STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Room 336 • Annapolis, Maryland 21401
Wes Moore, Governor – Aruna Miller, Lt. Governor
Edward J. Kasemeyer, Chair – Mark Luckner, Executive Director

Expanding Health Care Access and Promoting Health Equity

FY 2024 Request for Applications

April 4, 2024

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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 (1) expand access to health care for low-income Marylanders and underserved communities in the state, and (2) support the delivery of affordable, high-quality health services by bolstering the capacity of the State's health care safety net infrastructure. The CHRC is an independent commission, within the Maryland Department of Health (MDH), whose 11 members are appointed by the Governor. Since its inception, the CHRC has issued more than 23 Calls for Proposals (RFA) and awarded 824 grants totaling $238.1 million. The grants have supported projects in all 24 jurisdictions and collectively served more than 628,000 Marylanders.

The Maryland General Assembly created the CHRC because it recognized the need to have an independent commission focused solely 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 because health insurance coverage is not always sufficient for at-risk communities and vulnerable populations looking to receive affordable, high-quality health care services. This year's RFA will continue the Commission's commitment to promoting health equity; supporting the efficient delivery of health and social services; and promoting genuine community engagement.

Investing limited public resources efficiently and strategically and achieving post-grant project sustainability are two of the Commission's top priorities. CHRC grantees have used initial grant funds to leverage more than $44.7 million in additional federal, private, and local funding. Approximately 75% of Commission programs have been sustained at least one year or more after the initial grant funding has been expended.

The CHRC has a long history of addressing health disparities and serving vulnerable populations. In 2021, the Maryland General Assembly increased the CHRC's statutory responsibilities in recognition of the critical role the CHRC plays in promoting health equity and expanding access to care. Additional programs the CHRC was charged with implementing included the Maryland Health Equity Resource Act, emergency COVID-related grant funding for Maryland Developmental Disabilities Administration (DDA) providers, and the Maryland Consortium on Coordinated Community Supports.

The Maryland Consortium on Coordinated Community Supports was established through the Blueprint for Maryland's Future, which was enacted in 2021, and modified by SB 802 of 2022. The Consortium is made up of 25 experts from across the health, education, and social services sectors. The Consortium's mission is to develop a statewide framework to provide holistic behavioral health and wraparound services to students through community partnerships. Based on the recommendations of the Consortium, the Commission awarded 129 grants totaling over $111 million to expand behavioral health services to K-12 students statewide. More information about the Consortium can be found here.

Statewide Public Health Priorities:

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

1. **The Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, and the goals of the Statewide Integrated Health Improvement Strategy (SIHIS)**.[1] This health care access model aims to improve the overall health of the State's population while lowering costs across all payers through regional health care transformation and multi-payer alignment. The model supports delivering high-quality care, improved population health, care coordination, and health equity as well as increasing resources available for improving overall population health, support primary care, and transform health care in communities. Key SIHIS goals supported by this RFA include reducing the mean body mass index (BMI) for adult Maryland residents, improving overdose mortality, and reducing the rate of severe maternal morbidity.
2. **The Maryland Diabetes Action Plan** (January 2020). This plan highlights initiatives and strategies that broaden and strengthen collaborations among communities, organizations, businesses, local governments, and individuals that prevent and manage diabetes.[2]
3. **The Maryland Primary Care Program**. This program supports the delivery of advanced primary care throughout the state.[3]

FY 2024 RFA: Expanding Health Care Access and Promoting Health Equity

Under this RFA, the CHRC will consider projects that address both of the following strategic priorities:

1. **Advancing health equity by addressing health disparities and adverse social determinants of health (SDOH), including those affecting racial and ethnic minorities, and supporting place-based initiatives aligned with the AHEAD model's equitable approach; and**
2. **Promoting the efficient and strategic delivery of integrated health and social services through innovative and sustainable community partnerships that address the totality of medical and non-medical needs and promote genuine community engagement.**

Under this RFA, the Commission will receive projects in four areas of focus:

1. **Addressing chronic disease prevention and disease management, including diabetes and its comorbidities; hypertension, heart disease, and others;**
2. **Promoting maternal and child health;**
3. **Providing dental care to support the Maryland Medicaid Dental Benefit; and**
4. **Addressing behavioral health, including mental health, substance use disorder (SUD), and the ongoing impact of the opioid crisis.**

To avoid duplication of efforts with the Consortium grant awards, applicants seeking funding for programs that incorporate the fourth area of focus should prioritize serving individuals aged 18 and above. However, these programs will not be prohibited from serving individuals who are younger than 18 and otherwise eligible to receive the grantee's services.

The CHRC will award a limited number of grants as determined by funding availability at the time of award. Grants awarded under this RFA may last for up to three years.

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

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

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

KEY DATES TO REMEMBER

The following are the key dates and deadlines for the FY 2024 RFA	
April 4, 2024	Release of the Call for Proposals
April 17, 2024, 10:00 AM	Video Conference for applicants. Zoom link below: **Zoom link**: https://us06web.zoom.us/j/83925883786?pwd=rwA1dCNcamKJ8lwvtl2L88fAq9T1ss.1 **Meeting ID:** 839 2588 3786 / **Passcode:** 465889 Register and submit questions in advance HERE.
April 25, 2024, at 12:00 NOON	**Deadline for upload of Letters of Intent via SMARTSHEET LINK**
May 16, 2024, at 3:00 PM	**Deadline for upload of full applications and mandatory documents via SMARTSHEET LINK**
Mid-June 2024	Select number of applicants notified to make a presentation to the CHRC
Late June 2024	Applicants present to the CHRC; award decisions immediately follow presentations

GRANT ELIGIBILITY

Since its inception, the CHRC has used strategic grant funding to recognize and support the vital role public health agencies, safety net healthcare providers, and community-based organizations play in promoting equitable access to health care and social support services. In this RFA, the CHRC continues to emphasize programs that address health disparities and promote the delivery integrated health services in underserved communities.

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, provided they demonstrate that they offer their services on a **sliding scale fee schedule** or free of charge.

- 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

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

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

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

- Assist individuals in gaining access to reduced price clinical health care services;
- Offer their services on a sliding scale fee schedule or free of charge;
- Have a Memorandum of Understanding (MOU) or similar legally binding document in place prior to submission of the Letter of Intent (LOI) that demonstrates a referral relationship with a provider partner organization; and
- Offer services primarily to Maryland residents from service sites located in Maryland.

(4) Sliding Scale Fee Schedule Requirements

All applicant organizations, regardless of Community Health Resource type, 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 applicant 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. All applicants must submit their sliding fee schedules with their Letters of Intent.

STRATEGIC PRIORITIES FOR THE FY 2024 RFA

As stated above this year's Call for Proposals has two strategic priorities: 1) **Advancing health equity by addressing health disparities and adverse SDOH, including those affecting racial and ethnic minorities, and supporting place-based initiatives aligned with the AHEAD model's equitable approach;** and **2) Promoting the efficient and strategic delivery of integrated health and social services through**

innovative and sustainable community partnerships that address the totality of medical and non-medical needs, and promote genuine community engagement.

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

STRATEGIC PRIORITY 1:

Advancing health equity by addressing health disparities and adverse SDOH, including those affecting racial and ethnic minorities, and supporting place-based initiatives aligned with the AHEAD model's equitable approach.

Health equity is achieved when every individual has the fair and just opportunity live their healthiest life 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.[4] When individuals are not provided equal opportunities or resources to pursue optimal health and wellness, the result is health inequities and health disparities.

Despite decades of efforts to eliminate health disparities, preventable differences in disease incidence and severity continues to burden disadvantaged populations in Maryland. While some progress has been made in narrowing the health disparities gap, efforts to eliminate these disparities must continue if we hope to create change.[5] These disparities are unlikely to be eliminated or improved unless SDOH are addressed.

According to Healthy People 2030, conditions in the environments in which people live, work, play, worship, and age affect a wide range of health, functioning, and quality-of-life outcomes and risks.[6] The factors that shape these conditions include economic policies and systems, social norms, social policies, stigma, and political systems. Addressing SDOH is one of the most effective ways to improve health outcomes and reduce health disparities that contribute to wide health inequities. Increasing the availability of population health interventions is a widely recognized approach to reducing and addressing such health disparities.[7]

Maryland has also made improving health equity a point of emphasis under the Maryland AHEAD Model, which aims to improve health care quality and control health care costs for patients.[8] The AHEAD Model calls on state-funded health programs to address such inequities by supporting the delivery of high-quality care, improving population health and care coordination, advancing health equity, increasing the number of health care resources that are available, supporting primary care, and/or transforming the provision of health care within communities.

Understanding the intersection between SDOH, health disparities, and health outcomes is fundamental to advancing health equity. Therefore, all applicants will clearly outline how they will create policies, scalable approaches, and interventions that will address each of those factors to best meet the health and nonmedical needs of the target population they seek to serve. Some examples of acceptable approaches include the following:

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[4] https://www.cdc.gov/chronicdisease/healthequity/index.htm
[5] Maryland Chartbook of Minority Health and Minority Health Disparities Data, Third Edition (December 2012).pdf
[6] https://health.gov/healthypeople/objectives-and-data/social-determinants-health
[7] https://www.cdc.gov/minorityhealth/strategies2016/index.html
[8] https://hscrc.maryland.gov/Pages/ahead-model.aspx

a) Access to health care services, insurance coverage, and health care providers;

b) Social support systems and community engagement;

c) Affordable housing and safe neighborhoods;

d) Access to healthy food and opportunities for physical activity;

e) Educational, economic, and employment opportunities;

f) Access to transportation;

g) Safe environment (e.g., less violence or reduced exposure to toxins, or air and water pollution); and/or

h) Language and health literacy skills.

Applicants are encouraged to propose projects that address one or more SDOH. For example, some grantees have provided vouchers for transportation to health care appointments, or counseling that linked 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 a community.**

STRATEGIC PRIORITY 2:

Promoting the efficient and strategic delivery of integrated health and social services through innovative and sustainable community partnerships that address the totality of medical and non-medical needs, and promote genuine community engagement.

The concept and process models for "integrated" care have generally focused on health care delivery systems and the provision of primary and behavioral health care services within one health care system or provider location. That model has used 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 obstacles in 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 or emergency department (ED) for their essential health care needs. Approaches to integrated care continue to evolve and find more effective ways to improve the effectiveness and quality of care.

The CHRC has consistently supported innovative and sustainable community based partnerships that address the unmet medical needs and SDOH of Maryland's vulnerable, low-income, and underserved communities. This strategic priority further enhances this focus by increasing opportunities to fund projects designed to improve social factors that will contribute to better health outcomes, and increase the quality of life for residents of underserved communities over time.

In addition, the CHRC places strategic importance on multi-sectoral, public, and private partnerships that incorporate the participation of community stakeholders when planning and implementing their CHRC grant-funded projects. The CHRC encourages interventions developed and delivered through these partnerships to address the SDOH for specific population(s) by creating or expanding social, political, or economic support systems. It is critical that partnerships seek genuine community engagement when developing these interventions, as members, leaders, and providers in local communities are best positioned to identify health care and SDOH needs in their community and to prescribe the solutions that will best address those needs.

AREAS OF FOCUS (FUNDING CATEGORIES) FOR THE FY 2024 REQUEST FOR APPLICATIONS

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

The CHRC has approximately $7,000,000 to fund in this RFA. Potential funding ranges listed for each area of focus represent the total amount of funding for **all** projects in that category, rather than a per project cap (i.e., the Commission is not likely to approve a $2,000,000 budget for any one project). The overall distribution of grant funds will depend upon the proposals received and the amount of each grant awarded by the Commission. **The Commission has the discretion to make the awards in any amount; and anticipates making awards in the amount of $300,000 - $750,000 per grant in each of the categories below.**

Area of Focus 1: Addressing chronic disease prevention and disease management, including diabetes and its comorbidities; hypertension, heart disease, and others. *(The CHRC anticipates having a maximum of approximately $1,000,000 - $2,000,000 in total funds available to cover all grant awards issued under this category for up to 3 years.)*

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

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

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

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

Area of Focus 2: Promoting maternal and child health. *(The CHRC anticipates having a maximum of approximately $1,000,000 - $2,000,000 in total funds available to cover all grant awards issued under this category for up to 3 years).*

The Commission will consider projects that address maternal and child health. Interventions in this area can lead to meaningful improvements in short- and long-term health outcomes, positive educational outcomes, improved parental productivity, and reduced health care costs. Early interventions can improve an individual's health trajectory across their entire lifespan.

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

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

- linkages to care, care coordination, insurance coverage, and case management, particularly those that use the Postpartum Infant and Maternal Referral (PIMR) form and/or the Maryland Prenatal Risk Assessment (MDPRA) form;
- treatment and support for pregnant and postpartum individuals with Substance Use Disorders and/or mental health needs;
- expanded access to prenatal services in a primary care setting;
- Centering Pregnancy programs (see Centering Healthcare Institute for program requirements);[9]
- home visiting services (see the Department of Health and Human Services' Home Visiting Evidence of Effectiveness (HomVEE) review for best practices);[10]
- programs to serve the needs of mothers and children during the first twelve months after delivery (postpartum); and
- community-based doula programs.

Area of Focus 3: Providing dental care to support the Medicaid Dental Benefit. *(The CHRC anticipates having a maximum of approximately $1,000,000 - $2,000,000 in total funds available to cover all grant awards issued under this category for up to 3 years).*

The Commission will consider projects that advance oral health and build provider infrastructure and capacity for the expansion of dental care to individuals who may be covered by Medicaid.

Poor oral health can have a negative impact on an individual's overall physical health as well as their quality of life. Oral health problems have been shown to cause or exacerbate diseases in other parts of the body, and vice versa.[11] They can reduce an individual's ability to chew, swallow, and eat a balanced diet, and make it difficult to speak, smile, and interact with others. Stigma and pain associated with poor oral health can be limiting in the workforce and social settings. Twenty-nine percent of low-income adults reported that the appearance of their mouth and teeth affected their ability to interview for a job. One in four adults avoids smiling because of the condition of their mouth and teeth.[12]

The largest incidence of oral diseases occurs among marginalized groups, including racial and ethnic minorities, low-income individuals, the elderly, and others who face barriers to routine preventive services.[13] Nearly twice as many non-Hispanic Black or Mexican American adults have untreated cavities as non-Hispanic White adults.[14] Despite years of work, significant racial and ethnic disparities persist in preventative dental care for adults in the state of Maryland.[15]

While this policy change created new opportunities to expand access to oral health services, challenges remain. Like other sectors, the oral health workforce is strained and there is a shortage of both dentists and auxiliary personnel such as dental hygienists, particularly in Western Maryland and the Eastern Shore. Medicaid reimbursement rates for dental services may not be sufficient to cover the costs of providing care, and it is unclear how many dentists will accept patients newly covered by Medicaid. In addition, Medicaid will not cover the cost of dental prostheses.

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

[9] https://centeringhealthcare.org
[10] https://homvee.acf.hhs.gov
[11] https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475
[12] https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/us-oral-health-well-being.pdf
[13] https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Executive-Summary.pdf
[14] https://www.cdc.gov/oralhealth/publications/OHSR-2019-dental-carries-adults.html
[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5515044/

- Introducing or expanding integrated dental services at safety-net clinics on-site or through referrals;
- Opening new dental clinics and/or promoting mobile dental clinics in underserved areas (Note: CHRC grant funds cannot be used for major capital expenses);
- Funding dental prostheses and laboratory fees for low-income individuals;
- Expanding the number of oral health providers that accept Medicaid, including by using grant funds to help defray the cost differential between low Medicaid reimbursement rates versus the full cost of providing services, workforce development initiatives, and/or investments in technology, equipment and supplies;
- Conducting outreach and making linkages to connect eligible individuals to dental care, including through partnerships with community-based organizations, hospitals, behavioral health providers, Local Health Departments, and/or others; and
- Addressing SDOH barriers to dental care, such as transportation.

Area of Focus 4: Addressing Behavioral Health, including Mental Health and Substance Use Disorder (SUD) and the ongoing impact of the opioid crisis. *(The CHRC anticipates having a maximum of approximately $1,000,000 - $2,000,000 in total funds available to cover all grant awards issued under this category for up to 3 years).*

The Commission will consider projects that address behavioral health needs, including but not limited to mental health and substance use disorder and the ongoing impact of the opioid crisis.

To avoid duplication of efforts with the Consortium grant awards, applicants seeking funding for programs that incorporate this area of focus should prioritize serving individuals aged 18 and above. Nevertheless, these programs will not be prohibited from serving individuals who are younger than 18 and otherwise eligible to receive the grantee's services.

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

- programming designed to address racial disparities in access to care, such as culturally targeted programming;
- engagement/educational activities for communities and community leaders;
- integration of somatic and behavioral health services;
- case management and linkages to care;
- substance use disorder therapy programs;
- crisis centers;
- mobile health clinics;
- Maryland Certification of Recovery Residences (MCORR) certified recovery residences;
- the HOMEBUILDERS family preservation program;
- expanded behavioral health screenings and referrals to care;
- programs to address trauma and Adverse Childhood Experiences (ACEs);[16]
- peer recovery specialist recruitment/training programs;
- harm reduction outreach initiatives;
- drop-in services for recovery support;
- telehealth services; and
- programs that integrate SDOH interventions (e.g., housing programs).

[16] https://www.cdc.gov/violenceprevention/aces/index.html

As noted above (page 6), all applicant proposals must address *both* strategic priorities. Applicants must submit proposals for projects in ***one*** of the four areas of focus described above. There is no limit on the number of proposals that an applicant may submit, but an applicant that submits multiple proposals must clarify how the proposals represent wholly different projects.

UNDUPLICATED INDIVIDUALS SERVED

The CHRC requires that all grant-funded projects track and report the number of **unduplicated individuals served towards your service target goal.** Grantees must follow a clearly defined intake process that facilitates collection of required standardized data measures and uses a standard/universal definition of individuals being "served." Unduplicated individuals served should only represent **new** patients/participants receiving grant funded services under the RFA. The Commission's definition of "unduplicated individuals served" may be found below.

An unduplicated individual will be a participant or patient (as identified through use of a standardized intake assessment form or other reliable data collection and documentation method) that receives services, such as clinical health services or non-medical SDOH services. Grantees must have a process in place to "de-duplicate" or "un-duplicate" individuals who receive services from multiple grant-funded partners.

Delivery of **all** CHRC grant-funded services must be captured in the standardized intake or assessment form, and the data will be reflected in grantee reports to the CHRC. This includes both unduplicated individuals served and other individuals who receive grant-funded services but do not meet the definition of "unduplicated individuals served." It is incumbent on the grantee to have a process in place to deduplicate individuals served under the grant.

To be counted as an **unduplicated individual served,** the following criteria must be met:

1. The grantee and/or partnering organization must be able to provide documentation that clinical services and/or non-medical services were delivered. Maintaining an ongoing relationship is recommended but not required under this definition. If an individual is offered a referral for services to address one or more of these needs, the grantee or partner organization must have the ability to track and close the referral to document that the intended services were received for this individual to be counted as unduplicated. The process for obtaining this information from non-participating organizations or service providers should be identified.
2. The grantee or the partnering organization should develop and implement a patient intake form / process that is HIPAA-compliant and that enables the grantee (or partner organization) to maintain a list of individuals served such that they are only counted once. Grantees will never be asked to transmit protected health information, patient names, etc., to the CHRC.
3. Applicants are strongly encouraged, but not required, to empanel patients that receive grant funds services in the State's Health Information Exchange – the Chesapeake Regional Information Systems for our Patients (CRISP). CHRC staff are available to provide technical assistance after the grant is awarded.

Note: Proposals that do not include any projected "Unduplicated Individual Served" may be scored negatively based on the review criteria outlined in page 15.

SELECTION CRITERIA

Applications should include a clear description indicating how CHRC funding would not duplicate, but rather leverage current initiatives/resources, if present, 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.

The Commission will also use each of the criteria listed below 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 7-8).**
    a. Advance health equity by addressing health disparities and adverse social determinants of health (SDOH), including those affecting racial and ethnic minorities, and supporting place-based initiatives aligned with the Advancing All-Payer Health Equity Approaches and Development (AHEAD) model's equitable approach; and
    b. Promote the efficient and strategic delivery of integrated health and social services through innovative and sustainable community partnerships that address the totality of medical and non-medical needs and promote genuine community engagement.
2. **Project impact and prospects for success:**

    The proposal demonstrates that the project will lead to improved access to care for the target population, and will build capacity to deliver services that lead to improved (short-term) health outcomes, improved service experiences, more efficient use of hospital resources, and reduced health disparities.

    The project plan must clearly address the selected area of focus and present interventions that will have a high likelihood for success.

    The goals and objectives of the project must be clearly stated, measurable, and achievable. The workplan and budget are congruent and reasonable.

    The proposal includes a logic model attachment, which summarizes the project plan and links intervention strategies with expected outcomes.

    The proposal includes a Workplan project timeline representation of key project deliverables and corresponding timeframes for completion.

    The project incorporates the best available evidence-based interventions to address the priorities outlined in the proposal. In the absence of evidence-based intervention strategies, the CHRC also will consider alternative strategies (e.g., practice-based approaches) if: (1) the proposal presents a compelling logic for the use of these strategies; (2) these are innovative and closely monitored for effectiveness (e.g., use of telehealth); and (3) quantifiable data will be provided to demonstrate the impact.

    The proposal identifies other programs that may serve as a model and explains how this project complements and does not duplicate other efforts in the geographic area. The proposal clearly defines services or interventions that meet the criteria for "Unduplicated Individuals Served" according to the CHRC criteria (see above).

    Lastly, 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.

3. **Community need:** The proposal demonstrates a deep understanding of the community to be served and that the needs of the community exceed the existing health resources available or accessible to the target population. The target population is clearly identified and quantified, and the needs of this population are adequately documented through quantitative data that include demographics, rates of insurance coverage, and service utilization statistics.

   Data used to illustrate the needs of the identified population should be drawn from a reliable and known data source such as the U.S. Census Bureau, State Health Improvement Process (SHIP), Health Services Cost Review Commission (HSCRC), Chesapeake Regional Information System for our Patients (CRISP), individual hospital data, or the Maryland Health Equity data from the Maryland Office of Minority Health and Health Disparities. Applicants are strongly encouraged to consult their local Community Health Needs Assessments and Local Health Improvement Coalitions (LHICs). While not required, applicants may utilize the zip code-level public data files provided by CRISP for the CHRC Health Equity Resource Communities Call for Proposals located on the CHRC webpage (https://health.maryland.gov/mchrc/Pages/notices.aspx). Applicants are welcome to use other verifiable data sources (e.g., AHRQ SDOH database) if applicable to the project plan.[17]

4. **Community buy-in and participation of stakeholders and partners:** The application describes the organization's history of working with the target population. Community stakeholders have been engaged, played an active role in the development of the project, and will continue to be involved in the implementation and governance of the project. The application includes a list of key participants, relevant stakeholders, and partners from the community and appropriate agencies and organizations and **demonstrates genuine community engagement**.

   When applicable to the project plan and proposed interventions, proposals should identify any partnerships with community-based organizations that enjoy the trust of the target population. The proposal clarifies the roles and responsibilities of all partners. Letters of commitment from collaborators are required, should be uploaded as part of the mandatory Appendices. The letters should clearly state what they will contribute to the project and/or how they will participate in the project.

5. **Innovative, replicable, and aligned with statewide health priorities and/or legislative priorities:** 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 should illustrate alignment with statewide health priorities, including: The Advancing All-Payer Approaches and Development (AHEAD) Model, and goals of the Statewide Integrated Health Improvement Strategy (SIHIS), The Maryland Diabetes Action Plan, and The Maryland Primary Care Program (see page 4 for more information).

6. **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 quantitative and qualitative measures. The application should specify how data will be collected and reported to the CHRC, which analysis tools will be used, and what data source(s) will be utilized to document overall project impact over the short and longer term. Data and stated goals should be quantifiable (measurable), achievable, and consistent with the project plan. The application should

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

clearly specify the data that will be used to define success, including clearly defined process and health outcome measures.

Applications must contain a clear estimate of the number of "Unduplicated Individuals Served" consistent with CHRC criteria (see page 12) and an estimate for the number of grant-funded encounters. Applicants should describe processes that will be used to ensure referrals are closed and documented (e.g., if the applicant has a data-sharing or other arrangement with the service provider that allows provision of services to be confirmed). Application describes the documentation that will be used to verify receipt of services, e.g., electronic medical records (EMR), other HIPAA-compliant system, or CRISP. Where relevant, applications should document the use of an EMR system, use of the Encounter Notification Service (ENS) system in CRISP, data-sharing agreements with hospitals and/or community partners, Medicaid claims data, or other applicable data tools and resources.

Evaluation plans should be clear and consistent with the inputs, activities, and outcomes outlined in the project's logic model. The project team must have the ability to comply with the evaluation and monitoring requirements of the proposed grant project. Applicants with limited internal capability or capacity to collect and report data are permitted to include the projected costs of data collection and evaluation in their line-item budget and narrative.

7. **Project sustainability and organizational commitment:** 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. 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. The applicant's prior grant performance has been satisfactory.

   The project is likely to be sustained after the end of the 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. Applications that indicate matching fund commitments or leverage additional resources will be favorably reviewed. Letters of commitment that demonstrate financial support at the beginning, during, or after the project grant period are strongly encouraged, and these applications will be given added consideration. In-kind support will also be viewed favorably, but not as favorably as matching support provided by additional external partners, such as hospital partners, private/non-profit foundations, and the business community.

8. **Workforce Diversity:** Applicants should present an organizational assessment of racial and ethnic minority representation and cultural competency among the organization's healthcare professionals, key community service providers, and organizational leadership. When applicable, present the organizational approach to achieve racial and ethnic diversity proportional to the vulnerable communities served, to increase the quality of care and contribute to reducing health disparities.

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

Evaluation and Monitoring

As a condition of receiving grant funds, grantees must agree to participate in an ongoing CHRC evaluation of the grant program including participation in grant monitoring and technical assistance provided by CHRC. 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.

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

Use of Grant Funds

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

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

Grant funds may also be expended for a limited amount of essential equipment and minor infrastructure improvements required by the project. Grantees may subcontract with other organizations as appropriate to accomplish the goals of the project. 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 are 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 completing the Letter of Intent template and the submission of additional required documents (*e.g., Sliding fee scale, licenses, Memorandum of Understanding)* as described below, **no later than 12:00 pm (NOON) on April 25, 2024**. The submission of the Letter of Intent is **mandatory**; organizations that do not submit the Letter of Intent will not be invited to submit a full grant application. CHRC staff will review the materials submitted and determine applicants for eligibility to determine who will be invited to submit a full grant application, as described below. Applicants who have not received notice of eligibility are not permitted to submit to proceed further. **Full grant applications will be due to the Commission on May 16, 2024, 3:00 p.m.**

Applicants will be notified about the status of their grant applications in June 2024. **A select number of well-reviewed grant applications will then be considered for grant awards at the Commission's meeting in late June 2024.** 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 - due April 25, 2024.
NEW FOR THIS RFA All applicants must submit a **Letter of Intent (LOI) via Smartsheet** for the application to be considered. Letters of Intent must **completed and submitted 12:00 p.m. (noon) on April 25, 2024, via Smartsheet.**

The Letter of Intent submission must include a copy of the **Sliding scale fee schedule from** or verify that services are free, from **all entities** submitting a Letter of Intent.

Additionally, entities applying as an Outpatient Mental Health Clinic or other similar entity, a copy of the license issued by the Maryland Department of Health Behavioral Health Administration must be submitted.

Entities applying as an Access Services Community Health Resources must also submit a copy of a fully executed **Memorandum of Understanding** (MOU) or similar legally binding document in place prior to submission of the LOI template that demonstrates a referral relationship with a provider. In addition, applicants applying as an Access Services Community Health Resource must include a copy of the provider's Sliding fee scale.

STEP 2: Submission of Grant Applications - due May 16, 2024
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 submitted to the CHRC via Smartsheet no later than 3:00 p.m., on May 16, 2024.

Applicants may request an official confirmation of receipt by emailing: **jen.clatterbuck@maryland.gov** to confirm and document the uploaded submission.

The CHRC is requesting that applicants mail a "courtesy copy" of one original of the grant proposal. The original hard copy full grant application must include a signed original of each of the following:

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

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

The courtesy copy of all application documents should be **comb bound** or **spiral bound** with long edge binding. Do **not** use three ring binders. The courtesy copy of the full grant application should be sent to CHRC staff at the address below:

Jen Clatterbuck, 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) Grant Application Cover Sheet: The form should be completed using this link and contact information must be provided for the 1) chief executive officer or individual responsible for conducting the affairs of the applicant organization, and legally authorized to execute contracts on behalf of the applicant organization, 2) the project director(s) and 3) fiscal contact.

(3) Executive Summary: A one- to three-page overview of the purpose of your project summarizing the key points. The Executive Summary must include projections for the total number of "Unduplicated Individuals Served" by the project. Please see page 12 for more information on this requirement.

(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 Calibri 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 and uploaded as follows:

- Table of contents (not included in the 15-page limit)
- Executive Summary
- Background and Justification
- Organizational Capacity
- Project Plan
- Partnerships
- Evaluation
- Sustainability
- Project Budget and Budget Justification (Appendix III)
- 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) Financial audit or Form 990
(f) Résumés of key personnel
(g) Letters of commitment from collaborators or MOUs
(h) Logic model (See Appendix I)
(i) Workplan template (See Appendix II)

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 one-to-three-page summary of the proposal. The summary should clearly and concisely state:

- Applicant organization;
- Project funding category (area of focus);
- Project title;
- Project duration;
- Succinct overview of project;
- Population to be served;
- Total number of Unduplicated Individuals to be served (see page 12);
- Description of any other individuals in the community who will be engaged through grant-funded programs, but do not meet the criteria for Unduplicated Individuals Served;
- Estimate/range of total number of service encounters;
- 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/position 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?);
- 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). Specify the service area(s) where your target population lives and/or where your project will serve. Service maps, data, and other statistics on the target population may be provided as an appendix.
- ***Document the needs of this population using qualitative and quantitative data.*** Generally, what are the health needs of the target population? What are the gaps in the healthcare delivery system? What are the specific barriers that the target population faces in accessing health care services or services similar to your proposed project? Discuss the community conditions affecting the target population's health behaviors and outcomes. Statistics and data should be concisely presented.
- ***Describe the health disparity(ies) in the target population that the project will address***. Discuss the specific health disparity(ies) the project is intended to address and how the project will address the disparity(ies).
- ***Provide an estimate of the total number of "Unduplicated Individuals Served" by the grant.*** Describe your methodology for calculating this number. Describe your plan for ensuring nonduplication of individuals and the demographic information you will require participants to provide.

- ***Describe community buy-in for the project***. Discuss the process used to identify and engage community stakeholders when designing the proposed project. How were community members engaged in the development of the proposal? Will community stakeholders be consulted about or involved in project implementation?
- ***Describe any similar or complementary projects in the targeted community.*** Describe similar or complementary projects that are currently in place in the target area and discuss how the proposed project does not duplicate work already being done.
- ***Discuss the precedents for this project and the expected benefits***. Is the project based on a prior model or approach? What is the evidence that the proposed model or approach will be successful? If the project is a new or 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 state health priorities.*** The application should illustrate alignment with statewide health priorities, including: The Advancing All-Payer Approaches and Development (AHEAD) Model, and goals of the Statewide Integrated Health Improvement Strategy (SIHIS), The Maryland Diabetes Action Plan, and The Maryland Primary Care Program (see page 4 for more information).

(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 the organization's workforce diversity.*** Please provide an organizational assessment of racial and ethnic minority representation and cultural competency among the organization's health care professionals, key community service providers, and organizational leadership. If applicable, please discuss the organizational approach to achieve racial and ethnic diversity proportional to the vulnerable communities served.
- ***Describe how the organization is financed.*** Specify revenue sources and the percentage of total funding. What is the annual budget? As appendices to the proposal, provide an overall organizational budget (projected revenues and expenses) for the current fiscal year, the most recent financial audit or Form 990, its most recent filing. 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 and how the project will demonstrate genuine community engagement.
- ***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 their 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[18] or CDC guide.[19] A logic model template is provided in Appendix III.
- ***Describe the major steps or actions in carrying out the project.*** List key actions or steps in the implementation of the project. Describe the process and timeframe for reaching these benchmarks. A sample project workplan worksheet can be found in Appendix IV and can be used in preparing the project plan. The completed workplan should be included with the application.
- ***Provide an estimated range for the total number of anticipated service encounters.*** Describe your methodology for calculating this.
- ***Conduct a risk assessment*.** For example, if delivery of project services requires renovating an existing facility or constructing a new facility, potential delays in construction, the unavailability of materials and equipment, or trouble with receiving occupancy permits need to be factored into the timeframes for opening the project.
- ***Describe the documentation that will be used to verify receipt of services and, if applicable, the process for receiving this documentation.***
- ***Describe the project deliverables.*** What specific products/deliverables will be submitted to the Commission as evidence of completion of project milestones? How and when will these deliverables be produced? What are the associated quantifiable outcome metrics associated with these deliverables and overall goals of the project?
- ***Provide a timeline for accomplishing milestones and deliverables.*** Provide a Workplan listing project tasks and the time period in which these tasks will be undertaken.

(E) Partnerships

- ***Identify planned partners***. Name the community organization(s) and any partners from the business community that will play a defined role in the project.
- ***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.

[18] https://www.wkkf.org/resource-directory/resources/2004/01/logic-model-development-guide
[19] https://www.cdc.gov/dhdsp/evaluation_resources/guides/logic_model.html, https://www.cdc.gov/tb/programs/evaluation/Logic_Model.html

- ***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. ***Discuss what data will be collected and analyzed, including the data sources and planned analysis techniques***. Identify the data to be collected and analyzed. Identify data sources and the methodology that will be used for analysis. Discuss the capacity of the organization to carry out the evaluation plan, and collect and report data metrics and quantifiable outcomes.

(G) Sustainability

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

(H) Project Budget

Applicants must provide an annual budget for each year of the project. The total budget amount must reflect the specific amount requested by the applicant for CHRC funding, which may or may not be the project's total actual cost. If the grant request is a portion of the overall cost of the project, clarify this (such as the percentage that the grant request is of the overall project cost), and indicate the sources of other funding.

Applicants must use the CHRC Budget Template and Budget Narrative Forms provided in the appendices of this RFA. The CHRC Budget Template and related Budget Narrative must include the following budget line-item categories:

- *Personnel:* Include the number of full-time equivalents (FTEs) (only for W-2 employees of the grantee) by each position type, related dollars, and a brief description of the work to be performed.
- *Personnel Fringe*: The Commission advises that the fringe rate be calculated at no more than 25% of total personnel costs (only for W-2 employees of the grantee). 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:* Relates to grant activities but not employee training costs.
- *Staff Trainings/Development:* Includes travel costs related to employee training.
- *Contractual:* Any contract of more than $5,000 should be listed on the Budget Template and explained in the Budget Narrative. This should not include expenses for W-2 employees of the grantee.
- *Other Expenses:* Other miscellaneous or project expenses that do not fit into the other expense categories should be listed on the Budget Template and explained in the Budget Narrative.

- *Indirect Costs:* Indirect costs may not exceed 10% of direct project costs; however, the CHRC will consider permitting indirect cost rates above 10% on a case-by-case basis, if the applicant can demonstrate a higher rate has been approved by the federal government.

Instructions for Submitting Application Cover sheet and required documents
As noted on page 17 of this RFA, the application process for the FY 2024 RFA differs from previous years. Applicants requesting CHRC funding under this RFA should submit the Application Cover Sheet by clicking *HERE* (https://app.smartsheet.com/b/form/f341074cf7f6442db0de8914676e6338).

Once completed, you will be asked to upload several **required documents**. The file structures for these required documents are as follows:

- File 1: Signed transmittal letter
- File 2: Executive Summary
- File 3: Project Proposal (One file containing: Table of Contents, Background/Justification, Organizational Capacity, Project Plan, Partnerships, Evaluation and Sustainability Plan)
- File 4: Budget Template and Budget Narrative
- File 5: Grant Obligations and Assurances
- File 6: Mandatory Appendices (One file containing: IRS Determination letter (if applicable), List of Board of Directors, Organizational Chart, Letters of Commitment and MOUs, Resumes of project personnel)
- File 7: Logic Model and Workplan
- File 8: Optional Appendices (One file containing: Service Maps and other statistical data on the target population, Organization annual report)
- File 9: Financial Audit (or Organization fiscal data) or Form 990
- File 10: IRS Form W9

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 **April 17, 2024, at 10:00 am,** is optional, though encouraged, and will last approximately 90 minutes. Applicants may register and submit questions in advance by clicking here.

The Zoom link for the conference call is:
Meeting Link : https://us06web.zoom.us/j/83925883786?pwd=rwA1dCNcamKJ8lwvtl2L88fAq9T1ss.1
Meeting ID: 839 2588 3786 / **Passcode**: 465889 / **Dial-in #:** 1-301-715-8592

Questions from Applicants: Applicants are encouraged to submit written questions about the grants program in advance of the meeting, please click **here** to register and submit your questions. Commission staff will post the recording of the April 16, 2024, meeting *here*. If you have additional questions after the meeting, please email questions to Jen Clatterbuck at jen.clatterbuck@maryland.gov. Responses will be provided on a timely basis by CHRC staff.

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

Staff members are:

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

Bob Lally, Chief Financial Officer
E-mail: bob.lally@maryland.gov

Nellie Washington, HERC Director
E-Mail: nellie.washington@maryland.gov

Jen Clatterbuck, CHRC Administrator
E-mail: jen.clatterbuck@maryland.gov

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

Amy Yakovlev, Deputy Chief Financial Officer
E-mail: amy.yakovlev@maryland.gov

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

Emily Kilmon, Management Associate
E-mail: emily.kilmon@maryland.gov

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

Jonathan Seeman, Financial Advisor
E-mail: jonathan.seeman@maryland.gov

Nick Carpenter, Administrative Officer
E-mail: nick.carpenter@maryland.gov

Julie Wagner, Communications
E-mail: julie.wagner1@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

Edward J. Kasemeyer, Chair

Sadiya Muqueeth, Ph.D., Vice Chair

Scott T. Gibson

Flor D. Giusti

Maria J. Hankerson, Ph.D.

David Lehr

Karen-Ann Lichtenstein

Roberta “Robbie” Loker

Carol Masden, LCSW-C

Destiny-Simone Ramjohn, Ph.D.

TraShawn Thornton-Davis, MD

Important Links & Dates to Remember

1. **Frequently Asked Questions Call – April 17, 2024, 10:00 AM**
   - Link: https://us06web.zoom.us/j/83925883786?pwd=rwA1dCNcamKJ8lwvtl2L88fAq9T1ss.1
   - Meeting ID: 839 2588 3786 / Passcode: 465889 / Dial-in: 301-715-8592
   - CHRC FY 2024 RFA Question Submission Portal (click)
   - https://app.smartsheet.com/b/form/bc3ec240a35c4a478f622db916f0240c

2. **Letter of Intent and required documents** must be uploaded by **12:00 pm Thursday, April 25, 2024**. Failure to comply will result in the Letter of Intent not being considered.
   - FY 2024 Letter of Intent Template (click)
   - https://app.smartsheet.com/b/form/1ee660a080e3483395eefcff47b9def4

3. The **application cover sheet and required documents** must be uploaded **by 3:00 pm Thursday, May 16, 2024**. Failure to comply will result in the proposal not being considered.
   - Application Cover sheet & Proposal Submission (click)
   - https://app.smartsheet.com/b/form/f341074cf7f6442db0de8914676e6338

CHRC FY 2024 Request for Applications Form links

- Logic Model Template
- Workplan Template
- Grant Obligations & Assurances
- Federal Form W9
- Budget Template
- Budget Narrative Template

CHRC FY 2024 Request for Application Additional Reference Documents

- CRISP SDOH Data File
- CRISP Public Use Health Data File
- Information regarding CRISP Public Use Health & SDOH File

APPENDIX I: Logic Model Form

MCHRC
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

LOGIC MODEL – FY 2024 CALL FOR PROPOSALS				
Organization name:				
Program name:				
Amount requested:				
Area of focus:				
INPUTS►	**ACTIVITIES►**	**OUTPUTS►**	**SHORT- & LONG-TERM OUTCOMES►**	**IMPACT**
To accomplish the activities listed we will need the following: (e.g., staff, equipment, partner organization participation)	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 measurable changes in 1-3 years:	We expect that if accomplished these activities will lead to the following changes in 5 years:

APPENDIX II: Workplan Template

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION - RFP - A FY 2024 Work Plan Template

Organization Name:

Project Name:

Project Purpose: *Enter the overall goal of your project - the overall goal needs to align with the priorities of the Call for Proposals. Specify area(s) of focus (e.g., Diabetes management & prevention, food security) here.*

MCHRC
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

1. **GOAL: A measurable, expected project outcome (i.e., what the project seeks to achieve in each operational area of the project plan).**
2. **OBJECTIVE: What needs to be achieved to attain the goal.**
3. **KEY ACTIVITIES/ACTION STEPS: These are the measurable ways the project will achieve the corresponding obejctive(s). NOTE: CHRC recommends using the S.M.A.R.T. tool to formulate Goals and Objectives.**
4. **EXPECTED OUTCOME (TARGET): These are the measures of what is expected to occur to demonstrate that the objective is achieved (i.e., your measure of success).**
5. **DATA EVALUATION AND MEASUREMENT: How will progress towards achieving the goal be measured?**
6. **DATA SOURCE(S) AND BASELINE MEASURES: What data and/or other information will demonstrate that the objective and goal are achieved?**

(1) GOAL

Objective(s)	Key Activities/Action Steps	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	Person/Group Responsible	Timetable for Achieving the Objective
List objective(s), one per line, that when achieved will attain the goal.	*Define all actions/steps necessary to achieve the objective. List each activity/action step on its own row.*	*Define an outcome for each activity/action step*	*Identify the process and measure(s) to be used to determine if the outcome has been achieved.*	*Define where the data will come and what baseline data will be used to measure change.*	*Identify the person(s) and/or organization(s) primarily responsible*	*When will the activity/action step be completed?*

(2) GOAL

Objective(s)	Key Activities/Action Steps	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	Person/Group Responsible	Timetable for Achieving the Objective
List objective(s), one per line, that when achieved will attain the goal.	*Define all actions/steps necessary to achieve the objective. List each activity/action step on its own row.*	*Define an outcome for each activity/action step*	*Identify the process and measure(s) to be used to determine if the outcome has been achieved.*	*Define where the data will come and what baseline data will be used to measure change.*	*Identify the person(s) and/or organization(s) primarily responsible*	*When will the activity/action step be completed?*

APPENDIX III: Budget Form Template

Budget Form Template - FY 2024 Call for Proposals				
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION				
Organization Name:	Project Name:			
Revenues	**Budget Revenue**	**% of Total Project Budget**		
CHRC Grant Request		0%		
Patient/Program Revenues/Income		0%		
Organization Match		0%		
Other Grant/Funding Support		0%		
Total Project Cost	**$0**	**0%**		
Line Item Budget for CHRC Grant Request (add rows if needed)	**Year 1 Budget Request**	**Year 2 Budget Request**	**Year 3 Budget Request**	**Overall Budget Request**
Personnel Salary (enter the requested information for each FTE that is a **W-2 employee of the project**); do not provide the salaries as a single, total number)				
Number of FTEs - Position Type				$0
Number of FTEs - Position Type				$0
Number of FTEs - Position Type				$0
Personnel Subtotal	**$0**	**$0**	**$0**	**$0**
Personnel Fringe (no more than 25% of Personnel costs for only W-2 employees of the project listed in personnel salary section above)				**$0**
Personnel Fringe % of Overall Personnel Salary	0.0%	0.0%	0.0%	0.0%
Total Personnel Expenses (Salary & Fringe)	**$0**	**$0**	**$0**	**$0**
Equipment / Furniture				**$0**
Supplies				**$0**
Travel / Mileage / Parking (relates to grant activities but not employee training costs)				**$0**
Staff Training / Development (includes travel costs related to employee training)				**$0**
Contractual (>$5k itemize below with details in budget justification; excludes W-2 emloyees of applicant/project)				
a. Professional/other services by vendor/contractor (1)				$0
b. Professional/other services by vendor/contractor (2)				$0
c. Professional/other services by vendor/contractor (3)				$0
d. Advertising				$0
e. Lease or rental costs (not incl. under "Equipment/furniture", "Supplies", "Other Expenses" or "Indirect Costs")				$0
Total Contractual Expenses	**$0**	**$0**	**$0**	**$0**
Other Expenses (MUST detail below)				
a. Other				$0
b. Other				$0
c. Other				$0
Total Other Expenses	**$0**	**$0**	**$0**	**$0**
Indirect Costs: no more than 10% of all direct costs excluding indirect (>10% - refer to Budget Form instructions and RFP)	**$0**	**$0**	**$0**	**$0**
Indirect % of All Costs Excluding Indirect	0.0%	0.0%	0.0%	0.0%
Overall Total	**$0**	**$0**	**$0**	**$0**
Percent of Organization's Total Budget that this Project Budget Represents				**0%**