listed below).

A full grant proposal must be received electronically (via email delivery) by the CHRC no later than **12:00 p.m. (noon) on December 5, 2023**. The full grant proposal and any appendices must be sent to Jen Clatterbuck, CHRC Administrator at jen.clatterbuck@maryland.gov. In the subject line of the email, please state your organization's name and indicate "Health Equity Resource Communities Proposal".

If grant funded services are to be provided through **formal** partnerships with other organizations or groups, the CHRC will **require that a Letter of Intent or Commitment** for each entity and/or organization be submitted with the application. Additionally, a process for executing **Memoranda of Understanding** (MOUs), **Data Use Agreements** (DUAs) or other legally binding agreements or contracts must be defined in the application. The applicant must also determine under what circumstances an **Institutional Review Board** (IRB) approval is required. **Data Use Agreements** or similar legally binding agreements or contracts should be in place prior to the grant implementation and initiation of services. We expect that all agreements will be fully executed within the first three to six months, unforeseen circumstances notwithstanding.

NOTE: Applicants are strongly encouraged to confirm that all scanned documents are legible and complete prior to submitting the proposal to the CHRC as poor image quality and incomplete or missing pages could result in disqualification of the proposal.

The full grant proposal must follow the guidelines detailed below and include the following:

a) Transmittal or cover letter
b) Executive summary
c) Project proposal (including **ALL** elements described in Section 8, and listed below)
d) Project budget and budget narrative
e) Fiscal and contractual documentation
f) Appendices (described below)

NOTE: For the electronic submission, the full grant proposal must be submitted in Adobe Acrobat PDF format and all information be clearly visible.

In addition to the electronic submission, two **original** hard copies of the full grant proposal with all items listed below must be sent to the CHRC via USPS mail or express delivery service.

Delivery Options: If sent by USPS, it must be postmarked no later than **December 5, 2023**; if sent by an express delivery service, the package must indicate that the package was picked up for delivery by the close of business on **December 5, 2023, to be considered a complete proposal.**

One original full grant proposal includes a **signed original of each** of the following:

a) Transmittal letter
b) Grant application cover sheet
c) Executive summary and full project proposal (no signature required)
d) Contractual obligations, assurances, and certifications
e) Federal Form W-9
f) Financial audit or statement(s)

The **original** grant proposal, with all items listed above, and any appendices or attachments must be bound together and labeled "Original".

PLEASE NOTE: Hand delivery of the original hard copies of the full proposal may be delivered to 45 Calvert Street, Room 336, Annapolis, MD 21401, or you may choose one of the delivery options below. The two hard copies of all proposal documents should be spiral or comb bound.

As noted above, the original hard copy of the full grant proposal should be sent by USPS mail or express delivery service (with a post-mark or confirmed pick up for delivery date **no later than December 5, 2023)** to the address below:

Jen Clatterbuck, CHRC Administrator

Maryland Community Health Resources Commission

45 Calvert Street, Rm. 336

Annapolis, MD 21410

Full grant proposals must include the following items for full consideration:

(1) Transmittal Letter: This letter from the applicant organization's chief executive officer (CEO) should specify the title of the proposal, the applicant organization, and the project director and state that the applicant organization understands that submission of a proposal constitutes acceptance of the terms of the CHRC grant program.

(2) Executive Summary: A two-page overview of the purpose of your project summarizing the key points.

(3) Grant Application Cover Sheet: The form should be completed and signed by the project director(s) and either the CEO or the individual responsible for conducting the affairs of the applicant organization who is legally authorized to execute contracts on behalf of the applicant organization. A cover sheet is required and submitted electronically using this link. Applicants are required to print a copy to include with their applicant package.

(4) Table of contents: for the full proposal, including the project proposal and appendices.

NOTE: The above items will not count toward the 30-page limit stated below for the Project Proposal

(5) Project Proposal: See proposal guidelines and requirements in Section 8 above.

Project proposals should be well-written, clear, and concise. Applicants are strongly encouraged to limit their project proposal to 30 pages in length, using single-spacing on standard 8 ½" x 11" paper with one-inch margins and using 12-point Times New Roman or Arial font.

Tables and charts may use a 10-point font or larger. All pages of the proposal must be numbered. The appendices specified in the guidelines below are excluded from the 30-page limit guideline. The project proposal should be structured using these topic headings:

a) Executive Summary
b) Background and Justification
c) Project Plan
    - Community Outreach and Engagement Strategy
    - Recruitment and Retention Strategy
    - Hiring Plan or Strategy
    - Risk Assessment
    - Work Plan (including Problem Statement and Needs Assessment)
    - Logic Model
    - Data Collection and Evaluation Plan
d) Project Evaluator
e) Sustainability
f) Lead or Coordinating Organizational Capacity
g) Partnerships
h) Project Budget and Budget Justification

The following items will not count toward the 30-page limit stated for the Project Proposal.

(6) Contractual Obligations, Assurances, and Certifications: The agreement should be completed and signed by either the CEO or the individual responsible for conducting the affairs of the lead or coordinating applicant organization and who is authorized to execute contracts on behalf of the applicant organization.

(7) Mandatory proposal appendices:

(a) IRS determination letter indicating 501(c)(3) tax-exempt status, if applicable
(b) List of officers and board of directors or other governing body (if applicable) for the lead or coordinating organization applicant

(c) Organizational chart for the lead or coordinating organization applicant

(d) Proposed project organizational chart

(e) Overall organization budget

(f) Form 990, if applicable

(g) Résumés of key project personnel

(h) Logic Model and Work Plan

(i) Letters of commitment or MOUs from participating partners or collaborators

(8) Optional appendices

(a) Service maps, data, and other statistics on the target population

(b) Annual report for the lead or coordinating organization, if available

The suggested content of the following sections is discussed below. Provide as much detail as necessary. Appendices should be limited to only the material necessary to support the proposal. The Commission will request additional material if required.

(9) Project Budget

a) Applicants must provide an annual budget for each year of the project. The total budget amount must reflect the specific amount requested by the applicant for CHRC funding, which may or may not be the project's total actual cost. If the grant request is a portion of the overall cost of the project, clarify this (such as the percentage that the grant request is of the overall project cost), and indicate the sources of other funding.

b) Applicants must use the CHRC Budget Form provided in Appendix IV of this RFP. The CHRC Budget Form must include the following line-item categories:

- *Personnel:* Include the percent effort (FTE), position description, and title of the individual.
- *Personnel Fringe*: The Commission advises that the fringe rate be calculated at no more than 25%. If the grantee requests more than 25%, the applicant will be required to provide a compelling rationale for exceeding this amount. Requests that exceed 25% will be considered on a case-by-case basis.
- *Equipment/Furniture:* Small equipment and furniture costs.
- *Supplies*
- *Travel/Mileage/Parking*
- *Staff Trainings/Development*
- *Contractual:* Contracts for more than $10,000 require specific approval of the Commission prior to being implemented. The budget justification should provide additional details about the use of funds to support contractual costs.

- *Other Expenses:* Other miscellaneous expenses or project expenses that do not fit the other categories can be placed here. Detail each different expense in this area in the budget justification narrative.
- *Indirect Costs:* Indirect costs may not exceed 10% of direct project costs; however, the CHRC will consider permitting indirect cost rates above 10% on a case-by-case basis if the applicant can demonstrate a higher rate has been approved by the federal government.

c) Applicants must include a line-item budget justification detailing the purpose of each budget expenditure.

Step 2:

Presentation before the CHRC (invited applicants only): A select number of HERC applicants will be invited to present their proposal at a CHRC meeting. Dates are to be determined and will be posted on the CHRC website. Invited applicants will be provided presentation instructions upon being notified of their invitation to present.

14. Inquiries

CHRC Health Equity Resource Communities Call for Proposals FAQ Meeting for Applicants: The CHRC will host a conference call for interested applicants to provide information on the HERC Program grant and assistance with the proposal process. This virtual meeting and conference call is optional, though strongly encouraged, and will last approximately two hours, depending on the number of questions from potential applicants.

Zoom meeting details can be found here. CHRC staff will post the Frequently Asked Questions document as soon as practicable following the meeting.

Questions from Applicants: Applicants may also submit written questions about the HERC grant application process at any time. Please email questions to Nellie Washington at Nellie.Washington@maryland.gov or Jen Clatterbuck at jen.clatterbuck@maryland.gov. CHRC staff will respond on a timely basis. Following the public conference call, CHRC staff will post a **"Frequently Asked Questions"** document on the CHRC website.

Program Office: The HERC Program Office is located within the Maryland Community Health Resources Commission. CHRC staff members include:

Mark Luckner, Executive Director E-mail: mark.luckner@maryland.gov	Bob Lally, Chief Financial Officer E-mail: bob.lally@maryland.gov
Nellie Washington, Health Equity Resource Communities Project Director E-mail: nellie.washington@maryland.gov	Jen Clatterbuck, Administrator E-mail: jen.clatterbuck@maryland.gov
Michael Fay, Program Manager E-mail: michael.fay@maryland.gov	Ed Swartz, Financial Advisor E-mail: ed.swartz@maryland.gov

Lorianne Moss, Policy Analyst E-mail: lorianne.moss@maryland.gov	Jonathan Seeman, Financial Advisor Email: jonathan.seeman@maryland.gov

Appendix I: Community Health Resources Commission and HERC Advisory Committee Members

Current CHRC Commissioners

Edward J. Kasemeyer, Chair

Scott T. Gibson

Flor Giusti

Maria J. Hankerson, Ph.D.

David Lehr

Roberta Loker

Karen Ann Lichtenstein

Carol Masden, LCSW-C

Sadiya Muqueeth, DrPH

Destiny-Simone Ramjohn, Ph.D.

TraShawn Thornton-Davis, M.D.

Current HERC Advisory Committee Members

The Honorable Edward J. Kasemeyer, Chair,

Rebecca A. Altman

Jacqueline J. Bradley

Alyssa L. Brown

Elizabeth L. Chung

Jonathan Dayton

Camille Blake Fall

Maura Dwyer

The Honorable John A. Hurson, Esq.

Michelle Spencer

Mikayla A. Walker

Appendix II: Logic Model Form (Link)

CHRC HEALTH EQUITY RESOURCE COMMUNITIES CALL FOR PROPOSALS				
Organization name:				
Project name:				
Amount requested:				
Area of focus:				
RESOURCES	ACTIVITIES	OUTPUTS	SHORT- AND LONG-TERM OUTCOMES	IMPACT
In order to accomplish our set of activities we will need the following:	In order to address our problem or asset we will accomplish the following activities:	We expect that once accomplished these activities will produce the following evidence or service delivery:	We expect that if accomplished these activities will lead to the following changes in 1-2, then 3-5 years:	We expect that if accomplished these activities will lead to the following changes in 5 years and beyond:

Appendix III: Sample Work Plan Template (Link provided in Section 8.1)

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION - HERC Work Plan Template

Organization Name:

Project Name:

Project Purpose: *Enter the overall goal of your project - the overall goal needs to align with strategic priorities of the HERC program. The applicant may specify area(s) of focus (e.g., Diabetes management & prevention, food security) here.*

MCHRC MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

1. **GOAL**: A measurable, expected project outcome (i.e., what the project seeks to achieve in each operational area of the project plan).
2. **OBJECTIVE**: What needs to be achieved to attain the goal.
3. **KEY ACTIVITIES/ACTION STEPS**: These are the measurable ways the project will achieve the corresponding obejctive(s). NOTE: CHRC recommends using the S.M.A.R.T. tool to formulate Goals and Objectives.
4. **EXPECTED OUTCOME (TARGET)**: These are the measures of what is expected to occur to demonstrate that the objective is achieved (i.e., your measure of success).
5. **DATA EVALUATION AND MEASUREMENT**: How will progress towards achieving the goal be measured?
6. **DATA SOURCE(S) AND BASELINE MEASURES**: What data and/or other information will demonstrate that the objective and goal are achieved?

(1) GOAL - Strategic Priority - *Reduce Health Disparities*

Objective(s)	Key Activities/Action Steps	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	Person/Group Responsible	Timetable for Achieving the Objective
List objective(s), one per line, that when achieved will attain the goal.	*Define all actions/steps necessary to achieve the objective. List each activity/action step on its own row.*	*Define an outcome for each activity/action step*	*Identify the process and measure(s) to be used to determine if the outcome has been achieved.*	*Define where the data will come and what baseline data will be used to measure change.*	*Identify the person(s) and/or organization(s) primarily responsible*	*When will the activity/action step be completed?*

(2) GOAL - Strategic Priority - *Improve Health Outcomes*

Objective(s)	Key Activities/Action Steps	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	Person/Group Responsible	Timetable for Achieving the Objective

(3) GOAL - Strategic Priority - *Improve Access to Primary Care*

Objective(s)	Key Activities/Action Steps	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	Person/Group Responsible	Timetable for Achieving the Objective

(4) GOAL - Strategic Priority - *Promote primary and secondary prevention services*

Objective(s)	Key Activities/Action Steps	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	Person/Group Responsible	Timetable for Achieving the Objective

(5) GOAL - Strategic Priority - *Reduce health care costs and hospital admissions and readmissions*

Objective(s)	Key Activities/Action Steps	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	Person/Group Responsible	Timetable for Achieving the Objective

NOTE: The goals and related outcome(s) should align with the Logic Model

Appendix IV: Sample HERC Budget Form Template (Link provided in Section 8.24)

Budget Form Template - Health Equity Resource Communities Call for Proposals						
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION						
Organization Name:	Project Name:					
Revenues	**Budget Revenue**	**% of Total Project Budget**				
CHRC Grant Request		#DIV/0!				
Patient/Program Revenues/Income		#DIV/0!				
Organization Match		#DIV/0!				
Other Grant/Funding Support		#DIV/0!				
Total Project Cost	**0**	**#DIV/0!**				
Line Item Budget for CHRC Grant Request	**Year 1 Budget Request**	**Year 2 Budget Request**	**Year 3 Budget Request**	**Year 4 Budget Request**	**Year 5 Budget Request**	**Line Item Total Budget Request**
Personnel Salary (enter the requested information for each FTE; do not provide the salaries as a single, total number)						
% FTE - Position Title						0
% FTE - Position Title						0
Personnel Subtotal	**0**	**0**	**0**	**0**	**0**	0
Personnel Fringe (no more than 25% of Personnel costs)						0
Equipment / Furniture/ Minor Renovations						0
a.						
b.						
Supplies						0
Travel / Mileage / Parking						0
Staff Training / Development						0
Contractual (>$10k itemize below with details in budget justification)						0
a. Professional/other services by vendor/contractor (1)						0
b. Professional/other services by vendor/contractor (2)						0
d. Advertising						0
e. Lease or rental costs (not incl. under "Equipment/furniture", "Supplies", "Other Expenses" or "Indirect Costs")						0
Other Expenses (**MUST** detail below)						0
a. Other						0
c. Other						0
Indirect Costs: no more than 10% of direct costs (>10% - refer to Budget Form instructions and RFP)	0	0	0	0	0	0
Totals	**0**	**0**	**0**	**0**	**0**	**0**
Percent of Organization's Total Budget that this Project Budget Represents						#DIV/0!

Appendix V: CRISP Public Use Health and SDOH Files

CRISP

Health Equity Resource Community Request for Proposals Public Use Files

As part of the Health Equity Resource Community (HERC) Request for Proposals, the Community Health Resources Commission (CHRC) is providing potential applicants with data files to help support their applications. Applicants can use these data files to identify disparities in their communities and highlight areas of need; however, applicants may also use additional data sources with supplementary information on disparities in their communities.

CHRC is providing two files organized by zip code:

1. HERC Public Use Social Determinants of Health file
2. HERC Public Use Health Data file

Health Disparity Definition

The Maryland Health Equity Resource Act asks applicants to demonstrate how their programs will reduce health disparities in their communities. The Act defines a health disparity as a "particular type of health difference, such as a difference in rates of hypertension, heart disease, asthma, diabetes, substance abuse, mental health disorders, and maternal and infant mortality, that:

(1) is closely linked with social, economic, or environmental disadvantage; and
(2) adversely affects groups of individuals who have systematically experienced greater obstacles to health care based on their: (i) race or ethnicity; (ii) religion; (iii) socioeconomic status; (iv) gender, gender identity, or sexual orientation; (v) age; (vi) mental health status; (vii) cognitive, sensory, or physical disability; (viii) geographic location; or (ix) other characteristic historically linked to discrimination or exclusion."

Social Determinants of Health File

The Social Determinants of Health File includes information from the American Community Survey on zip codes in Maryland. The specific variables chosen were based on the variables included in the CDC's Social Vulnerability Index[1], elements highlight in the Maryland Health Equity Act and public comments from the Pathways project.

[1] CDC Social Vulnerability Index:
https://www.atsdr.cdc.gov/placeandhealth/svi/data_documentation_download.html

Disparities listed in the Act	Variable(s) included in SDOH spreadsheet
Race or ethnicity	Minority
Religion	X
Socioeconomic status	Poverty, Per Capita Income, Unemployment, No High School Diploma
Gender, gender identity, sexual orientation	X
Age	Age <18, Age 65+
Mental health status	X
cognitive, sensory, or physical disability	X
Geographic location	Zip, County
Additional variables (not in Act)	Limited English Speaking, crowding, no vehicle access, internet access

Health data file

The Health data File includes information from the Health Services Cost Review Commission on hospital visits as well as low birth weight information from the Maryland Vital Statistics Administration. The specific variables chosen were based on the health disparities highlighted in the Maryland Health Equity Act, and public comments. Cell sizes less than 11 are suppressed, so a pivot table was not created to support applicants combining zip codes. However, advanced users can use the hidden numerator data available for some of the health outcomes to create their own pivot tables if there is valid (non-suppressed) data for selected zip codes.

Health outcomes listed in Act	Data provided on:	Group breakdown available by:
Hypertension	Hospital visits with Hypertension	Race, Ethnicity, Gender, Age
Heart Disease	Hospital visits with heart disease	Race, Ethnicity, Gender, Age
Diabetes	Inpatient admissions with Diabetes	Race, Ethnicity, Gender, Age
Substance Use	Hospital Emergency Department Visits with Substance Use Disorder	Race, Ethnicity, Gender, Age
Mental Health Disorders	Hospital Emergency Department Visits with Mental Health Disorder	Race, Ethnicity, Gender, Age
Asthma	Hospital Emergency Department Visits with Asthma	Race, Ethnicity, Gender, Age

Breakdowns for religion, socioeconomic status, mental health status, disability, and gender identity were not available based on available data.

Other Data Sources

Applicants are not required to use the two public data files for their application. Applicants are welcome to use other data sources to show how an intervention may impact and improve health disparities in their communities. Applicants may have access to sources such as local surveys, health records, or may be interested in using data from other available data sources listed below.

Environmental Public Health Tracking Network
https://ephtracking.cdc.gov/
Data on community characteristics data to identify households or geographies likely to be affected by a public health emergency.

County Health Rankings by State and County
https://www.countyhealthrankings.org/
Provides data, evidence, guidance, and examples to build awareness of the multiple factors that influence health and support community leaders working to improve health and increase health equity.

Behavioral Risk Factor Surveillance Survey (BRFSS)
State and county level data: https://www.cdc.gov/brfss/brfssprevalence/index.html
Local level data (PLACES): https://www.cdc.gov/places/index.html (data cannot be trended over time per CDC)
Maryland BRFSS site: https://health.maryland.gov/phpa/ccdpc/Reports/Pages/brfss.aspx
Health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services.

The Annie E. Casey Foundation KIDS Count Data Center
https://datacenter.kidscount.org/
Data center provides resources and develops and distributes reports on important child well-being issues.

Maryland- State Open Data Portal (iMAP)
https://imap.maryland.gov/Pages/health.aspx
Interactive maps below providing information and statistics on human services, infectious disease and environment-related health, domestic violence, and zip codes at risk for lead or food systems.

AARP Livability Index
https://livabilityindex.aarp.org/
Livability factors include housing, transportation, civic and social engagement, environment

City Health Dashboard
https://www.cityhealthdashboard.com/
Dashboard on clinical care, health behaviors, health outcomes, and physical environment for large, small, and mid-size cities

Maryland – Governor's Office for Children
https://goc.maryland.gov/wellbeingscorecard/
Describes the general well-being of Maryland's children and families and measures progress in realizing these core results by tracking quantifiable proxies for success called Indicators. (kindergarten readiness, crime, graduation rates, etc)

Maryland – Governor's Office of Crime Prevention, Youth, and Victim Services
https://goccp.maryland.gov/crime-statistics/
Provides information on crime statistics for more than the past 30 years.

Medical shortage areas
https://data.hrsa.gov/tools/shortage-area
Medically Underserved Areas/Populations are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population. Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), population (e.g. low income or Medicaid eligible) or facilities (e.g. federally qualified health center or other state or federal prisons).

Appendix A. Additional Proposed Variables

SDOH File

Staff original proposed a more limited set of SDOH variables, and public comments from Data Subcommittee meeting on September 16, 2021 requested to add age categories, disability, uninsured, foreign born population, and internet access. Some SDOH or disparity categories listed in the Act or via public comment do not have a reliable, recent, and updated data source that could be used across Maryland zip codes.

The following variables were listed in Act, but CRISP could not identify a comprehensive data source at a zip code level for the state of Maryland: Religion, Gender Identity, Sexual Orientation, Mental Health Status.

The following variables were suggested in the public comments, but were not updated recently enough to include: Food environment index (last updated 2015)

Health File

Staff originally proposed to include the following health outcomes: asthma ED visits, substance Use ED overdoses, ED visits, diabetes hospitalizations, and low birthweight babies. Public comments requested rates of clinical outcomes by breakdowns (including by age and gender), to include substance use disorder generally to include alcohol use, inclusion of non-utilization-based measures, and to show disparity index where cell sizes would need to be suppressed.

In response, staff aligned the health outcomes more generally to the health disparities outlined in the Act and showed breakdowns by four groupings: race, ethnicity, age, and gender. Staff found that the suggested disparity index approach resulted in unstable estimates that could not be used reliably for comparisons. Applicants are welcome to use other data sources for additional data.

Appendix VI: Links to Additional Tools and Resources

Links to Federal Resources

CDC – Health People 2030 Resources (array of tools and resources)

https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality

https://health.gov/healthypeople/tools-action/browse-evidence-based-resources

https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/health-literacy-healthy-people-2030

CDC - Promoting Health Equity – Resource to Help Communities Address Social Determinants of Health

https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf

CDC – Developing an Effective Evaluation Plan

https://www.cdc.gov/obesity/downloads/cdc-evaluation-workbook-508.pdf

CDC – High Impact Prevention (HIP) and Interventions to Improve Community Health

https://www.cdc.gov/nchhstp/highimpactprevention/index.html

https://www.cdc.gov/nccdphp/dch/pdfs/Planning-High-Impact-Interventions.pdf

CDC - Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide

https://www.cdc.gov/eval/guide/index.htm

CDC – Developing Evaluation Questions

https://www.cdc.gov/library/researchguides/evaluationquestions.html

https://www.cdc.gov/std/Program/pupestd/Developing%20Evaluation%20Questions.pdf

CDC – Health Impact in 5 Years Initiative

https://www.cdc.gov/policy/hst/hi5/index.html

CMS – Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

AHRhttps://innovation.cms.gov/innovation-models/ahcm

Q - Pathways Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes

https://www.ahrq.gov/innovations/hub/index.html

AHRQ - Patient Surveys and Guidance

https://www.ahrq.gov/tools/index.html

https://www.hcup-us.ahrq.gov/faststats/OpioidUseMap

AHRQ – National Health Care Quality and Disparities Report (2019)

https://www.ahrq.gov/research/findings/nhqrdr/index.html

HRSA - Medically underserved areas (MUAs):

https://data.hrsa.gov/tools/shortage-area/mua-find

HRSA - Health Professional Shortage Areas (HPSAs):

https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas

Links to Maryland Resources

Community Health Needs Assessments (CHNAs) – a link to available CHNAs will be posted to the CHRC website following release of this Call for Proposals

Maryland childhood poverty

https://mda.maryland.gov/about_mda/Documents/SNAB/Maryland-Poverty-Profiles_2018_1-15-2018_T.pdf

Maryland - CHW Advisory Council under MD Population Health

https://health.maryland.gov/pophealth/Community-Health-Workers/Pages/Advisory-Committee.aspx

Maryland Department of Health – Environmental Public Health Data, Health Indicators and Reports (e.g., Asthma ED visits)

https://health.maryland.gov/phpa/OEHFP/EH/tracking/Pages/Home.aspx

Maryland Primary Care Program – the MDPCP site provides a Resource Directory Master List compiled by the Program Management Office with publicly available resources and resource directories organized by category (social needs, behavioral health, etc.).

https://health.maryland.gov/mdpcp/Documents/MDPCP%20Resource%20Directories.pdf

Maryland Department of Health – 2018 Joint Chairmen's Report on the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

https://health.maryland.gov/phpa/Documents/2018-JCR-p.-80-Report-on-the-Special-Supplemental-Nutrition-Program-for-Women-Infants-and-Children-WIC.pdf#search=Percent%20of%20Eligible%20People%20Not%20Receiving%20WIC%20in%20Maryland

Links to Other Sources:

United Way of Central Maryland – Study of Financial Hardship in Maryland (report by ALICE - Asset Limited, Income Constrained, Employed)

https://www.uwcm.org/alice

https://www.unitedforalice.org/maryland

America's Health Rankings (a variety of state-level health reports including health disparities)

https://www.americashealthrankings.org

Communities in Action: Pathways to Health Equity (Guide available from the National Academy of Sciences)

https://pubmed.ncbi.nlm.nih.gov/28418632/

Prevention Institute (non-profit organization that offers publications, resources, and tools for healthier more equitable communities)

https://www.preventioninstitute.org/

https://www.preventioninstitute.org/publications/measuring-what-works-achieve-health-equity-metrics-determinants-health

https://www.preventioninstitute.org/publications/developing-effective-coalitions-eight-step-guide