STATE OF MARYLAND
Community Health Resources Commission
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Larry Hogan, Governor – Boyd Rutherford, Lt. Governor
Elizabeth Chung, Chair – Mark Luckner, Executive Director

Promoting Community Health Resources:

Addressing health disparities and supporting community health resources as they serve vulnerable populations and respond to the COVID-19 pandemic

FY 2021 Call for Proposals

November 2, 2020

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OVERVIEW

The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly through the *Community Health Care Access and Safety Net Act of 2005* to expand access to health care for low-income Marylanders and underserved communities in the state and to bolster the capacity of the health care safety net infrastructure to deliver affordable, high-quality health services. The CHRC is an independent commission within the Maryland Department of Health (MDH), and its 11 members are appointed by the Governor. In creating the Commission, the Maryland General Assembly recognized the need to have an independent commission that focuses on supporting projects that serve the unique health needs of vulnerable populations, strengthen the state's network of community health resources, and address service delivery gaps in Maryland's dynamic health care marketplace. The fundamental policy objective of the CHRC's authorizing statute is the need to expand ***access*** to community health providers, since health insurance coverage alone is not always sufficient for at-risk communities and vulnerable populations to receive affordable, high-quality health care services. This year's RFP will direct specific attention to efforts that expand access to health care and address the social determinants of health to reduce health disparities, promote integrated population health interventions through sustainable community partnerships, and help safety net providers continue to provide essential services as they respond to the impacts of the COVID-19 virus pandemic.

Since its inception, the CHRC has issued 15 Calls for Proposals and awarded 312 grants totaling $79.2 million, supporting projects in all 24 jurisdictions. Of these 312 grants, 266 support projects that have to-date provided essential health and social services to 498,613 residents, resulting in 1,241,250 service encounters. Over the same period, the Commission has received 946 grant proposals for consideration, totaling more than $415 million in funding requests.

Investing limited public (CHRC) resources efficiently and strategically and achieving post-grant project sustainability are top priorities of the Commission, and CHRC grantees have used initial grant funds to leverage $31.8 million in **additional** federal, private/non-profit, and local funding. Commission funded projects have achieved a demonstrable return on investment (ROI) by reducing avoidable hospital and 911 system utilization.

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	77	$19,479,428	99,046	300,474
Providing access to integrated behavioral health services	72	$19,481,102	89,979	320,728
Increasing access to dental care for low-income Marylanders	44	$8,750,606	71,142	160,146
Promoting women's health and addressing infant mortality	27	$5,658,294	19,427	61,762
Reducing obesity and promoting food security	32	$5,765,000	1,910	6,771
Health Enterprise Zones	5	$15,335,997	217,109	391,639
Supporting community health providers during COVID-19 pandemic	46	$1,445,932	COVID Emergency Funding	
Promoting health information technology at community health centers	9	$3,268,661	Health Information Technology	
Total Grant Funding Provided	**312**	**$79,185,020**	**498,613**	**1,241,520**
Total Funding Requested	**946**	**$415,084,177**		
Number of Patient/Clients Served		**498,613**		
Number of Patient/Client Encounters		**1,241,520**		
Additional federal and private resources leveraged		**$31,792,229**		

Increasing affordable and accessible primary and preventative medical, dental, and women's health services using multi-sectoral approaches are the bedrock goals of the CHRC. Of the 266 project grants awarded, 77 grants totaling $19.5 million were for primary care; 44 grants totaling $8.8 million were for dental care; and 27 grants totaling $5.7 million funded women's health care services.[1] These grants have: (1) increased access to primary care services and supported new health care access points in underserved communities; (2) supported interventions that address chronic diseases; (3) provided preventative and restorative dental care and oral hygiene education to adults and children; (4) targeted "super-utilizers" of emergency care through hospital Emergency Department (ED) and emergency medical (EMS) diversion, and care coordination; and (5) provided prenatal and perinatal services for women who would otherwise lack access. These projects have in total served 189,615 Marylanders. In addition, the CHRC has awarded 72 grants totaling $19.4 million to support the integration of behavioral health and primary care services and expand access to substance use treatment in total serving over 71,000 individuals.

CHRC Goals and Objectives

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

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

Innovative:

The CHRC looks to fund projects that are **innovative**. According to the World Health Organization, a health care innovation responds to "unmet public health needs by creating new ways of thinking and working with a focus on the needs of vulnerable populations. It aims to add value in the form of improved efficiency, effectiveness, quality, sustainability, safety, and/or affordability."[2] Successful CHRC-funded projects are newly developed, evidence-based projects which improve health policies, systems, services or delivery methods, or those that have been successfully implemented in other states and planned for use in Maryland for the first time.

Sustainable:

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

Replicable:

The CHRC also supports projects that are **replicable**. Several projects that have been funded by the Commission in the past have led to statewide adoption of initiatives in behavioral health and

[1] https://health.maryland.gov/mchrc/Pages/grantees-by-focus-area.aspx
[2] http://www.who.int/topics/innovation/en/

care coordination services in many underserved communities in the state. For example, the CHRC funded the initial Behavioral Health Home pilot implemented by Way Station in FY 2012. The Maryland Department of Health has implemented the Medicaid Behavioral Health Home Initiative statewide, and there are now more than 80 Health Homes in the state.

Measurable Impact:

The CHRC prioritizes projects that use **evidence-based intervention strategies** to meet a specific community need and are designed to provide measurable improvements in health outcomes. To achieve this objective, applicants are strongly encouraged to identify discrete data variables that allow measurement of the intended impact of project interventions. If project interventions are intended to achieve a measurable improvement in health outcomes, the project plan should describe how this data will be collected and analyzed to demonstrate the intended impact on health outcomes and (to the extent possible) the anticipated cost savings to be achieved as a result. For example, a project to address the needs of individuals with poorly controlled diabetes aims to increase access to diabetes self-management education (DSME) with the goals of improving diabetic control (as measured by HbA1c) and demonstrating the cost effectiveness of DSME by reducing the number of hospital admissions and readmissions for managing hyperglycemia, and reducing the risk of diabetes complications (e.g., diabetic peripheral neuropathy). The applicant could also perform a "formal" cost-benefit analysis that compares the cost of implementing an innovative project intervention(s) against existing interventions and calculating the cost saving(s) that result from the project intervention(s).[3] This could apply to projects that address the Social Determinants of Health (SDOH), for example securing health insurance coverage for vulnerable populations that otherwise would not get routine health screenings and preventive care and are at greater risk for serious health problems and poor health outcomes.[4]

THE CHRC RESPONSE TO THE COVID-19 PANDEMIC

Early in the COVID-19 virus pandemic, the CHRC recognized the unprecedented challenges facing Maryland's safety net infrastructure caused by this public health crisis. Safety net service providers faced dramatic reductions in revenue as operational costs increased, while their capacity to provide essential health and social services was challenged, and these challenges brought by COVID-19 continue to have a profound impact on our most vulnerable populations. These challenges have exacerbated existing, persistent health disparities experienced by racial and ethnic minorities and increased the burden for those most susceptible to the immediate and longer-term consequences of the pandemic (e.g., elderly seniors and young children). Further, some safety net providers may not recover sufficiently to restore these vital services.

To help ameliorate the impact of COVID-19 on community health resources, the CHRC implemented a series of actions. First, the Commission authorized a number of COVID-19 impact mitigation options for all current CHRC grantees. These grant modification relief options included: 1) adjusting the grant reporting schedules and reporting requirements; 2) revising the original project service goals; 3) reallocating up to 25% (not to exceed $50,000) of unspent grant funds to cover increased or unanticipated costs related to COVID-19 pandemic response (e.g., telehealth capacity); and 4) extending the grant end date by up to 12 months.

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

[4] https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/increase-proportion-people-health-insurance-ahs-01

Second, the CHRC issued its first ever emergency funding Call for Proposals to provide immediate relief, resources and financial support to safety net providers and support continued delivery of much-needed services for vulnerable populations. Supported by federal funding made available by the Maryland Department of Health, the CHRC awarded 46 grants totaling $1.5 million. The CHRC COVID-19 emergency funding grants were utilized to support the delivery of services via telehealth (e.g., laptops, upgraded internet security, video capability), procurement of PPE, and measures to implement social distancing and infection control guidelines.

Following the issuance of the COVID-19 emergency funding awards, the CHRC recognizes the continuing need to support Maryland's safety net providers on a mid- and longer-term basis as they continue to serve vulnerable populations during the COVID-19 virus pandemic. The CHRC also recognizes that the COVID-19 virus pandemic has exacerbated persistent, ongoing health disparities for racial and ethnic minority populations. From experiences related to the COVID-19 pandemic response and the State's efforts to navigate the impacts of the pandemic over the past several months, the CHRC has developed the following two strategic priorities for this year's Call for Proposals: (1) Addressing health disparities exacerbated by COVID-19; and (2) Promoting overall service integration of health and social services in underserved communities.

Public – Private Community Partnerships

Improving the health of all Marylanders through local coalition action and partnerships with community health resources is an ongoing goal of the CHRC. **The current Call for Proposals places greater emphasis on community-based public/private partnership approaches to achieve the strategic priorities of the CHRC.**

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

1. **The Maryland Total Cost of Care Model** and the Health Services Cost Review Commission's Draft Recommendations for Competitive Regional Partnership Catalyst Grants which support the goals of the Total Cost of Care Model.[5]
2. **The Maryland Primary Care Program**, which supports the delivery of advanced primary care throughout the state.[6]
3. **The Maryland Diabetes Action Plan** (January 2020) which highlights initiatives and strategies to broaden and strengthen collaboration among communities, organizations, businesses, local governments and individuals to prevent and manage diabetes.[7]
4. **The Maryland Office of Minority Health and Health Disparities (MHHD), Minority Outreach and Technical Assistance Program.** The Minority Outreach and Technical Assistance (MOTA) program was established to improve the health outcomes for racial and ethnic minority communities through community engagement, partnerships, outreach and technical assistance.[8]

[5] https://hscrc.maryland.gov/Pages/regional-partnerships.aspx
[6] https://health.maryland.gov/mdpcp/Pages/Home.aspx
[7] https://phpa.health.maryland.gov/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf
[8] https://health.maryland.gov/mhhd/MOTA/Pages/Index.aspx

FY 2021 CALL FOR PROPOSALS

Promoting Community Health Resources: Addressing health disparities and supporting community health resources as they serve vulnerable populations and respond to the COVID-19 pandemic

This year's RFP will direct specific attention to efforts that expand access to health care and address the SDOH to reduce health disparities and help safety net providers continue to provide essential services as they respond to the impacts of the COVID-19 virus pandemic. Under this Call for Proposals, the Commission will receive projects in three areas of focus:

(1) Addressing chronic disease prevention and disease management, with particular focus on the prevention and management of diabetes;

(2) Addressing the health and social needs of vulnerable populations who are disproportionately impacted by the COVID-19 pandemic; and

(3) Addressing the immediate and longer-term recovery needs of Maryland's safety net providers as they navigate the impact of the COVID-19 pandemic through efforts that restore capacity to deliver essential health services and help support the basic needs of the disproportionately impacted vulnerable communities they serve.

The CHRC has since inception and through its strategic grant funding recognized and supported the essential, vital role of public health agencies, safety net healthcare providers and community-based organizations in promoting equitable access to healthcare and social support services that help to reduce health disparities through innovative projects specifically tailored to the vulnerable underserved communities they serve. The current Call for Proposals places even greater emphasis on the need to support Maryland's safety net providers who have a historical mission of serving low-income, economically disadvantaged and medically underserved individuals. These providers also have a demonstrated track record of implementing projects that serve these vulnerable populations, especially those impacted by health disparities and use innovative approaches to tackle the social determinants of health.

The current areas of focus recognize the ongoing impact of the COVID-19 pandemic on these organizations and their ability to continue providing essential healthcare and social services to vulnerable individuals who are at greater risk, in particular those with chronic diseases and complex care needs.

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

KEY DATES TO REMEMBER

The following are the key dates and deadlines for the FY 2020 Call for Proposals.

November 2, 2020	Release of the Call for Proposals
November 12, 2020 at 10:00 a.m.	Conference Call for Applicants Dial in number is 1.617.675.4444 Conference code is 912 029 186 1120#
November 18, 2020 – 12 noon	**Deadline for receipt of Letters of Intent**
December 17, 2020 – 12 noon	**Deadline for email receipt of full applications**
Late January 2021	Select number of applicants notified to present to the CHRC
February-March 2021	**Applicant presentations to the CHRC; award decisions immediately follow presentations**

GRANT ELIGIBILITY

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

What is a Community Health Resource?

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

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

- Federally qualified health centers (FQHCs) and FQHC "look-alikes"
- Community health centers
- Migrant health centers
- Health care projects for the homeless
- Primary care projects for public housing projects
- Local nonprofit and community-owned health care projects
- School-based health centers
- Teaching clinics
- Wellmobile Projects
- Community health center-controlled operating networks
- Historic Maryland primary care providers
- Outpatient mental health clinics
- Local health departments
- Substance use treatment providers

Organizations not designated above may also qualify as a community health resource. To qualify these organizations must demonstrate that they meet the Commission's criteria as a Primary

Health Care Services Community Health Resource or an Access Services Community Health Resource.

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

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

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

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

(4) Sliding Scale Fee Schedule Requirements

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

THE GRANTS PROGRAM - STRATEGIC PRIORITIES OF THE FY 2021 CALL FOR PROPOSALS

This year's Call for Proposals has two strategic priorities: (1) promoting health equity by addressing health disparities and SDOH, with a particular emphasis on addressing disparities that disproportionately impact racial and ethnic minorities and have been exacerbated by the COVID-19 pandemic; and (2) promoting the efficient and strategic delivery of integrated health and social services for vulnerable residents through the support of innovative, sustainable community partnerships that focus on underserved communities, such that the totality of needs for the targeted populations are addressed.

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

STRATEGIC PRIORITY 1:

Promoting health equity by addressing health disparities and Social Determinants of Health (SDOH), with a particular emphasis on addressing disparities that disproportionately impact racial and ethnic minorities and have been exacerbated by the COVID-19 pandemic.

Health equity is achieved when every individual has the ability to attain optimal health and wellness without being disadvantaged due to their race, ethnicity, age, gender, gender identity, sexual orientation, socioeconomic status or other factors such as geographic location and disability status.[9] When individuals are not provided equal opportunities or the resources to pursue optimal health and wellness, this creates health inequities which invariably result in health disparities. Health disparities are preventable differences in health outcomes and their causes (e.g., the burden of disease) observed between groups of people.[10] The burden of chronic disease and the preventable differences in health outcomes are significantly greater for racial and ethnic minorities in the U.S. compared to non-Hispanic whites.[11]

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

Despite decades of efforts to eliminate health disparities in Maryland, preventable differences in disease burden in disadvantaged populations continue to persist. Whilst some progress has been made in narrowing the health disparities gap, efforts to eliminate these disparities must continue in Maryland.[12] Elimination or improvement in these disparities is unlikely to be achieved without addressing the SDOH. According to Healthy People 2020, SDOH are conditions in the environments in which people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The forces that shape these conditions include economic policies and systems, social norms, social policies and stigma, and political systems. Addressing SDOH is one of the most effective ways to improve health and reduce health disparities.[13]

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

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

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

[9] https://www.cdc.gov/chronicdisease/healthequity/index.htm
[10] https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities
[11] https://www.cdc.gov/mmwr/pdf/other/su6203.pdf
[12] https://health.maryland.gov/mhhd/Documents/Maryland%20Chartbook%20of%20Minority%20Health%20and%20Minority%20Health%20Disparities%20Data,%20Third%20Edition%20(December%202012).pdf
[13] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

encourages interventions developed and delivered through these partnerships that create or expand social, political, or economic support systems to address the SDOH for specific population(s)

The value of increasing the availability of population health interventions as one approach to reducing health disparities and addressing SDOH is widely recognized.[14]

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

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

A key area for applicant consideration under this strategic priority is **expanding access to essential health care services and health insurance coverage,** as one of the SDOH that contributes to health disparities. Following the passage of the Affordable Care Act, Maryland, like many states, achieved dramatic increases in health insurance coverage rates. There has been a dramatic drop in the uninsured rate for Marylanders between the ages of 18 and 64, from 11.3% in 2013 to 6% in 2019.[15] Despite these coverage gains, the uninsured rate remains high for certain racial and ethnic groups. For example, the uninsured rate for Hispanic/Latino individuals was 37.1% in 2019.[16] According to an analysis by the Maryland Health Benefit Exchange, as of October 2019, an estimated 252,011 exchange eligible individuals remain uninsured with or without a subsidy.

Another area for applicants to consider under this strategic priority is **workforce diversity**. A landmark study supported by the HHS Office of Minority Health and conducted by the Institute of Medicine "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" was published in 2003, and concluded that racial and ethnic minority groups tend to receive a lower quality of healthcare compared to non-minority groups despite efforts to address access issues such as health insurance coverage. The study recommends increasing the representation of racial and ethnic minorities in the healthcare workforce and providing patients with culturally appropriate health education as an effective way to improve the quality of healthcare provided to racial and ethnic minority populations.[17] Increasing racial and ethnic minority representation among healthcare professionals and the leaders of the organizations that provide health and social services proportionally to the communities they serve will help to improve the cultural

[14] https://www.cdc.gov/minorityhealth/strategies2016/index.html
[15] https://www.census.gov/library/publications/2020/demo/p60-271.html
[16] https://www.kff.org/uninsured/state-indicator/distribution-uninsured-nonelderly-race-ethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[17] https://unequaltreatment.com/

competency of the healthcare workforce, support improved health literacy and understanding to better meets the needs of these communities and help to reduce health disparities.

The CHRC also encourages applicants to consider including measures that increase language access and the associated costs for language accommodation in their grant budget to support community outreach and the delivery of services to immigrant communities.

STRATEGIC PRIORITY 2:

Promoting the efficient and strategic delivery of integrated population health interventions for vulnerable residents through the support of innovative, sustainable community partnerships that focus on underserved communities, such that the totality of needs for the targeted populations are addressed.

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

The CHRC has consistently supported innovative, sustainable community-based partnerships that address the unmet medical and SDOH needs of Maryland's vulnerable, low-income underserved communities. The current strategic priority further enhances this focus by increasing the opportunities to fund projects designed to identify more effective approaches to improving chronic disease management and addressing the social factors that will contribute to better health outcomes and increase the quality of life for residents of underserved communities.

General Guidance for FY 2021 applicants:

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

4. **Under this Call for Proposals, the CHRC will support one and two-year grant projects.**

Further information about the selection criteria for this Call for Proposals can be found later in this document, pages 18 through 21.

AREAS OF FOCUS (FUNDING CATEGORIES)

The strategic priorities of this year's Call for Proposals will apply to **all** grant proposals submitted in **any** of the three areas of focus listed below. Applicants will need to be very specific in how their proposals align with the strategic priorities above. The CHRC will receive applications with project proposals that address any of the following three areas of focus:

1. **AREA 1: Addressing chronic disease prevention and disease management, with specific focus on the prevention and management of diabetes, and the complications and comorbidities of diabetes.**

(The CHRC anticipates having a maximum of approximately $1,000,000 in total funds available to cover all grant awards issued under this category for up to 2 years).

The CDC estimates that six in 10 Americans live with at least one chronic disease such as diabetes, heart disease and stroke.[18] Chronic diseases are the leading causes of death and disability in United States and result in significant health and economic costs.[19] As noted, the burden of chronic disease and the preventable differences in health outcomes are significantly greater for racial and ethnic minorities in the U.S. compared to non-Hispanic whites.[20]

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 Maryland, accounting for seven of every 10 deaths. Medical costs for people with chronic diseases account for 86% of the nation's $2.9 trillion in medical costs.[21] Medical expenses for people with diabetes are more than two times higher than for people without diabetes.

Chronic Disease Prevention and Management

The onset of many chronic diseases is attributed to key risk behaviors, which include tobacco and excessive alcohol use, physical inactivity, poor nutrition, and being overweight and obese.[22] By making healthy choices, individuals can reduce the likelihood of getting a chronic disease and maintain or improve their quality of life.

Chronic disease management involves an integrated care approach to managing illness which includes regular screenings, check-ups, monitoring and coordinating treatment, and patient education.[23] When the effects of chronic diseases are prevented or minimized this can improve the quality of life whilst reducing health care costs. Integrated approaches to improving chronic disease management particularly for primary care providers brings together various elements in healthcare delivery to improve quality with disease specific approaches including self-management for individuals with diabetes.

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[18] https://www.cdc.gov/chronicdisease/
[19] https://www.cdc.gov/chronicdisease/about/costs/index.htm
[20] https://www.cdc.gov/chronicdisease/about/costs/index.htm
[21] http://www.cdc.gov/chronicdisease/
[22] https://www.cdc.gov/chronicdisease/about/index.htm
[23] https://www.healthcare.gov/glossary/chronic-disease-management/

Primary Focus on Diabetes Prevention and Management

The primary focus under this category is on diabetes prevention and improving diabetes management; however, the CHRC will also consider applications that address the management of diabetes comorbidities, and the prevention and management of other chronic diseases that occur more frequently in vulnerable populations including cardiovascular disease, stroke and serious mental illnesses.

Diabetes is a growing health problem in the U.S. and Maryland and is a leading cause of preventable death and disability. According to the latest national statistics over 30 million Americans have diabetes and of those 7.2 million are undiagnosed.[24] It is estimated that 84 million Americans have prediabetes, a condition that often leads to diabetes and 90% of those affected are unaware of the condition.[25] In 2019, it is estimated that 489,000 or 10.5% of Maryland adults have diabetes and another 1.6 million (34%) have prediabetes.[26] Diabetes is the sixth leading cause of death in Maryland.[27] The prevalence of diabetes in Maryland among African American and Hispanic populations is 50% higher than non-Hispanic whites.[28] The increasing prevalence of diabetes reflects significant racial, ethnic, economic, educational and geographic disparities.[29]

Improving the management of diabetes and reducing the risk of developing diabetes through lifestyle modifications and health care interventions have been demonstrated to be effective.[30,31] To this end, the Maryland Department of Health released the inaugural Maryland Diabetes Action Plan in January 2020, that provides current data on the burden and consequences of diabetes, with prevention measures to reduce the number of newly diagnosed diabetics and intervention strategies for improved control of diabetes to reduce the risk of secondary chronic conditions.[32] The Plan is designed to help the State and its partners achieve the Healthy Maryland goal of reducing the disease burden of diabetes and improving the quality of life for all persons who have diabetes or are at risk for diabetes.

The Diabetes Action Plan presents Maryland's population health categories and corresponding goals and objectives (listed below). The Plan includes a number of action steps and below are selected intervention strategies that could be supported by CHRC grant funding this year.

Keeping a Healthy Weight Population

1. Increasing access to healthy nutrition with the goal of achieving healthy weight for 32% of Maryland adults by 2024:
    a. Expanding implementation of healthy cooking and eating education and skill-building though evidence-based community projects

[24] https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf
[25] https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf
[26] https://phpa.health.maryland.gov/ccdpc/Reports/Pages/brfss.aspx
[27] https://health.maryland.gov/vsa/Pages/reports.aspx
[28] https://www.cdc.gov/diabetes/data/statistics/statistics-report.html
[29] https://ibis.health.maryland.gov/
[30] https://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp/
[31] https://www.niddk.nih.gov/about-niddk/strategic-plans-reports/diabetes-in-america-3rd-edition
[32] https://phpa.health.maryland.gov/CCDPC/Pages/diabetes-action-plan.aspxhttps://phpa.health.maryland.gov/ccdpc/Documents/Diabetes Action Plan documents/Diabetes Action Plan DRAFT FOR COMMENT FINALv2.pdf

b. Promoting healthy lifestyle family planning with OB/GYN practices with women of childbearing age

2. Achieving and maintaining recommended physical activity levels:
    a. Engaging healthcare professionals to promote increased physical activity to reduce sedentary behaviors

Reducing overweight and obese populations

1. Improving clinical care services for overweight and obese children and adults:
    a. Promoting provider use of z-codes (e.g., Z68.54) in primary care and pediatric practices, and provide social and case-management support
2. Improving the availability of health lifestyle options for overweight and obese children:
    a. Expanding implementation of healthy cooking teaching kitchens and healthy eating education and skill-building opportunities for overweight/obese adults and children

Prediabetes and Gestational Diabetes populations

1. Improving prediabetes outcomes:
    a. Increasing the number of people at risk who are tested, referred, complete and reach evidence-based lifestyle change goals
2. Reducing the risk of diabetes in women with a history of gestational diabetes:
    a. Increasing the number of women with a history of gestational diabetes referred to evidence-based lifestyle projects or nutritional counseling

Managing diabetes and controlling diabetes with complications

1. Improving use of standardized quality of care and chronic care models for diabetes through:
    a. Appropriate patient referrals for vision, oral and podiatry services
    b. Dental-to-primary care provider partnerships for high risk patient referrals to primary care for potential diabetes diagnosis and treatment
2. Reducing the number of hospital and ED visits by people with diabetes through:
    a. Appropriate linkage to case management based on screening and risk-stratification

Recent data suggests that food insecurity is more prevalent in households where a person with diabetes is living and diabetes is more prevalent in households that are more food insecure.[33] Food insecurity occurs when the food intake of household members is reduced and their normal eating patterns are disrupted because the household lacks the money and other resources for food, or their access to healthier food choices such as fresh fruit and vegetables is limited. From 2016-2018, the prevalence of household-level food insecurity (low and very low food security) nationally was estimated at 11.7% of households affecting 14.3 million people; the prevalence rate was approximately the same for Maryland during this period.[34] One consequence of food insecurity is the higher consumption of nutrient poor, high calorie foods which contribute to higher rates of obesity and diabetes. The most recent data from the CDC for 2017-2018, shows

[33] Gucciardi, E., Vahabi, M., Norris, N., Del Monte, J. P., & Farnum, C. (2014). The Intersection between Food Insecurity and Diabetes: A Review. *Current nutrition reports*, *3*(4), 324–332. https://doi.org/10.1007/s13668-014-0104-4

[34] https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx

42.4 percent of adults and 18.5 percent of children ages 2-19 years were considered obese.[35] The prevalence of obesity in Maryland is similar to that of the rest of the country with 28.3% of adults considered obese, and 23% of adults who were obese have diabetes.[36] The association between a less-healthy diet, being overweight and obese, and having an increased risk for serious chronic diseases such as diabetes has been established.[37]

Applicants in this category are strongly encouraged to consult the Maryland Diabetes Action Plan when developing proposals in this category this year.

Projects in this category may include the provision of new services or the expansion of existing services that are effective in meeting the health needs of adults and children in the community. Proposals must demonstrate efficiency in service delivery including: (1) innovation to address barriers to accessing health services; (2) promoting access to health insurance and other social services; and (3) capacity to bill third-party payers to achieve sustainability.

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

The CHRC has funded 32 projects for $5.8 million aimed at preventing or reducing food insecurity and addressing chronic disease prevention and management with specific focus on diabetes.

2. AREA 2: Addressing the health and social needs of vulnerable populations[38] who are disproportionately impacted by the COVID-19 pandemic.

(The CHRC anticipates having a maximum of approximately $1,000,000 in total funds available to cover all grant awards issued under this category for up to 2 years).

Proposals under this area of focus will address the health and social needs of vulnerable individuals who due to their age or physical, developmental, intellectual and emotional limitations face additional barriers and disadvantages in accessing basic primary and preventive healthcare and social services, as well as experiencing health disparities due to race, ethnicity and socioeconomic disadvantage. These conditions have been exacerbated by the disruptions caused by the COVID-19 pandemic and place these vulnerable individuals at greater health risk compared to the general population.

These vulnerable populations include, but are not limited to:

1. School-aged children who receive their primary and behavioral healthcare through their school-based health and wellness centers.
2. Children with a disability that falls under one or more of the Individuals with Disabilities Education Act (IDEA)[39] disability categories (e.g., hearing, visual, developmental or intellectual learning impairments) who are no longer able to access school-based, in-person services vital to addressing their physical, emotional, nutritional and learning needs.

[35] https://www.cdc.gov/obesity/
[36] https://phpa.health.maryland.gov/ccdpc/healthy-lifestyles/Pages/obesity.aspx
[37] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4584410/
[38] https://ephtracking.cdc.gov/showPcMain.action
[39] https://sites.ed.gov/idea/

3. Elders with physical or cognitive limitations who face disruptions to basic services such as transportation, and barriers to essential healthcare as they manage chronic diseases and the significantly higher risk of serious COVID-19 disease, as well as social isolation with the loss or reduction in social support systems and other services.
4. Individuals across age groups who have intellectual, developmental, physical, sensory, cognitive and emotional limitations who are disproportionately impacted by the pandemic, including individuals with serious mental illnesses.
5. Underserved individuals in rural and urban communities.

Applicants are encouraged under this area of focus to propose projects that address the conditions that increase the negative impact of the COVID-19 pandemic on vulnerable at-risk populations. This could include but is not limited to the following:

- interventions that seek to restore access to essential primary, behavioral and preventive healthcare particularly for those at greater risk of poor health outcomes and more serious COVID-19 disease
- community level activities to reduce transmission of the COVID-19 virus through culturally competent education and contact tracing
- initiatives that address the broader secondary health effects of the pandemic including worsening of existing physical and mental health conditions, increased alcohol and substance use, social isolation, stress, and physical and emotional abuse
- community initiatives that increase the availability of food, housing assistance and income support for those in acute need due to lost employment, reduced income and the threat of eviction
- finding more effective ways to outreach communities at greater risk to identify the most critical needs in these communities, align and prioritize services to address these needs.

3. <u>AREA 3</u>: Addressing the immediate and longer-term recovery needs of Maryland's safety net providers as they navigate the impact of the COVID-19 pandemic through efforts that restore capacity to deliver essential health services and help support the basic needs of the disproportionately impacted vulnerable communities they serve.

(The CHRC anticipates having a maximum of approximately $1,000,000 in total funds available to cover all grant awards issued under this category for up to 2 years).

The COVID-19 virus pandemic is placing an unprecedented demand on the safety net infrastructure whilst community health resources continue to face significant reductions in revenue and increased operational costs resulting in ongoing disruptions to projects and services. These disruptions only exacerbate existing health disparities and increase the burden for those most susceptible to the immediate and longer-term consequences of the pandemic.

Non-profit community health centers are the frontline healthcare providers for underserved, uninsured and underinsured low-income residents, particularly those with underlying health issues and other challenges in accessing care. Whilst the federal and state governments have taken a number of actions, including expanding Medicaid eligibility and coverage options, increasing Medicare reimbursement, and providing other pandemic financial resources available to community health centers and safety net providers, these measures may not be sufficient to help all organizations fully restore services or recover financially and operationally.

As Maryland's community safety net providers continue to persevere and recover from the COVID-19 pandemic and restore essential health and social services, they face a number of challenges. To address these challenges, organizations may need to re-evaluate their existing services to determine the viability of maintaining, restoring or altering these services in response to reduced financial resources and capacity, and determine how to respond to higher demands for health and social support services. The process of bringing clients and staff back to the physical workplace and restoring in-person services may involve prohibitively expensive re-purposing and retrofitting of facilities to ensure compliance with infection controls and social distancing guidelines. Similarly, there may be significantly higher expenses incurred for environmental cleaning and for the evolving technology requirements to maintain and expand virtual telework and telehealth services.

These challenges warrant providing access to COVID-19 recovery grant funding through this Call for Proposals, which is consistent with the CHRC's responsibilities to respond to the emerging needs of our safety net providers and the vulnerable populations they serve.

To the extent possible under the CHRC's legislative mandate and responsibilities, the CHRC will permit applicants the flexibility and latitude necessary to request funding that the applicants consider essential for general operating expenses as well as direct project costs to transition, restore, maintain and/or expand essential health and social support services that assist the vulnerable populations at greatest risk due to the impact of COVID-19. The CHRC acknowledges that the greatest need in the near term will be restoring access to essential health services as well as help to address basic needs. For many non-profits, the current estimates for recovery from the impact COVID-19 could take two or more years.

Projects that clearly demonstrate how grant funds will help to support restoration of health and social service capacity and serve additional individuals in underserved communities, or provide support and technical assistance to safety net providers as they struggle to recover from the COVID-19 virus pandemic to ensure continued service delivery for vulnerable populations will be given special consideration.

Applicants may submit proposals for projects in one of the three areas of funding focus described above. The CHRC recognizes that these areas of focus may overlap in scope and have elements common to all areas. 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.

Again, it is crucial that the project proposals submitted under each area of funding focus address both of the CHRC's strategic priorities in this year's RFP.

SELECTION CRITERIA

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

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

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

1. **The strategic priorities of the CHRC must be clearly identified and addressed in the application (refer to the descriptions provided on pages 9-13 above).**

   1a). Promoting health equity by addressing health disparities and Social Determinants of Health (SDOH), with a particular emphasis on addressing disparities that disproportionately impact racial and ethnic minorities and have been exacerbated by the COVID-19 pandemic.

   1b). Promoting the efficient and strategic delivery of integrated health interventions for vulnerable residents through the support of innovative, sustainable community partnerships that focus on underserved communities, such that the totality of needs for the targeted populations are addressed.

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

services to lead to improved health outcomes, improved service experiences, more efficient use of hospital resources and reduced health disparities. The project has the potential for expansion or replication in neighboring areas or more broadly across the state. The goals and objectives of the project are clear, measurable, and achievable. The proposed project has a high likelihood of achieving its overall goal(s).

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

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

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

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

8. **Workforce Diversity:** The application presents an organizational assessment of racial and ethnic minority representation and cultural competency among the organization's healthcare professionals and organizational leadership, and when applicable presents the organizational

approach to achieve racial and ethnic diversity proportional to the vulnerable communities served to increase the quality of care and contribute to reducing health disparities.

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 CHRC.

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

Use of Grant Funds

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

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

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

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

How to Apply

The application process begins by submitting a Letter of Intent and a copy of the most recent financial audit as described below, by **12:00 p.m. (noon) November 18, 2020.** CHRC staff will

review these materials and screen applicants for eligibility to determine who will be invited to submit a full grant application as described below. **Full grant applications will be due to the Commission on December 17, 2020 by 12:00 p.m. (noon).**

Applicants will be notified about the status of their grant applications in late January 2021. **A select number of well-reviewed grant applications will then be considered for grant awards at the Commission's meeting in February or March 2021.** Grant awards will be made by the CHRC following this meeting and applicants will be notified shortly after the meeting.

STEP 1: Letter of Intent and Financial Audit - due November 18, 2020

All applicants must submit a **Letter of Intent (LOI)** for the application to be considered. Letters of Intent **must be received by 12:00 p.m. (noon) on November 18, 2020, via email** delivery to Jen Thayer at **mdh.chrc@maryland.gov**. In the subject line of the email, please state your organization's name and the Call for Proposals area of focus category for your application. A hard copy original of the Letter of Intent is not necessary.

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

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

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

2. The LOI template must be filled out completely and must adhere to the posted word limits.
3. **Financial audit**. Organizations must submit **an electronic version of the most recent financial audit of the organization**. The audit should be submitted at the same time as the LOI. Receipt of the LOI and financial audit are a condition for moving forward in the grant process.

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

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

STEP 2: Submission of Full Grant Applications - due December 17, 2020

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

Full grant applications (see components listed below) must be received electronically by the CHRC no later than 12:00 p.m. (noon) on December 17, 2020.

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

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

In addition to the electronic grant application submission, one hard copy original of the full application with all items listed below must be sent via USPS mail or express delivery service. If sent by USPS, it must be post-marked no later than **December 18, 2020**; if sent by an express

delivery service, the package must indicate that the package was picked up for delivery by the close of business on **December 18, 2020, to be considered a complete application.**

One original full grant application, including a signed original of each of the following:

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

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

PLEASE NOTE:

1. **Hand-delivery of the hard copy original of the full application is not permitted due to building access restrictions at 45 Calvert Street. Therefore, all applicants must choose one of the delivery options listed under Step 2 above.**
2. The hard copy original of all application documents should be bound with binder clips, two-prong report fasteners, or spiral bound. If two-prong fasteners are used, cardboard or plastic covers and backs can be used. Do **not** use three ring binders.

The original hard copy of the full grant application should be sent by USPS mail or express delivery service (with a post-mark or confirmed pick up for delivery date **no later than December 18, 2020)** to the address below:

Jen Thayer, CHRC Administrator

Maryland Community Health Resources Commission

45 Calvert Street, Room 336

Annapolis, MD 21401

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

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

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

(3) Grant Application Cover Sheet: The form should be completed and signed by the project director(s) and either the chief executive officer or the individual responsible for conducting the affairs of the applicant organization and legally authorized to execute contracts on behalf of the applicant organization.

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

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

Project proposals should be well-written, clear, and concise. Applicants are strongly encouraged to limit their project proposal to 15 pages in length, using single-spacing on standard 8 ½" x 11" paper with one-inch margins and using 12-point Times New Roman or Arial font. Tables and charts may use a 10-point font or larger. All pages of the proposal must be numbered. The appendices specified in the guidelines below are excluded from the 15-page limit guideline.

The project proposal should be structured using these topic headings:

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

Mandatory appendices

(a) IRS determination letter indicating 501(c)(3) tax-exempt status, if applicable

(b) List of officers and Board of Directors or other governing body

(c) Organizational Chart

(d) Overall organization budget

(e) Form 990, if applicable

(f) Résumés of key personnel

(g) Logic model

(h) Letters of commitment from collaborators

Optional appendices

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

(b) Annual report, if available

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

The required components of the proposal are as follows:

(A) Executive Summary of the Project Proposal

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

- Applicant organization;

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

(B) Background and Justification

- ***Describe the target population.*** Identify the population(s) to be served (i.e., estimated numbers, demographics, insurance coverage, income levels, other distinguishing characteristics) with baseline and total projected numbers of individuals to be served by the end of the project. Please provide a brief explanation of how the projected numbers of individuals to be served were calculated. Specify the service area(s) where your target population lives and/or where your project will serve. Service maps, data, and other statistics on the target population may be provided as an appendix.
- ***Document the needs of this population using qualitative and quantitative data.*** Generally, what are the health needs of the target population? What are the gaps in the health care delivery system? What are the specific barriers that the target population faces in accessing health care services or services similar to your proposed project? Discuss the community conditions affecting the target population's health behaviors and outcomes. Statistics and data should be concisely presented.
- ***Describe the health disparity(ies) in the target population that the project will address***. Discuss the specific health disparity(ies) the project is intended to address and how the project will address the disparity(ies).
- ***Describe community buy-in for the project***. Discuss the process used to identify and engage community stakeholders when designing the proposed project. Will community stakeholders be consulted about or involved during project implementation?
- ***Describe any similar or complementary projects in the targeted community.*** Describe similar or complementary projects that are currently in place in the target area and discuss how the proposed project does not duplicate work already being done.
- ***Discuss the precedents for this project and the expected benefits***. Is the project based on a prior model or approach? What is the evidence that the proposed model or approach will be successful? If the project is a new, original approach, articulate why this approach will likely meet the project's stated goals and objectives. If the project is successful, what visible, tangible, objectively verifiable results will be reported at the end

of the grant? What longer term benefits are expected for the target population and the broader community?

- ***Show how the project addresses legislative priorities.*** Discuss the extent to which the project addresses the priorities for community health resources in the Community Health Care Access and Safety Net Act of 2005 [for more information, refer to the legislation (SB 775/HB627 – 2005)]. The proposal may also discuss other public/population health and health care delivery initiatives such as the State Health Improvement Process (SHIP) and Total Cost of Care Model.

(C) Organizational Capacity

- ***Describe the organization's mission, structure, governance, facilities, and staffing.*** Describe the organization's mission, projects, and service area. Discuss the organizational strengths and challenges. Is the applicant a for-profit or not-for-profit organization? If applicable, attach as an appendix the organization's determination letter from the IRS indicating 501(c)(3) tax-exempt status. Describe the type of organization (e.g., federally qualified health center, free-standing clinic, clinic affiliated with a hospital or local health department, private primary care practice). Specify the governance structure. In an appendix, provide a list of the officers and board of directors or other governing body. Describe the current and proposed staffing and provide an organizational chart as an appendix. Describe the facilities owned and/or operated by the organization.
- ***Describe how the organization is financed.*** Specify revenue sources and the percentage of total funding. What is the annual budget? As appendices to the proposal, provide an overall organizational budget (projected revenues and expenses) for the current fiscal year, and, if your organization files a Form 990, its most recent filing. <u>It is not necessary to include the financial audit previously submitted with the LOI</u>. The Commission will request additional information if necessary.
- ***Describe the organization's history of working with the target population and with partnerships in this community.*** Discuss previous work in this community and with this target population.
- ***Discuss the organization's history with other/similar grants, including any prior CHRC funding.*** Discuss the organization's grant funding history. Discuss any notices of insufficient progress that your organization may have received and how issues were resolved.
- ***Discuss project staffing.*** Identify the project director and describe his/her level of responsibility within the applicant organization, qualifications to lead the project, and the role in carrying out the project. Identify other essential staff, their roles in the project, and their relevant qualifications. As an appendix, include résumés (**maximum three pages each**) for all key personnel. Describe any positions that the organization will need to hire new/additional staff to fill.
- ***Does the organization publish an annual report?*** If so, provide a copy as an appendix. If your organization has submitted the latest annual report for a previous grant round, please provide a statement that the report was submitted and which year it covers.

(D) Project Plan

- ***Discuss the project's goals and objectives.*** What are the project's goals and objectives? Use SMART objectives (**S**pecific, **M**easurable, **A**chievable, **R**ealistic and includes a **T**imeframe). Provide a logic model as an Appendix. For information on how to create a Logic Model, refer to the Kellogg Foundation guide.[40] A logic model template is provided in Appendix II.
- ***Describe the major steps or actions in carrying out the project.*** List key actions or steps in the implementation of the project. Describe the process and timeframe for reaching these benchmarks. A sample project 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.

(E) 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.

(F) Evaluation

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

(G) Sustainability

Discuss how the project will be sustained after support ends. Discuss the process by which the project will work towards sustainability. Will support come from revenue/billing fee for

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

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

(H) Project Budget

- 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 project's total actual cost. If the CHRC grant request is a portion of the overall cost of the project, clarify this (such as the percentage that the CHRC grant request is of the overall project cost), and indicate the sources of other funding.
- Applicants must use the Budget Form provided in Appendix IV of the Call for Proposals. The CHRC Budget Form must include the following line item areas:
  - *Personnel:* Include the percent effort (FTE), name, and title of the individual.
  - *Personnel Fringe*: The Commission advises that the fringe rate be calculated at no more than 25%. If the grantee requests more than 25%, the applicant will be required to provide a compelling rationale for exceeding this amount. Requests that exceed 25% will be considered on a case-by-case basis.
  - *Equipment/Furniture:* Small equipment and furniture costs.
  - *Supplies*
  - *Travel/Mileage/Parking*
  - *Staff Trainings/Development*
  - *Contractual:* Contracts for more than $10,000 require specific approval of the Commission prior to being implemented. The budget justification should provide additional details about the use of funds to support contractual costs.
  - *Other Expenses:* Other miscellaneous expenses or other project expenses that do not fit the other categories can be placed here. Detail each different expense in this area in the budget justification narrative.
  - *Indirect Costs:* Indirect costs may not exceed 10% of direct project costs; however, the CHRC will consider on a case-by-case basis permitting higher indirect cost rates (above 10%) if the applicant can demonstrate that a higher rate that has been approved by the federal government.
- Applicants must include a line-item budget justification detailing the purpose of each budget expenditure.

INQUIRIES

Conference Call for Applicants: The Commission will host a conference call for interested applicants to provide information on the grants program and assistance with the application process. This conference call, on **Thursday, November 12th at 10:00 a.m.,** is optional, though encouraged, and will last approximately one hour, depending on the number of questions from potential applicants.

The conference call-in number is **1.617.675.4444**, and the conference code is: **912 029 186 1120#.**

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

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

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

Staff members are:

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

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

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

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

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

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

ABOUT THE MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

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

Current Commissioners (one vacancy)

Elizabeth Chung, Chair

J. Wayne Howard, Vice Chair

Scott T. Gibson

Celeste James

Maulik Joshi, Dr. P.H.

Karen Ann Lichtenstein

Carol Masden, LCSW-C

Destiny-Simone Ramjohn, Ph.D.

Erica I. Shelton, M.D.

Carol Ivy Simmons, Ph.D.

APPENDIX I: LETTER OF INTENT FORM AND INSTRUCTIONS

CHRC LETTER OF INTENT FY 2021	
1. Organization Name	Click here to enter text.
2. Organization Address	Click here to enter text.
3. Name, telephone and email of organization CEO, project director, and contact person for the project	Click here to enter text.
4. Additional Contact – name, title, email, and telephone	Click here to enter text.
5. Project Title	Click here to enter text.
6. Project Focus Area: (check one box)	☐ **Addressing chronic disease/diabetes prevention and disease management** ☐ **Addressing the health and social needs of vulnerable populations** ☐ **Addressing the immediate and longer-term recovery needs of safety net providers as they navigate the impact of the COVID-19 pandemic**
7. Program Jurisdiction	Click here to enter text.
8. Year One/Total CHRC budget request:	Year One $ Total $
9. Program duration (check one box):	☐ One Year ☐ Two Year
10. This program is (check one box):	☐ A New Program ☐ An Expansion of Existing Services
11. A description of the applicant organization (maximum 250 words): Click here to enter text.	
12. Has the applicant organization received CHRC funding in prior years? ☐ Yes ☐ No 12A. Submission of Eligibility Documents: **Sliding Fee Scale** ☐ **Financial Audit** ☐ MOU (if applicable) ☐ BHA License (if applicable) ☐ If the required documents (or when applicable documents) are NOT submitted, describe how your organization meets the definition of a "Community Health Resource. Click here to enter text.	
13. 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): Click here to enter text.	
14. A list of other organizations participating or partnering in the program: Click here to enter text.	

APPENDIX I: LETTER OF INTENT FORM AND INSTRUCTIONS

INSTRUCTIONS FOR CHRC LETTER OF INTENT TEMPLATE

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

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

Line 3. The name, telephone number and email addresses of the applicant organization's CEO, project director and, if different, the contact person for the project.

Line 4. The name, telephone number and email address of any additional contact person for the project

Line 5. The title of the proposed project

Line 6. The project focus area of the proposed project (select one of the three areas of focus).

Line 7. The jurisdiction where the project will be carried out.

Line 8. The funds that will be requested for the first year, and the funds requested for the entire project (for all years).

Line 9. The proposed duration of the grant funding.

Line 10. If the application proposes a service not currently being provided in that location by the organization, it will be considered a **New Project**. If the application proposes providing existing services to a new population of patients, it will be considered an **Expansion of Existing Services**.

Line 11. A description of the applicant organization, including its mission, its history of providing services in the community, and its history with grant-funded projects. The description should not exceed 250 words.

Line 12. 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 12A – Provide a copy of the of the organization's sliding fee scale (Primary Health Care & Access Community Health resource), an electronic copy of the most recent financial audit. If your organization will be providing behavioral health services under the grant, the LOI must include a copy of your license(s) issued by the MD BHA. If grant funded services are provided through **formal** partnerships with another organization or group, the CHRC will require that a **Memorandum of Understanding** (MOU) or similar legally binding document is in place prior to submission of the LOI, and a copy of the fully executed document(s) are included with the LOI. If your organization has not previously been awarded a CHRC grant, describe how your organization meets Community Health Resource

Line 13. 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 14. A list of any organizations that will be involved in the implementation of the project..

APPENDIX II: Logic Model Form

LOGIC MODEL – CHRC FY 2021 CALL FOR PROPOSALS				
Organization name:				
Project name:				
Amount requested:				
Area of focus:				
RESOURCES	ACTIVITIES	OUTPUTS	SHORT- AND LONG-TERM OUTCOMES	IMPACT
In order to accomplish our set of activities we will need the following:	In order to address our problem or asset we will accomplish the following activities:	We expect that once accomplished these activities will produce the following evidence or service delivery:	We expect that if accomplished these activities will lead to the following changes in 1-3 then 4-6 years:	We expect that if accomplished these activities will lead to the following changes in 7-10 years:

APPENDIX III: Workplan Template

Workplan Template

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Organization Name: _____

Project Name: _____

PROJECT PURPOSE:

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

APPENDIX IV: Budget Form Template

Budget Form Template FY2021			
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION			
Organization Name:	Project Name:		
Revenues	**Budget Revenue**	**% of Total Project Budget**	
CHRC Grant Request		#DIV/0!	
Patient/Program Revenues/Income		#DIV/0!	
Organization Match		#DIV/0!	
Other Grant/Funding Support		#DIV/0!	
Total Project Cost	**0**	**#DIV/0!**	
Line Item Budget for CHRC Grant Request	**Year 1 CHRC Budget Request**	**Year 2 CHRC Budget Request**	**Line Item Total Budget Request**
Personnel Salary (enter the requested information for each FTE; do not provide the salaries as a single, total number)			
% FTE - Name, Title			0
% FTE - Name, Title			0
% FTE - Name, Title			0
Personnel Subtotal	**0**	**0**	**0**
Personnel Fringe (no more than 25% of Personnel costs)			**0**
Equipment / Furniture		0	0
Supplies			0
Travel / Mileage / Parking			0
Staff Training / Development			0
Contractual (>$5k itemize below with details in budget justification)			
a. Professional/other services by vendor/contractor (1)		0	0
b. Professional/other services by vendor/contractor (2)			0
c. Professional/other services by vendor/contractor (3)			0
d. Advertising			0
e. Lease or rental costs (not incl. under "Equipment/furniture", "Supplies", "Other Expenses" or "Indirect Costs")			0
Other Expenses (**MUST** detail below)			
a. Other			0
b. Other			0
c. Other			0
Indirect Costs: no more than 10% of direct costs (>10% - refer to Budget Form instructions and RFP)	0		0
Totals	**0**	**0**	**0**
Percent of Organization's Total Budget that this Project Budget Represents			#DIV/0!