STATE OF MARYLAND

Community Health Resources Commission

4201 Patterson Avenue, Room 400• Baltimore, Maryland 21215

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John A. Hurson, Chair
Grace S. Zaczek, Executive Director

Aligning Community Health Resources: Improving Access to Care for Marylanders

Request for Proposals

August 26, 2008

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."

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 six priority areas.

Projects in the first priority area will demonstrate innovative approaches to functional integration of services for individuals, particularly children and adolescents, who have mental illness, or co-occurring mental illness and substance abuse disorders. The integration can include primary care services, establishing a medical home for these individuals, and social services leading to coordinated, community-based care. For example, telepsychiatry projects are a strategy to increase accessibility, availability, and acceptability of mental health services for children and adolescents, especially in rural areas. Another example could be crisis intervention services such as mobile crisis treatment.

Projects in the second priority area should address the creation of new school-based health centers, or the expansion of existing services. Strategies related to school based health services could include expanding the hours of an existing center, offering services to school staff, and/or the siblings and families of students, or adding dental services.

The Commission's third priority area is projects to increase access to primary care for low-income and uninsured Maryland residents. The Commission is seeking proposals which clearly define the primary care needs in a local area or for a population and identify specific strategies to address those needs. Strategies could include planning to develop primary care services capacity, case management, language interpretation, transportation, additional clinic hours, adding a nurse practitioner, or a diabetes educator. A focus for a primary care proposal could be a program which addresses chronic disease management or patient self-management of chronic disease.

In the fourth priority area, the Commission will consider projects to increase access to dental care for low-income, under- and uninsured Marylanders, with an emphasis on, but not limited to children and Medicaid recipients. The Commission's fifth priority area is the creation of new "access" programs in counties where they don't exist, and the expansion of existing access programs. These projects should create networks of care and services in a specific county or

defined geographic area including primary care and specialty physicians, and other health care providers.

The sixth priority area for the Commission is "opportunity" proposals. Strategies could include innovative projects which link patients to services which support health status improvement, develop service networks of care among health providers and other "helping organizations," or innovative projects which the applicant clearly demonstrates meet the health care needs in their service area. This priority area is intended to invite innovation and unique proposals which could serve as model programs for expansion throughout the state.

The Commission anticipates awards totaling as much as $1.5 million for dental services, and as much as $6 million in the other priority areas during this round of grantmaking.

- **Access Enhancement**:

All proposals under the Grants Program section will be reviewed not only by the Commission's external reviewers and the Commissioners but also by the Weinberg Foundation. The Trustees of the Weinberg Foundation may choose **up to six proposals** with the most positive reviews and **match up to 50% of the Commission's grant** to the same applicant. In other words, if the Commission awards a $500,000 grant over three years, the Weinberg Foundation may offer **up to an additional $250,000 award** for a maximum grant award from both the Commission and the Weinberg Foundation of $750,000. The Trustees of The Harry and Jeanette Weinberg Foundation ("Weinberg Foundation") may award "access enhancement" grants for only those proposals

- submitted under the Grants Program section of this RFP
- that received positive reviews from a majority of the Commission's external peer reviewers
- are awarded a grant by the Commission
- reviewed positively by the Weinberg Foundation.

All "access enhancement" grants will require negotiation between the applicant and the Weinberg Foundation and a contractual agreement to serve a specific number of unduplicated patients greater than the number promised to the Commission in the grant application. The Trustees of the Weinberg Foundation may award up to $1.5 million in "access enhancement" grants limited to community-based health centers, including somatic health, mental health, oral health, and substance abuse treatment clinics. The Weinberg Foundation grant award can be used only for direct services to patients and for salaries of newly hired, front-line clinical staff.

In line with the Weinberg Foundation's mission, the access enhancement grants are limited only to community based health centers. School based health centers cannot be considered for these grants.

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 may submit a proposal that addresses more than one priority area, but it must detail how the proposal will address each priority area separately, and why one proposal addressing separate priority areas has advantages over one complete proposal for each priority area. A proposal must address all elements and contain all documents listed in the "Proposal Guidelines" described on pages 15-18 of this Request for Proposals. A proposal which includes more than one priority area, for each area must address items 1-4, and 6-8 under the "Proposal Guidelines" on pages 15-18. The description and documents listed under item 5 "The Applicant Organization" need only be provided once in the proposal.

A separate Letter of Intent must be submitted by September 16, 2008 for each proposal. If a Community Health Resource plans to submit a single proposal which addresses more than one priority area, the Letter of Intent must address for each priority area:

- the priority area for which the applicant will apply**:**
- a succinct description of the proposed project that does not exceed 250 words in length.
- estimated project cost and duration;
- name and location of the applicant organization or site at which each priority area project will be located; and
- name, title, address, telephone number, and e-mail for the proposed project director.

What is a Community Health Resource?

An organization can demonstrate that it is a community health resource in any of three ways:
➔**As a Designated Community Health Resource.** The legislation and the Commission designated as community health resources the fourteen organization types listed below. All of these are 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.

➔**As a 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

➔**As an 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

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

1. **Functionally Integrating Services for Individuals with Mental Illness or Co-Occurring Mental Illness and Substance Abuse Disorders, Particularly Children and Adolescents**

Data from the DHMH Mental Hygiene Administration indicate that DHMH paid mental health services claims of over $472 million for 95,623 Marylanders in Fiscal Year 2008. Of these dollars, $195,017,195, or 41.3 percent was for treatment of mental illness in 41,609 Maryland residents ages zero to 17 years of age. The Commission is interested in projects to provide mental health care for children and adolescents across the state.

Kathryn Power, M.Ed., Director Center for Mental Health Services in the federal Substance Abuse and Mental Health Services Administration in a December, 2004 speech remarked: "Mental and substance use disorders overlap to a dramatic degree. Research demonstrates that up to half of those with a mental illness will develop a substance use disorder at some point in their lives. From an alternative perspective, research demonstrates that those with a substance use disorder are almost three times as likely to have a mental illness as those without a disorder. *Outlook and Outcomes 2006*, published by the Department of Health and Mental Hygiene's Alcohol and Drug Abuse Administration (ADAA) states: "Co-occurring disorders commonly involve simultaneous abuse of substances or a substance abuse problem and a psychiatric disorder or mental health problem. …The co-occurring substance abuse and mental health population has been increasing as a percentage of admissions for several years, either in number or because intake counselors are better able to identify them."
Data from ADAA indicates that 4,489 adolescents were admitted to ADAA funded treatment programs in Fiscal Year 2008 for services to address substance abuse problems. Mental Hygiene Administration (MHA) data demonstrate that DHMH paid claims in FY 2008 of $16,501,916 was for treatment of co-occurring disorders in 1,086 individuals ages zero to 17 years of age.

Strategies to address the complex needs of this challenging population may include innovative approaches to functionally integrate counseling and treatment services with primary care and social services in a continuous care model implemented by a care management team. Services for mental illness could encompass counseling and medication management, and group therapy and outreach services to identify and enroll in treatment those individuals at high risk for mental illness. Telepsychiatry and crisis treatment such as mobile crisis intervention programs could be other approaches to addressing the needs of the mentally ill.
The services for co-occurring disorders might include outreach activities tailored to the needs of these clients, such as coordinated counseling which addresses both disorders in the same setting, or by the same professional, and links to supportive services such as those in school-based health centers to maintain these clients in the community.

The Commission will consider proposals to address the particular challenges of accessibility, availability and acceptability of mental health services for children and adolescents, especially in rural areas. The projects could link local providers with academic or urban-based psychiatrists and other mental health providers for one-on-one therapy and medication management. The proposal could include the costs of clinicians and developing and installing the electronic hardware, software and connections for the services. The project could include support services of the parents of these children.

The Commission will fund projects of one-to-three years duration for up to $500,000 for each grant award.

2. School-Based Health Services

In 2007, the Commission contracted with the Center for Health Program Development and Management at the University of Maryland, Baltimore County, to conduct a study of school-based health services in Maryland. Study findings showed that School-Based Health Centers (SBHCs) provide on-site preventive services, acute care, mental health services, and oral health

care to students of all ages. These centers are an important safety net provider for children and adolescents who have limited access to the health care system. SBHCs are not intended to be a medical home; rather, they are a convenient place where students can access needed care and referrals in a familiar and non-threatening environment.

In Maryland, according to the study, there are over 66 SBHCs in 10 jurisdictions providing access to health services to the more than 50,000 students enrolled in affiliated schools. The SBHCs are sponsored by seven local health departments, two school systems, two Federally Qualified Health Centers (FQHCs) and one hospital.

The Commission will consider proposals to create new school based health centers or expand services in existing school based health centers. Sponsors of SBHCs may also include in their request funding to plan and implement new or enhanced services provided by SBHCs. The Commission will give preference to efforts to create or expand the provision of primary health care services, preventive health services, oral health services, and behavioral health services. The expanded services may be provided by a single SBHC or multiple SBHCs under the umbrella of the sponsoring community health resource. Planning for services must include the development of strategies for long-term sustainability and maximizing patient care revenue. Cross-sponsor collaboration is encouraged, as well as collaboration across individual SBHCs.

Grant funds may be used for salaries and fringe benefits of staff involved in planning and implementing the service expansion; salaries and fringe benefits of staff providing the new service(s); medical supplies and equipment; software; and consultants. Grant funds may also be expended for essential equipment and minor infrastructure improvements, such as minor office or clinic upgrades or renovations to accommodate the service expansion.

Grant funds may not be used for major equipment other than dental equipment, for 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. Grantees may subcontract with other organizations as appropriate to accomplish the purposes of the 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.

For proposals to create new SBHCs, the Commission will award one-time grants for new SBHCs in jurisdictions that currently lack a SBHC. Applicants may request up to $500,000 to expend over a period of up to two years. For proposals to expand existing services, the Commission will award grants with a base of $225,000 with $15,000 for each additional SBHC site up to a maximum of $400,000.

3. Primary Care Services:

According to the Robert Wood Johnson Foundation's "Covering the Uninsured" project, 13.4 percent of Maryland's 5.6 Million residents lack health insurance coverage, making it difficult for them to obtain basic health care. Kaiser's State Health Facts report that in 2006 60 percent of Marylanders at or below 200 percent of Federal Poverty level were uninsured. A growing portion of the population has one or more chronic illnesses. According to the DHMH Center for Preventive Health Services, heart disease is the leading cause of death in MD accounting for 26% annually of all deaths in the state. The Center also reports that the prevalence of diabetes

has increased approximately 50 percent among adults in MD between 1995 and 2006. In 2006, nearly 2.5 Million, or about 61% of Marylanders, were classified as overweight or obese. The 2005 MD Behavioral Risk Factor Surveillance Survey shows that 26 percent of adults in Maryland reported having high blood pressure.

The Commission is interested in proposals which increase access to primary care that clearly define the primary care needs in a local area or for a population and identify specific strategies to address those needs, including establishing primary care services as a medical home for low-income and uninsured Marylanders. Strategies could include case management, language interpretation, transportation, additional clinic hours, adding a nurse practitioner, or a diabetes educator. Strategies to address chronic disease could include patient self-management, with clinician oversight of focused programs designed to teach patient self-management techniques such as medication, adherence and lifestyle behaviors, diabetes and asthma self-manage education with incremental goal setting.

The Commission will fund projects from one to three years duration for a total award of up to $500,000.

4. **Dental Services**

Access to oral health care is a critical problem for underserved and minority populations in Maryland. *The 2005-2006 Survey of the Oral Health Status of Maryland School Children* conducted by the University of Maryland Dental School found that 31% of children in kindergarten and 3rd grade had at least one tooth with dental caries. The Commission is interested in proposals which create new sources of dental care, or expand existing services with an emphasis on, but not limited to services for children.

New Sources of Dental Care:

Creating new sources of dental care will increase the number of Maryland residents with access to a comprehensive and continual source of dental care. The ideal base model the Commission will consider for a new clinical dental program will be a 3-chair minimum clinic staffed by at least 1 dentist, 1 dental hygienist, 1 dental assistant and 1 program coordinator. These proposals can include clinical facilities, minor renovations to accommodate the expansion for dental services, staff, and equipment. The Commission will consider applications for new services with a minimum of two chairs if the applicant in an area where it is particularly difficult to recruit staff and can clearly justify why the applicant cannot develop a new service with three chairs.

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 14 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. The Commission will consider proposals up to $550,000 one time grants spread over one to two years for new dental services.

Expansion of Current Sources of 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 for up to $300,000 for one year-one time projects, with expanded dental services beginning at least by the end of the project year. Applicants must ensure access to comprehensive dental care, including preventive, diagnostic, emergency, and restorative care.

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. 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. These strategies also may include: targeted case management for oral health services (transportation, home visits, family education, etc.), translation services, education and outreach, creation of new or the expansion of existing partnerships with community organizations in support of oral health, and/or 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.

5. New Access Programs:

The Commission has funded "access" programs in central and southern Maryland which have expanded care for low-income and uninsured residents in those areas. These programs also have attracted additional funding from other sources to supplement services. Access programs create a network of care and services in a specific county or defined geographic area including primary care and specialty physicians, mental health and substance abuse services, and dentists who offer care for free or at reduced fee rates. The Commission is interested in proposals which include laboratory and radiology services for reduced fees in the care network. The access program services might include outreach, case management, and health education tailored to individual patients' needs. The program provides links and referrals to social service agencies such as food banks and homeless shelters, advocacy agencies, or to specific staff of the local Department of Social Services who will work with patients to obtain the social services for which they are eligible and which are needed to carry out their health treatment plan.

The Commission will fund awards for one to three years and for up to $500,000.

6. Opportunity Grants:

Applicants can propose innovative projects which will link patients to services which support health status improvement, develop service networks of care among health providers and other

"helping organizations," or innovative projects which the applicant clearly demonstrates meet the ambulatory health care needs in their service area This priority area is intended to invite innovation and unique proposals which could serve as model programs for expansion throughout the state.

The Commission will fund opportunity projects for one to three years for up to $500,000. The Commission will consider proposals for opportunity grants under this Request for Proposals. The Commission will consider opportunity grant proposals throughout the rest of the year, to the extent that funds are available.

Selection Criteria

Applicants may submit proposals for projects in any of the six areas described above. The Commission will use the following criteria to assess and select proposals for funding:

Prospects for Success: The goals and objectives of the proposed 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 or dental 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 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 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 a 20 percent match to Commission funding from internal sources or community matching support. Preference will be given to those applicants that can demonstrate community-wide, local support 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 match can be in-kind as tangible assets, such as furniture or computers, not staff time. The local community contribution of 20 percent 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 match can be internal 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, but letters alone may not be sufficient for demonstrating active engagement.

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. 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 other than dental equipment for proposals in priority area 4, 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.

Awards

The Commission anticipates awarding grants totaling up to $1.5 Million for dental services and up to $6 Million for the other five priority areas. The Trustees of the Weinberg Foundation may choose **up to six proposals** with the most positive reviews and **match up to 50% of the Commission's grant** to the same applicant. The Trustees of the Weinberg Foundation may award up to $1.5 million in "access enhancement" grants limited to community-based health centers, including somatic health, mental health, oral health, and substance abuse treatment clinics. School-based clinics cannot be considered for these grants. The Weinberg Foundation grant award can be used only for direct services to patients and for salaries of newly hired, front-line clinical staff.

As part of the grant application review process, the Commission may request that an applicant organization provide additional information or revise its application as a condition of approving an award. Awards will be made by the Commission. The Commission will consider geographic diversity within the state of Maryland in making awards.

How to Apply

There are three steps in the competitive application process:

Step 1: Letter of Intent

Applicants must submit a letter of intent for each of the applicant's proposals in order for each of the proposals to be considered. Letters of intent must be received by 5:00 p.m. EST on September 17, 2008 at the Commission's offices by hand delivery, U.S. Postal Service, or private courier. The letter of intent should include:

The type of grant for which the applicant will apply**:**

A succinct description of the proposed project that does not exceed 250 words in length.

- Estimated project cost and duration.
- Name and location of the applicant organization.
- Name, title, address, telephone number, and e-mail for the proposed project director.
- Name, affiliation, and e-mail address of individuals in addition to the project director who would like to receive updates related to this grants program.

If a Community Health Resource plans to submit a single proposal which addresses more than one priority area, the Letter of Intent must address for each priority area:

- the priority area for which the applicant will apply**:**
- a succinct description of the proposed project that does not exceed 250 words in length.
- estimated project cost and duration;
- name and location of the applicant organization or site at which each priority area project will be located; and
- name, title, address, telephone number, and e-mail for the proposed project director.

Letters of intent should be sent to:

Grace S. Zaczek
Executive Director
Maryland Community Health Resources Commission
4201 Patterson Avenue, Room 400
Baltimore, MD 21215

Step 2: The Proposal
Applicants should prepare proposals following the "Proposal Guidelines" in this Call for Proposals.

Step 3: Submission of Applications
Grant applications are due at the Commission's offices by 5:00 p.m. EST on October 7, 2008 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. **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.
3. **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.
4. **Proposal:** See "Proposal Guidelines" in the Call for Proposals.

By the deadline for receipt of applications (October 7, 2008, 5:00 p.m. EDT), applicants should e-mail an electronic version of their transmittal letter, Grant Application Cover Sheet, and proposal to Ms. Lynda M. Brown, the Commission's Health Policy Analyst at brownlm@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) nine bound copies of transmittal letter, Grant Application Cover Sheet, signed Contractual Obligations, Assurances, and Certifications, and proposal. The hard copy original and nine 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. If the proposal addresses more than one priority area, then 12 hard copies of the proposal must be submitted.

Grace S. Zaczek
Executive Director
Maryland Community Health Resources Commission
4201 Patterson Avenue, Room 400
Baltimore, MD 21215

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 September 9, 2008, at 1:00 p.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 September 4, 2008, to hensonk@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 brownlm@dhmh.state.md.us Questions may be submitted at any time. Responses to Frequently Asked Questions (FAQs) 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:

Grace S. Zaczek, Executive Director
E-mail:zaczekg@dhmh.state.md.us

Lynda M. Brown, Health Policy Analyst
E-mail: brownlm@dhmh.state.md.us

Karaleigh Henson, Special Assistant to the Director
E-mail: hensonk@dhmh.state.md.us

Kimberly Isaac-Dallas, Executive Associate
E-mail:kisaac@dhmh.state.md.us

Telephone: 410-764-4660
Fax: 410-358-4194
Website: http://dhmh.state.md.us/mchrc

Timetable

By close of business August 26, 2008	Call for Proposals Released
September 9, 2008 1 PM EDT	Frequently Asked Questions Call Optional Conference Call with Applicants Registration Required (FAQs) posted at http://dhmh.state.md.us/mchrc/ (to be updated periodically)
September 17, 2008 5 PM EST	Deadline for Receipt of Letters of Intent
October 7, 2008 5:00 p.m. EST	Deadline for receipt of applications
October – November 2008	Review of Applications
November 20, 2008	Applicant Presentations to the Commission
December 19, 2008	Successful Applicants will be Notified of Awards by December 19, 2008

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 25 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 and the appendices specified in the guidelines below are excluded from the 25-page limit. The hard copy original and nine 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. If the proposal addresses more than one priority area, then 12 hard copies of the proposal must be submitted.

The proposal should be structured using these topic headings:
Table of contents (not included in the 25 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 possible.

If the proposal addresses more than one priority area, the applicant organization section (item 5 below) can be located as the first section of the proposal, with the other sections for each priority area following after item 5.

1. Project Summary

- Provide a one-page summary of the proposal.

2. The Project

- *What will the project do?* 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).
- *Who is the target population?* Identify the population(s) to be served (i.e., estimated numbers, demographics, insurance coverage, income levels, other distinguishing characteristics). 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.

- *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 Gantt 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.
- *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.
- *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.

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. If the project spans more than one year, the line item budget should be broken down into annual budget periods. 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
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Judith L. Boyer-Patrick, M.D., M.P.H.
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Karla Ruhe Roskos, B.S.N., M.P.H.
Douglas Wilson, Ph.D.
John L.Young, M.D.

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 nonemergency 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.