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

Promoting Community Health Resources:

Expanding Health Care Access and Advancing Health Equity

FY 2023 Call for Proposals

October 25, 2022

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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. Since its inception, the CHRC has issued more than 20 Calls for Proposals and awarded 668 grants totaling $117.5 million, supporting projects in all 24 jurisdictions, and serving more than 500,00 Marylanders.

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 (see page 10 for examples of SDOH), and promote integrated population health interventions through sustainable community partnerships.

The CHRC has worked to help Maryland safety net providers navigate the challenges of the COVID-19 pandemic and support their ability to provide vital services to vulnerable residents. The CHRC recognizes the continuing need to support Maryland's safety net providers and to address persistent, ongoing health disparities exacerbated by the pandemic. Accordingly, this year's Call for Proposals places a priority on projects that support the needs of groups disproportionately impacted by the COVID-19 pandemic, including racial and ethnic minorities, as well as projects that utilize approaches that address pandemic-related service delivery challenges.

Investing limited public resources efficiently and strategically and achieving post-grant project sustainability are top priorities of the Commission. CHRC grantees have used initial grant funds to leverage more than $31 million in **additional** federal, private/non-profit, and local funding. CHRC-funded projects have achieved a demonstrable return on investment (ROI) by reducing avoidable hospital and 911 system utilization.

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

The Maryland Consortium on Coordinated Community Supports was established through the Blueprint for Maryland's Future legislation, which was enacted in 2021, and modified by SB 802 of 2022. The Consortium is made up of 24 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.

The CHRC will implement a grant program based on the Consortium's recommendations. The first Call for Proposals for the Consortium program is expected to be released during the spring of calendar year 2023. More information about the Consortium can be found at: https://health.maryland.gov/mchrc/Pages/Maryland-Consortium-on-Consolidated-Community-Supports.aspx?slrid=598e53a0-28a7-5022-088c-3b58763c2f50

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."[1] 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 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

[1] https://www.who.int/phi/2016_05health_innovation-brochure.pdf

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 A1c) 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).[2] 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.[3]

New to this year's RFP is a requirement to clearly project the number of "**Unduplicated Individuals Served**" by the applicant's program, according to criteria described on pages 21-22. Applicants **may** utilize the Chesapeake Regional Information System for our Patients (CRISP) to meet CHRC requirements for "Unduplicated Individuals Served" and to analyze reduced hospitalizations for program participants. CRISP utilization is encouraged but **not** required. Applicants who cannot project and count the number of "**Unduplicated Individuals Served**" by their programs will **not** be considered for grant funding under this year's Call for Proposals.

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 encourages community-based public/private partnership approaches. The CHRC will be interested in funding projects that involve the business community as co-funders or as partners in driving program utilization.

Statewide Public Health Priorities:

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 goals of the Statewide Integrated Health Improvement Strategy (SIHIS)**.[4] Key SIHIS goals supported by this Call for Proposals 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 Primary Care Program**, which supports the delivery of advanced primary care throughout the state.[5]
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.[6]

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

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

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

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

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

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.[7]

FY 2023 Call for Proposals: Expanding Health Care Access and Advancing Health Equity

Under this Call for Proposals, the Commission will receive projects that address ***both*** of the following strategic priorities:

(1) Advancing health equity by addressing health disparities and adverse Social Determinants of Health (SDOH), with a particular emphasis on groups disproportionately impacted by the COVID-19 pandemic, including racial and ethnic minorities; and

(2) Promoting the efficient and strategic delivery of integrated health and social services through innovative, sustainable community partnerships that address the totality of medical and non-medical needs, with emphasis on approaches that address COVID-19 pandemic-related service delivery challenges.

Under this Call for Proposals, 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) Addressing Behavioral Health, including Mental Health and Substance Use Disorder (SUD) and the ongoing impact of the opioid crisis; and

(4) Providing dental care to support the launch of the new Maryland Medicaid Dental Benefit.

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 (see page 10 for examples of examples of SDOH).

The CHRC will consider up to three-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.

[7] https://health.maryland.gov/mhhd/MOTA/Pages/Index.aspx

KEY DATES TO REMEMBER

The following are the key dates and deadlines for the FY 2023 Call for Proposals	
October 24, 2022	Release of the Call for Proposals
November 3 at 9:30 a.m.	Conference call for applicants. Zoom Info: https://us06web.zoom.us/j/82674133771?pwd=MnlYcmdTZ2drNEJHL1BhaWFmSE5VQT09 **Dial-in #: 1-301-715-8592** **Meeting ID:** 826 7413 3771/ **Passcode:** 786331
November 17 at 12:00 NOON	**Deadline for receipt of Letters of Intent**
December 19 at 12:00 NOON	**Deadline for receipt of full applications**
February 2023	Select number of applicants notified to present to the CHRC
March 2023	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, 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

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 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 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.

To be considered for funding for the FY 2023 RFP, all applicants must also provide an estimate for the total number of "Unduplicated Individuals Served" by their proposed program. **Applications that do not provide an estimate for "Unduplicated Individuals Served" according to the criteria on pages 21-22 will not be considered for funding under this year's Call for Proposals.**

STRATEGIC PRIORITIES FOR THE FY 2023 CALL FOR PROPOSALS

This year's Call for Proposals has two strategic priorities: (1) Advancing health equity by addressing health disparities and adverse Social Determinants of Health (SDOH), with a particular emphasis on groups disproportionately impacted by the COVID-19 pandemic, including racial and ethnic minorities; and (2) Promoting the efficient and strategic delivery of integrated health and social services through innovative, sustainable community partnerships that address the totality of medical and non-medical needs, with emphasis on approaches that address COVID-19 pandemic-related service delivery challenges.

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 Social Determinants of Health (SDOH), with a particular emphasis on groups disproportionately impacted by the COVID-19 pandemic, including racial and ethnic minorities

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.[8] 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.[9] 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.[10] Geography is also significant. According to the CDC, residents of rural America are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their counterparts in urban areas.[11]

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

Building trust with marginalized communities is essential. Applicants must discuss their record of working with the targeted communities and are encouraged to partner with community-based organizations that are trusted by community members. Applicants are encouraged to consider a wide range of layered interventions and strategies to reach out and begin to engage marginalized individuals who may lack trust in health care systems. Such outreach activities may be funded through this Call for Proposals, so long as overall programs ultimately result in some number of "Unduplicated Individuals Served." (See pages 21-22.)

Despite decades of efforts to eliminate health disparities in Maryland, preventable differences in disease burden among disadvantaged populations persist. While some progress has been made in narrowing the health disparities gap, efforts to eliminate these disparities must continue.[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]

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[8] https://www.cdc.gov/chronicdisease/healthequity/index.htm
[9] https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities
[10] https://www.cdc.gov/chronicdisease/resources/publications/factsheets/reach.htm
[11] https://www.cdc.gov/ruralhealth/about.html
[12] https://health.maryland.gov/mhhd/Documents/2018%20Minority%20Health%20and%20Health%20Disparities%20Annual%20Report%20.pdf
[13] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Understanding the intersection between the social determinants and health outcomes is fundamental to advancing health equity. SDOH include, but are not limited to, the following:

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

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 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 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;
- 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; and
- projects that target reductions in health risk behaviors such as tobacco use.

Note: Some interventions listed above do not meet the criteria for "services" for the purpose of estimating the number of "Unduplicated Individuals Served" through the grant. Applicants should include a clear description and estimates for both "Unduplicated Individuals Served" and any *other* individuals who would be engaged through other grant-funded activities that do not meet the criteria for "Unduplicated Individuals Served." Activities that support community health are eligible for grant funding – even if the activities themselves do not meet the criteria for "Unduplicated Individuals Served" – so

[14] https://www.cdc.gov/minorityhealth/strategies2016/index.html

long as the overall program will result in some number of "Unduplicated Individuals Served." (See pages 21-22.)

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 Social Determinants of Health 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 2021.[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 is more than twice the rate for White Marylanders.[16]

Other areas for applicants to consider under this strategic priority are **workforce diversity, health literacy,** and **cultural and linguistic competency**. 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," 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 competency of the workforce and organizational leadership, support improved health literacy and understanding to better meets the needs of these communities, and help to reduce health disparities.

Expanding health literacy and addressing cultural and linguistic competence are important considerations in addressing health disparities and improving the quality of care. The CHRC encourages applicants to consider strategies and interventions that address these areas and include 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 health and social services through innovative, sustainable community partnerships that address the totality of medical and non-medical needs, with emphasis on approaches that address COVID-19 pandemic-related service delivery challenges.

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

[15] https://www.marylandhbe.com/news-resources/reports-data/
[16] https://www.marylandhbe.com/wp-content/docs/COVID_Uninsured_Analysis_Dashboard_April2021.html
[17] https://unequaltreatment.com/

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 address the social factors that will contribute to better health outcomes and increase the quality of life for residents of underserved communities. The current Call for Proposals recognizes that the COVID-19 pandemic has necessitated new means of providing health care and other services, including telehealth, remote patient monitoring, socially distanced programs, countermeasures to reduce transmission, etc. The CHRC encourages applicants to consider additional innovative strategies that address the ongoing impact of COVID-19 on service delivery especially for populations disproportionately affected by the pandemic.

AREAS OF FOCUS (FUNDING CATEGORIES) FOR THE FY 2023 CALL FOR PROPOSALS

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 three listed below.

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.

1. **AREA 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 $1,500,000 - $2,000,000 in total funds available to cover all grant awards issued under this category for up to 3 years.)

The CDC estimates that six in 10 Americans live with at least one chronic disease such as diabetes, heart disease and stroke, and four in 10 have two or more chronic diseases.[18] Chronic diseases are the leading causes of death and disability in the United States and result in significant health and economic costs.[19] The burden of chronic disease and the preventable differences in health outcomes are significantly greater for racial and ethnic minorities compared to non-Hispanic Whites.[20] Individuals with certain chronic diseases may be at heightened risk for severe COVID-19.

Chronic diseases, including heart disease, cancer, stroke, and diabetes, are the leading causes of illness, disability, and death in the United States, and are the leading drivers in annual health care costs.[21] Chronic diseases continue to be the leading causes of death and disability in Maryland, accounting for seven of every 10 deaths.[22]

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.[23]

[18] https://www.cdc.gov/chronicdisease/
[19] https://www.cdc.gov/chronicdisease/about/costs/index.htm
[20] https://www.cdc.gov/mmwr/pdf/other/su6203.pdf
[21] https://www.cdc.gov/chronicdisease/programs-impact/pop/index.htm
[22] https://www.cdc.gov/nchs/pressroom/states/maryland/maryland.htm
[23] https://www.cdc.gov/chronicdisease/about/index.htm

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 screenings, check-ups, monitoring and coordinating treatment, patient self-management education, and shared decision making.[24] When the effects of chronic diseases are prevented or minimized, this can improve the quality of life while 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.

Diabetes

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 37 million Americans have diabetes and one in four adults with diabetes don't know they have it. It is estimated that 96 million Americans have prediabetes, a condition that often leads to diabetes, and 85% of those affected are unaware of the condition.[25] In 2019, it was estimated that 521,000 or 11.1% of Maryland adults have diabetes[26] and another 1.6 million (34%) have prediabetes.[27] Diabetes is the sixth leading cause of death in Maryland,[28] and the fifth leading cause of death among African American/Black Marylanders.[29] The prevalence of diabetes in Maryland among the non-Hispanic African American/Black (13.3%) population is significantly higher than the rate for the non-Hispanic White population (8.0%).[30] The increasing prevalence of diabetes reflects significant racial, ethnic, economic, educational and geographic disparities.[31]

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.[32,33] To this end, the Maryland Department of Health released the Maryland Diabetes Action Plan in January 2020, which 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.[34] The Plan is designed to help the State and its partners achieve the Healthy Maryland goal of reducing diabetes mortality and 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 categories and corresponding goals and objectives (listed below). The Plan includes a number of action steps, and below are selected intervention strategies by various stakeholders that could be supported by CHRC grant funding

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[24] https://www.cdc.gov/learnmorefeelbetter/programs/general.htm
[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://phpa.health.maryland.gov/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf
[28] https://health.maryland.gov/vsa/Pages/reports.aspx
[29] https://phpa.health.maryland.gov/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf
[30] https://health.maryland.gov/phpa/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf
[31] https://health.maryland.gov/phpa/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf
[32] https://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp/
[33] https://www.niddk.nih.gov/about-niddk/strategic-plans-reports/diabetes-in-america-3rd-edition
[34] https://phpa.health.maryland.gov/CCDPC/Pages/diabetes-action-plan.aspx

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

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
    b. Promoting healthy lifestyles planning by pediatricians and 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 providing social and case-management support
2. Improving the availability of healthy 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
3. Collaborating with community partners to promote increased physical activity and decreased sedentary activity:
    a. Expanding the number of physical activity and healthy eating offerings at parks and recreation centers, places of worship, community and civic centers, and senior centers
    b. Leading a community group to draft a community walking plan or to assess the community for walkability

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 who receive their postnatal follow-up glucose test within 6-12 weeks
    b. Making referrals 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:
    a. Ensuring that patients are referred for annual vision, oral and podiatry services, and have regular A1c/blood glucose monitoring;
    b. Developing 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:

a. Providing 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 lives, and diabetes is more prevalent in households that are more food insecure.[35] 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. In 2020, the prevalence of household-level food insecurity (low and very low food security) nationally was estimated at 10.5% of households (or 13.8 million households); the prevalence rate was approximately 9.2% for Maryland during this period.[36] 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 2017-2020, shows 41.9% of adults and 19.7% of children ages 2-19 years were considered obese.[37] The CDC estimates that in 2020, the prevalence of obesity among adults in Maryland was 31%.[38] 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.[39]

Based on data from 2017, in Maryland, 30.8% of the population is obese and an additional 34.6% of the population is overweight. Five-year trend data shows that the proportion of Marylanders who are obese is increasing, and the proportion of Marylanders who are overweight has been relatively stable. In addition, the healthy weight population in Maryland is decreasing from 35.1% in 2013 to 32.7% in 2017.[40]

Heart Disease and Hypertension

Heart disease was the leading cause of death in Maryland in 2020.[41] In 2019, an estimated 35% of Marylanders had hypertension and 33% had high cholesterol.[42] Black non-Hispanic Marylanders had more than twice as many hypertension-related emergency department visits as White non-Hispanic Marylanders in 2017.[43] Smoking, inactivity, and poor diet increase the risk of heart disease.

Applicants may develop projects that address heart disease prevention, management, or both. Many of the healthy lifestyle interventions listed above for diabetes are also recommended to address heart disease. Other interventions may include but are not limited to the following:

- health education and screening programs, particularly those that utilize Community Health Workers (CHWs);
- mobile health clinics;
- programs that screen individuals for high blood pressure and cholesterol in trusted, non-traditional venues such as barbershops, beauty salons, or churches, and make referrals to primary care providers and specialists;

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[35] 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

[36] https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/

[37] https://stacks.cdc.gov/view/cdc/106273

[38] https://www.cdc.gov/obesity/data/index.html

[39] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4584410/

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

[41] https://health.maryland.gov/vsa/Pages/reports.aspx

[42] https://health.maryland.gov/phpa/ccdpc/Reports/Documents/2019%20MD%20BRFSS%20-%20Chronic%20Disease%20Risk%20Behaviors%20and%20Outcomes.pdf

[43] https://health.maryland.gov/mhhd/

- self management blood pressure programs (SMBP) that allow patients to monitor their blood pressure in a familiar setting such as their home, and regularly provide the readings to their providers; this could include the use of interactive digital devices that allow bidirectional communication directly with the providers; and
- programs to encourage medication adherence, including: culturally sensitive patient education; improving access to insurance coverage and pharmacies; utilizing dosing reminders via text message and/or electronic devices that monitor dosing; and simplified treatment regimens.[44, 45]

Applicants may refer to ***The Guide to Community Preventive Services*** for an assessment of evidence-based interventions.[46]

Other considerations for addressing chronic disease

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.

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

2. <u>AREA 2</u>: Promoting maternal and child health.

(The CHRC anticipates having a maximum of approximately $1,500,000 - $2,000,000 in total funds available to cover all grant awards issued under this category for up to 3 years).

As part of this year's Call for Proposals, 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.

After decades of decline, maternal deaths nationally have risen from a historic low of 6.6 maternal deaths per 100,000 live births in 1987 to 23.8 maternal deaths per 100,000 live births in 2020.[47] Maryland's overall maternal mortality rate (MMR) in 2017 was slightly better than the national average, at 24.8 maternal deaths per 100,000 live births. However, the MMR for African American/Black Marylanders is four times the rate of White Marylanders (44.7 maternal

[44] https://millionhearts.hhs.gov/data-reports/factsheets/adherence.html
[45] https://www.ahajournals.org/doi/10.1161/HYP.0000000000000203
[46] https://www.thecommunityguide.org
[47] https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm#Table

deaths vs. 11.3 per 100,000 live births). Comparing the time periods 2008-2012 and 2013-2017, MMR for White Marylanders decreased 35.4% while MMR increased 11.9% for Black Marylanders.[48]

Disparities also exist in the incidence of Severe Maternal Morbidity (SMM), defined as unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. African American/Black Marylanders experience nearly twice the rate of SMM as White Marylanders. The rate of SMM for Hispanic Marylanders and Asian/Pacific Islanders is nearly 1.4 times the rate of White Marylanders.[49]

Infant mortality and low birth weights also exhibit racial disparities. Maryland's overall infant mortality rate in 2020 was 5.7 infant deaths per 1,000 live births, while the rate for African American/Black Marylanders was 9.9 infant deaths per 1,000 live births. The average infant mortality rate in Maryland has fallen from an average of 6.1 per 1,000 live births during the years 2011-2015 to an average of 6.1 per 1,000 live births during 2016-2020. However, the average infant mortality rate increased by 2% over the two periods among Hispanic infants.[50] In 2019, 8.7% of Maryland babies were born with low birth weight (defined as less than 2,500 grams or 5 lbs. 8 oz. or less). The rate of low birth weight for White babies was 6.65% versus 12.5% for African American/Black babies.[51]

In 2020, the rate of preterm births among African American/Black women in the U.S. was nearly 50% higher than the rate of preterm birth among White or Hispanic women.[52] Premature birth can lead to a range of negative long-term outcomes, including cerebral palsy, intellectual disabilities, chronic lung disease, blindness, and hearing loss. A 2007 study by the Institute of Medicine found that the cost associated with premature birth in the United States was $26.2 billion annually, including: additional labor and delivery costs, additional medical and health care costs for the baby, early intervention services for children with disabilities and developmental delays, special education services, and lost productivity.[53]

Access to pre-pregnancy care and prenatal care beginning during the first or second trimester can improve outcomes for mothers and infants. Adequate prenatal care has been found to reduce the likelihood of infant mortality fivefold.[54] Adequate prenatal care also has been found to reduce the likelihood of preterm birth[55] and SMM.[56] Group prenatal care has been demonstrated to be even more effective than one-on-one care. One study found that group prenatal care resulted in a 37% lower risk of preterm birth and a 38% lower risk of having a low birth weight baby compared with traditional one-on-one care.[57]

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

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[48] https://phpa.health.maryland.gov/mch/Documents/Health-General%20Article,%20%C2%A713-1207,%20Annotated%20Code%20of%20Maryland%20-%202019%20Annual%20Report%20%E2%80%93%20Maryland%20Maternal%20Mortality%20Review.pdf

[49] https://hscrc.maryland.gov/Documents/Modernization/SIHIS%20Proposal%20-%20CMMI%20Submission%2012142020.pdf

[50] https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Infant%20Mortality/Infant_Mortality_Report_2020.pdf

[51] https://health.maryland.gov/mchrc/Documents/Pathways%20to%20Health%20Equity%20Docs/Pathways%20Public%20Use%20Health%20Data%20filev3%20-%20Updated%20November%203.xlsx

[52] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm

[53] https://www.marchofdimes.org/mission/the-economic-and-societal-costs.aspx

[54] https://www.ncbi.nlm.nih.gov/books/NBK235274/

[55] https://www.ajog.org/article/S0002-9378(02)00404-0/fulltext

[56] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/

[57] https://www.liebertpub.com/doi/10.1089/jwh.2017.6817

- 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 perinatal mood disorders;
- expanded access to prenatal services in a primary care setting;
- coordination of care for those with perinatal mental healthcare needs;
- Centering Pregnancy programs (see Centering Healthcare Institute for program requirements);[58]
- home visiting services (see the Department of Health and Human Services' Home Visiting Evidence of Effectiveness (HomVEE) review for best practices);[59]
- programs to serve the needs of mothers and children during the first twelve months after delivery (postpartum); and
- community-based doula programs.

Special consideration will be given to proposals from jurisdictions facing the most acute maternal and child health disparities, including: 1. Baltimore City, 2. Montgomery County, 3. Howard County, 4. Washington County, 5. Carroll County, 6. Charles County, 7. Baltimore County, 8. Prince George's County, 9. Anne Arundel County, 10. Frederick County, 11. Harford County, and 12. Wicomico County. However, these are not the only jurisdictions facing disparities.

3. <u>AREA 3</u>: 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 $1,500,000 - $2,000,000 in total funds available to cover all grant awards issued under this category for up to 3 years).

Behavioral health needs and the opioid crisis have been exacerbated by the COVID-19 pandemic. Suicide attempts are increasing nationally and in Maryland. Social isolation, trauma, multiple stressors, and other factors related to the pandemic have led to increases in depression and anxiety among adults and children.[60]

The number of drug- and alcohol-related intoxication deaths occurring in Maryland rose by nearly 18% in 2020, from 2,379 in 2019 to 2,799 in 2020. Ninety percent of all intoxication deaths in Maryland in 2020 were opioid-related. Opioid overdose fatality rates, after a slight 1.7% decline in 2019, increased by 19.6% between 2019-2020. Fentanyl remains the largest cause of opioid-related deaths, and from 2019 to 2020, the number of fentanyl-related deaths increased by 21.5%, from 1,927 to 2,342.[61]

Racial and ethnic disparities in this area are significant and worsening. According to a report issued by the Maryland Department of Health, between 2017-2020, overdose mortality rose by 64.5% for African American/Black Marylanders and by 15.3% for White Marylanders.[62] In 2019, the rate of mental health emergency department visits per 1,000 was 67.9 for African American/Black Marylanders and 57.1 for White Marylanders. The rate of substance use

[58] https://centeringhealthcare.org
[59] https://homvee.acf.hhs.gov
[60] https://www.thelancet.com/journals/lanam/article/PIIS2667-193X(21)00087-9/fulltext#seccesectitle0019
[61] https://health.maryland.gov/vsa/Documents/Overdose/Annual_2020_Drug_Intox_Report.pdf
[62] https://beforeitstoolate.maryland.gov/wp-content/uploads/sites/34/2022/07/2021-DORM-Annual-Report-Final.pdf

emergency department visits per 1,000 was 68.7 for Black Marylanders and 37.6 for White Marylanders.[63] Specific interventions are sought to address these issues.

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;
- 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);[64]
- 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).

Special consideration will be given to programs that address overdose among the African American/Black communities in four target jurisdictions identified by the Maryland Racial Disparities in Overdose Taskforce: Baltimore City, Baltimore County, Prince George's County, and Anne Arundel County.

4. <u>AREA 4</u>: Providing dental care to support the launch of the new Medicaid Dental Benefit.

(The CHRC anticipates having a maximum of approximately $1,500,000 - $2,000,000 in total funds available to cover all grant awards issued under this category for up to 3 years).

As part of this year's Call for Proposals, the Commission will consider projects that advance oral health and build provider infrastructure and capacity for the expansion of dental care to individuals who will soon be covered by Medicaid.

Poor oral health can have can 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.[65] 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.[66]

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[63] https://health.maryland.gov/mchrc/Documents/Pathways%20to%20Health%20Equity%20Docs/Pathways%20Public%20Use%20Health%20Data%20filev3%20-%20Updated%20November%203.xlsx

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

[65] https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475

[66] https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/us-oral-health-well-being.pdf

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.[67] Nearly twice as many non-Hispanic Black or Mexican American adults have untreated cavities as non-Hispanic White adults.[68] Despite years of work, significant racial and ethnic disparities persist in preventative dental care for adults in the state of Maryland.[69] Dental office closures and delays in seeking routine care related to the COVID-19 pandemic have worsened overall oral health conditions nationally and in Maryland.

Through preventative and restorative dentistry, unnecessary ED utilization for dental problems can be reduced, leading to improved health outcomes and cost savings. According to the NIH, there were 2.4 million ED visits for nontraumatic dental conditions nationally in 2014, accounting for more than $1.6 billion in charges, with Medicaid as the primary payor. Racial and ethnic minorities exhibit higher rates of ED utilization for dental conditions than Whites.[70] Moreover, dental care received through ED visits tends to be largely palliative, including through prescribed opioids, without addressing underlying conditions.[71]

Cost is the primary reason individuals do not receive regular dental care.[72] A national survey by CareQuest Institute found that 76.5 million adults lack dental insurance.[73] Millions of other Americans are underinsured. According to a recent NIH report, "Dental expenses constitute more than a quarter of overall health care out-of-pocket expenditures and are reported to present higher financial barriers than medical, prescription pharmaceutical, and mental health care. This especially affects working-age adults, followed by older adults, and then by those age 18 and younger."[74]

During the 2022 session, the Maryland General Assembly approved and the Governor signed into law a bill to expand coverage for dental services for adults who are covered by Medicaid. Beginning January 1, 2023, Maryland Medicaid will cover dental services including diagnostic, preventive, restorative, and periodontal, for adults with household incomes up to 133% of the federal poverty level (FPL). An estimated 791,373 individuals will be newly eligible for dental care.

While this policy change will create 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:

- introducing or expanding integrated dental services at safety-net clinics on-site or through referrals;

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[67] https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Executive-Summary.pdf
[68] https://www.cdc.gov/oralhealth/publications/OHSR-2019-dental-carries-adults.html
[69] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5515044/
[70] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5515044/
[71] https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Executive-Summary.pdf,
[72] https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/us-oral-health-well-being.pdf
[73] https://www.carequest.org/system/files/CareQuest_Institute_A%20Snapshot%20of%20the%2076.5%20Million%20Americans%20Without%20Dental%20Insurance_Visual%20Report.pdf
[74] https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Executive-Summary.pdf, https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0800

- 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.

Special consideration will be given to programs that are located in Dental Health Professional Shortage Areas (HPSA), Baltimore City, Eastern Shore, and Western Maryland. Programs may target children and/or adults.

Applicants must submit proposals for projects in ***one*** of the four areas of focus described above. The CHRC recognizes that these areas of focus may overlap in scope and have elements in common. 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.

For any area of focus, it is crucial that proposals address *both* of the CHRC's strategic priorities in this year's RFP.

NEW - CRITERIA FOR UNDUPLICATED INDIVIDUALS SERVED

All applicants must use the following criteria to project the number of individuals who will receive services as "Unduplicated Individuals Served" under the grant:

1. **Applicant must be able to demonstrate that the individual is unduplicated** (i.e., the same individual is not counted more than once). This could be achieved through the creation of a patient/client registry with unique patient identifiers and/or another internal tracking mechanism to eliminate duplicate records or accounts. To ensure non-duplication (i.e., not counting an individual more than once), grantees will need to collect some basic demographic data from patients/clients. At minimum, this data includes: Full Name, Date of Birth, and Address (if available).
2. **Applicant must be able to provide documentation that services have, in fact, been provided.** Clinical services may include primary and preventative services, oral health services, and mental health and substance use treatment. Non-clinical services may include but are not limited to SDOH supports (e.g., food security, housing security, transportation, linkage to health insurance), navigation to care services, and certain classes. Services may be provided on an on-going basis (e.g., management of chronic conditions, obstetrical care, therapy, diabetes classes, etc.) or a one-time basis (e.g., crisis stabilization, dental prostheses, completed referral to a social service support, etc.).

All services must be documented. Referrals must be documented, and receipt of referred services must be documented. The receipt of referred **medical services** must be documented through EMR or other HIPAA-compliant method. The receipt of referred **SDOH services** may be documented through written correspondence with the provider of the service. For both medical/dental and non-medical services, self-reporting from the individual served is **not**

sufficient. The service itself must actually be received and documented, not just the referral or attempts to complete the referral.

Participants in health education classes, including but not limited to diabetes classes, may be considered "Unduplicated Individuals Served" if the classes meet all of the following requirements: (1) classes are evidence-based, (2) classes are on-going (i.e. more than one session), (3) attendance is documented, (4) participants' basic demographic information is collected, and (5) an assessment of individual learning is conducted.

Applicants are encouraged but not required to empanel patients in Chesapeake Regional Information System for our Patients (CRISP) to meet these requirements.

Examples of activities that, in and of themselves, do **not** meet the threshold to be included as a "service" for an "Unduplicated Individual Served," unless they lead to documented services, include: health or SDOH screenings, referrals, navigation services, 211 services, media campaigns, Public Service Announcements (PSAs), flyers, health fairs, brief educational encounters, outreach, food markets, and community gardens.

Community outreach activities such as those listed above may be supported by grant funding. Applicants are encouraged to use outreach strategies, screenings, etc. to begin to engage individuals in the community as a means of identifying individuals who require further care and beginning to build relationships. Applications should describe all interventions and characterize the potential impact of these interventions, but ensure that the projected number of "Unduplicated Individuals Served" is consistent with the CHRC's criteria.

For example, a program seeking to address diabetes among a difficult-to-reach sub-population may have the following components: (1) distribute culturally-relevant hand-outs at local events; (2) engage with individuals on social media; (3) partner with a trusted community-based organization or church to educate members about diabetes; and (4) perform diabetes screenings and provide referrals to care. These kinds of multiple "touchpoints" may be essential for successfully engaging individuals to receive needed care. However, such a program will not be funded by this year's Call for Proposals unless the applicant is also able to **document** that some individuals actually **received** the services to which they were referred. Grant funds are available for all aspects of the program, including outreach components, provided that the program as a whole generates some number of "Unduplicated Individuals Served."

Proposals that do not include any projected "Unduplicated Individual Served" will not be considered for funding under the FY 2023 Call for Proposals.

GUIDANCE FOR FY 2023 APPLICANTS

1. **The CHRC will prioritize applications that present detailed data 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 ratio 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, the business community, or additional grant funding.**
4. **Applicants must provide 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.**
5. **Under this Call for Proposals, the CHRC will support up to three-year grant projects.**

Further information about the selection criteria for this Call for Proposals is below.

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.

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 8-11 above).**

   1a). Advancing health equity by addressing health disparities and adverse Social Determinants of Health (SDOH), with a particular emphasis on groups disproportionately impacted by the COVID-19 pandemic, including racial and ethnic minorities.

   1b). Promoting the efficient and strategic delivery of integrated health and social services through innovative, sustainable community partnerships that address the totality of medical and non-medical needs, with emphasis on approaches that address COVID-19 pandemic-related service delivery challenges.

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 Gantt chart or other project timeline representation of key project deliverables and corresponding time frames 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: a) the proposal presents a compelling logic for the use of these strategies; b) these are innovative and closely monitored for effectiveness (e.g., use of telehealth); and, c) 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 pages 21-22), and describes any additional services or interventions that will be used to engage the community but do not meet the criteria for "Unduplicated Individuals Served." (See page 21.) 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/or (2) long term impacts such as reduction in hospital and emergency service utilization for treatment of ambulatory care-sensitive acute and chronic conditions.

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 Pathways to Health Equity 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.[75]
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. 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 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.
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 and/or legislative priorities including but not limited to the Community Health Care Access and Safety Net Act

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

of 2005 (SB 775/HB627 – 2005), the State Health Improvement Process (SHIP), Diabetes Action Plan, and Total Cost of Care Model.

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 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 pages 21-22) 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., EMR, other HIPAA-compliant system, or CRISP. 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. 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, and 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. 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.

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 17, 2022.** 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 19, 2022 by 12:00 p.m. (noon).**

Applicants will be notified about the status of their grant applications in February 2023. **A select number of well-reviewed grant applications will then be considered for grant awards at the Commission's meeting in February 2023.** 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 17, 2022.

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 17, 2022, via email** delivery to Jen Clatterbuck at jen.clatterbuck@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.

For all types of Community Health Resources, the Letter of Intent submission must include the following three 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

   The LOI template must be filled out completely and must adhere to the posted word limits.

2. **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.

3. **Sliding scale fee schedule**. **All** types of Community Health Resources must provide their sliding scale fee schedule.

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 that demonstrates a referral relationship with a provider. Other applicants that intend to provide grant-funded services through formal partnerships with another organization or group must also include their MOUs or other documents as part of their LOI submission.

NOTE: Applicants are strongly encouraged to confirm that all scanned documents are legible and complete prior to submitting to the CHRC. Poor image quality, incomplete submissions, or missing pages could result in disqualification of the proposal.

STEP 2: Submission of Grant Applications - due December 19, 2022

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 19, 2022.

The full electronic grant application should be emailed to: **jen.clatterbuck@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, 3, or 4 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, five (5) hard copies of the full application with the items listed below must be sent via express delivery service, USPS mail, or hand delivery. 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 19, 2022,** to be considered a complete grant application package. Due to the high volume during this time of year, applicants mailing proposals via USPS are encouraged to post them several days earlier than December 19. **All hard copy proposals must be received by the CHRC no later than 3:00 p.m. on December 20.**

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

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

PLEASE NOTE:

The five hard copies of all application documents should be **comb bound** or **spiral bound** with long edge binding. Do **not** use three ring binders.

As noted above, the five (5) hard copies of the full grant application must be received by CHRC staff no later than 3:00 p.m. on December 20, 2022, sent to 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 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.

(3) Executive Summary: A half-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 pages 21-22 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 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) Letters of commitment from collaborators
(h) Logic model (See Appendix III)
(i) Workplan template (See Appendix IV)

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 (area of focus);
- Project title;
- Project duration;
- Succinct overview of project;
- Population to be served;
- Total number of Unduplicated Individuals to be Served (see pages 21-22);
- 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 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).
- ***NEW: 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, 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), Diabetes Action Plan, 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 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, and, if your organization files a Form 990, its most recent filing. It is not necessary to include the financial audit previously submitted with the LOI. 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 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[76] or CDC guide.[77] 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

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

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.

- ***NEW: Provide an estimated range for the total number of anticipated service encounters.*** Describe your methodology for calculating this.
- ***NEW: 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 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) and any partners from the business community 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. What quantifiable data will be collected? 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 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 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 V 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 **November 3, 2022 at 9:30 a.m.,** is optional, though encouraged, and will last approximately one hour, depending on the number of questions from potential applicants.

The Zoom link for the conference call is:

https://us06web.zoom.us/j/82674133771?pwd=MnlYcmdTZ2drNEJHL1BhaWFmSE5VQT09

Dial-in #: 1-301-715-8592

Meeting ID: 826 7413 3771/ **Passcode:** 786331

Questions from Applicants: Applicants may also submit written questions about the grants program. Please email questions to Jen Clatterbuck at jen.clatterbuck@maryland.gov or Michael Fay at michael.fay@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

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

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

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

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

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

J. Wayne Howard, Vice Chair

TraShawn Thornton-Davis

Scott T. Gibson

Flor de Maria Giusti

David Lehr

Karen-Ann Lichtenstein

Roberta “Robbie” Loker

Carol Masden, LCSW-C

Sadiya Muqueeth, Dr.PH

APPENDIX I: Letter of Intent

Maryland Community Health Resources Commission
Letter of Intent FY 2023 Call for Proposals

1. **Organization Name**:
2. **Organization Address**:
3. **Name, Email and Telephone of Organization CEO**:

4. **Name, Title, Email and Telephone of Project Director**:

5. **Additional Contact Information**:

6. **Project Title**:
7. **Area of Focus** (check one): ☐Addressing Chronic Disease Prevention and Disease Management
   ☐ Promoting Maternal and Child Health
   ☐ Addressing Behavioral Health, including the Opioid Crisis
   ☐ Providing Dental Care to Support the launch of the new Maryland Medicaid Dental Benefit
8. **Program Jurisdiction**:
9. **Year One / Total CHRC Request**: Year 1 $: Total Request: $
10. **Program Duration (check one):** ☐ One Year ☐ Two Year ☐ Three Year
11. **This program is (check one)**: ☐ A New Program ☐ An Expansion of Existing Services
12. **Has the applicant received CHRC funding in prior years**? ☐ Yes ☐ No

If NO, describe how your organization meets the definition of a "Community Health Resource":

12A. **Type of Organization**: ☐ Primary Care Provider ☐ Hospital ☐ Non-Profit Community-Based Organization

☐ Local Health Department ☐ Behavioral Health Provider ☐ FQHC ☐ Other (explain)

Links to definition of a Community Health Resource: Primary Community Health Resource, Designated Community Health Resource, Access Community Health Resource (Note: if applying as an Access Community Health Resource, an MOU with a Primary Care Provider must be submitted with your Letter of Intent).

Maryland Community Health Resources Commission
Letter of Intent FY 2023 Call for Proposals

13. **A description of the applicant organization** (maximum 250 words):

14. **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):

15**. Letter of Intent – Required Documents**:

☐ Audited Financial Statement

☐ Federal Form W9

☐ Sliding Fee Scale (All Applicants)

Access Services Community Health Resource Eligibility Documents - Required:

☐ Executed Memorandum of Understanding or similar referral relationship (memorialized) with a Primary Care provider (Access Community Health Resources) that **pre-dates** the Letter of Intent submission and the

☐ Sliding fee scale of the primary care/referral partner.

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.

Line 4. The name, telephone number and email addresses of the applicant organization's project director.

Line 5. Additional contact information for program.

Line 6. Project title

Line 7. Project Focus Area

Line 8. Program jurisdiction (county(ies) and/or Baltimore City)

Line 9. The funds that will be requested for the first year, and the funds requested for the entire project (for all years).

Line 10. The proposed duration of the grant funding.

Line 11. Type of Program: New or Expansion of Existing Services. (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 12. Yes/No – Has your organization received funding from CHRC in prior years? If your organization has not received prior CHRC funding, 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. Type of Applicant Organization – check the box that most closely identifies your type of organization. Indicate whether your organization is a Primary Community Health Resource, a Designated Community Health Resource, or an Access Community Resource. Access Community Health Resources must submit an MOU with a Primary Care Provider with your Letter of Intent.

Line 13. 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 14. 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 15. List of required documents that must accompany the Letter of Intent.

APPENDIX II: Application Cover Sheet

STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Room 336 • Annapolis, Maryland 21401
Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Edward J. Kasemeyer, Chair – Mark Luckner, Executive Director

Grant Application Cover Sheet
Maryland Community Health Resources Commission
FY 2023 Call for Proposals
Expanding Healthcare Access and Advancing Health Equity

***For an application to be deemed complete, all fields are required.**

Lead or Coordinating Organization Applicant:

Name:

Federal Tax ID Number (EIN):

Street Address:

City: State: Zip Code:

Grant Request – Programmatic Details:

Project Title:

Total Budget Request: # of Program Years One Year Two Year Three Year

Jurisdiction(s) to be served by Project:

Proposed Number of Unduplicated Individuals Served (required):

Estimated number of Service Encounters with Unduplicated Individuals Served:

Targeted Health Disparities:

Summarize / List Key Interventions:

List Partner Organizations:

APPENDIX II: Application Cover Sheet

Applicant Contact Information:

Official Authorized to Execute Contract(s):

Name: Title:

Email Address:

Phone Number:

Project Director:

Name: Title:

Email Address:

Phone Number:

Fiscal Contact:

Name: Title:

Email Address:

Phone Number:

Signatures:

Official Authorized to Execute Contracts:

Signature:

Project Director:

Signature:

Fiscal Contact:

Signature:

Additional Contact Information:

Name: Title:

Email Address:

Phone Number:

APPENDIX III: Logic Model Form

LOGIC MODEL – CHRC FY 2023 CALL FOR PROPOSALS				
Organization name:				
Project 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 then 4-6 years:	We expect that if accomplished these activities will lead to the following changes in 7-10 years:

APPENDIX IV: Workplan Template

Workplan Template - FY 2023 Call for Proposals

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Organization Name: _____

Project Name: _____

PROJECT PURPOSE:

(1) GOAL

Objective	Key Action Step	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	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 x% of BH related emergency situations and divert individuals who would have been hospitalized into appropriate BH care.	Projected number of **unduplicated individuals** who will receive BH related crisis intervention services from the Crisis Team. Of these, the expected number who will be diverted from ED visits to Hospital X for BH related conditions and referred by the Crisis Team to a BH specialist.	EMR (e.g., number of encounters and services provided by Crisis Team, number of referrals to BH specialists). Data on BH ED visits at Hospital X obtained from CRISP or individual hospital partner. CRISP data for BH ED visits to Hospital X for CY 202x will be used as baseline from which to calculate change in # of ED visits.	J. Doe - Project Manager	4/30/25

(2) GOAL

Objective	Key Action Step	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	Person/Area Responsible	Timetable for Achieving Objective

(3) GOAL

Objective	Key Action Step	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	Person/Area Responsible	Timetable for Achieving Objective

APPENDIX V: Budget Form Template

Budget Form Template - FY 2023 Call for Proposals				
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 Budget Request**	**Year 2 Budget Request**	**Year 3 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**	**0**
Personnel Fringe (no more than 25% of Personnel costs)				**0**
Equipment / Furniture				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
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	0	0
Totals	**0**	**0**	**0**	**0**
Percent of Organization's Total Budget that this Project Budget Represents				#DIV/0!