DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Prevention and Health Promotion Administration

Office for Genetics and People with Special Health Care Needs

FUNDING OPPORTUNITY ANNOUNCEMENT
For
Local Health Departments

State Fiscal Year 2017

Announcement Title:
Family Centered, Community-based Systems of Coordinated Care for Children and Youth with Special Health Care Needs

Application Due Date: May 13, 2016

Webpage: Office of Genetics and People with Special Health Care Needs

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I. INTRODUCTION AND BACKGROUND

The Office of Genetics and People with Special Health Care Needs (OGPSHCN) (The Office)

The Office is the sole state agency dedicated to addressing health issues for children and youth with special health care needs in Maryland. The Maternal and Child Health Bureau defines children with special health care needs as "*those who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally*"[1]

Under direction of the OGPSHCN director, the office receives, and allocates federal funds through the Title V block grant. Title V funds to states are determined through a formula that calculates the percent of low income children in a state, and states are given the flexibility to design and implement a wide range of maternal and child health programs that meet the national and state needs. Through a comprehensive needs assessment, states develop their own priorities of how to allocate the federal funds that address the needs of their population appropriately. The OGPSHCN priorities are aligned with the MCHB priorities for CYSHCN.

- Improve the health of children and youth with special health care needs
- Families of CYSHCN partner in decision making at all levels and are satisfied with the services they receive
- CYSHCN receive coordinated ongoing comprehensive care within a medical home
- Families of CYSHCN have adequate private and or public insurance to pay for the services they need
- All children in the state are screened early and continuously for special health care needs
- Improve Access to preventive, primary, specialty, behavioral health services and medical homes for CYSHCN
- All CYSHCN have access to well organized and easily accessible services in their communities
- Youth with special health care needs receive the services that are necessary to make transitions to all aspects of adult life, including adult health care, work and independence.

Our Mission

OGPSHCN's mission is to promote and improve the coordination of a comprehensive, culturally effective and consumer-friendly system of care through strengthening the infrastructure and improving the capacity of these systems; and to continuously evaluate their effectiveness in order to improve the health and well-being of children and youth with special health care needs in Maryland.

Our Vision

The vision of the office is to become the driving force in developing the optimal health outcomes and well-being of every Maryland child and young person served through our systems of care.

[1] McPherson M, Arango P, Fox H, Lauver C, McManus M, Newacheck P, Perrin J, Shonkoff J, Strickland B. A new definition of children with special health care needs. *Pediatrics,* 102(1):137–140, 1998

WHAT WE DO

The OGPSHCN administers a broad range of programs that address the needs of the CYSHCN population in Maryland by promoting and evaluating the system of care for this population. Activities in the OGPSHCN include providing leadership in infrastructure development and support, workforce development, planning, implementing and evaluating programs serving CYSHCN, and through its systems change unit, the OGPSHCN provides funds and technical support for new and innovative community led initiatives aimed at improving the health and wellbeing of CYSCN.

Programmatic Areas of Administration:

- Birth Defects Reporting System
- Children's Medical Services
- Early Hearing Detection and Intervention
- Family Professional Partnerships
- Infrastructure and Systems Development
- Medical Homes Implementation
- Newborn Screening and Follow-up program
- Family and Provider Resources
- Sickle Cell Anemia Disease Follow-up Program
- Youth to Adult Health Care Transition
- Genetic Services

Transformation 3.0

The Title V Block Grant 2014/2016 Report and application brought significant programmatic changes to how states run Title V programs. The Maternal Child Health Bureau (MCHB) develop a common vision for improving, innovating, and transforming the Title V MCH Block Grant. The changes are intended to drive improvements throughout its program. This change has been titled "Transformation 3.0". Transformation 3.0 involves revamping process and reexamining of strategies and development of State's 5 year Action Plan with the need to address National Outcome Measures (NOM's), National Performance Measures (NPM), and the development and implement Evidence-Based Strategy Measures (ESMs). This new performance measure system is intended to show more clearly the contributions of Title V programs in addressing the most pressing and emerging needs for their MCH populations. [2]

MCHB has identified national priority areas for Title V Programs. For the population of CYSHCN, the OGPSHCN will address National Performance Measure #11-Medical Home and National Performance Measure #12-Health Care Transition, over the course of the next five-year period. The OGPSHCN aims to improve the health and health care system for children and youth with special Health Care Needs using Medical Home Implementation & Health Care Transition approach.

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[2] **. Title V Maternal and Child Health Services Block Grant Program (2015, December) Retrieved from http://mchb.hrsa.gov/blockgranttransformation/index.html**

Title V-Maternal and Child Health Block Grant Funding

Grants are provided to support infrastructure building for systems of care. The OGPSHCN is seeking to provide funding opportunities that will support the current priorities of the office and will assist in achieving the objectives and outcomes established in the office Action Plan. The OGPSHCN is seeking to support new and innovative community led initiatives aimed at improving the health and wellbeing of CYSCN. Grants are awarded to academic centers, medical day care centers, community organizations, family support organization, condition specific organization, genetic centers and local health departments to fill gaps in services and support infrastructure building in the system of care for CYSHCN. Grants are awarded based on funding priorities and the availability of Title V funds**.**

More information on the Federal Title V Grants Program and National Performance Measures can be found at:

- http://mchb.hrsa.gov/blockgranttransformation/index.html
- http://mchb.hrsa.gov/programs/titlevgrants/stateactionplans.html

Target Population: The OGPSHCN aims to targets children and youth with special health care needs, defined as: *those who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally,* residing in the highest need communities statewide. Given limited public health resources, it is necessary to target activities to areas of highest need with consideration for where impact will be greatest, particularly with regard to racial, ethnic and economic disparities in priority outcomes. [3]

Characterizing the Special Health Care Needs Population: The CSHCN classifies CYSHCN in a non-categorical fashion by the consequences of their chronic conditions using a screener. The CSHCN Screener identifies children across the range and diversity of childhood chronic conditions and special needs – allowing a more comprehensive and robust assessment their needs and health care system performance than is attainable by focusing on a single diagnosis or type of special need[4]. To meet the CSHCN Screener criteria a child's parent must report the child has an ongoing health condition for which he/she experiences one or more of the following:

1. Need or use of prescription medications;
2. Above routine use of services;
3. Need or use of specialized therapies or services
4. Need or use of mental health counseling
5. Functional limitation

Supporting Data: There is an estimated 264,729 children with special health care needs among 0-17 year olds in Maryland.[5] The prevalence of special needs is greatest in Maryland's children and youth over the age of 5

[3] State of Maryland 2015 Comprehensive Needs assessment for Children and Youth with Special Health Care Needs. Retrieved [11/15/15] from http://phpa.dhmh.maryland.gov/genetics/Pages/Grants.aspx

[4] Children with Special Health Care Needs Screener. Fast Facts (http://childhealthdata.org/docs/cshcn/cshcn-screener-cahmi-quickguide-pdf.pdf). Retrieved 03/23/2015

[5] National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved [3/18/2015] from www.childhealthdata.org.

years, reaching a high of 23.7% of children and youth between the ages of 12 to 17 years based on data from the 2011/12 NSCH. Although there has been a significant decline in this age group from 28.1% from the 2007 prevalence. The prevalence among the 0-5 year old increased from 11.2% to 12.6% while the prevalence among 6-11 year olds increased from 20.7% to 22.5%. In Maryland, mirroring the nation as whole, special needs are present more frequently in males than in females; it is estimated that in Maryland, 23.4% of male children aged 0 to 17 years have special health care needs, compared to 15.9% of female children. The prevalence was 21.8% and 18.4% respectively in the 2007 NSCH.

Standards for Systems of Care for Children and Youth with Special Health Care Needs

The Maternal and Child Health Bureau Title V Children and Youth with Special Health Care Needs program encourage the use of the *Six Systems Outcomes* to create a comprehensive, quality system of care for this population. More information about the System Standards can be found online at: *http://www.amchp.org/programsandtopics/CYSHCN/Documents/Standards%20Charts%20FINAL.pdf.*

It is the Shared goal of the OGPSHCN and its partners to move all CYSHCN and their families in Maryland closer to reaching each of the following six system outcomes. Priorities for funding include projects that address one or more areas from the three components of the following System of Care Shared Goals:

Component 1: System Outcomes (More information about each system outcome can be found by visiting the provided website):

1) ***Family Professional Partnerships***: Families of CYSHCN will partner in decision making at all levels and are satisfied with the services they receive (http://www.fv-ncfpp.org);

2) ***Medical Home***: CYSHCN will receive family-centered, coordinated, ongoing comprehensive care within a medical home (http://www.medicalhomeinfo.org);

3) ***Insurance and Financing***: Families of CYSHCN have adequate private and/or public insurance and financing to pay for the services they need (http://hdwg.org/catalyst);

4) ***Early and Continuous Screening and Referral***: Children are screened early and continuously for special health care needs;

5) ***Easy to Use Services and Supports***: Services for CYSHCN and their families will be organized in ways that families can use them easily and include access to patient and family-centered care coordination (http://www.communitybasedservices.org);

6) ***Transition to Adulthood***: Youth with special health care needs receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence: and (http://www.gottransition.org).

Component 2: Disparities

It is the shared goal of the Office and its partners to ensure all CYSHCN and their families received care that is culturally and linguistically appropriate to achieve the six systems outcomes:

- region of residence within state;
- socioeconomic status;
- race/ethnicity;
- primary language spoken at home; and
- Severity or complexity of condition.

Component 3: System Characteristics

It is the shared goal of the Office and its partners to ensure that CYSHCN will receive care in a health care system that is:

- community-based
- coordinated

- family-centered
- Culturally competent

Quick links for more information about Children and Youth with Special Health Care Needs (CYSHCN) and families, the OGPSHCN needs assessment, previous awarded grantees, and other important sources of data and reports on CYSHCN in Maryland, can be found below:

- **Office of Genetics and People with Special Health Care Needs**
- **OGPSHCN 2015 Needs Assessment**
- **OGPSHCN Grant Funding and Partnership**
- **OGPSHCN Reports and Data(Database of resources specific to MD CYSHCN and families; available to providers, parents, caregivers, families, youth and other interest parties in CYSHCN)**
- **Maryland Consortium for Children with Special Health Care Needs (the "COC")**
- **The Parent's Place of Maryland(Maryland's Family Voices Affiliate Organization, Maryland's Family-to-Family Health Information Center, Parent Training Information Center (special education), co-leader of the Consortium for Children with Special Health Care Needs).**

II. FUNDING FOCUS AREAS: MEDICAL HOME AND HEALTH-CARE TRANSITION

WHO MAY APPLY

In addition to working with larger institutions, such as academic centers, OGPSHCN is also committed to working with smaller entities, such as community-based groups. The OGPSHCN also invites applications from organizations that have not previously applied for funding. Priority will be given to innovative proposal that address the needs of diverse populations, build organization's capacity and infrastructure to serve CYSHCN and/or demonstrates strong collaboration, including subcontracts, with other partner agencies/organizations that provide health, educational and supportive services for CYSHCN. The department will not support funding of activities that can be billed to insurance. Applications should be consist of activities and services that are *no*t reimbursed by insurance, even if the reimbursement is inadequate.

Eligible Applicants

Community-based ambulatory patient care centers include, but are not limited to:

- Federally qualified health centers, as defined in section 1905(l)(2)(B) of the Social Security Act
- Community mental health centers, as defined in section 1861(ff)(3)(B) of the Social Security Act
- Rural health clinics, as defined in section 1861(aa) (2)of the Social Security Act
- Health centers operated by the Indian Health service, an Indian tribe or tribal organization, or an
- Non-profit organizations

Any application that fails to satisfy the deadline requirements referenced in *Section III* will be considered non-responsive and will not be considered for funding under this announcement.

Award and Funding Range

Applicants responding to this announcement may request funding for a project period of up to one (1) year with the option of continuation to expand your project. Funding to support projects beyond the first budget year will be contingent upon congressional appropriation, availability of funds, grantee satisfactory performance progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

Estimated Total Program Funding: $734,000
Award Ceiling: $100,000
Award Floor: $5,000

This program is expected to provide funding for State Fiscal Year 2017. The funding will support the period of 7/1/2016-06/30/17 to support a one year project. The start date of the project may vary, but the end date will remain on 6/30/2017.

COMPONENT A: MEDICAL HOMES

MEDICAL HOMES OVERVIEW

Vision: The Medical Home Program envisions a future in which **all** Maryland CYSHCN will receive comprehensive care through a medical home partnership. Through Medical home partnerships we aim for improved health, functioning, and quality of life for Maryland CYSHCN and their families and an increase in professional satisfaction for all health care providers serving CYSHCN

BACKGROUND INFORMATION:

As emphasized in the Institute of Medicine (IOM) report, "Health care for chronic conditions is very different from care for acute episodic illnesses. Care for the chronically ill needs to be a collaborative, multidisciplinary process."[6] Integrated health care delivery systems represent an important step towards addressing the coordination needs of those with chronic conditions.[7] As stressed in the definition of MCHB, CSHCN typically require care coordination with systems and services outside of the health care delivery system, such as with schools, vocational settings, and others. Programs that coordinate care across multiple systems and services are needed for an effective care of CSHCN. In a recent policy statement, American Academy of Pediatrics (AAP), Council on Children with Disabilities defined care coordination as "*a process that facilitates the linkage of children and their families with appropriate services and resources in a coordinated effort to achieve good health*"[8] The basic notion of 'a process that facilitates linkage' constitutes the core of care coordination activities. In practice, this basic notion has been operationalized in at least two different ways. One way is that care coordination has been included as one of the pillars of the "Medical Home".[9] Medical Home serves as a point of entry for CSHCN and helps coordinate care in an otherwise decentralized system of health care delivery. The AAP Medical Home Initiatives for Children with Special Needs Project Advisory Committee maintains that comprehensive care provided through the medical home "should be delivered or directed by well-trained physicians who provide primary care".[10]

Care coordination programs that stand alone without being part of a medical home represent a second way that the basic notion of 'a process that facilitates linkage' has been implemented nationwide.[11]

SUPPORTING DATA:

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[6] 2 Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academies Press; 2001, p. 9

[7] See Gillies RR, Shortell SM, Anderson DA, Mitchell JB, Morgan KL. Conceptualizing and Measuring Integration: Findings from the Health Systems Integration Study, Hospital and Health Services Administration. 1993; 38(4):467-489; Shortell SM, Gillies RR, Anderson DA, Mitchell JB, Morgan KL. Creating Organized Delivery Systems: The Barriers and Facilitators, Hospital and Health Services Administration. 1993; 38(4):447-466; and Watson D, Townsley R, Abbott D. Exploring Multi-Agency Working in Services to Disabled Children with Complex Healthcare Needs and Their Families, Journal of Clinical Nursing. 2002; 11:367-375.

[8] American Academy of Pediatrics, Council on Children with Disabilities. Care Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children with Special Health Care Needs. Pediatrics. 2005; 116(5):1238-1244.

[9] See American Academy of Pediatrics, Medical Home Initiatives for Children with Special Needs Project Advisory Committee. The Medical Home. Pediatrics. 2002; 110(1):184-186; Sia C, Tonniges TF, Osterhus E, Taba S. History of the Medical Home Concept. Pediatrics. 2004; 113(5, Suppl.):1473-1478; and Stille CJ, Antonelli RC. Coordination of Care for Children with Special Health Care Needs. Current Opinion in Pediatrics. 2004; 16:700-705.

[10] See American Academy of Pediatrics, Medical Home Initiatives for Children with Special Needs Project Advisory Committee. The Medical Home. Pediatrics. 2002; 110(1):184-186, p.18

[11] State Care Coordination Programs for Children with Special Health Care Needs
Institute for Child Health Policy – University of Florida

The National Survey of Children with Special Health Care Needs (NS-CSHCN) is designed to provide information on the CYSHCN population and to assist in the measurement of its core outcomes. Since 2001, the NS-CSHCN has been conducted every four years. The NS-CSHCN measures each core outcome with low-threshold criteria. Outcome #2 assesses if CYSHCN receive care within a medical home, a key American Academy of Pediatrics priority. Nationally, 43.0% of CYSHCN meet this outcome, with states ranging from 34.2% - 50.7%, as measured in the 2009/10 NS-CSHCN. In Maryland, 44.2% of CYSHCN meet this outcome. Maryland ranks 28th in the nation. Assessment of the variation between states and within demographic or other subgroups of CYSHCN is critical to developing appropriate interventions and policy responses.

OGPSCHN FOCUS:

Care coordination is a critical factor in a high performance health care system. It is described in a Commonwealth Fund report as one of seven elements needed to organize care and information around the patient. [12] The Institute of Medicine has explicitly stated that care coordination is paramount to improving the quality of health care in the United States.[13] Yet consensus is lacking regarding the competencies and core functions of care coordination, who should provide it, what the desired outcomes are, and how to measure and pay for care coordination services. In addition, the cost-effectiveness of care coordination has not yet been definitively demonstrated. In order to achieve a high performance health care system, it is essential and timely to define high-quality care coordination and outline the competencies and accountabilities required for community-based providers of care coordination. Throughout 2014 and 2015, The Medical Home Program leadership in OGPSHCN and its Care Coordination Work Group, developed the following definition of care coordination:

"*Care coordination is the deliberate organization of patient care activities between two or more Participants, including the patient, involved in a patient's care. The goal is to facilitate the appropriate delivery of health services*."

[12] 8.Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework,Richard C. Antonelli, Jeanne W. cAllister, and Jill Popp May 2009

[13] Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academies Press; 2001, p. 9.

Funding Opportunity Focus Areas with Medical Home

In order to meet established goals, the OGPSHCN has identified specific Medical Home projects that the OGPSHCN are interested in funding to support our efforts. Below are categories of possible projects with targeted outcomes that are appropriate to this year's funding initiatives. Applicants may choose to apply for one or more of the projects below. Your project(s) should be aligned with and based on your agency or jurisdiction's identified needs for gaps or challenges in service provision of CYSHCN. Applications submitted can address one or more of the target areas. Application submissions should describe specifically how your agency or jurisdiction plans to utilize the OGPSHCN funding to achieve outcomes. Applicants have the flexibility to propose specific strategies that they determine will be most effective in addressing their identified needs, in the context of the strengths and capacity of their target community.

Implementing Strategies towards "Patient-Centered Medical Home" for Children and Youth with Special Health Care Needs

This announcement solicits applications for Medical Home Interventions. This project's aim is to utilize tools and activities that are targeted and standardized that will help improve the functioning of a Patient-Centered Medical Home. Application submissions should address ***two*** or more of the target areas. Proposals submitted should describe specifically how your agency or jurisdiction plans to utilize the OGPSHCN funding to achieve outcomes listed. Applicants have the flexibility to propose specific strategies that they determine will be most effective in addressing their identified needs, in the context of the strengths and capacity of their target community.

For example: An applicant that proposes to focus on Improve Access to Medical Home, Health Care and other Resources: applicants must submit an application that describes specifically what strategies your agency or jurisdiction plans to utilize to achieve the targeted intervention listed.

1. **Improve Access to Medical Home, Health Care and Other Resources for CYSHCN: Targeted Interventions**:
    - Identify and register the CYSHCN population
    - Establish with families effective means for medical home/office access
    - Provide accessible office contract for family and community agencies
    - Catalog resources to link families to appropriate educational, information and referral sources
    - Promote and "market" practice-based care coordination to families and others (e.g. brochures, posters, outreach efforts)

2. **Establish Community Connections and Improving and Sustaining Quality for CYSHCN**
    - Establish alliances with community partners
    - Facilitate practice & family linkages with agencies (e.g. family support, schools, early intervention, home care, day care
      &agencies offering respite, housing, & transportation)
    - Align transition support activities with schools & other groups

- Collaborate to improve systems of care for CYSHCN (families, payers, provides, and agencies)

3. Provide Proactive Care Planning for CYSHCN

- Help to maintain health and wellness & prevent secondary disease complications
- Maximize outcomes (e.g. alleviation of the burden of illness, effective communication across organizations, enrollment in needed services, and school attendance/success)
- Listen, counsel, educate, & foster family skill building
- Screen for unmet family needs
- Develop written care plans; implement, monitor and update regularly
- Plan for future transition needs; incorporate into plan of care
- Facilitate sub specialty referrals, communication & help family integrate recommendations of specialists
- Link family, staff to educational/financial resources

Performance Measures

An essential component of Transformation 3.0 is the development of Performance Measure Framework. A performance measure is a generally accepted, objective standard of measurement against which a grantee's level of performance can be compared; it establishes the level of performance expected. Collectively, these performance measures serve to describe specific, tangible processes and outcomes that need to be accomplished through this particular initiative. They contribute to the achievement of the overarching goals of improved health outcomes for CYSHCN. Performance measures provide a framework to guide applicants and funded grantees in their proposed projects.

SELECTION OF REQURIED PERFORMANCE MEASURES FOR MEDICAL HOME PROJECTS:

Below is a menu of possible performance measures potential grantees can utilize to measure program performance for Medical Home. Performance measures are a requirement of application submissions. Performance measures chosen should reflect the nature of the Medical Home program and activities of the project.

- The number of identified and registered CYSHCN population
- The number of Trainings on Medical Home conducted to providers and partners
- The number of Trainings on Cultural Competency/family Sensitivity
- The number of parent/caregivers that receive education on advocacy, family and patient rights and guardianship.
- The number of parent/caregiver education workshops conducted
- The educational opportunities offered to collaborative partners
- The number of providers (primary, adult or specialty) that were identified and received training
- The number of identified collaborative partners
- The number of linkages established between health care and community providers
- The number of child patients age 0-18 the receives care coordination services
- The type of care coordination services that the child needs
- The type of care coordination activity performed by office to fulfil child need

- The type of outcome prevented as a result of care coordination activity
- The amount of Time Spent on Care Coordination
- The focus of Encounter at the point of entry to care coordination services.
- The number of locally identified resources
- The patients level at the point of entry to care coordination services.
- Family Satisfaction-decrease in worry and frustration, increased sends of partnership with professionals, improved satisfaction with team communication
- Improved child/youth outcomes-Decrease in ER visits, hospitalization, and school absences
- Increase in access to needed resources, Enhanced self-management skills
- Improved System outcomes-decreased duplication, decreased fragmentation, improved communication and coordination

For agencies that provide direct clinical care to CYSHCN:
Below is a recognized tool used for more in-depth understanding of how to apply measures to established outcomes/goals and optional sources for measures. You may find more examples and measures relative to each of these on the tools and resources page.

Dimension or Domain	**Potential Measures**	**Outcomes or Goals**	**Source for measure**
Clinical	Increasing communication among partners in care by measuring : % increase in Number of care plans, % increase in number of emergency plans (action plans) % increase in number of collaborative care agreements	Reduced percentage of children seen by specialists without info from primary care provider Reduced percentage of children seen by primary care providers (PCP) without information from specialists	Shared Care plans Care team documentation i.e an activity log, or Care Coordination Measurement Tool
Identification of population of CYSCHN	Tool to identify, follow and collect outcome data on CYSHCN	CYSHCN will be identified and a data base will be established to adequately report activities affecting health outcomes	Care team documentation i.e as an activity log, or Care Coordination Measurement Tool

Costs of care	Reduced emergency department visits Increase in measures of health	Baseline of emergency or urgent care usage % decrease in usage of emergency or urgent care	Activity log, or Care Coordination Measurement Tool
Function(addressing the improved function of the CYSHCN or the family of CYSHCN)	• Ease of access to resource information Achieve self-management skills • Enhance communication among providers, family, community partners • Increase functional abilities • Support achievement of optimal developmental trajectory	Baseline Family Reports (CMHI Family Survey) % Increase in family and professional access to information about resources % Increase in documentation of care plan or medical summary use establish baseline and compare % increase in any of following: improved functional assessment, increase in and number of care plans developed and shared; improved school attendance and or school success; improved ability to perform activities of daily living.	Patient, family, PCP, and specialist report Patient, family, PCP, and specialist report Care plans Functional assessments Standardized screening Family report, plan report, school reports. Center for Medical Home Improvement survey tools (see links and resource page the AAP file has examples)

<u>Additional examples of strategies that grantees may undertake to influence change may include</u>:

- Integration of peer mentors or community health workers into health care practice teams to provide ongoing reinforcement, follow-up and systems navigation support for patients and families
- Training staff to facilitate communication among the patient, family and other (e.g., use of care plans, emergency plans, collaborative care agreements)
- Staff satisfaction, including improved communication and coordination of care, improved efficiency of care, or elevated challenge and professional role (measurement of staff satisfaction in effectively making above improvements)
- Implementation of activities related to improving systems outcomes, and service delivery outcomes for CYSHCN
- Document time spent on care coordination improving child/youth outcomes: measuring outcomes such as : Decrease in ER visits, hospitalizations, & school absences (family, plan report, school reports) increase in access to needed resources (CMHI survey tools), enhanced self-management skills (CMHI survey tools)
- Staff Development opportunities-inter/intra-agency wide

- Facilitate specific linkages between community health and human service providers to support improved cross-referrals;
- Convene community advisory groups or coalitions to facilitate the identification of families and youth with common interest and needs and strategies to address them across geographical locations community organizations and providers.
- Coordinate efforts to gain family feedback regarding their experience with health care (focus groups, surveys, and other means); participate in interventions that address family/youth articulated needs

COMPONENT B: HEALTH-CARE TRANSITION

HEALTH-CARE TRANSITION OVERVIEW

Mission: The mission of the Health Care Transition Program is to promote and improve health care transition services for Maryland youth and young adults with special health care needs (12 to 26 years old) and to improve better outcomes of health care transition among racial/ethnic and economic disparities among Maryland's youth.
Vision: The Health Care Transition Program envisions a future in which **all** Maryland youth and young adults with special health care needs in partnership with their families and providers has established health care transition plans leading to continuous health care access.

BACKGROUND INFORMATION:

Health care transition is the process of changing from a pediatric to an adult model of health care. The goal of transition is to optimize health and assist youth in reaching their full potential. There is a strong need for a seamless transfer of care and personal health information from pediatric care setting to more adult settings and for all youth to function as independently as possible in promoting their own health as adults. [14]To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care. Transition must take place in a number of different arenas. Transition planning should be a standard part of providing care for all youth and young adults, regardless of his or her specific health care needs. Successful transition involves the engagement and participation of the medical home team (physicians, nurse practitioners, physicians' assistants, nurses, and care coordinators) the family and other caregivers, and the individual youth collaborating in a positive and mutually respectful relationship. [15] Got Transition/Center for Health Care Transition Improvement, in a cooperative agreement between the Maternal and Child Health Bureau and The National Alliance to Advance Adolescent Health, provides the national standards for transition. The aim is to improve transition from pediatric to adult health care through the use of new and innovative strategies for health professionals and youth and families via the "six core elements". The Six Core Elements of Health Care Transition define the basic components of health care transition support. These components include establishing a policy, tracking progress, administering transition readiness assessments, planning for adult care, transferring, and integrating into an adult practice. [16]

SUPPORTING DATA:

On the 2009/10 NS-CSHCN, about 45.3% of families of CYSHCN reported that they had providers who have talked with them about changing needs as an adult. [17] On the 2013 Maryland Transitioning Youth Parents Survey, 32.4% of respondents with CYSHCN aged 13 years or older reported that their child's primary care doctor has talked to them about how their child's needs might change as he/she becomes an adult.[18] Maryland performs slightly worse than the nation with only 36.8% of YSHCN ages 12-17 years that successfully transition. The 2013 Maryland Transition Survey indicated that only 16.5% of respondents were involved in health care transition planning for their YSCHN. There are racial/ethnic and economic disparities noted by the presence of one or more emotional, behavioral disorder E/B/D with only 28% of these children achieving this

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[14] American academy of pediatrics, American academy of family physicians, American college of physicians, transitions clinical report authoring group: Clinical Report—Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home ; **2011; pg 183**
[15] American academy of pediatrics, American academy of family physicians, American college of physicians, transitions clinical report authoring group: Clinical Report—Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home ; **2011; pg 187**
[16] "Six Core Elements of Health Care Transition" [Retrieved] November 2015 from**: http://www.gottransition.org/resources/index.cfm**
[17] National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved [3/18/2015] from www.childhealthdata.org.
[18] Maryland 2013 Transitioning Youth Survey

outcome, compared to 42.5% of CYSHCN without. However Whites achieve this outcome at more than 1.5 times the rate of non- Hispanic Blacks.[19]

Funding Opportunity Focus Areas within Health Care Transition

In order to meet established goals, the OGPSHCN has identified specific Health Care Transition projects to support our efforts. Below are projects with targeted outcomes that are appropriate to this year's funding initiatives. Applicants may choose to apply for one or more of the projects below. Your project(s) should be aligned with and based on your agencies or jurisdiction's identified needs for gaps or challenges in service provision of CYSHCN. Proposals submitted can address one or more of the target areas. Proposals submitted should describe specifically how your agency or jurisdiction plans to utilize the OGPSHCN funding to achieve outcomes. Applicants have the flexibility to propose specific strategies that they determine will be most effective in addressing their identified needs, in the context of the strengths and capacity of their target community.

1. Health Care Transition Youth and Family Readiness

This announcement solicits applications for Youth and Family Readiness project. This projects' aim is to outreach, identify and engage local transitioning youth with special health care needs and their parent/caregiver. The project's purpose is to understand and address the youth and parents/caregivers' perspectives, challenges and needs as the youth enter adulthood and prepare youth and family for transition. Normalizing the transition process address the parent/caregivers' anxieties or questions and foster's a team approach to help facilitate the acquisition of skills and tools that the youth can use both in transition and beyond. [20]It is noted that internists find it challenging to care for a child or youth with special health care needs when the youth lacks preparation to be his or her own health advocate and the referring physician sends only minimal information about the youth and/or his or her condition.[21]Providing services that will prepare the youth and family for transition is a critical component of this project.

The target outcomes of youth and family readiness project are:

- Families and Youth are educated and informed about their role in the transition process.
- Families and Youth are educated about the transition and change in health care environment when the youth legally becomes an adult at 18
- Families and Youth are informed about the differences between pediatric and adult medicine models.
- Families and Youth are informed about the importance of Oral Health Care when Transitioning
- Youth and Families are involved in decision making process of transition.
- Youth and Families have access to locally available resources and supports necessary to make a successful transition.
- Transitioning Youth are provided patient education on self-management skills

[19] State of Maryland 2015 Comprehensive Needs assessment for Children and Youth with Special Health Care Needs. Retrieved [11/15/15] from http://phpa.dhmh.maryland.gov/genetics/Pages/Grants.aspx

[20]American academy of pediatrics, American academy of family physicians, American college of physicians, transitions clinical report authoring group: Clinical Report—Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home ; **2011; pg 187**

[21] Peter NG, Forke CM, Ginsburg KR, Schwarz DF. Transition from pediatric to adult care: internists' perspectives. *Pediatrics*. 2009; 123(2):417– 423

Additional examples of support strategies for youth and families that grantees may undertake to aid this effort may include:

- Provide information that will encourage the family to learn about any upcoming changes in health coverage
- Encourage autonomous decision-making and self-care on the part of the youth,
- Encourage families to share their questions and/or concerns with their provider as they adjust to their role shifting from primary decision-maker and caregiver to a more supportive role.
- When possible, empower youth by encouraging families to allow youth to assume increasing responsibility for his or her own health care to the fullest extent possible.
- Develop standardized letters that will notify physicians when youth are starting 9th grade prompting physicians to begin discussions and plans for HCT
- Host/offer interagency developmental team conferencing which brings together the team working with the youth (i.e parent/caregiver, school staff, healthcare staff, youth, other entities that youth may be affiliated with) as part of the transitioning planning process to exchange information and discuss and develop a plan for the transitioning youth.
- Develop a transition readiness assessment and plan of care
- Educate families on guardianship and capacity building (especially for youth with intellectual disabilities)
- Conduct surveys and focus groups to Solicit feedback from youth and parent/caregiver on their satisfaction and understanding of transition planning services.
- Provide youth engagement activities that promote empowerment.
- Ensure the education provided to youth and families are presented in a manner that is culturally and linguistically effective.
- Link families to community organizations and other services and supports that help facilitate transition into adult care and other aspects of adult life, such as work and independence.
- Provide Staff Development, inter/intra-agency training opportunities on the care of CYSHCN, Health Care Transition, and cultural sensitivity.
- Integration of parent mentors or community health workers into health care practice teams to provide ongoing reinforcement, follow-up and systems navigation support for patients and families

2. Health Care Transition Provider Education and Readiness

This announcement solicits applications for HCT provider education and readiness project. This project aim is to outreach, identify and engage primary, adult, and specialty care providers. The purpose of this project is to engage, collaborate, and provide support to health care providers that provide services to transitioning youth with special health care needs. Applicants targeting high-need populations in multiple high need areas should engage providers that provide services in each of those high need areas.

There are many barriers that are responsible for the lack of successful health care transition for youth with special health care needs. According to the American Academy of Pediatrics Clinical Report on Health Care Transition, "most pediatric practices neither initiate transition planning early in adolescence nor offer transition-support services, it is also noted that "gaps in transition support are due in part to limited staff training; lack of an identified staff person responsible for transition; financial barriers; and anxiety on the part of pediatricians, adolescents, and their parents about planning for their future health care." Other authors have cited the lack of developmentally appropriate tools for assessing child and family readiness for transition as a barrier to Transition. The result is that many pediatricians, youth, and families have found a limited availability of adult providers with whom to arrange a smooth transition of care. In addition, evidence indicates that many adult providers feel unprepared to care for young adults with complex chronic conditions"[22]

Despite barriers, there are a number of strategies and activities that exist that will support the process of successful Health Care Transition for YSHCN. This projects aim is to improve information flow and services providers using a nationally recognized model/standard such as Got Transition strategies; the six core elements and beyond.

The target outcomes of provider education and readiness project are:

- Develop relationships and increase information flow to community of health care providers so they are better prepared and more knowledgeable about Health Care Transition for YSHCN.
- Health Care Providers (Primary, Adult, and Specialty Care) are educated and informed about health care transition and providing care for the population YSHCN
- Health Care Providers are provided information about the importance of implanting an adult model of care, developmentally appropriate tools for assessing child and family readiness, developing or adopting transition tracking and monitoring system, and supporting broader transition planning such as educational attainment, career choices and independent living needs.

Additional examples of strategies to improve provider readiness that grantees may undertake include:

[22] American academy of pediatrics, American academy of family physicians, American college of physicians, transitions clinical report authoring group: Clinical Report—Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home ; **2011; pg 183**

- Assist in identifying and encouraging alternative means of engaging providers and access to care, such as teleconferencing.
- Link to educational, financial, legal, and adult/specialty providers.
- Develop and promote a standardized policy, case plan and other readiness materials that includes addressing cultural awareness related to one's local community.
- Prepare a transfer package for the adult provider
- Identify and outreach to adult providers
- Develop or adopt then promote a transition readiness assessment and plan of care
- Develop a data base to track outcome/follow-up of transition youth
- Promote and educate on best practice transition model such as Got Transition
- Train adult providers to care for transitioning youth with special health care needs
- Engage medical providers in rural communities through teleconferencing
- Facilitate future transition needs by education and outreach to the community and providers.
- Utilize surveys to develop a database of local adult and specialty providers that list specifics about the provider i.e area of expertise or specialty, the services they provide, the age of children they accept, criteria of inclusion etc.
- Partner with medical schools to create platforms and opportunities to disseminate information about HCT and youth with special health care needs.
- Collaborate with condition specific groups and organizations to increase awareness of the need for Health Care Transition services for YSHCN
- Develop events and/or trainings that offer CME's for Adult Providers.
- Integration of parent mentors or community health workers into health care practice teams to provide ongoing reinforcement, follow-up and systems navigation support for patients and families

3. Health Care Transition Community Education and Readiness

This announcement solicits applications for Community Readiness project. This project's aim is to outreach engage and establish community connections and collaborations around Health Care Transition for YSHCN. Strategies to improve child health including children with special health care needs should involve the community as a complement to any facility-based component.[23] This project focuses on helping community supports assist youth in preparing them to self-manage their health and wellness. In its landmark publication *The Future of Public Health*, the Institute of Medicine stated that the mission of public health is "creating conditions in which people can be healthy"-and highlighted the importance of partnerships between public health and numerous other community partners to accomplish this mission.[24] This requires partners to identify and address the broader "upstream" determinants of health, many of which may appear to be outside the traditional scope of public health and health care sectors[25]

Applicants are strongly encouraged to work in close collaboration with other community partners to meet established outcomes. With a focus on community supports and education, there is opportunity to identify and engage hard to reach youth, who are not typically seen. Applicants targeting high-need populations in multiple high need areas should engage partners in each of those areas,

The Target outcomes for Community Education and Readiness are:

- Increase public awareness about the seriousness of transition issues
- creating a stronger, consumer- and youth-driven interagency collaboration to address transition issues

[23] The Lancet: Community Participation: Lessons for Maternal, Newborn, and Child Health, Vol 372 issue 9642 13-19 Sept 2008 pg 962-971
[24] The Institute of Medicine, National Academy of Sciences. The future of public health. Washington D.C.:National Academies Press, 1988.
[25] Schutchfield, F.D. and Howard, A.F. Moving on Upstream: The Role of Health Departments in Addressing Sociologic Determinants of Disease. Am Journal of Prev Medicine 2011;40(1s1):S80-83.

- Increase the number of external contacts and partners that you collaborate with to address issues affecting CYSHCN and related shared goals
- Build reciprocal linkages between health care and other community providers that serve CYSHCN and their families
- Leverage existing initiatives and strategies to promote the agenda of Successful Health Care Transition for CYSHCN

Additional examples of strategies to improve community readiness that grantees may undertake include:

- Disseminate Health Care Transition information to entities such as schools, colleges, vocational programs, parent/youth groups, and parent focused groups.
- Promote Health Care Transition, resources and information through means of social media such as Facebook, Twitter, YouTube, and Pinterest
- Provide links for information and resources about CYSCH on agency website for parents, providers and community.
- Promote family support by developing a plan to educate and train school health nurses and IEP Coordinators about Health Care Transition
- Develop and create a system for sharing data and information among collaborating agencies about health care transition and measurement results from transition
- Utilize surveys to develop a database of community organizations that list specifics about the organization i.e the agencies area of focus, the services they provide, model used the age of children they accept, criteria of inclusion of services
- Establish alliances and collaboration with community partners such as;
  DHR-Foster Care Programs, Behavioral Health Programs, Maryland Managed Care Organizations, other appropriate local organizations and community groups
- Develop or expand existing community coalitions, advisory boards or other forums for convening partners representing diverse segments of the community to identify and address community issues related to CYSHCN
- Conduct community-based participatory problem-solving to engage members of the community in raising awareness of health disparities and identifying specific community health issues and solutions;
- Promote the implementation of protocols across multiple community organizations for uniform screening and cross-referral of CYSHCN to assure a “no wrong door” community-wide approach so that CSHCN can access care and services regardless of where they enter the system;
- Development of coordinated outreach, intake and referral processes across community health and social service programs, to assure cross-systems communication, collaboration and coordination
- Promote staff development, inter/intra-agency training opportunities on the care of CYSHCN, Health Care Transition, and cultural sensitivity.
- Integration of parent mentors or community health workers into health care practice teams to provide ongoing reinforcement, follow-up and systems navigation support for patients and families

Performance Measures

An essential component of Transformation 3.0 is the development of Performance Measure Framework. A performance measure is a generally accepted, objective standard of measurement against which a grantee's level of performance can be compared; it establishes the level of performance expected. Collectively, these performance measures serve to describe specific, tangible processes and outcomes that need to be accomplished through this particular initiative. They contribute to the achievement of the overarching goals of improved health outcomes for CYSHCN. Performance measures provide a framework to guide applicants and funded grantees in their proposed projects.

SELECTION OF REQUIRED PERFORMANCE MEASURES FOR HEALTH CARE TRANSITION:
Below is a menu of possible performance measures potential grantees can utilize to measure program performance for Health Care Transition. Performance measures are a requirement of application submissions. Performance measures chosen should reflect the nature of the Medical Home program and activities of the project.

1. The number of providers that received training on HCT of CYSHCN
2. The number of transition care plans initiated for transitioning youth.
3. The number of adult and specialty care providers in the community willing to see/accept CSHCN.
4. The number of transition resources available to providers and parents/families of CSHCN.
5. The number of families who are participating in transition planning for their CSHCN.
6. Increased the number of CSHCN ages 12-17 who receive preparation, planning, and coordination to achieve successful transition to adult health care.
7. The number of identified external partners utilized for collaboration
8. The number of staff development opportunities created to address agency Health Care Transition activities.
9. The number of follow-up services provided to transitioning aged youth.
10. The number of cultural sensitivity training provided to internal and external partners
11. The number of resource referrals provided to youth and families
12. The number of youth solicited for feedback on HCT process
13. The number of outreach events/activities (families/youth/community base) that your agency attended and/or hosted
14. Increase the number of educational materials developed and distributed care transition, using the six core elements
15. Percentage of (All) youth transferred into adult care, using the Six Core Element's Tool

LINKS FOR TOOLS AND RESOURCES FOR MEDICAL HOME AND HEALTH CARE TRANSITION:

- **National Center for Medical Home Implementation**
- **Coordinating Care in a Medical Home Neighborhood**
- **AAP Clinical Report Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home**
- **Commonwealth Fund**
- **Building Medical Homes: Improvement Strategies in Primary Care for Children With Special Health Care Needs**
- **National Health Care Transition: http://gottransition.org/**
- **Family Voices, Inc http://www.familyvoices.org/**
- **Family-to-Family Health Information & Education Center http://www.bridges4kids.org**
- **Kids as Self Advocates (KASA) http://www.fvkasa.org**
- **National Alliance to Advance Adolescent Health http://www.thenationalalliance.org**
- **Data Resource Center http://childhealthdata.org/browse/survey**

COMPONENT C: Family Support Services

Respite Services

Consistent with the Title V funding priorities, medical home and health care transition, the OGPSHCN is assessing its previously funded programs and activities to determine if and how to better support building the infrastructure and systems of care for children with special needs. To allow for a thorough analyses and consideration, support for camperships and respite services will be announced in January 2017.

HOW TO APPLY-APPLICATION AND SUBMISSION INFORMATION

Applicants may choose to apply for one or more of the projects listed. Your project(s) should be aligned with and based on your agencies or jurisdiction's identified needs for gaps or challenges in service provision of CYSHCN. The application submissions can address one or more of the target areas and should describe specifically how your agency or jurisdiction plans to utilize the OGPSHCN funding to achieve outcomes. Applicants have the flexibility to propose specific strategies that they determine will be most effective in addressing their identified needs, in the context of the strengths and capacity of their target community.

Note: One application submission for multiple projects, i.e 1. Medical Home project and 1. Transition Project is *allowable*

ADDRESS TO REQUEST FOR APPLICATION PACKAGE

OGPSHCN ***requires*** applicants for this funding opportunity announcement to download electronically through OGPSHCN website. Applicants must submit application according to the instructions in this funding opportunity announcement in conjunction with application format. The application contains additional general information and instructions for content, narratives, and budgets. The instructions may be obtained from the following site by:

- Downloading the application from OGPSHCN website under grants and partnership http://phpa.dhmh.maryland.gov/genetics/Pages/Grants.aspx

Each funding opportunity contains a unique set of performance measures posted with an opportunity will be recommended for that project.

Application submissions for this funding opportunity are ***required*** to submit ***electronically*** through OGPSHCN mailbox. For directions on how to apply and submit an application electronically, please use the APPLY FOR GRANTS section at website. When using OGPSHCN you will be able to download a copy of the application package, complete it off-line, and then submit the application via the dedicated mailbox dhmh.ugagenetics@maryland.gov. OGPSHCN will provide a confirmation email with date received.

Submission and Time

Application Due Date -The due date for the application under this funding opportunity announcement is ***May 13, 2016 at 5:00 P.M. ET***. Applications completed online are considered formally submitted when the application has been successfully sent by your organization's through the OGPSHCN dedicated mailbox and will be validated by notification on or before the deadline date and time.

Late Applications:
Applications which do not meet the criteria above are considered late applications and will not be considered.

Other Submission Requirements
All grantee communication should go through the DHMH mailbox at dhmh.ugagenetics@maryland.gov. for the Local Health Department. This is a central mailbox which is administered by the Grants Administrator but may also be accessed by other Office staff members. Use this mailbox for submitting application, correspondence, required reports, requests for technical assistance and other types of grantee communication. Any written communication to Office staff becomes part of the grantee file.

Frequently Asked Questions:

Q: *How do I apply?*

A: *Download electronically through the OGPSHCN website. Applicants must submit the application according to the instructions under How to apply (link)*

Q: *How to I submit my application*?

A: *Applications completed online are considered formally submitted when all documents have been successfully sent by your organization through the OGPSHCN dedicated mailbox and will be validated by notification on or before the deadline date and time.*

Q*:* *What Need Assessment data is available at this time?*

A*: A comprehensive needs assessment report is available on the OGPSHCN webpage.*
http://phpa.dhmh.maryland.gov/genetics/Pages/Grants.aspx

Q: *What is Direct Services?*

A: *Direct services**:** The salaries and fringe benefits of direct service providers, contracted services, costs for supplies and materials, equipment, and other charges for provision of direct services to CYSHCN and their families.*

Q: *What are Administrative Cost?*

A: *Administrative Costs: The salaries and fringe benefits of administrative personnel, contracted services, cost for supplies and materials, equipment, and other charges that are not for direct services.*

Q *If my agency wants to submit an application for multiple projects, is an application required for each project?*

A: *No, applicants can submit one application for multiple projects.*

Q: *What If my agency would like to submit an application for another project not listed in the announcement document?*

A:. *Further discussion of other funding opportunities needs to be discussed with the Office Director-Donna Harris*

Q: *What if I have questions about the project areas listed in the announcement?*

A: *OGPSHCH is hosting 90 minutes pre-application conference calls to assist potential applicants in preparing applications that address the requirements of this funding announcement and answer questions. Call Date of 4/15/16 for LHD and 4/18/2016 for System Grantees.*

Q: *What is grant period for the awarded grant?*

A: *The grant period for the FY 2017 grants will be July 1, 2016 to June 30, 2017. In some cases the start date of the grant period may vary, for example 1/1/2017-9/30/16. The end date of the grant period will be June 30, 2017. (No exceptions.).*

Q: *When is the Application due?*

A: *The due date for the application is due on May 13, 2016 at 5:00 P.M. ET/*

Q: *Can I can request an extension of my application submission after the due date*

A: *No, we are unable to grant extension of application submissions due to strict timelines.*

SUMMARY TIMETABLE FOR SFY 2017

March 28, 2016	Annual Grants Webinar/Meeting for Local Health Departments and System Development Grantee and/or designee(s) and fiscal staff. Meeting location: MD State Department of Health and Mental Hygiene, 201 West Preston Street, Baltimore, MD 21201
April 15, 2016	Technical Assistance (TA) call - 10:00 a.m. to 11:00 a.m.
May 13, 2016	Due date for to submit SFY 2017 proposals to the OGPSHCN
July 1, 2016	Start date for SFY 2017 grants from approvable, timely submissions.
October 31, 2016	Due date for 1St quarterly monthly invoicing (if applicable)
January 15, 2017	Due date for 2nd quarterly monthly invoicing (if applicable)
January 31, 2017	Due date for Mid-Term Progress Reporting
April 15, 2017	Due date of budget amendment for grant ending in 6/30/17
April 15 2017	Due date for 3rd Quarterly invoice (if applicable)
June 30, 2017	End date for SFY 2017 Local Health Department grant
August 31, 2017	Due date for final program report
September 30, 2017	Last day to submit the Final DHMH 440 and 440a must be submitted to the General Accounting Office for reconciliation.

CONTENT FORMAT AND REQUIREMENTS FOR SUBMISSION

This section provides instructions to applicants on how to complete their application, and identifies the specific criteria and parameters on which the application will be evaluated.

The total size of the application may not exceed the equivalent of 80 pages when printed by OGPSHCN. This 80 pages limit includes the, project format and budget narrative, attachments, and letter of commitment and support. Standard budget forms are NOT included in the page limit

All pages of the application must be numbered. All parts of the application must be submitted together, and must be submitted electronically no later than **May 13, 2016**. All application materials must be complete prior to the application deadline. Non-responsive proposals will not be considered under this funding announcement.

It is important to follow the instructions provided in this section to ensure that your application can be printed efficiently and consistently for review. Failure to follow instructions will make your applicaton non-responsive. Non- responsive will not be considered under this funding announcement. Application for funding must consist of the following documents in the following order

i. *Application Cover Page*

Prepare according to the instructions provided in the form itself. (Attachment #1).

DUNS Number-All applicant organizations (and sub recipient of OGPSHCN award funds) are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant. The DUNS number is a unique nine-character identification number provided by the commercial company, DUN and Bradstreet. There is no charge to obtain a DUNs number. Information about obtaining a DUNS number can be found at http://fedgov.dnb.com. Additionally, the applicant organization (and subreceipient) required to register annually with the Federal Government's Central Contractor Registration (CCR). CCR registration must be maintained with current, accurate information at all times during which an entity has an active award or application under consideration. To verify that your CCR registration information is active and current can be found at htt://www.ccr.gov

ii. Application Checklist

Complete the required application Checklist. Each application must contain the following information, assembled in the order indicated below. (Attached # 2)

iii. **Application Format**-All pages of the application must be numbered. All parts of the application must be submitted together, and the application must be submitted electronically no later than **May 13, 2016**.

Grant Proposal must include the following:

- Application Cover Page

- Application Checklist
- Table of Contents
- Content Format
- Project Work Plan
- Budget and Budget Justification

APPLICATION NARRATIVE: Follow the suggested outline when developing your application as this format will be used as a guide on the review process.

- ***AGENCY DESCRIPTION* (Limit 2 pages):** This section should briefly describe your agency's description, mission, experience and capacity for working with CYSHCN.
  Provide information on scope of current activities and describe how these all contribute to the ability of the organization to conduct the program requirements and meet program expectations. Describe how the unique needs of target populations of the communities served are routinely assessed and improved.
  Describe, if applicable, affiliations to academic health centers or other academic institutions and their contribution to the quality of education and training.

- ***STATEMENT OF NEED***: This section outlines the needs of your project. Demographic data should be used and cited whenever possible to support the information provided. Please discuss any relevant barriers in the service area that the project hopes to overcome. This section should help reviewers understand the community and/or organization that will be served by the proposed project, especially as it relates to improving health outcomes for the target population of children and youth with special health care needs.

- ***METHODOLOGY***: Describe methods that will be used to implement the proposed program requirements and respond to expectations in this funding opportunity announcement. As appropriate, include development of effective tools and strategies for ongoing staff training, outreach, collaborations, clear communication, and information sharing/dissemination with efforts to involve patients, families and communities of culturally, linguistically, socio-economically and geographically diverse backgrounds if applicable.

- ***PROJECT WORK PLAN***
  The work plan should include goals, objectives, performance measures and outcomes that are SMART (**s**pecific, measurable, achievable, realistic, and time measurable). Applicants who choose to submit an application for both medical home and transition projects ***are required to submit separate work plans for each componen***t (s). Include on the project work plan (s) template the anticipated total project cost of each project (s)

  The work plan shall include the following information:

  1. The **Goal** statement is measurable, realistic, long range and based on outcomes not process. The goal statement (s) includes the core elements clarifying deadlines, specific quantitative level of success, target population, baseline, and a means of measuring success.
  2. **Outcomes:** represents the desired results of overall project

3. **Performance Measures**-accepted, objective standard of measurement against which a grantee's level of performance can be compared. Performance measures are required for each objective stated in work plan and are measurable, realistic and based on outcomes not process.
4. **Objectives**: are brief, clear statements that describe the desired outcome
5. **Action Steps-Strategies/Activities** are approaches (methods, procedures and techniques) used to accomplish goal (s) and objectives. State why strategies were chosen and how they will help to achieve the specific objectives. List Timeline for activity completion.
6. **Target Audience:** List the target audience for the action step or activity *i.e. patients, families, providers, stakeholders etc.*
7. **Staff responsible for activity**-As appropriate, identify meaningful support and collaboration with key stakeholders in planning, designing and implementing all activities.
8. **Total Estimated Cost of Project**: The anticipated cost of project component.

STAFFING PLAN

Applicants must present a staffing plan and provide a justification for the plan that are included education and experience qualification and rationale for the amount of time being requested for each staff position. Position descriptions that include the roles and responsibilities and qualification of proposed project staff must be included. When applicable, biographical sketches should include training, language fluency and experience working in a culturally and linguistically diverse population that will be served by the project. Each project should have a Program Director or principal investigator who is responsible for the administration and program oversight.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

As appropriate, describe the data collection strategy to collect, analyze and track data to measure process and impact/outcomes, with different cultural groups (e.g., race, ethnicity, language) and explain how the data will be used to inform program development and service delivery. Discuss and assess the factors which will contribute to the sustainability of program efforts.

Evaluative measures must be able to assess: 1) to what extent the program objectives have been met, and 2) to what extent these can be attributed to the project. Evaluative measures may be expressed in quantitative as well as qualitative terms.

1. Results of all performance measures[26]related to the program's specific activities, and
2. For all services provided, provide a summary report of the following
   a) unduplicated number of children served,
   b) age of children served,
   c) gender of children served, and
   d) race and ethnicity of children, according to DHMH guidelines:
      I. Ethnicity: Is the child Hispanic or Latino-yes or no
      II. Child's race (if multiracial, check all that apply)
         - ☐ American Indian or Alaska Native
         - ☐ Asian
         - ☐ Black or African American
         - ☐ Native Hawaiian or Pacific Islander
         - ☐ White

[26] "Performance Measures" should be reflected in the proposal narrative, as well as the corresponding Performance Measure tab in the DHMH 4542 Budget Package.

e) diagnoses of children (continue to use your program categorization approach; OGPSHCN diagnosis categories to be release in future fiscal year),
f) insurance status, according to following categories:

- ☐ Private
- ☐ Medical Assistance/Medicaid
- ☐ Maryland Children Health Insurance Program (MCHP)
- ☐ Medicare
- ☐ Military
- ☐ No insurance
- ☐ Other

g) type of service (training event, enabling service, care coordination, information sharing, specialty clinic, respite, etc.),
h) number of request for service; any waiting list and length that exists for the service,
i) primary language spoken at home,
j) number of instances where interpretive services were used for service provision.

3. For specialty clinics, include:

a) number of clinics,
b) type of clinics
c) show rate
d) located of clinic-tertiary center, community site/local hospital, or local health department

4. For case management/care coordination/service coordination include level of service provided i.e., information only, enabling services or total management, e.g. finding resources, scheduling appointments, providing enabling services and following up.

5. Partnerships/collaboration: As applicable to your program. Provide the following information:

a) List any new partnership with provider, agencies, organization, and any other stakeholders groups.
b) Describe efforts to strengthen existing partnership.
c) Describe how these partnerships contribute to the CYSHCN Systems Outcomes.

Attachments

Please provide the following items to complete the content of the application. Unless otherwise noted, attachments count toward the application page limit. **Each attachment must be clearly labeled**.

Attachment 1: Application Cover Page
Attachment2: Application Checklist
Attachment 3: Project Work Plan (for each component)
Attachments 4: Other Documents Relevant to the Proposed Project
Provide any documents (i.e. brochures, pamphlets that describe working relationships between the applicant organization and other agencies and programs cited in the application. Letters of agreement must be dated.

Funding Restrictions

Allocations- This award is subject to the requirements and conditions set forth in this application. The Department of Health and Mental Hygiene's federal grants have a finite availability period which must be adhered to by the applicants; therefore, expenditures cannot exceed the availability period.

25% of the grant award will be funded with the prior year federal funds for the time period of 7/1/16-9/30/16. The availability period for expenditures cannot exceed the amount awarded and must be expended with that time period.

75% of the grant award will be funded with the current year federal funds for the time period of 10/1/16-6/30/17. The availability period for expenditures cannot exceed the amount awarded and must be expended within that time period.

Form 4542M-Grant Status Sheet in the 4542 budget package is completed by the funding agency and identifies the fund year that the allocation is base on. The completed grant status form returned to the applicant upon approval of the budget.

Note: First In-First Out (FIFO) when preparing your budget for SFY 2017 be aware that 25% of your award with be funded with prior year federal funds FY 2016 for the time period of 7/1/16-9/30/16 and must be liquidated October 15, 2016. 75% of the grant award will be funded with the current year federal funds for the time period of 10/1/16-6/30/17.

Budget and Budget Justification

To complete the DHMH 4542Budget package for the project period. Click on the link http://dhmh.maryland.gov/Pages/sf_gacct.aspx to find the budget forms and the following the instructions

The local health department budget package is an EXCEL-based spreadsheet that includes links to subsidiary schedules. Some of the schedules include cells that are shaded to identify how or by whom that particular field is filled. A four color code scheme is used in the budget package.

- Yellow shaded cells-To be completed by the LHD Staff
- Blue shaded cells are formulated and links to another sheet within the budget package. (Do not enter data).
- Tan shaded cells-To be completed by the DHMH funding administration staff
- Mint green cells-To be completed by the Division of General Accounting/Grant Section

When submitting the initial budget, submit the 4542 forms to the dedicated mail box: dhmh.ugagenetics@maryland.gov. If the 4542 form does not contain enough information to justify the calculations for any line item, attach a written budget justification. For example training cost breakdown, educating materials and speaker honoraria, etc. A separate sub-vendor budget, submitted on sub-vendor letterhead, is required for the following budget line items:

- Consultants (tab f)
- human service contracts (tab I)
-

Note: For all budget forms, columns and rows must calculate correctly.

Budget Forms Checklist

The current DHMH Budget forms/Instructions can be found on the Fiscal Services Administration's website at: http://dhmh.maryland.gov/Pages/sf_gacct.aspx

Schedule Form 4542 A-Program Budget Page (Do not insert or delete rows from this budget pages)

Form 4542 B-Budget Modification, Supplement or Reduction (Line Item Changes/Justification

Form 4542 C –Estimated Performance Measures (Detail estimated performance measures for the fiscal year

Form 4542 D-Schedule of Salary Cost (All fields should be complete on the form)

Form 4542 E- Schedule Special Payment Payroll Costs (All fields should be complete on this page. List the individual' or business name. The total cost must equal to hourly rate times the total number of hours

Form 4542 F-Schedule of Consultant Costs (All fields should be complete on this page. List the individual' or business name. List consultant's professional area; the hourly rate and the budgeted total annual hours. The total is calculated by multiplying the "Hourly Rate times the Total Hours"

Form 4542 G-Schedule of Equipment Costs (Detail all equipment $500 or move per item to be purchased)

Form 4542 H-Purchase or Care Service (form and line item 0881 should only be used for health related unit price contracts and fixed price contracts with organizations)

Form 4542 I-Human Service Contract (form and line item 0896 is to be used only for health related cost reimbursement contracts with organizations

Form 4542 J-Special Projects (form and line item 0899 is to be used only for Non-health related cost reimbursement contracts with individual or organizations

Form 4542 K-Indirect Cost Calculation Form (For LHD indirect cost rate is limited to 7% of departmental award, defined as DHMH funds and collections. Regardless of methodology, the indirect cost calculation must be shown on this form.

Form 4542 L-Budget Upload Sheet (DGLHA Use Only, Do not enter data or modify this sheet)

Form 4542 M-Grant Status Sheet (Completed by Funding Administration Only) Form 4542M-Grant Status Sheet in the 4542 budget package is completed by the funding agency and identifies the fund year that the allocation is base on. The completed grant status form returned to the applicant upon approval of the budget.

DHMH 440-Annual Report-Year End Reconciliation (Must be submitted 60 days after the close of the grant. LHD my used FMIS in lieu of the DHMH440) OGPSHGN recommends that you complete the DHMH form 440.

Budget Justification-

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget justification MUST be concise. Do NOT use the justification to expand the project narrative.

Personnel Costs: Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percentage of full-time equivalency, and annual salary.

Fringe Benefits: List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plans, and tuition reimbursement. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project.

Travel: List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member completing the travel should be outlined. The

budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops.

Equipment: List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of $5,000 or more and a useful life of one or more years).

Supplies: List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, and the like; medical supplies are syringes, blood tubes, plastic gloves, etc., and educational supplies may be educational materials. Remember, they must be listed separately.

Contractual: Applicants are responsible for ensuring that their organization or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Reminder: recipients must notify potential sub recipients that entities receiving sub awards must be registered in the Central Contractor Registration (CCR) and provide the recipient with their DUNS number.

Other: Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. In some cases, rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate.

Applicants may include the cost of access accommodations as part of their project's budget, including sign interpreters, plain language and health literate print materials in alternate formats (including Braille, large print, etc.); and cultural/linguistic competence modifications such as use of cultural brokers, translation or interpretation services at meetings, clinical encounters, and conferences, etc.

Process for Requesting a Budget Modification, Supplement or Reduction

When a grantee realizes that it will be unable to expend its awarded funds, contact with your assigned grant monitor should occur immediately.

1. **Submit your modification request in writing to your grant monitor**. **Please include the following information**:

- the nature of the modification request (e.g., request to move money from one line item to another)
- justification for the modification request
- project impact to CYSHCN program and/or CYSHCN and families (e.g., more families will receive respite funding; fewer families will receive case management services, no impact, etc.)

2. Following receipt of your email, your preliminary request for a modification[27], supplement or reduction will be reviewed.[28] Following review of your request for budget modification, supplement or reduction, further information may be requested or you may be requested to put in a formal budget change request by resubmitting the 4542 form, indicating a budget modification.

3. If you are asked to put in a formal budget change request by resubmitting the 4542 form, please submit it to dhmh.ugagenetics@maryland.gov.When completing a 4542 form budget request for modification, supplement or reduction; please ensure that you use the version with the DHMH approvals.

- An approved budget will contain electronic signatures within the following signature blocks on the first tab:
  - DHMH Program Approval (indicated by orange shading); and
  - DGLHA Approval (indicated by green shading).
- Please be sure to indicate all tabs relevant to the budget modification, including tab b, the justification page. On the justification tab, please indicate:
  - the amount of funding change,
  - the type of funding (DHMH), and
  - Justification for change for each line item requested to change. If the 4542 form does not contain enough information to justify the calculations for any line item, please attach a

[27] Generally, requests for modification are for moving funding between line items, while still maintaining the same amount of funding.

[28] In general, requests for budget supplements will not be approved unless a health department is advised of the availability of supplemental funding and is requested by the Office to submit a supplement request.

budget justification. For example, if you request funding for training, please provide a breakdown of the training costs, such as cost of educational materials, speaker honoraria, etc.

- A separate sub-vendor budget, submitted on sub-vendor letterhead, is required for the following line items:
  - consultants (tab f)
  - human service contracts (tab)

Unbudgeted Expenditures and Over Expenditures

Certain line items in the budget are considered controlled line items. That is expenditures for these line items may not exceed the budget by more than a specified amount. The tolerances for the controlled line items are as follows:

Line Items	Tolerances
Total salaries, consultants, special payment and fringe costs	4% for LHD 3% for other vendors
Purchase or Services	Greater of 3% or $2,000 for vendors other than LHD
Equipment	$1,000 (purchase must be detailed on a supplementary schedule listing item and cost
Renovation/Remodeling	10% (expenditures over $5,000 or greater must be pre-approved
Third Party Income (including fee collections)	5%

Expenditure, which exceed these tolerances, or unbudgeted expenditures in any line item, which have not been previously approved by the program administration, is subject to non-recognition. **The vendor for recognition by attaching letter or justification to the DHMH 440 which states the nature of, or rationale for, the over expenditures and unbudgeted expenditures.** The director of the program administration may disapprove any unauthorized expenditure. Please note, a shortfall in third party income requires a brief written explanation.

PROGRAM REVISION REQUEST

There are three types of program revision requests:

(1) Changes to Grantee Information
(2) Notification of Staff Vacancy/New Hire
(3) Changes to the Scope of the Program (from the Approved Proposal)

Changes to Grantee Information

If the grantee has a change of address, email, or phone/fax number change, the Office must be notified in writing within 10 days of the change on grantee letterhead. If the grantee is issued a new federal ID number they should notify the Office immediately. Please submit the ID change notification on your organization's letterhead complete with the address and list the old and new federal id number that is being used. See Appendix for template letter.

Notification of Staff Vacancy/New Hire

When/if a staff member that is funded by the grant leaves the project, the grantee must notify the Office of the vacancy as well as when a new hire for the position is made by email, so that the person is added to the Office contact listing.

Changes to the Scope of the Program

Changes to the approved program (e.g. target group, services, objectives, performance measures, etc.) must be submitted to the Office for approval before they are made. An approval to change the scope of the program is effective as of the date

of the approval letter or e-mail. Strong justification for the modification must be made for the Scope of the Program changes. For example, if a public event associated with goals and objectives was postponed until the following year, then the associated goals and objectives would be removed from the scope of work.

Application Review Information

1. **Review Criteria**

Grants are awarded following a proposal and the evaluation process. Please verify that that all required proposal components are completed before submission. Only grant proposal containing the entire application components listed in this document and submitted by **May 13, 2016 at 5:00 pm** deadline will be reviewed, no exceptions. As grants proposals are awarded on a competitive basis, OGPSHCN has a standard procedure for evaluating proposal using the review criteria, described below:

There are six review criteria, with corresponding scoring points. The following categories and questions will help guide the development of your proposal:

Criterion 1-**Need (20 points)**

- To what extent does the proposed project describe an existing need(s) among the CYSHCN population in Maryland and associated contributing factors to the need?
- Is the need described using both quantitative and qualitative measures?
- To what extent do the proposed project activities avoid duplicating existing resources, services, or materials?
- Do the proposal address disparities, includes geography, SES, race/ethnicity, primary

Criterion 2- **Response-(20 points)**

- To what extent does the proposed project address the described need(s) and at least one area from each of the three components from the "System of Care Shared Goals"?
- Does the applicant explicitly state which area(s) of the three components the project addresses and describe how the project will foster attainment of the Shared Goals?
- Are the proposed goals and objectives clearly identified:
- To what extent do the project activities related to the proposed objectives?
- To What extent does the proposal identify anticipated barriers? Are the proposed resolutions to challenges practical?
- Is the proposed budget appropriate and reasonable for the proposed and anticipated results?

Criterion 3-**Evualuative Measures-(20 points)**

- To what extent is the method proposed to monitor and evaluate the project results for effectiveness?
- The effectiveness of the method proposed to monitor and evaluate the project results (evaluative measures may be expressed in quantitative as well as qualitative terms.)

Criterion 4-**Impact- (20 points)**

- Is the proposed project cost effective? (i.e., the project number of children and families served as compared to the funding requested)?
- To what extent does the proposal address the proposed project sustainability and describe other source of funding to support the project activities.
- To what extent do the project activities create and/or strengthen existing linkages and partnerships with other organizations and/or components of the system of services for CHYSHCN and their families in Maryland?

Criterion 5-**Resources/Capabilities-(10 points**)

- To what extent are the project personnel qualified by training and/or experience to implement and carry out the projects?
- What are the capabilities of the applicant organization, quality, availability of facilities and personnel to fulfill the needs and requirements of the proposed project? (If you plan to partner with another institution, include letter of support in your application is strongly encouraged). For applicants who have previously or are currently receiving OGPSHCN funding, past performance will be also considered. proposed projects

Criterion 6- **Organizational capacity for collaboration (10 points)**

- The extent to which the organization demonstrates strong collaboration, including subcontracts, with other partner agencies/organizations that provide health, educational and supportive services for CYSHCN.

Note: Applicants should pay strict attention to addressing all these criteria, as they are the basis upon which the reviewers will evaluate their application.

PURPOSE OF PROGRAMMATIC REPORTING REQUIREMENTS

Notice: The templates for program reporting are still in development and will be distributed at a later date.

Complete the Mid-term and Final Programmatic reporting template located in the OGPSHCN budgeting Forms and Reporting Workbook.

Mid-term Performance Report- serves as a measure of progress achieved on a project and help to identify programmatic and administrative problems that may need to be resolved.

Final Performance Report- becomes a permanent record of project accomplishments. This report provides qualitative and quantitative data information that the OGPSHCN staff uses to measure and evaluate the significance impact of system development.

Mid-Year Performance Report	**Due January 31, 2017**
Final Program Narrative Report	**Due August 31, 2017**

At the discretion of the Office, quarterly reports from a grantee may be requested. Grantees requiring quarterly reports will receive written notice regarding the new reporting schedule. For extenuating circumstances, a grantee may request in writing an extension to submit a report(s) late.

The **mid-year and final programmatic reports** will be reviewed by your assigned Grant Monitor report accomplishment and barriers of the stated goals and projected expenditures of your proposal. Grant Monitors will provide feedback, comments and recommendation upon completion of the review. Non-compliance of programmatic reporting and/or invoicing may result in the withholding of grant funds. For extenuating circumstances, a grantee may request in writing an extension to submit a report(s) late. See Appendix for template letter.

Award Administration/Other Information

Award Notices-Each approved applicant will receive written notification of approval from the OGPSHCN. The approved budget will be forward to you by the General Accounting Office. You may be begin to obligated their funds on July 1, 2016 and liquidate on June 30, 2017.

The Conditions of Award for programmatic and budgetary expectations for the categorical grant are outlined below.

- You will be required to submit mid-year and annual reports.
- The mid-year report is due on or before **January 31, 2017** and the end of year report is due on or before **August 31, 2017**.
- Reports should also provide data on the performance and evaluative measures listed in the grant proposal.
- Reports should include a narrative update on progress in meeting the project goals/objectives and address barriers, when appropriate.
- Grantees must agree to make staff available for meetings and training opportunities, as appropriate or on request from the Office for Genetics and People with Special Health Care Needs.
- Local health department CYSHCN are required to attend an annual meeting of local health departments in the region (either central/capitol, southern, western, or eastern shore regions).
- This program is supported by MCH Title V funds. Grants are awarded based on the availability of Title V funds. Awards may be adjusted based on the availability of funds.
- All recipients of federal grant funds must use the funds as indicated by the grant agreement and must ensure that funds are expended in the time frame specified by the grant award.
- Local Health Department's Annual Report of Expenses, Receipts and Performance Measures (DHMH 440) for the budget period must be submitted to the DPCA by **August 31** for the immediately preceding fiscal year or by sixty **(60)** days after close of funding period, unless the LHD elects to use FMIS.

PERIOD OF AVAILABILITY OF GRANT FUNDS

- ***Obligation:*** An obligation occurs when funds are encumbered, such as in a valid purchase order or requisition to cover the cost of purchasing an authorized item on or after the begin date and up to the last day of the grant period in the award. Any funds not properly obligated by the recipient within the grant award period will lapse and revert to the awarding agency. The obligation deadline is the last day of the grant award period unless otherwise stipulated. (**Example:** If the award period is **July 1, 2016 to June 30, 2017** the obligation deadline is **(June 30).** You may begin to obligate these funds on **July 1, 2016.**

- All recipients of federal grant funds must use the funds as indicated by the grant agreement and must ensure that funds are expended in the time frame specified by the document. Federal regulations prohibit the use of funds from grants outside its specified time period, unless authorized by the award agency.
- ***Liquidation:*** Funds which have been properly obligated by the end of the award period will have sixty (**60** days in which to be liquidated (expended). Any funds not liquidated at the end of the sixty (**60)** day period will lapse and revert to the awarding agency, unless a grant adjustment notice extending the grant period has been approved. (**Example:** If the award period is **July 1, 2016 to June 30, 2017**, the expenditure deadline is **June 30**). This period is the time frame in which all grant expenditures must occur. Those expenditures that occur outside this time frame will usually be disallowed and could result in an audit finding for your agency.

- Grantees have a sixty **(60)-**day liquidation period. It is during this period that final payments for all purchases must occur by **August 31, 2017**.

- System Development Grants Annual Report of Expenses, Receipts and Performance Measures (DHMH 440, 440A) for the budget period must be submitted to the office on or before or by sixty (**60)** days after close of the grant period.

- ***State Fiscal Year Close-out- Form 440/440A must be submitted on or before 8/31/17. Expenditures according to the approve budget line-item, approved budget, variance and summary of receipts for 7/1/2016-6/30/2017.***

- Non submission of this report within the specified time may result in funds being withheld until the reports are filed and reconciliation is complete.

More information about grant management can be found online at www.whitehouse.gov/omb/grants_circulars

CFR§200.430 NEW TIME AND EFFORT REPORTING REQUIREMENTS UNDER OMB UNIFORM GUIDANCE

"Charges to Federal awards for salaries and wages must ….. Be supported by a system of internal control which provides reasonable assurance that the charges are accurate not budgeted, allowable, and properly allocated"

Where is this requirement established?

Time and effort reporting requirements are part of the allowable costs as defined by the U.S. Office of Management and Budgets (OMB). OMB circulars are applied to all federal grants, contracts and cooperative agreements.

OMB Circular A-87 provides detailed rules on the use of federal funds. The circular is entitled "Cost Principles for State, Local, and Indian Tribal Governments. One of the selected items of allowable costs is salaries and fringe benefits. In general, salaries and wages of employees who work on federally funded programs may be paid with federal funds as long as they are working on the grant's objectives and appropriate "time and effort" records are maintained.

Each entity also needs to consider internal controls over the existence of employees and the reasonableness of compensation. For employees whose salary is paid by federal awards, it is considered reasonable if it is consistent with compensation for similar work in other areas of the entity.

Many organizations previously had, and continue to have, strong systems of internal control surrounding the time end effort reporting that met the requirements of the previous OMB circulars. Those systems may continue to be appropriate to meet the new requirements. In other words, don't fix what's not broken! However, if you've had previous internal control weaknesses in this area, or if your current process is unnecessarily complex or inefficient, now is a good time to take a fresh look at these requirements.

All employees charged to federal grants must maintain time and effort reporting. Any employee funded with federal grants must document the time they spend working on the grant's objectives to demonstrate that the amount budgeted and claimed is accurate.

What is required?

The Uniform Guidance requires that time distribution records must be maintained for all employees whose salary is paid in whole or in part with federal funds or is used to meet a match or cost-share requirement for a grant. Payroll allocations among grant awards cannot be based on budgeted distributions alone. Rather, allocations of salaries and wages among grant programs need to be supported by actual hours worked. If budgeted numbers are used to allocate salaries and wages among grant programs, the entity's system of internal controls should include an after-the-fact review of the grant programs. If actual time worked differs from the budgeted allocations, adjustments should be made such that the final amount charged to each grant is accurate, allowable, and appropriately allocated.

The primary focus of the revised time and effort requirements is that strong internal controls must exist for the reporting of salaries and wages to ensure that the payroll charged to various grants match were actual time is spent. While the previous standards were more prescriptive in the documentation requirements (for example, the use of semi-annual certifications for those employees working full-time in a program or personnel activity reports for those employees working under multiple grants), the new standards provide more flexibility in the process, with the focus being on controls to ensure that time is charged to grants appropriately.

Another requirement of the Uniform Guidance as it relates to time and effort reporting is that all time worked for the organization should be included in order to calculate what portion relates to federal awards. Nonexempt employees must prepare records indicating the total number of hours worked each day.

There are two types of required time and effort records: general semi-annual certifications and detailed monthly reports. The type of record that must be kept is based on the job responsibilities of the individual charged to the grant. The job responsibilities are referred to as either a "single cost objective" or "multiple cost objectives."

The difference between single and multiple cost objectives is determined by how an employee *works*, not how the employee is funded.

S*ingle Cost Objective – Semi-Annual Certification*

An individual who has a "single cost objective" has a position that is dedicated to a singular purpose. For instance, a nurse is considered to have a single cost objective because the nurse works only with special needs population. An individual who has a single cost objective would complete semi-annual certifications. A semi-annual certification is a sign-off twice a year (usually every six months) by the employee or a supervisor with first-hand knowledge of the employee's work.

Multiple Cost Objective – Personnel Activity Reports (PARS)

An individual who serves different student populations needs to complete monthly Personnel Activity Reports, often referred to as "PARs."

PARs need to be completed at least monthly, after the work has been completed. The PAR must reflect the individual's total work time and identify the portion of time spent on the federal project. The PAR must be signed by the employee.

The PAR must be supported with documentation of actual effort, not estimates. Supporting documentation could be a work calendar, work product, time log, or class schedule. The employee who signs off on the PAR must have supporting documentation for the time reported. Relying on time estimates identified in the grant budget rather than actual time recorded through a work calendar or class schedule will result in an audit or monitoring finding of unallowable costs.

Time and effort records are housed by the grantee and not submitted to the awarding agency. Time and effort records become subject to review during audits, monitoring or other situations that require the grantee to provide evidence that time funded by the federal grant was spent working towards the grant's objectives.

GRANTEE PUBLICATIONS, WEBSITES AND OTHER RESOURCES

Please add the name "DHMH, PHPA, Office for Genetics & People with Special Health Care Needs" and indicate support in any brochures, publications, webinars, presentations, etc. *For example, "this brochure/publication/webinar/DVD was produced with partial funding support from Maryland's Title V CYSHCN Program, the Office for Genetics & People with Special Health Care Needs." Also, provide a copy of any of these products that result from a program funded by the Office so that it can be included in the grantee file.*

CFR§200.448 INTELLECTUAL PROPERTY

(a) *Patent costs.* (1) The following costs related to securing patents and copyrights are allowable:

(i) Costs of preparing disclosures, reports, and other documents required by the Federal award, and of searching the art to the extent necessary to make such disclosures;

(ii) Costs of preparing documents and any other patent costs in connection with the filing and prosecution of a United States patent application where title or royalty-free license is required by the Federal Government to be conveyed to the Federal Government; and

(iii) General counseling services relating to patent and copyright matters, such as advice on patent and copyright laws, regulations, clauses, and employee intellectual property agreements (See also §200.459 Professional service costs).

(2) The following costs related to securing patents and copyrights are unallowable:

(i) Costs of preparing disclosures, reports, and other documents, and of searching the art to make disclosures not required by the Federal award;

(ii) Costs in connection with filing and prosecuting any foreign patent application, or any United States patent application, where the Federal award does not require conveying title or a royalty-free license to the Federal Government.

(b) *Royalties and other costs for use of patents and copyrights.* (1) Royalties on a patent or copyright or amortization of the cost of acquiring by purchase a copyright, patent, or rights thereto, necessary for the proper performance of the Federal award are allowable unless:

(i) The Federal Government already has a license or the right to free use of the patent or copyright.

(ii) The patent or copyright has been adjudicated to be invalid, or has been administratively determined to be invalid.

(iii) The patent or copyright is considered to be unenforceable.

(iv) The patent or copyright is expired.

(2) Special care should be exercised in determining reasonableness where the royalties may have been arrived at as a result of less-than-arm's-length bargaining, such as:

(i) Royalties paid to persons, including corporations, affiliated with the non-Federal entity.

(ii) Royalties paid to unaffiliated parties, including corporations, under an agreement entered into in contemplation that a Federal award would be made.

(iii) Royalties paid under an agreement entered into after a Federal award is made to a non-Federal entity.

(3) In any case involving a patent or copyright formerly owned by the non-Federal entity, the amount of royalty allowed must not exceed the cost which would have been allowed had the non-Federal entity retained title thereto.

[78 FR 78608, Dec. 26, 2013, as amended at 79 FR 75886, Dec. 19, 2014]

Pre –Application Conference Call

OGPSHCH is hosting a 90 minutes pre-application conference call on **April 15, 2016** at **10am** to assist potential applicants in preparing applications that address the requirements of this funding Announcement. Participation in a pre-application conference call is optional. Conference call-in number and access code will be forwarded at a later date.

Tips for Writing a Strong Application

A concise resource offering tips for writing proposals for grants and cooperative agreements can be accessed online at: Write a Strong Application

Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting:

Keisha Peterson-Program Chief, Systems Change; Medical Home Program
200 West Preston Street
Baltimore, MD
410-767-6801

Florence C. Harvey-Grants Administrator
200 West Preston Street
Baltimore, MD 21201
410-767-6749
florence.harvey@maryland.gov

Additional information related to the overall program issues and/or technical assistance for Health-Care Transition regarding this funding announcement may be obtained by contacting:

Mary Price-Health Care Transition Coordinator
200 West Preston Street
Baltimore, MD 21201
410-767-5581

Additional information related to the overall program issues and/or technical assistance for Medical Homes regarding this funding announcement may be obtained by contacting:

Vacant, Medical Homes Coordinator, Office of Genetics and People with Special Health Care Needs
200 West Preston Street
Baltimore, MD 21201
410-767-5298

Attachments

Attachment 1: Application Cover Page

SFY 2017-LOCAL HEALTH DEPARTMENTS

APPLICATION Cover Sheet

Local Health Department: _____

DUNS #: _____

Federal Tax ID#: _____

Title of Grant /Project Priority Addressed: _____

Grant Amount Requested: _____

Project Director/Principal Investigator _____

Telephone: _____ FAX Number: _____

E-mail: _____

Mailing Address: _____

_____

Grants Office Contact, Name & Title: _____

E-mail address: _____ Telephone: _____

Mailing Address: _____

_____

Finance or Business Office Contact, Name & Title: _____

E-mail address: _____ Phone number: _____

Mailing Address:_____

Attachment 2: Application Checklist

DEPARMENT OF HEALTH AND MENTAL HYGIENE

PREVENTION AND HEALTH PROMOTION ADMISTRATION

OFFICE FOR GENETICS AND PEOPLE WITH SPECIAL HEALTH CARE NEEDS

SFY 2017 LOCAL HEALTH DEPARTMNET

APPICATION Checklist

(To be completed and included with the APPLICATION)

Each APPICATION must contain the following information, assembled in the order indicated below.

_____ Application Cover Sheet*

_____ Application Checklist*

_____ Project Work Plan*

_____ Application Narrative

- _____ Extent of Need
- _____ Goals, Objectives and Milestones
- _____ Strategies, Activities, Roles, and Resources
- _____ Staffing Plan
- _____ Evaluation and Dissemination
- _____ Budget and Budget Detail**

*Use the appropriate forms included in Attachments

**Complete the 4542 Budget forms available on the DHMH website http://dhmh.maryland.gov/Pages/sf_gacct.aspx
.

Attachment 3: - Work Plan Template **Total Project Funding _____**

Component:_____

GOAL 1:				
PERFORMANCE MEASURE:				
OUTCOMES:				
Objectives	***Strategy/Activities***	***# and Target Audience***	***Responsible Staff***	***Timeline***
Staff and personnel of medical facilities with Local Health Departments, Pediatric to provide transition outreach and training	Training will be provided by consultants and parents with children with special needs. Develop a toolkit for parents	*10 Parents and Health Department Staff*	*Consultants*	Begin scheduling training in June 30, 2016

Attachment: 4: Other Documents Relevant to the Proposed Project

Provide any documents (i.e. brochures, pamphlets that describe working relationships between the applicant organization and other agencies and programs cited in the proposal. Letters of agreement must be dated.