STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Annapolis, MD 21401, Room 336
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Martin O'Malley, Governor - Anthony G. Brown, Lt. Governor
John A. Hurson, Chairman - Mark Luckner, Executive Director

Supporting Community Health Resources: Building Capacity, Expanding Access, and Improving Population Health

Call for Proposals

November 3, 2014

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 Maryland's health care safety net infrastructure. The CHRC is a quasi-independent commission within the Maryland Department of Health & Mental Hygiene (DHMH), 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 focused on strengthening the state's vibrant network of community health resources and addressed service delivery gaps in Maryland's dynamic health care marketplace. The Maryland General Assembly approved legislation last year that re-authorized the CHRC for another ten years, through June 2025.

Over the last nine years, the Commission has awarded 143 grants totaling $42 million. As shown in the table below, these programs have provided services for more than 144,000 patients, resulting in more than 439,000 patient visits. Over this same period, the Commission has received 432 requests for consideration, totaling almost $147.3 million in direct funding requests. Program sustainability is a top priority of the Commission, and CHRC grantees have used initial grant funds to leverage $14.7 million in additional federal and private funding sources.

Maryland Community Health Resources Commission				
Focus Area	**# of Projects Funded**	**Total Award Provided**	**Cumulative Total**	
			Patients Seen/Enrolled	**Visits Provided**
Expanding Access to Primary Care at Maryland's safety net providers	29	$8,562,650	57,227	194,888
Increasing Access to Dental Care for Low-income Marylanders	23	$5,275,606	43,795	94,292
Addressing Infant Mortality	15	$3,205,697	11,558	32,754
Reducing Health Care Costs through ED Diversions	6	$1,994,327	13,804	27,943
Promoting Health Information Technology at community health centers	9	$3,268,661	Health Information Technology	
Providing Access to Behavioral Health and Drug Treatment Services	25	$8,005,917	17,164	89,156
Supporting Local Health Improvement Coalitions (LHICs)	24	$1,955,048		
Health Enterprise Zones	5	$7,710,000		
Safety Net Capacity Building	4	$475,570	0	0
Childhood Obesity	3	$1,560,000	600	0
Total Grant Funding Provided	**143**	**$42,013,476**	**144,148**	**439,033**
Total Funding Requested	**432**	**$147,297,981**		
Number of Patients Served/Enrolled	**144,148**			
Number of Patients Visits/Services Provided	**439,033**			
Additional federal and private resources leveraged	**51**	**$14,708,459**		

Supporting Community Health Resources: Building Capacity, Expanding Access, and Improving Population Health is the grants program of the CHRC. The program will award grants to community health resources serving Maryland residents. In this year's Call for Proposals, the Commission will consider projects in four categories:

(1) Promoting comprehensive women's health services and reducing infant mortality rates;
(2) Expanding access to dental care;
(3) Supporting new access points and expanding primary care capacity; and
(4) Building safety net provider capacity.

Key Dates to Remember

The following are the dates and deadlines for the FY 2015 Call for Proposals.

November 3, 2014	Release of Call for Proposals
November 13, 2014 at 10:00 a.m.	Conference Call for Applicants Dial in number is 1.866.247.6034 Conference code is 4102607046
November 18, 2014 – 3:00 p.m.	**Deadline for receipt of Letters of Intent and Financial Audit**
November 24, 2014	Applicants notified to submit a full proposal
December 16, 2014 – 12 noon	**Deadline for receipt of applications**
Mid-January, 2015	Select number of applicants notified to present to the CHRC
February, 2014	**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 at COMAR 10.45.05.

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 programs for the homeless
- Primary care programs for public housing projects
- Local nonprofit and community-owned health care programs
- School-based health centers
- Teaching clinics
- Well-mobiles
- 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 do so, organizations must demonstrate that they meet the Commission's criteria for either a Primary Health Care Services Community Health Resource or an Access Services Community Health Resource. If an organization has received a grant from the Commission in a prior year, then it is a qualifying 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; and
- Serve individuals residing 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; and
- Serve individuals residing in Maryland.

Sliding Scale Fee Schedule Requirements

Organizations seeking to demonstrate that they are a Primary Health Care Services Community Health Resource or an Access Services Community Health Resource must offer a sliding scale fee schedule consistent with the following guidelines established by the Commission. 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.

The Grants Program - Strategic Priorities of this year's Call for Proposals

Expanding access in underserved communities and supporting the work of community health resources are core statutory missions of the CHRC. This year's Call for Proposals includes the following three overall strategic priorities: (1) Building capacity; (2) Addressing health disparities and promoting health equity; and (3) Reducing avoidable hospital utilization.

Building capacity. Over the past year, more than 450,000 Marylanders[1] gained access to public and private health insurance under the Affordable Care Act. It is critical that Maryland respond to the increased demand for health care services by these newly insured residents and build the capacity to deliver care in the community. The Commission will support proposals that help

[1] Maryland Health Care Connection Monthly Report, October 3, 2014
http://marylandhealthconnection.gov/assets/MHBEMonthlyReport100314.pdf

boost the capacity of community health resources to serve additional individuals and provide support and technical assistance to safety net providers, many of whom have a historical mission of serving low-income and uninsured individuals. Projects that clearly demonstrate the ability to deliver services or expand capacity in underserved communities and/or serve newly insured individuals will be given special consideration in this year's Call for Proposals.

Addressing health disparities and promoting health equity. Supporting access to affordable, high-quality health care for every Marylander regardless of ability to pay, health insurance status, income, or race, is embedded in the Commission's statutory mission. The CHRC, with DHMH, has been implementing the Maryland Health Enterprise Zones Initiative, which is designed to expand access in underserved communities, address racial and geographic health disparities, and reduce hospital admissions and readmissions. This year's Call for Proposals looks to build on the work of the Health Enterprise Zones Initiative and other efforts to promote health equity and will provide special consideration for proposals that provide innovative community-based projects that aim to reduce the gap in health outcomes between minorities and whites in Maryland. Proposals that identify specific, documented health disparities and offer intervention strategies that are tailored to address the identified disparities will be given special consideration in this year's Call for Proposals.

Reducing avoidable hospital utilization. Earlier this year, Maryland began implementation of a new All-Payer Hospital Waiver, which shifts the state's hospital revenue structure from rewarding volume (utilization) to promoting value (population health) and quality of care (patient experience). The new Waiver aligns the hospital payment structure with the state's overall population health improvement goals and provides incentives for hospitals to focus on care coordination, improved quality and continuity of care, and other efforts to improve the health of individuals in their communities while avoiding unnecessary care. Under the agreement with the federal government, the Health Services Cost Review Commission (HSCRC) is working with Maryland hospitals to achieve several aggressive goals: (1) A cost savings of at least $330 million in reduced Medicare expenditures over the next five years; (2) Limit hospital revenues to an annual growth rate of 3.58%, which is tied to the state's economic growth; and (3) Reduce the readmission rate in Maryland's hospitals to the national average within five years.

Achieving these goals will require creative hospital-community partnerships, innovative, data-driven intervention strategies, and strategic deployment of capital and resources. Promoting continuity of care through hospital-community partnerships, and helping to reduce avoidable hospital admissions and readmissions are policy goals that are central to the mission of the CHRC. In light of its statutory goals and in support of the new waiver, the CHRC is sponsoring a number of regional forums with DHMH, HSCRC, and the Maryland Hospital Association to highlight innovative hospital-community partnerships under implementation, discuss lessons learned from these programs, and begin a dialogue about how these programs could be sustained and replicated. For more information about the regional forums or current hospital-community partnerships, please visit the CHRC's website[2]. For more information about the new All-Payer Waiver, please visit the HSCRC's website[3].

[2] http://dhmh.maryland.gov/mchrc/SitePages/hospital_community_partnerships.aspx
[3] http://www.hscrc.state.md.us/

As this year's Call for Proposals adds a new Strategic Priority, "Avoiding Unnecessary Hospital Utilization," special consideration will be given to projects that will produce results-based relationships between hospitals and community partners, promote continuity of care, and yield measurable health improvements. Applications that are very specific about the nature of the hospital-community partnerships (letters of intent or MOUs are encouraged), the target population and selected intervention strategy, and the expected outcomes will be given special consideration this year.

As in previous Calls for Proposals, the Commission will support both one year and multi-year grant programs. Unlike prior Calls for Proposals, the CHRC will consider applications this year that represent requests to continue programs previously supported with a prior grant from the CHRC. These requests should be submitted as full grant proposal requests (like any other proposal), and will be evaluated on a case-by-case basis by the CHRC. Applicants that are submitting "continuation requests" should be very clear in terms of program impact to date, efforts to achieve program sustainability in the past, and how continuation of the program is responsive to the strategic goals of this year's Call for Proposals.

Following are the four areas of focus that the CHRC will be looking to support in this year's Call for Proposals:

1. Promoting comprehensive women's health services and reducing infant mortality rates
(Potential award funding available in year one in this category is $200,000-$300,000).
Since 2007, the Commission has awarded 15 grants totaling more than $3.2 million to support programs to help address infant mortality and provide access to comprehensive health and other services for underserved women. These programs have collectively served 11,558 women, and organizations funded by the CHRC have included federally qualified health centers, local health departments, and community-based organizations.

In 2008, the O'Malley-Brown Administration set the goal of reducing Maryland's infant mortality rate by 10% by 2012. The state has achieved a statistically significant decrease of 15% in infant mortality rates between 2004-2008 and 2009-2013, and the Administration has announced a new goal of reducing the state's infant mortality rate by an additional 10% by 2017.[4]

There was a slight increase in the rate in 2013, from 6.3 per 1,000 in 2012 to 6.6 per 1,000 in 2013, which was mainly the result of a 10% increase in white infant mortality. The black infant mortality rate increased by 2%. Cause-specific mortality rates continued to be higher for black infants than white infants for nearly all leading causes of death. Compared with white infants, black infants were four times more likely to die in 2013 as a result of SIDS, three times more likely to die as a result of low birth weight, and twice as likely to die from congenital abnormalities or maternal complications of pregnancy.

In light of the new goal and this continued public health challenge, the CHRC will look to support projects that identify priority risk factors and evidence-based interventions for

[4] Governor O'Malley's Strategic Health Goals, September 27, 2014
https://data.maryland.gov/goals/infant-mortality

addressing infant mortality and disparities in infant mortality in Maryland. Applicants are strongly encouraged to consider strategies outlined in the State Plan for Reducing Infant Mortality in Maryland[5] and informed by local, regional and state-wide data and findings. Proposals could include interventions designed to improve outcomes before pregnancy(such as promoting access to comprehensive women's health services to ensure women are healthier at time of conception), during pregnancy(to ensure earlier entry into risk-appropriate prenatal care and case management programs),and after delivery (to ensure comprehensive, high-quality follow up care for mother and infant). Strong proposals would support implementation of a "no-wrong door" or "one-stop shopping" model of services, such as integrating women's health services with existing addictions or WIC programs and strategies to ensure long-term sustainability of the proposed activities.

(2) Expanding access to dental care *(Potential award funding available in year one in this category is $100,000-$200,000).*
The CHRC has prioritized supporting programs to expand dental care services for low-income communities for several years, with a particular focus on pediatric dental programs. Since 2007, the Commission has awarded 23 grants totaling more than $5.2 million for dental programs. These programs have collectively served more than 43,000 Marylanders.

The DHMH Office of Oral Health has advised that despite recent strides to increase dental care capacity, there are still some areas of the state that lack safety net dental providers. The Maryland Dental Action Coalition released *The Maryland Oral Health Plan for 2011-2015,*[6] which articulates three key focus areas: (1) Access to Oral Health Care; (2) Oral Disease and Injury Prevention; and (3) Oral Health Literacy and Education.

In this year's Call for Proposals, the Commission will fund programs for dental and oral health services which support *The Maryland Oral Health Plan for 2011-2015*. Specifically, applicants may wish consider the following types of programs:

- ER diversion programs that facilitate access to adult emergency dental treatment services in outpatient settings to divert/reduce hospital ED visits. Successful applicants should demonstrate calculated potential cost savings to the state achieved through reduced ED visits;
- Oral health literacy programs that increase Marylanders' awareness of the importance of oral health and empower residents to improve personal oral hygiene practices;
- Case manager/care coordinator models that support case manager/care coordinators to link patients to dental education, prevention, and treatment services;
- Dental-medical collaborations such as enhanced interdisciplinary training efforts or joint oral health public education/awareness projects between the dental associations and various other medical associations;
- Dental programs that provide services for special needs children and adults for whom services are currently very limited due to the challenges this population presents to practitioners; and/or

[5] http://dhmh.maryland.gov/babiesbornhealthy/pdf/Plan_Reducing_Infant_Mortality_MD_Dec2011.pdf
[6] The full report for *The Maryland Oral Health Plan 2011-2015* can be found at http://www.mdac.us/wp-content/uploads/2011/02/MOHP-Dental-Action-r4.pdf

- Perinatal oral disease prevention programs that are interdisciplinary, evidenced-based, and empower mothers and pregnant women to engage in appropriate oral health care for themselves and their infants and children.

All proposals must include strategies for addressing the unique oral health needs of local populations. Program proposals may be for new services or the expansion of existing services that are effective in meeting the oral health needs of the community. Proposals must demonstrate efficiency in service delivery and innovation to addressing barriers to accessing oral health services, including screening and facilitating enrollment into Medicaid. All projects must have the capacity to determine client eligibility for financial assistance to programs such as Medicaid, assure children are enrolled in these programs, and bill Medicaid and other third party payers whenever possible for services provided under a CHRC grant-funded program.

3. Supporting new access points and expanding primary care capacity *(Potential award funding available in year one in this category is $500,000-$600,000).*
A fundamental policy objective of the CHRC is to support comprehensive, interconnected systems of care in communities and to expand access to affordable, high-quality primary care services in underserved areas of the state. Since 2007, the Commission has awarded 29 grants totaling more than $8.5 million to expand primary care access. These programs have collectively served more than 57,000 Marylanders.

As Maryland implements the Affordable Care Act, it is essential that the state expand its capacity to deliver primary care services in the community. More than 450,000 previously uninsured individuals have gained access to public and private health insurance,[7] and it is critical that the state build the capacity of community health resources to meet the expected demand for essential health services by Maryland's newly insured.

The CHRC will continue to support efforts to expand access to primary care and other critical health services in this Call for Proposals. Projects that would be considered under this category include support for "New Access Points" or other programs that will increase direct service capacity. In addition to building capacity and expanding access, consideration will be also be given to programs that develop intervention strategies that target specific chronic conditions and identify demonstrable improvement in patient outcomes and reductions in avoidable hospital admissions and readmissions. Proposals that include meaningful hospital-community partnerships and articulate specific and demonstrable health improvement goals are encouraged in this category.

4. Building safety net provider capacity *(Potential award funding available in year one in this category is $200,000-$300,000).*
Two years ago, as Maryland prepared to implement the Affordable Care Act, the CHRC issued a business plan (http://dhmh.maryland.gov/mchrc/Home/PDF/CHRC_Business_Plan.pdf) that outlined specific recommendations for how the state could assist safety net providers in their efforts to respond to new challenges and opportunities brought by the ACA. Recommendations of the business plan included promoting safety net provider readiness and capacity, promoting

[7] Maryland Health Connection Monthly Report, October 3, 2014
marylandhealthconnection.gov/assets/MHBEMonthlyReport100314.pdf

long-term financial stability through billing third-party payers, and addressing workforce shortage issues. These recommendations were highlighted in last year's Call for Proposals, and the CHRC awarded four grants totaling $475,000 to support safety net capacity.

In this year's Call for Proposals, the CHRC will again look to award grants to enable safety net providers to enhance their administrative capacity to serve more individuals and assist these essential community providers in their efforts to deliver care for newly insured communities as insurance coverage is expanded. The CHRC will look to support programs that will: (1) promote the long-term financial stability of safety net providers, as many providers will transition from a grant-based revenue model to billing third-party payers; (2) Promote use of EMR and other IT services to achieve administrative efficiencies, promote patient care, and improve population health; and (3) support workforce efforts as providers continue to recruit new practitioners to meet the increase in demand by Maryland's newly insured for essential health services in 2015.

Potential safety net provider capacity-building grants could include the following activities:

- Assisting grant-based providers in their efforts to transition to a system of billing third-party payers, which could include assistance in EMR selection and purchase; assistance in provider credentialing; and assistance in joining Medicaid MCO and commercial health insurance networks;
- Assisting providers in developing a long-term financial sustainability plan and/or strategic business planning efforts; or
- Supporting workforce efforts that would enable safety net providers to encourage their current eligible employees to gain two-year nursing degrees from Maryland institutions by attending classes in the evening and working during the day.

Selection Criteria

Applicants may submit proposals for projects in any one of these four areas. As has occurred in previous Calls for Proposals, the Commission will use all of the following criteria to assess, prioritize, and select proposals for funding:

Prospects for Success: 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 work plan and budget are 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 develop and include a program logic model, which summarizes the project and links intervention strategies with expected outcomes. For more information and a sample logic model, please visit the CDC website[8].

Potential impact: The project is likely to lead to increased access to care for the target population, improved health outcomes, patient experience, and/or more efficient use of hospital resources. The project has potential for expansion or replication within the community, in neighboring areas, or more broadly across the state. Applicants are encouraged to cite specific data sets and sources that will be utilized to document program impact.

[8] http://www.cdc.gov/dhdsp/programs/nhdsp_program/evaluation_guides/docs/logic_model.pdf

Community need: The applicant 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 such as demographics, rates of insurance coverage, and service utilization statistics. Data utilized to illustrate the needs of the identified population should be drawn from a reliable and known data source such as the State Health Improvement Process (SHIP), the Maryland Health Equity data from the Maryland Office of Minority Health and Health Disparities, or hospital utilization data.

Addresses Health Disparities: The applicant demonstrates knowledge of racial and ethnic health disparities among its proposed target population. The applicant provides an effective and sustainable plan to mitigate these disparities and improve health outcomes. The plan includes efforts to increase workforce diversity and includes participation by community health workers or patient navigators. The applicant indicates prior participation in, or plans to participate in, cultural competency training for staff.

Sustainability/matching funds: The Commission is looking to support programs that are sustainable after the CHRC funding has ended. 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. Proposals should identify likely sources of future revenue and comment on efforts to achieve long-term program/financial sustainability. Applications that indicate matching fund commitments or leverage additional resources will be favorably reviewed. Letters of commitment that demonstrate financial support are highly encouraged. In-kind support will be viewed favorably, but not as favorably as matching support provided by additional external partners, such as hospital partners or private/non-profit foundations.

Reducing avoidable hospital admissions and readmissions: Applications that promote results-based partnerships among hospitals and community partners; promote care coordination and continuity of care; and yield measurable health improvements in terms of patient/community health and reductions in avoidable admissions and readmissions will be prioritized in this Call for Proposals. For examples of types of projects that the CHRC has funded in prior years, please visit the hospital-community partnership page on the CHRC's website.[9] Potential types of programs could include partnerships among hospitals and community-based partners such as Federally Qualified Health Centers, health departments, and others that target "at-risk" populations and "super-utilizers," implement care coordination, establish a primary care medical home for these individuals, and address other social/health service needs of the target population. The application should be very detailed and specific in identifying the target population and how the proposed intervention strategies will in fact achieve reductions in avoidable admissions and readmissions. Proposals that include a letter of support/commitment from a hospital partner, detailing the contribution or role of the hospital in supporting or implementing the program, will be favorably reviewed.

[9] http://dhmh.maryland.gov/mchrc/SitePages/hospital_community_partnerships.aspx

Building capacity and supporting implementation of the Affordable Care Act: Applications should support Maryland's ongoing implementation of the ACA by increasing current capacity and expanding new access points, promoting continuity of care efforts, and/or ensuring newly insured Marylanders have access to affordable, high-quality health care. Programs that increase capacity to deliver direct services, promote the long-term financial stability of safety net providers, and encourage quality improvement/assurance and use of data analytics will be favorably reviewed.

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 strongly encouraged, 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.

Program monitoring, evaluation and capacity to collect/report data: The applicant has the capacity to measure and report progress in achieving goals and objectives of the project through qualitative and quantitative measures. The project team must also have the ability to comply with the evaluation and monitoring requirements of this grant program. Evaluation plans should be consistent with the inputs, activities and outcomes outlined in the program's logic model. The applicant should be very clear and specify how data will be collected and reported to the CHRC and what data source(s) will be utilized to document overall program impact.

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, and is capable of managing grant funds.

Includes implementation of evidenced-based clinical practices: The program incorporates the best available evidence-based interventions and actions that will address the priorities outlined in the applicant's proposal. The evidence-based intervention(s) should be drawn from the principles of scientific reasoning, including systematic uses of data and information systems and the appropriate use of program planning models. In the absence of evidence-based intervention strategies, the CHRC will also consider alternative strategies with a compelling case for logical and closely monitored innovation.

Evaluation and Monitoring

Grantees will be required to submit periodic progress and expenditure reports as well as deliverables produced under the grant as a condition of payment of Commission grant funds. To facilitate project monitoring, clearly defined data elements will be required from all grantees on a regular basis to assure that project accomplishments can be monitored, compared, and compiled.

The project team may be asked to attend meetings, participate in site visits, and give reports on progress and accomplishments to the Commission, its staff and advisors, and other grantees. At

the conclusion of the project, the grantee will be required to provide a written report on the project.

As a condition of receiving grant funds, grantees must agree to participate in an ongoing evaluation of the grants program. This requirement includes assisting with any data collection and information-gathering required such as participation in surveys, site visits, meetings, and interviews with the evaluators.

Use of Grant Funds

Grant funds may be used for project staff salaries and fringe benefits, consultant fees, data collection and analysis, project-related travel, conference calls and meetings, and office supplies and expenses. Indirect costs are limited to 10% of the total grant funds requested. 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. Grant funds may not be used for 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 contractor agency and not directly by the applicant, the applicant may not take a fee for passing through the funds to the contractor agency.

How to Apply

In this round of grant making, applicants will submit a Letter of Intent and a copy of the most recent Financial Audit by **November 18, 2014** as described below. The Commission will review the materials and screen the applicants to determine who will be invited to submit a full proposal as described below. The selected full grant applications will be due to the Commission on **December 16, 2014 by 12 noon.** A select number of well-reviewed applicants will be invited to present their proposals at the Commission's meeting in **February 2015.** Based on the full proposals and presentations, the Commission will select projects for grant awards and applicants will be notified after this meeting.

Step 1: Letter of Intent and Financial Audit

Applicants must submit a Letter of Intent for the proposal to be considered. **Letters of Intent must be received via email by 3:00 p.m. EDT on November 18, 2014** to Edith Budd at edith.budd@maryland.gov by electronic copy delivery. In the subject line of the email, please state your organization's name and the Call for Proposals area of focus for your proposal. Hard copy of the Letter of Intent is not necessary.

The letter should **not** exceed four single-spaced pages in length. The Letter of Intent should include the following items:

- Name, location, and brief description of the applicant organization.
- The project's title.
- The amount of funds being requested and the project's estimated duration.
- Whether this is a new project or an expansion of existing services and expected outcomes of the project.

- The services the project will provide and the site(s) where the services will be delivered.
- A precise, clear description of the target population.
- A concise description of the population the organization serves and the project's target population with relevant data and information to support the need for the project.
- A one-page budget for the total project with major line items. Categories of personnel or types of professional contracts in the project should be listed.
- The budget should also include a time line for projected numbers of individuals served (at least twice a year for the duration of the project) and overall public health outcome data that will be positively impacted by the program. The application should also include overall project goals that will determine the efficacy of the program and how the organization will track and report this data to the Commission.
- A list of other organizations participating in the project and a brief statement of their role in or contribution to the project.
- A short description of how the project activities will be sustained when the grant funding ends.
- Name, title, address, telephone number, and e-mail for the organization's chief executive officer, the proposed project director, and a contact person for the project.
- If this is the first time your organization is applying for Commission funds, you must include with the Letter of Intent documentation that clearly demonstrates your organization meets the definition of a "Community Health Resource." This documentation is not included in the four-page limit for the Letter of Intent. If your organization has received a grant from the Commission in the past, then your entity is a Community Health Resource.

Organizations must also submit one hard copy of the most recent financial audit of the organization. The audit is not included in the Letter of Intent's page limit, but should be submitted at the same time as the letter. Receipt of the Letter of Intent and financial audit are a condition for moving forward in the grant process.

Hard copies of the financial audit should be mailed or delivered **by 3:00 p.m. EDT on November 18, 2014** to:

Edith Budd
Administrator
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Step 2: Submission of Proposals
Applicants that are invited to submit a grant proposal should follow the application and proposal guidelines detailed below. **Grant proposals are due at the Commission's offices by 12 noon December 16, 2014** by email **and** hand delivery, U.S. Postal Service, or private courier to the address below.

Electronic versions of applications and proposals should be emailed to Edith Budd at edith.budd@maryland.gov. In the subject line of the email, please state your organization's name and the Call for Proposals category area of your proposal.

In addition to electronic proposal submission, the following must be received by noon on **December 16, 2014** to be considered a complete application package:

(1) One original application, including original signed Transmittal Letter, original signed Grant Application Cover Sheet, original signed Contractual Obligations, Assurances, and Certifications, and original proposal, all bound together and labeled "original;" and
(2) Ten bound copies of the application, including copies of the Transmittal Letter, Grant Application Cover Sheet, signed Contractual Obligations, Assurances, and Certifications, the proposal, and appendices.

The hard copy original and ten copies of all 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.

Hard copies of the proposal should be mailed or hand delivered to:

Edith Budd
Administrator
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

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) Proposal: See "Proposal Guidelines" below for detailed instructions.
Proposals should be well-written, clear, and concise. Proposals may not exceed 15 pages single-spaced 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 budget and budget justification are included in the 15-page limit. The appendices specified in the guidelines below are excluded from the 15-page limit.

The hard copy original and ten copies of all 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.
The proposal should be structured using these topic headings:

- Table of contents (not included in the 15-page limit)
- Project Summary
- The Project
- Evaluation
- Work Plan
- Applicant Organization
- Key Personnel
- Partners and Collaborators
- Project Budget
- Appendices (not included in the 15-page limit)

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.

(1) Project Summary

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

- Applicant organization;
- Project priority area;
- Project title;
- Project duration;
- Succinct overview of program;
- Population to be served;
- Health disparity(ies) to be addressed;
- Funding amount requested;
- Describe how CHRC funds will be specifically utilized. If grant funds will be used to hire health providers, indicate the provider type and percent FTE;
- Provide information on how the program will be sustained after program funds are utilized (i.e., will the program be able to bill third party payers);
- Baseline numbers of population to be served and expected number of people to be served by the project's end;
- Expected improved outcomes for the target population; and
- Describe how this project helps the state implement health reform.

(2) The Project

- ***What will the project do?*** What is the overarching purpose of the project? What are the measurable goals and objectives of the project? What are the key programmatic components of the project? Quite literally, who will do what for whom, with whom, where, and when?
- ***Who is 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 projected numbers of individuals to be served were calculated. Specify the service area(s) where your target

population lives and/or where your program 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? Statistics and data should be concisely presented.
- ***What problem(s) will be addressed?*** Identify the specific problem(s) encountered by the target population(s) in accessing health care services and how this project will ameliorate the problem(s).
- ***Does the proposal address health disparities that exist in Maryland?*** Discuss the specific health disparity(ies) the project is intended to address and how the project will address the disparity(ies).
- ***Is there a precedent for this project?*** 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.
- ***What will be the benefits of success?*** If the project is successful, what visible, tangible, objectively verifiable results will you be able to report at the end of the grant? What longer term benefits do you expect for the target population and the broader community?
- ***How will the project be sustained after grant support ends****?* Will the project require ongoing outside support after the proposed grant ends? If so, describe your plans for securing ongoing funding or, if plans are not yet firm, the process you will employ to work towards sustainability. Do you foresee opportunities for expanding or replicating this project within the community, in neighboring areas, or more broadly?
- ***Does the project address 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) or the discussion of legislative priorities in the Call for Proposals.

(3) Evaluation

- ***What are the goals and objectives of the program?*** Provide the overarching goals and specific objectives for the program proposal. The objectives must be SMART (Specific, Measurable, Achievable, Realistic, and Time-bound).
- ***How will you measure project success?*** What will be your methodology for evaluating whether the project meets the stated goals and objectives? What data will you collect and analyze? Does your organization have the capacity to collect and analyze data, or must new capacity be acquired or developed?

(4) Work Plan

- ***What are the major steps or actions in carrying out the project to achieve the goals?*** List planned key actions or steps to achieve program goals. Describe the process and timeframe for reaching these benchmarks.
- ***What are the project deliverables?*** What specific products would be submitted to the Commission as evidence of completion of project milestones? How and when will these deliverables be produced?

- ***What is the timeline for accomplishing milestones and deliverables?*** Prepare a Gantt chart or other timeline listing project tasks and the time period over which these tasks will be undertaken. The work plan chart may be attached as an appendix to the proposal.
- ***Why will your program make a difference?*** Prepare a logic model that links the programs work to the desired outcomes. Show how the inputs, activities, and outputs will produce successful results. (See link on page nine for more information on developing a logic model)

(5) Applicant Organization

- ***Is the applicant organization a community health resource?*** Provide documentation that your organization qualifies as a community health resource pursuant to the Maryland *Community Health Care Access and Safety Net Act of 2005* and related regulations. If your organization has applied previously to the Commission and has not been notified that you are not eligible, please just include a statement identifying under which section of the regulations your organization qualifies as a community health resource.
- ***What is the applicant organization's mission?*** Describe your mission, programs, and service area. Discuss your organizational strengths and challenges.
- ***What is the organizational structure?*** 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).
- ***How is the organization governed?*** Specify the governance structure. In an appendix, provide a list of the officers and board of directors or other governing body.
- ***How is the organization staffed?*** Describe the staffing and provide an organizational chart as an appendix.
- ***How is the organization financed?*** Specify revenue sources and the percentage of total funding. What is the annual budget? As appendices to the proposal, provide your overall organizational budget (projected revenues and expenses) for the current fiscal year, your most recent audited financial statements and accompanying management letter, and, if your organization files a Form 990, your most recent filing. If your organization has submitted audited financial statements and a Form 990 to the Commission that cover your organization's latest audited fiscal year, please provide just a statement listing which documents and their fiscal years have been submitted. The Commission will request additional information if necessary.
- ***What facilities are available?*** Describe the facilities owned and/or operated by the organization.
- ***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.

(6) Key Personnel

- ***Who will direct the project?*** Identify the project director and describe his/her level of responsibility within the applicant organization, qualifications to lead the project, and role in carrying out the project.
- ***Who are the other key staff?*** 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.

- ***What staff/positions, if any, will need to be filled?*** Please describe any positions that the organization will need to hire new/additional staff to fill. If this is a hard-to-fill position, such as a healthcare provider, please provide information on the recruitment strategy to fill the position within the stated timeframes of your project work plan.

(7) Partners and Collaborators

- ***Who are the key partners?*** What other community organizations will play a crucial role in the proposed project? Why is their participation important?
- ***In what ways will the partners contribute to the project?*** Who are the leaders of these organizations and what are their roles? Which staff will be involved, what will be their responsibilities, and how much time will they devote to the project? What other resources will partners contribute? In an appendix, provide letters of commitment from the leaders of these organizations and résumés (**maximum three pages each**) for key staff.
- ***What is the management plan?*** What processes and organizational structures will be put into place to ensure that the partnership(s) are effective?

(8) Project Budget

- Applicant must provide an annual budget for each year of their program. The total budget amount must reflect amount requested by the applicant for CHRC funding, which may or may not be the program's total actual cost.
- Applicants must use the Budget Form provided in the Appendix section of the Call for Proposals followed by a line-item budget justification detailing the purpose of each budget expenditure.
- The CHRC Budget Form must include the following line item areas:
    a) *Personnel:* Include the percent effort (FTE), name, and title of the individual.
    b) *Personnel Fringe*: Fringe benefits should be shown at the applicant organization's standard rate.
    c) *Equipment/Furniture:* Small equipment and furniture costs.
    d) *Supplies*
    e) *Travel/Mileage/Parking*
    f) *Staff Trainings/Development*
    g) *Contractual:* Contracts for more than $10,000 require approval of the Commission.
    h) *Other Expenses:* Other miscellaneous expenses or other program expenses that do not fit the other categories can be placed here. Detail each different expense in this area in the budget justification narrative.
    i) *Indirect Costs:* Indirect costs may not exceed 10 percent of direct project costs.

Inquiries

Conference Call for Applicants: The program office 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 **Thursday, November 13 at 10:00 a.m.,** is optional. The conference call-in number is **1.866.247.6034**, and the conference code is **4102607046**.

Questions from Applicants: Applicants may also submit written questions about the grants program at any time. Please email questions to edith.budd@maryland.gov, and responses will be provided on a timely basis by CHRC staff.

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

Maura Dwyer, Senior Policy Advisor
maura.dwyer@maryland.gov

Edith Budd, Administrator
E-mail: edith.budd@maryland.gov
Telephone: 410-260-6290

Caleb Wolf, Program Analyst
E-Mail: caleb.wolf@maryland.gov
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Fax: 410-626-0304

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. Governor Martin O'Malley appointed the current members of the Commission. In 2014,he Maryland General Assembly approved legislation that re-authorized the CHRC for another ten years, until June 2025.

2014 Commissioners
John A. Hurson, Chairman
Nelson Sabatini, Vice Chairman
Charlene M. Dukes, Ed.D.
Maria Harris-Tildon
William Jaquis, M.D.
Sue Kullen
Ken Hunter
Paula McLellan
Margaret Murray, M.P.A.
Barry Ronan
Elizabeth Chung

Appendix

Excerpt from: Community Health Care Access and Safety Net Act of 2005 - MD Community Health Resources Commission provisions, Annotated Code of Maryland, Health-General Article

Health General § 19-2201 (g)
In developing regulations under subsection (f) (1) of this section, the Commission shall:

(1) Consider geographic balance; and
(2) Give priority to community health resources that:
    (i) In addition to normal business hours, have evening and weekend hours of operation;
    (ii) Have partnered with a hospital to establish a reverse referral program at the hospital;
    (iii) Reduce the use of the hospital emergency department for non-emergency services;
    (iv) Assist patients in establishing a medical home with a community health resource;
    (v) Coordinate and integrate the delivery of primary and specialty care services;

(vi) Promote the integration of mental and somatic health with federally qualified health centers or other somatic care providers;
(vii) Fund medication management or therapy services for uninsured individuals up to 200% of the federal poverty level who meet medical necessity criteria but who are ineligible for the public mental health system;
(viii) Provide a clinical home for individuals who access hospital emergency departments for mental health services, substance abuse services, or both; and
(ix) Support the implementation of evidence-based clinical practices.

Sample Workplan

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Organization Name: _____

Project Name: _____

PROJECT PURPOSE:

(1) GOAL					
Objective	**Key Action Step**	**Expected Outcome**	**Data Evaluation and Measurement**	**Person/Area Responsible**	**Timetable for Achieving Objective**
(2) GOAL					
Objective	**Key Action Step**	**Expected Outcome**	**Data Evaluation and Measurement**	**Person/Area Responsible**	**Timetable for Achieving Objective**
(3) GOAL					
Objective	**Key Action Step**	**Expected Outcome**	**Data Evaluation and Measurement**	**Person/Area Responsible**	**Timetable for Achieving Objective**

STANDARD BUDGET FORM

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Organization Name: _____

Project Name: _____

Revenues	$ Amount	% of Total Project Cost
CHRC Grant Request		
Patient/Program Revenues/Income		
Organization Match		
Other Grant/Funding Support		
Total Project Cost		

Budget Request for CHRC Grant Funding	Year 1	Year 2	Year 3	Line Item Total
Personnel Salary				
% FTE - Name, Title				
% FTE - Name, Title				
% FTE - Name, Title				
Personnel Subtotal				
Personnel Fringe (% - Rate)				
Equipment/Furniture				
Supplies				
Travel/Mileage/Parking				
Staff Trainings/Development				
Contractual				
Other Expenses				
Indirect Costs (no more than 10% of direct costs)				
Total (YEARLY) Budget				