STATE OF MARYLAND

Community Health Resources Commission

201 W. Preston Street, Room 424 • Baltimore, Maryland 21201

Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Dr. Samuel Lin, Chair

Aligning Community Health Resources: Improving Access to Care for Marylanders

Call for Proposals

October 4, 2006

Notice to Applicants

The Maryland Community Health Resources Commission is charged under Health Gen. §19-2109 and §19-2201 with promulgating regulations to operate its grants program. The Commission submitted regulations for review and approval by the legislature's Administrative, Executive and Legislative Review (AELR) Committee on September 26, 2006. A copy of those draft regulations is available on the Commission's website at http://dhmh.state.md.us/mchrc/. Final approval of the regulations is anticipated in fall 2006. Only the Commission's final regulations as adopted will determine the processes and criteria under which grants will be awarded.

Overview

On May 10, 2005, the Governor of Maryland, Robert L. Ehrlich, Jr., signed into law the *Community Health Care Access and Safety Net Act of 2005*. This legislation authorized the creation of the Maryland Community Health Resources Commission. 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 new grants program of the Maryland Community Health Resources Commission. The program will award grants to community health resources serving Marylanders in Maryland. In this initial offering, the Commission encourages projects that will reduce non-emergency use of hospital emergency rooms by redirecting patients to community health resources for primary care. In addition, the Commission is seeking projects that will integrate mental health services with primary care services, substance abuse treatment, and social services to provide patients with a medical home leading to coordinated, comprehensive community-based care. The Commission will also consider proposals from community health resources for other projects that will improve access to care and/or promote service integration for low-income families and under- and uninsured populations in new and creative ways. The Commission anticipates awards totaling as much as $3.5 million during this first round of grantmaking.

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 three areas:

1. 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-emergency visits to hospital emergency rooms.

2. Integrating Community-Based Mental Health and Substance Abuse Services with Somatic Services

Adults with severe mental 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 abuse and mental health disorders are also confronted by a disjointed health care system that does not routinely provide effective integrated clinical interventions.

Strategies to link mental health and substance abuse services with primary care include 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 mental health professionals. Similarly, services for individuals with co-occurring substance abuse 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 abuse services with somatic care.

3. Other Initiatives to Develop Coordinated, Integrated Systems of Community-Based Care
The Commission will also consider proposals from community health resources for projects that will improve access to care and/or promote service integration for low-income families and under- and uninsured populations in new and creative ways.

Selection Criteria

Applicants may submit proposals for projects in the three 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, 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.

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.

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 evidenced 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 Commission will consider the extent to which the applicant organization demonstrates use of a sliding scale fee schedule effectively to increase access to care for low-income uninsured and under-insured individuals in Maryland.

The Commission will also consider the funding priorities in the regulations submitted on September 26, 2006, to the legislature's Administrative, Executive and Legislative Review (AELR) Committee. These funding priorities are listed in the Appendix to this Call for Proposals.

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. With the Commission's approval, 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 construction projects, to support clinical trials or unapproved devices or drugs, or for lobbying or political activity.

Awards

The Commission will award grants totaling up to $3.5 million during this first round of grantmaking. Single-year and multiple-year one-time grants will be awarded:

- Single-year grants of up to $100,000 are anticipated
- Multiple-year grants of up to $500,000 with a duration of up to three years

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 are requested to submit a letter of intent, but a letter of intent is not required. Letters of intent should be received by 5:00 p.m. EDT on September 20, 2006, 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) Redirecting Non-Emergency Use of Hospital Emergency Departments to Community Health Resources; 2) Integrating Community-Based Mental Health and Substance Abuse Services with Somatic Services; or 3) Other Initiatives to Develop Coordinated, Integrated Systems of Community-Based Care.
- 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:

Joyce Meyers
Center for Health Program
Development and Management
UMBC
Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, MD 21250

Step 2: The Proposal
Applicants should prepare proposals following the "Proposal Guidelines" on pages 8-9 of this Call for Proposals.

Step 3: Submission of Applications
Grant applications are due by 5:00 p.m. EDT on October 20, 2006. 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 the individual responsible for conducting the affairs of the applicant and legally authorized to execute contracts on behalf of the applicant.
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 the individual responsible for conducting the affairs of the applicant and authorized to execute contracts on behalf of the applicant.
4. **Proposal:** See "Proposal Guidelines" in the Call for Proposals.

By the deadline for receipt of applications (October 20, 2006, 5:00 p.m. EDT), applicants should e-mail an electronic version of their transmittal letter, Grant Application Cover Sheet, and proposal to jmeyers@chpdm.umbc.edu.

Also by the required deadline, the following must be received at the address below by hand delivery, U.S. Postal Service, or private courier: 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) ten bound copies of transmittal letter, Grant Application Cover Sheet, and proposal.

Joyce Meyers
Center for Health Program
Development and Management
UMBC
Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, MD 21250

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 3, 2006, at 3:00 p.m. EDT, is optional. Registration is required. To register, send an e-mail by October 2, 2006, to jmeyers@chpdm.umbc.edu 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 jmeyers@chpdm.umbc.edu. 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 Center for Health Program Development and Management at the University of Maryland, Baltimore County (UMBC). Staff members are:

John O'Brien, Consultant
E-mail: jobrien@chpdm.umbc.edu

Joyce Meyers, Staff Assistant
E-mail: jmeyers@chpdm.umbc.edu

Telephone: 410-455-6377
Fax: 410-455-6850
Website: http://dhmh.state.md.us/mchrc/

Timetable

September 20, 2006 5:00 p.m. EDT	Deadline for receipt of letters of intent
October 3, 2006 3:00 p.m. EDT	Optional conference call with applicants (registration required)
October 4, 2006	Frequently Asked Questions (FAQs) posted at http://dhmh.state.md.us/mchrc/ (to be updated periodically)
October 20, 2006 5:00 p.m. EDT	Deadline for receipt of applications
November – December 2006	Review of applications
January 15, 2007	Notification of grant awards
February 1, 2007	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. 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.

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 510(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 county 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 are the other key staff?* Identify other essential staff, their roles in the project, and their relevant qualifications. As an appendix, include resumes (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 February 1, 2007.
- *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

Governor Robert L. Ehrlich, Jr., signed into law the *Community Health Care Access and Safety Net Act of 2005* on May 10, 2005. The law authorized establishment of the 11-member Maryland Community Health Resources Commission. The Commission was created to help communities in Maryland improve access to care for low-income families and under- and uninsured individuals. In January 2006, Governor Ehrlich appointed members of the Commission with the advice and consent of the Senate.

Maryland Community Health Resources Commission

Samuel Lin, M.D., Ph.D., M.B.A., Chair
Yvette J. Benjamin, P.A., M.P.H.
Judith L. Boyer-Patrick, M.D., M.P.H.
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Jorge E. Calderon, M.D., M.P.H.
Kendall D. Hunter
John A. Hurson, J.D.
Leon Kaplan, C.P.A., M.B.A.
Donald C. Roane, M.D.
Karla R. Roskos, B.S.N., M.P.H.
Joseph P. Ross

Appendix

Chapter 10.45.07.02. Funding Priorities

In selecting community health resources' proposals to be funded under this subtitle, the Commission shall:

A. Consider geographic balance; and

B. Give priority to community health resources that:

(1) In addition to normal business hours, operate during evening and weekend hours;

(2) Have partnered with a hospital to establish a reverse referral program at the hospital;

(3) Reduce the use of the hospital emergency department for non-emergency services;

(4) Assist patients in establishing a medical home with a community health resource;

(5) Coordinate and integrate the delivery of primary and specialty care services;

(6) Promote the integration of mental and somatic health with federally qualified health centers or other somatic care providers;

(7) 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;

(8) Provide a clinical home for individuals who access hospital emergency departments for mental health services, substance abuse services, or both; and

(9) Support the implementation of evidence-based clinical practices.