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

Supporting innovative and sustainable projects that serve vulnerable populations and promote health equity

FY 2018 Call for Proposals

October 19, 2017

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OVERVIEW

The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly through the *Community Health Care Access and Safety Net Act of 2005* to expand access to health care for low-income Marylanders and underserved communities in the state and to bolster the capacity of the health care safety net infrastructure to deliver affordable, high-quality health services. The CHRC is an independent commission within the Maryland Department of Health (MDH), and its 11 members are appointed by the Governor. In creating the Commission, the Maryland General Assembly recognized the need to have an independent commission that focuses on supporting projects that serve vulnerable populations, strengthening the state's 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 issued 13 Calls for Proposals and awarded 190 grants totaling $60.3 million, supporting programs in all 24 jurisdictions. These programs have provided services for more than 332,000 patients, resulting in more than 860,000 patient visits. Over this same period, the Commission has received 741 proposals for consideration, totaling more than $356.8 million in funding requests. Investing public (CHRC) resources efficiently and strategically and achieving post-grant program sustainability is a top priority of the Commission, and CHRC grantees have used initial grant funds to leverage $20.3 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.

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	60	$15,954,428	81,529	249,908
Providing access to integrated behavioral health services	48	$12,656,487	67,813	230,868
Increasing access to dental care for low-income Marylanders	36	$7,170,606	54,049	117,035
Promoting women's health and addressing infant mortality	20	$3,808,294	16,017	54,595
Reducing obesity and promoting food security	12	$2,145,000	464	4,248
Promoting health information technology at community health centers	9	$3,268,661	Health Information Technology	
Health Enterprise Zones	5	$15,335,997	109,938	205,111
Total Grant Funding Provided	**190**	**$60,339,473**	**332,680**	**861,689**
Total Funding Requested	**741**	**$356,819,228**		
Number of Patient/Clients Served	**332,680**			
Number of Patient/Client Encounters	**861,689**			
Additional federal and private resources leveraged		**$20,253,397**		

Responding to the unique health care needs of vulnerable populations. Health disparities in terms of access, delivery, and outcomes persist in Maryland and throughout the country. Disparities can be found in rural, urban, and suburban communities. Racial and ethnic minorities, uninsured and underinsured, economically disadvantaged, elderly, homeless, those with behavioral health disorders, and immigrants are less likely to have a usual source of care or

have had a health or dental visit in the previous year.[1] These groups also confront more barriers to care, are impacted by social determinants of health, and receive poorer quality care than higher-income individuals. The CHRC has prioritized funding projects that offer innovative ways to address disparities and promote health equity, and the FY 2018 Call for Proposals looks to redouble these efforts. Given the uncertainty of health reform at the federal level and what impact this reform could have for Maryland's vulnerable populations, it is more critical than ever that Maryland supports and protects the integrity of the state's safety net providers. These providers have a historical mission of serving low-income individuals and have a demonstrated track record of implementing programs that serve vulnerable populations and offer innovative approaches to tackling the social determinants of health.

Supporting innovative and replicable projects to address the heroin and opioid epidemic and promote access to integrated behavioral health services. In March 2017, Governor Hogan declared a state of emergency on the heroin and opioid crisis in Maryland. In 2016, Maryland saw 2,089 deaths related to overdoses, a 66% increase from the year before.[2] Opioid addiction destroys lives, resulting in an individual's inability to work and care for his or her family, and ultimately can lead to death. The epidemic is impacting urban, rural, and suburban communities throughout the state and is placing burdens on Maryland's health care, social service, and criminal justice systems.

The depth and breadth of the latest opioid epidemic has focused attention on and highlighted the gaps in accessing an array of community-based substance use treatment services. In light of this epidemic, the CHRC will continue to prioritize supporting innovative and sustainable projects that increase access and help remove the stigma associated with accessing substance use treatment services. The Commission will look to continue distributing its grant funding to assist behavioral and somatic health care providers in their efforts to grow, innovate, and scale services to provide a wide range of treatment options for individuals with substance use disorder and break down social stigmas.

Promoting Community Health Resources: Supporting innovative and sustainable projects that serve vulnerable populations and promote health equity is the grants program of the CHRC. The program will award grants to community health resources serving Maryland residents. In the FY 2018 Call for Proposals, the Commission will consider projects in three categories:

(1) Promoting delivery of essential health services: primary/preventative care, dental, and women's health services;

(2) Addressing the heroin and opioid epidemic through behavioral health integration; and

(3) Promoting food security and addressing childhood and family obesity.

[1] http://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/

[2] https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Documents/Maryland%202016%20Overdose%20Annual%20report.pdf

KEY DATES TO REMEMBER

The following are the key dates and deadlines for the FY 2018 Call for Proposals.

October 19, 2017	Release of the Call for Proposals
November 6, 2017 at 10:00 a.m.	Conference Call for Applicants Dial in number is 1.866.247.6034 Conference code is 4102607046
November 14, 2017 – 12 noon	**Deadline for receipt of Letters of Intent and Financial Audit**
November 20, 2017	Applicants notified to submit a full proposal
December 18, 2017 – 12 noon	**Deadline for receipt of applications**
Late January 2018	Select number of applicants notified to present to the CHRC
February 2018	**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
- 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 2018 CALL FOR PROPOSALS

This year's Call for Proposals has three overall strategic priorities: (1) preserving or enhancing the state's ability to serve vulnerable populations regardless of insurance status; (2) promoting health equity by reducing health disparities and addressing the social determinants of health; and (3) supporting community-based programs that are innovative, sustainable, and replicable.

Preserving or enhancing the state's ability to serve vulnerable populations regardless of insurance status. Following the passage of the Affordable Care Act, Maryland, like many states, achieved dramatic increases in health insurance coverage rates. In 2012, Maryland's uninsured percentage was 10.1%; in 2015, it was 6.6%.[3] Despite these coverage gains, the uninsured rate remains high for certain racial and ethnic groups (the uninsured rate for Hispanic/Latino individuals was 23.6% in 2015).[4]

[3] http://www.marylandhbe.com/wp-content/uploads/2012/10/MHBE_AnnualReport2016_Web.pdf
[4] http://mgaleg.maryland.gov/Pubs/LegisLegal/2017-Impact-Health-Care-Reform.pdf

In addition to the health disparities associated with lack of access to health insurance, the affordability of health insurance plans for the individual market is becoming a growing concern. Recent rate increases approved earlier this year may result in previously insured individuals choosing not to purchase health insurance and to, instead, bear the tax penalty.

The affordability of health insurance coverage and the continued ambiguity about the likelihood of substantive health care reform at the federal level and what this reform might mean for Maryland and its vulnerable residents place greater and greater emphasis on the need to support Maryland's safety net providers, most of whom have a historical mission of serving low-income individuals and vulnerable populations, regardless of their insurance status. It is more important now than ever before that Maryland protects and promotes the ability of the state's safety net providers to serve vulnerable populations. This year, the CHRC will continue to 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 as they weather the storm of potential changes coming from the federal government. **Projects that clearly demonstrate the ability to deliver new or expanded services, increase capacity in underserved communities, and/or ensure continued service delivery for vulnerable populations will be given special consideration in this year's Call for Proposals.**

Promoting health equity by reducing health disparities and addressing the social determinants of health. 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 Maryland.[5] Elimination or improvement in these disparities is unlikely to be achieved 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 stigma, 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 where they live or are born.

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

[5] 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

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 approach and implement evidence-based interventions such as community health workers, patient navigators, multi-sectoral 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.

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

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

The CHRC also supports programs that are **replicable**. Several projects that have been funded by the Commission in the past have led to statewide adoption of initiatives in behavioral health and care coordination services in many underserved communities in the state. For example, the CHRC funded the initial Behavioral Health Home pilot implemented by Way Station in FY 2012. The Maryland Department of Health has rolled out the Medicaid Behavioral Health Home Initiative statewide, and there are now 81 health homes in the state.

Applicants are strongly encouraged to submit proposals that illustrate how their project is innovative, sustainable, and replicable. **The application should demonstrate that the proposed project is likely to continue to provide benefits to the target population and the community at large beyond the duration of the proposed grant period. Proposals should identify specific sources of project revenue and describe the likelihood of achieving post-grant sustainability. Successful applicants will clarify whether future project funds will be derived from a fee-for-service model or whether the project will likely require future (outside) financial support from hospitals, outside organizations, or future grant funding.**

The strategic priorities of preserving or enhancing the state's ability to serve vulnerable populations regardless of insurance status; promoting health equity by reducing health disparities and addressing the social determinants of health; and supporting community-based projects that are innovative, sustainable, and replicable will apply to grant proposals in **each** of the three funding categories in the FY 2018 Call for Proposals. Applicants should be very specific in how their proposals align with one or more of these strategic priorities. **The CHRC will provide added emphasis for applications 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 12 through 14.

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 three categories that the CHRC will be looking to support this year:

1. Promoting delivery of essential health care services: primary/preventative care services, dental services, and women's health care services *(Potential award funding available in year one in this category is $750,000 to $1,000,000).*

Increasing access to affordable and accessible primary and preventative medical, dental, and women's health services are bedrock goals of the Commission. The CHRC has awarded 60 grants totaling $15.9 million for primary care; 36 grants totaling $7.2 million for dental care; and 20 grants totaling $3.8 million for women's health care services.[6] These programs have expanded access to care for more than 150,000 Marylanders. These grants have: (1) increased access to primary care services by supporting new health care access points in underserved communities; (2) supported interventions that address chronic diseases; (3) provided preventative and advanced oral health care and oral hygiene education to both adults and children; (4) targeted super-utilizers and involved hospital Emergency Department (ED) diversion efforts and care coordination for these individuals; and (5) provided prenatal and perinatal services for women otherwise lacking access to these services. The Commission has prioritized interventions that reduce the barriers to accessing care using multi-sectoral approaches. It is critical that the state continue to build the capacity to deliver these health care services in the community for vulnerable populations, regardless of their ability to pay or health insurance status. Many of these individuals have underutilized or delayed accessing essential preventative care services, resulting in demonstrable poor health outcomes.

The Maryland Department of Health 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 in medical costs.[7] Medical expenses for people with diabetes are more than two times higher than for people without diabetes. Projects in this category could include (but are not limited to): expansion of the delivery of primary or preventative care services; evidenced-based interventions that address chronic diseases, such as the Million Hearts Program, the Diabetes Prevention Program, or provision of care coordination services for high-utilizers of hospital resources. Impacts from selected projects may include, but are not limited to: (1) medium term – increase in the number of individuals connected to a medical home; increase in the number of individuals with access to care coordination services; increase in community supports; and (2) long term – reduction in avoidable hospital admissions, readmissions, and ED usage.

According to a 2017 report from Dentaquest, poor oral health affects overall physical health and significantly contributes to the expanding cost of the U.S. health care system. The report details that "adults in rural communities are more likely to have all natural teeth missing than their non-rural peers and children living in rural areas are more likely to have unmet dental needs, less likely to have visited a dentist in the past year, and less likely to see a dental care team for ongoing preventive care." [8] Additionally, in the state of Maryland, significant racial and ethnic

[6] https://health.maryland.gov/mchrc/Pages/grantees-by-focus-area.aspx
[7] http://www.cdc.gov/chronicdisease/
[8] https://www.dentaquestinstitute.org/sites/default/files/Initiating-Rural-IPOHNs_Closing-the-Gap_42717_v3.pdf

disparities exist in preventative dental care for adults.[9] Over the past few years, the CHRC has partnered with the State's Office of Oral Health, making significant investments in Maryland's public oral health infrastructure, but much work remains to be done. 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. Impacts from selected projects may include, but are not limited to: (1) medium term – increase in individuals connected to a dental home; increase in individuals with knowledge of good oral hygiene; and (2) long term – reduction in avoidable hospital admissions, readmissions, and ED usage.

The Maryland Department of Health 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 shows that there has been a slight increase in statewide infant mortality rates from 2012 (6.3) to 2015 (6.7).[10] Moreover, disparities in infant mortality continue to persist, with the infant mortality rate for Blacks being more than two times higher than the rate for Whites.[11] Therefore, reducing infant mortality remains an area of priority for the Commission. 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). Impacts from selected projects may include, but are not limited to: (1) medium term – increase in pregnant women receiving care in the first trimester; increase in women with access to contraception; and (2) long term – reduction in infant mortality; increase in babies born full term; reduction in low birth weight babies.

2. **Addressing the heroin and opioid epidemic through integrated behavioral health service delivery** *(Potential award funding available in year one in this category is $750,000 to $1,000,000).*
   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. Since 2007, the Commission has awarded 48 grants totaling $12.7 million.[12] These programs have collectively served more than 67,000 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 behavioral health programs; (2) medication-assisted therapy 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.

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5515044/
[10] http://dhmh.maryland.gov/vsa/Documents/Infant_Mortality_Report_2015.pdf
[11] http://ship.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship2
[12] https://health.maryland.gov/mchrc/Pages/grantee_behavioral-health.aspx

Projects in this category could include (but are not limited to): provision of medication-assisted treatment in outpatient settings; promoting the use of peer-recovery support specialists; provision of stabilization or sobering services; the creative use of technology/telehealth to address workforce challenges and promote care continuity; the implementation of mobile crisis teams; promoting access to a housing-first model and/or recovery housing with medication-assisted treatment; and interventions that promote behavioral health supports and respite care for homeless individuals and other vulnerable populations.

Applications should include a clear description indicating how CHRC funding would not duplicate, but rather leverage, current initiatives/resources from the Maryland Department of Health, Behavioral Health Administration, and Governor's Opioid Operational Command Center to further the reach and impact on heroin and opioid treatment activities in the state. Impacts from selected projects may include, but are not limited to: (1) medium term – increase in individuals with access to medication-assisted treatment; increase in access to integrated behavioral and somatic health services; and (2) long term – reduction in hospital utilization for addiction related conditions; reduction in heroin and opioid overdoses; reduction in drug related deaths.

3. **Promoting food security and addressing childhood and family obesity** *(Potential award funding available in year one in this category is $250,000 to $350,000);*
Childhood obesity is a national epidemic, with one in three 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.[13] 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 MDH'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.[14] These efforts are designed to help Maryland reach its Healthy People 2020 goal of reducing childhood obesity by 15.7% by 2020.[15] The CHRC has previously funded 12 programs for $3.1 million aimed at preventing or reducing childhood obesity.[16]

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 expand the Healthy Stores Program or other efforts to promote food security in food deserts; (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.[17]

[13] http://phpa.dhmh.maryland.gov/ccdpc/Reports/Pages/yrbs.aspx
[14] http://phpa.dhmh.maryland.gov/ccdpc/healthy-lifestyles/Pages/about.aspx
[15] http://dhmh.maryland.gov/ship/pages/home.aspx
[16] http://dhmh.maryland.gov/mchrc/pages/grantee_childhood-obesity.aspx
[17] http://phpa.dhmh.maryland.gov/ccdpc/Reports/Documents/CO_2009_Childhood_obesity_legis_rpt.pdf

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. Impacts from selected projects may include, but are not limited to: (1) medium term – increase in availability of fresh fruits and vegetables in local stores; increase in access to physical activity programs for children; and (2) long term – decrease in obesity rates; increase in the number of individuals with healthy eating and active lifestyles.

SELECTION CRITERIA

Applicants may submit proposals for projects in any one of the three 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 three categories of project funding, addressing strategic priorities is crucial.** The strategic priorities must be clearly identified and addressed in the application.

   1a. Preserving or enhancing the state's ability to serve vulnerable populations regardless of insurance status: The application demonstrates the ability to deliver new or expanded services, increase capacity in underserved communities, and/or ensure continued service for vulnerable populations. 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. Promoting health equity by reducing health disparities and addressing the social determinants of health: The application demonstrates thorough 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 multi-sectoral plans to address upstream determinants. The plan could include efforts to increase workforce diversity and 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. Supporting community-based programs that are innovative, sustainable, and replicable: The proposal describes a project that employs innovations in methodology, use of technology, and/or multi-sectoral partnerships to expand/improve the provision of health care services to underserved populations. The proposal describes how the proposed project, after successful completion, could serve as a model to be replicated in other areas of the state. The application demonstrates that the proposed project is likely to continue to provide benefits to the target population and the community at large beyond the duration of the proposed grant period. The proposal identifies likely sources of future revenue and describes efforts to achieve long-term 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?). Additionally, applications that indicate matching fund commitments or leverage additional resources will be favorably reviewed. Letters of commitment that demonstrate financial support at the beginning, during, or after the project 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.

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 sources 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 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 model. The application should clearly specify the metrics that will be used to define success. The application should specify how data will be collected and reported to the CHRC, which analysis tools will be used for quantitative and qualitative evaluation, and what data source(s) will be utilized to document overall 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, Medicaid claims data, or other applicable data tools and resources. The project team must also have the ability to comply with the evaluation and monitoring requirements of this grant program. <u>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</u>.

5. **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.

6. **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 technical advisors, and other grantees. At the conclusion of the project, the grantee will be required to provide a final written report on the project.

USE OF GRANT FUNDS

Grant funds may be used for project staff salaries and fringe benefits (fringe benefits are limited to 25% of the total salaries), consultant fees, data collection and analysis, project-related travel, conference calls and meetings, and office supplies and expenses. If the grantee requests more than 25% in fringe benefits, the applicant will be required to provide a compelling rationale for exceeding this amount. Requests to exceed 25% will be considered on a case-by-case basis. In light of the CHRC's limited overall budget this fiscal year, applicants are encouraged to be efficient in the use of public resources. **Applications that reflect frugality in budget requests will be viewed favorably by the Commission**. 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, and the role of the subcontractor organization in terms of achieving the fundamental goals and objectives of the project should be explicit in the proposal. Grant funds may not be used for depreciation expenses, major equipment or new construction projects, to support clinical trials, or for lobbying or political activity. Grant funds may be used for those renovations necessary to carry out the proposed project.

If the services in an applicant's proposal will be delivered by a subcontractor organization and not directly by the lead applicant, the applicant may not take a fee for passing through the funds to the contractor agency.

HOW TO APPLY

Applicants will begin by submitting a Letter of Intent and a copy of the most recent financial audit by **November 14, 2017** as described below. The Commission staff 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 18, 2017 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 February 2018.** 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 14, 2017** 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 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 and instructions for completing the template** can be found in Appendix I of this document and online at: http://health.maryland.gov/mchrc/Documents/2018%20Call%20for%20Proposals/LOI%20Form%20and%20Instructions,%20FY%202018.docx. 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 14, 2017** 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 18, 2017 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 18, 2017** 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 and Budget Justification
- Appendices (not included in the 15-page limit)

Mandatory appendices

(a) IRS determination letter indicating 501(c)(3) tax-exempt status, if applicable
(b) List of officers and Board of Directors or other governing body
(c) Organizational Chart
(d) Overall organization budget
(e) Form 990, if applicable
(f) Résumés of key personnel
(g) Logic model
(h) Letters of commitment from collaborators

Optional appendices

(a) Service maps, data, and other statistics on target population
(b) Annual report, if available

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

(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 disparity(ies) in the target population that the project will address***. Discuss the specific health disparity(ies) the project is intended to address and how the project will address the disparity(ies).

- ***Describe 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, and, if your organization files a Form 990, its most recent filing. <u>It is not necessary to include the financial audit previously submitted with the LOI</u>. The Commission will request additional information if necessary.

- ***Describe the organization's history of working with the target population and with partnerships in this community.*** Discuss previous work in this community and with this target population.

- ***Discuss the organization's history with other/similar grants, including any prior CHRC funding.*** Discuss the organization's grant funding history. Discuss any notices of insufficient progress that your organization may have received and how issues were resolved.

- ***Discuss project staffing.*** Identify the project director and describe his/her level of responsibility within the applicant organization, qualifications to lead the project, and the role in carrying out the project. Identify other essential staff, their roles in the project, and their relevant qualifications. As an appendix, include résumés (**maximum three pages each**) for all key personnel. Describe any positions that the organization will need to hire new/additional staff to fill.

- ***Does the organization publish an annual report?*** If so, provide a copy as an appendix. If your organization has submitted the latest annual report for a previous grant round, please provide a statement that the report was submitted and which year it covers.

(4) Project Plan

- ***Discuss the project's goals and objectives.*** What are the project's goals and objectives? Use SMART objectives (**S**pecific, **M**easureable, **A**chievable, **R**ealistic and includes a

Timeframe). Provide a logic model as an Appendix (For information on how to create a Logic Model, refer to the Kellogg Foundation guide[18]). See Appendix II.

- ***Describe the major steps or actions in carrying out the project.*** List key actions or steps in the implementation of the project. Describe the process and timeframe for reaching these benchmarks. A sample project 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.

- ***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

[18] https://www.wkkf.org/resource-directory/resource/2006/02/wk-kellogg-foundation-logic-model-development-guide

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. Requests to exceed 25% will be considered on a case-by-case basis.
  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. The budget justification should provide additional details about the use of funds to support contractual costs.
  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% of direct project costs.

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

INQUIRIES

Conference Call for Applicants: The Commission will host a conference call for interested applicants to provide information on the grants program and assistance with the application process. This conference call, on **Monday, November 6 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.

Following the public conference call and after all questions are received by the CHRC, Commission staff will circulate a master question and answer document and post this document on the CHRC's website.

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

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

Moira Lawson, Senior Health Policy Advisor
moira.lawson@maryland.gov

Edith Budd, Administrator
E-mail: 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 the Governor and are subject to confirmation by the Maryland State Senate. In 2014, the Maryland General Assembly approved legislation that re-authorized the CHRC until June 2025.

Current Commissioners

Allan Anderson, M.D., Chairman
Elizabeth Chung
Maritha Gay
Scott T. Gibson
J. Wayne Howard
Surina Jordan, Ph.D.
Barry Ronan
Erica I. Shelton, M.D.
Carol Ivy Simmons, Ph.D.
Julie Wagner
Anthony Wisniewski, Esq.