



STATE OF MARYLAND

Community Health Resources Commission

4201 Patterson Avenue, Room 315 • Baltimore, Maryland 21215

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

**Aligning Community Health Resources:
Improving Access to Care for Marylanders**

Call for Proposals

October 19, 2007

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 four priority areas. Projects in the first priority area will demonstrate innovative approaches to functional integration of services for individuals who have 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. The Commission's second priority area seeks projects which will reduce non-emergency use of hospital emergency rooms by redirecting patients to community health resources for primary care. The third priority area is projects that will improve access to care and/or promote service integration for low-income and under- and uninsured immigrants in new and creative ways. 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 anticipates awards totaling as much as \$3.6 million during this round of grantmaking.

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 proposals in more than one priority area, but a separate, complete proposal must be submitted for each priority area. Each proposal must address all elements and contain all documents listed in the "Proposal Guidelines" described on pages 12- 14 of this Call for Proposals. A separate Letter of Intent must be submitted by for each proposal.

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 collect 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 four areas:

1. Functionally Integrating Services for Individuals with Co-occurring Mental Illness and Substance Abuse Disorders

Outlook and Outcomes 2006, published by the Department of Health and Mental Hygiene's Alcohol and Drug Abuse Administration 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." The report shows that 23.1% of the 47,527 clients admitted for substance abuse treatment from 2002 to 2006 had a mental illness at the time of admission. The report goes on to say: "These data support the accepted view that patients with co-occurring disorders are among the most difficult to treat effectively. 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 functionally 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.

2. Redirecting Non-Emergency Use of Hospital Emergency Departments to Community Health Resources

Emergency room visits to Maryland hospitals increased 22 percent in five years to 2.2 million visits in 2004, far exceeding the 13 percent increase nationally during the same period. In 2001, 17 percent of visits to Maryland emergency departments were non-urgent; another 17 percent were urgent, but treatable in a primary care setting. Many of the 14 percent of Marylanders who lack health insurance coverage turn to emergency rooms when they require routine medical care. The cost of the average emergency room visit has been estimated to be as much as six times the cost of a physician's office visit.

Not only does the use of emergency rooms for non-emergency care contribute to overcrowding and escalating costs, but it also diverts resources away from patients with life-threatening conditions and compromises the ability of emergency departments to respond to more serious events such as a natural disaster, epidemic, or terrorist attack.

A number of strategies may help reduce emergency room use for non-emergency conditions. In addition to offering discounted fees and subsidized services, access to community health centers and other community health resources might be increased through marketing and consumer education, expanded operating hours, and infrastructure and service improvements. Programs to



improve chronic disease management might also reduce demand for emergency room care. The Commission will consider applications proposing any of these, or other, approaches to reducing non-urgent emergency room visits.

3. Improving Access to Care and/or Promoting Service Integration for Low-Income and Under- and Uninsured Immigrants

Immigrants comprised 8% of Maryland's population in 2005 according to The Kaiser Foundation's *State Health Facts*. The U.S. Census *American Community Survey* indicates that in 2006, 683,000 Maryland residents were foreign-born, an increase of 165,000 from the year 2000. In 2006, according to the survey, approximately 780,000 Maryland residents spoke a language other than English at home, 158,000 more than in 2000. According to the Maryland Health Care Commission's *Health Insurance Coverage in Maryland through 2002*, non-elderly, non-citizens comprise 30 percent of the state's uninsured. The report further shows that 68% of non-elderly, non-citizens below 200% of the federal poverty level are uninsured and 49% of these individuals between 201-400% are uninsured. Yet Kaiser notes that low-income non-citizen adults are not relying on emergency department for care. Many rely on clinics and health centers.

The Commission recognizes the role of Community Health Resources in caring for immigrants. Approaches to increasing access for the foreign-born and non-English speaking residents may include creating or expanding culturally sensitive and appropriate primary care, mental health and substance abuse treatment services. Certified medical interpretation training for staff, outreach programs designed for specific groups, linguistically-focused care coordination and case management could be effective strategies to caring for the Maryland's immigrant communities. Culturally sensitive and appropriate chronic disease management programs may help improve health status. The Commission will consider applications proposing any of these, or other stratagems to increasing effective services for the State's foreign-born and non-English speaking populations.

4. Improving Access to Dental Care for Marylanders

Access to oral health care is a critical problem for underserved and minority populations in Maryland. *The 2000 – 2001 Survey of Oral Health Status of Maryland School Children* conducted by the University of Maryland Dental School found that 53% of children in kindergarten and third grade had untreated tooth decay in their primary teeth. Children residing on the Eastern Shore or in Central Maryland had the highest rates of untreated tooth decay. Low-income, African-American and Hispanic children suffer even higher rates of tooth decay. Adults and disabled individuals with advanced dental problems or with medical complications are often 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.

All proposals the Commission will consider for Creation of New Sources of Dental Care and for Expanding Existing Sources of Dental Care should ensure and demonstrate access to comprehensive dental care, including preventive, diagnostic, emergency, and restorative care.



Creation of 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.

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.

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

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.



Selection Criteria

Applicants may submit proposals for projects in any of the four 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 funding from internal sources or community matching support, including "in kind" support. Preference will be given to those applicants that can demonstrate community-wide, local support: at least 10% 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.

Preferences will be given to those applicants that can make at least an additional 5% financial commitment to this project from their own internal funds (operating funds or reserves). For proposals for new or expanded dental services, a separate equipment maintenance fund or equipment replacement fund or small endowment for the dental clinic will be counted as internal financial commitment. In other words, in addition to the requirement of other funding commitments, the Commission expects to see an institutional financial commitment from the applicant.

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 unapproved devices or



drugs, 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 \$3.6 million during this round of grantmaking. Single-year and multiple-year one-time grants will be awarded:

- Single-year grants of up to \$100,000 are anticipated for priority areas 1, 2 and 3
- Multiple-year grants of up to \$500,000 with a duration of up to three years for priority areas 1, 2 and 3
- The Commission will consider proposals up to \$550,000 one time grants spread over one to two years for new dental services
- The Commission will consider proposals which expand existing dental services 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. Dental projects may emphasize, but do not have to be limited to services for families and children
- Grantees must provide a match for awarded funds at 10% for all proposals.

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 November 6, 2007 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: **1) Functionally Integrating Services for Individuals with Co-occurring Mental Illness and Substance Abuse Disorders; 2) Redirecting Non-Emergency Use of Hospital Emergency Departments to Community Health Resources; 3) Improving Access to Care and/or Promoting Service Integration for Low-Income and Under- and Uninsured Immigrants; or 4) Improving Access to Dental Care for Marylanders**

- 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.



Letters of intent should be sent to:

Grace S. Zaczek
Acting Executive Director
Maryland Community Health Resources Commission
4201 Patterson Avenue, Room 315
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 November 27, 2007 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 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 (November 27, 2007, 5:00 p.m. EDT), applicants should e-mail an electronic version of their transmittal letter, Grant Application Cover Sheet, and proposal to zaczekg@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.

Grace S. Zaczek
Acting Executive Director
Maryland Community Health Resources Commission
4201 Patterson Avenue
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 October 25, 2007, 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 October 23, 2007, to kisaac@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 kisaac@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, Acting Executive Director
E-mail: zaczekg@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 October 19, 2007	Call for Proposals Released
October 25, 2007 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)
November 6, 2007 5 PM EST	Deadline for Receipt of Letters of Intent
November 27, 2007 5:00 p.m. EST	Deadline for receipt of applications
November – December 2007	Review of applications
January 30, 2008	Notification of grant awards
February 7-8, 2008	Signing of Grant Awards
March 11, 2008	Grant funding begins



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 proposal should be structured using these topic headings:

1. Table of contents (not included in the 25 page limit)
2. Project Summary
3. The Project
4. Evaluation
5. Work Plan
6. Applicant Organization
7. Key Personnel
8. Partners and Collaborators
9. Project Budget

The suggested content of each of these eight sections is discussed below. Provide as much detail as possible.

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. Grant funding will be available beginning March 11, 2008.
- *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
Yvette J. Benjamin, P.A., M.P.H.
Judith L. Boyer-Patrick, M.D., M.P.H.
Stanley A. Goldman, Ph.D.
Kendall D. Hunter
Leon Kaplan, C.P.A., M.B.A.

Paula B. McLellan
Margaret Murray, M.P.A.
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.

