



STATE OF MARYLAND

## Community Health Resources Commission

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# **Supporting Community Health Resources: Building Capacity, Expanding Access, Promoting Health Equity, and Improving Population Health**

## **Call for Proposals**

October 26, 2016

# Table of Contents

<b>Overview</b> .....	3
<b>Key Dates to Remember</b> .....	5
<b>Grant Eligibility</b> .....	5
<b>The Grants Program – Strategic Priorities</b> .....	6
Building Capacity .....	6
Addressing health disparities and promoting health equity .....	7
Reducing avoidable hospital utilization and promoting community-hospital partnerships .....	8
<b>Funding Categories</b> .....	9
Expanding access to primary and preventative care services and chronic disease management .....	9
Integrating behavioral health service delivery in the community and addressing the heroin and opioid epidemic .....	10
Addressing childhood and family obesity and promoting food security .....	10
Expanding access to dental care .....	11
Promoting comprehensive women’s health services and reducing infant mortality rates .....	11
<b>Selection Criteria</b> .....	12
<b>Evaluation and Monitoring</b> .....	14
<b>Use of Grant Funds</b> .....	15
<b>How to Apply</b> .....	15
Step 1: Letter of Intent and Financial Audit .....	15
Step 2: Submission of Proposals .....	16
<b>Inquiries</b> .....	22
<b>About the Maryland Community Health Resources Commission</b> .....	23
<b>Appendix I, CHRC Letter of Intent</b> .....	24
<b>Appendix II, Instructions for CHRC Letter of Intent Template</b> .....	25
<b>Appendix III, Workplan Template</b> .....	26
<b>Appendix IV, Budget Form Template</b> .....	27

## 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 Maryland's health care safety net infrastructure to deliver affordable, high-quality health services. The CHRC is an independent commission within the Maryland Department of Health and 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 focuses on strengthening the state's vibrant network of community health resources and addressing 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.

Since its inception, the Commission has awarded 169 grants totaling \$55.8 million, supporting programs in all 24 jurisdictions. These programs have provided services for more than 315,000 patients, resulting in more than 763,000 patient visits. Over this same period, the Commission has received 664 proposals for consideration, totaling more than \$307.8 million in funding requests. Program sustainability is a top priority of the Commission, and CHRC grantees have used initial grant funds to leverage \$19.1 million in additional federal, private/non-profit, and local funding sources. The following table summarizes the types of grants that have been awarded by the CHRC since its inception.

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	38	\$11,072,650	58,791	192,262
Increasing access to dental care for low-income Marylanders	31	\$6,295,606	49,872	108,761
Promoting women's health and addressing infant mortality	17	\$3,565,697	15,236	50,196
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 integrated behavioral health services	31	\$10,035,917	65,289	168,981
Supporting Local Health Improvement Coalitions (LHICs)	24	\$1,955,048	1,127	3,676
Health Enterprise Zones	5	\$15,335,997	109,938	205,111
Safety net capacity building	5	\$725,570	818	2,599
Childhood obesity	3	\$1,510,000	328	3,668
<b>Total Grant Funding Provided</b>	<b>169</b>	<b>\$55,759,473</b>	<b>315,203</b>	<b>763,197</b>
<b>Total Funding Requested</b>	<b>664</b>	<b>\$307,870,180</b>		
<b>Number of Patient/Clients Served</b>	<b>315,203</b>			
<b>Number of Patient/Client Encounters</b>	<b>763,197</b>			
<b>Additional federal and private resources leveraged</b>	<b>57</b>	<b>\$19,071,437</b>		

***Responding to the health care needs of the newly insured.*** During the last enrollment period, more than 500,000 Marylanders<sup>1</sup> gained access to public and private health insurance under the Affordable Care Act. Of these, more than 376,000 were deemed eligible for Medicaid and 135,000 purchased commercial policies on the Maryland Health Benefit Exchange. The Exchange continues to reach out to uninsured Marylanders and expects the number of insured individuals will continue to rise in 2017. This increase in health insurance coverage will lead to

<sup>1</sup> <https://www.healthinsurance.org/maryland-state-health-insurance-exchange/>

an increased demand for essential health services in the community. It is critical that the state continues to build the capacity of safety net health care providers, most of whom have a historical mission of serving low-income individuals and at-risk communities, and meet this demand for affordable and accessible health services by the newly insured.

***Supporting community-hospital partnerships to serve vulnerable populations and promote goals of All-Payer Model.*** Expanding the capacity to deliver services in the community will also serve to support the policy goals of Maryland's unique All-Payer Model, which transitions the hospital revenue structure to encourage value (population health) and quality of care (patient experience) rather than volume. Under an agreement with the federal government, the Health Services Cost Review Commission (HSCRC) is working with Maryland hospitals to achieve several ambitious goals, among these are: (1) a cost savings of at least \$330 million in reduced Medicare per-beneficiary expenditures over the next five years; (2) limiting hospital revenues to a per capita growth rate of 3.58%, which is tied to the state's historical economic growth; and (3) reducing the Medicare readmission rate in Maryland's hospitals to the national average within five years. Results released by the HSCRC (April 2016) show that Maryland is well on its way towards achieving the cost savings and per capita cost growth targets, and is pursuing additional targeted incentives to achieve greater reductions in Medicare readmission rates.<sup>2,3</sup> Programs that are tailored to address the needs of vulnerable populations, including low-income seniors and individuals with behavioral health conditions, may assist in helping achieve readmission reductions. Achieving the goals of the All-Payer Model will require new and expanded community-hospital partnerships, and these partnerships will present new opportunities, challenges, and expectations of community health resources. The CHRC will continue to work to promote these partnerships, while also maintaining its statutory focus on building the capacity of safety net providers and expanding access for low-income individuals, Medicaid enrollees, and vulnerable populations.

***Supporting Community Health Resources: Building Capacity, Expanding Access, Promoting Health Equity, and Improving Population Health*** is the grants program of the CHRC. The program will award grants to community health resources serving Maryland residents. In the FY 2017 Call for Proposals, the Commission will consider projects in five categories:

- (1) Expanding access to primary and preventative care services and chronic disease management;**
- (2) Integrating behavioral health service delivery and addressing the heroin and opioid epidemic;**
- (3) Addressing childhood and family obesity and promoting food security;**
- (4) Expanding access to dental care; and**
- (5) Promoting comprehensive women's health services and reducing infant mortality rates.**

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<sup>2</sup> <http://hscrc.state.md.us/documents/legal-legislative/reports/HSCRC-Biannual-Report-on-All-Payer-Model-April-2016.pdf>

<sup>3</sup> <http://www.mhaonline.org/docs/default-source/transforming-health-care/tracking-maryland's-all-payer-experiment/printable-version-of-october-2015-dashboard.pdf?sfvrsn=2>

## KEY DATES TO REMEMBER

The following are the key dates and deadlines for the FY 2016 Call for Proposals.

October 27, 2016	Release of Call for Proposals
November 7, 2016 at 10:00 a.m.	Conference Call for Applicants Dial in number is 1.866.247.6034 Conference code is 4102607046
<b>November 16, 2016 – 12 noon</b>	<b>Deadline for receipt of Letters of Intent and Financial Audit</b>
November 23, 2016	Applicants notified to submit a full proposal
<b>December 19, 2016 – 12 noon</b>	<b>Deadline for receipt of applications</b>
Late January 2017	Select number of applicants notified to present to the CHRC
<b>February 2017</b>	<b>Applicant presentations to the CHRC; award decisions immediately follow presentations</b>

## 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
- Wellmobiles
- 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, it is a 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 THE FY 2017 CALL FOR PROPOSALS**

This 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 and promoting innovative community-hospital partnerships.

**Building capacity.** During the last enrollment period, more than 500,000 Marylanders<sup>1</sup> gained access to public and private health insurance under the Affordable Care Act. Of these, more than 376,000 were deemed eligible for Medicaid and 135,000 purchased commercial policies on the Exchange. Many of those newly insured individuals have delayed seeking routine primary care for some time and may have complex and chronic health conditions. Community health resources are equipped to help address the full range of health and social services needs of these newly insured and other vulnerable populations, which include the elderly, homeless, disabled, individuals with low literacy/health literacy, and those with impaired mental capacity.

According to a study<sup>4</sup> in 2012 supported by the Commonwealth Fund and undertaken by health policy researchers from the George Washington University School of Public Health, safety net patients continue to encounter barriers as they try to access primary and specialty care, and problems with care coordination are pervasive. 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 and address the complex health and social services needs of vulnerable populations. The CHRC will support proposals that help 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 and vulnerable populations. **Projects that clearly demonstrate the ability to deliver new or expanded services, increase capacity in underserved communities, and/or serve newly insured individuals and vulnerable populations will be given special consideration in this Call for Proposals.**

**Addressing health disparities and promoting health equity.** Despite decades of efforts to eliminate health disparities in Maryland, preventable differences in disease burden in disadvantaged populations continue to persist. While some progress has been made in narrowing the health disparities gap, efforts to eliminate these disparities must continue in the State.<sup>5</sup> Elimination or improvement in these disparities is unlikely without addressing the Social Determinants of Health (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 political systems. Achieving health equity means that every person has the opportunity to achieve optimal health regardless of race/ethnicity, gender identity, educational level, sexual orientation, disability status or the neighborhood they live in.

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

- Access to health care services
- Access to educational, economic, and job opportunities
- Access to safe and affordable housing
- Access to healthy foods
- Racism and discrimination
- Access to transportation
- Health literacy
- Exposure to crime, violence and trauma
- Residential segregation
- Poverty

Applicants are encouraged to propose projects that address one or more of the social determinants of health. **The Commission will prioritize proposals which utilize a holistic**

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<sup>4</sup> [http://publichealth.gwu.edu/departments/healthpolicy/DHP\\_Publications/pub\\_uploads/dhpPublication\\_618A2D24-5056-9D20-3D475D756ACE11FB.pdf](http://publichealth.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/dhpPublication_618A2D24-5056-9D20-3D475D756ACE11FB.pdf)

<sup>5</sup> Maryland Chartbook of Minority Health and Disparities Data  
[http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Chartbook%20of%20Minority%20Health%20and%20Minority%20Health%20Disparities%20Data,%20Third%20Edition%20\(December%202012\).pdf](http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Chartbook%20of%20Minority%20Health%20and%20Minority%20Health%20Disparities%20Data,%20Third%20Edition%20(December%202012).pdf)

**approach and implement evidence-based interventions such as community health workers, patient navigators, multisectoral partnerships, and community-based participatory approaches.** Interventions that propose collaborations with multiple entities and community-based partnerships that create social, political or economic support systems to address the social determinants of health for a specific population are strongly encouraged.

**Reducing avoidable hospital utilization and promoting community-hospital partnerships.**

Achieving the goals of the All-Payer Model will require creative community-hospital partnerships, data-driven intervention strategies, and strategic deployment of capital and resources. Promoting continuity of care through community-hospital partnerships and helping to reduce avoidable hospital ED visits, admissions, and readmissions are critical and universal policy goals. In 2014, the CHRC sponsored a number of regional forums with DHMH, HSCRC, and the Maryland Hospital Association to highlight innovative community-hospital partnerships taking place in the State, discuss lessons learned from these programs, and begin a dialogue about how these programs could be sustained and replicated. The lessons learned from these forums were summarized in the white paper released in January 2015, *“Sustaining Community-Hospital Partnerships to Improve Population Health.”*<sup>6</sup> Several of these programs were recently highlighted in a statewide conference on behavioral health hosted by the Maryland Hospital Association<sup>7</sup>.

The HSCRC awarded approximately \$30.5 million in Transformation Implementation Grants in CY 2016 to hospitals<sup>2</sup>, which were targeted at well-planned initiatives that can have immediate and significant impact on reducing potentially avoidable utilization, achieving return on investment, and providing direct savings to payers and purchasers of care. The CHRC’s Call for Proposals this year will look to build on the work being done in these grants and other innovative projects that are underway without duplicating funding opportunities that are now available to hospitals and their community partners from the HSCRC. For more information about the All-Payer Model or the implementation of the Health System Transformation Grants, please visit the HSCRC website<sup>8</sup>. **Projects that help prevent avoidable hospital utilization by building the capacity to deliver and access services in the community, promote community-hospital partnerships, and present specific data metrics and concrete outcome goals will receive special consideration in this Call for Proposals. Proposals involving community-hospital partnerships should provide a clear delineation of how CHRC grant funds will be utilized and how the expenditure of CHRC grant funds does not duplicate funding provided to hospitals by the HSCRC.**

**The strategic priorities of expanding access, promoting health equity, and reducing avoidable hospital utilization and promoting community-hospital partnerships will apply to grant proposals in each of the five categories.** Applicants should be very specific in how their proposals align with one or more of these strategic priorities. **In addition to these priorities, the CHRC will support projects that offer a sound sustainability plan to continue the program after initial CHRC grant funding has been expended.** Sustainability plans could include the strong feasibility to bill for services and/or letters of commitment to support/continue

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<sup>6</sup> Frances B. Phillips, RN, MHA. *“Sustaining Community Hospital Partnerships to Improve Population Health.”* Annapolis, MD 2015. Available from: [http://dhmh.maryland.gov/mchrc/SitePages/hospital\\_community\\_partnerships.aspx](http://dhmh.maryland.gov/mchrc/SitePages/hospital_community_partnerships.aspx)

<sup>7</sup> <http://www.mhaonline.org/events/annual-meeting>

<sup>8</sup> <http://www.hscrc.state.md.us/>



the program from other entities such as hospital partners or private/non-profit foundations. Applicants are encouraged to consult the CHRC's January 2015<sup>6</sup> white paper for concepts to achieving mid- to long-term program sustainability. **The CHRC will also provide added emphasis for applications this year that present detailed evaluation plans and demonstrate the capacity of the applicant organization to produce well-defined, quantifiable outcomes. Successful applications will include specific data metrics and clear, quantifiable outcome goals.** Further information about the selection criteria for this Call for Proposals can be found later in this document, pages 10 through 13.

As in previous Calls for Proposals, the Commission will support both one-year and multi-year grant programs. The CHRC will also consider requests to continue current CHRC-funded projects, on a case-by-case basis, based on performance and the outcomes associated with these projects. Following are the five categories that the CHRC will be looking to support this year:

**1. Expanding access to primary and preventative care services and chronic disease management** (*Potential award funding available in year one in this category is \$1,000,000 to \$1,500,000*).

Increasing access to affordable and accessible primary care services is a bedrock goal of the Commission. The CHRC has awarded 38 grants totaling \$11.1 million, and these programs have expanded primary care access for approximately 58,800 Marylanders. Several grants recently awarded by the CHRC have targeted super-utilizers and have involved hospital ED diversion efforts and care coordination for these individuals. Recent CHRC grants have also increased access to primary care services by supporting new health care access points in underserved communities. It is critical that the state continue to build the capacity to deliver primary care services in the community for the newly insured as well as un/underinsured individuals. Many of these same individuals also have underutilized or delayed accessing essential preventative care services. DHMH has advised that chronic diseases, including heart disease, cancer, stroke, diabetes, and obesity, continue to be the leading causes of death and disability in the United States and Maryland, accounting for 7 of every 10 deaths. Medical costs for people with chronic diseases account for 86% of the nation's \$2.9 trillion medical costs<sup>9</sup>. Medical expenses for people with diabetes are more than two times higher than for people without diabetes. Expanded access to primary care could also include access to services for individuals with hearing loss, a vulnerable population who face barriers to care. According to the NIH, National Institute on Deafness or other Communication Disorders, more than 28 million Americans could benefit from using hearing aids,<sup>10</sup> but the cost is not attainable for many individuals.

Projects in this category could include (but are not limited to): expansion of the delivery of primary care services; interventions that reduce the barriers to accessing care using multisectoral approaches; evidenced-based interventions that address chronic diseases, such as the Million Hearts Program, the Diabetes Prevention Program, and the Chronic Disease Self-Management Training Program; or interventions that screen for hearing loss and provide access to hearing aids.

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<sup>9</sup> <http://www.cdc.gov/chronicdisease/>

<sup>10</sup> <https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing>

2. **Integrating behavioral health service delivery in the community and addressing the heroin and opioid epidemic** (*Potential award funding available in year one in this category is \$1,000,000 to \$1,500,000*).

The CHRC has supported programs to expand access to mental health and substance use treatment services and integrate the delivery of these services in a primary care setting. Over the last several years, the Commission has awarded 31 grants totaling \$10 million. These programs have collectively served more than 55,000 individuals. Projects funded by the CHRC have included: (1) Access to integrated behavioral health services, either by adding behavioral health in traditional primary care settings or adding primary care to existing outpatient behavioral health programs; (2) Medication assisted therapy (MAT) for those suffering from opioid addiction, including programs that involve supportive housing, peer recovery support specialists, and/or telehealth; (3) Re-entry programs for ex-offenders with behavioral health needs that offer assistance in transitioning back to the community; (4) Mobile crisis intervention programs and a walk-in crisis center; (5) Screening, Brief Intervention and Referral to Treatment (SBIRT) in community settings; and (6) ED diversion programs that promote post-hospital care coordination and facilitate access to ongoing primary and behavioral health services.

Projects in this category could include (but are not limited to): efforts that are designed to expand access to Naloxone (grants could cover the costs of training on overdose education and the actual medicine) in settings such as mental health programs where opioid users are not engaged regarding their opioid use; promoting the use of peer-recovery support specialists; the implementation of SBIRT in community settings; the creative use of technology/telehealth to address workforce challenges and promote care continuity; the implementation of mobile crisis teams; promoting access to recovery housing (grant could cover voucher costs for low-income individuals); and interventions that promote behavioral health supports and respite care for homeless individuals and other vulnerable populations.

3. **Addressing childhood and family obesity and promoting food security** (*Potential award funding available in year one in this category is \$250,000 to \$350,000*);

Childhood obesity is a national epidemic, with 1 in 3 children being overweight and at risk for serious chronic diseases such as diabetes. In 2014, 26.4% of Maryland's youth ages 12-19 were considered overweight or obese.<sup>11</sup> The risk factors and prevalence of childhood obesity demonstrate health disparities, since many early life risk factors for childhood obesity are more prevalent among the African American/Black and Hispanic populations. The DHMH's Cancer and Chronic Disease Bureau leads childhood obesity prevention efforts to improve nutrition standards and physical activity opportunities in child care, school, and community settings<sup>12</sup>. These efforts are designed to help Maryland reach its Healthy People 2020 goal of reducing childhood obesity by 15.7% by 2020<sup>13</sup>. The CHRC has previously funded 3 programs for \$1.5 million aimed at preventing or reducing childhood obesity<sup>14</sup>.

This year, the Commission will consider supporting evidenced-based, family-focused approaches to improve nutrition, reduce food insecurity, and increase physical activity in family, school and community settings. Projects in this category could include (but are not limited to): (1) Efforts to

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<sup>11</sup> <http://phpa.dhmdh.maryland.gov/ccdpc/Reports/Pages/yrbs.aspx>

<sup>12</sup> <http://phpa.dhmdh.maryland.gov/ccdpc/healthy-lifestyles/Pages/about.aspx>

<sup>13</sup> <http://dhmdh.maryland.gov/ship/pages/home.aspx>

<sup>14</sup> [http://dhmdh.maryland.gov/mchrc/pages/grantee\\_childhood-obesity.aspx](http://dhmdh.maryland.gov/mchrc/pages/grantee_childhood-obesity.aspx)

expand the Healthy Stores Program; (2) Interventions which provide training, awareness, and behavior modification for women of child bearing age to yield sustainable healthy child rearing practices; (3) Programs that provide assessment and culturally-sensitive and appropriate treatment and/or resources for children who are overweight or obese; and (4) Interventions which enhance community access to physical activity opportunities and also provide alternative fitness solutions in the absence of the built environment. Applicants may wish to consult the 2009 legislative report from the Committee on Childhood Obesity<sup>15</sup>.

Applications should include a brief description indicating how CHRC funding would not duplicate, but rather leverage, current initiatives/resources to further the reach and impact on childhood obesity prevention activities. The Commission may also consider supporting programs that include community partnerships and focus on policy, systems, and environmental strategies.

**4. Expanding access to dental care** (*Potential award funding available in year one in this category is \$250,000 to \$350,000*).

The CHRC has targeted efforts to increase access to dental services in the community for several years, making significant investments in the state's public oral health infrastructure. Partnering with the state's Office of Oral Health, the Commission has awarded 31 grants totaling \$6.3 million. These programs have collectively provided dental services to more than 49,800 individuals, most of whom are low-income children. Maryland has made enormous strides in recent years in increasing access to oral health services for children; this year's Call for Proposals will have an emphasis on dental care for seniors and other low-income adults.

All proposals under this category must include strategies for addressing the unique oral health care needs of local populations. Projects in this category may include provision of new services or the expansion of existing services that are effective in meeting the oral health needs of adults and/or children in the community. Proposals must demonstrate efficiency in service delivery including: (1) Innovation to address barriers to accessing oral health services; (2) Screening for and facilitating enrollment into Medicaid; and (3) Capacity to bill third-party payers to achieve sustainability.

**5. Promoting comprehensive women's health services and reducing infant mortality rates** (*Potential award funding available in year one in this category is \$250,000 to \$350,000*).

The Commission has included supporting comprehensive women's health services in its last five Calls for Proposals in recognition of the state's ongoing goal of reducing infant mortality rates. The CHRC has awarded 17 grants totaling \$3.6 million, and these programs have collectively served more than 15,200 individuals. DHMH has articulated the current goal of reducing the state's infant mortality rate by 10% by 2017. While progress has been achieved towards reducing infant mortality rates since the initiative began in 2009, recent data from DHMH shows that there has been a slight increase in statewide infant mortality rates from 2012 to 2015<sup>16</sup>. Moreover, disparities in infant mortality continue to persist with the infant mortality rate for Blacks being over 2 times higher than the rate for Whites<sup>16</sup>. Therefore, reducing infant mortality remains an area of priority for the commission. Projects funded in the past have included:

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<sup>15</sup> [http://phpa.dhmdh.maryland.gov/ccdpc/Reports/Documents/CO\\_2009\\_Childhood\\_obesity\\_legis\\_rpt.pdf](http://phpa.dhmdh.maryland.gov/ccdpc/Reports/Documents/CO_2009_Childhood_obesity_legis_rpt.pdf)

<sup>16</sup> [http://dhmh.maryland.gov/vsa/Documents/Infant\\_Mortality\\_Report\\_2015.pdf](http://dhmh.maryland.gov/vsa/Documents/Infant_Mortality_Report_2015.pdf)

(1) Multi-disciplinary plans to integrate behavioral health and social services for substance using women and expectant mothers; (2) Expansion of family planning centers providing Title X and prenatal services in areas of high need; (3) Home visitation programs for low-income pregnant women and new mothers; and, (4) Addition of care coordination services to existing women's health providers.

Projects in this category could include (but are not limited to): evidence-based interventions designed to improve outcomes before pregnancy (such as promoting access to comprehensive women's health services to ensure that women are healthier at the 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).

## **SELECTION CRITERIA**

Applicants may submit proposals for projects in any one of the five funding categories described above. There is no limit on the number of proposals that an applicant may submit, though an applicant that submits multiple proposals must clarify how the proposals represent wholly different projects. The Commission will use all of the following criteria to assess, prioritize, and select proposals for funding:

1. **For all five categories of project funding, addressing strategic priorities is crucial.** The strategic priorities must be clearly identified and addressed in the application.

***1a. Building capacity:*** The application supports Maryland's ongoing implementation of the Affordable Care Act (ACA) by increasing current capacity and expanding new access points, promoting continuity of care efforts, and/or ensuring that 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. The CHRC will also consider proposals that focus on engaging underserved, "hard-to-reach" populations and facilitating access to existing, affordable, high-quality health care services in the community.

***1b. Addressing health disparities and promoting health equity:*** The application demonstrates knowledge of racial and ethnic health disparities among its proposed target population. The application clearly describes the specific disparity(ies) that are targeted and presents an effective and sustainable plan to mitigate these disparities and improve health outcomes. The application demonstrates an understanding of the SDOH affecting the target population and describes any multisectoral plans to address upstream determinants. The plan includes efforts to increase workforce diversity and includes participation by community health workers or patient navigators. The application indicates prior participation in, or plans to participate in, cultural competency training for staff.

***1c. Reducing avoidable hospital utilization and promoting community-hospital partnerships:*** Applications that promote results/outcome-based partnerships among community and hospital 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 the types of projects that the CHRC has funded in prior years, please visit the community-hospital partnership page on the CHRC's website.<sup>17</sup> Potential types of projects this year 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 ED visits, 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.

2. ***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 such as demographics, poverty levels, education levels, 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), HSCRC, CRISP, individual hospital data, or the Maryland Health Equity data from the Maryland Office of Minority Health and Health Disparities.
3. ***Project Impact and Prospects for Success:*** The application demonstrates that the project will lead to improved access to care for the target population and will build capacity to deliver services to lead to improved health outcomes, improved patient experience, and/or more efficient use of hospital resources. The project has potential for expansion or replication across the state, 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 program impact.
4. ***Program 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 program's logic

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<sup>17</sup> [http://dhmh.maryland.gov/mchrc/SitePages/hospital\\_community\\_partnerships.aspx](http://dhmh.maryland.gov/mchrc/SitePages/hospital_community_partnerships.aspx)

model. The application should clearly specify the metrics that will be used to define success. The application should specify how and from which sources 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 program impact. Where relevant, applications should document the use of an EMR system, use of the ENS system in CRISP, data-sharing agreements with hospitals, or other applicable data tools and resources. The project team must also have the ability to comply with the evaluation and monitoring requirements of this grant program. Applicants are encouraged to include the projected costs of IT and data collection in their line item budget and narrative and include the expected costs for evaluation in the overall grant budget request.

5. ***Sustainability/matching funds:*** 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. Proposals should identify likely sources of future revenue and describe efforts to achieve long-term program/financial sustainability. Will future project funds come from a fee-for-service model or will the project require outside funding from hospitals, outside organizations, or grant funding? 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 period are strongly encouraged, and those applications will be given added consideration. 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.
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.

## **EVALUATION AND MONITORING**

As a condition of receiving grant funds, grantees must agree to participate in an ongoing CHRC evaluation of the grants 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 Commission.

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.

## 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 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 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

Applicants will begin by submitting a Letter of Intent and a copy of the most recent Financial Audit by **November 16, 2016** as described below. The Commission will review the materials and screen the applicants for eligibility to determine who will be invited to submit a full proposal as described below. **Full grant applications will be due to the Commission on December 19, 2016 by 12:00 p.m. (noon).** Applicants will be notified about the status of their application in late January. **A select number of well-reviewed applicants will be invited to present their proposals at the Commission's meeting in mid-February 2017.** Grant awards will be made by the CHRC following these presentations, and applicants will be notified following these presentations.

### 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 12:00 p.m. (noon) on November 16, 2016** to Edith Budd at [edith.budd@maryland.gov](mailto: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 category area for your proposal. A hard copy of the Letter of Intent is not necessary.

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

1. **The Letter of Intent template**, which can be found in Appendix I of this document and online at:



<http://oit-msdn-sp3:81/mchrc/Documents/LOI%20Form%20and%20Instructions.docx>.  
Instructions for the template can be found in Appendix II. The template must be completely filled out, and applicants must adhere to the posted word limits.

2. **Financial audit.** Organizations must also submit **an electronic version and one hard copy of the most recent financial audit of the organization.** The audit 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 12:00 p.m. (noon) on November 16, 2016** to:

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

### **Step 2: Submission of Proposals**

Applicants 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 12:00 p.m. (noon) December 19, 2016** 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](mailto: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 19, 2016** 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) Eight 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 eight 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 eight 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
- Background and Justification
- Organizational Capacity
- Project Plan
- Partnerships
- Evaluation

- Sustainability
- 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 funding category;
- 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 program);
- 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 program will be sustained after program funds are utilized (i.e., will the program 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.

### **(2) 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 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? Discuss the community conditions affecting the target population's health behaviors and outcomes. Statistics and data should be concisely presented.

- ***Describe the health disparit(y)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 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) and All-Payer Model.

### **(3) Organizational Capacity**

- ***Describe the organization's mission, structure, governance, facilities and staffing.*** Describe the organization's mission, programs, 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, the most recent audited financial statements and accompanying management letter, and, if your organization files a Form 990, its most recent filing. If the organization has submitted audited financial statements and a Form 990 to the Commission that covers the organization's latest audited fiscal year, provide a statement listing which documents and their fiscal years that have been submitted. 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.

#### (4) 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). Include a Logic Model in the Appendix (For information on how to create a Logic Model, refer to the CDC template<sup>18</sup>).
- **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 work plan worksheet can be found in Appendix III and can be used in preparing the project plan, and the completed work plan 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 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.

#### (5) Partnerships

- **Identify planned partners.** Name the community organization(s) that will play a defined role in the project. Identify the leadership of the partner organization.

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<sup>18</sup> [http://www.cdc.gov/oralhealth/state\\_programs/pdf/logic\\_models.pdf](http://www.cdc.gov/oralhealth/state_programs/pdf/logic_models.pdf)

- ***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 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.

## **(6) 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.

## **(7) 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.

## **(8) Project Budget**

- Applicant must provide an annual budget for each year of its project. The total budget amount must reflect the specific amount requested by the applicant for CHRC funding, which may or may not be the program's total actual cost. If the CHRC grant request is a portion of the overall cost of the program, 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:
  - a) *Personnel:* Include the percent effort (FTE), name, and title of the individual.

- b) *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.
  - 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 specific approval of the Commission prior to being implemented.
  - 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.
- Applicants must include a line-item budget narrative detailing the purpose of each budget expenditure.

## 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 **Monday, November 7 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](mailto: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](mailto:mark.luckner@maryland.gov)

Moira Lawson, Senior Health Policy Advisor  
[moira.lawson@maryland.gov](mailto:moira.lawson@maryland.gov)

Edith Budd, Administrator  
E-mail: [edith.budd@maryland.gov](mailto:edith.budd@maryland.gov)  
Telephone: 410-260-6290

## **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. The current members of the Commission have been appointed by Governor Martin O'Malley or Governor Larry Hogan. In 2014, the Maryland General Assembly approved legislation that re-authorized the CHRC for another ten years, until June 2025.

### **2016 Commissioners**

John A. Hurson, Chairman

Allan Anderson, M.D.

Elizabeth Chung

Maritha Gay

J. Wayne Howard

William Jaquis, M.D.

Surina Jordan, Ph.D.

Barry Ronan

Carol Ivy Simmons, Ph.D.

Julie Wagner

Anthony Wisniewski, Esq.

**APPENDIX I**



<b>CHRC LETTER OF INTENT</b>	
1. Organization Name	
2. Organization Address	
3. Name, telephone and email of organization CEO, project director, and contact person for the project	
4. Project Title	
5. Project Focus Area (Check one Box)	<input type="checkbox"/> Primary Care <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Obesity/Food Security <input type="checkbox"/> Dental <input type="checkbox"/> Women’s Health/Infant Mortality
6. Program Jurisdiction	
7. Year One/Total CHRC funds requested	Year One _____ Total _____
8. Program duration (Check one Box)	<input type="checkbox"/> One Year <input type="checkbox"/> Two Year <input type="checkbox"/> Three Year <input type="checkbox"/> Four Year
9. This program is: (Check one box)	<input type="checkbox"/> A New Program <input type="checkbox"/> An Expansion of Existing Services
10. A description of the applicant organization (maximum 250 words):	
11. Has the applicant organization received CHRC funding in prior years? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, describe how your organization meets the definition of a “Community Health Resource”:	
12. 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):	
13. A list of other organizations participating or partnering in the program:	



## APPENDIX II

### 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, project director and, if different, the contact person for the project.

Line 4. The title of the proposed project.

Line 5. The focus area of the proposed project which can include: Dental, Behavioral Health, Women's Health/Infant Mortality, Childhood Obesity or Primary Care.

Line 6. The jurisdiction where the project will be carried out.

Line 7. The funds that will be requested for the first year and the funds requested for the entire project (for all years). **Applicants invited to submit a full proposal (due December 19<sup>th</sup>) will be required to submit a detailed line item budget as part of the full proposal.**

Line 8. The proposed duration of the grant funding.

Line 9. If the application proposes a service not currently being provided in that location by the organization it will be considered a **New Program**. If the application proposes providing existing services to a new population of patients, it will be considered an **Expansion of Existing Services**.

Line 10. A description of the applicant organization including its mission, its history of providing services in the community and its history with grant funded programs. The description should not exceed 250 words.

Line 11. Yes/ No – Has your organization received funding from CHRC in prior years. If no, please demonstrate how your organization meets the definition of a "Community Health Resource" as described in the grant eligibility section of the RFP.

Line 12. 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 13. A list of any organizations that will be involved in the implementation of the program.

**APPENDIX III**

<b>Workplan Template</b>						
<b>MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION</b>						
Organization Name:						
Project Name:						
<b>PROJECT PURPOSE:</b>						
<b>(1) GOAL</b>						
Objective	Key Action Step	Expected Outcome	Data Evaluation and Measurement	Data Source and Baseline Measure	Person/Area Responsible	Timetable for Achieving Objective
<i>Example: Reduce the # of BH related ED visits at Hospital X by 20%</i>	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	12/31/2017
<b>(2) GOAL</b>						
Objective	Key Action Step	Expected Outcome	Data Evaluation and Measurement	Data Source and Baseline Measure	Person/Area Responsible	Timetable for Achieving Objective
<b>(3) GOAL</b>						
Objective	Key Action Step	Expected Outcome	Data Evaluation and Measurement	Data Source and Baseline Measure	Person/Area Responsible	Timetable for Achieving Objective

**APPENDIX IV**

<b>Budget Form Template</b>				
<b>MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION</b>				
Organization Name:				
Project Name:				
<b>Revenues</b>	<b>Total Project Cost</b>	<b>% of Total Project Cost</b>		
CHRC Grant Request				
Patient/Program Revenues/Income				
Organization Match				
Other Grant/Funding Support				
<b>Total Project Cost</b>	<b>0</b>	<b>0%</b>		
<b>Budget Request for <u>CHRC</u> Grant Funding</b>	<b>Year 1 CHRC Budget Request</b>	<b>Year 2 CHRC Budget Request</b>	<b>Year 3 CHRC Budget Request</b>	<b>Line Item Total Budget Request</b>
<b>Personnel Salary</b>				
% FTE - Name, Title				
% FTE - Name, Title				
% FTE - Name, Title				
<b>Personnel Subtotal</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Personnel Fringe</b> (no more than 25% of Personnel costs)				
<b>Equipment/Furniture</b>				
<b>Supplies</b>				
<b>Travel/Mileage/Parking</b>				
<b>Staff Trainings/Development</b>				
<b>Contractual</b>				
<b>Other Expenses</b>				
<b>Indirect Costs</b> (no more than 10% of direct costs)	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Totals</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Percent of Organization's Total Budget that this Project Budget Represents</b>				