STATE OF MARYLAND
Community Health Resources Commission
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Martin O'Malley, Governor - Anthony G. Brown, Lt. Governor
John A. Hurson, Chairman - Mark Luckner, Executive Director

Aligning Community Health Resources: Improving Access to Care for Marylanders

Request for Proposals

April 28, 2010

Overview

The Community Health Care Access and Safety Net Act of 2005 authorized the creation of the Maryland Community Health Resources Commission. Governor Martin O'Malley appointed the current Commissioners in May, 2007. Through grants, community assessments, and technical assistance, the Commission will work to increase access to care for low-income families and under- and uninsured individuals. The Commission will help communities develop more coordinated, integrated systems of community-based care, redirect non-emergency care from hospital emergency rooms to other providers in the community, and assist individuals in establishing a medical home. The cornerstone of these efforts will be community-based health care centers and programs, referred to in the legislation as "community health resources."

The current RFP process will be similar to previous RFPs, but the schedule will be accelerated, as occurred with the last Commission RFP. Letters of Intent (which should include a copy of the applicant's most recent audit) must be submitted by Friday, May 7, 2010, and the Commission will select applicants who will be invited to submit a full application, which will be due to the Commission on Thursday, May 27, 2010.

Aligning Community Health Resources: Improving Access to Care for Marylanders is the grants program of the Maryland Community Health Resources Commission. The program will award grants to community health resources serving Marylanders in Maryland. In this offering, the Commission will consider projects in four areas, some of which represent areas that the Commission has supported in previous RFPs.

Which Community Health Resources May Apply for these Grants?

In this grantmaking round, the Commission will consider proposals from any Community Health Resource eligible under the Commission's regulations at COMAR 10.45.05. A Community Health Resource must submit a proposal as outlined under "How to Apply" below.

- **A separate Letter of Intent (LOI) must be submitted by May 7, 2010 for each proposal. See page 13 of this RFP for the information that must be included in the LOI.**

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 legislation and the Commission designated the fourteen organization types listed below as community health resources. Each of these types of entities is eligible to apply for and receive grants from the Commission.

- Federally qualified health centers (FQHCs) and FQHC "look-alikes"
- Community health centers
- Migrant health centers
- Health care programs for the homeless

• Primary care programs for public housing projects
• Local nonprofit and community-owned health care programs
• School-based health centers
• Teaching clinics
• Wellmobiles
• Community health center-controlled operating networks
• Historic Maryland primary care providers
• Outpatient mental health clinics
• Local health departments
• Substance abuse treatment providers

Organizations not designated above may also qualify as a community health resource. To do so, organizations must demonstrate that they meet the Commission's criteria for either a Primary Health Care Services Community Health Resource or an Access Services Community Health Resource.

(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
• Serve individuals residing in Maryland.

(3) **Access Services Community Health Resource**. Organizations must demonstrate that they:
• Assist individuals in gaining access to reduced price clinical health care services
• Offer their services on a sliding scale fee schedule
• Serve individuals residing in Maryland.

Sliding Scale Fee Schedule Requirements

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

The Grants Program

Due to fiscal constraints for the Commission's budget in FY 2011, the Commission will be looking for grant applicants to demonstrate creativity in developing their budget proposals in this round of grant-making. In this RFP, the Commission will consider awarding a total of $500,000 for projects to be implemented over a multi-year period in three of four areas targeted in this RFP: (1) Infant Mortality; (2) Integrated Behavioral Health; and (3) New Access. The fourth area, Dental Care, will involve awards up to a total of $300,000, to be implemented in a multi-year period.

Aligning Community Health Resources: Improving Access to Care for Marylanders seeks to award grants to community health resources in Maryland in the following four areas.

1. Strategies to Reduce Infant Mortality, Pre-Term Births, Low-Birth Weight Babies and Teenage Pregnancy through Pre-natal Initiatives

Reducing infant mortality is a public health priority in Maryland. Although Maryland is one of the wealthiest states, it has consistently ranked among the worst for infant mortality. Significant progress toward reducing infant mortality and improving birth outcomes in Maryland that had been achieved during the 1990's has now stalled, with virtually no further improvement for nearly a decade.

The Maryland Community Health Resources Commission included reducing infant mortality in its previous RFP, and has awarded a number of grants to help make critical investments in Maryland's health care infrastructure to help expand access to comprehensive women's health services in the community. This RFP will build on these efforts, and continues the Commission's work to help build comprehensive, integrated systems of care in the community for underserved, at-risk populations.

<u>Geographic Disparities</u>
In 2008, infant deaths in Prince George's County and Baltimore City together accounted for 42% of all infant deaths in Maryland (22% and 20% respectively). The larger population in these two jurisdictions affects the overall Maryland rate. In addition to these two jurisdictions, there are other areas of the state, such as Allegany, Charles, Dorchester, Somerset and Wicomico Counties, with infant mortality *rates* (infant deaths per 1000 births) that are higher than the overall state rate, even though the actual numbers of deaths may be smaller.

<u>Racial and Ethnic Disparities</u>
Infant mortality among African American infants is nearly 3 times higher than among white infants in Maryland. While overall infant mortality rates are lower than the state rate in many jurisdictions, racial disparities in infant deaths are from 2.4 to 6.8 times higher among African American infants in Anne Arundel, Caroline, Carroll, Frederick, Howard, Montgomery, Queen Anne's, St. Mary's and Worcester counties.

Risk Factors

In Maryland, an estimated 40% of births are unintended. Women who experience unintended (unwanted or mistimed) pregnancy are more likely to delay getting prenatal care. Behavioral health issues such as drug and alcohol abuse, depression, and domestic violence also contribute to late or no prenatal care. Early prenatal care rates in Maryland, once among the best in the country, at nearly 90% during the 1990's, fell to 79.5% in 2007. Like infant mortality, both prematurely and low birthweight rates in Maryland have not improved over the past decade. Preterm and low-birthweight infants are at higher risk of infant death and have higher risks of long-term developmental and health problems. Women with a previous poor pregnancy outcome are more likely to have another poor outcome if they do not receive the appropriate inter-conception care. Chronic diseases among women of child-bearing age, such as diabetes, high blood pressure, heart disease, asthma, obesity and depression, are at much higher risk for pregnancy complications and poor outcomes.

Strategies for Reducing Infant Mortality and Improving Birth Outcomes

There are many factors that influence pregnancy outcomes, but research supports interventions to improve the health of women before they become pregnant, prevent unintended pregnancies, assure early entry into prenatal care, and provide close follow-up of mothers and infants at risk. Many complications of pregnancy associated with infant mortality and poor pregnancy outcomes would be best addressed prior to pregnancy with improved primary care, family planning, and preconception health screening. Identification and treatment of chronic diseases among women of childbearing age, and chronic disease management in very early pregnancy could have a significant impact on pregnancy outcomes.

Applicant Guidance

Projects must identify specific service strategies to address infant mortality, pre-term births, and low birth weight babies. These may include provision of comprehensive women's health services (primary care, family planning, prenatal and postpartum care), utilizing an interdisciplinary model of providers, which may include primary care physicians, obstetricians, nurse practitioners/nurse-midwife, physician's assistants, nurses, health educators, social workers, community based outreach workers and/or patient navigators. In addition to clinical services, projects may also include supportive and enabling services such as health education and anticipatory guidance regarding prenatal, postpartum and newborn care, counseling and referral for behavioral health, and risk-appropriate case-management. Language support services (translation/interpreter services), if needed, should be available.

Projects must have the capacity to determine client eligibility for financial assistance programs such as Medicaid, assure eligible women and infants are expeditiously enrolled in these programs, and bill Medicaid and other 3rd party payors whenever possible. Projects will be required to report specific process and outcome indicators every six months utilizing a template provided by the Commission, as a condition of payment of CHRC funds.

2. Functionally Integrating Behavioral Health Services for Individuals with Mental Illness or Co-Occurring Mental Illness and Substance Use Disorders

The Commission has included behavioral health service integration in previous RFPs, and the CHRC has awarded a number of grants that have provided integrated services in the community. This RFP is designed to build on these efforts, and support continued service integration in this area. The National Council for Community Behavioral Health issued a report in March 2010 that found that nearly 60% of individuals with a bi-polar disorder and 52% of persons with schizophrenia have a co-occurring disorder. The report also stated that approximately 41% of individuals with an alcohol use disorder and 60% of individuals with a drug use disorder have a co-occurring mood disorder. Adults with behavioral health illness have higher rates of chronic medical conditions such as diabetes, hypertension, and HIV/AIDS, which further compounds the already high levels of functional impairment in this population. This population is less likely to have health insurance coverage and encounters more barriers to obtaining quality medical care. Adults and adolescents with co-occurring substance use and mental health disorders are also confronted by a disjointed health care system that does not routinely provide effective integrated clinical interventions. The Council's March 2010 report also stated that 45% of Americans have one of more chronic health conditions and treating these conditions accounts for 75% of direct medical care in the United States.

Previous reports issued by the Alcohol and Drug Abuse Administration (ADAA) of the Department of Health and Mental Hygiene have produced data that has demonstrated the accepted view that patients with co-occurring disorders are among the most difficult to treat effectively. The reports have stated, "Many of these patients undergo repeated referrals among substance abuse treatment programs and other health care entities, and their mental health issues frequently interact with multiple substance use to present extremely difficult challenges to recovery. In addition, this population is more likely to be homeless and unemployed." Strategies to address the complex needs of this challenging population may include innovative approaches to integrate counseling and treatment services with primary care and social services in a continuous care model implemented by a care management team. The services might include outreach activities tailored to the needs of these clients, coordinated counseling which addresses both disorders in the same setting or by the same professional, and links to supportive services such as housing and employment to maintain these clients in the community.

The Commission looks to support efforts to integrate mental health and substance abuse services with primary care services, including clinical integration strategies such as case management services, deployment of primary care providers with expertise in behavioral health, and co-location of primary care providers and behavioral health professionals. Similarly, services for individuals with co-occurring substance use and mental health disorders might be better coordinated through clinical models that provide services in a single setting. The Commission will consider applications proposing strategies such as these or other approaches that will integrate mental health and substance use disorder treatment services with somatic care. It is hoped that the Commission's grants in this area will encourage community health resources to implement behavioral health

screening, integrate behavioral health as part of core primary care services, and help develop comprehensive, integrated access to behavioral health services at community health resources (either through direct services or referral).

Promoting access to integrated substance use treatment and mental health services as a means to promote public safety in Maryland is a priority of the Commission, and proposals that facilitate "public health-public safety" partnerships will be given particular consideration by the Commission in this RFP. The Commission will provide an added emphasis for applications that look to provide integrated behavioral health and "re-entry" services for the criminal justice population, and provide aggressive case management and wrap-around services for individuals post-release from incarceration. In light of federal reform that will expand access to health insurance for previously uninsured Marylanders, the Commission will be looking for applications that seek to inform individuals participating in the program of their entitlement benefits and assist these individuals in gaining access to health insurance and other public health and social services programs.

3. Dental Services

Access to oral health care is a critical problem for underserved and minority populations in Maryland. *The 2005 – 2006 Survey of Oral Health Status of Maryland School Children* conducted by the University of Maryland Dental School found that 31% of children in kindergarten and third grade had untreated tooth decay. Children residing on the Eastern Shore or in Southern Maryland had the highest rates of untreated tooth decay. Low-income, African-American and Hispanic children suffer even higher rates of tooth decay. Children with special health care needs are two times more likely to have unmet dental needs than children without special health care needs *(Oral Health for Children and Adolescents with Special Health Care Needs: Challenges and Opportunities,*2005, National Maternal and Child Health Resource Center, Georgetown University.) Adults and disabled individuals with advanced dental problems or with medical complications are oftentimes referred for services at distant locations or frequently unable to access treatment. According to the Centers for Disease Control, 16.7% of Maryland adults over the age of 65 have lost all of their teeth and 43.5% of adults in the state have lost six teeth or more. Nationally, 90% of adults over the age of 40 have tooth decay and 5-15% of adults have advanced gum disease.

Recent statewide efforts towards increased access to dental care for children have been effective; however two counties remain priority areas requiring increased access to dental services. Accordingly, projects proposing new or expanded services targeted towards increase access to dental care for children residing in (1) Queen Anne's County and (2) Kent County will receive special consideration from the Commission.

Creation of New Sources of Dental Care

Applicants should submit an application that proposes to create new or expanded sources of dental care services that will increase the number of Maryland children with access to a comprehensive and continual source of dental care. These proposals should include the minimum clinical capacity to consist of 3-chairs, staffed by at least 1 dentist, 1

dental hygienist, 1 dental assistant and 1 program coordinator. The Commission will consider applications for new or expanded clinical dental services with a minimum of two chairs if the applicant is in an area where it is particularly difficult to recruit staff, and can clearly justify why the applicant cannot develop a new or expanded service with three chairs.

The Commission welcomes multi-year proposals that provide new or expanded dental services that encompass one or more of the following models:

- **Model 1**: cooperative agreements with existing dental offices to include staff, equipment, supplies, and leasing agreements; and/or
- **Model 2**: subcontracting agreements with local dental offices including staff, equipment, and supplies; and/or
- **Model 3**: development of new or expanded dental services including staff, equipment, and supplies in partnership with a new or existing public health facility (e.g., Federally Qualified Health Center, Federally Qualified Health Center look-alike, Local Health Department; private, non-profit hospital); and/or
- **Model 4**: renovations to existing space to accommodate new or expanded dental services including staff, equipment, and supplies.

Expansion of Current Sources of Dental Care

Local Health Departments, Federally Qualified Health Centers, FQHC "look-alikes," and Maryland Qualified Health Centers provide essential dental services to low-income individuals. Often times, these types of clinics are the only providers of dental care for underserved populations. Due to the demand for dental services, many of these clinics are at capacity and some have waiting lists that are up to four months long. Strategies to increase the capacity at Local Health Departments, FQHC's, FQHC "look-alikes," and Maryland Qualified Health Centers will result in more individuals receiving dental care. The Commission will consider proposals seeking to expand current clinical dental programs by adding additional clinical facilities, minor renovations to accommodate the expansion for dental services, staff, or equipment.

The Commission will consider proposals up to $300,000 in grants, allocated over multiple years for new or expanded dental services. These proposals can include clinical facilities, minor renovations to accommodate the expansion for dental services, staff, and equipment. The Commission will consider proposals seeking to create new clinical dental programs that ensure access to comprehensive dental care including preventive, diagnostic, emergency, and restorative care. The Commission encourages the start of services as soon as possible, but recognizes the complexity of developing an initial dental program. Therefore the Commission will give greater consideration to proposals that can deliver new dental services in as quickly a timeframe as possible, but expects that service delivery will begin within 12 months of receiving a grant. The Commission will consider applications with a longer timeframe if the applicant can clearly demonstrate with historical data or information why such an extended timeframe is necessary.

All Programs

All proposals considered by the Commission should ensure and demonstrate access to comprehensive dental care, including preventive, diagnostic, emergency, and restorative care, and demonstrate the creation of a "dental home" for the communities focused in the project. The Commission is specifically looking to support programs that are sustainable after the Commission's funding has expired.

The Commission will give special consideration to applications that emphasize providing dental services to low-income families and children.

All proposals must demonstrate strategies for addressing the unique needs of local populations, including the establishment of a "dental home" to ensure the consistent availability of dental services in the community. It is encouraged although not required that strategies incorporate use of public health dental hygienists, where and when applicable, to provide risk assessment and related services within these dental hygienist practitioners' scope of practice. These strategies also may include the establishment of a specialty referral network to increase access to specialty dental services. Proposals must demonstrate efficiency in service delivery and innovation in regard to addressing barriers to oral health services.

In general, the commission's priorities for awarding grant funds are: establishing a "dental home" for families and children, providing evening and weekend hours in New Sources of Dental Care, and increased evening and weekend hours in Expansion of Existing Sources of Dental Care, and sustainability of project activities after grant funds end. The Commission expects applicants to identify additional sources of funding for their proposed project, such as internal or external matching funds, or "in kind" goods and services or external donations. Funds for both the Creation of New Sources of Dental Care and for Expanding Existing Sources of Dental Care can be used to renovate existing space to accommodate a dental suite, expand a dental facility, purchase dental equipment, and to provide competitive salaries and/or incentive/retainer funds for dental personnel in the new start-up or initial expansion phases only.

4. New Access

The Commission, as a part of its central mission, is looking to provide support that will enable local communities to build integrated, interlocking systems of comprehensive care for low-income Marylanders. To that end, the Commission has funded "Access Programs" to help make health care services readily accessible to low-income and uninsured residents. Access programs create a network of health care services in a geographically defined jurisdiction, to include primary care, specialty physicians, radiology and laboratory diagnostic services, and dentists at reduced rates. Ideally, Access Programs also include integrated behavioral health services (mental health and substance use services); outreach; case management; preventive programs such as early screening and health education; and other enabling services, such as referrals to food banks, homeless shelters, advocacy agencies*, organizations to provide cultural and language assistance* or Department of Social Services staff. Access programs supported in this RFP are also expected to facilitate enrollment of previously uninsured Marylanders into the Medicaid program, in keeping with federal health care reform

principles and guidance. In addition, the Commission is looking to support pilot programs that provide innovative prevention strategies that are geared to address the health care needs of the minority community.

Selection Criteria

Applicants may submit proposals for projects in any one of these four areas. As has occurred in previous RFP's, the Commission will use the following criteria to assess and select proposals for funding:

Prospects for Success: The proposed project directly addresses the priority area of this Request for Proposals. The goals and objectives of the project are clear, feasible, measurable, and achievable. The work plan and budget are reasonable. The team assembled possesses the skills, competencies, commitment, and sufficient capacity to carry out the proposed work and has a supportive organizational and community environment. The Commission's priorities for awarding grant funds include establishing a "medical home" for families and children, and providing evening and weekend hours in new projects, and increased evening and weekend hours in expansion of existing projects.

Potential Impact: The project is likely to lead to improved access to care for the target population and improved health (and birth) outcomes. The project has potential for expansion or replication within the community, in neighboring areas, or more broadly across the state.

Community Need: The target population is clearly identified and geographically defined, the number of individuals targeted is reliably quantified, and the needs of this population are adequately documented through qualitative and quantitative data, such as demographics, rates of insurance coverage, and service utilization statistics. The organization's baseline number of the target population currently served is clearly stated. The applicant demonstrates a deep understanding of the community to be served.

Sustainability: The project is likely to continue to provide benefits to the target population and the community at large beyond the duration of the proposed grant. Proposals must identify likely sources of future revenue or funding sufficient to sustain the project activities after the grant funds end. The Commission will give strong preference to those projects that can demonstrate funding from internal sources or community matching support, including "in kind" support. The Letter of Intent can describe the applicant's plans for securing the external match. Full applications must include specific progress towards obtaining the match, and plans for having acquired firm commitments for the full match by the time the project starts.

Preference will be given to those projects that can demonstrate community-wide, local support: at least 15% of the budget should come from funding commitments (cash or signed pledges) restricted to this project from other community partners such as chambers of commerce, hospitals, medical organizations, community organizations, individual donors, foundations, and corporations to ensure the sustainability of the project. (Funding commitments are to be fully paid within the inclusive dates of the grant award). If the project's community support is not yet in place, then the applicant should provide

information that details the plan for generating such support. Five percent of the community match can be in-kind as tangible assets, such as furniture or computers, not staff time.

Preferences will be given to those Community Health Resources that can make at least an additional 5% financial commitment to this project from their own internal funds (operating funds or reserves). The 5% of the match can be in-kind as tangible assets, such as furniture or computers, not staff time. Indirect costs are limited to 10% of the total grant.

The local community contribution of 15% is intended to encourage applicants to raise public and private funds in their local communities to ensure sustainability of Commission funded initiatives. Letters of commitment for challenge funding or of intent to consider funding should be submitted as part of the full proposal. The source of the internal match can be funds which the applicant has, as long as those funds are for activities related to the proposed project.

Participation of Stakeholders and Partners: The project has enlisted as key participants relevant stakeholders and partners from the community and appropriate agencies and organizations. These collaborators will be actively engaged as demonstrated by participation in the planning and implementation process, dedicated staff and other resources allocated to the project, contributions of facilities and equipment, and/or provision of free or discounted health care services. Letters of commitment from collaborators are required, and must be included in the proposal but letters alone may not be sufficient for demonstrating active engagement. The letters of commitment from outside organizations must clearly state what they will contribute to the project, and how they will participate in the project.

Data Collection: The project team has the ability to measure and report progress in achieving project goals and objectives through quantitative measures, such as the number, demographics, characteristics, and service utilization of the target population, both at baseline and as the project proceeds. The project team must also have the ability to comply with the evaluation and monitoring requirements of this grants program.

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.

Financial Viability and Accountability: The applicant organization is in sound financial standing, has adequate financial management systems, and is capable of managing grant funds.

Provision of Sliding Scale Fee Schedule Services: The extent to which the applicant organization demonstrates use of a sliding scale fee schedule to increase access to care for low-income uninsured and under-insured individuals in Maryland.

The Commission will also consider the statutory priorities specified in Health General §19-2201(g). These are provided in the Appendix.

Evaluation and Monitoring

Grantees will be required to submit periodic progress reports and expenditure reports, as well as deliverables produced under the grant, as a condition of payment of Commission funds. To facilitate project monitoring, clearly defined data elements will be required from all grantees on a regular basis so that project accomplishments can be monitored, compared, and compiled.

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

As a condition of receiving grant funds, grantees must agree to participate in an evaluation of the grants program. This includes assisting with any data collection and information gathering required, such as participation in surveys, site visits, meetings, and interviews with the evaluators.

Use of Grant Funds

Grant funds may be used for project staff salaries and fringe benefits, consultant fees, data collection and analysis, project-related travel, conference calls and meetings, and office supplies and expenses. 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 purposes of the project. Grant funds may not be used for major equipment or new construction projects, to support clinical trials, or for lobbying or political activity. Grant funds may be used for those renovations necessary to carry out the proposed project. If the services in an applicant's proposal will be delivered by a contractor agency, not directly by the applicant, the applicant may not take a fee for passing through the funds to the contractor agency.

How to Apply

The Commission has streamlined its grant project selection process. The Letter of Intent has been expanded, and the full proposal for those applicants invited to submit one, has been reduced to accommodate a faster timeline for grant ward decisions. For this round of grant making, applicants will submit a Letter of Intent as described below. The Commission will review the letters and select from them a number of applicants who will be invited to submit a full proposal as described below. The selected full grant applications will be due to the Commission on Thursday, May 27, 2010. Applicants submitting a full proposal will present their projects at the Commission's June 24, 2010 meeting. Based on the full proposals and presentations, the Commission will select projects for grant awards.

Step 1: Letter of Intent

Applicants must submit one original of a Letter of Intent for the proposal to be considered. **Letters of Intent must be received via email by 5:00 p.m. EDT on May 7, 2010** to the Commission's e-mail address (mdchrc@dhmh.state.md.us) by electronic copy delivery. The letter should not exceed four single-spaced pages in length.

The Letter of Intent should include the following items:

- Name and location of the applicant organization.
- The project's title.
- The amount of funds being requested and the project's estimated duration.
- Whether this is a new project or an expansion of existing services and expected outcomes of the project.
- The services the project will provide and the site(s) where the services will be delivered.
- A precise, clear description of the target population.
- A concise description of the population the organization serves and the project's target population with relevant data and information to support the need for the project.
- A copy of the most recent audit of the organization.
- A brief description of the applicant organization.
- A one page budget for the total project with major line items. Categories of personnel or types of professional contracts in the project should be listed.
- The budget should also include a time line for projected numbers of individuals served (at least twice a year for the duration of the project) and overall public health outcome data that will be positively impacted by the program. The applicant should also include overall project goals that will determine the efficacy of the program, and how the organization will track and report this data to the Commission.
- A list of other organizations participating in the project and a brief statement of their role in or contribution to the project.
- A short description of how the project activities will be sustained when the grant funding ends.
- Name, title, address, telephone number, and e-mail for the organization's chief Executive officer, the proposed project director, and a contact person for the project.
- If this is the first time your organization is applying for Commission funds, you must include with the Letter of Intent documentation that clearly demonstrates your organization meets the definition of a "Community Health Resource." This documentation is not included in the four page limit for the letter of Intent. Further documentation of the applicant organization's financial viability and board structure will be requested if the applicant is invited to submit a full application.

Hard copies of the Letters of Intent should be mailed to:

Mark Luckner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Step 2: The Proposal
Applicants invited to submit a full proposal should prepare proposals following the "Proposal Guidelines" in this Request for Proposals.

Step 3: Submission of Proposals
Grant proposals are due at the Commission's offices by 5:00 p.m. EDT on May 27, 2010 by hand delivery, U.S. Postal Service, or private courier. Applications must include:

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

2. **Executive Summary:** A half page overview of the purpose of your organization summarizing the key points.

3. **Grant Application Cover Sheet:** This form is posted at http://dhmh.state.md.us/mchrc. 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 and legally authorized to execute contracts on behalf of the applicant organization.

4. **Contractual Obligations, Assurances, and Certifications:** A form for this agreement is available at http://dhmh.state.md.us/mchrc. The agreement should be completed and signed by either the chief executive officer or the individual responsible for conducting the affairs of the applicant and authorized to execute contracts on behalf of the applicant organization.

5. **Proposal:** See "Proposal Guidelines" in the Request for Proposals.
By the deadline for receipt of applications (May 27, 2010, 5:00 p.m. EDT), applicants invited to submit a full proposal should e-mail an electronic version of their transmittal letter, Grant Application Cover Sheet, proposal, and all appendices to the Commission at mdchrc@dhmh.state.md.us

Also by the required deadline, the following must be received at the address below by hand delivery, U.S. Postal Service, or private courier for each proposal: 1) original signed transmittal letter, original signed Grant Application Cover Sheet, original signed Contractual Obligations, Assurances, and Certifications, and original proposal, all bound together and labeled "original;" and 2) seven bound copies of transmittal letter, Grant Application Cover Sheet, signed Contractual Obligations, Assurances, and Certifications, the proposal, and appendices. The hard copy original and seven copies of all documents should be bound with two-prong report fasteners or spiral bound. If two-prong fasteners are used, cardboard or plastic covers and backs can be used. Do not use three ring binders.

Mark Luckner

Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Inquiries

Conference Call for Applicants: The program office will host a conference call for interested applicants to provide information on the grants program and assistance with the application process. This conference call, on May 6, 2010, at 10:00 a.m. EDT, is optional. Information on the conference call will be posted at http://dhmh.state.md.us/mchrc/. Registration is required. To register, send an e-mail by May 4, 2010, to tuggled@dhmh.state.md.us with the name(s) of the individual(s) who will participate in the call, the name of the applicant organization, and contact information.

Questions from Applicants: Applicants may also submit written questions about the grants program. Send questions to tuggled@dhmh.state.md.us Questions may be submitted at any time. Responses to Frequently Asked Questions (FAQ's) will be posted periodically at http://dhmh.state.md.us/mchrc.

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: lucknerm@dhmh.state.md.us
Dee Tuggle, Executive Associate
E-mail: tuggled@dhmh.state.md.us
Telephone: 410-260-6290
Fax: 410-626-0304
Website: http://dhmh.state.md.us/mchrc

Timetable

By close of business April 28, 2010	Call for Proposals Released
May 6, 2010	Frequently Asked Questions Call 10:00 a.m. EDT Optional Conference Call with Applicants Registration Required (FAQs) posted at http://dhmh.state.md.us/mchrc (to be updated periodically)
May 7, 2010 5:00 p.m. EDT	Deadline for Receipt of Letters of Intent
May 14, 2010	Selected Applicants Notified To Submit a Full Proposal
May 27, 2010 5:00 p.m. EDT	Deadline for receipt of applications
May 27-June 3, 2010	Review of Applications

Proposal Guidelines

Proposals should be well written, clear, and concise. Original and creative approaches to addressing access to health services are encouraged. Proposals may not exceed 12 pages single-spaced on standard 8 ½" x 11" paper with one-inch margins and using 12-point Times New Roman or Arial font. Tables and charts may use a 10-point font or larger. All pages of the proposal must be numbered. The budget and budget justification are included in the twelve page limit. The appendices specified in the guidelines below are excluded from the 12-page limit. The hard copy original and seven copies of all documents should be bound with two-prong report fasteners or spiral bound. If two-prong fasteners are used, cardboard or plastic covers and backs can be used. Do not use three ring binders.

The proposal should be structured using these topic headings:
Table of contents (not included in the 12 page limit)
1. Project Summary
2. The Project
3. Evaluation
4. Work Plan
5. Applicant Organization
6. Key Personnel
7. Partners and Collaborators
8. Project Budget

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

1. Project Summary

• Provide a one-page summary of the proposal. The first paragraph should clearly and concisely state:

1. Applicant organization
2. Project priority area
3. Project title
4. Project duration
5. Fund amount requested
6. Population to be served
7. Baseline numbers of population to be served and total population to be served by

the project's end
8. Whether this is a new service or expansion of an existing service
9. Services to be provided with the grant funds
10. Expected improved outcomes for the target population.

2. The Project

• *What will the project do?* Please "Project Summary for items to be addressed in the first paragraphs of the project description. What are the goals and measurable objectives of the project? Quite literally, who will do what for whom, with whom, where, and when?
• *Does the project address 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 or the discussion of legislative priorities in the Call for Proposals).
• *How will the project establish a primary care medical home for patients*? How will the project establish a primary care medical home for patients, either within the applicant organization or by case-managed referral to a primary care provider that accepts the patient's healthcare coverage or offers a sliding fee scale. How will the applicant organization document that the patient is enrolled with and actually receiving care with the primary care provider?
• *Who is the target population?* Identify the population(s) to be served (i.e., estimated numbers, demographics, insurance coverage, income levels, other distinguishing characteristics) with baseline and total projected numbers of individuals to be served by the end of the project.
• .Document the needs of this population using qualitative and quantitative data. Specify the service area(s). Service maps, data, and other statistics on the target population may be provided as an appendix. Statistics and data should be concisely presented.
• *What problem will be addressed?* Identify the specific problem(s) encountered by the target population(s) in accessing health care services and how this project will ameliorate the problem(s).
• *Does the proposal address health disparities that exist in Maryland?* Discuss the specific health disparity(s) the project is intended to address and how the project will address that disparity(s).
• *Is there a precedent for this project?* 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, how does it improve service delivery to Marylanders?
• *What will be the benefits of success?* If the project is successful, what visible, tangible, objectively verifiable results will you be able to report at the end of the grant? What longer-term benefits do you expect for the target population and the broader community?
• *How will the project be sustained after grant support ends?* Will the project require ongoing outside support after the proposed grant ends? If so, describe your plans for securing ongoing funding or, if plans are not yet firm, the process you will employ to work towards sustainability. Do you foresee opportunities for expanding or replicating this project within the community, in neighboring areas, or more broadly?

3. Evaluation

• *How will you measure project success?* What will be your methodology for evaluation of project outcomes? What data will you collect and analyze? Does the applicant

organization have the capacity to collect and analyze data, or must new capacity be acquired or developed?

4. Work Plan

• *What are the major milestones in carrying out the project?* List key benchmarks of project progress. Describe the process and timeframe for reaching these benchmarks.
• *What are the project deliverables?* What specific products would be submitted to the Commission as evidence of completion of project milestones? How and when will these deliverables be produced?
• *What is the timeline for accomplishing milestones and deliverables?* Prepare a grant chart or other timeline listing project tasks and the time period over which these tasks will be undertaken. This may be attached as an appendix to the proposal.

5. Applicant Organization

• *Is the applicant organization a community health resource?* Provide documentation that your organization qualifies as a community health resource pursuant to the Maryland *Community Health Care Access and Safety Net Act of 2005* and related regulations. If your organization has applied previously to the Commission, and not been notified that you are not eligible, please just include a statement of under which section of the regulations your organization qualifies as a community health resource.
• *What is the applicant organization's mission?* Describe your mission, programs, and service area. Discuss your organizational strengths and challenges.
• *What is the organizational structure?* 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).
• *How is the organization governed?* Specify the governance structure. In an appendix, provide a list of the officers and board of directors or other governing body.
• *How is the organization staffed?* Describe the staffing and provide an organizational chart as an appendix.
• *How is the organization financed?* Specify revenue sources and the percentage of total funding. What is the annual budget? As appendices to the proposal, provide your overall organizational budget (projected revenues and expenses) for the current fiscal year, your most recent audited financial statements and accompanying management letter, and, if your organization files a Form 990, your most recent filing. If your organization has submitted audited financial statements and a Form 990 to the Commission that cover your organization's latest audited fiscal year, please provide just a statement listing which documents and their fiscal years have been submitted. The Commission will request additional information if necessary.
• *What facilities are available?* Describe the facilities owned and/or operated by the organization.
• *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.

6. Key Personnel

• *Who will direct the project?* Identify the project director and describe his/her level of responsibility within the applicant organization, qualifications to lead the project, and role in carrying out the project.
• *Who is the other key staff?* 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.

7. Partners and Collaborators

• *Who are the key partners?* What other community organizations will play a crucial role in the proposed project? Why is their participation important?
• *In what ways will the partners contribute to the project?* Who are the leaders of these organizations and what is their role? Which staff will be involved, what will be their responsibilities, and how much time will they devote to the project? What other resources will partners contribute? In an appendix, provide letters of commitment from the leaders of these organizations and resumes (maximum three pages each) for key staff.
• *What is the management plan?* What processes and organizational structures will be put into place to ensure that the partnership(s) are effective?

8. Project Budget

• *General Format:* Provide a line-item budget. To the extent possible, break down the budget into major tasks or phases of work consistent with the project work plan. Provide a line item budget for the total project and for each project year. The beginning and ending date should be indicated for each budget period.
• *Personnel:* The name, title, percent effort, annual salary, and fringe benefits should be listed separately for each individual in the budget. Fringe benefits should be shown at the applicant organization's standard rate.
• *Project Co-Funding:* If the project will be supported by funder(s) other than the Commission, the line-item budget should include a separate column for each funding source along with a "total funding" column.
• *Indirect Costs:* Indirect costs may not exceed 10 percent of direct project costs. Direct costs generally include project-related personnel, consultants, travel, equipment, and office expenses.
• *Budget Justification:* A budget justification should accompany the line-item budget detailing the purpose of each budgeted expenditure.

About the Commission

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. Governor Martin O'Malley appointed the current members of the Commission in May, 2007.

Maryland Community Health Resources Commission

John A. Hurson Chair
Judith L. Boyer-Patrick, M.D., M.P.H.
Maria Harris-Tildon
Kendall D. Hunter
Margaret Murray, M.P.A.
Karla Ruhe Roskos, B.S.N., M.P.H.
Douglas Wilson, Ph.D.
Dr. Mark Li
Nelson Sabatini
Enrique Martinez-Vidal
Paula McLellan

Appendix

Excerpt from: Community Health Care Access and Safety Net Act of 2005 - MD Community Health Resources Commission provisions, Annotated Code of Maryland, Health-General Article

Health General § 19-2201 (g)

In developing regulations under subsection (f) (1) of this section, the Commission shall:
(1) Consider geographic balance; and
(2) Give priority to community health resources that:
(i) In addition to normal business hours, have evening and weekend hours of operation;
(ii) Have partnered with a hospital to establish a reverse referral program at the hospital;
(iii) Reduce the use of the hospital emergency department for non-emergency services;
(iv) Assist patients in establishing a medical home with a community health resource;
(v) Coordinate and integrate the delivery of primary and specialty care services;
(vi) Promote the integration of mental and somatic health with federally qualified health centers or other somatic care providers;
(vii) Fund medication management or therapy services for uninsured individuals up to 200% of the federal poverty level who meet medical necessity criteria but who are ineligible for the public mental health system;
(viii) Provide a clinical home for individuals who access hospital emergency departments for mental health services, substance abuse services, or both; and
(ix) Support the implementation of evidence-based clinical practices.