MCHRC

Maryland Community Health Resources Commission

Annual Report

FY 2012, 2013, 2014

Executive Director – Mark Luckner

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MCHRC
Maryland Community Health Resources Commission

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

FY2012/2013/2014 Annual Report

I. Executive Summary

The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 to expand access to health care services in underserved communities in Maryland. The CHRC is a quasi-independent commission operating within the Maryland Department of Health & Mental Hygiene (DHMH), whose members are appointed by the Governor. Since its inception, the CHRC has awarded 142 grants totaling $41.9 million, supporting programs in every jurisdiction of the state. These programs have collectively served more than 140,000 Marylanders, and grants awarded by the CHRC have enabled grantees to leverage $14.7 million in additional federal and private/non-profit resources.

The roles and responsibilities of the CHRC have grown over the last few years in recognition of the Commission's demonstrated track record in delivering resources in an efficient and strategic basis and in recognition of the critical role that community health resources are playing as Maryland implements the Affordable Care Act (ACA). The budget of the CHRC has increased in recent years, from $3 million to $8 million, as the Maryland General Assembly voted in 2012 to amend the Budget Reconciliation and Financing Act (BRFA), approving language that ensured the CHRC's budget "shall be no less than" $8 million starting in FY 2014 and in perpetuity. The legislature also approved legislation during the 2014 session to re-authorize the Commission through June 2025. These actions by the Maryland General Assembly to increase the CHRC's budget and re-authorize the Commission demonstrate strong continued legislative support of the work of the CHRC.

The CHRC fulfills many of its statutory responsibilities by issuing annual Calls for Proposals and has aligned its grantmaking activities to support the public health priorities of the Administration and DHMH. Another major responsibility of the CHRC is implementing the Health Enterprise Zones (HEZ) Initiative jointly with DHMH. In addition, the CHRC has worked on a variety of special projects as requested by the state. This includes supporting the State Health Improvement Process created by DHMH in 2012. The CHRC has also executed a number of special projects, which include the Access to Care Program and the DDA Infrastructure Grants, and the Commission has co-chaired the DHMH Task Force of Regulatory Efficiency.

II. Background and Mission

The Maryland General Assembly created the Community Health Resources Commission in 2005 to expand access to affordable, high quality health care services in the state's underserved communities; support the adoption of health information technology in community health resources; increase access to specialty health care services for the uninsured and low-income individuals; and promote interconnected systems of care and partnerships among community health resources and hospitals. The CHRC is a quasi-independent commission

within the Maryland Department of Health & Mental Hygiene, and its 11 members are appointed by the Governor (see Appendix A). The CHRC fulfils its authorizing statutory responsibilities through its grantmaking activities, awarding 142 grants totaling $41.9 million, supporting programs in all 24 jurisdictions of the state. These programs have collectively served more than 140,000 Marylanders and enabled CHRC grantees to leverage $14.7 million in additional federal and private/non-profit resources.

In creating the CHRC, the Maryland General Assembly recognized the need to have an independent commission that focused on strengthening Maryland's diverse network of community health centers and safety net providers and addressed service delivery gaps in Maryland's dynamic health care marketplace. The role that the CHRC plays in strengthening Maryland's network of community health resources and safety net providers becomes increasingly important as Maryland implements the ACA and hundreds of thousands of individuals gain access to health insurance. The newly insured individuals will place increasing demands on Maryland's community health centers and safety net providers as they seek health care services in higher volumes. In response to legislation approved by the Maryland General Assembly in 2011, the Commission developed a business plan that outlined specific recommendations for how the state could support the work of safety net providers during ACA implementation. For a copy of this business plan, see Appendix B. The CHRC has awarded a number of grants and provided technical assistance to enable safety net providers to build capacity and expand access and to promote their transition from a grant-based revenue model to a more sustainable system of billing third-party payers. In addition, Maryland is currently implementing a new Medicare All-Payor Waiver (Waiver) which transitions the hospital revenue structure from an inpatient fee-for-service model (quantity) to a system based on total patient revenue and global budgeting that rewards quality and promotes reductions in inpatient care costs. This Waiver presents enormous challenges for Maryland's hospitals and may provide an increased focus on importance of the delivery and accessibility of services in an ambulatory care setting. This transition presents new opportunities for community health resources and safety net providers. A number of recent grants awarded by the CHRC have promoted innovative community-hospital partnerships and programs that target reductions in hospital emergency department visits, admissions, and readmissions. These types of community-hospital partnerships to reduce hospital inpatient costs and efforts to build capacity of community health resources are expected to continue.

The CHRC supports the work of community health care resources and fulfills its statutory mission in the following activities: (1) Awarding grants to expand access in underserved areas and support public health priorities; (2) Supporting the Local Health Improvement Coalitions (LHIC) and efforts to promote population health initiatives; (3) Implementing the Health Enterprise Zones Initiative jointly with DHMH; and (4) Executing additional special projects.

III. Grantmaking Activity

Since its inception, the CHRC has awarded 142 grants totaling $41.9 million through its Calls for Proposals, which have supported programs in every jurisdiction in Maryland. The CHRC has aligned its grantmaking activities to support the policy priorities of the O'Malley-Brown Administration and DHMH leadership. As shown in the table below, CHRC grants have

supported programs which have provided services for 140,644 patients, resulting in 433,692 patient visits.

Table 1:

Maryland Community Health Resources Commission				
Focus Area	# of Projects Funded	Total Award Provided	Cumulative Total	
			Patients Seen/Enrolled	Visits Provided
Expanding Access to Primary Care at Maryland's safety net providers	29	$8,562,650	57,202	194,758
Increasing Access to Dental Care for Low-income Marylanders	23	$5,275,606	42,540	93,947
Addressing Infant Mortality	15	$3,205,697	9,934	27,888
Reducing Health Care Costs through ER Diversions	6	$1,994,327	13,804	27,943
Promoting Health Information Technology at community health centers	9	$3,268,661	Health Information Technology	
Providing Access to Mental Health and Drug Treatment Services	18	$5,775,075	12,390	46,723
Addressing Health Care Needs of Co-Occurring Individuals	7	$2,230,842	4,774	42,433
Supporting Local Health Improvement Coalitions (LHICs)	24	$1,955,048		
Health Enterprise Zones	5	$7,710,000		
Safety Net Capacity Building	3	$455,000	0	0
Childhood Obesity	3	$1,560,000	0	0
Total Grant Funding Provided	**142**	**$41,992,906**	**140,644**	**433,692**
Total Funding Requested	**432**	**$147,297,981**		
Number of Patients Served/Enrolled	**140,644**			
Number of Patients Visits/Services Provided	**433,692**			
Additional federal and private resources leveraged	**51**	**$14,708,459**		

The CHRC awards grants by issuing a Call for Proposals approximately once a year. Grants are awarded in a competitive process, and priority areas and review criteria are determined by CHRC Commissioners. Grant proposals are evaluated by independent subject matter experts on a range of criteria outlined in each Call for Proposals, including the ability of the grantee to achieve stated program objectives and achieve sustainability once initial grant funds are utilized. Evaluation criteria utilized include: (1) the use of evidenced-based practices in the proposed program; (2) the ability of the program to collect and report outcomes data; (3) demonstration of a community need; (4) program sustainability; and (5) likelihood of overall program success.

Since 2012, the Commission has issued four Calls for Proposals. The most recent Call for Proposals targeted three policy objectives: (1) Building capacity as Maryland implements the ACA; (2) Reducing health disparities; and (3) Reducing hospital admissions and readmissions. Following is a summary of the grants awarded by the CHRC in recent years. For a complete list of the CHRC grants awarded in recent years, see Appendix C.

Addressing Infant Mortality

In 2008, the O'Malley-Brown Administration set the goal of reducing Maryland's infant mortality rate by 10% by 2012. The Administration announced that the state's infant mortality rate has decreased by 21%, effectively achieving the original strategic goal. The Administration subsequently announced a new goal of reducing the state's infant mortality rate by an additional 10% by 2017. To support this new goal, the CHRC has awarded 6 grants totaling $751,650 since 2012. These grants support expanding access to women's comprehensive health services in the community and have served 2,979 patients between 2012 and 2014.

Increasing Access to Integrated Behavioral Health Services

Promoting access to integrated mental health, substance abuse, and somatic health care services is a priority of the Commission as the state moves to support an integrated behavioral health care delivery system. This integration presents new challenges and opportunities to behavioral health providers. The CHRC has awarded 8 grants totaling $1.6 million since 2012 to promote overall behavioral health integration efforts. These grants support programs which provide behavioral health services in rural and urban settings to individuals with serious mental illness, co-occurring disorders, and/or significant somatic concerns and have also supported emergency department diversion/referral programs. Between 2012 and 2014, these programs have served 6,898 patients.

Expanding Access to Dental Care Services

In a recent report from The Pew Center on the States, Maryland received an "A" grade for the second consecutive year for children's dental health. However, the DHMH Office of Oral Health advised that despite recent strides to increase dental care capacity, there remain areas of the state that lack dental safety net providers. The CHRC has awarded 6 grants totaling $641,428 since 2012. These grants support programs which provide dental services and education through mobile dental clinics, school health and wellness centers, and programs that offer dental services at a discounted rate to underserved populations throughout the state. Between 2012 and 2014, these programs have served 2,707 patients.

Building Capacity of Safety Net Providers

Building on the CHRC's business plan to support the work of safety net providers as Maryland implements the ACA, the CHRC has awarded 3 grants totaling $455,000 since 2012. These grants support overall efforts of safety net providers to serve more patients and their transition from a grant-based revenue model to a more sustainable model of billing third-party payers.

Expanding Access to Primary Care Services in Underserved Communities

A core policy mission of the CHRC is to support comprehensive, interconnected systems of care in the local communities and to expand access to affordable, high-quality primary care services in underserved areas of the state. As Maryland implements the ACA, it is essential that the state expand its capacity to deliver primary care services in the community. The CHRC has awarded 7 grants totaling $1.3 million since 2012. These grants fund programs that support the opening of new access points implemented by Federally Qualified Health Centers and programs that will encourage the reduction of hospital emergency department visits, admissions, and readmissions. Between 2012 and 2014, these programs have served 10,944 patients.

Reducing Childhood Obesity

Childhood obesity is a national epidemic, with one in three children being overweight and at risk for serious chronic diseases such as diabetes. In 2010, 27.6% of Maryland's youth ages 12 to 19 were considered overweight or obese (Maryland Youth Tobacco Survey, 2010). Many early life risk factors for childhood obesity are more prevalent among the African American/Black and Hispanic populations. Because of this demonstrated health disparity, the CHRC's 2014 Call for Proposals included reducing childhood obesity, and the Commission awarded 3 grants totaling $520,000. These grants support efforts that focus on reducing obesity rates of youth through school-based programs, increasing access to healthy food options in known food deserts, and providing increased availability of physical activities in the community. These programs are expected to serve over 13,000 residents within their communities.

Grantee Performance Monitoring
The CHRC has developed and implements a robust system for grantee performance management that requires grantees to report on a series of standard and customized process and outcome measures to ensure that grant resources are utilized efficiently and that program objectives are achieved effectively. These performance measures include a core set of common data variables that all grantees are required to report, focus-area specific measures (i.e., measures specific to all infant mortality grants), as well as many grant-specific evaluation measures.

The CHRC requires data reporting as a condition of payment of Commission grant funds. At the beginning of the grant period, grantees are required to submit projected totals for the duration of the program and then report actual figures in subsequent reporting periods. CHRC staff reviews the actual data reported by the grantees and compares these figures to the grantee's projections. Grantees are held accountable for performance and progress towards meeting the goals of the programs. When programs do not achieve objectives, the Commission redirects grant funding to other successful grantees.

Supporting Sustainable Systems of Care and Leveraging Additional Resources
Promoting long-term financial sustainability of grant programs is a key priority of the Commission, and the grant funding provided by the CHRC has enabled grantees to leverage approximately $14.7 million in additional federal, private/non-profit resources, and other resources. The Commission has served as an "incubator" for innovative programs and supports the efforts of grantees to continue programs once initial CHRC grant funding has been expended. Several recent CHRC grantees that have leveraged additional funding include Community Clinic, Inc., Way Station, Inc., and Catholic Charities - Esperanza Center's Health Clinic.

Community Clinic, Inc., a Federally Qualified Health Center in the Washington D.C. metropolitan region, utilized CHRC grant funding to expand services for high-risk patients in Montgomery and Prince George's Counties and supported the integration of Community Health Workers. This program was able to expand its service delivery programming to target obesity prevention efforts and chronic conditions for patients under the age of 18. Community Clinic, Inc. leveraged CHRC grant funds to raise an additional $1.9 million in private and local funding support, including a three-year grant for $1.5 million from CareFirst. The program has served 6,168 individuals to date.

Way Station, Inc. provides comprehensive community-based mental health services to adults and children in Baltimore City, Frederick, Carroll, Howard, and Washington Counties. Way Station utilized CHRC grant funds to increase access to primary care services in their existing behavioral health clinic. The pilot program utilizes three methods to achieve its two goals of improving health and reducing medical costs: i) enhancing integration of primary care and behavioral health by imbedding primary care nurse care managers in mental health teams; ii) increasing access to primary care by co-locating primary care satellite sites in mental health facilities; and iii) enhancing patient participation in care by implementing a SAMHSA-endorsed evidence-based practice that teaches adults with mental illness the skills and motivation to manage their physical health. This program provided more than 1,500 health education sessions to assist individuals in managing chronic disease. Way Station, Inc. leveraged CHRC grant funds to raise an additional $1.7 million in private and local funding support. DHMH used the experience of the pilot to successfully secure new federal Medicaid funding available under the Affordable Care Act and to replicate the project with additional

agencies and sites through the state. The program has served 736 individuals to date, and many of these individuals have complex primary and behavioral health needs.

Catholic Charities is a 501(c)3 non-profit organization that operates the Esperanza Center's Health Clinic in Baltimore City. The CHRC grant enabled Catholic Charities to expand the successful Asociación Comunidad Saludable Project and increased access to care for this underserved population. Grant funds enabled the hiring of a bilingual nurse who tripled monthly patient visits after hiring and addresses communication barriers for this patient population. Catholic Charities leveraged CHRC grant funds to raise an additional $500,000, including a $200,000 grant from Catholic Health Initiatives. The program has served an additional 3,156 patients to date and provided 6,498 visits.

IV. Local Health Improvement Coalitions

DHMH established the State Health Improvement Process (SHIP) in 2012, which focuses on improving population health outcomes and measures in every jurisdiction based on their performance on 39 population health metrics. These metrics include reducing emergency department visits related to behavioral health; reducing diabetes-related emergency department visits; and reducing the percent of children considered obese. In support of SHIP, the CHRC has issued two Calls for Proposals in recent years and awarded 24 grants totaling $1.95 million to assist in the planning and implementation activities of Local Health Improvement Coalitions, which are led by local health departments and hospital systems. Seven grants are under current implementation.

The CHRC's most recent LHIC Call for Proposals generated a total of sixteen applications requesting $3.4 million (See Appendix D). Based on available funding, the CHRC awarded 7 LHIC grants totaling $1.3 million. The LHIC Call for Proposals was designed to support the long-term capacity of the LHICs and to support the framework for the State's future Community Integrated Medical Home model. In addition to CHRC funds, DHMH contributed $191,000 in federal funding to support the activities of these grantees. The bulk of LHIC grant funds are being utilized to support the costs of hiring new personnel, including community health workers, program administrators, and community health nurses. Non-personnel costs are being utilized by LHICs to support medical equipment in a new patient-centered medical home, purchase of computer equipment, and trainings for new personnel. A list and summary of the current LHIC grants can be found in Appendix E.

V. Implementation of the Health Enterprise Zones Initiative

During the 2012 legislative session, the Maryland General Assembly passed SB 234, the Maryland Health Improvement and Disparities Reduction Act, legislation championed by Lt. Governor Anthony G. Brown. Governor Martin O'Malley signed SB 234 into law in April 2012. This Act provides $4 million per year over the four year duration of the program and created the policy framework to create Health Enterprise Zones, which are geographically defined areas that demonstrate poor health outcomes and economic disadvantages. The HEZ Initiative provides a range of incentives, including income tax credits, hiring tax credits, loan repayment assistance, and grant funding from the CHRC, to attract new health practitioners to serve in HEZs and expand access in these underserved communities. The policy objectives of the HEZ Initiative

are to: (1) Improve health outcomes and expand access in underserved areas; (2) Reduce health disparities; and (3) Reduce health care costs and hospital admissions and readmissions. For more information about the HEZ Initiative, please visit the HEZ website and review the annual report for 2013. This information can be found at: http://dhmh.maryland.gov/healthenterprisezones/SitePages/Updates.aspx

After the Act was signed into law, a public comment period was held during the summer of 2012 to solicit feedback on the selection criteria for the HEZs, the potential uses of HEZ funding, and the outcome metrics that should be developed to monitor the progress and implementation of the HEZs. The Call for Proposals issued by the CHRC in October 2012 (see Appendix F) generated a total of 19 applications from 17 jurisdictions, representing rural, urban, and suburban areas of the state. Applications for HEZ designation were required to demonstrate health care needs and specific disparities and offer intervention strategies to improve health outcomes in the potential Zone. The HEZ applications were evaluated competitively on 13 review principles by an independent HEZ Review Committee comprised of experts in the fields of public health, health care finance, health disparities, and health care delivery. On January 24, 2013, based on recommendations from the CHRC, DHMH Secretary Sharfstein designated Maryland's first five HEZs:

(1) The Annapolis Community Health Partnership;
(2) The Caroline/Dorchester Competent Care Connections HEZ;
(3) Greater Lexington Park Zone;
(4) The Prince George's County Zone; and
(5) The West Baltimore Primary Care Access Collaboration.

These five designations involved a total funding commitment of $3.85 million in the first year of the program. A map of the designated five Zones can be found in Appendix G. Activities of the five HEZs began in earnest in March 2013, and the Zones completed their first year of implementation by April 30, 2014. A copy of the first annual HEZ report submitted to the Governor and Maryland General Assembly in January 2014 can be found in Appendix H.

The HEZ Initiative is jointly implemented by the CHRC and DHMH. The DHMH Secretary designated Health Enterprise Zones, and the CHRC administers the HEZ Reserve Fund. A shared governance model has been utilized to execute a management strategy for oversight of the five Zones and overall implementation of the HEZ Initiative in year one. Day-to-day program oversight is executed by the HEZ Project Director (hired by the CHRC in January 2014), while technical assistance and content area expertise are provided by DHMH staff. Fiscal and administrative oversight is provided by the CHRC. Overall executive direction and leadership are provided by the DHMH Secretary.

As part of the overall program management and oversight, the CHRC provides monitoring of the activities of the HEZs through site visits, conference calls, and quarterly progress reports. Each Zone is required to submit quarterly progress reports to the Commission as a condition for payment of public funds. A customized HEZ Dashboard has been developed which tracks performance towards key milestones and deliverables and overall progress towards key goals of each Zone. The Dashboards facilitate public reporting, transparency, and accountability of the Zones. Each HEZ has core clinical outcome goals, and all five Zones include a focus on diabetes. Assessment of progress towards improved clinical outcomes will be based on

standardized metrics such as those from the National Quality Forum and Uniform Data System, and these measures will be incorporated in HEZ reporting in year two of the program. Dashboards are included as Appendix I.

VI. CHRC Special Projects

In addition to its grantmaking activities, the CHRC has been tapped in recent years to support several public health initiatives and special projects. Following is an overview of these activities: (1) Access to Care Program; (2) Developmental Disabilities Administration Infrastructure Grants; and (3) DHMH Task Force on Regulatory Efficiency.

Access to Care Program

In 2011, the Maryland General Assembly approved legislation (SB 514/HB 450) that directed the CHRC to assist community health resources in their efforts to respond to the implementation of the ACA. The CHRC developed a business plan in 2012 that outlined specific recommendations for how the state could promote the readiness of safety net providers and assist in their efforts to build capacity and achieve long-term financial sustainability. As part of these efforts, the state launched the Access to Care Program, an interagency collaboration of the CHRC, DHMH, and the Maryland Health Benefit Exchange. The purpose of the Access to Care Program was to build the capacity of safety net providers to serve more patients as the newly insured individuals access primary, preventive, and specialty care services in higher volumes. The state hosted six forums in June 2013 and invited safety net providers, Medicaid Managed Care Organizations, and Quality Health Plans. These forums were designed to encourage networking opportunities and promote the participation of essential community providers in Medicaid Managed Care Organizations and commercial health insurance networks. A copy of the presentation from these forums may be found in Appendix J.

Developmental Disabilities Administration Infrastructure Grants

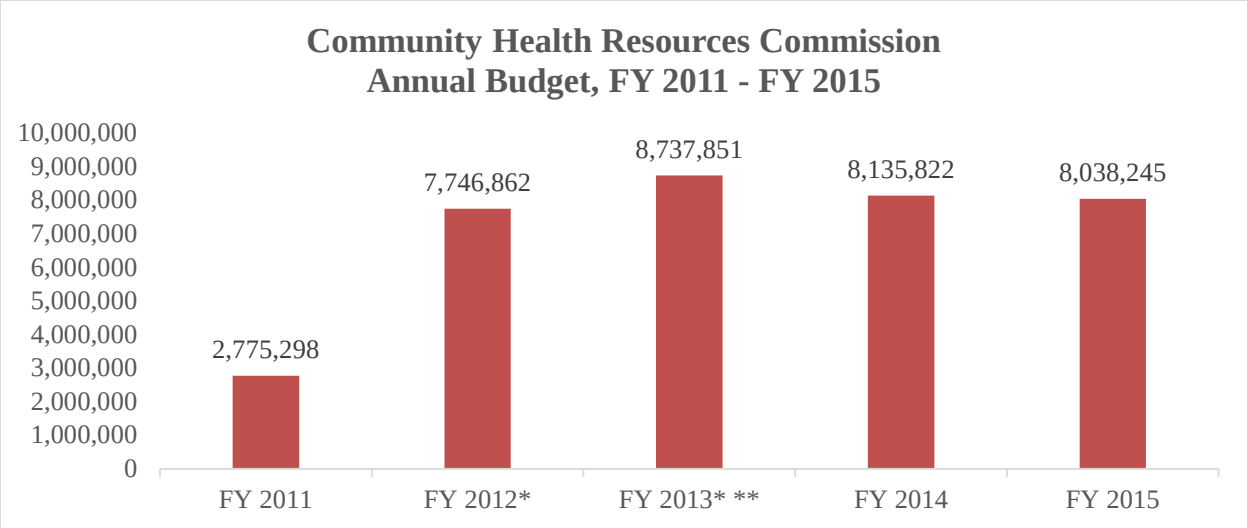
At the request of DHMH leadership, the CHRC worked with the DHMH Developmental Disabilities Administration (DDA) to issue the DDA Infrastructure Grant Call for Proposals on April 2, 2012. This Call for Proposals generated a total of 121 awards to DDA licensees, totaling $5,997,975 in one-time only infrastructure grants. The grants were supported with funds provided by the DDA (funds were transferred to the CHRC's budget) and were awarded to support projects in one of the following six categories: (1) New vehicles and other forms of transportation; (2) Adaptation of, or modification to, existing DDA licensee-owned vehicles; (3) Information technology equipment, software, or related services; (4) Adaptations, modifications, repairs, or improvements to existing provider-owned properties/programs that address critical health and safety issues or improve access or quality of life for individuals with developmental disabilities. (Programs include day, vocational, and residential services such as group homes and Assisted Living Units); (5) Start-up funds for or expansion of infrastructure for innovative programs that increase community integration or integrated employment for people with developmental disabilities; and (6) Staff training in areas directly related to working with people with developmental disabilities. Grant funds supported projects that included the purchasing of new vans for programs to provide transportation for clients to and from health care appointments and providing repairs for existing properties which provided DDA services (e.g., window replacements, updating of HVAC units, and new flooring).

DHMH Task Force on Regulatory Efficiency

At the request of DHMH leadership, the CHRC Executive Director co-chaired the DHMH Task Force on Regulatory Efficiency with the DHMH Chief-of-Staff. The Task Force was tasked with conducting a cross-agency review of DHMH regulations and soliciting public comment to promote greater transparency, efficiency, and effectiveness in regulations. An initial public comment period generated 73 proposals from the public. Following a second public comment period, the Task Force issued its final report in June 2012. Of the 73 proposals received, 42 were supported by DHMH and moved forward for implementation or further review. Proposals that were implemented include such changes as allowing patients to return unused medications to help reduce health care costs at nursing homes. For copies of the Interim and Final Reports, see Appendices K and L.

VII. Legislation and Budget

The roles and responsibilities of the CHRC have grown over the last few years in recognition of the Commission's demonstrated track record in delivering resources in an efficient and strategic basis and in recognition of the critical role that community health resources are playing as Maryland implements the Affordable Care Act. The budget of the CHRC has increased in recent years, from $3 million to $8 million, as the Maryland General Assembly voted in 2012 to amend the Budget Reconciliation and Financing Act, approving language that ensured the CHRC's budget "shall be no less than" $8 million starting in FY 2014 and in perpetuity. The legislature also approved legislation during the 2014 session to re-authorize the Commission through June 2025.



Notes:

* The budgets in FY 2012 and FY 2013 contain a one-time transfer of DDA funds to the CHRC for the DDA Infrastructure grants.

** The FY 2013 budget reflects the first year of the Health Enterprise Zone Initiative, which provides $4 million per year over the duration of the Act (FY 2013 through FY 2016).

APPENDICES

Appendix A

MCHRC
Maryland Community Health Resources Commission

Maryland Community Health Resources Commission

Commissioners, June 2014

The Hon. John A. Hurson, Chairman
Executive Vice President, Personal Care Products Association

Nelson J. Sabatini, Vice Chairman
Former Secretary, Maryland Department of Health and Mental Hygiene

Elizabeth Chung
Executive Director, Asian American Center, Frederick

Charlene Dukes
President, Prince George's Community College

Kendall Hunter
Senior Vice President, Health Insurance Exchange Operations and Federal Employees Health Benefits, Kaiser Permanente

William Jaquis, M.D.
Chief, Department of Emergency Medicine, Sinai Hospital

The Hon. P. Sue Kullen
Staff for Senator Ben Cardin

Paula McLellan
CEO, Family Health Centers of Baltimore

Meg Murray
CEO, Association for Community Affiliated Plans

Barry Ronan
President and CEO, Western Maryland Health System

Maria Tildon
Senior Vice President, Public Policy and Community Affairs, CareFirst BlueCross BlueShield

Appendix B

(See DLS Library for a Copy)

Appendix C

Appendix C:
List of Grantees

CHRC Areas of Focus for Grants during FY 2012 and 2014

Focus Area: REDUCING INFANT MORTALITY

- **Access to Wholistic and Productive Living (Year One Grant Award $50,000)**
  Jurisdiction: Prince George's County
  Grant funds support expanded services for pregnant and early postpartum women over two years in order to improve birth outcomes and rates of first trimester prenatal care in underserved communities in Prince George's County. Services include targeted case management, home visiting, linkage to prenatal care, smoking cessation services, and/or health education. Grant funds will be utilized to hire staff to increase the number of zip codes in Prince George's County served by the Bright Beginnings program.

- **Calvert County Health Department (Year One Grant Award $85,000)**
  Jurisdiction: Calvert County
  Grant funds support a program to improve overall health outcomes for reproductive age women and reduce infant mortality rates by creating a new, "one-stop shop" of integrated behavioral health and social services for substance abusing women and expectant mothers. Grant funds will be utilized to support staff to develop and implement the multi-disciplinary program, which includes intensive case management and linkage to local obstetric providers, family planning, folic acid supplements, behavioral health services, WIC, social services, dental care, health insurance enrollment, and community resources such as education and job training opportunities.

- **Mary's Center (Year One Grant Award $200,000)**
  Jurisdictions: Prince George's and Montgomery County
  Grant funds support a program which seeks to reduce health disparities and the State's infant mortality rate by expanding its current prenatal services at the Adelphi clinic to include primary health care for women of reproductive age so that if they become pregnant, they will be in good health and will give birth to healthy birth weight babies. Grant funds will be used to support the salary costs of a Primary Care Adult/Family Medical Doctor, a Certified Nurse Midwife, a Family Support Worker, and a Life Cycle Health Educator at the Adelphi health center, which targets underserved communities in Prince George's County.

- **Harford County Health Department (Grant Award: $156,052)**
  Jurisdiction: Harford County
  Grant funds launched a comprehensive women's health services program aimed at assisting women in need of subsidized clinical family planning care to receive a comprehensive set of services that include Medicaid screening/eligibility, WIC nutrition services, dental referrals, substance abuse/mental health referrals, smoking cessation services, domestic violence screening/prevention, and other prevention services. Grant funds will be utlized to support costs of personnel and case management services.

- **Planned Parenthood-Maryland (Year One Grant Award $125,000)**
  Jurisdictions: Baltimore County, Anne Arundel County and Wicomico County
  Grant funds support a program that seeks to reduce infant mortality rates by increasing access to comprehensive women's health services in Baltimore, Anne Arundel, and Wicomico Counties by building on evidenced-based strategies currently used in Baltimore City. Grant funds will be utilized to provide same-day access to Long Acting Reversible Contraception (LARC), prevent substance-exposed pregnancies by implementing use of SAMHSA's evidence-based practice of Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool, and outreaching to clients to educate and connect those eligible to provisions of the Affordable Care Act.

- **Tri State Community Health Center (Grant Award: $135,598)**
  Jurisdiction: Allegany County
  Grant funds enabled the health center to create a program to increase positive pregnancy outcomes for low-income women, teens, and high risk women by integrating services available to women through Tri-State and the Allegany County Health Department in one location. Grant funds will be utilized to provide OB/GYN and postnatal care services through Tri-State providers and case-management, education, and home visiting services through the ACHD staff.

Focus Area: INCREASING ACCESS TO DENTAL CARE SERVICES

- **Allegany Health Right (Year One Grant Award $45,000)**
  Jurisdiction: Allegany County
  Grant funds support a program that targets low-income, special needs patients with low health literacy and provides access to dental care services and oral health education for underserved communities in Allegany County. Grant funds will be utilized to support a Dental Case Manager's time, to pay for discounted dental treatment, and to support collaboration with the Western Maryland Health System Emergency Department to divert dental patients to discounted urgent dental care services.

- **Baltimore City Health Department (Grant Award: $58,428)**
  Jurisdiction: Baltimore City
  Grant funds support a partnership between the Oral Health Services Program and the Immunization Program to ensure at-risk children and families receive preventative oral health education and dental care at an early juncture in the child's development. Grant funds will be utlized to support personnel costs; increase the number of children with dental homes, increase the number of children who receive fluoride varnish and sealants, and improve the oral health literacy of parents and caregivers.

- **Bel Alton Alumni Association (Grant Award: $250,000)**
  Jurisdiction: Charles County
  Grant funds enabled Bel Alton to provide comprehensive dental screenings and oral health education to children in eight elementary schools in Charles County. Grant funds will be utlized to support personnel costs of providing services in schools throughout Charles

County.

- **Charles County Health Department (Year One Grant Award $100,000)**
  Jurisdiction: Charles County
  Grant funds support a school-based dental program that screens children in the Charles County public school system and provides access to fluoride, dental sealants, and clinical services in an area of southern Maryland that is lacking in oral health safety net infrastructure. Grant funds will be utilized to support the salaries of a dentist, dental hygienist, dental assistant, and community health worker.

- **Frederick Community Action Agency (Year One Grant Award $90,000)**
  Jurisdiction: Frederick County
  Grant funds support a program which seeks to improve oral health and reduce hospital emergency department visits for non-emergent dental needs by expanding access to oral health care for underserved residents in Frederick County. Grant funds will be utilized to recruit dentists to provide non-emergent dental services and a Registered Dental Hygienist to provide fluoride varnish and oral health education to lower-income children and adults.

- **Walnut Street Community Health Center (Grant Award: $98,000)**
  Jurisdiction: Washington County
  Grant funds enabled Walnut Street to support the planning and implementation of an integrated practice management, electronic dental records, and electronic medical records system. Grant funds will be used to support the purchase of necessary systems and training for providers.

Focus Area: INTEGRATING BEHAVIORAL HEALTH IN THE COMMUNITY

- **Frederick Mental Health Association (Year One Grant Award $120,000)**
  Jurisdiction: Frederick County
  Grant funds support expanding access to behavioral health care services in the region and reducing behavioral-health related hospital emergency department visits at Frederick Memorial Hospital. Grant funds will be utilized to expand the hours of a new behavioral health urgent care/walk-in service that is available to residents regardless of ability to pay or health insurance status.

- **Lower Shore Clinic (Grant Award: $240,000)**
  Jurisdiction: Lower Shore
  Grant funds targeted individuals with behavioral health care issues who often have co-occurring somatic conditions but experience significant barriers to appropriate care. Grant funds will be utlized to support primary care services provision in existing behavioral health care services, providing regular physicals, preventative services, and chronic disease management for individuals with an exisiting mental health or substance use disorder.

- **Mary's Center for Maternal and Child Health (Grant Award: $198,318)**
  Jurisdiction: Prince George's County

Grant funds enabled Mary's Center to integrate behavioral health care at their primary care services locations in Silver Spring and Adelphi sites. Grant funds will be utlized to support program management and personnel costs for integrated care.

- **Mobile Medical (Grant Award: $136,000)**
  Jurisdiction: Montgomery County
  Grant funds enabled Mobile Medical to increase access to primary care and integrate behavioral health care services in a model that leveraged grant funding with existing County resources. Grant funds will be utlized to open a new primary care clinic in Rockville which is co-located with existing behavioral health care services provided by Montgomery County.

- **Mosaic (Year One Grant Award $300,000)**
  Jurisdiction: Baltimore City
  Grant funds promoted access to bi-directional, integrated health care by "co-locating" Mosaic behavioral health professionals and Baltimore Medical Systems (BMS) primary care services in four clinic locations. CHRC grant funding will be utilized to support two physicians and two full time care managers to implement the integrated model at two BMS locations and two Mosaic locations. Services include somatic, case management, addiction and behavioral health, which are traditionally provided across "siloed" programs.

- **Walden Sierra (Grant Award: $250,000)**
  Jurisdiction: Southern Maryland
  Grant funds enabled a pilot program co-locating behavioral health services with primary care partners serving low-income and uninsured individuals. Grant funds will be utlized to support personnel costs to provide primary care services and to support clinical space for Walden Sierra behavioral health care providers.

- **Way Station Inc. (Grant Award: $170,000)**
  Jurisdiction: Baltimore County
  Grant funds enabled Way Station to pilot a new service model which integrated three evidenced-based practices to improve the effectiveness of behavioral health care and primary care services for low income individuals with serious and persistent mental illness and co-occurring disorders. Grant funds will be utilized to support personnel costs to support the new pilot program.

- **Worcester County Health Department (Year One Grant Award $250,000)**
  Jurisdiction: Worcester County
  Grant funds developed an integrated behavioral health unit in Worcester County by adding access to primary care services in an existing behavioral health facility, providing screening and preventive services. CHRC grant funds will be utilized to support the salary costs of one nurse practitioner, one community health nurse, one health services clerk, and one community health worker. The new unit will provide team-based care and access to publicly supported psychiatrists and therapists.

Focus Area: PROMOTING CAPACITY OF SAFETY NET PROVIDERS

- **Access Carroll (Year One Grant Award $125,000)**
  Grant funds promoted the long-term financial sustainability of the grantee, a free clinic in Westminster, as it transitioned to a revenue model that involves billing third-party payers. Grant funds will be utilized to hire a full time biller/coder and consultant help to design and implement billing systems and enhance the use of its IT system.

- **Allegany County Health Department (Year One Grant Award $30,000)**
  Jurisdiction: Allegany County
  Grant funds addressed workforce challenges in this rural area of the state by supporting a "behavioral health learning collaborative" that provided training and technical assistance to providers in the region. Grant funds will be utilized to support the start-up costs of the collaborative, which will provide access to training and technical assistance and enable behavioral health providers to participate in Maryland's ongoing efforts to promote functional behavioral health integration.

- **Health Partners (Year One Grant Award $110,000)**
  Jurisdiction: Charles County
  Grant funds promoted the long-term financial sustainability of the grantee, a free clinic in Waldorf, as it transitions to a revenue model that involves billing third-party payers. Grant funds will be utilized to support the salary costs of four new health clinicians in a patient-centered medical home model.

- **Omini House Behavioral Health System (Grant Award: $150,000)**
  Jurisdiction: Anne Arundel County
  Grant funds supported the implementation of an electronic medical records system at Omni House's Day Program, Residential Program, and clinic. Grant funds will be utilized to provide technology training for data migration, staff training, and installation of new hardware and software systems.

- **Prince George's Health Department (Grant Award: $75,000)**
  Jurisdiction: Prince George's County
  Grant funds supported a comprehensive plan to implement electronic health records and associated functionality in the health department's nine clinics. The overall goal of the program is to facilitate EHR adoption that will increase the health department's efficiency, capacity, and quality in the county's communicable disease and maternal and child health clinics.

Focus Area: EXPANDING ACCESS TO PRIMARY CARE IN UNDERSERVED AREAS

- **Catholic Charities- Esperenza Center (Grant Award: $219,400)**
  Jurisdiciton: Baltimore City
  Grant funds enabled Catholic Charities to expand the successful Asociación Comunidad Saludable (ACS) Project that increased access to care for underserved populations. Grant

funds will be utilized to hire a full-time nurse practitioner who provides primary care visits to children and adults.

- **Community Clinic Inc. (Grant Award: $280,000)**
  Jurisdictions: Montgomery and Prince George's County
  Grant funds enabled Community Clinic to expand services for high-risk patients in Montgomery and Prince George's Counties by supporting the integration of Community Health Workers and other staff into its primary care clinical program. Grant funds will be utilized to support the new Community Health Worker program.

- **West Cecil Community Health Center (Year One Grant Award $180,000)**
  Jurisdiction: Cecil County
  Grant funds supported expanding access in a Medically Underserved Area in Harford County. Grant funds will be utilized to support the start-up operational costs of opening a new Federally Qualified Health Center site that will serve residents of Cecil and Harford Counties.

- **Health Care Access Maryland (Year One Grant Award $200,000)**
  Jurisdiction: Baltimore City
  Grant funds helped target individuals with chronic disease conditions who frequently utilize hospital departments and promoted access to primary and preventative care services in the community. Grant funds will be utilized to support new ED diversion teams deployed in one Baltimore City hospital (Sinai).

- **Health Care for the Homeless (HCH) (Year One Grant Award $140,000)**
  Jurisdiction: Baltimore City
  Grant funds supported an emergency department diversion/referral program that will target homeless individuals in Baltimore City who utilize hospital emergency departments at high rates and establish a "medical home" for these individuals. CHRC grant funds will be utilized to enable the grantee to implement an emergency room diversion team, partner with three Baltimore hospitals, facilitate access to comprehensive primary and preventative care services, and promote health insurance enrollment for homeless individuals in Baltimore.

- **Mobile Medical Care Aspen Hill Multicultural Clinic (Year One Grant Award $180,000)**
  Jurisdiction: Montgomery County
  Grant funds supported the opening of a multicultural, safety net health clinic in Aspen Hill, a Medically Underserved Area of Montgomery County. Grant funds will be utilized to open the new clinic and expand access for a highly diverse and underserved area of Montgomery County.

- **Shepherds Clinic (Grant Award: $160,000)**
  Jurisdiction: Baltimore City
  Grant funds supported a nonprofit that targeted the medical needs of the uninsured by offering afforable primary and diagnostic health care services to low-income adults without

any health care coverage. Grant funds were utilized to fund part-time clincial staff and I.T./EHR Specialist to oversee the organization's transition to electronic health records.

Focus Area: ADDRESSING CHILDHOOD OBESITY

- **University of Maryland-Baltimore Department of Pediatrics (Year One Grant Award $195,000)**
  Jurisdiction: Baltimore City
  Grant funds reduced rates of childhood obesity by engaging three public schools in the Promise Heights neighborhood of West Baltimore. Grant funding will be utilized to support efforts to promote adoption of healthy lifestyle choices and increase physical activity, including the development of home and school environments that support those healthy choices. A secondary goal of the program is to develop an inter-professional pediatric obesity prevention training program for future leaders in medicine, nursing, and social work. CHRC grant funding will support the salary costs for a full-time program manager, partial clinical coordinator, research assistant, and minimal funding for Community School Coordinators.

- **Baltimore City Health Department (Year One Grant Award $275,000)**
  Jurisdiction: Baltimore City
  Grant funds supported efforts to reduce childhood obesity by addressing food insecurity for residents in known food deserts throughout the city. Grant funds will build on the current Virtual Supermarkets Program, a national, award-winning program that uses online grocery ordering and delivery, to bring food to community sites in food desert neighborhoods. The program will engage corner stores to provide retail options for affordable, healthy food options.

- **Somerset County Health Department (Year One Grant Award $50,000)**
  Jurisdiction: Somerset County Grant funds support a public outreach campaign that will build community awareness and support for healthy lifestyle choices to reduce rates of childhood obesity. Grant funds will be utilized to create new after-school opportunities for physical activity, expanded access to affordable healthy food options, and provide home visitation and health coaching for youths between the ages of 4 and 18 deemed at highest risk of obesity by their health care provider.

Appendix D

STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Annapolis, MD 21401, Room 336
Office (410) 260-6290 Fax No. (410) 626-0304

State Health Improvement Process:

Supporting Local Health Improvement Coalitions to Fuel Local Action and Improve Community Health

Call for Proposals

May 1, 2013

I. Overview

The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly to expand access to affordable, high-quality health care services for every Marylander and help address the unmet health care needs of underserved communities. Since its inception in 2005, the CHRC has awarded 115 grants, totaling $29.6 million, supporting programs in all 24 jurisdictions of the state. These grants have collectively provided health care services for approximately 110,000 Marylanders. The grant funding provided by the Commission has enabled its grantees to leverage $10.1 million in additional federal and private/non-profit resources. Grants awarded by the Commission have expanded access to comprehensive women's health services to support the Governor's goal of reducing infant mortality rates; have increased access to dental services for low-income children; have promoted the integration of behavioral health services in the community; have expanded primary care capacity in underserved areas; and have promoted the adoption of health information technology by Maryland's safety net providers.

The CHRC is working with the Maryland Department of Health and Mental Hygiene (DHMH) to implement the Maryland Health Improvement and Disparities Reduction Act of 2012, legislation that created the Health Enterprise Zones Initiative. Five Zones designated by the state earlier this year will help expand access to health care services in communities facing tremendous health care challenges, will help address persistent health care disparities, and will help reduce health care costs by reducing preventable hospital admissions and re-admissions.

The statutory mission of the CHRC and its work to build capacity in Maryland's safety net infrastructure gains greater importance as Maryland prepares to implement the Affordable Care Act (ACA). The CHRC will be working very closely with DHMH, Maryland's Health Benefit Exchange (MHBE), local health departments, and safety net providers to build capacity and meet the expected demand for primary, preventative, and specialty care services by the estimated 250,000 Marylanders who will become eligible for health insurance in 2014.

Improving the health of Marylanders through local action and partnerships with community health resources is a mutual goal of the CHRC and DHMH. In support of the State Health Improvement Process (SHIP), which was launched by DHMH last year, the CHRC awarded 17 grants in FY 2012, totaling $600,000, to support the work of Local Health Improvement Coalitions (LHICs). The grants supported targeted population health interventions and fueled innovative LHIC partnerships with community health resources.

In the 2013 LHIC Call for Proposals, the CHRC will be making available a potential total of $1,200,000 (funding across FY 2013 and FY 2014) to continue to support the efforts of LHICs to improve population health in their communities, support continuous quality improvement activities, and build on innovative partnerships with community health resources. Unlike last year's LHIC Call for Proposals, the CHRC will be awarding grants exclusively on a **competitive** basis this year. Please see page 4 of this Call for Proposals for the review criteria that will be utilized by the Commission this year. Based on available funding, grant awards issued by the CHRC are expected to range from $150,000 to $250,000 each, and LHIC applicants are encouraged to develop and submit proposals for projects or programs to be implemented over a 12-16 month period, beginning this summer (2013). Funding requests below $150,000 will also be considered by the CHRC.

In the 2013 Call for Proposals, the CHRC will provide special consideration for projects that continue to support LHIC capacity in the following areas: (1) Facilitate the development of interconnected, comprehensive, patient-centered systems of care; (2) Promote LHIC collaboration and data sharing across multiple types of community health resources and efforts to use this data to improve community health outcomes; (3) Encourage innovative partnerships and programs that will expand access for underserved communities and address health disparities in the region/jurisdiction; (4) Identify potential cost savings or a return on investment (ROI) and suggest methods where these cost savings could be re-invested to support sustainability; and (5) Align with the Community Integrated Medical Home (CIMH) concept, as articulated in DHMH's proposal for the State Innovation Model (SIM) grant recently awarded to Maryland. Suggested areas of focus or specific types of projects for consideration by LHIC applicants are provided on pages 3-4 of this Call for Proposals.

II. Key Dates to Remember

The following are the dates and deadlines for this Call for Proposals.

May 1, 2013	**Release Call for Proposals**
May 9, 2013 9:30 a.m.	**Question & Answer Conference Call** **Dial in number: 1.866.247.6034** **Conference code: 4102607046**
May 30, 2013 5:00 p.m.	**Deadline for submission of Proposals to CHRC**
June 26, 2013	**A select number of applicants invited to present to CHRC; awards will be made following presentations**

II. Grant Eligibility

What is a Community Health Resource?

Pursuant to Health-General §19-2102 *et seq*. and its implementing regulations, the Commission may only award grants to an entity that meets the definition of a "community health resource." "Community health resource" is defined in Maryland Health-General §19-2102 (d)(1) to include specific examples of entities or programs meeting this definition, as well as "any other center or program identified by the Commission as a community health resource." The Commission has explicitly recognized a local health department as a "community health resource" in its regulations found at COMAR 10.45.05.

Given that each LHIC by its nature includes at least one local health department, the statutory definition of "community health resource" found at COMAR 10.45.05 is met. Similar to last year's Call for Proposals, **only Local Health Improvement Coalitions are eligible to respond to the 2013 Call for Proposals.** While the Commission typically requires an entity submitting a proposal to provide documentation showing that it meets the "community health resource" definition, such documentation is ***not necessary*** as part of the response to the 2013 Call for Proposals.

III. Requirements in the 2013 Call for Proposals

In keeping with the CHRC's overall support of the State Health Improvement Process (SHIP), LHIC applicants will be required to provide a copy of their updated Local Health Action Plan and provide documentation demonstrating how the activities in this year's grant proposal will facilitate the achievement of the measurable core goals identified in the Local Health Improvement Plan.

In addition, LHIC applicants will be **required** to identify a **10% local match** in their proposal this year by providing a letter of commitment confirming that at least 10% of the overall grant request will be supported with local backing such as a contribution by a hospital, foundation, or other resource (in addition to the CHRC grant). For example, if the overall LHIC grant request is $200,000, then at least 10% ($20,000) of the $200,000 (making a total budget of $220,000) must be provided in a local match. The CHRC may consider in-kind contributions to count towards this 10% matching requirement, but these requests by LHICs will be evaluated on a case-by-case basis by the Commission.

IV. The Grants Program- Specific Types of Projects

Following are examples of types of projects that the CHRC is looking to support in this year's Call for Proposals. LHIC applicants may utilize one or several of the following types of projects in this year's Call for Proposals.

- ***Projects that will support specific population health/community health interventions and reflect the main goals of the LHIC and its local health improvement plan.*** These efforts would support new activities of the LHIC (beyond activities currently implemented by the LHIC), reflect priority areas identified by the LHIC based on SHIP data, and demonstrate the ability to improve LHIC performance in areas where the region/jurisdiction shows the potential for improvement in community health.

- ***Projects that will build the capacity of LHICs for continuous quality improvement efforts through important primary (e.g., care coordination) and secondary (e.g., performance monitoring) uses of health data.*** The efforts could include establishing innovative partnerships or programs involving multiple types of providers (such as community health resources, hospitals, and others), facilitating data sharing and data integration across multiple types of providers, and/or utilizing data provided by CRISP to drive continuous quality improvement efforts and support population health improvement.

- ***Projects that will facilitate the integration of public health, social services, and other community health resources with the health care delivery system to address social determinants of health***. These efforts could include using grant funds to hire non-traditional professionals like community health workers by the LHIC or other community health resources to integrate schools and public housing as potential sites of care delivery and to support comprehensive case management services in the region/jurisdiction. These efforts might also include innovative partnerships among health care providers, Patient Centered Medical Homes (PCMHs), social services organizations and other local partners to help address social determinants of health. These partnerships might incorporate comprehensive care management service models and identify methods to capture cost savings through reductions in hospital admissions/re-admissions and re-deploying these savings to promote long-term sustainability of the model. One example of such a partnership

can be found in the Camden Coalition in New Jersey, which identifies individuals with complex health and social service needs, coordinates and ensures the delivery of the full array of health and other social needs, and helps achieve cost savings by removing barriers in accessing health care services in the community. The Camden Coalition of Healthcare Providers website can be found at http://www.camdenhealth.org/. Additional information about the work of the Camden Coalition and other organizations integrating public health, social services, and community health resources to address social determinants of health can be found in an article in *The New Yorker* entitled "The Hot Spotters," which can be found at http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande?currentPage=all.

V. Review Criteria

As stated previously, the CHRC will be awarding grants on a **competitive** basis this year. LHIC proposals will be evaluated on the following review criteria, and a select number of the highest-scoring applicants will be invited to present to the CHRC on June 26, 2013 in Annapolis.

1. The proposal clearly indicates what the areas of greatest population health need are within the geographic area, provides data to support those claims, and puts forth evidence-based or innovative interventions that are likely to address those needs;
2. The proposal leverages community health resources (in addition to local health departments) and facilitates innovative partnerships among multiple providers, especially among partners that may not have been part of the LHIC previously;
3. The proposal includes a post-CHRC award sustainability plan for maintaining LHIC activities and has a high degree of enabling the LHIC or providers in the region/jurisdiction to participate in the future Community Integrated Medical Home (CIMH) Initiative;
4. The proposal includes strategies that will assist in building a collaborative, interconnected, and efficient health care system at the local/regional level;
5. The proposal supports continuous quality improvement efforts, clearly indicates what the core goals are, articulates the core goals as measurable outcomes, and includes a statement defining baseline performance on those measures. The proposal should also include a clear evaluation plan to ensure that the goals of the proposal are met;
6. The proposal includes specific strategies to address unmet health needs of low-income, uninsured, and underinsured populations;
7. The proposal helps reduce health disparities in the region/jurisdiction and advances the overall concept of health equity; and
8. The proposal assists the state's overall implementation of the Affordable Care Act by expanding access for Marylanders who will become eligible for health insurance in 2014.

VI. Evaluation and Monitoring

As a condition of receiving any grant funds, LHIC grantees must agree to participate in an ongoing evaluation of the grants program, which will be discussed with successful LHIC applicants post-award. Compliance with these reporting requirements will be considered in future LHIC grant opportunities provided by the CHRC.

VII. Use of Grant Funds

CHRC funds must be used to help LHICs implement Local Health Action Plans, in part or in their entirety. **Requests for CHRC grant funds that are not directly supported/evidenced by**

the Local Health Action Plans will not be considered. CHRC grant funds may be used for project staff salaries and fringe benefits, consultant fees, data collection and analysis, conference calls and meetings, and office supplies and expenses. **Indirect costs are limited to 10% of the total direct costs of the proposed actions**. CHRC grant funds may also be expended for a limited amount of essential equipment and supplies required by the LHIC. CHRC grantees may subcontract with other organizations as appropriate to accomplish the goals of the LHIC proposal. Any one LHIC subcontract for more than $10,000 requires **prior** approval of the Commission (post-award). If the services in the proposal will be delivered by a contractor agency rather than directly by the LHIC, the LHIC may **not** take a fee for passing through the funds to the contractor entity. CHRC grant funds may **not** be used for major equipment or new construction projects, to support clinical trials, or for lobbying or political activity.

VIII. How to Apply

The deadline for submitting proposals is **5:00 p.m. EDT on May 30, 2013**. The CHRC will review the materials to determine if all necessary items are provided.

Please review the Table **CHRC FY2013 LHIC Application Check List** on page 9 and include all required items/materials for the funding in one proposal package. Information on each of the required documents and materials for the funding proposals is detailed below.

A. Required Proposal Items

All LHICs must submit the following items to be eligible for the funding awards (please submit these documents/items in the order listed below):

(1) Grant Application Cover Sheet: This form is located in the Appendix section of this Call for Proposals and also can be accessed by visiting the Maryland Community Health Resources website (http://www.dhmh.maryland.gov/mchrc) and clicking on "Forms" on the left side menu.

(2) The LHIC Local Health Action Plan: Include a copy of the most recent Local Health Action Plan and a clear demonstration of how requested grant funds from the CHRC will support the core goals of the latest Plan.

(3) Project Narrative: The Project Narrative should be succinctly written and be approximately 10 to 12 pages in length (not including attachments such as the Local Health Action Plan, budget, or key staff involved with the project). The proposal should clearly state specific action items in the LHIC Local Health Action Plan that will be implemented, in part or in its entirety, using CHRC grant funds. This proposal should focus on the key action steps that will be supported with CHRC grant funding and will be undertaken over the next 12-16 months and should address priority areas or action steps in the Local Health Action Plan. An applicant is encouraged to address the 8 review criteria (listed on page 4 of this Call for Proposals). In addition, this proposal must include evaluation measures that will assess whether the LHIC's funding proposal's objectives and milestones have been achieved.

(4) Post-CHRC Funding Sustainability Plan: LHICs must include information on how the coalition will sustain actions initially supported by CHRC grant funds once these grant funds have been expended. The Sustainability Plan should be one page or less.

(5) Project Budget: LHICs must provide a budget and budget for the total grant request. LHICs must use the Project Budget Form provided in the Appendix section of the 2013 Call for Proposals followed by a line-item budget justification detailing the purpose of each budget item (the line-item budget justification is a simple list of expenditures and a one-sentence description for each expenditure). The budget request should be between $150,000 and $250,000 and support a program to be implemented over a 12-16 month period. The amount of the grant awards will be determined by the CHRC following presentations on June 26, 2013. Funding requests below $150,000 will also be considered by the CHRC.

The CHRC Project Budget Form includes the following line item areas:

a) *Personnel:* Include the percent effort (FTE) and title of the individual.
b) *Personnel Fringe*: Fringe benefits should be shown at the LHIC lead LHD's standard rate.
c) *Equipment/Furniture:* Small equipment and furniture costs.
d) *Supplies*
e) *Travel/Mileage/Parking*
f) *Staff Trainings/Development*
g) *Contractual:* Contracts for more than $10,000 require prior approval of the Commission.
h) *Other Expenses:* Other miscellaneous expenses or other program expenses that do not fit the other categories should be placed here. Detail each different expense in this area in the budget justification narrative.
i) *Indirect Costs:* Indirect costs may not exceed 10% of direct proposal costs.
j) *Matching funds:* The LHIC is required to confirm that at least 10% of the overall CHRC grant request is provided in matching funds. **LHICs must provide a copy of a signed letter of commitment from the organization(s) contributing the matching funds.**

(6) Key staff. The proposal should indicate the key staff who will be involved in implementing and evaluating the proposal. If the LHIC engages outside consultants or participating partners (external to the LHIC), these staff should be identified in the proposal. The specific roles, duties, and responsibilities should be provided in the proposal. Accompanying biographies or C.V.s may be included as well.

B. Additional Information

Proposals must be 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 CHRC requires:

(1) Five original applications, including all required materials for the request funding application in one package. The hard copy original should be bound with two-prong report fasteners or with clips. If two-prong fasteners are used, cardboard or plastic covers and backs can be used. Do not send three ring binders or spiral bound proposals. Please send the hard copy original to:

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

(2) One electronic copy of all the application materials should be emailed to edith.budd@maryland.gov. In the subject line of the email, please state the coalition's full name and the following reference: "LHIC 2013 Call for Proposals".

Grant proposals, both original hard copy and electronic copy, are due at the Commission's offices by 5:00 p.m. on Thursday, May 30, 2013.

IX. Inquiries

Conference Call for Applicants: The CHRC will host a conference call on May 9, 2013 at 9:30 am for interested applicants to provide information on the grants program and assistance with the application process. The dial in number for the conference call is 1.866.247.6034. The conference code is 4102607046. Participation in this conference call is ***optional.***

Questions from Applicants: Applicants may also submit written questions about the grants program. Send questions to Mark Luckner (mark.luckner@maryland.gov). Questions may be submitted at any time.

The Maryland Community Health Resources Commission

The *Community Health Care Access and Safety Net Act of 2005* became law on May 10, 2005. The law authorized establishment of the 11-member Maryland Community Health Resources Commission to help communities in Maryland improve access to care for low-income families and under- and uninsured individuals. The Commissioners are appointed by Governor Martin O'Malley.

Commissioners

John A. Hurson, Chairman
Charlene M. Dukes, Ed.D.
Kendall D. Hunter
Sue Kullen
Paula McLellan
Nelson Sabatini, Vice Chairman
Maria Harris-Tildon
William Jaquis, M.D.
Mark Li, M.D.
Margaret Murray, M.P.A.

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Telephone: (410) 260-6290
Fax: (410) 626-0304
Website: http://www.dhmh.maryland.gov/mchrc

CHRC FY13 LHIC Application Check-List

Required Items

1. **Grant Application Cover Sheet – required.**

2. **Copy of updated Local Health Action Plan – required.**
   The LHIC should include a copy of the most recent Local Health Action Plan (it may be the same document supplied to DHMH). The grant proposal should include a clear demonstration of how requested grant funds from the CHRC will support the core goals of the latest Plan.

3. **Project Narrative – required.**
   The Project Narrative should clearly and succinctly describe how requested grant funds will be utilized by the LHIC and how the activities supported with CHRC grant funds will enable the LHIC to achieve the core goals of the Local Health Action Plan. The Project Narrative should be no more than 10-12 pages. The Project Narrative must also include evaluation measures and address the eight criteria listed on page 4 of the Call for Proposals. The page limit requirement only pertains to the Project Narrative; it does not include the Application Cover Sheet, Local Health Action Plan, Sustainability Funding Plan, or Project Budget Form and Budget Justification.

4. **Post-CHRC Funding Sustainability Plan – required.**
   LHICs must include information on how the coalition will sustain actions initially supported by CHRC grant funds once these grant funds have been expended. The Sustainability Plan should be no more than one page.

5. **Project Budget Form and Budget Justification – required.**
   This budget must reflect action strategy/ies that the CHRC's funding will support. The amount and source of matching funds must be included in the Project Budget Form. Please note the 10% matching funds requirement.

6. **Letter of Commitment for Matching Funds - required.**
   LHICs must provide a copy of signed letter of commitment from the organization(s) contributing the matching funds.

Additional items that may be included (optional)

7. **Key Staff – optional.**
   Biographies or C.V.s of key staff may be included. The inclusion of these materials will not be counted towards the overall page limit for the Project Narrative.

STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Annapolis, MD 21401, Room 336
Office (410) 260-6290 Fax No. (410) 626-0304

Martin O'Malley, Governor - Anthony G. Brown, Lt. Governor
John A. Hurson, Chairman – Nelson J. Sabatini, Vice Chairman – Mark Luckner, Executive Director

LHIC Grant Application Cover Sheet FY 2013-FY 2014

State Health Improvement Process:
Supporting Local Health Improvement Coalitions (LHICs)
to Fuel Local Action and Improve Community Health

LHIC Designated Applicant Organization:

Name of Organization: _____

Federal Identification Number (EIN): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

LHIC Official Authorized to Execute Grants/Contracts:

Name: _____

Title: _____ E-mail: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

LHIC Project Director (if different than the official authorized to execute contracts)

Name: _____

Title: _____ E-mail: _____

Phone: _____ Fax: _____

Overall LHIC Grant Funding Request:

(Range of $150,000 to $250,000 may be provided by CHRC on a <u>competitive</u> basis; funding requests below $150,000 will also be received and considered).

Project Budget Form for LHIC Grant Funding Request	
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION	
State Health Improvement Process: ***Supporting Local Health Improvement Coalitions (LHICs) to Fuel Local Action and Improve Community Health***	
LHIC/Organization Name:	
Project Name:	
Budget Request for CHRC Grant Funding	**Amount of Request**
Personnel Salary	
% FTE - Title	
% FTE - Title	
% FTE - Title	
Personnel Subtotal	
Personnel Fringe (% - Rate)	
Equipment/Furniture	
Supplies	
Travel/Mileage/Parking	
Staff Trainings/Development	
Contractual	
Other Expenses	
Indirect Costs (no more than 10% of direct costs)	
Matching Funds – at least 10% of the overall CHRC grant request must be provided in matching funds	
Total	

Appendix E

Appendix E:

Local Health Improvement Coalition FY 2013 Grantees

- **Allegany County Health Department (Grant award: $185,048)**
  This proposal seeks to reduce health disparities and address social determinants of health by deploying community health workers to link patients to community resources. Grant funds will be utilized to create a community resource guide, to support cultural competency provider training, and to provide access to subsidized transportation services.

- **Cecil County Health Department for Cecil County Community Health Advisory Committee (Grant Award: $189,659)**
  This proposal seeks to reduce behavioral health-related visits to Union Hospital by embedding a nursing case management program in the hospital to link patients with services in the community. The grant also supports a mobile mental health crisis program in Cecil County, which is supported by Cecil County Government (in addition to CHRC grant funding).

- **The Partnerships for a Healthier Charles County (Grant award: $159,756)**
  This proposal seeks to expand access to primary care services in an underserved area in western Charles County and utilizes CHRC grant funds to establish a new Patient-Centered Medical Home (PCMH) in Nanjemoy.

- **Harford County Health Department (Grant award: $250,000)**
  This proposal seeks to improve overall health outcomes for high-risk residents by providing comprehensive coordinated care and preventative mental health services to decrease ED utilization. Grant funds will be utilized to hire three clinical nurse social workers and to expand the Comprehensive Women's Health Project care coordination model to 3 additional sites.

- **Howard County Local Health Improvement Coalition (Grant award: $250,000)**
  This proposal seeks to increase access to health care and enhance chronic disease prevention by utilizing "hotspotting" data analysis and targeting resources to address the complex health needs of individuals identified in this analysis. Grant funds will be utilized to establish a community health worker program; increase the number of PCMHs in the community; and create shared savings blueprint.

- **Montgomery County Department of Health and Human Services (Grant award: $236,672)**
  This proposal seeks to promote obesity prevention efforts and reduce behavioral health-related ED visits. Grant funds will be utilized to promote comprehensive care coordination efforts.

- **Tri-County / Worcester County Health Department (Grant award: $250,000)**
  This proposals targets diabetes-related hospital ED visits and develops a comprehensive care coordination model to link frequent ED users with access to primary care services in the

community. The model leverages community partnerships and addresses social determinants of health in the Lower Shore. Grant funds will be utilized to develop and implement regional diabetes care management teams to assist diabetic patients in gaining access to a range of health care and social support resources.

Appendix F

STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Annapolis, MD 21401, Room 336

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor
John A. Hurson, Chairman – Mark Luckner, Executive Director

Health Enterprise Zones

Call for Proposals

October 5, 2012

Table of Contents

I. Executive Summary

The state of Maryland has numerous advantages for its residents to enjoy good health care, such as the 3rd highest median household income; the 2nd highest number of primary care physicians per capita; the 10th lowest rate of smoking; and outstanding medical schools. Despite these advantages, Maryland continues to lag behind other states on a number of key health indicators, such as ranking 43rd in infant mortality, 31st in early prenatal care, 28th in obesity prevalence, 31st in diabetes prevalence, 35th in cardiovascular deaths, 32nd in cancer deaths, and 33rd for geographic health disparities.

In recognition of these unacceptable disparities, Lieutenant Governor Anthony G. Brown, as Chair of the Maryland Health Quality and Cost Council, established the Health Disparities Work Group, led by Dean E. Albert Reece, M.D, Ph.D., M.B.A. of the University of Maryland School of Medicine. The Work Group issued its final report in January 2012, which provided several recommendations for best practices, monitoring, and financial incentives for the reduction of disparities in Maryland's health care system. The Work Group developed bold recommendations, including the concept of utilizing enterprise zones typically used to drive economic development, and applied this principle in the field of public health and health disparities. The Work Group concluded that improvement in overall health in communities and reductions in health care costs may be achieved by saturating underserved communities with primary care providers and other essential health care services.

The recommendations of the Maryland Health Quality and Cost Council provided the structure for legislation, The Maryland Health Improvement and Disparities Reduction Act of 2012 (SB 234/Chapter 3 of 2012), which was approved by the Maryland General Assembly and signed into law on April 10 by the Governor. The Act combats continued health disparities and attempts to improve public health in underserved communities by creating the framework for the establishment of Health Enterprise Zones (HEZ), contiguous geographic areas that demonstrate measurable and documented health disparities and poor health outcomes and that are small enough for the incentives in this program to have a significant impact on improving health outcomes and reducing health disparities. The purpose of the HEZ Initiative is to target state resources to:

- Reduce health disparities among racial and ethnic minority populations and among geographic areas;
- Improve health care access and health outcomes in underserved communities; and
- Reduce health care costs and hospital admissions and re-admissions.

The HEZ Initiative is a new, four-year pilot program, and the FY 2013 budget provides $4 million in new funding to the Community Health Resources Commission (CHRC) to support the activities of HEZs. Through this Call for Proposals, communities may apply for HEZ designation, which will enable access to a range of incentives which include state income tax credits; hiring tax credits; loan repayment assistance; priority entrance into the state's Patient Centered Medical Home Program; priority for available state electronic health record (EHR) grant funding; additional grant funding from the CHRC; and capital grant support. Applicants seeking HEZ designation may draw upon any or all of these incentives when developing their

intervention strategies to address health disparities, to expand access, and to help attract needed health care practitioners into the area. The application for HEZ designation will be a combination of **both** demonstrated need and intervention strategies to improve health outcomes in the potential HEZ.

The HEZ Initiative will be jointly administered by the Maryland Department of Health & Mental Hygiene (DHMH) and the CHRC. The Commission is issuing this HEZ Call for Proposals, will evaluate applications requesting HEZ designation, and will provide recommendations to the DHMH Secretary. Final HEZ designation decisions will be made by the Secretary by the end of calendar year 2012. It is anticipated that the state will award between two to four Zones in this first year of the program.

An internal steering committee led by DHMH Secretary Joshua M. Sharfstein, M.D., comprised of DHMH, Lt. Governor, and CHRC staff, was established to help guide implementation of the HEZ Initiative. The committee received guidance and input from several external sources including the Health Disparities Collaborative, which included more than 175 Marylanders participating in five committees.

In addition, a public comment period was launched in the summer of 2012, and the following three documents were distributed in draft form to solicit public feedback:
1. Threshold eligibility criteria for communities seeking HEZ designation;
2. Additional benefits that could be provided by the state to assist HEZ awardees; and
3. Principles that will be used to review HEZ applications.

The committee received more than 150 comments which led to a range of changes in the implementation plan and are summarized in a Joint Chairmen's Report submitted in August to the Maryland General Assembly (this report is available at http://dhmh.maryland.gov/healthenterprisezones/SitePages/Updates.aspx). In addition, public forums were held earlier this year in Baltimore City, Montgomery, Prince George's, and Charles Counties, the Eastern Shore, and western Maryland. The public comment period and these public forums informed the development of this Call for Proposals.

Key Dates

October 11, 2:30 PM	Proposal Question & Answer Conference Call Dial-In Number: (866) 233-3852 Participant Access Code: 267478
October 19, 5:00 p.m.	Initial Letters of Interest are due to the CHRC
November 13, 12:00 p.m.	HEZ Proposals due to the CHRC
December 11	Select applicants invited to present at CHRC meeting
December 21	DHMH Secretary makes HEZ designations

Overview of the CHRC
The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly when it approved the *Community Health Care Access and Safety Net Act of 2005* legislation to expand access to health care for low-income Marylanders and underserved communities in the state and bolster Maryland's health care safety net infrastructure. The CHRC is a quasi-independent commission operating within the DHMH, and its 11 members are appointed by the Governor. In creating the Commission, the Maryland General Assembly recognized the need for having an independent commission that focused on strengthening the state's diverse network of community health centers and safety net providers and addressed service delivery gaps in Maryland's dynamic health care marketplace.

Over the last seven years, the Commission has awarded 110 grants totaling approximately $26.3 million, supporting programs in every jurisdiction of the state. These 110 programs have collectively served more than 105,000 underserved Marylanders. The CHRC has awarded grants to help reduce infant mortality; expand access to substance use treatment; integrate behavioral health services in primary care settings; increase access to dental care; boost primary care capacity; and invest in health information technology for safety net providers. Program sustainability is a top priority of the Commission, and CHRC grantees have used initial grant funds to leverage more than $10 million in additional federal and private funding sources to support their programs.

II. Information for Health Enterprise Zone Applicants

The designation of HEZ status will enable access to a range of incentives to support strategies to address health disparities, to expand access, and to help attract needed health care practitioners into the HEZ. Incentives and benefits include state income tax credits; hiring tax credits; loan repayment assistance; priority entrance into the state's Patient Centered Medical Home Program; priority for state EHR grant funding; additional grant funding from the CHRC; and capital grant support. These benefits and incentives are described in greater detail on page six. The purpose of the HEZ Initiative is to target state resources to:

- Reduce health disparities among racial and ethnic minority populations, and among geographic areas;
- Improve health care access and health outcomes in underserved communities; and
- Reduce health care costs and hospital admissions and re-admissions.

HEZ applicants are expected to submit applications which demonstrate the needs of the community, provide a comprehensive plan to address these needs, and achieve the overall policy goals of the HEZ Initiative. Eligible applicants should develop strategies using the benefits and incentives available to designated HEZs described in this Call for Proposals.

Community Eligibility
An HEZ is a community or a cluster of contiguous communities that are comprised of one or more zip codes. In order to be designated an HEZ, the proposed zip code(s) within a potential HEZ area must meet <u>each</u> of the following four criteria:

1. An HEZ must be a community, or a contiguous cluster of communities, defined by zip code boundaries (one or multiple zip codes);
2. An HEZ must have a resident population of at least 5,000 people;
3. An HEZ must demonstrate economic disadvantage by having either:
   a) a Medicaid enrollment rate above the median value for all Maryland zip codes; or
   b) a WIC participation rate above the median value for all Maryland zip codes.
4. An HEZ must demonstrate poor health outcomes by having either:
   a) a life expectancy below the median value for all Maryland zip codes, or
   b) a percentage of low birth weight infants above the median value for all Maryland zip codes.

A proposed HEZ made up of multiple zip codes must meet these criteria in each zip code if the values are known. ***Applicants are permitted to propose an alternative approach in eligibility determinations, using sub-zip code geographic bounds*** *(e.g. Census Tracts, Public Use Microdata Areas),* ***if the following criteria are met****:*

1. The area proposed is contiguous geographically;
2. The population in the proposed area is at least 5,000; and
3. The zip code(s) where the sub-zip code geographic bounds are located must meet the criteria for demonstrating economic disadvantage and poor health outcomes.

Data regarding the economic disadvantage and poor health outcomes, by zip code, has been compiled by DHMH and is available at: http://eh.dhmh.md.gov/hez/index.html. ***Applicants seeking designation status for sub-zip code geographic bounds will be required to provide data confirming eligibility for economic disadvantage and poor health outcomes.***

Letters of Interest are due to the CHRC no later than 5:00 p.m., October 19, 2012, but will be accepted and reviewed on a **rolling basis**. Applicants are encouraged to submit the Letter of Interest as soon as it ready, and not wait until October 19. The CHRC will review the Letters of Interest and Eligibility Worksheets (see Appendix Item A) as soon as is possible, certify each applicant's eligibility, and contact eligible applicants to submit the full application, hopefully within 48 hours of submission of LOI. Once eligibility is certified and applicants are notified, LOIs will be posted on the HEZ website. The full grant application is due to the CHRC no later than 12:00 p.m., November 13, 2012. For a more detailed description of the LOI, please see page 11 of this Call for Proposals.

Organizations Eligible to Apply for HEZ Designation on Behalf of a Community
An applicant for this Call for Proposals must be either a local government entity or a non-profit community-based organization. Applications should be submitted by one organization, the Coordinating Organization (local government entity or local non-profit entity), on behalf of a coalition of key community stakeholders and proposed HEZ geographic area. The community coalition should include a combination of health and community partners with specific roles and demonstrated historical experience working in the proposed zone. Applicants will be required to provide evidence validating that genuine efforts were made to include members of the target populations and minority groups in the HEZ application, and in the planning and program implementation, post-designation award.

Health Care Provider/Practices Eligibility
Individual health care providers and practices providing services within a Zone are eligible to receive state tax credits against their income, loan repayment assistance, funding for electronic health records, capital improvements and equipment in accordance with the HEZ Initiative and regulations to be proposed and adopted regarding tax credits. In addition, providers and practices may only receive incentives and benefits under the HEZ Initiative for the duration of their service/employment in a designated HEZ.

HEZ Benefits and Incentives
The HEZ Initiative provides a range of benefits and incentives to address health disparities and expand access to health care services. These benefits and incentives are available to non-profit organizations, local government entities, and eligible health care providers to achieve the HEZ's program goals at the community level. Following are examples of benefits and incentives that HEZ applicants may include in their application. If these benefits and incentives are included, then their cost must be included in the overall budget request of the HEZ application. Successful applicants will finalize the specific benefits and incentives utilized in the Zone in a post-designation conference.

- Tax credits against the State income tax: State income tax credits are available to eligible health care providers as part of an overall HEZ strategy to increase health care capacity and access to services. An eligible practitioner may claim a credit against the state income tax in an amount equal to 100% of the amount of the state income tax derived from income received from practice in the HEZ. Based on the language of the HEZ Act, tax credits are available for calendar years 2013, 2014, and 2015. Tax credits may become available for calendar year 2016, pending legislative approval and budget appropriation.

- Hiring Tax credits: Hiring tax credits are available to eligible health care provider practices as part of an overall HEZ strategy to increase health care capacity and access to services. An eligible practitioner may claim a refundable credit of $10,000 against the state income tax for hiring a qualified position in the Health Enterprise Zone. Based on the language of the HEZ Act, tax credits are available for calendar years 2013, 2014, and 2015. Tax credits may become available for calendar year 2016, pending legislative approval and budget appropriation.

- Loan repayment assistance: Loan repayment assistance is available to eligible health care providers for qualified education loan repayments.

- Priority to enter the state's Patient Centered Medical Home Program (PCMH): Priority entry into Maryland's PCMH program may be available to eligible health care providers and practices who meet the standards developed by the Maryland Health Care Commission for entry into the PCMH Program.

- Grant funds for electronic health records: Grants for obtaining and/or implementing electronic health records systems are available to eligible health care providers and

practices.

- Grants to defray the costs of capital or leasehold improvements**:** Grants for capital/leasehold improvements are available to eligible health care providers and practices to improve or expand capacity for the delivery of primary healthcare, behavioral, or dental services in the HEZ.

- Grants to defray the costs of medical or dental equipment**:** Grants for medical or dental equipment are available to eligible health care providers and practices for equipment which must be used to provide medical or dental services in the HEZ. Grants are not to exceed the lesser of $25,000 or 50% of the cost of the equipment. Providers/Practitioners must leave working medical and dental equipment in the designated Zone for continued community use, should the providers/practitioners choose to leave the Zone.

- Grant funding for innovative public health strategies: Grant funding is available to non-profit organizations and local government entities to facilitate innovative public health strategies and other incentives to help address the goals of the HEZ Initiative. Examples of fundable innovative public health strategies could include (but are not limited to) the following:
  a) Internship and volunteer programs for students in an HEZ;
  b) Funding for improvements to the environment in an HEZ, including improvements intended to increase access to recreation, healthy food, and quality housing;
  c) Grants to integrate behavioral health care into existing primary care practices in an HEZ;
  d) Funding for better health information technology tools for providers in an HEZ; and
  e) Funding for resources to enhance provider capacity to serve non-English speakers in an HEZ.

In addition to these incentives and benefits, CHRC and DHMH will provide the following types of assistance and support to HEZ designees, which do not need to be included in the application's budget.

- General support for program planning, implementation, and evaluation;
- Working with HEZ grantees and coalition members to provide access to DHMH data resources for approved HEZs;
- Invitation to participate in appropriate collaboratives and work groups;
- Assistance in connecting to existing grant-writing resources;
- Opportunity to apply for J-1 Visa Waiver primary care placements in HEZ sites that are located in federally designated Health Professional Shortage Areas and Medically Underserved Areas or Populations; and
- Priority assistance in achieving Health Information Exchange connectivity at the individual practice level.

Program Duration

HEZ designation will be for a four-year period and applications for HEZ designation should reflect a four-year period of activities. Designations made by the Secretary will be for the duration of the four-year program. Applicants should submit a detailed work-plan and evaluation plan with specific activities, objectives, milestones, and deliverables for each year of

the potential four-year program. In order to receive funding in years two, three, and four of the designation, HEZ Coordinating Organizations will need to meet the terms and conditions of the designation award, namely submitting the required reporting documents on a quarterly basis. In addition, Coordinating Organizations must demonstrate progress in terms of meeting performance measures developed by the Coordinating Organization and CHRC. HEZs that fail to comply with the reporting requirements or do not demonstrate performance in year one may be subject to revocation of designation status, and would no longer have access to benefits and incentives under the HEZ Act. The CHRC retains the right to "claw-back" funds distributed to the Zones or revoke the designation award if the Coordinating Organization is not compliant under the terms and conditions of the designation or does not meet performance measures during implementation.

Program Budget and Use of Funds
HEZ funding requests should be between $500,000 and $2 million per year for the duration of the four-year program. Annual budgets should be based on the calendar year (January – December). The Secretary and the CHRC, post-designation decisions (in January 2013), will meet with grantees to finalize the distribution of benefits and incentives to each designated Zone.

Overall or Global Budget
Applicants will be required to submit an overall or global budget requested, per year, for the duration of the four-year program. The global budget should include the total dollar amount allocated to **each** of the above benefit and incentive areas in the budget, per year. (see Appendix Item F). For example, if the HEZ applicant is requesting a total of $1 million in year one (calendar year 2013), the sum of each incentive or benefit requested should total $1 million. Please refer to Appendix Item G for a sample global budget. In the global budget, applicants are not expected to include/list the specific/actual provider names or practices that will receive each of the incentives or benefits. The global budget simply requires sub-totals for each incentive or benefit utilized in the Zone for each year of the program duration. In the months following the HEZ designation, the Coordinating Organizations will work to identify the individual providers and practices that will receive these benefits and incentives, and the CHRC will work with the Coordinating Organization to develop a mechanism to distribute these benefits and incentives.

Grant Program Budget (by Implementing Organization)
In addition to submitting the global budget, applicants may also be required to submit in their HEZ application a program-specific budget, if they request CHRC grant funding for innovative public health strategies. Applicants are required to provide the total grant funding amount requested for **each** participating partner organization that may receive CHRC grant funding and an accompanying line-item budget, by organization, showing precisely how each organization will utilize CHRC grant funding. Please refer to Appendix Item I for a sample line-item budget. In addition to the Grant Program Budget form, applicants must also provide an accompanying budget justification which details how each line item of grant funding will support the overall objectives of the HEZ. Funding amounts to partners should be appropriate to their responsibilities in the implementation of the HEZ programs and strategies. Applicants are expected at the time of the application to indicate in their application which organizations are committed to partnering in the implementation of the program's strategies by providing either an executed Memorandum of Understanding or Letter of Commitment.

Depending on the distribution mechanism agreed upon by the HEZ Coordinating Organization and CHRC, grant funding and certain incentives will be made directly by the CHRC to the partnering organization or providers who will be implementing the program and/or receiving the benefit. Coalition organizations and providers receiving funding under the HEZ program are expected to work with the CHRC and Coordinating Organizations to ensure all HEZ program reporting and evaluation guidelines are followed.

Incentives and benefits must be used for the purposes indicated in the HEZ Call for Proposals. As required in previous CHRC Call for Proposals, grant funds for innovative public health strategies may be used for program staff salaries and fringe benefits, consultant fees, data collection and analysis, in-state program-related travel, conference calls and meetings, and office supplies and expenses. Indirect costs are limited to 10% of the total grant funds requested (not 10% of the overall HEZ budget). If the services in an application will be delivered by a contractor agency or sub-grantee, and not directly by the applicant, the applicant may not take a fee for passing through the funds to the contractor agency. Funding under the HEZ program may not be used to support clinical trials, for lobbying, or for political activity.

III. Review Principles

Applications will be evaluated by a Review Committee, which will be comprised of experts in the fields of public health, health disparities, chronic diseases, social determinants of health and program management, and economic development. Individuals volunteering on the Review Committee may not be involved in any of the HEZ applications. The Review Committee will be asked to review and score each application on the following 13 review criteria:

1. Purpose. The application addresses the core statutory goals of the HEZ Initiative of reducing health disparities, including racial/ethnic and geographic health disparities, in Maryland.

2. Description of need. The application demonstrates the health and health services needs of the proposed HEZ resident population. The application demonstrates that the needs of the community exceed existing health resources and that the community's health and socio-economic outcomes are worse than/below the State's average and/or comparable communities. Applicants are permitted to draw on the data submitted in the Letter of Interest (the economic disadvantage or poor health outcomes) for threshold eligibility consideration or draw on other data metrics or factors demonstrating the need of the proposed Zone.

3. Core disease targets and conditions. The application identifies at least one or more specific diseases and/or conditions for improvement, and the data provided in the description of need supports the targeted disease(s) and/or conditions(s).

4. Goals. The applicant provides goals for health improvement by January 2016 in the HEZ that are achievable and measurable. The goals reflect the disparities being addressed (in terms of racial, ethnic and/or geographic) and reflect each of the following areas:
   a. Improved risk factor prevalence or health outcomes (Maryland State Health Improvement Process or Local Health Improvement Coalition measures, or others);
   b. Expanded primary care workforce ;

c. Increased community health workforce (including public health and outreach workers);
d. Increased community resources for health (housing, built environment, food access, etc.);
e. Reduced preventable emergency department visits and hospitalizations; and
f. Reduced unnecessary costs in health care (costs that would not have accrued if preventive services and adequate primary care had been provided).

5. Strategies. The strategies and interventions proposed in the application have a high degree of achieving success or achieving the goals stated in the application.

6. Cultural, linguistic and health literacy competence. The application explains how the strategies will be implemented in a culturally competent manner and designed to be accessible to the target population. This includes addressing translation and interpretation issues for non-English speakers and issues of low health literacy in the target population. The application describes the efforts that will be undertaken to recruit a racially, ethnically, and linguistically diverse workforce for the HEZ.

7. Balance. The proposed strategies are balanced between community-based approaches and primary care provider-based incentives. The strategies combine grants for public health and community services with the provider credits and incentives to expand health care capacity/services.

8. Contributions from local partners. Explicit financial or in-kind contributions from local partners and stakeholders are part of the strategic resource mix in order to amplify the impact of the State-provided pilot funding and incentives.

9. Coalition. The application demonstrates that the coalition includes a diverse array of health and community partners, with specific roles and historical experience working in the HEZ. A potential coalition could be led by the Coordinating Organization (the entity submitting the HEZ application and ultimately responsible for reporting requirements and Zone performance) and be comprised of participating partners that are delivering services in the Zone and community advisory groups involved in assisting overall implementation of the activities in the Zone. The application demonstrates inclusion of members of the target populations and minority groups in planning and ongoing oversight of the program. The application describes the coalition team members and participating partners and what assets, experience, knowledge, etc., are brought to the HEZ. There should be a clear governance structure of the coalition with a point of accountability for the Coordinating Organization and each key coalition member. There should be an advisory and oversight entity composed primarily of community members or residents of the designated Zone to provide advice and input to the coalition and the Coordinating Organization. This advisory/oversight entity should reflect experience in serving minority communities or populations.

10. Work-plan. The application provides a detailed work-plan that provides a clear understanding of how the program will be implemented over a four-year period and includes a detailed list of program activities, measurable outcomes, timelines, responsible entities and other logistics that enable tracking of effort; describes roles of the listed partners; includes interim milestones and deliverables; and supports appropriate data collection and reporting. See Appendix E for a sample work-plan.

11. Program management and guidance. The application provides a plan for quarterly reporting to the CHRC regarding progress and challenges regarding implementation of the HEZ work-plan and interim values for the evaluation metrics. The application includes a plan of quarterly reporting that meets the criteria in this Call for Proposal (see section V. Evaluation and Implementation, page 18) and that make sense given the core disease targets and conditions of the HEZ as well as the goals of the HEZ.

12. Sustainability. The application provides a feasible short-term and long-term sustainability strategy and acquisition of resources beyond state funding. Explicit financial or in-kind contributions from local partners and stakeholders should be part of the strategic resource mix and can be described here either as pledges or potential contributions to be pursued by the Coordinating Organization. Investments from insurers who stand to gain from cost savings in the HEZ are a potential component of a sustainability plan.

13. Internal evaluation and progress monitoring. The application provides a draft internal evaluation plan which tracks its progress in meeting each of the goals within the HEZ. The evaluation plan should include implementation and process metrics and performance measures with time-specific milestones and targets to allow assessment of the deployment of the interventions in the work-plan.

A Review Committee will evaluate applications on these review principles and will provide the CHRC with recommendations for selected organizations to present their applications before the full Community Health Resources Commission. Applicants not invited to present will be notified that they are not eligible to receive HEZ designation in this Call for Proposal opportunity. Recommendations by the CHRC to the Secretary will be based upon the recommendations of the Review Committee and presentations before the Commission. The Secretary will issue final HEZ designation awards in late December, 2012.

IV. Submitting an Application for Health Enterprise Zone Designation

The HEZ designation application has three steps:
Step 1: Submit a Letter of Interest, due no later than October 19, 2012, 5:00 p.m.
Step 2: Submit full Application, due no later than November 13, 2012, 12:00 p.m.
Step 3: Present Applications before the CHRC, December 11 (invited applicants only)

Step 1: Letter of Interest
The Letter of Interest should include the following items:
1. Name of the applicant organization (the Coordinating Organization);
2. Name, title, address, telephone number, and e-mail for the Chief Executive Officer and the proposed program director (if different) of the Coordinating Organization;
3. Documentation that shows the Coordinating Organization is either a community-based non-profit organization or local government entity;
4. Name of organizations partnering in the coalition;
5. A description of the location/geographic area of the proposed Health Enterprise Zone (i.e., community/neighborhood names); and

6. HEZ Eligibility Worksheet (Appendix Item A).

Letters of Interest are due to the CHRC no later than 5:00 p.m., October 19, 2012, but will be accepted and reviewed on a **rolling basis**. Applicants are encouraged to submit the Letter of Interest as soon as it is ready, and not wait until October 19. Letters of Interest should be submitted as a PDF or Word Document attachment, sent via email to dhmh.hez@maryland.gov. Please save file attachments using the following format: Organization Name, HEZ Letter of Interest, Date.

The CHRC will review the Letters of Interest and Eligibility Worksheets (see Appendix Item A) as soon as is possible, certify each applicant's eligibility, and contact eligible applicants to submit the full application, hopefully within 48 hours of submission of LOI. Once eligibility is certified and applicants are notified, LOIs will be posted on the HEZ website.

Only applicants whose proposed HEZ meets the eligibility criteria (see page 4) will be invited to proceed in submitting a full application (Step 2). CHRC staff will review the Letters of Interest, certify applicants' eligibility, and will invite eligible applicants to submit a formal application for HEZ designation. The CHRC will notify applicants of their eligibility as soon as is possible, hopefully within a 48-hour period of submission of the Letter of Interest.

Step 2: Submission of Applications
Following are guidelines and the requested structure of the HEZ application. The overall length of the HEZ application should be no more than 25 pages and will contain Standard Forms located in the Appendices of this Call for Proposals and narrative written sections. The HEZ application should be structured using these topic headings and forms, in the following order:

Topic Heading and Forms	Narrative versus Standard Form	Included in Page Limit
Table of Contents	Narrative	Not included
1. Grant Application Cover Sheet	Standard Form – CFP Appendix Item B	Not included
2. Contractual Obligations, Assurances, and Certifications	Standard Form – CFP Appendix Item C	Not included
3. Program Summary	Narrative	Included
4. Program Purpose	Narrative	Included
5. HEZ Geographic Description (HEZ map)	Narrative	Included (map not included)
6. Community Needs Assessment	Narrative	Included
7. Core Disease(s) and Condition(s) Targeted	Narrative	Included
8. Goals	Narrative	Included
9. Strategy to Address Health Disparities	Narrative	Included
10. Use of Incentives and Benefits	Narrative	Included

11. Cultural, linguistic and health literacy competency	Narrative	Included
12. Applicant Organization and Key Personnel	Narrative	Included
13. Coalition Organizations and Governance	Narrative	Included
14. Work-plan	Standard Form – CFP Appendix Items D and E	Not included
15. Evaluation Plan	Narrative	Included
16. Sustainability Plan	Narrative	Included
17. Program Budget and Justification	Standard Form – CFP Appendix Items F - I	Not included
18. Financial Audit		Not included
Appendices		Not included

The suggested content of each of these sections is provided below. Appendices should be limited to only the material necessary to support the application.

1. Grant Application Cover Sheet: The form should be completed and signed by the program 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. This form is attached as Appendix Item B and also can be accessed at the Maryland Community Health Resources website (http://dhmh.maryland.gov/mchrc/ - click on "Forms" on the left hand side menu) and the DHMH HEZ website (http://dhmh.maryland.gov/healthenterprisezones/).

2. Contractual Obligations, Assurances, and Certifications**:** The agreement should be completed and signed by either the Chief Executive Officer or the individual responsible for conducting the affairs of the applicant and authorized to execute contracts on behalf of the applicant organization. This document is attached as Appendix Item C and also can be accessed at the Maryland Community Health Resources website (http://dhmh.maryland.gov/mchrc/ - click on "Forms" on the left hand side menu) and the DHMH HEZ website (http://dhmh.maryland.gov/healthenterprisezones/).

3. Program Summary: The program summary is a concise, one-page overview of the proposed HEZ community(ies), the community needs, and the overall strategies that will be implemented to achieve the HEZ program's goals.

4. Program Purpose: The application should describe how the activities in the application will address the core goals of HEZ Initiative.

5. HEZ Geographic Description: The application should provide a brief description of the geographic location of the proposed HEZ, including the zip code(s) or sub-zip code geographic units that will be part of the HEZ. Applications should provide names of the community(ies) or

neighborhood(s) that are participating as part of the HEZ and any other relevant details that help to describe the physical location of the proposed HEZ. Applications should include a map of the proposed HEZ area that delineates the geographic units that are the boundaries of the zone (i.e., zip code, Census Tracts, etc). This can be the same map provided as part of the Letter of Interest.

6. Community Needs Assessment: The application should describe the health and health service needs of the population in the proposed HEZ. Examples of metrics to describe community need include (but are not limited to) indicators of health status, risk factor prevalence, health insurance status, primary care access, Medically Underserved Area or Medically Underserved Population designations, and other needs that impact the health of the community. This data should be presented, where possible, by racial groups and by Hispanic ethnicity. The application should also discuss other socio-economic factors that contribute to poor health in the community, such as data regarding education, employment, income, housing, physical environment, and other community factors that impact health.

7. Core Disease Targets and Conditions. Based upon the community need, the application should identify specific disease(s) and/or condition(s) that will be targeted for improvement. Applications are encouraged to target at least one of the following conditions identified by the Health Disparities Workgroup of the Maryland Health Quality and Cost Council: cardiovascular disease, diabetes, and asthma. Applications may address other major conditions where the community experiences poor health outcomes, such as behavioral health, dental health, birth outcomes, or related co-morbid conditions.

8. Goals: The application should propose ***measurable*** goals for health improvement in the HEZ by January 2016. The goals should reflect the disparities being addressed. Each goal should be included in the work-plan (see item 16, page 17). Goals should cover each of the following areas:

- Improved risk factor prevalence or health outcomes (e.g., SHIP or LHIP measures, or others);
- Expanded primary care workforce;
- Increased community health workforce (including public health and outreach workers);
- Increased community resources for health (e.g., housing, built environment, food access, etc.);
- Reduced preventable emergency department visits and hospitalizations; and
- Reduced unnecessary costs in health care (costs that would not have accrued if preventive services and adequate primary care had been provided).

9. Strategies. The application should provide a clear description of each strategy, including the key programmatic components, implementation steps, and partnering organizations who will assist in the implementation of the proposed strategy. The application should reference the key action steps included in the work-plan (see item 16, page 17). The evidence and rationale for each of the strategies and interventions should be presented. Examples of potential strategies could include:

- A strategy to increase provider capacity by a specified percentage;
- A strategy to improve the quality of service delivery as indicated by HEDIS measures;
- A strategy to address community barriers to healthy lifestyles;
- A strategy to improve health outcomes through the use of community health workers;

- A plan to strengthen community and environmental policies to support good health in schools, day care, recreation centers, senior centers, and workplaces;
- A strategy to provide better access to healthy foods or facilities for physical activities;
- A strategy to engage underserved racial and ethnic minority persons in the Health Enterprise Zone;
- A strategy to improve the built environment in an HEZ, including improvements intended to increase access to recreation, healthy food, and quality housing;
- A strategy to integrate behavioral health care into existing primary care practices in an HEZ;
- A strategy to improve health information technology tools for providers in an HEZ; and
- A strategy to enhance provider capacity to serve non-English speakers in an HEZ.

Applicants are encouraged where possible to adopt strategies that are evidence-based, generally accepted as promising practices, or new/innovative ideas. Applicants are encouraged to bring health information technology (electronic medical records and health information exchange) and the patient-centered medical home model to their strategic approaches.

10. Use of Incentives and Benefits. The applications should describe which incentives and benefits will be utilized as part of its strategies. The proposed strategies should be balanced between community-based approaches and provider-based incentives, and it should combine grants for public health and community services with the provider credits and incentives that are available to HEZs. The application must include a proposal to use funding available under this Initiative to provide for loan repayment incentives to induce health enterprise zone practitioners to practice in the HEZ.

11. Cultural, linguistic and health literacy competency. The application should explain how the strategies will be implemented in a culturally competent manner and designed to be accessible to the target population. This includes addressing translation and interpretation issues for non-English speakers, and issues of low health literacy in the target population. The application should describe the efforts that will be undertaken to recruit a racially, ethnically, and linguistically diverse workforce for the HEZ.

12. Applicant Organization and Key Personnel: The application should provide a description of the Coordinating Organization (applicant organization) and the organization's capacity to implement and lead the HEZ program. This can include any relevant experience in leading a coalition of organizations, community-based work, and implementation of multi-year programs. The application should identify the program director and describe his/her role within the Coordinating Organization, qualifications to lead the program, and responsibilities in carrying out the program. The application should also identify other essential staff, their roles in the program, and their relevant qualifications. Résumés for all key personnel should be included as appendices, and do not count as part of the overall page limit of the application. The application should describe any positions for which the organization that will need to hire new/additional staff.

13. Coalition Governance and Participating Partners: The application should provide a list of all HEZ coalition members (this list may be included as an appendix item if needed [not included in

the overall page limit]). The application should describe the coalition team members and what assets, experience, knowledge, etc. each brings to the proposed HEZ. The application should also describe the roles and responsibilities (if any) of coalition members in the implementation of any of the proposed strategies and intervention. The application should describe the governance structure that will be used by the Coordinating Organization, which provides a point of accountability for each core coalition member and participating partner. The application should describe plans to include members of the target populations and minority groups in planning and ongoing oversight of the program.

14. Work-Plan (Chart): The application should include a work-plan for implementing the HEZ program across each goal and strategies. The work-plan is a comprehensive program management tool for HEZ performance (see Appendix E for a sample chart) that describes the key strategies, activities, and evaluation measures and links these with the overall goals of the HEZ. The work-plan should provide a "step-by-step" understanding of the key actions, the timing to implement these actions, and who (which participating partners or personnel) is responsible for implementing these actions. In addition, the work-plan will describe the time-specific milestones or deliverables that will be used to evaluate the success of the activities in the HEZ. The work-plan should be in a chart format which provides a clear understanding of how the program's goals will be achieved over the four-year program duration and should include the following components:

a. Goals;
b. Objectives;
c. Key program activities/action steps;
d. Data evaluation and measurement;
e. Responsible organization/entity; and
f. Timeline for implementation.

Some information presented in the other parts of the application, such as goals, specific strategies, activities, and the evaluation plan, will be repeated in the work-plan. A template (blank) work-plan chart and sample work-plan are included in this Call for Proposals (see Appendix Items D and E).

15. Evaluation Plan: The evaluation plan should include implementation and process metrics and performance measures with time-specific milestones and targets to assess the deployment of the interventions and strategies in the work-plan. Whereas the work-plan is in chart format (see Appendix D), the evaluation plan is in narrative (written prose) form. The primary purpose of the evaluation plan is to describe how the Coordinating Organization will measure the implementation and success of the proposed strategies on an ongoing basis to achieve the goals of the HEZ and report this information to the CHRC on a regular basis. This evaluation plan should include the specific activities/methods the Coordinating Organization (and sub-grantees/participating partners, where applicable) will undertake to capture needed information (e.g., health outcome data) and how the Coordinating Organization will evaluate the success of the activities within the HEZ on a regular basis. The evaluation plan should also include the health outcome metrics that will be tracked/reported to demonstrate that the HEZ is achieving its health improvement goals. Time-specific milestones for the health outcome metrics should be included. Methods for collecting the health outcome data within the HEZ or assembling data from external sources should be discussed. The metrics of reach (deployment) and impact

(health outcomes) should be analyzed in categories of race and ethnicity to assess the impact on minority health and health disparities.

In addition, the internal evaluation plan should describe how the Coordinating Organization plans to monitor the activities and progress of sub-grantees/participating partners in the implementation of specific program activities. This could include any information/data the Coordinating Organization will require from sub-grantees, how sub-grantees will be held accountable for program achievement, and how this information will be reported to the CHRC. The information gathered by the Coordinating Organization should be linked to specific milestones, data measures, and/or other metrics that evaluate the progress on key activities, objectives, and program goals. Applications should reference the data and evaluation measures included in the Work-Plan (see item 16, page 17).

Applications should show a budgeted line-item between 5% and 10% of the overall HEZ global budget for data collection and evaluation efforts. If the applicant organization plans to utilize external organizations or other tools/resources to assist to evaluation of the program, this should be described here (e.g., hiring an external organization to administer a survey or group interviews, purchasing software to capture particular data).

16. Sustainability: The application should describe a plan for sustainability and acquisition of resources beyond State funding, including partnership with entities in the health care system that have the financial incentive for better outcomes. The application should include a specific plan for developing and implementing a short-term and long-term sustainability strategy.

17. Program Budget and Justification (Standard form): The HEZ funding request should be between $500,000 to $2 million per year for the duration of the four-year program. All applicants must complete the Global Budget Form which provides the annual and total budget request by program benefit and incentive requested (see Appendix Item F for a template (blank) global budget form and Appendix Item G for a sample global budget form).

Applicants requesting CHRC grant funding for innovative health programs may also be required to complete a separate Grant Program Budget Form, which is a line-item budget for each organization that will be partnering in the implementation of the public health grant program (see Appendix Item H for a template (blank) organization program budget form and Appendix Item I for a sample organization program budget). For example, if the application requests CHRC grant support for the salaries of five community health workers to be hired by a participating partner, then the Line-Item Grant Budget Form is required in addition to the Global Budget.

The budget justification should detail what is included in each line-item and describe how each item will support the achievement of the program's goals and objectives. Funding levels to implementing organizations should be appropriate to their roles and responsibilities in the work-plan.

18. Financial Audits: Non-profit Coordinating Organizations must submit a copy of their most recent financial audit of the organization. As in previous CHRC Call for Proposals, financial audits are not required for local government entities.

Application Formatting
Applications should be approximately 20 to 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. Please number pages. The hard copy of the application documents should be bound with prong report fasteners or clips. Please do not use spiral binding or three ring binders.

Applications are due to the CHRC no later than 12:00 p.m., November 13, 2012 by email **and** hand delivery, U.S. Postal Service, or private courier.

Electronic versions of applications should be submitted in one PDF or Word Document attachment, sent via email to dhmh.hez@maryland.gov. Please save file attachments using the following format: Organization Name, HEZ Proposal, Date.

In addition to electronic application submission, the following must be received by November 13, 2012, 12:00 p.m. to be considered a complete application package:

(1) One original application, labeled "original"; and

(2) Eight bound copies of the application.

Send hard copies of applications to:

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

Step 3: Presentation before the CHRC (invited applicants only)
A selected number of applicants will be invited to present their proposal at a Community Health Resources Commission meeting. This meeting will be held on December 11, Additional information regarding time and location of this meeting will be forthcoming. Invited applicants will be provided presentation instructions upon notification of invitation to present.

V. Program Evaluation and Implementation

The CHRC implements a robust system of grantee performance management that holds grantees accountable for performance and is designed to ensure that finite grant resources are utilized wisely and efficiently. The CHRC will work with each HEZ Coordinating Organization and its participating partners to develop standard and customized performance measures that will be reported by the grantees on a quarterly basis. These performance measures will reflect the four-year duration of the program and will be a combination of interim and longer-term measures.

Internal Evaluation
At the beginning of the grant period (January 2013), CHRC staff and the HEZ Coordinating Organization will meet to finalize the internal evaluation plans, which will be developed from the work-plan and proposed internal evaluation plan submitted in the original HEZ application. As part of this internal evaluation, HEZ Coordinating Organizations will be required to submit the following three deliverables on a quarterly basis. CHRC staff will make sample reports available to HEZ Coordinating Organizations after HEZ designations are made.

1. **Milestone & Deliverable Report (M&D)**. Quantitative report (excel file) which reports on a core set of common measures for all HEZ programs and specific measures that are unique to each HEZ program. These measures will be developed from the work-plan and proposed evaluation measures provided in the HEZ application. Grantees will be expected to provide baseline data/projections on evaluation measures and subsequent data will be compared to baseline data/projected outcomes;

2. **Narrative reports**. Qualitative report (word document) summarizing the status of implementation of key strategies of the HEZ proposal. The narrative reports should be based on the key time-specific milestones and deliverables in the M&D report (above), and the work-plan and proposed evaluation plan that were provided in the HEZ application. These reports provide details about each grant program including any major events or activities that took place as part of the implementation; any problems or barriers encountered during the reporting period and how these barriers were resolved or will be addressed; and details about why the grantee has not achieved program goals to date. Any successes or unexpected outcomes from the program activities should be highlighted in the narrative report; and

3. **Expenditure reports.** A line-item budget detail (excel file) showing exactly how HEZ resources were expended and utilized. Activities or expenditures by participating partners should be included. Recipients of HEZ funds are expected to retain all documentation of the use of grant funds and provide these to the CHRC upon request.

HEZ grantees will provide these reports throughout the program's four-year duration. Compliance will be required as a condition of receipt of funding in years two, three, and four of the program.

External Evaluation
Under the Maryland Health Improvement and Disparities Reduction Act, the CHRC and DHMH are required to submit an annual report to the Maryland General Assembly and Governor documenting the impact of the activities in the Health Enterprise Zones. To fulfill this reporting requirement, the CHRC will solicit proposals to contract with an outside entity to perform an independent, external evaluation of the program. This evaluator will not only analyze the periodic reports submitted by the HEZ Coordinating Organizations, but will also perform additional data collection and analysis to assess the impact of the activities of the HEZs on the outcomes specified in the Act and the proposals. The external evaluation activities will be coordinated and funded through the CHRC and DHMH, and, as such, do not need to be included as part of budget requests submitted by HEZ Coordinating Organizations. As a condition of receiving HEZ grant funds, however, HEZ grantees will be required to participate in this external evaluation. This may include the Coordinating Organization and participating partners assisting

with any data collection and information gathering required, such as participation in surveys, focus groups, site visits, meetings, and key informant interviews with the evaluators.

Program Implementation and Benefits Distribution
The HEZ program period will begin in January 2013, and reporting requirements will be organized around a calendar year. Once HEZ designations are made by the Secretary, CHRC staff and HEZ Coordinating Organizations will develop and finalize program budgets, internal evaluation plans, and periodic reports submitted to the CHRC. Once these documents are finalized, it is expected that the Coordinating Organization and partnering entities will begin implementing the HEZ strategies immediately. In addition, the HEZ Coordinating Organization and CHRC will determine the mechanics of distributing incentives or benefits. In some cases, the Coordinating Organization will receive funds from the CHRC to distribute the benefits to participating partners, and in other cases, the CHRC will distribute benefits directly to the individual participating partners.

Providers and practices who wish to receive benefits and incentives in the HEZ strategies (income and hiring tax credits, loan repayment assistance, EHR, capital and equipment funding) must apply to the Coordinating Organization. Within six months of designation (July 2013), the Coordinating Organization must evaluate the applications of providers and practices, certify their eligibility, and provide the CHRC with the specific/actual providers and practices that will receive the benefits and incentives budgeted for year one of the program. The CHRC and DHMH will distribute funding and incentives directly to each provider/practice.

Grant Modifications
HEZ Coordinating Organizations are permitted to request changes to their approved HEZ proposal/programs by submitting a formal Grant Modification Form (see Appendix Item H), and when required, an updated Global or Program Budget to the CHRC. Grantees may be asked to present their grant modification request before the CHRC.

VI. Inquiries and Other Information

Conference Call for Applicants
The program office will host a conference call for interested applicants to provide information on the HEZ program and assistance with the application process. This conference call, on **October 11, 2:30 p.m.,** is ***optional***. This call will be available on a first come, first serve basis. Multiple participants from the same organization are encouraged to use one phone line when calling into the conference call. The call in information is:

Dial-In Number: (866) 233-3852
Participant Access Code: 267478

Questions from Applicants
Applicants may also submit written questions at any time to dhmh.hez@maryland.gov.

COMMUNITY HEALTH RESOURCES COMMISSION
2012 Commissioners
John A. Hurson, Chairman
Nelson Sabatini, Vice Chairman
Dr. Charlene Dukes
Maria Harris-Tildon
Kendall D. Hunter
P. Sue Kullen
Dr. Mark Li
Paula McLellan
Margaret Murray, M.P.A.

CHRC Staff and Contact Information
The Maryland Community Health Resources Commission is located at:

45 Calvert Street, Room 336
Annapolis, MD 21401
Fax: 410-626-0304
Website: http://dhmh.maryland.gov/mchrc/

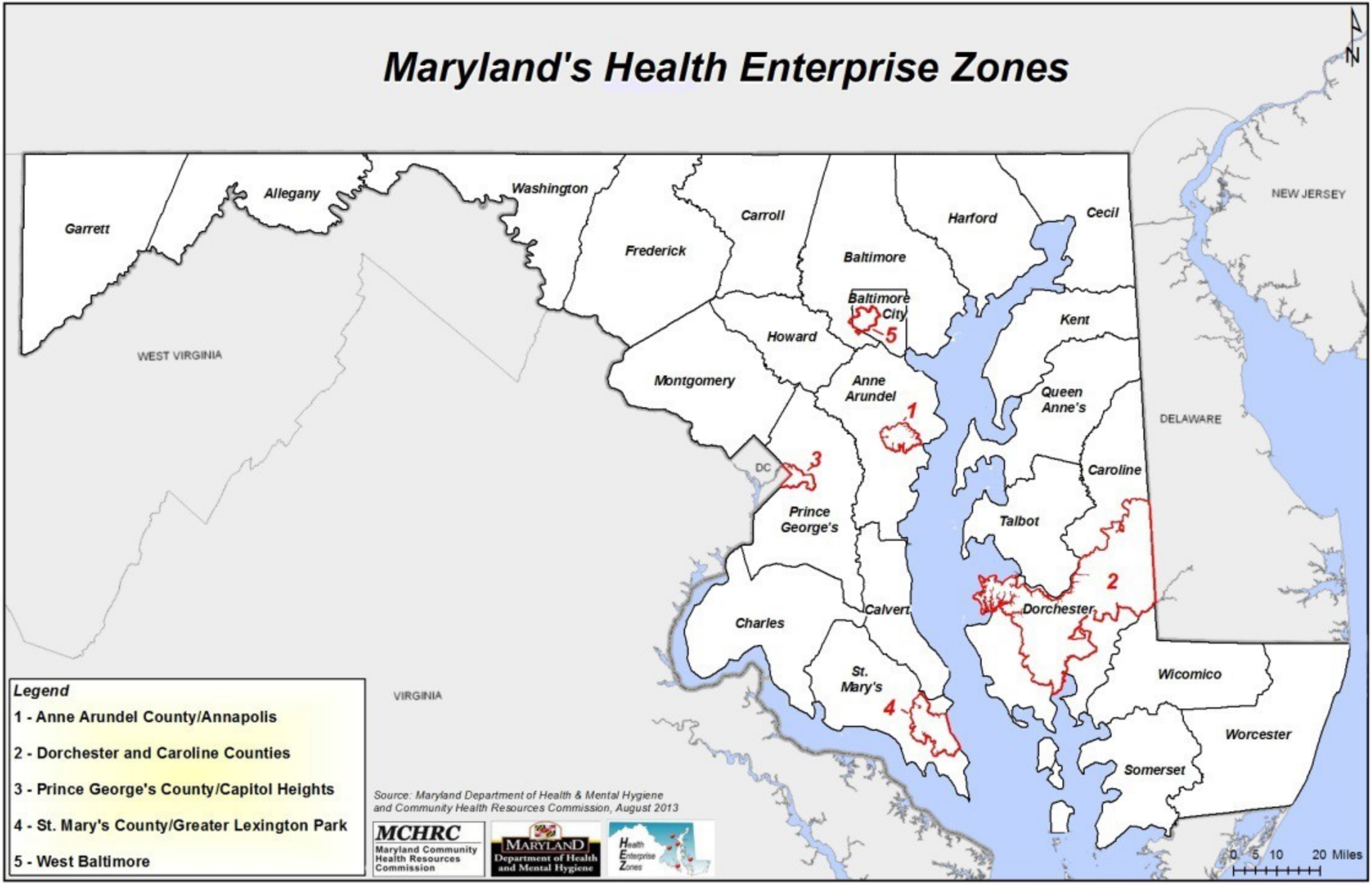
CHRC Staff
Mark Luckner, Executive Director
E-mail: mark.luckner@maryland.gov

Edith Budd, Administrator
E-mail: edith.budd@maryland.gov
Telephone: 410-260-6290

Melissa Noyes, Health Policy Analyst
E-Mail: melissa.noyes@maryland.gov

Appendix G

Maryland's Health Enterprise Zones



Legend

1 - Anne Arundel County/Annapolis

2 - Dorchester and Caroline Counties

3 - Prince George's County/Capitol Heights

4 - St. Mary's County/Greater Lexington Park

5 - West Baltimore

Source: Maryland Department of Health & Mental Hygiene and Community Health Resources Commission, August 2013

MCHRC Maryland Community Health Resources Commission

MARYLAND Department of Health and Mental Hygiene

Health Enterprise Zones

Appendix H

(See DLS Library for a copy)

Appendix I

Zone: Prince George's County

Total Population of Zone: 38,626

Date: January – March 2014 (Q4)

Health Enterprise Zones Dashboard

Prince George's County Health Department
Greater Baden Medical Services
Sister Circles, Inc.
Concentra Urgent Care
Global Vision Community Health Center
Medical Mall Health Services
Dimensions Hospital
Doctors Community Hospital
Gerald Family Care
University of Maryland School of Public Health
Prince George's County Dept. of Social Services
Prince George's County Dept. of Family Services

Hospital Utilization		Annual Rates		2014			
		CY 2012	CY 2013	Q1	Q2	Q3	Year
Capitol Heights	Hospitalization Rate*	99.3	92.1				
	Readmission Rate	14.4%	14.3%				
Maryland	Hospitalization Rate*	110.1	105.0				
	Readmission Rate	13.3%	13.8%				

*Rate per 1,000 residents.
Maryland residents hospitalized out of state are not included in data.

Process Measures	Year One Goals	Year One Cumulative Totals			
		Q1	Q2	Q3	Q4
# of HEZ practitioners added* (FTE)	7	0	0	2.5	8.3
# of CHWs added (FTE)	5	0	0	3.0	5.0
# of patients (unduplicated) across Zone		Opened Q4			925
# of patient visits across Zone					3,251
# of CHW outreach encounters					6,000

Clinical Measures	Baseline	Year Two			
		Q1	Q2	Q3	Q4
# of sites reporting					
# of primary care providers reporting					
# of patients receiving services across sites					
Asthma					
Use of appropriate medications **(NQF 36)**					
Behavioral Health					
Screening for clinical depression and follow up plan **(NQF 418)**					
Antidepression medication management **(NQF 105)**					
Diabetes					
Diabetes: HbA1c Control **(NQF 575)**					
Diabetes: LDL Management **(NQF 64)**					
Diabetes: BP Management **(NQF 61)**					
Hypertension					
Hypertension: BP Control **(NQF 18)**					
Smoking					
Smoking Screening & Counseling **(NQF 28)**					
Obesity					
BMI Screening & Follow-Up **(NQF 421)**					

Key Milestones	Year One			
	Q1	Q2	Q3	Q4
Goal 1: Increase access to primary care services				
Open and/or expand 2 new PCMH sites in the Zone (in Year 1)				
Develop and Initiate Community Health Worker program				
Goal 2: Increase community health resources				
Develop a Health Information Exchange (HIE) and connect various electronic medical records to the HIE				
Develop and implement care coordination software application				
Establish post discharge care coordination protocols				
Develop and implement electronic Healthy Eating Active Living Wellness Plan Template				
Conduct health literacy surveys				
Goal 3: Promote Cultural Competency				
Develop comprehensive cultural competency training curriculum				

Completed **On-Task** **Delayed**

Completed Milestones

√	Open and staff Global Visions PCMH site
√	Expand services at Greater Baden PCMH site
√	Identify additional services provided by Prince George's County Health Department (to complement PCMH-related services in the Zone)

*Includes direct and indirect licensed health care providers who provide primary care, behavioral health or dental services in the Zone (physicians, NPs, PAs, psychiatrists, psychologists, dentists, RNs, dental hygienists, LCSWs, licensed clinical professional counselors, and licensed substance abuse service providers).

Zone: Caroline/Dorchester
Total Population of Zone: 36,123
Date: January – March 3014 (Q4)

Health Enterprise Zones Dashboard

Associated Black Charities
Eastern Shore Area Health Education Center
Dorchester County Health Department

Maryland State Medical Society
Chesapeake Voyagers, Inc./DRI Dock
Affiliated Sante Group

Shore Wellness Partners
Maryland Healthy Weighs
Caroline County Health Department

Hospital Utilization		Annual Rates		2014			
		CY 2012	CY 2013	Q1	Q2	Q3	Year
Dorchester/ Caroline	Hospitalization Rate*	143.0	134.5				
	Readmission Rate	12.2%	12.0%				
Maryland	Hospitalization Rate*	110.1	105.0				
	Readmission Rate	13.3%	13.8%				

*Rate per 1,000 residents.
Maryland residents hospitalized out of state are not included in data.

Process Measures	Year One Goals	Year One Cumulative Totals			
		Q1	Q2	Q3	Q4
# of HEZ practitioners added* (FTE)	**9**	3.5	5.7	5.7	10.3
# of unduplicated patients seen across Zone	**687**	29	200	440	591
Average response time to calls for the mobile crisis team	**<60 mins**	NA	45 mins	16 mins	10 mins
# of patient visits (unduplicated) across Zone		NA	580	1630	3,267
# of students (unduplicated) served in school based wellness centers		NA	60	150	196
# of individuals (unduplicated) participating in Maryland Healthy Weighs		12	23	33	46

Clinical Measures	Baseline	Year Two			
		Q1	Q2	Q3	Q4
# of sites reporting					
# of primary care providers reporting					
# of patients receiving services across sites					
Asthma					
Use of appropriate medications **(NQF 36)**					
Behavioral Health					
Screening for clinical depression and follow up plan **(NQF 418)**					
Antidepression medication management **(NQF 105)**					
Diabetes					
Diabetes: HbA1c Control **(NQF 575)**					
Diabetes: LDL Management **(NQF 64)**					
Diabetes: BP Management **(NQF 61)**					
Hypertension					
Hypertension: BP Control **(NQF 18)**					
Smoking					
Smoking Screening & Counseling **(NQF 28)**					
Obesity					
BMI Screening & Follow-Up **(NQF 421)**					

Key Milestones	Year One			
	Q1	Q2	Q3	Q4
Goal 1: Increase access to primary care services				
Develop and implement SBWC in Caroline County				
Open Federalsburg adult mental health clinic				
Expand primary care services at Chesapeake Women's Health				
Goal 2: Increase community health resources				
Implement Community Health Outreach Teams				
Implement peer substance abuse recovery program				
Implement Shore Wellness home visiting program				
Goal 3: Promote Cultural Competency				
Provide cultural competency training to collaborative partners				

Completed **On-Task** **Delayed**

Completed Milestones	
√	Develop and implement SBWC in Dorchester County
√	Initiate new mobile health crisis team
√	Initiate Maryland Healthy Weighs program

*Includes direct and indirect licensed health care providers who provide primary care, behavioral health or dental services in the Zone (physicians, NPs, PAs, psychiatrists, psychologists, dentists, RNs, dental hygienists, LCSWs, licensed clinical professional counselors, and licensed substance abuse service providers).

Zone: Greater Lexington Park

Total Population of Zone: 34,035

Date: January – March 2014 (Q4)

Health Enterprise Zones Dashboard

MedStar Health Research Institute
St. Mary's County Government Agencies
Community Development Corporation
Southern Maryland Center for Independent Living
The Healthy St. Mary's Partnership LHIC
The Minority Outreach Coalition
Greater Baden Medical Service
MedStar St. Mary's Hospital
Walden Sierra Inc.

Hospital Utilization		Annual Rates		2014			
		CY 2012	CY 2013	Q1	Q2	Q3	Year
Greater Lexington Park	Hospitalization Rate*	93.8	88.4				
	Readmission Rate	9.6%	9.0%				
Maryland	Hospitalization Rate*	110.1	105.0				
	Readmission Rate	13.3%	13.8%				

*Rate per 1,000 residents.
Maryland residents hospitalized out of state are not included in data.

Process Measures	Year One Goals	Year One Cumulative Totals			
		Q1	Q2	Q3	Q4
# of HEZ practitioners added* (FTE)	**3**	0.0	1.2	4.3	4.8
# of CHWs added (FTE)	**3**	0	1.0	2.0	2.0
# of residents who use mobile medical route	**200**	0	0	0	387
# residents who are assisted by CHWs		0	0	13	85
# of patients (unduplicated) receiving primary care services		N/A	135	310	490
Number of visits across the Zone		N/A	280	545	791

Clinical Measures	Baseline	Year Two			
		Q1	Q2	Q3	Q4
# of sites reporting					
# of primary care providers reporting					
# of patients receiving services across sites					
Asthma					
Use of appropriate medications **(NQF 36)**					
Behavioral Health					
Screening for clinical depression and follow up plan **(NQF 418)**					
Antidepression medication management **(NQF 105)**					
Diabetes					
Diabetes: HbA1c Control **(NQF 575)**					
Diabetes: LDL Management **(NQF 64)**					
Diabetes: BP Management **(NQF 61)**					
Hypertension					
Hypertension: BP Control **(NQF 18)**					
Smoking					
Smoking Screening & Counseling **(NQF 28)**					
Obesity					
BMI Screening & Follow-Up **(NQF 421)**					

Key Milestones	Year One			
	Q1	Q2	Q3	Q4
Goal 1: Increase access to primary care services				
Develop and implement Care Coordination program targeting eligible residents who utilized ED or were inpatients				
Initiate mobile dental program				
Open Community Health Center in target zip code(s)				
Goal 2: Increase community health resources				
Hire/place CHWs throughout the Zone				
Implement Hair, Heart and Health program*				
Goal 3: Promote Cultural Competency				
Provide cultural competency training				

Completed **On-Task** **Delayed**

Completed Milestones	
√	Initiate and implement mobile medical route
√	Integrate primary care services with behavioral health services at Walden Sierra
√	Expand behavioral health services at Walden Sierra

*Includes direct and indirect licensed health care providers who provide primary care, behavioral health or dental services in the Zone (physicians, NPs, PAs, psychiatrists, psychologists, dentists, RNs, dental hygienists, LCSWs, licensed clinical professional counselors, and licensed substance abuse service providers).

Zone: Annapolis / Morris Blum

Total Population of Zone: 36,805 / 184

Date: January – March 2014 (Q4)

Health Enterprise Zones Dashboard

Anne Arundel County Health Department
Housing Authority, City of Annapolis

Anne Arundel Health System
Anne Arundel County Department of Aging and Disabilities

Hospital Utilization		Annual Rates		2014			
		CY 2012	CY 2013	Q1	Q2	Q3	Year
Morris Blum	Hospitalization Rate*	138.5	121.8				
	Readmission Rate	13.6%	12.3%				
Maryland	Hospitalization Rate*	110.1	105.0				
	Readmission Rate	13.3%	13.8%				

*Rate per 1,000 residents.
Maryland residents hospitalized out of state are not included in data.

Process Measures	Year One Goals	Year One Cumulative Totals			
		Q1	Q2	Q3	Q4
# of HEZ practitioners added* (FTE)	2	N/A	2.0	2.0	2.0
# of 911 calls from Morris Blum Center		N/A	39	87	144
# of ED visits from Morris Blum residents		N/A	56	103	152
# of Morris Blum residents (unduplicated) who receive services at new PCMH		Opened Oct. 9th		45	81
# of additional residents (outside Morris Blum) who receive services (unduplicated)		Opened Oct. 9th		252	470
# of patients (unduplicated) with diabetes seen for primary care		Opened Oct. 9th		33	70

Clinical Measures	Baseline	Year Two			
		Q1	Q2	Q3	Q4
# of sites reporting					
# of primary care providers reporting					
# of patients receiving services across sites					
Asthma					
Use of appropriate medications **(NQF 36)**					
Behavioral Health					
Screening for clinical depression and follow up plan **(NQF 418)**					
Antidepression medication management **(NQF 105)**					
Diabetes					
Diabetes: HbA1c Control **(NQF 575)**					
Diabetes: LDL Management **(NQF 64)**					
Diabetes: BP Management **(NQF 61)**					
Hypertension					
Hypertension: BP Control **(NQF 18)**					
Smoking					
Smoking Screening & Counseling **(NQF 28)**					
Obesity					
BMI Screening & Follow-Up **(NQF 421)**					

Key Milestones	Year One			
	Q1	Q2	Q3	Q4
Goal 1: Increase access to primary care services				
Begin providing primary care services to Morris Blum residents				
Inform greater Annapolis area about new PCMH				
Goal 2: Increase community health resources				
Develop diabetes management program for residents				
Implement self-management support activities (e.g., shopping field trips, cooking and nutrition events)				
Goal 3: Promote Cultural Competency				
Provide cultural competency training				

Completed **On-Task** **Delayed**

Completed Milestones	
√	Hire new providers for PCMH at Morris Blum
√	Make capital improvements to new PCMH
√	Open new PCMH at Morris Blum

*Includes direct and indirect licensed health care providers who provide primary care, behavioral health or dental services in the Zone (physicians, NPs, PAs, psychiatrists, psychologists, dentists, RNs, dental hygienists, LCSWs, licensed clinical professional counselors, and licensed substance abuse service providers).

Zone: West Baltimore

Total Population of Zone: 137,823

Date: January – March 2014 (Q4)

Health Enterprise Zones Dashboard

Baltimore Medical Center
University Maryland Medical Centers
Mosaic Community Services
Park West Health System
Bon Secours Baltimore Health System
Total Health Care
People's Community Health Centers
Saint Agnes Hospital
Coppin State University
Light Health and Wellness Comprehensive Services
National Council on Alcohol and Drug Dependence
Sinai Hospital, Baltimore

Hospital Utilization		Annual Rates		2014			
		CY 2012	CY 2013	Q1	Q2	Q3	Year
West Baltimore	Hospitalization Rate*	222.0	206.3				
	Readmission Rate	17.7%	16.9%				
Maryland	Hospitalization Rate*	110.1	105.0				
	Readmission Rate	13.3%	13.8%				

*Rate per 1,000 residents.
Maryland residents hospitalized out of state are not included in data.

Process Measures	Year One Goals	Year One Cumulative Totals			
		Q1	Q2	Q3	Q4
# of HEZ practitioners added* (FTE)	**16**	12.0	24.0	24.0	26.0
# of CHWs added (FTE)	**11**	0	10.5	10.5	10.5
# of community "mini-grants" awarded by HEZ	**4**	0	7	7	7
# new community health resources created for HEZ residents	**5**	8	10	15	25

Clinical Measures	Baseline	Year Two			
		Q1	Q2	Q3	Q4
# of sites reporting					
# of primary care providers reporting					
# of patients receiving services across sites					
Asthma					
Use of appropriate medications **(NQF 36)**					
Behavioral Health					
Screening for clinical depression and follow up plan **(NQF 418)**					
Antidepression medication management **(NQF 105)**					
Diabetes					
Diabetes: HbA1c Control **(NQF 575)**					
Diabetes: LDL Management **(NQF 64)**					
Diabetes: BP Management **(NQF 61)**					
Hypertension					
Hypertension: BP Control **(NQF 18)**					
Smoking					
Smoking Screening & Counseling **(NQF 28)**					
Obesity					
BMI Screening & Follow-Up **(NQF 421)**					

Key Milestones	Year One			
	Q1	Q2	Q3	Q4
Goal 1: Increase access to primary care services				
Establish and implement Community Health Worker Team linked to HEZ primary care providers				
Establish and implement Care Coordination Programs with HEZ primary care providers				
Goal 2: Increase community health resources				
Initiate health education and fitness classes				
Develop scholarship program for Zone residents				
Expand Virtual Supermarket Program				
Goal 3: Promote Cultural Competency				
Provide cultural competency training to collaborative partners				

Completed **On-Task** **Delayed**

Completed Milestones

√	Recruit and place Primary Care Providers in the Zone for year one
√	Recruit and hire Community Health Workers
√	Create healthy food options in the community
√	Develop and implement Chronic Disease Management classes
√	Award Partnership Mini-grants

*Includes direct and indirect licensed health care providers who provide primary care, behavioral health or dental services in the Zone (physicians, NPs, PAs, psychiatrists, psychologists, dentists, RNs, dental hygienists, LCSWs, licensed clinical professional counselors, and licensed substance abuse service providers).

Appendix J

Health Care Reform Coordinating Council

October 16, 2013

Access to Care

Mark Luckner
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Community Health Resources Commission
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Supporting Safety Net Provider Capacity

- CHRC business plan in February 2012 – specific recommendations to bolster capacity of safety net providers:

1. Transition from grant-based revenue models to billing third-party payers (more sustainable);
2. Promoting IT/EMR adoption and administrative efficiencies;
3. Supporting workforce development; and
4. Leverage public-private partnerships.

Access to Care Regional Forums

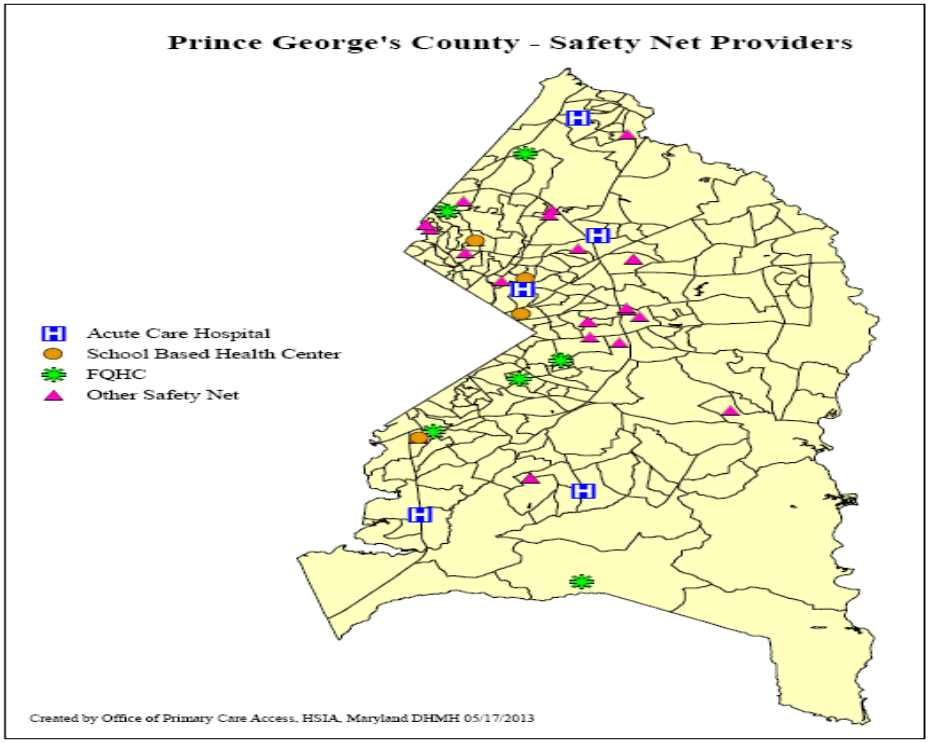
- Launched in early 2013, Access to Care Program is designed to help promote robust participation of safety net providers (history of serving low-income/uninsured) in new health insurance options made available under Affordable Care Act
- Promote continuity of care for newly insured
- Prepare to meet the expected demand for new health services by Maryland's newly insured (estimated to be 250,000)
- Interagency program of DHMH, Maryland Health Benefit Exchange, and CHRC

Access to Care Regional Forums

- Invited safety net provider organizations, Medicaid Managed Care Organizations, and commercial carriers to attend six regional networking forums held earlier this summer:
  - **Southern Maryland**: June 6
  - **Eastern Shore**: June 10
  - **Central Maryland**: June 12
  - **Western Maryland**: June 18
  - **Washington Metro region**: June 20
  - **Baltimore Metro region**: June 25
- A total of 363 individuals, representing 191 organizations, attended the forums.

Access to Care Regional Forums

- Encourage providers to establish contacts with MCOs and carriers participating in their regions
- Provide information about safety net providers to MCOs and carriers
- Promote network development



Safety Net Capacity-building Efforts

- The CHRC is scheduled to release its Call for Proposals later this month to solicit grant applications. There is just under $3M to award in new grant funding this fiscal year.
- The Call for Proposals is expected to include efforts to provide technical assistance and support safety net capacity-building efforts.
- The CHRC was recently awarded a $50,000 grant from Kaiser Permanente to support Maryland's safety net capacity building.