STATE OF MARYLAND
Community Health Resources Commission
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Promoting Community Health Resources:

Advancing health equity and addressing the continuing impact of the COVID-19 pandemic

FY 2022 Call for Proposals

February 4, 2022

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Overview

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 Marylanders and underserved communities in the state and to bolster the capacity of the health care safety net infrastructure to deliver affordable, high-quality health services. The CHRC is an independent commission within the Maryland Department of Health (MDH), and its 11 members are appointed by the Governor. In creating the Commission, the Maryland General Assembly recognized the need to have an independent commission that focuses on supporting 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. The fundamental policy objective of the CHRC's authorizing statute is the need to expand ***access*** to community health providers, since health insurance coverage alone is not always sufficient for at-risk communities and vulnerable populations to receive affordable, high-quality health care services. This year's RFP will direct specific attention to efforts that expand access to health care and address the social determinants of health to reduce health disparities and promote integrated population health interventions through sustainable community partnerships.

The CHRC has a long history of addressing health disparities and serving vulnerable populations. In recognition of the critical role the CHRC plays in promoting health equity and expanding access to care, during the 2021 session, the Maryland General Assembly increased the CHRC's statutory responsibilities. Additional programs the CHRC was charged with implementing include the Maryland Health Equity Resource Act and Pathways to Health Equity grant program, $5 million in emergency COVID-related grant funding for Maryland Developmental Disabilities Administration (DDA) providers, and the Consortium on Coordinated Community Supports. More information about the Health Equity Resource Act and Pathways to Health Equity grants can be found on pages 6-7.

Recently, the CHRC has worked to help Maryland safety net providers navigate the challenges of the COVID-19 pandemic and support their ability to provide vital services to vulnerable residents. First, the CHRC provided immediate relief to existing grantees by allowing grantees to: adjust reporting schedules; revise service goals; reallocate some unspent grant funds to cover unanticipated costs; and extend grant end dates. The CHRC also issued its first ever emergency funding Call for Proposals, which resulted in 46 grants totaling $1.5 million to support telehealth, PPE procurement, social distancing, and infection control measures. The CHRC recognizes the continuing need to support Maryland's safety net providers and to address persistent, ongoing health disparities exacerbated by the pandemic. Accordingly, this year's Call for Proposals places a priority on projects that support the needs of groups disproportionately impacted by the COVID-19 pandemic, including racial and ethnic minorities, as well as projects that utilize approaches that address pandemic-related service delivery challenges.

Since its inception, the CHRC has issued 16 Calls for Proposals and awarded 639 grants totaling $98.4 million, supporting projects in all 24 jurisdictions. To date, these grants have provided essential health and social services to more than 517,000 residents, resulting in more than 1.3 million service encounters. Over the same period, the Commission has received 946 grant proposals for consideration, totaling more than $415 million in funding requests.

Investing limited public resources efficiently and strategically and achieving post-grant project sustainability are top priorities of the Commission. CHRC grantees have used initial grant funds to leverage $31.8 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.

In January 2021, the Commission reviewed the FY 2016 grants to determine whether these programs were sustained for at least one year after CHRC funds were expended. Of the 15 grants awarded, 10 (77%) were sustained for at least one year, with one grant (8%) partially sustained (services are continuing but assumed by the grantee from the partner organization).

Increasing affordable and accessible primary and preventative medical, dental, and women's health services using multi-sectoral approaches are the bedrock goals of the CHRC. Since 2005, the CHRC has awarded: 93 grants totaling more than $19.5 million for primary care; 47 grants totaling more than $8.8 million for dental care; and 29 grants totaling more than $6.8 million for women's health care services. These grants have: (1) increased access to primary care services and supported new health care access points in underserved communities; (2) supported interventions that address chronic diseases; (3) provided preventative and restorative dental care and oral hygiene education to adults and children; (4) targeted "super-utilizers" of emergency care through hospital Emergency Department (ED) and emergency medical (EMS) diversion, and care coordination; and (5) provided prenatal and perinatal services for women who would otherwise lack access. These projects have in total served more than 194,000 Marylanders. In addition, the CHRC has awarded 77 grants totaling over $20 million to support the integration of behavioral health and primary care services and expand access to substance use treatment, serving more than 95,000 individuals.

CHRC Goals and Objectives

Supporting community-based projects that are innovative, sustainable and replicable and help accelerate overall state population health improvement goals.

The Commission serves as an incubator for innovative projects and supports the efforts of grantees to continue projects once initial CHRC grant funding has been expended. Community health providers are at the front lines of the evolving health care delivery landscape, having the ability to respond to changes in market conditions and the health and social service needs in their communities. The CHRC has and will continue to prioritize projects that are innovative, sustainable and replicable, and that utilize evidence-based intervention strategies that meet a specific community need and present quantifiable improvements in health care outcomes for vulnerable underserved populations.

Innovative:

The CHRC looks to fund projects that are **innovative**. According to the World Health Organization, a health care innovation responds to "unmet public health needs by creating new ways of thinking and working with a focus on the needs of vulnerable populations. It aims to add value in the form of improved efficiency, effectiveness, quality, sustainability, safety, and/or affordability."[1] Successful CHRC-funded projects are newly developed, evidence-based projects

[1] https://www.who.int/phi/2016_05health_innovation-brochure.pdf

which improve health policies, systems, services or delivery methods, or those that have been successfully implemented in other states and planned for use in Maryland for the first time.

Sustainable:

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

Replicable:

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

Measurable Impact:

The CHRC prioritizes projects that use **evidence-based intervention strategies** to meet a specific community need and are designed to provide measurable improvements in health outcomes. To achieve this objective, applicants are strongly encouraged to identify discrete data variables that allow measurement of the intended impact of project interventions. If project interventions are intended to achieve a measurable improvement in health outcomes, the project plan should describe how this data will be collected and analyzed to demonstrate the intended impact on health outcomes and (to the extent possible) the anticipated cost savings to be achieved as a result. For example, a project to address the needs of individuals with poorly controlled diabetes aims to increase access to diabetes self-management education (DSME) with the goals of improving diabetic control (as measured by A1c) and demonstrating the cost effectiveness of DSME by reducing the number of hospital admissions and readmissions for managing hyperglycemia, and reducing the risk of diabetes complications (e.g., diabetic peripheral neuropathy). The applicant could also perform a "formal" cost-benefit analysis that compares the cost of implementing an innovative project intervention(s) against existing interventions and calculating the cost saving(s) that result from the project intervention(s).[2] This could apply to projects that address the Social Determinants of Health (SDOH), for example securing health insurance coverage for vulnerable populations that otherwise would not get routine health screenings and preventive care and are at greater risk for serious health problems and poor health outcomes.[3]

Public – Private Community Partnerships

Improving the health of all Marylanders through local coalition action and partnerships with community health resources is an ongoing goal of the CHRC. The current Call for Proposals encourages community-based public/private partnership approaches. The CHRC will be

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

interested in funding projects that involve the business community as co-funders or as partners in driving program utilization.

The Commission has aligned its grantmaking activities with current statewide efforts to improve population health, which include:

1. **The Maryland Total Cost of Care Model and the goals of the Statewide Integrated Health Improvement Strategy (SIHIS)**.[4] Key SIHIS goals supported by this Call for Proposals include: reducing the mean Body Mass Index (BMI) for adult Maryland residents, improving overdose mortality, reducing the rate of severe maternal morbidity, and decreasing asthma-related emergency department visit rates for ages 2-17.
2. **The Maryland Primary Care Program**, which supports the delivery of advanced primary care throughout the state.[5]
3. **The Maryland Diabetes Action Plan** (January 2020), which highlights initiatives and strategies to broaden and strengthen collaboration among communities, organizations, businesses, local governments and individuals to prevent and manage diabetes.[6]
4. **The Maryland Office of Minority Health and Health Disparities (MHHD), Minority Outreach and Technical Assistance Program.** The Minority Outreach and Technical Assistance (MOTA) program was established to improve the health outcomes for racial and ethnic minority communities through community engagement, partnerships, outreach and technical assistance.[7]

FY 2022 Call for Proposals and the Pathways to Health Equity Program

"The Maryland Health Resource Communities Act," passed by the Maryland General Assembly during the 2021 session, provides significant new grant funding and state resources for local communities to address health disparities, improve health outcomes, expand access to primary care and prevention services, and reduce health care costs. The CHRC is implementing this Act with the assistance of the Health Equity Resource Community Advisory Committee, the Maryland Department of Health's Office of Minority Health and Health Disparities, and Chesapeake Regional Information System for our Patients (CRISP).

In November 2021, the CHRC issued the Pathways to Health Equity Call for Proposals, a program intended to lay the foundation for the future Health Equity Resource Communities (HERC) program. The application period closed in December 2021 and generated 40 proposals requesting more than $42 million. Pathways awards will be made in February 2022.

While both the HERC/Pathways grant program and the FY 2022 Call for Proposals include a focus on health equity, there are important distinctions between the two.

1. The HERC/Pathways program is place-based, and applicants must focus on particular zip codes. The FY 2022 Call for Proposals does not have these geographic requirements.

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[4] https://hscrc.maryland.gov/Documents/Modernization/Statewide%20Integrated%20Health%20Improvement%20Strategy/SIHIS%20Proposal%20-%20CMMI%20Submission%2012142020.pdf

[5] https://health.maryland.gov/mdpcp/Pages/Home.aspx

[6] https://phpa.health.maryland.gov/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf

[7] https://health.maryland.gov/mhhd/MOTA/Pages/Index.aspx

2. HERC/Pathways applicants must demonstrate the capacity to address each of five policy objectives from the Maryland Health Equity Resource Act (reduce health disparities, improve health outcomes, improve access to primary care, promote primary and secondary prevention services, and reduce health care costs and hospital admissions and readmissions). FY 2022 applicants are not required to address all five of these goals.
3. Requirements for HERC/Pathways lead applicants do not apply to the FY 2022 Call for Proposals. Applicant eligibility requirements for the FY 2022 Call for Proposals can be found on pages 8-9.
4. The CHRC and CRISP provided data files for use in applying for Pathways grants. While these data files remain accessible and may be used by FY 2022 applicants, they are not required for FY 2022 applicants. No additional data files will be provided for the FY 2022 Call for Proposals.[8]

Applicants not selected for Pathways grants are invited to apply for grant funding under the FY 2022 Call for Proposals. Project proposals previously submitted but not selected under the Pathways program should be modified to fit the criteria and submission requirements of the FY 2022 Call for Proposals.

FY 2022 Call for Proposals: Advancing Health Equity and Addressing the Continuing Impact of the COVID-19 Pandemic

Under this Call for Proposals, the Commission will receive projects that address both of the following strategic priorities:

(1) Advancing health equity by addressing health disparities and adverse Social Determinants of Health (SDOH), with a particular emphasis on groups disproportionately impacted by the COVID-19 pandemic, including racial and ethnic minorities; and

(2) Promoting the efficient and strategic delivery of integrated health and social services through innovative, sustainable community partnerships that address the totality of medical and non-medical needs, with emphasis on approaches that consider the ongoing challenges of delivering services during the COVID-19 pandemic.

Under this Call for Proposals, the Commission will receive projects in three areas of focus:

(1) Addressing chronic disease prevention and disease management, including diabetes and its comorbidities, hypertension, heart disease, and others;

(2) Promoting family health, including maternal and child health, and childhood asthma; and

(3) Addressing Behavioral Health, including Mental Health and Substance Use Disorder (SUD) and the ongoing impact of the opioid crisis.

The CHRC has since inception and through its strategic grant funding recognized and supported the essential, vital role of public health agencies, safety net healthcare providers and community-based organizations in promoting equitable access to healthcare and social support

[8] CRISP Data files prepared for the Pathways to Health Equity Call for Proposals may be found here: https://health.maryland.gov/mchrc/Pages/notices.aspx

services that help to reduce health disparities through innovative projects specifically tailored to the vulnerable underserved communities they serve. The current Call for Proposals places even greater emphasis on the need to support Maryland's safety net providers who have a historical mission of serving low-income, economically disadvantaged and medically underserved individuals. These providers also have a demonstrated track record of implementing projects that serve these vulnerable populations, especially those impacted by health disparities, and use innovative approaches to tackle the social determinants of health.

The CHRC will consider up to three-year grants under this Call for Proposals. The CHRC will award a limited number of grants as determined by funding availability at the time of award.

Key Dates to Remember

The following are the key dates and deadlines for the FY 2022 Call for Proposals	
February 4, 2022	Release of the Call for Proposals
February 14 at 10:00 a.m.	Conference call for applicants. Zoom Info: https://zoom.us/j/93361463380?pwd=WnZHdHV0UG10OHVDZzhMMjFhL01iZz09 Dial-in #: 1-301-715-8592 Meeting ID: 933 6146 3380 / Passcode: 159826
February 28 at 12:00 NOON	**Deadline for receipt of Letters of Intent**
March 22 at 12:00 NOON	**Deadline for receipt of full applications**
Late April/Early May 2022	Select number of applicants notified to present to the CHRC
Mid-May, 2022	Applicant presentations to the CHRC; award decisions immediately follow presentations

Grant Eligibility

The Commission will consider proposals from any community health resource eligible under the Commission's regulations found at Title 10, Subtitle 45 [10.45.01.02B(7)] of the Code of Maryland Regulations (COMAR).

What is a Community Health Resource?

An organization can demonstrate that it is a community health resource in any of three ways:

(1) Designated Community Health Resource. The CHRC has designated the following types of organizations, listed below, as community health resources. Each of these entities is eligible to apply for and receive grants from the Commission.

- Federally qualified health centers (FQHCs) and FQHC "look-alikes"
- Community health centers
- Migrant health centers
- Health care projects for the homeless
- Primary care projects for public housing projects
- Local nonprofit and community-owned health care projects
- School-based health centers

- Teaching clinics
- Wellmobile Projects
- Community health center-controlled operating networks
- Historic Maryland primary care providers
- Outpatient mental health clinics
- Local health departments
- Substance use treatment providers

Organizations not designated above may also qualify as a community health resource. To qualify, these organizations must demonstrate that they meet the Commission's criteria as a Primary Health Care Services Community Health Resource or an Access Services Community Health Resource.

(2) Primary Health Care Services Community Health Resource. Organizations must demonstrate that they:

- Provide primary health care services;
- Offer those services on a sliding scale fee schedule or free of charge; and
- Offer services primarily to Maryland residents from service sites located in Maryland.

(3) Access Services Community Health Resource. Organizations must demonstrate that they:

- Assist individuals in gaining access to reduced price clinical health care services;
- Offer their services on a sliding scale fee schedule or free of charge;
- Have a Memorandum of Understanding (MOU) or similar legally binding document in place **prior** to application submission if they intend to offer grant services jointly through a formal arrangement with a provider partner organization; and
- Offer services primarily to Maryland residents from service sites located in Maryland.

(4) Sliding Scale Fee Schedule Requirements

Organizations must offer a sliding scale fee schedule consistent with the following guidelines established by the Commission or offer services free of charge. An applicant organization's sliding scale fee schedule must provide discounts to individuals with a family income at or below 200 percent of the federal poverty level, with no more than a nominal charge for individuals with a family income at or below 100 percent of the federal poverty level. No additional fees may be charged, such as an enrollment fee. The availability of discounted fees must be publicly displayed, and discounted services must be available to all who meet the eligibility criteria. The organization must review documentation on income from applicants. An organization that provides discounted or free care to all individuals who seek service, or to those with family income at or below 200 percent of the federal poverty level, complies with this requirement.

Strategic Priorities for the FY 2022 Call for Proposals

This year's Call for Proposals has two strategic priorities: (1) Advancing health equity by addressing health disparities and adverse Social Determinants of Health (SDOH), with a particular emphasis on groups disproportionately impacted by the COVID-19 pandemic,

including racial and ethnic minorities; and (2) Promoting the efficient and strategic delivery of integrated health and social services through innovative, sustainable community partnerships that address the totality of medical and non-medical needs, with emphasis on approaches that consider the ongoing challenges of delivering services during the COVID-19 pandemic.

NOTE: Grant applications in this Call for Proposals will need to address **both** strategic priorities and demonstrate how this will be achieved in their project plan.

STRATEGIC PRIORITY 1:

Advancing health equity by addressing health disparities and adverse Social Determinants of Health (SDOH), with a particular emphasis on groups disproportionately impacted by the COVID-19 pandemic, including racial and ethnic minorities

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.[9] When individuals are not provided equal opportunities or the resources to pursue optimal health and wellness, this creates health inequities which invariably result in health disparities. Health disparities are preventable differences in health outcomes and their causes (e.g., the burden of disease) observed between groups of people.[10] The burden of chronic disease and the preventable differences in health outcomes are significantly greater for racial and ethnic minorities in the U.S. compared to non-Hispanic Whites.[11] Geography is also significant. According to the CDC, residents of rural America are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their counterparts in urban areas.[12]

Applicants are encouraged in their grant proposals to consider the full-range of factors contributing to health disparities including race, ethnicity, and socioeconomic status, taking into account the disruptions in essential services caused by the COVID-19 pandemic and the added burdens this places on those who are the most vulnerable.

Despite decades of efforts to eliminate health disparities in Maryland, preventable differences in disease burden among disadvantaged populations persist. While some progress has been made in narrowing the health disparities gap, efforts to eliminate these disparities must continue.[13] Elimination or improvement in these disparities is unlikely to be achieved without addressing the SDOH. According to Healthy People 2020, SDOH are conditions in the environments in which people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The forces that shape these conditions include economic policies and systems, social norms, social policies and stigma, and political systems. Addressing SDOH is one of the most effective ways to improve health and reduce health disparities.[14]

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[9] https://www.cdc.gov/chronicdisease/healthequity/index.htm
[10] https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities
[11] https://www.cdc.gov/chronicdisease/resources/publications/factsheets/reach.htm
[12] https://www.cdc.gov/ruralhealth/about.html
[13] https://health.maryland.gov/mhhd/Documents/2018%20Minority%20Health%20and%20Health%20Disparities%20Annual%20Report%20.pdf
[14] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Understanding the intersection between the social determinants and health outcomes is fundamental to advancing health equity. SDOH include the following:

- Health insurance coverage and provider availability
- Social support systems and community engagement
- Healthy foods and food security
- Educational, economic, and job opportunities
- Access to transportation

Applicants are encouraged to propose projects that address one or more SDOH. For example, some grantees have provided vouchers for transportation to health care appointments or counseling to link patients to education and employment opportunities. **The Commission will prioritize proposals that use a holistic, integrated approach to health and utilize evidence-based interventions such as deployment of community health workers within their communities.** In addition, the CHRC places strategic importance on multi-sectoral, public and private partnerships that engage the participation of community stakeholders to contribute to the planning and implementation process for developing CHRC grant funded projects. The CHRC encourages interventions developed and delivered through these partnerships that create or expand social, political, or economic support systems to address the SDOH for specific population(s).

The value of increasing the availability of population health interventions as one approach to reducing health disparities and addressing SDOH is widely recognized.[15]

CHRC grants have supported health population management activities in vulnerable underserved communities that include:

- increasing access to affordable healthy food in underserved communities through the development of community gardens and local food pantries;
- increasing the availability of healthy foods in local grocery stores in neighborhoods designated as healthy food priority areas ("food deserts");
- promoting access to effective screening and diagnostic testing for diabetes, high blood pressure, and high cholesterol;
- projects that foster healthy living across life stages among disadvantaged groups through nutrition and physical activity education and employer sponsored health promotion projects; and
- projects that target reductions in health risk behaviors such as tobacco use.

A key area for applicant consideration under this strategic priority is **expanding access to essential health care services and health insurance coverage,** as one of the Social Determinants of Health that contributes to health disparities. Following the passage of the Affordable Care Act, Maryland, like many states, achieved dramatic increases in health insurance coverage rates. There has been a dramatic drop in the uninsured rate for Marylanders between the ages of 18 and 64, from 11.3% in 2013 to 6% in 2021.[16] Despite these coverage gains, the uninsured rate

[15] https://www.cdc.gov/minorityhealth/strategies2016/index.html
[16] https://www.marylandhbe.com/news-resources/reports-data/

remains high for certain racial and ethnic groups. For example, the uninsured rate for Hispanic/Latino individuals is more than twice the rate for White Marylanders.[17]

Other areas for applicants to consider under this strategic priority are **workforce diversity, health literacy,** and **cultural and linguistic competency**. A landmark study supported by the HHS Office of Minority Health and conducted by the Institute of Medicine, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," was published in 2003, and concluded that racial and ethnic minority groups tend to receive a lower quality of healthcare compared to non-minority groups despite efforts to address access issues such as health insurance coverage. The study recommends increasing the representation of racial and ethnic minorities in the healthcare workforce and providing patients with culturally appropriate health education as an effective way to improve the quality of healthcare provided to racial and ethnic minority populations.[18] Increasing racial and ethnic minority representation among healthcare professionals and the leaders of the organizations that provide health and social services proportionally to the communities they serve will help to improve the cultural competency of the workforce and organizational leadership, support improved health literacy and understanding to better meets the needs of these communities, and help to reduce health disparities.

Expanding health literacy and addressing cultural and linguistic competence are important considerations in addressing health disparities and improving the quality of care. The CHRC encourages applicants to consider strategies and interventions that address these areas and include measures that increase language access and the associated costs for language accommodation in their grant budget to support community outreach and the delivery of services to immigrant communities.

STRATEGIC PRIORITY 2:

Promoting the efficient and strategic delivery of integrated health and social services through innovative, sustainable community partnerships that address the totality of medical and non-medical needs, with emphasis on approaches that consider the ongoing challenges of delivering services during the COVID-19 pandemic.

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

The CHRC has consistently supported innovative, sustainable community-based partnerships that address the unmet medical and SDOH needs of Maryland's vulnerable, low-income underserved communities. The current strategic priority further enhances this focus by increasing

[17] https://www.marylandhbe.com/wp-content/docs/COVID_Uninsured_Analysis_Dashboard_April2021.html
[18] https://unequaltreatment.com/

the opportunities to fund projects designed to address the social factors that will contribute to better health outcomes and increase the quality of life for residents of underserved communities.

The current Call for Proposals recognizes that the COVID-19 pandemic has necessitated new means of providing health care and other services, including telehealth, remote patient monitoring, socially distanced programs, countermeasures to reduce transmission, etc. The CHRC encourages applicants to consider innovative strategies that take into account both the current state of the pandemic and possible future conditions.

Additional guidance for FY 2022 applicants:

1. **The CHRC will prioritize applications that present detailed data evaluation plans and demonstrate the capacity of the applicant organization to produce well-defined, quantifiable health outcomes. Successful applications will include specific data metrics and clear, quantifiable outcome goals. In addition, applicants should determine the cost/benefit ratio of project interventions and services provided to participants with measurement methodology.**
2. **Applicants are strongly encouraged to submit proposals that illustrate how their project is innovative, sustainable, and replicable. The application should demonstrate that the proposed project is likely to continue to provide benefits to the target population and the community at large beyond the duration of the proposed grant period.**
3. **Proposals should identify all sources of current and future project revenue and provide a probability assessment of post-grant sustainability. Successful applicants will identify future revenue sources including billing and reimbursement from Medicaid, Medicare or third-party insurers; self-pay or user fees; and/or future financial support from hospitals, outside organizations, the business community, or additional grant funding.**
4. **Under this Call for Proposals, the CHRC will support up to three-year grant projects.**

Further information about the selection criteria for this Call for Proposals can be found later in this document, pages 23 through 26.

Areas of Focus (Funding Categories) for the FY 2022 Call For Proposals

The two strategic priorities listed above must apply to all grant proposals. In addition to meeting the criteria of **both** strategic priorities, applicants must choose **one** area of focus from the three listed below.

1. **<u>AREA 1</u>: Addressing chronic disease prevention and disease management, including diabetes and its comorbidities, hypertension, heart disease, and others.**

(The CHRC anticipates having a maximum of approximately $2,000,000-$3,000,000 in total funds available to cover all grant awards issued under this category for up to 3 years).

The CDC estimates that six in 10 Americans live with at least one chronic disease such as diabetes, heart disease and stroke, and four in 10 have two or more chronic diseases.[19] Chronic diseases are the leading causes of death and disability in the United States and result in significant health and economic costs.[20] The burden of chronic disease and the preventable

[19] https://www.cdc.gov/chronicdisease/
[20] https://www.cdc.gov/chronicdisease/about/costs/index.htm

differences in health outcomes are significantly greater for racial and ethnic minorities in the U.S. compared to non-Hispanic Whites.[21] Individuals with certain chronic diseases may be at heightened risk for severe COVID-19.

Chronic diseases, including heart disease, cancer, stroke, and diabetes, are the leading causes of illness, disability, and death in the United States, and are the leading drivers in annual health care costs.[22] Chronic diseases continue to be the leading causes of death and disability in Maryland, accounting for seven of every 10 deaths.[23]

The onset of many chronic diseases is attributed to key risk behaviors, which include tobacco and excessive alcohol use, physical inactivity, poor nutrition, and being overweight and obese.[24] By making healthy choices, individuals can reduce the likelihood of getting a chronic disease and maintain or improve their quality of life.

Chronic disease management involves an integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, patient self-management education, and shared decision making.[25] When the effects of chronic diseases are prevented or minimized, this can improve the quality of life while reducing health care costs. Integrated approaches to improving chronic disease management particularly for primary care providers brings together various elements in healthcare delivery to improve quality with disease-specific approaches.

Diabetes

Diabetes is a growing health problem in the U.S. and Maryland, and is a leading cause of preventable death and disability. According to the latest national statistics, over 34 million Americans have diabetes and of those 7.3 million are undiagnosed. It is estimated that 88 million Americans have prediabetes, a condition that often leads to diabetes, and 85% of those affected are unaware of the condition.[26] In 2019, it is estimated that 521,000 or 11.1% of Maryland adults have diabetes[27] and another 1.6 million (34%) have prediabetes.[28] Diabetes is the sixth leading cause of death in Maryland,[29] and the fifth leading cause of death among African American/Black Marylanders.[30] The prevalence of diabetes in Maryland among the non-Hispanic African American/Black (13.3%) population is significantly higher than the rate for the non-Hispanic White population (8.0%).[31] The increasing prevalence of diabetes reflects significant racial, ethnic, economic, educational and geographic disparities.[32]

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[21] https://www.cdc.gov/mmwr/pdf/other/su6203.pdf
[22] https://www.cdc.gov/chronicdisease/programs-impact/pop/index.htm
[23] https://www.cdc.gov/nchs/pressroom/states/maryland/maryland.htm
[24] https://www.cdc.gov/chronicdisease/about/index.htm
[25] https://www.cdc.gov/learnmorefeelbetter/programs/general.htm
[26] https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf
[27] https://phpa.health.maryland.gov/ccdpc/Reports/Pages/brfss.aspx
[28] https://phpa.health.maryland.gov/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf
[29] https://health.maryland.gov/vsa/Pages/reports.aspx
[30] https://phpa.health.maryland.gov/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf
[31] https://health.maryland.gov/phpa/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf
[32] https://health.maryland.gov/phpa/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf

Improving the management of diabetes and reducing the risk of developing diabetes through lifestyle modifications and health care interventions have been demonstrated to be effective.[33,34] To this end, the Maryland Department of Health released the Maryland Diabetes Action Plan in January 2020, which provides current data on the burden and consequences of diabetes, with prevention measures to reduce the number of newly diagnosed diabetics and intervention strategies for improved control of diabetes to reduce the risk of secondary chronic conditions.[35] The Plan is designed to help the State and its partners achieve the Healthy Maryland goal of reducing diabetes mortality and the disease burden of diabetes, and improving the quality of life for all persons who have diabetes or are at risk for diabetes.

The Diabetes Action Plan presents Maryland's population categories and corresponding goals and objectives (listed below). The Plan includes a number of action steps, and below are selected intervention strategies by various stakeholders that could be supported by CHRC grant funding this year. **Applicants in this category are strongly encouraged to consult the Maryland Diabetes Action Plan when developing proposals**.

Keeping a Healthy Weight Population

1. Increasing access to healthy nutrition with the goal of achieving healthy weight for 32% of Maryland adults by 2024:
    a. Expanding implementation of healthy cooking and eating education and skill-building though evidence-based community projects
    b. Promoting healthy lifestyles planning by pediatricians and OB/GYN practices with women of childbearing age
2. Achieving and maintaining recommended physical activity levels:
    a. Engaging healthcare professionals to promote increased physical activity to reduce sedentary behaviors

Reducing overweight and obese populations

1. Improving clinical care services for overweight and obese children and adults:
    a. Promoting provider use of z-codes (e.g., Z68.54) in primary care and pediatric practices, and providing social and case-management support
2. Improving the availability of healthy lifestyle options for overweight and obese children:
    a. Expanding implementation of healthy cooking teaching kitchens and healthy eating education and skill-building opportunities for overweight/obese adults and children
3. Collaborating with community partners to promote increased physical activity and decreased sedentary activity:
    a. Expanding the number of physical activity and healthy eating offerings at parks and recreation centers, places of worship, community and civic centers, and senior centers

[33] https://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp/
[34] https://www.niddk.nih.gov/about-niddk/strategic-plans-reports/diabetes-in-america-3rd-edition
[35] https://phpa.health.maryland.gov/CCDPC/Pages/diabetes-action-plan.aspx

b. Leading a community group to draft a community walking plan or to assess the community for walkability

Prediabetes and Gestational Diabetes populations

1. Improving prediabetes outcomes:
    a. Increasing the number of people at risk who are tested, referred, complete and reach evidence-based lifestyle change goals
2. Reducing the risk of diabetes in women with a history of gestational diabetes:
    a. Increasing the number of women with a history of gestational diabetes who receive their postnatal followup glucose test within 6-12 weeks
    b. Making referrals to evidence-based lifestyle projects or nutritional counseling

Managing diabetes and controlling diabetes with complications

1. Improving use of standardized quality of care and chronic care models for diabetes:
    a. Ensuring that patients are referred for annual vision, oral and podiatry services, and have regular A1c/blood glucose monitoring;
    b. Developing dental-to-primary care provider partnerships for high risk patient referrals to primary care for potential diabetes diagnosis and treatment
2. Reducing the number of hospital and ED visits by people with diabetes:
    a. Providing appropriate linkage to case management based on screening and risk-stratification

Recent data suggests that food insecurity is more prevalent in households where a person with diabetes lives, and diabetes is more prevalent in households that are more food insecure.[36] Food insecurity occurs when the food intake of household members is reduced and their normal eating patterns are disrupted because the household lacks the money and other resources for food, or their access to healthier food choices such as fresh fruit and vegetables is limited. In 2020, the prevalence of household-level food insecurity (low and very low food security) nationally was estimated at 10.5% of households (or 13.8 million households); the prevalence rate was approximately 9.2% for Maryland during this period.[37] One consequence of food insecurity is the higher consumption of nutrient poor, high calorie foods which contribute to higher rates of obesity and diabetes. The most recent data from the CDC for 2017-2018, shows 42.4% of adults and 19.3% of children ages 2-19 years were considered obese.[38] The CDC estimates that in 2020, the prevalence of obesity among adults in Maryland was 31%.[39] The association between a less-healthy diet, being overweight and obese, and having an increased risk for serious chronic diseases such as diabetes has been established.[40]

[36] Gucciardi, E., Vahabi, M., Norris, N., Del Monte, J. P., & Farnum, C. (2014). The Intersection between Food Insecurity and Diabetes: A Review. *Current nutrition reports*, *3*(4), 324–332. https://doi.org/10.1007/s13668-014-0104-4
[37] https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/
[38] https://www.cdc.gov/obesity/
[39] https://www.cdc.gov/obesity/data/index.html
[40] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4584410/

Based on data from 2017, in Maryland, 30.8% of the population is obese and an additional 34.6% of the population is overweight. Five-year trend data shows that the proportion of Marylanders who are obese is increasing, and the proportion of Marylanders who are overweight has been relatively stable. In addition, the healthy weight population in Maryland is decreasing from 35.1% in 2013 to 32.7% in 2017.[41]

The CHRC has funded 45 projects totalling more than $7.5 million aimed at preventing or reducing food insecurity and addressing diabetes prevention and management.

Heart Disease and Hypertension

Heart disease was the leading cause of death in Maryland in 2019.[42] In 2019, an estimated 35% of Marylanders had hypertension and 33% had high cholesterol.[43] Black non-Hispanic Marylanders had more than twice as many hypertension-related emergency department visits as White non-Hispanic Marylanders in 2017.[44] Smoking, inactivity, and poor diet increase the risk of heart disease.

Applicants may develop projects that address heart disease prevention, management, or both. Many of the healthy lifestyle interventions listed above for diabetes are also recommended to address heart disease. Other interventions may include but are not limited to the following:

- health education and screening programs, particularly those that utilize Community Health Workers (CHWs);
- mobile health clinics;
- programs that screen individuals for high blood pressure and cholesterol in trusted, non-traditional venues such as barbershops, beauty salons, or churches, and make referrals to primary care providers and specialists;
- self management blood pressure programs (SMBP) that allow patients to monitor their blood pressure in a familiar setting such as their home, and regularly provide the readings to their providers; this could include the use of interactive digital devices that allow bidirectional communication directly with the providers; and
- programs to encourage medication adherence, including: culturally sensitive patient education; improving access to insurance coverage and pharmacies; utilizing dosing reminders via text message and/or electronic devices that monitor dosing; and simplified treatment regimens.[45, 46]

Applicants may refer to ***The Guide to Community Preventive Services*** for an assessment of evidence-based interventions.[47]

Other considerations for addressing chronic disease

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[41] https://health.maryland.gov/phpa/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf
[42] https://health.maryland.gov/vsa/Pages/reports.aspx
[43] https://health.maryland.gov/phpa/ccdpc/Reports/Documents/2019%20MD%20BRFSS%20-%20Chronic%20Disease%20Risk%20Behaviors%20and%20Outcomes.pdf
[44] https://health.maryland.gov/mhhd/
[45] https://millionhearts.hhs.gov/data-reports/factsheets/adherence.html
[46] https://www.ahajournals.org/doi/10.1161/HYP.0000000000000203
[47] https://www.thecommunityguide.org

Projects in this category may include the provision of new services or the expansion of existing services that are effective in meeting the health needs of adults and children in the community. Proposals must demonstrate efficiency in service delivery including: (1) innovation to address barriers to accessing health services (e.g. overcoming transportation barriers, utilizing telehealth or remote monitoring technologies); (2) promoting access to health insurance and other social services; and (3) the capacity to bill third-party payers for billable grant-funded services to achieve sustainability once the grant ends.

Impacts from selected projects may include but are not limited to 1) increasing the number of individuals connected to a medical home; 2) increasing individual knowledge of behaviors that impact health; and (3) reducing avoidable hospital admissions, readmissions, and ED usage, and improving health outcomes.

The CHRC will prioritize projects that demonstrate the ability to collect and report aggregated, de-identified clinical outcome measures (e.g. A1c levels, blood glucose levels, blood pressure readings, etc.). Applications should describe both the metrics chosen and the capacity to collect this data.

Applicants in this area of focus must specify which chronic disease or diseases they are addressing. Applicants may select more than one chronic disease.

2. <u>AREA 2</u>: Promoting family health, including maternal and child health, and childhood asthma.

(The CHRC anticipates having a maximum of approximately $2,000,000-$3,000,000 in total funds available to cover all grant awards issued under this category for up to 3 years).

As part of this year's Call for Proposals, the Commission will consider projects that address maternal and child health and/or childhood asthma. Substantial health disparities exist in both. Interventions in this area can lead to meaningful improvements in short- and long-term health outcomes, positive educational outcomes, improved parental productivity, and reduced health care costs. Early interventions can improve an individual's health trajectory across their entire lifespan.

Maternal and Child Health

After decades of decline, maternal deaths nationally have risen from a historic low of 6.6 maternal deaths per 100,000 live births in 1987 to 31.3 maternal deaths per 100,000 live births in 2017, the latest year for which national data are available.[48] Maryland's overall maternal mortality rate (MMR) in 2017 was slightly better than the national average, at 24.8 maternal deaths per 100,000 live births. However, the MMR for African American/Black Marylanders is four times the rate of White Marylanders (44.7 maternal deaths vs. 11.3 per 100,000 live births). Comparing the time periods 2008-2012 and 2013-2017, MMR for White Marylanders decreased 35.4% while MMR increased 11.9% for Black Marylanders.[49]

[48] https://health.maryland.gov/phpa/mch/Documents/Health-General%20Article,%20§13-1207,%20Annotated%20Code%20of%20Maryland%20-%202019%20Annual%20Report%20–%20Maryland%20Maternal%20Mortality%20Review.pdf

[49] https://phpa.health.maryland.gov/mch/Documents/Health-General%20Article,%20%C2%A713-1207,%20Annotated%20Code%20of%20Maryland%20-%202019%20Annual%20Report%20%E2%80%93%20Maryland%20Maternal%20Mortality%20Review.pdf

Disparities also exist in the incidence of Severe Maternal Morbidity (SMM), defined as unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. African American/Black Marylanders experience nearly twice the rate of SMM as White Marylanders. The rate of SMM for Hispanic Marylanders and Asian/Pacific Islanders is nearly 1.4 times the rate of White Marylanders.[50]

Infant mortality and low birth weights also exhibit racial disparities. Maryland's overall infant mortality rate in 2019 was 5.9 infant deaths per 1,000 live births, while the rate for African American/Black Marylanders was 9.3%. The average infant mortality rate has fallen by 4% in Maryland overall during the past decade, but the Hispanic infant mortality rate has risen by 15%.[51] In 2019, 8.7% of Maryland babies were born with low birth weight (defined as less than 2,500 grams or 5 lbs. 8 oz. or less). The rate of low birth weight for White babies was 6.65% versus 12.5% for African American/Black babies.[52]

In 2020, the rate of preterm births among African-American/Black women in the U.S. was nearly 50 percent higher than the rate of preterm birth among White or Hispanic women.[53] Premature birth can lead to a range of negative long-term outcomes, including cerebral palsy, intellectual disabilities, chronic lung disease, blindness, and hearing loss. A 2007 study by the Institute of Medicine found that the cost associated with premature birth in the United States was $26.2 billion annually, including: additional labor and delivery costs, additional medical and health care costs for the baby, early intervention services for children with disabilities and developmental delays, special education services, and lost productivity.[54]

Access to pre-pregnancy care and prenatal care beginning during the first or second trimester can improve outcomes for mothers and infants. Adequate prenatal care has been found to reduce the likelihood of infant mortality five fold.[55] Adequate prenatal care also has been found to reduce the likelihood of preterm birth[56] and SMM.[57] Group prenatal care has been demonstrated to be even more effective than one-on-one care. One study found that group prenatal care resulted in a 37% lower risk of preterm birth and a 38% lower risk of having a low birth weight baby compared with traditional one-on-one care.[58]

Maternal and child health interventions funded under this Call for Proposals may include but are not limited to the following:

- programs to develop awareness and expand access to care beginning during the first and second trimesters of pregnancy;

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[50] https://hscrc.maryland.gov/Documents/Modernization/SIHIS%20Proposal%20-%20CMMI%20Submission%2012142020.pdf

[51] https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Infant%20Mortality/Infant_Mortality_Report_2019.pdf

[52] https://health.maryland.gov/mchrc/Documents/Pathways%20to%20Health%20Equity%20Docs/Pathways%20Public%20Use%20Health%20Data%20filev3%20-%20Updated%20November%203.xlsx

[53] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm

[54] https://www.marchofdimes.org/mission/the-economic-and-societal-costs.aspx

[55] https://www.ncbi.nlm.nih.gov/books/NBK235274/

[56] https://www.ajog.org/article/S0002-9378(02)00404-0/fulltext

[57] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/

[58] https://www.liebertpub.com/doi/10.1089/jwh.2017.6817

- linkages to care, care coordination, insurance coverage, and case management;
- treatment and support for pregnant and postpartum individuals with Substance Use Disorders and/or perinatal mood disorders;
- expanded access to prenatal services in a primary care setting;
- Centering Pregnancy programs (see Centering Healthcare Institute for program requirements);[59]
- home visiting services (see the Department of Health and Human Services' Home Visiting Evidence of Effectiveness (HomVEE) review for best practices);[60]
- programs to serve the needs of mothers and children during the first twelve months after delivery (postpartum); and
- community-based doula programs.

Special consideration will be given to proposals from jurisdictions facing the most acute maternal and child health disparities, including: 1. Baltimore City, 2. Montgomery County, 3. Howard County, 4. Washington County, 5. Carroll County, 6. Charles County, 7. Baltimore County, 8. Prince George's County, 9. Anne Arundel County, 10. Frederick County, 11. Harford County, and 12. Wicomico County.

Since 2005, the CHRC has awarded 29 grants totaling over $6.8 million to improve access to comprehensive women's health services and reduce infant mortality, serving over 20,000 individuals.

Childhood Asthma

Approximately 9.7% of children in Maryland have asthma. Pediatric asthma contributes to negative health outcomes, increased healthcare utilization and spending, missed classroom instruction hours, and a loss of parental productivity.[61] Asthma is responsible for more emergency department visits than other major chronic diseases such as hypertension and diabetes. In 2018, there were 10,974 emergency department visits for ages 2-17 in Maryland with asthma as the primary diagnosis. Children with asthma miss an average of 2.3 days of school per year.[62]

[59] https://centeringhealthcare.org
[60] https://homvee.acf.hhs.gov
[61] https://hscrc.maryland.gov/Documents/Modernization/SIHIS%20Proposal%20-%20CMMI%20Submission%2012142020.pdf
[62] https://hscrc.maryland.gov/Documents/Modernization/SIHIS%20Proposal%20-%20CMMI%20Submission%2012142020.pdf

Pediatric asthma exhibits striking racial disparities. According to the Maryland Health Services Cost Review Commission (HSCRC), in 2018, the rate of pediatric ED visits for African American/Black Maryland children was more than four times the rate for White children.[63]

Pediatric asthma interventions that could be funded under this proposal include but are not limited to:

- home- and/or neighborhood-based environmental interventions that identify, reduce, and/or eliminate asthma triggers;
- reducing barriers to outpatient asthma care and/or asthma medications;
- care coordination;
- Asthma Self-Management Education (AS-ME);
- referral protocols utilizing CRISP or other means to promote more efficient and rapid referrals by providers to community-based services, including but not limited to local health department home visiting programs;[64]
- improved asthma management including through single maintenance and reliever therapy (SMART) guidelines;[65]
- school-based programs including direct observed treatment, care coordination, referrals to home visiting programs,[66] and asthma education;
- employer-based interventions focused on working teenagers; and
- programs to encourage adherence to treatment plans and proper use of medications.

The CDC's EXHALE technical package describes a number of evidence-based approaches to address asthma.[67] Applications must specifically indicate whether and how proposed interventions will improve disparities in asthma outcomes, and the evidence on which the proposed interventions are based. If interventions are focused on specific populations that have been underserved or difficult to reach, this should also be indicated.

3. AREA 3: Addressing Behavioral Health, including Mental Health and Substance Use Disorder (SUD) and the ongoing impact of the opioid crisis.

(The CHRC anticipates having a maximum of approximately $2,000,000-$3,000,000 in total funds available to cover all grant awards issued under this category for up to 3 years).

Behavioral health needs and the opioid crisis have been exacerbated by the COVID-19 pandemic. Suicide attempts are increasing nationally and in Maryland. Social isolation, trauma,

[63] https://hscrc.maryland.gov/Documents/Modernization/SIHIS%20Proposal%20-%20CMMI%20Submission%2012142020.pdf
[64] https://health.maryland.gov/phpa/OEHFP/EH/Pages/CHIPEnvCaseMgmt.aspx
[65] https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/2020-focused-updates-asthma-management-guidelines
[66] https://health.maryland.gov/phpa/OEhfp/eh/Pages/asthma.aspx
[67] https://www.cdc.gov/asthma/pdfs/EXHALE_technical_package-508.pdf

multiple stressors, and other factors related to the pandemic have led to increases in depression and anxiety among adults and children.[68]

The number of drug- and alcohol-related intoxication deaths occurring in Maryland increased by 18% during the past year, from 2,379 in 2019 to 2,799 in 2020. Ninety percent of all intoxication deaths in Maryland in 2020 were opioid-related. Opioid overdose fatality rates, after a slight 2% decline in 2019, increased by 20% between 2019-2020. Fentanyl remains the largest cause of opioid-related deaths, and from 2019 to 2020, the number of fentanyl-related deaths increased by 22%, from 1927 to 2342.[69]

Racial and ethnic disparities in this area are significant and worsening. According to the Maryland Opioid Operational Command Center, between 2017-2019, overdose mortality decreased by 11% for White Marylanders, while increasing by nearly 40% for African American/Black Marylanders. In 2019, the rate of mental health emergency department visits per 1,000 was 67.9 for African American/Black Marylanders and 57.1 for White Marylanders. The rate of substance use emergency department visits per 1,000 was 68.7 for Black Marylanders and 37.6 for White Marylanders.[70] Specific interventions are sought to address these issues.

Examples of interventions that could be supported under this area of focus include:

- culturally targeted programming;
- engagement/educational activities for communities and community leaders;
- integration of somatic and behavioral health services;
- case management and linkages to care;
- drug addiction therapy programs;
- crisis care centers;
- mobile health clinics;
- residential recovery programs;
- the HOMEBUILDERS family preservation program;
- expanded behavioral health screenings and referrals to care;
- programs to address trauma and Adverse Childhood Experiences (ACEs);[71]
- peer recovery specialist recruitment/training programs;
- harm reduction outreach initiatives;

[68] https://www.thelancet.com/journals/lanam/article/PIIS2667-193X(21)00087-9/fulltext#seccesectitle0019
[69] https://health.maryland.gov/vsa/Documents/Overdose/Annual_2020_Drug_Intox_Report.pdf
[70] https://health.maryland.gov/mchrc/Documents/Pathways%20to%20Health%20Equity%20Docs/Pathways%20Public%20Use%20Health%20Data%20filev3%20-%20Updated%20November%203.xlsx
[71] https://www.cdc.gov/violenceprevention/aces/index.html

- drop-in services for recovery support;
- telehealth services; and
- programs that integrate SDOH interventions (e.g., housing programs).

Special consideration will be given to programs that address overdose among the African American/Black communities in four target jurisdictions identified by the Maryland Racial Disparities in Overdose Taskforce: Baltimore City, Baltimore County, Prince George's County, and Anne Arundel County.

Since 2005, the CHRC has awarded 77 grants totaling over $20 million to increase access to mental health and substance use treatment programs across Maryland. These programs have served over 95,000 residents to date.

Applicants must submit proposals for projects in ***one*** of the three areas of focus described above. The CHRC recognizes that these areas of focus may overlap in scope and have elements in common. There is no limit on the number of proposals that an applicant may submit, but an applicant that submits multiple proposals must clarify how the proposals represent wholly different projects.

For any area of funding focus, it is crucial that proposals address *both* of the CHRC's strategic priorities in this year's RFP.

Selection Criteria

Applications should include a clear description indicating how CHRC funding would not duplicate, but rather leverage current initiatives/resources from the Maryland Department of Health, federal, and other state and/or private foundation funding sources that serve the strategic priorities and areas of focus under this Call for Proposals.

Impacts from selected projects may include, but are not limited to: (1) medium term impacts such as increased access to primary and integrated behavioral health services, and school-based prevention and education and/or (2) long term impacts such as reduction in hospital and emergency service utilization for treatment of ambulatory care-sensitive acute and chronic conditions.

The Commission will also use all of the following criteria to assess, prioritize, and select proposals for funding:

1. **The strategic priorities of the CHRC must be clearly identified and addressed in the application (refer to the descriptions provided on pages 10-13 above).**

   1a). Advancing health equity by addressing health disparities and adverse Social Determinants of Health (SDOH), with a particular emphasis on groups disproportionately impacted by the COVID-19 pandemic, including racial and ethnic minorities.

   1b).Promoting the efficient and strategic delivery of integrated health and social services through innovative, sustainable community partnerships that address the totality of

medical and non-medical needs, with emphasis on approaches that consider the ongoing challenges of delivering services during the COVID-19 pandemic.

2. **Supporting community-based projects that are innovative, sustainable, and replicable (as described on pages 4-5 above):** The proposal describes a project that employs innovations in methodology, use of technology, and/or multi-sectoral partnerships to expand/improve the provision of health care services to underserved populations. The proposal describes how the proposed project, after successful completion, could serve as a model to be replicated in other areas of the state. The application demonstrates that the proposed project is likely to continue to provide benefits to the target population and the community at large beyond the duration of the proposed grant period. The proposal identifies likely sources of future revenue and describes efforts to achieve long-term project/financial sustainability, which could include future funding from a fee-for-service model, outside funding from hospitals, outside organizations, or grants. Additionally, applications that indicate matching fund commitments or leverage additional resources will be favorably reviewed. Letters of commitment that demonstrate financial support at the beginning, during, or after the project grant period are strongly encouraged, and these applications will be given added consideration. In-kind support will also be viewed favorably, but not as favorably as matching support provided by additional external partners, such as hospital partners, private/non-profit foundations, and the business community.
3. **Community need:** The application demonstrates a deep understanding of the community to be served and that the needs of the community exceed the existing health resources available (or accessible) to the target population. The target population is clearly identified and quantified, and the needs of this population are adequately documented through quantitative data that include demographics, rates of insurance coverage, and service utilization statistics. Data used to illustrate the needs of the identified population should be drawn from a reliable and known data source such as the U.S. Census Bureau, State Health Improvement Process (SHIP), Health Services Cost Review Commission (HSCRC), Chesapeake Regional Information System for our Patients (CRISP), individual hospital data, or the Maryland Health Equity data from the Maryland Office of Minority Health and Health Disparities. Applicants are strongly encouraged to consult their local Community Health Needs Assessments and Local Health Improvement Coalitions (LHICs). While not required, applicants may utilize the zip code-level public data files provided by CRISP for the CHRC Pathways to Health Equity Call for Proposals located on the CHRC webpage (https://health.maryland.gov/mchrc/Pages/notices.aspx). Applicants are welcome to use other verifiable data sources (e.g., AHRQ SDOH database[72]). The proposal must also demonstrate that community stakeholders are engaged and have played an active role in the development of the project and the proposed intervention strategies. Applicants are encouraged to describe the process used to determine community buy-in for the project and how community stakeholders will continue to be involved.
4. **Project impact and prospects for success:** The application demonstrates that the project will lead to improved access to care for the target population, will build capacity to deliver services to lead to improved health outcomes, improved service experiences, more efficient use of hospital resources and reduced health disparities. The project has the potential for

[72] https://www.ahrq.gov/sdoh/data-analytics.html

expansion or replication in neighboring areas or more broadly across the state. The goals and objectives of the project are clear, measurable, and achievable. The proposed project has a high likelihood of achieving its overall goal(s).

The project incorporates the best available evidence-based interventions and actions that will address the priorities outlined in the proposal. In the absence of evidence-based intervention strategies, the CHRC will also consider alternative strategies from the proposal if there is a compelling case for logical and closely monitored innovation. The proposal includes a logic model attachment which summarizes the project and links intervention strategies with expected outcomes. The work plan and budget are congruent and reasonable. The project team possesses the skills, competencies, commitment, and sufficient capacity to carry out the proposed work and has a supportive, organizational, and community environment. Applicants are encouraged to cite specific data sets and sources that will be utilized to document project impact.

5. **Project monitoring, evaluation, and capacity to collect/report data:** The application demonstrates the capacity to measure and report progress in achieving goals and objectives of the project through qualitative and quantitative measures. Evaluation plans should be clear and consistent with the inputs, activities, and outcomes outlined in the project's logic model. The application should clearly specify the metrics that will be used to define success, including clearly defined process and health outcome measures. The application should specify how data will be collected and reported to the CHRC, which analysis tools will be used for quantitative and qualitative evaluation, and what data source(s) will be utilized to document overall project impact. Where relevant, applications should document the use of an EMR system, use of the ENS system in CRISP, data-sharing agreements with hospitals and/or community partners, Medicaid claims data, or other applicable data tools and resources. The project team must also have the ability to comply with the evaluation and monitoring requirements of the proposed grant project. Applicants with limited internal capability or capacity to collect and report data are permitted to include the projected costs of data collection and evaluation in their line-item budget and narrative.

6. **Participation of stakeholders and partners:** The application lists as key participants relevant stakeholders and partners from the community and appropriate agencies and organizations. These collaborators will be actively engaged as demonstrated by participation in the planning and implementation process, dedicating staff or other resources to the project, contributions of facilities and equipment, and/or the provision of free or discounted health care services. Letters of commitment from collaborators are **required**, should be included in the Appendix section of the proposal, and must clearly state what they will contribute to the project and/or how they will participate in the project.

7. **Organizational commitment and financial viability:** The applicant organization is committed to improving access to care for the target population and can demonstrate that the proposed project will significantly contribute to this goal. In addition, the applicant organization is in sound financial standing, has adequate financial management systems, is capable of managing grant funds, and presents the strong likelihood of achieving the overall objective(s) of the grant proposal.

8. **Workforce Diversity:** Applicants are encouraged to present an organizational assessment of racial and ethnic minority representation and cultural competency among the organization's

healthcare professionals, key community service providers, and organizational leadership, and when applicable present the organizational approach to achieve racial and ethnic diversity proportional to the vulnerable communities served to increase the quality of care and contribute to reducing health disparities.

9. **Cultural, linguistic and health literacy competency**: Applicants are encouraged to present strategies for working with the target population/community in a culturally sensitive and linguistically competent manner. Proposals should include strategies and interventions to address low health literacy in the target population/community, including facilitating translation and interpretation for non-English speakers and expanding the cultural, linguistic, and health literacy competencies of professional and paraprofessional health care workforce.

Evaluation and Monitoring

As a condition of receiving grant funds, grantees must agree to participate in an ongoing CHRC evaluation of the grant program. Grantees will be required to submit regular project progress and fiscal/expenditure reports as well as deliverables produced under the grant as a condition of 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 virtual or in-person meetings, participate in site visits, and give reports on progress and accomplishments to the Commission, 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.

Use of Grant Funds

Grant funds may be used for project staff salaries and fringe benefits (fringe benefits are limited to 25% of the 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 to exceed 25% will be considered on a case-by-case basis.

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 higher 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 terms of achieving the fundamental goals and objectives of the project should be explicit in the proposal. Grant funds may not be used for depreciation expenses, major equipment or new construction projects, to support clinical trials, or for lobbying or political activity. Grant funds may be used for those renovations necessary to carry out the proposed project.

If the services in an applicant's proposal will 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.

How to Apply

The application process begins by submitting a Letter of Intent and a copy of the most recent financial audit as described below, by **12:00 p.m. (noon) February 28, 2022.** CHRC staff will review these materials and screen applicants for eligibility to determine who will be invited to submit a full grant application as described below. **Full grant applications will be due to the Commission on March 22, 2022 by 12:00 p.m. (noon).**

Applicants will be notified about the status of their grant applications in April/May 2022. **A select number of well-reviewed grant applications will then be considered for grant awards at the Commission's meeting in May 2022.** Grant awards will be made by the CHRC following this meeting and applicants will be notified shortly after the meeting.

STEP 1: Letter of Intent and Financial Audit - due February 28, 2022.

All applicants must submit a **Letter of Intent (LOI)** for the application to be considered. Letters of Intent **must be received by 12:00 p.m. (noon) on February 28, 2022, via email** delivery to Jen Thayer at **mdh.chrc@maryland.gov**. In the subject line of the email, please state your organization's name and the Call for Proposals area of focus category for your application. A hard copy original of the Letter of Intent is not necessary.

The Letter of Intent submission must include the following two items:

1. **A completed Letter of Intent.** The LOI template and completion instructions can be found in Appendix I of this document and online at:

   https://health.maryland.gov/mchrc/Pages/notices.aspx

   The LOI template must be filled out completely and must adhere to the posted word limits.

2. **Financial audit**. Organizations must submit **an electronic version of the most recent financial audit of the organization**. The audit should be submitted at the same time as the LOI. Receipt of the LOI and financial audit are a condition for moving forward in the grant process.

If grant funded services are provided through **formal** partnerships with another organization or group, the CHRC will require that a **Memorandum of Understanding** (MOU) or similar legally binding document be in place prior to submission of the LOI, and a copy of the fully executed document(s) be included with the LOI.

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

STEP 2: Submission of Grant Applications - due March 22, 2022

Applicants who are invited to submit a full grant application must follow the application guidelines detailed below.

Full grant applications (see components listed below) must be received electronically by the CHRC no later than 12:00 p.m. (noon) on March 22, 2022.

The full electronic grant application should be emailed to: **mdh.chrc@maryland.gov**

In the subject line of the email, please state your organization's name and the Call for Proposals area of focus category (Area 1, 2 or 3 is sufficient) of your proposal. **NOTE:** for the electronic submission, the **Executive Summary and Project Proposal** must be submitted in these two file formats: (1) Adobe Acrobat PDF, and (2) MS Word (version 2010 or later).

In addition to the electronic grant application submission, two hard copy originals of the full application with the items listed below must be sent via USPS mail or express delivery service. If sent by USPS, it must be post-marked no later than **March 22, 2022**; 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 **March 22, 2022,** to be considered a complete grant application package.

The original hard copy full grant application must include a signed original of each of the following:

- Transmittal Letter
- Grant Application Cover Sheet
- Executive Summary and Full Project Proposal (no signature required)
- Contractual Obligations, Assurances, and Certifications
- Form W-9

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

PLEASE NOTE:

1. **Hand-delivery of these documents by anyone other than USPS or an express delivery service is not permitted due to building access restrictions.**
2. The two hard copies of all application documents should be bound with binder clips, two-prong report fasteners, or spiral bound. If two-prong fasteners are used, cardboard or plastic covers and backs can be used. Do **not** use three ring binders.

As noted above, the two hard copies of the full grant application should be sent by USPS mail or express delivery service with a post-mark or confirmed pick up for delivery date **no later than March 22, 2022**, sent to the address below:

Jen Thayer, CHRC Administrator

Maryland Community Health Resources Commission

45 Calvert Street, Room 336

Annapolis, MD 21401

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

(1) Transmittal Letter: This letter from the applicant organization's chief executive officer 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 grants program.

(2) Executive Summary: A half-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 chief executive officer or the individual responsible for conducting the affairs of the applicant organization and legally authorized to execute contracts on behalf of the applicant organization.

(4) Contractual Obligations, Assurances, and Certifications: The agreement should be completed and signed by either the chief executive officer or the individual responsible for conducting the affairs of the applicant organization and authorized to execute contracts on behalf of the applicant organization.

(5) Project Proposal: See proposal guidelines below for detailed instructions.

Project proposals should be well-written, clear, and concise. Applicants are strongly encouraged to limit their project proposal to 15 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 15-page limit guideline.

The project proposal should be structured using these topic headings:

- Table of contents (not included in the 15-page limit)
- Project Summary
- Background and Justification
- Organizational Capacity
- Project Plan
- Partnerships
- Evaluation
- Sustainability
- Project Budget and Budget Justification
- Appendices (not included in the 15-page limit)

Mandatory 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

(c) Organizational Chart

(d) Overall organization budget

(e) Form 990, if applicable

(f) Résumés of key personnel

(g) Logic model

(h) Letters of commitment from collaborators

Optional appendices

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

(b) Annual report, if available

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

The required components of the proposal are as follows:

(A) Executive Summary of the Project Proposal

Provide a two-page summary of the proposal. The summary should clearly and concisely state:

- Applicant organization;
- Project funding category (area of focus);
- Project title;
- Project duration;
- Succinct overview of project;
- Population to be served;
- Health disparity(ies) to be addressed;
- Funding amount requested, noting year one request and total request (for a multi-year project);
- Description of how CHRC funds will be specifically utilized. If grant funds will be used to hire health providers, indicate the provider type and percent FTE;
- Information on how the project will be sustained after grant funds are utilized (i.e., will the project be able to bill third party payers?);
- Baseline numbers of the population to be served and expected number of people to be served by the project's end; and
- Expected improved outcomes for the target population.

(B) Background and Justification

- ***Describe the target population.*** Identify the population(s) to be served (i.e., estimated numbers, demographics, insurance coverage, income levels, other distinguishing characteristics) with baseline and total projected numbers of individuals to be served by the end of the project. Please provide a brief explanation of how the projected numbers of individuals to be served were calculated. Specify the service area(s) where your target population lives and/or where your project will serve. Service maps, data, and other statistics on the target population may be provided as an appendix.
- ***Document the needs of this population using qualitative and quantitative data.*** Generally, what are the health needs of the target population? What are the gaps in the healthcare delivery system? What are the specific barriers that the target population faces in accessing health care services or services similar to your proposed project? Discuss

the community conditions affecting the target population's health behaviors and outcomes. Statistics and data should be concisely presented.

- ***Describe the health disparity(ies) in the target population that the project will address***. Discuss the specific health disparity(ies) the project is intended to address and how the project will address the disparity(ies).
- ***Describe community buy-in for the project***. Discuss the process used to identify and engage community stakeholders when designing the proposed project. How were community members engaged in the development of the proposal? Will community stakeholders be consulted about or involved in project implementation?
- ***Describe any similar or complementary projects in the targeted community.*** Describe similar or complementary projects that are currently in place in the target area and discuss how the proposed project does not duplicate work already being done.
- ***Discuss the precedents for this project and the expected benefits***. Is the project based on a prior model or approach? What is the evidence that the proposed model or approach will be successful? If the project is a new, original approach, articulate why this approach will likely meet the project's stated goals and objectives. If the project is successful, what visible, tangible, objectively verifiable results will be reported at the end of the grant? What longer term benefits are expected for the target population and the broader community?
- ***Show how the project addresses legislative priorities.*** Discuss the extent to which the project addresses the priorities for community health resources in the Community Health Care Access and Safety Net Act of 2005 [for more information, refer to the legislation (SB 775/HB627 – 2005)]. The proposal may also discuss other public/population health and health care delivery initiatives such as the State Health Improvement Process (SHIP), Diabetes Action Plan, and Total Cost of Care Model.

(C) Organizational Capacity

- ***Describe the organization's mission, structure, governance, facilities, and staffing.*** Describe the organization's mission, projects, and service area. Discuss the organizational strengths and challenges. Is the applicant a for-profit or not-for-profit organization? If applicable, attach as an appendix the organization's determination letter from the IRS indicating 501(c)(3) tax-exempt status. Describe the type of organization (e.g., federally qualified health center, free-standing clinic, clinic affiliated with a hospital or local health department, private primary care practice). Specify the governance structure. In an appendix, provide a list of the officers and board of directors or other governing body. Describe the current and proposed staffing and provide an organizational chart as an appendix. Describe the facilities owned and/or operated by the organization.
- ***Describe how the organization is financed.*** Specify revenue sources and the percentage of total funding. What is the annual budget? As appendices to the proposal, provide an overall organizational budget (projected revenues and expenses) for the current fiscal year, and, if your organization files a Form 990, its most recent filing. <u>It is not necessary to include the financial audit previously submitted with the LOI</u>. The Commission will request additional information if necessary.

- ***Describe the organization's history of working with the target population and with partnerships in this community.*** Discuss previous work in this community and with this target population.
- ***Discuss the organization's history with other/similar grants, including any prior CHRC funding.*** Discuss the organization's grant funding history. Discuss any notices of insufficient progress that your organization may have received and how issues were resolved.
- ***Discuss project staffing.*** Identify the project director and describe his/her level of responsibility within the applicant organization, qualifications to lead the project, and the role in carrying out the project. Identify other essential staff, their roles in the project, and their relevant qualifications. As an appendix, include résumés (**maximum three pages each**) for all key personnel. Describe any positions that the organization will need to hire new/additional staff to fill.
- ***Does the organization publish an annual report?*** If so, provide a copy as an appendix. If your organization has submitted the latest annual report for a previous grant round, please provide a statement that the report was submitted and which year it covers.

(D) Project Plan

- ***Discuss the project's goals and objectives.*** What are the project's goals and objectives? Use SMART objectives (**S**pecific, **M**easurable, **A**chievable, **R**ealistic and includes a **T**imeframe). Provide a logic model as an appendix. For information on how to create a Logic Model, refer to the Kellogg Foundation guide.[73] A logic model template is provided in Appendix II.
- ***Describe the major steps or actions in carrying out the project.*** List key actions or steps in the implementation of the project. Describe the process and timeframe for reaching these benchmarks. A sample project workplan worksheet can be found in Appendix III and can be used in preparing the project plan, and the completed workplan should be included with the application.
- ***Describe the project deliverables.*** What specific products/deliverables would be submitted to the Commission as evidence of completion of project milestones? How and when will these deliverables be produced? What are the associated quantifiable outcome metrics associated with these deliverables and overall goals of the project?
- ***Provide a timeline for accomplishing milestones and deliverables.*** Provide a Gantt chart or other project timeline listing project tasks and the time period in which these tasks will be undertaken.

(E) Partnerships

- ***Identify planned partners***. Name the community organization(s) and any partners from the business community that will play a defined role in the project. Identify the leadership of the partner organization.
- ***Discuss the ways the partners will contribute to the project.*** Clearly define the role of the partner(s) in the project. Include a description of the added capacity that they bring to

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

the project. Include a letter of commitment in the appendix that includes the specific role that the partner organization agrees to play. Only organizations that have submitted a letter of commitment will be considered as partners in the project.

- ***Discuss the management plan for the project.*** Describe the processes and organizational structures that will be put into place to ensure that the partnership(s) are effective.

(F) Evaluation

- ***Discuss how success will be measured***. Discuss the methodology that will be used for evaluating whether the project meets its stated goals and objectives. How will success be determined?
- ***Discuss what data will be collected and analyzed, including the data sources and planned analysis techniques***. Identify the data to be collected and analyzed. Identify data sources and the methodology that will be used for analysis. Discuss the capacity of the organization to carry out the evaluation plan and collect and report data metrics and quantifiable outcomes.

(G) Sustainability

Discuss how the project will be sustained after support ends. Discuss the process by which the project will work towards sustainability. Will support come from revenue/billing fee for service? Organizational support? Other grant funds? Will the project require ongoing outside support after the proposed grant ends? If so, describe the plans for securing ongoing funding or, if plans are not yet firm, the process to be employed to work towards sustainability. Are there opportunities for expanding or replicating this project within the community, in neighboring areas, or more broadly? Applications offering a strong sustainability plan, such as billing for services or funding commitments from other sources, will be favorably reviewed.

(H) Project Budget

- 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 CHRC grant request is a portion of the overall cost of the project, clarify this (such as the percentage that the CHRC grant request is of the overall project cost), and indicate the sources of other funding.
- Applicants must use the Budget Form provided in Appendix IV of the Call for Proposals. The CHRC Budget Form must include the following line item areas:
  - *Personnel:* Include the percent effort (FTE), name, 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 other 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 on a case-by-case basis permitting higher indirect cost rates (above 10%) if the applicant can demonstrate that a higher rate that has been approved by the federal government.

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

INQUIRIES

Conference Call for Applicants: The Commission will host a conference call for interested applicants to provide information on the grants program and assistance with the application process. This conference call, on **February 14, 2022 at 10:00 a.m.,** is optional, though encouraged, and will last approximately one hour, depending on the number of questions from potential applicants.

The Zoom link for the conference call is:

https://zoom.us/j/93361463380?pwd=WnZHdHV0UG10OHVDZzhMMjFhL01iZz09

Dial-in #: 1-301-715-8592
Meeting ID: 933 6146 3380 / Passcode: 159826

Questions from Applicants: Applicants may also submit written questions about the grants program at any time. Please email questions to Chris Kelter at chris.kelter@maryland.gov. Responses will be provided on a timely basis by CHRC staff.

Following the public conference call, Commission staff will post a "Frequently Asked Questions" document on its website.

Program Office: The program office for the grants program is located at the Maryland Community Health Resources Commission.

Staff members are:

Mark Luckner, Executive Director
E-mail: mark.luckner@maryland.gov

Chris Kelter, Chief Financial Officer
E-mail: chris.kelter@maryland.gov

Michael Fay, Program Manager
E-mail: michael.fay@maryland.gov

Jen Thayer, Administrator
E-mail: jen.thayer@maryland.gov

Lorianne Moss, Policy Analyst
E-mail: lorianne.moss@maryland.gov

Ed Swartz, Financial Advisor
E-mail: ed.swartz@maryland.gov

About the Maryland Community Health Resources Commission

The Community Health Care Access and Safety Net Act of 2005 became law on May 10, 2005. The law authorized establishment of the 11-member Maryland Community Health Resources Commission to help communities in Maryland improve access to care for low-income families and under- and uninsured individuals. Current members of the Commission have been appointed by the Governor and are subject to confirmation by the Maryland State Senate. In 2014, the Maryland General Assembly approved legislation that re-authorized the CHRC until June 2025.

Current Commissioners

Eddward J. Kasemeyer, Chair

J. Wayne Howard, Vice Chair

Scott T. Gibson

Flor de Maria Giusti

Celeste James

David Lehr

Karen-Ann Lichtenstein

Carol Masden, LCSW-C

Sadiya Muqueeth, Dr.PH

Destiny-Simone Ramjohn, PhD

Carol Ivy Simmons, PhD

APPENDIX I: LETTER OF INTENT FORM AND INSTRUCTIONS

Maryland Community Health Resources Commission
Letter of Intent FY 2022 Call for Proposals

1. Organization Name:

2. Organization Address:

3. Name, Email and Telephone of Organization CEO:

4. Name, Title, Email and Telephone of Project Director:

5. Additional Contact Information:

6. Project Title:

7. Area of Focus (check one):
- ☐ Addressing Chronic Disease Prevention and Disease Management
- ☐ Addressing Maternal and Child Health/Childhood Asthma
- ☐ Addressing Behavioral Health, including the Opioid Crisis

8. Program Jurisdiction:

9. Year One / Total CHRC Request: Year 1 $: Total Request: $

10. Program Duration (check one): ☐ One Year ☐ Two Year ☐ Three Year

11. This program is (check one): ☐ A New Program ☐ An Expansion of Existing Services

12. Has the applicant received CHRC funding in prior years? ☐ Yes ☐ No

If NO, describe how your organization meets the definition of a "Community Health Resource":

12A. Type of Organization: ☐ Primary Care Provider ☐ Hospital ☐ Non-Profit Community-Based Organization ☐ ☐ ☐

☐ Local Health Department Behavioral Health Provider FQHC Other (explain)

Links to definition of a Community Health Resource: Primary Community Health Resource, Designated Community Health Resource, Access Community Health Resource (Note: if applying as an Access Community Health Resource, an MOU with a Primary Care Provider must be submitted with your Letter of Intent).

Maryland Community Health Resources Commission
Letter of Intent FY 2022 Call for Proposals

13. A description of the applicant organization (maximum 250 words):

14. A description of the project including: the services the project will provide, the target population, and the need for the program in this community (maximum 500 words):

15. Letter of Intent – Required Documents:

- ☐ Audited Financial Statement
- ☐ Federal Form W9

Eligibility Documents:

- ☐ Sliding Fee Scale (Applicant)
- ☐ Executed Memorandum of Understanding with Primary Care provider (Access Community Health Resources) and the sliding fee scale of the primary care provider.

APPENDIX I: Letter of Intent Form and Instructions

INSTRUCTIONS FOR CHRC LETTER OF INTENT TEMPLATE

Line 1. The formal name of the applicant's organization which must match the name included on official tax forms/audit documents.

Line 2. The main address of the organization as found on official tax forms/audit documents.

Line 3. The name, telephone number and email addresses of the applicant organization's CEO.

Line 4. The name, telephone number and email addresses of the applicant organization's project director.

Line 5. Additional contact information for program.

Line 6. Project title

Line 7. Project Focus Area

Line 8. Program jurisdiction (county(ies) and/or Baltimore City)

Line 9. The funds that will be requested for the first year, and the funds requested for the entire project (for all years).

Line 10. The proposed duration of the grant funding.

Line 11. Type of Program: New or Expansion of Existing Services. (If the application proposes a service not currently being provided in that location by the organization, it will be considered a **New Project**. If the application proposes providing existing services to a new population of patients, it will be considered an **Expansion of Existing Services**.)

Line 12. Yes/No – Has your organization received funding from CHRC in prior years. If your organization has not received prior CHRC funding, please demonstrate how your organization meets the definition of a "Community Health Resource" as described in the grant eligibility section of the RFP.

Line 12A. Type of Applicant Organization – check the box that most closely identifies your type of organization. Indicate whether your organization is a Primary Community Health Resource, a Designated Community Health Resource, or an Access Community Resource. Access Community Health Resources must submit an MOU with a Primary Care Provider with your Letter of Intent.

Line 13. A description of the applicant organization, including its mission, its history of providing services in the community, and its history with grant-funded projects. The description should not exceed 250 words.

Line 14. A description of the project, including: the services that will be provided, the communities that will be impacted, and the disparity that will be addressed.

Line 15. List of required documents that must accompany the Letter of Intent.

APPENDIX II: Logic Model Form

LOGIC MODEL – CHRC FY 2022 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 1-3 then 4-6 years:	We expect that if accomplished these activities will lead to the following changes in 7-10 years:

APPENDIX III: Workplan Template

Workplan Template

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Organization Name: _____

Project Name: _____

PROJECT PURPOSE:

(1) GOAL						
Objective	**Key Action Step**	**Expected Outcome**	**Data Evaluation and Measurement**	**Data Source and Baseline Measure**	**Person/Area Responsible**	**Timetable for Achieving Objective**
Example: Reduce the # of BH related ED visits at Hospital X by 20%	Mobilize BH mobile crisis team to respond to emergency BH calls	Crisis team will be able to de-escalate BH related emergency situations and divert individuals who would have been hospitalized into appropriate BH care.	# of individuals referred to a BH specialist, # of ED visits to Hospital X for BH related conditions	Data on BH ED visits at Hospital X will be obtained from CRISP or individual hospital partner. 2014 CRISP data for BH ED visits to Hospital X will be used as baseline	J. Doe - Project Manager	12/31/2018
(2) GOAL						
Objective	**Key Action Step**	**Expected Outcome**	**Data Evaluation and Measurement**	**Data Source and Baseline Measure**	**Person/Area Responsible**	**Timetable for Achieving Objective**
(3) GOAL						
Objective	**Key Action Step**	**Expected Outcome**	**Data Evaluation and Measurement**	**Data Source and Baseline Measure**	**Person/Area Responsible**	**Timetable for Achieving Objective**

APPENDIX IV: Budget Form Template

Budget Form Template - FY 2022 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**	**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 - Name, Title			0
% FTE - Name, Title			0
% FTE - Name, Title			0
Personnel Subtotal	**0**	**0**	**0**
Personnel Fringe (no more than 25% of Personnel costs)			**0**
Equipment / Furniture			0
Supplies			0
Travel / Mileage / Parking			0
Staff Training / Development			0
Contractual (>$5k itemize below with details in budget justification)			
a. Professional/other services by vendor/contractor (1)			0
b. Professional/other services by vendor/contractor (2)			0
c. Professional/other services by vendor/contractor (3)			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)			
a. Other			0
b. 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
Totals	**0**	**0**	**0**
Percent of Organization's Total Budget that this Project Budget Represents			#DIV/0!