

*Shauna A.S. Chabot*, MBA, CFRE

[saschabot@verizon.net](mailto:saschabot@verizon.net)

443-370-8899

Letter of Recommendation for Tarra Nystrom

To Whom It May Concern:

It is a genuine pleasure to recommend Tarra Nystrom, who served as a contracted grant writer for Hospice of the Chesapeake for approximately four and a half years. During that time, Tarra consistently exceeded expectations and played a pivotal role in strengthening

From her first year with us, Tarra made a measurable and lasting impact. She more than tripled the number of submitted grant applications, significantly increasing both the volume and quality of our proposals. Through her expertise and persistence, the organization's grants program raised more than \$1.2 million during her tenure — a remarkable achievement, particularly given that grantor budgets remained largely unchanged during those years. Tarra's success was rooted in her ability to identify well-aligned funding opportunities, craft compelling and competitive proposals, and cultivate strong, trusted relationships with funders.

Tarra approaches her work with impressive discipline and strategic insight. She systematically developed, implemented, and evaluated comprehensive grant funding strategies to maximize secured dollars throughout each fiscal year. Her skillful writing and attention to detail elevated our proposals and narratives, strengthening the organization's reputation with both corporate and foundation funders.

Beyond her core grant writing responsibilities, Tarra was invaluable in assisting me, as Chief Advancement Officer, with complex projects such as applications for State bond funding and tax credit programs. She took on these additional responsibilities with enthusiasm and professionalism, demonstrating a clear commitment to the success of the organization as a whole.

Her collaborative nature and reliability made her a pleasure to work with. Tarra partnered effectively with internal teams to ensure accuracy, alignment, and timeliness in every submission, and she maintained strong working relationships with grantors and external partners, earning their respect and trust. She is also known for her "whatever it takes to get

it done” attitude — willingly putting in the extra time, including evenings, weekends, and holidays, to meet deadlines and ensure excellence.

Tarra also remains committed to her own professional growth, participating regularly in professional development activities to stay informed of trends and best practices. In addition, she provided valuable data, trends, and insights that supported not only the advancement and philanthropy teams but also other departments across the organization.

In every respect, Tarra proved to be a highly skilled, dependable, and mission-driven professional. She would be an exceptional asset to any organization seeking a results-oriented grant writer and strategic thought partner.

I recommend her without reservation.

Sincerely,

A handwritten signature in black ink, appearing to read "S. Chabot". The signature is stylized with overlapping loops and a long horizontal stroke extending to the right.

*Shauna A.S. Chabot, MBA, CFRE*  
*Chief Advancement Officer (retired)*  
Hospice of the Chesapeake Foundation

# Tarra Nystrom, MBA, CBA

## Narrative samples for fundraising and grant applications:

### Veterans experiencing homeless

Every year, between seven and 10 veterans in [xxxxxxx area] experience homelessness. Seven to 10. That number may sound small in a world overwhelmed with statistics, but in our community, it represents real people. It represents men and women who once stood in uniform and answered when their country called. They trained, deployed, and sacrificed time with their families. Some now carry visible scars; others carry the kind you can't see. And yet when the uniform comes off, stability is not guaranteed. In a region as proud and closely knit as ours, even one veteran without a home should stop us in our tracks. Seven to ten stories interrupted. Seven to ten individuals navigating cold nights and uncertain mornings along their quiet way of housing insecurity after a lifetime of service.

Homelessness here doesn't always look like a tent on the sidewalk. Sometimes it's a couch for surfing. Sometimes it's a car in a parking lot. And sometimes it's choosing between rent and medication. It is instability hiding in plain sight. These veterans are not statistics to manage - they are our neighbors to support. Their service was a promise to protect us, and addressing housing insecurity is our promise to protect them. Seven to ten veterans per year is not just a number; it is a call to act.

### Community health resource collaborative:

V. 1

Community partner efforts of money, goods, or services through ABC Collaborative have translated into more than 354,200 individuals served. That's one of your neighbors on social security who received a box of fresh fruits and vegetables. That's your friend's daughter who has access to long-acting reversible contraception, allowing her to delay her family until she has met her educational goals. That's a minority student paired with a literacy tutor to help him achieve on-track goals for third-grade reading, which is a marker for everything from high school graduation to whether he'll develop diabetes later in life. That's a new mother who received in-home support for breast feeding. That's a ride someone received to a cancer treatment facility. Times 354,200. With that said, **YOU** play a critical role in shaping better community health outcomes.

V. 2 (for a grant application)

Valuable CareSource Foundation funding will help ABC Collaborative reach at least 400 more community members. That's one of our neighbors on social security who receives a box of fresh fruits and vegetables. That's a friend's daughter who has access to long-acting reversible contraception, allowing her to delay her family until she has met her educational goals. That's a minority student being paired with a literacy tutor to help him achieve on-track goals for third-grade reading, which is a marker for everything from high school graduation to whether he'll develop diabetes later in life. That's a new mother who will have in-home support for breastfeeding. That's a ride someone can take to a cancer treatment facility. Times 400. The resources made possible by this grant will play a critical role in shaping better community health outcomes.

Maryland Community Health Resource Commission  
FY2025 Grant Application

**Tarra Nystrom**

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**From:** Smartsheet Forms <forms@app.smartsheet.com>  
**Sent:** Monday, January 13, 2025 9:28 AM  
**To:** Tarra Nystrom  
**Subject:** Confirmation - Maryland Community Health Resources Commission - FY 2025 Application Cover Sheet

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STATE OF MARYLAND

# Community Health Resource

45 Calvert Street, Room 336, Annapolis, MD 21401

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Wes Moore, Governor; Aruna Miller, Lt. Governor;  
Edward J. Kasemeyer, Chair; Mark Luckner, Executive Dir.

Thank you for submitting your entry. A copy is included below for your records.

Maryland Community Health Resources Commission - FY 2025 Application Cover Sheet

**Submission Date** 01/13/2025

**Applicant Organization Name** XXXXXXXX XX XXX XXXXXXXXXXXX.ORG

**Federal Tax ID Number (EIN)** 52- [REDACTED]

**Street Address** [REDACTED]

**City** PASADENA

**State** MD

**Zip Code** 21122

**Project Title** Addressing Chronic Disease (Heart and Lung Diseases) Prevention and Management through Community Outreach and Service

**Area of Focus** Addressing chronic disease prevention and disease management, including diabetes and its comorbidities, hypertension, heart

**# of Program Years**      **Proposed # of New**

**Jurisdiction (County) to be served**

**Zip Codes to be served**

**ENOUGH Act Census Tracts**

ip codes in Anne Arundel, Calvert, Charles, Prince George's Counties Yes

Three Years

3390

Anne Arundel,  
Calvert, Charles,  
Prince George's  
Counties

21012, 21054,  
21060, 21061,  
21090, 21113,  
21122, 21144,  
21146, 21225,  
20701, 20711,  
20714, 20724,  
20733, 20615,  
20629, 20  
20610, 20688,  
20685, 20689,  
20601, 20602,  
20603, 20607,  
20611, 20612,  
20613, 20640,  
20645, 20646,  
20744, 20772,  
20783, 20

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**Individuals Served**

**Proposed # of Existing Patients to be Served** 1645

**Estimated # of Service Encounters** 629375

**Targeted Health Disparities** Chronic disease (heart and lung diseases)

**Social**

**Determinants of Health to be addressed** Access to healthcare, access to healthcare education, economic stability, mental health and well-being, familial and social rela

**List of Grant-funded Partner Organizations** Charles County Charitable Trust, Qlarant Foundation (pending), Anne Arundel County Department of Aging and Disabilities, PN

**Official Authorized to Execute Contract(s)** Monica Escalante

**Email address of Authorized Official** mescalante@hospicechesapeake.org

**Phone Number of** +1 (141) 098-7151

**Authorized  
Official**

**Name of  
Project  
Director**

[REDACTED]

**Email  
Address of  
Project  
Director**

[REDACTED]@[REDACTED].org

**Phone  
Number of  
Project  
Director**

+ [REDACTED]

**Name of  
Fiscal  
Contact**

[REDACTED]

**Email  
address of  
Fiscal  
Contact**

[REDACTED]@[REDACTED].org

**Phone  
Number of  
Fiscal  
Contact**

+1 (141) 083-7152

**Required  
Documents  
Checklist &  
Upload  
Structure**

File 1: Signed Transmittal Letter & One-page Executive Summary, File 2: Grant Obligations & Assurances and Legal & Financial D Proposal (One file containing: Table of Contents, Background/Justification, Organizational Capacity, Project Plan, Partnerships, Template, File 5 - Budget Narrative, File 6 - W-9, File 7 - Logic Model and Workplan, File 8 - Mandatory Appendices (One file cont of Board of Directors, Organizational Chart, Letters of Commitment and MOUs, Resumes of project personnel), File 9 - Optional other statistical data on the target population, Organization annual report), File 10: Financial Audit (or Organization fiscal data) o

## File Attachments

-  **FY2025 MCHRC File 2 XXX.pdf** (705k)
-  **FY2025 MCHRC File 6 XXX.pdf** (1536k)
-  **FY2025 MCHRC File 10 XXX.pdf** (11959k)
-  **FY2025 MCHRC File 3 XXX.pdf** (236k)
-  **FY2025 MCHRC File 1 XXX.pdf** (330k)
-  **FY2025 MCHRC File 9 XXX.pdf** (446k)
-  **FY2025 MCHRC File 5 XXX.pdf** (216k)
-  **FY2025 MCHRC File 7 XXX.pdf** (487k)
-  **FY2025 MCHRC File 8 XXX.pdf** (3097k)
-  **FY2025 MCHRC File 4 XXX.xlsx** (92k)

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Maryland Community Health Resource Commission  
FY2025 Grant Application Transmittal Letter

To Whom It May Concern:

Xxxxxxx xx xxx XXXXXXXXXXXX (XXX), Inc. 501(c)3 is grateful to submit our application for FY2025 grant funding for our project entitled "Addressing Chronic Disease (Heart and Lung Diseases) through Expanded Targeted Community Outreach and Services." Our project director, [REDACTED], is our highly qualified Chief Strategy and Information Officer.

Xxxxxxx xx xxx XXXXXXXXXXXX understands that submission of a proposal constitutes acceptance of the terms of the grants program.

Best regards,

[REDACTED]  
Chief Executive Officer/President  
Xxxxxxx xx xxx XXXXXXXXXXXX

## EXECUTIVE SUMMARY

The impact of chronic disease (including cardiac and lung disease) eludes few families. Heart and lung diseases are leading causes of death in the US and throughout Maryland with diagnoses (per capita), and even more significantly in our service area. An integral part of XXXXXX xx xxx XXXXXXXXXXX - Community Outreach - understands it is crucial that patients, family members, and caregivers have access to quality, multi-faceted, ongoing support beginning with the diagnosis through end-of-life planning. Although the research and evidence are scalable across the country, it is noteworthy that the research was conducted with constituents in our region.

XXX recognizes that although heart and lung disease are not emergent in our communities, we cannot expand our current community outreach for care quickly enough or implement new, more longitudinal care broadly enough, including respite care. The demand is great, and our interest is in addressing it before it becomes overwhelming across the region.

As an explanation, our “Addressing Chronic Disease (Heart and Lung Disease) Prevention and Management through Community Outreach” project (under the funding area of chronic disease prevention and management) stems from the need to expand our outreach program more quickly. The strategic plan includes operationalizing the prevention and management of chronic disease care alongside hospice and palliative support, with longitudinal and ongoing deliverables. For the benefit of patients and caregivers, scaling outreach and education about care focuses on a continuum of services that help keep the loved one with heart disease, lung disease, or even comorbidities in their home as long as possible. Our strategic continuum also provides a variety of community outreach assessments and assistance across XXX’s business landscape.

This initiative combines expert community education, enhanced community awareness, strategic collaborations, and individualized support to empower patients, caregivers, and family members. By integrating medical, emotional, and practical assistance, we aim to ease the burden of chronic disease. Key benchmarks include:

1. **Community Education and Awareness:** Events, activities, printed and digital resources, workshops, and seminars that inform patients, families, caregivers, staff, partners, and volunteers about disease management, advance care planning, and available resources.
2. **Caregiver Support:** Respite care, support groups, and training to reduce caregiver stress and enhance their ability to provide quality care while managing their own determinants of health.
3. **Partnerships and Advocacy:** Collaboration, professional development, and shared inputs with local healthcare providers, community organizations, and policymakers to expand access to resources and advocate for patient-centered care.

Our goals of enhanced quality of life, diminished cultural barriers, increased accessibility, and the empowerment of education and awareness need your support because they will positively impact the quality of life of so many living with heart and lung diseases. Our need to expand community outreach is additionally rooted in our commitment to best serve our communities.

XXXXXXXX XX XXX XXXXXXXXXXXX, INC 501(c)3

Proposal for FY2025 MCHRC Grant Funding

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## BACKGROUND AND JUSTIFICATION

For more than 45 years, XXXXXX xx xxx XXXXXXXXXXXX has been the region's number one hometown hospice, palliative care, and bereavement support provider. Led by a highly qualified team of experts and long-time professionals, XXX is the trusted resource for chronic disease management, including heart and lung disease diagnoses. With a mission to serve all residents regardless of their inability to pay, we have provided care for patients and comfort to their family members and caregivers.

Although XXXXXX xx xxx XXXXXXXXXXXX has long been a trusted provider of compassionate end-of-life care, serving individuals and families with dignity and excellence, the healthcare landscape has seen a significant rise in the prevalence of chronic diseases such as heart disease, chronic obstructive pulmonary disease (COPD), lung disease, other chronic conditions, and neurodegenerative disorders. These conditions often lead to prolonged periods of illness, complex care needs, and a decline in quality of life, requiring holistic, patient-centered support that extends beyond traditional hospice services, many times with comorbidities. In 2022, one of the leading causes of death in Maryland was heart disease. Additionally, a 2024 report supported the common assumption that heart and lung diseases are a primary cause of rehospitalization, especially in older patients.

Research shows that community outreach is a crucial first step in effectively preventing and managing chronic diseases. Because chronic conditions such as heart disease and lung disease often require ongoing care, lifestyle adjustments, and patient engagement, community outreach serves as a bridge between healthcare providers and patients. This fosters better outcomes through education, support, and accessibility. Below are the key reasons why community outreach is crucial:

### 1. Promote Awareness and Education

- **Understanding Disease Management:** Outreach programs educate individuals about their conditions, helping them understand the importance of medication adherence, dietary adjustments, and regular monitoring.
- **Preventive Measures:** Educating the broader community on risk factors, healthy behaviors, and early warning signs can reduce the prevalence and complications of chronic diseases.

### 2. Improve Access to Resources

- **Healthcare Accessibility:** Community initiatives provide screenings, clinics, and support programs, especially in underserved or remote areas.
- **Navigating Healthcare Systems:** Outreach efforts help individuals access healthcare services by providing guidance on insurance, transportation, and other logistical barriers.

### 3. Encourage Behavior Change

- **Lifestyle Interventions:** Programs often include nutrition counseling, exercise workshops, and smoking cessation initiatives tailored to community needs.
- **Peer Support:** Group activities and peer mentoring foster a supportive environment, encouraging sustained lifestyle changes.

### 4. Build Trust and Relationships

- Cultural Sensitivity: Outreach tailored to a community's cultural and linguistic needs helps build trust between healthcare providers and patients.
  - Consistent Engagement: Regular contact through outreach efforts reinforces the importance of disease management and creates a sense of accountability.
5. Reduce Health Disparities
- Equity in Care: Targeted outreach addresses social determinants of health, such as poverty, education, and housing, that disproportionately impact vulnerable populations.
  - Closing Gaps: These programs help bridge gaps in care, ensuring that high-risk groups receive the support they need.
6. Enhance Early Detection and Intervention
- Screening and Monitoring: Community-based health fairs and mobile clinics often offer screenings that lead to early diagnosis and timely intervention.
  - Preventing Complications: Outreach efforts help individuals recognize symptoms that require medical attention, reducing the risk of severe complications.
7. Empower Patients and Communities
- Self-Management Skills: By equipping patients with knowledge and tools, outreach programs empower them to take control of their health.
  - Community Mobilization: Encouraging collective action fosters a sense of ownership and responsibility for communal health outcomes.

Cultural sensitivity is perhaps XXX's overarching objective for the "Addressing Chronic Disease Prevention and Management through Community Outreach" initiatives. Understanding the community fosters inclusive communication through appropriate messaging and language access. Services and staffing can be adjusted to meet cultural needs, breaking down barriers to access high-quality healthcare. In the end, community outreach builds trust.

We know from much academic and practical data that trust is a cornerstone of chronic disease management, addressing barriers to care and enabling sustainable health improvements. By integrating education, access, and support into communities, these efforts empower individuals to lead healthier lives while reducing the burden of chronic diseases on healthcare systems.

XXX's leadership and board governance have relied on strategic planning to ensure sustainability over the decades. Our strategies, in part, address:

- Epidemiological Trends - chronic diseases account for 7 out of 10 deaths annually in the United States, with 6 in 10 adults living with at least one chronic condition. The population served by XXXXX xx xxx XXXXXXXXX increasingly faces these challenges earlier in their health journeys, necessitating supportive care that bridges the gap between active treatment and end-of-life care.
- Alignment with Organizational Mission - providing chronic disease management services aligns with XXXXX xx xxx XXXXXXXXX's mission to enhance the quality of life for patients and families. Addressing the complex physical, emotional, and psychosocial needs of individuals with chronic diseases expands the organization's ability to support patients holistically.

- Continuum of Care - chronic disease management programs can serve as a bridge between palliative and hospice care, enabling the organization to intervene earlier in the disease trajectory. This allows patients to experience improved symptom management, reduced hospitalizations, and better overall quality of life.
- Community Demand - there is a growing need in the community for chronic disease services that emphasize coordinated care, education, and emotional support. Patients and caregivers frequently seek resources for managing conditions that fall outside the traditional scope of hospice care but align with the principles of comfort and dignity.
- Healthcare System Challenges - chronic diseases place a significant burden on healthcare systems due to frequent hospital admissions, emergency room visits, and fragmented care. By introducing chronic disease services, XXXXXXXX xx xxx XXXXXXXXXXXX can position itself as a leader in reducing these burdens by offering proactive, patient-centered care that supports individuals in the home setting.
- Strategic Growth Opportunity - expanding into chronic disease management allows XXXXXXXX xx xxx XXXXXXXXXXXX to diversify its service offerings, increase referrals, and strengthen partnerships with healthcare providers. This positions the organization to serve a broader population while ensuring sustainability in a competitive healthcare environment.

Across Maryland, 55+ populations are the fastest-growing demographic. Their quality of life is crucial to our region's sustainability and growth, access to quality, patient-centered health care, and local and regional economies. Maryland's State Plan on Aging projects that Maryland will have over 1.79 million individuals aged 60+ by 2040, a 23% increase from today. This age group is steadily increasing its share of the region's total population, and the boom in senior communities and services across our four counties served provides daily evidence of this growth. Over half of this population is living longer with the disabling symptoms of advanced disease and late-stage illness, resulting in reduced quality of life for many. As medicine continues to advance and extend life expectancy for this age group, there is an ongoing need for increased caregiving, long-term services, and improved management of chronic disease and illness. XXX's Continuum of Care focuses on improving access to, or the quality of, education, training, support services, and independent living services for older adults.

Scaling up community outreach is absolutely necessary, too, to help improve Maryland's hospice use rate, including use with heart or lung diseases. Evidence shows that lower-income portions of our service area lag significantly behind more abundantly resourced areas in having a higher quality of life and dignity when living with life-limiting illnesses. In 2019, Anne Arundel reported the highest hospice use rate in our four-county service area, reporting 53.2% use. Calvert County's hospice use rate was 42.9% during the same year. Charles and Prince George's Counties experience the greatest inequities and disparities with social determinants of health and reported 27.4% and 27.8% hospice use in 2019, respectively.

### ORGANIZATIONAL CAPACITY

XXXXXXXX xx xxx XXXXXXXXXXXX is a fully licensed, independent, community-based nonprofit organization certified by Medicare and the State of Maryland, and accredited by the Joint Commission.

XXX provides physical, psycho-social, and spiritual support services to individuals living with and affected by advanced illnesses, including chronic diseases. Our services are delivered by an interdisciplinary team of professionals, including physicians, nurses, certified nursing assistants, social workers, chaplains, counselors, and specially trained volunteers. This team-based approach ensures comprehensive care tailored to the needs of patients with chronic illnesses. In 2024, staffing exceeded 320 full-time and 150 part-time employees, assisted by more than 200 volunteers, providing thousands of hours of volunteer value.

Strategic planning has been at the core of our success for 45+ years. The executive team works with the 20-member Board of Directors, overseeing strategic priorities and policies and our \$42M annual operating budget. An 18-member Foundation Board has oversight of donor engagement and fundraising. This oversight monitors and adjusts services, staffing, and activities continually.

These governance and financial resources support our capacity to provide extensive outreach and care services. This approach aims to improve the quality of life for both patients, caregivers, and families.

XXX views capacity and, thus, sustainability (e.g., serving our communities, including outreach and education) as a multi-pronged scaling process. By scaling up community outreach services and the human resources necessary to do so, XXX can expand to provide hospice and supportive care services for heart and lung disease diagnoses to additional Maryland residents, as well as providing support for patient families and caregivers. We will be able to maintain the capacity to meet the growing needs more closely.

## PROJECT PLAN

Community outreach is a foundation of chronic disease management, addressing barriers to care, and facilitating sustainable health improvements. By integrating education, access, and support into communities, these efforts empower individuals to lead healthier lives while reducing the burden of

chronic diseases on healthcare systems. Empowering individuals with their own healthcare positively impacts many, if not all, social determinants of health.

To achieve such positive and lasting impacts, community outreach about prevention and care is vital to engaging residents in the conversations, particularly populations whose culture might be averse to the concept of hospice or palliative care. As with all communication, the first step to robust community outreach is understanding the community... the audience.

“Addressing Chronic Disease (Heart and Lung Disease Diagnoses) through Community Outreach” has been carefully planned to most prudently use funders’ money, most abundantly expend our expertise and staff experience, collaboratively engage the residents in service communities and populations, and cooperatively connect with community partners.

Research shows that community outreach is a crucial first step in effectively preventing and managing chronic diseases. Because chronic conditions such as heart disease and lung disease often require ongoing care, lifestyle adjustments, and patient engagement, community outreach serves as a bridge between healthcare providers and patients. This fosters better outcomes through education, support, and accessibility. Below are the key reasons why community outreach is crucial and why our project plan involves:

### 1. Promoting Awareness and Education

- **Understanding Disease Management:** Outreach programs educate individuals about their conditions, helping them understand the importance of medication adherence, dietary adjustments, and regular monitoring.
- **Preventive Measures:** Educating the broader community on risk factors, healthy behaviors, and early warning signs can reduce the prevalence and complications of chronic diseases.

### 2. Improving Access to Resources

- **Healthcare Accessibility:** Community initiatives provide screenings, clinics, and support programs, especially in underserved or remote areas.
- **Navigating Healthcare Systems:** Outreach efforts help individuals access healthcare services by providing guidance on insurance, transportation, and other logistical barriers.

### 3. Encouraging Behavior Change

- **Lifestyle Interventions:** Programs often include nutrition counseling, exercise workshops, and smoking cessation initiatives tailored to community needs.
- **Peer Support:** Group activities and peer mentoring foster a supportive environment, encouraging sustained lifestyle changes.

### 4. Building Trust and Relationships

- **Cultural Sensitivity:** Outreach tailored to a community's cultural and linguistic needs helps build trust between healthcare providers and patients.

Maryland Community Health Resource Commission – FY2025 Grant Application Project Proposal

- Consistent Engagement: Regular contact through outreach efforts reinforces the importance of disease management and creates a sense of accountability.

5. Reducing Health Disparities

- Equity in Care: Targeted outreach addresses social determinants of health, such as poverty, education, and housing, that disproportionately impact vulnerable populations.
- Closing Gaps: These programs help bridge gaps in care, ensuring that high-risk groups receive the support they need.

6. Enhancing Early Detection and Intervention

- Screening and Monitoring: Community-based health fairs and mobile clinics often offer screenings that lead to early diagnosis and timely intervention.
- Preventing Complications: Outreach efforts help individuals recognize symptoms that require medical attention, reducing the risk of severe complications.

7. Empowering Patients, Caregivers, Families, and Community Members

- Self-Management Skills: By equipping patients with knowledge and tools, outreach programs empower them to take control of their health.
- Community Mobilization: Encouraging collective action fosters a sense of ownership and responsibility for communal health outcomes.

To achieve these objectives and meet the expectations of our communities and partners, our aggressive plan will:

- Through needs assessments, identify the groups and geographical areas where heart and lung disease are prevalent and/or have increasing diagnoses
- The same assessments will provide vision for prioritizing the calendar as events and activities are scheduled, and media is produced
- Partner and faith leader engagement will help XXX create marketing content to fully connect with and in these targeted populations, often underserved or sensitive populations.
- Content with appropriate language and design will boost participation and result in preventing and better managing chronic diseases by breaking down barrier - the barriers that frequently inhibit determinants of health improvement
- Printed, electronic, and digital/visual marketing tools will be updated and created with expert input from faith leaders and other community partners who understand the populations targeted for our expanded outreach
- Printed collateral will include the National Partnership for Healthcare and Hospice Innovation (NPHI) Patient and Caregiver Guide, which will also carry the Xxxxxxx xx xxx Xxxxxxxxxx logo and contact information. Similar collateral could include informational one-pagers, community surveys, or resources.
- Electronic versions of printed collateral will be available for email response to inquiries, downloadable from our website, and partner resources.
- Podcasts (quarterly in Project Year 1 and monthly in Years 2 and 3) will feature internal and external experts, patients, caregivers, family members, volunteers, community partners, and faith leaders will be part of the digital library. Shorter videos will feature educational resources, chronic disease navigation advice, medical information, testimonials, and more.

- Digital and video resources will be distributed on a variety of social media platforms to maximize saturation of the targeted markets.
- It is vital that community and faith leaders help guide our communications and community outreach teams to develop a comprehensive and practical compendium of content in order to attract the populations who are more culturally sensitive or underserved.

## PARTNERSHIPS

Because Xxxxxxx xx xxx XXXXXXXXXXXX was established to serve all living with or affected by advanced illness or loss, regardless of age, race, ethnicity, or inability to pay, no one is turned away for hospice, supportive care, or bereavement services.

Additionally, the psychosocial needs of patients are assessed by our social workers. Quality hospice and supportive care are complemented when those on care have transportation, food security, housing, and other daily needs met whenever possible. Because our social workers offer recommendations and connections to additional community services of which many times an underserved patient might be unaware, the “whole person” receives optimum care.

Our fundraising and strategic partnerships development teams, in part, engage medical, nonprofit, and civic organizations through community outreach, educational programs (hospice, supportive care, and bereavement), program activities, and volunteer opportunities so that everyone across the service area has access to information and superior care.

Xxxxxxx xx xxx XXXXXXXXXXXX is proud to partner with the region’s highest-qualified experts, dedicated community partners, and the most energized volunteers and staff. Here is a sample of our distinguished collaborators:

- Collective Empowerment Group
- Anne Arundel Senior Provider Group
- Prince George’s Senior Provider Network
- Community Health Improvement Roundtable – Calvert County
- Access to Care Coalition – Charles County
- Leading Age Maryland
- Leadership Anne Arundel
- Leadership Southern Maryland
- Calvert Commission on Aging
- University of Maryland - Baltimore Washington Medical Center
- Calvert Health
- University of Maryland – Charles Regional Medical Center
- Anne Arundel County Department of Disabilities and Aging

## EVALUATION

Evaluation of our care and services is tracked by nationally standardized and XXX-specific tools and data to measure impact and help drive decisions on areas for service improvement.

- Monitoring patient care, clinical activity, effectiveness, quality improvement opportunities, and tracking populations served
- Remote 24/7 patient monitoring
- "Healthcare Safety Zone" assesses processes of care, services, and operations
- Electronic medical records (EMR) practice management platform
- The National Hospice & Palliative Care Organization's (NHPCO) Evaluation of Grief Support Services (EGSS) survey
- XXX's Evaluation of Counseling Services survey
- Completion of Joint Commission accreditation reviews as required every three years for hospice as well as supportive care

Specific to this MCHRC grant-funded project, our Project Director and Director of Quality Assurance will coordinate with appropriate project team members to:

- Ensure all project goals and objectives are being met and/or are on schedule
- Identify overarching goals and objectives as well as all requirements in funding agreements
- List all possible types of events appropriate for project, along with (desired) dates and locations
- All internal and external expectations and requirements are met in a timely manner

Financial and Clinical teams periodically review respective reports on those receiving free/reduced-cost clinical care, support services, and the cost of care provided. Our Community Education Manager assesses our reach to the community regularly.

Specially trained older volunteers who have lived a hospice experience call every patient each week to ensure they have everything they need as they navigate their hospice own experience, reporting back to nurses, CNAs, and social workers.

Ongoing and comprehensive qualitative and quantitative metrics tracking allows XXX to continually evaluate services and care to provide the most responsive care.

We maintain a Gold Transparency rating with both GuideStar and Candid.

## SUSTAINABILITY

The impacts of cardiac and lung disease elude no community, and these impacts continue to significantly increase as heart disease and lung disease diagnoses are only predicted to increase. This is why our leadership has carefully and continually planned and evaluated operations at XXXXXX xx xxx XXXXXXXXXXXX for more than 45 years. Prudent leadership allows the organization to proactively adapt to changing healthcare, patient demographics, numbers requiring services, and expanding geographical service areas, including rural regions and workforce environments.

Our history, leadership, and governance speak for themselves: Our planned Center of Excellence will set the standard across the region and country. XXX is managed by an executive team including a Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Chief Financial Officer, and Chief Strategy and Information Officer.

The service and activities across all XXX entities and departments are conducted by experts and care teams including specially trained and licensed physicians, nurses, and nurse practitioners with specialties in geriatrics/gerontology, family medicine, cardiac disease, oncology, and palliative medicine, plus licensed clinical social workers/counselors, CNAs, therapists, integrative arts specialists, and chaplains.

XXX is financially sound, retaining an investment portfolio designed for long-term growth. We experience no remarkable fluctuations in revenue, annually receive strong audit reports, and maintain an operating reserve of approximately \$8M. Our board-directed reserve helps to ensure the continuation of services in the event of unanticipated ongoing impacts, unexpected census increases, or changes in Medicare payments. XXX is governed by a 20-member Board of Directors overseeing our organizational leadership, strategic priorities and policies, and our average \$42M annual operating budget. An 18-member Foundation Board has oversight of donor engagement and fundraising. XXX's Foundation implements a multi-pronged fundraising strategy, adding approximately \$3.8 million to cover the costs of uncompensated clinical care, supportive services, bereavement services, community outreach/education, and professional development. XXX's fundraising benefits from three signature events annually.

**Budget Form Template for Schedule 1 Overall Project Cost - FY 2025 Call for Proposals**



**MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION**

Organization Name: XXXXXXXX XX XXX XXXXXXXXXXXX

Entity Current Fiscal Year Total Budget: \$42,675,254

Revenues/Total Project Cost	Year 1 Revenue	Year 2 Revenue	Year 3 Revenue	Total Revenue	% of Total Project Cost
<b>CHRC Grant Funding Request</b>	<b>\$220,000</b>	<b>\$203,800</b>	<b>\$147,500</b>	<b>\$571,300</b>	<b>7%</b>
Patient/Program Revenues/Income Collected NET	\$2,271,800	\$2,378,595	\$2,488,059	\$7,138,454	90%
Other Grant/Funding Support	\$37,500	\$42,500	\$45,000	\$125,000	2%
Organization Match	\$37,500	\$42,500	\$45,000	\$125,000	2%
<b>Total Project Cost</b>	<b>\$2,566,800</b>	<b>\$2,667,395</b>	<b>\$2,725,559</b>	<b>\$7,959,754</b>	<b>100%</b>

  

Line Item Budget for Overall Total Project Cost (add rows if needed)	Year 1 Project Cost	Year 2 Project Cost	Year 3 Project Cost	Overall Project Cost	CHRC Overall Budget Request (see Schedule 2 for details)
<b>Personnel Salary</b> (enter the requested information for each position type and applicable FTEs that are W-2 employees of the project)					
FTE, Position Type 1: Project Manager (10% CSI Officer)	\$25,000	\$26,500	\$28,090	\$79,590	\$0
FTE, Position Type 2: Director Community Outreach (10%)	\$16,000	\$16,960	\$17,677	\$50,637	\$0
FTE, Position Type 3: VP Medical Affairs & Medical Director (5%)	\$11,250	\$11,925	\$12,640	\$35,815	\$0
FTE, Position Type 4: Director Quality Assurance (5%)	\$6,500	\$6,890	\$7,303	\$20,693	\$0
FTE, Position Type 5: Director Communications (20%)	\$24,000	\$25,440	\$26,966	\$76,406	\$0
<b>Personnel Salary Subtotal</b>	<b>\$82,750</b>	<b>\$87,715</b>	<b>\$92,676</b>	<b>\$263,141</b>	<b>\$0</b>
<b>Personnel Fringe Benefits</b> (up to 25% of Personnel costs for only W-2 employees of the project listed in personnel salary section above)	<b>\$14,895</b>	<b>\$15,788</b>	<b>\$16,681</b>	<b>\$47,364</b>	<b>\$0</b>
Personnel Fringe Benefits % of Overall Personnel Salary	18.0%	18.0%	18.0%	18.0%	0.0%
<b>Total Salary &amp; Fringe Benefits Expense</b>	<b>\$97,645</b>	<b>\$103,503</b>	<b>\$109,357</b>	<b>\$310,505</b>	<b>\$0</b>
<b>Total Salary &amp; Fringe Benefits Expense % of Total Expenses</b>	<b>22.6%</b>	<b>23.1%</b>	<b>25.4%</b>	<b>23.7%</b>	<b>0.0%</b>
<b>Equipment/Furniture/IT &amp; Telecom/Minor Infrastructure Improvements/Vehicle(s)</b>					
a. Equipment	\$0	\$0	\$0	\$0	\$0
b. Furniture	\$0	\$0	\$0	\$0	\$0
c. IT/Telecom	\$6,000	\$4,500	\$3,000	\$13,500	\$10,800
d. Minor Infrastructure Improvements	\$0	\$0	\$0	\$0	\$0
e. Vehicle(s)	\$0	\$0	\$0	\$0	\$0
<b>Total Equipment/Furniture/IT &amp; Telecom/ Minor Infrastructure Improvements/ Vehicle(s)</b>	<b>\$6,000</b>	<b>\$4,500</b>	<b>\$3,000</b>	<b>\$13,500</b>	<b>\$10,800</b>
<b>Total Equipment/Furniture/IT &amp; Telecom/ Minor Infrastructure Improvements/ Vehicle(s) % of Total Expenses</b>	<b>1.4%</b>	<b>1.0%</b>	<b>0.7%</b>	<b>1.0%</b>	<b>1.9%</b>
<b>Total Supplies</b>	<b>\$23,500</b>	<b>\$25,000</b>	<b>\$28,500</b>	<b>\$77,000</b>	<b>\$30,000</b>
<b>Total Supplies % of Total Expenses</b>	<b>5.4%</b>	<b>5.6%</b>	<b>6.6%</b>	<b>5.9%</b>	<b>5.3%</b>
<b>Travel/Mileage/Parking</b> (relates to travel for grant activities but not employee travel related to training)					
a. Program Participants (Client Costs)	\$5,700	\$6,200	\$6,700	\$18,600	\$0
b. Staff Costs	\$11,400	\$12,400	\$13,400	\$37,200	\$0
<b>Total Travel/Mileage/Parking</b>	<b>\$17,100</b>	<b>\$18,600</b>	<b>\$20,100</b>	<b>\$55,800</b>	<b>\$0</b>
<b>Total Travel/Mileage/Parking % of Total Expenses</b>	<b>4.0%</b>	<b>4.2%</b>	<b>4.7%</b>	<b>4.3%</b>	<b>0.0%</b>
<b>Total Staff Training/Development</b> (includes employee certifications and employee travel related costs to conferences, training sessions, etc. and excludes salaries related to W-2 employees attending training)	<b>\$20,000</b>	<b>\$20,000</b>	<b>\$20,000</b>	<b>\$60,000</b>	<b>\$54,000</b>
<b>Total Staff Training/Development % of Total Expenses</b>	<b>4.6%</b>	<b>4.5%</b>	<b>4.7%</b>	<b>4.6%</b>	<b>9.5%</b>
<b>Contractual</b> (>\$5k itemize below with details in budget justification; excludes W-2 employees of applicant/project)					
a. Part-time contract faith community liason (40 hrs/mnth x \$40 hr)	\$19,200	\$19,200	\$9,600	\$48,000	\$48,000
b. Consultant - community outreach materials development (sensitive populations)	\$38,000	\$38,000	\$15,000	\$91,000	\$91,000
c.				\$0	\$0
d.				\$0	\$0
e.				\$0	\$0
<b>Total Contractual Expenses</b>	<b>\$57,200</b>	<b>\$57,200</b>	<b>\$24,600</b>	<b>\$139,000</b>	<b>\$126,500</b>
<b>Total Contractual Expenses % of Total Expenses</b>	<b>13.2%</b>	<b>12.8%</b>	<b>5.7%</b>	<b>10.6%</b>	<b>22.1%</b>
<b>Total Program Marketing Related Expenses</b>	<b>\$152,000</b>	<b>\$157,000</b>	<b>\$162,000</b>	<b>\$471,000</b>	<b>\$350,000</b>
<b>Total Program Marketing Related Expenses % of Total Expenses</b>	<b>35.2%</b>	<b>35.1%</b>	<b>37.7%</b>	<b>36.0%</b>	<b>61.3%</b>
<b>Total Other Expenses</b> (expenses that do not fit in any of the other direct expense categories outlined above; i.e. expense associated with employee background checks/finger printing)	<b>\$8,300</b>	<b>\$9,400</b>	<b>\$10,500</b>	<b>\$28,200</b>	<b>\$0</b>
<b>Total All Other Expenses % of Total Expenses</b>	<b>1.9%</b>	<b>2.1%</b>	<b>2.4%</b>	<b>2.2%</b>	<b>0.0%</b>
<b>Total Indirect Costs:</b> up to 15% of direct costs (direct costs = total costs minus indirect costs; indirect cost rates above 15% refer to Budget Narrative and RFA)	<b>\$50,074</b>	<b>\$52,550</b>	<b>\$51,794</b>	<b>\$154,418</b>	<b>\$0</b>
Indirect Costs % of Direct Costs	13.1%	13.3%	13.7%	13.4%	0.0%
<b>Overall Total Project Cost</b> (must tie back to total project cost amount which is above in row 10)	<b>\$431,819</b>	<b>\$447,753</b>	<b>\$429,851</b>	<b>\$1,309,423</b>	<b>\$571,300</b>



**MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION**

Organization Name: XXXXXXXX XX XXX XXXXXXXXXXXX

Entity Current Fiscal Year Total Budget: \$42,675,254

Revenues/Total Project Cost	Year 1 Revenue	Year 2 Revenue	Year 3 Revenue	Total Revenue	% of Total Project Cost
<b>CHRC Grant Funding Request</b>	<b>\$220,000</b>	<b>\$203,800</b>	<b>\$147,500</b>	<b>\$571,300</b>	<b>7%</b>
Patient/Program Revenues/Income Collected	\$2,271,800	\$2,378,595	\$2,488,059	\$7,138,454	90%
Other Grant/Funding Support	\$37,500	\$42,500	\$45,000	\$125,000	2%
Organization Match	\$37,500	\$42,500	\$45,000	\$125,000	2%
<b>Total Project Cost</b>	<b>\$2,566,800</b>	<b>\$2,667,395</b>	<b>\$2,725,559</b>	<b>\$7,959,754</b>	<b>100%</b>

Line Item Budget for CHRC Grant Funding Request (add rows if needed)	Year 1 CHRC Budget Request	Year 2 CHRC Budget Request	Year 3 CHRC Budget Request	Overall CHRC Budget Request
<b>Personnel Salary</b> (enter the requested information for each position type and applicable FTEs that are <b>W-2 employees of the project</b> )				
FTE, Position Type 1: Project Manager (10% CSI Officer)	\$0	\$0	\$0	\$0
FTE, Position Type 2: Director Community Outreach (10%)	\$0	\$0	\$0	\$0
FTE, Position Type 3: VP Medical Affairs & Medical Director (5%)	\$0	\$0	\$0	\$0
FTE, Position Type 4: Director Quality Assurance (5%)	\$0	\$0	\$0	\$0
FTE, Position Type 5: Director Communications (20%)	\$0	\$0	\$0	\$0
<b>Personnel Salary Subtotal</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Personnel Fringe Benefits</b> (up to 25% of Personnel costs for only <b>W-2 employees of the project</b> listed in personnel salary section above)	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
Personnel Fringe Benefits % of Overall Personnel Salary	0.0%	0.0%	0.0%	0.0%
<b>Total Salary &amp; Fringe Benefits Expense</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Total Salary &amp; Fringe Benefits Expense % of Total Expenses</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>
<b>Equipment/Furniture/IT &amp; Telecom/Minor Infrastructure Improvements/Vehicle(s)</b>				
a. Equipment	\$0	\$0	\$0	\$0
b. Furniture	\$0	\$0	\$0	\$0
c. IT/Telecom	\$4,800	\$3,600	\$2,400	\$10,800
d. Minor Infrastructure Improvements	\$0	\$0	\$0	\$0
e. Vehicle(s)	\$0	\$0	\$0	\$0
<b>Total Equipment/Furniture/IT &amp; Telecom/ Minor Infrastructure Improvements/ Vehicle(s)</b>	<b>\$4,800</b>	<b>\$3,600</b>	<b>\$2,400</b>	<b>\$10,800</b>
<b>Total Equipment/Furniture/IT &amp; Telecom/ Minor Infrastructure Improvements/ Vehicle(s) % of Total Expenses</b>	<b>2.2%</b>	<b>1.8%</b>	<b>1.6%</b>	<b>1.9%</b>
<b>Total Supplies</b>	<b>\$10,000</b>	<b>\$10,000</b>	<b>\$10,000</b>	<b>\$30,000</b>
<b>Total Supplies % of Total Expenses</b>	<b>4.5%</b>	<b>4.9%</b>	<b>6.8%</b>	<b>5.3%</b>
<b>Travel/Mileage/Parking</b> (relates to travel for grant activities but not employee travel related to training)				<b>\$0</b>
a. Program Participants (Client Costs)	\$0	\$0	\$0	\$0
b. Staff Costs	\$0	\$0	\$0	\$0
<b>Total Travel/Mileage/Parking</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Total Travel/Mileage/Parking % of Total Expenses</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>
<b>Total Staff Training/Development</b> (includes employee certifications and employee travel related costs to conferences, training sessions, etc. and excludes salaries related to W-2 employees attending training)	<b>\$18,000</b>	<b>\$18,000</b>	<b>\$18,000</b>	<b>\$54,000</b>
<b>Total Staff Training/Development % of Total Expenses</b>	<b>8.2%</b>	<b>8.8%</b>	<b>12.2%</b>	<b>9.5%</b>
<b>Contractual</b> (>\$5k itemize below with details in budget justification; excludes W-2 employees of applicant/project)				
a. Part-time contract faith community liason (40 hrs/mnth x \$40 hr)	\$19,200	\$19,200	\$9,600	\$48,000
b. Consultant - community outreach materials development (sensitive populations)	\$38,000	\$38,000	\$15,000	\$91,000
c.				\$0
d.				\$0
e.				\$0
<b>Total Contractual Expenses</b>	<b>\$52,200</b>	<b>\$52,200</b>	<b>\$22,100</b>	<b>\$126,500</b>
<b>Total Contractual Expenses % of Total Expenses</b>	<b>23.7%</b>	<b>25.6%</b>	<b>15.0%</b>	<b>22.1%</b>
<b>Total Program Marketing Related Expenses</b>	<b>\$135,000</b>	<b>\$120,000</b>	<b>\$95,000</b>	<b>\$350,000</b>
<b>Total Program Marketing Related Expenses % of Total Expenses</b>	<b>61.4%</b>	<b>58.9%</b>	<b>64.4%</b>	<b>61.3%</b>
<b>Total Other Expenses</b> (expenses that do not fit in any of the other direct expense categories outlined above; i.e. expense associated with employee background checks/finger printing)	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Total All Other Expenses % of Total Expenses</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>
<b>Total Indirect Costs:</b> up to 15% of direct costs (direct costs = total costs minus indirect costs; indirect cost rates above 15% refer to Budget Narrative and RFA)	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
Indirect Costs % of Direct Costs	0.0%	0.0%	0.0%	0.0%
<b>Overall CHRC Total Funding Request</b> (must tie back to total CHRC grant funding request amount which is above in row 6)	<b>\$220,000</b>	<b>\$203,800</b>	<b>\$147,500</b>	<b>\$571,300</b>
<b>Percent of Organization's Total Project Cost</b>	<b>9%</b>	<b>8%</b>	<b>5%</b>	<b>7%</b>



**MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION**

Organization Name: XXXXXXXX XX XXX XXXXXXXXXXXX

Entity Current Fiscal Year Total Budget: \$42,675,254

Revenues/Total Project Cost	Year 1 Revenue	Year 2 Revenue	Year 3 Revenue	Total Revenue	% of Total Project Cost
<b>CHRC Grant Funding Request</b>	<b>\$220,000</b>	<b>\$203,800</b>	<b>\$147,500</b>	<b>\$571,300</b>	<b>7%</b>
Patient/Program Revenues/Income Collected	\$2,271,800	\$2,378,595	\$2,488,059	\$7,138,454	90%
Other Grant/Funding Support	\$37,500	\$42,500	\$45,000	\$125,000	2%
Organization Match	\$37,500	\$42,500	\$45,000	\$125,000	2%
<b>Total Project Cost</b>	<b>\$2,566,800</b>	<b>\$2,667,395</b>	<b>\$2,725,559</b>	<b>\$7,959,754</b>	<b>100%</b>

Line Item Budget for <u>CHRC</u> Grant Funding Request (add rows if needed)	Year 1 CHRC Budget Request	Year 2 CHRC Budget Request	Year 3 CHRC Budget Request	Overall CHRC Budget Request
<b>Individuals to be Served for Overall Grant Period</b>				
Total Number of Unduplicated Individuals to be Served (new patients)				3,390
Total Cost Per Unduplicated Individuals to be Served (new patients) to acquire				<b>\$168.53</b>
Total Number of Existing Patients to be Served (receiving new services)				1,645
Total Cost Per Existing Patients to be Served (receiving new services) to retain				<b>\$347.29</b>
Overall Number of Individuals to be Served (new and existing patients)				5,035
Total Cost Per Overall Individuals to be Served (new and existing patients) to acquire/retain				<b>\$113.47</b>

XXXXXXXX XX XXX XXXXXXXXXXXX

**BUDGET NARRATIVE**

Please comment on the potential or likelihood that cost savings or retained revenue will be re-invested to support the project after initial CHRC grant funding has been expended. The CHRC is proud that over 75% of its grants have been sustained at least one year or more after the initial grant funding has been expended.

**Organization Name/Entity Current Fiscal Year Total Budget**

Provide in the **Schedule 1 Budget Template** the organization name and the organization’s total current fiscal year budget. **There is no action required on your part to input the same information in the Schedule 2 Budget Template as this information will automatically carry over when you complete Schedule 1.**

**Revenues/Total Project Cost**

Provide in the **Budget Templates (Schedule 1 and Schedule 2)** all project revenue sources for each year in the requested funding period. Details on what needs to be input in these schedules are outlined below.

**Schedule 1 Overall Project Cost Template:** In the **Revenue/Total Project Cost top section** of the Schedule 1 template, input the CHRC grant funding amount requested and any other types of anticipated revenue amounts (patient/program revenues/income collected, other grant/funding support, organization match, etc.) for each year in the requested funding period that will fund the overall project cost.

In the **Line-Item Expense budget section** following the Revenue/Total Cost section, provide the line-item expense details for each year in the requested funding period. The total project cost amount in the Revenues/Total Project Cost section must match the Overall Total Project Cost amount in the line-item expense detailed budget. **There is no action required on your part to input information in the CHRC Overall Budget Request column as this information will automatically carry over when you complete Schedule 2.**

**Schedule 2 CHRC Funding Request Template:** **There is no action required on your part to input information for the CHRC grant funding amount requested and other types of revenue amounts that were input on Schedule 1 as this information will automatically carry over when you complete Schedule 1.** The CHRC grant funding revenue award amount requested needs to match the CHRC grant budgeted expenses.

Provide in this **Budget Narrative Template** in the text box below a brief description of anticipated revenue (patient/program revenues/income collected, other grant/funding support, organization match, etc.) for each year in the requested funding period that will fund the overall project cost.

Xxxxxxx xx xxx XXXXXXXXXX anticipates patient revenues directly impacting this community outreach project at \$2,271,800 Year 1, \$2,378,595 Year 2, and \$2,488,059 Year 3. (Additional patient revenues will not allocated or attributed to the MCHRC project.)

XXX Foundation will strive to secure \$37,500 Year 1, \$42,500 Year 2, and \$45,000 Year 3 in restricted grant funding in addition to any MCHRC grant funds awarded.

XXX operating and/or non-grant fundraising will match expected secured grant funding dollar for dollar.

### **Personnel Salaries**

Provide in the **Schedule 2 CHRC Funding Request Budget Template** salary dollars and Full Time Equivalent (FTE) details by position type for **only** W-2 employees. Contractual positions should not be included in the salary section but would be included as a line item in the Contractual section. Salary expenses should include all forms of compensation to W-2 employees including services and/or training related to this grant, should not be duplicated by indirect costs, and should be netted by any other revenue sources (i.e., Other Grants, Medicare, Medicaid, etc.).

Provide in this **Budget Narrative Template** in the text box below the salary cost and related FTEs by **position type** along with a brief description of work to be performed by each position type. Identify any anticipated salary increases during the life of the grant (i.e., 3% COLA raises in years 2 and 3).

XXX is not requesting any salaries or wages by covered by MCHRC grant funding.

Project Lead: Chief Strategy and Information Officer will use 10% of her total time on the project to oversee the project components and ensure achieving benchmarks. The salary for the project is estimated at \$25,000 Year 1, \$26,500 Year 2, and \$28,090 Year 3; calculated at a 6% increase each year.

Director of Communications will use 20% of her total time on the project to create and direct creation of all content, secure faith community consultant, coordinate with other directors and Project Lead. The salary for the project is estimated at \$24,000 Year 1, \$25,440 Year 2, and \$26,966 Year 3; calculated at a 6% increase each year.

Director of Community Outreach will use 10% of her total time on the project to coordinate and direct all internal and external community outreach activities. The salary for the project is estimated at \$16,000 Year 1, \$16,960 Year 2, and \$17,677 Year 3; calculated at a 6% increase each year.

Maryland Community Health Resource Commission – FY2025 Grant Application Project Proposal

Director of Medical Affairs & Medical Director will use 5% of her total time on the project to oversee and coordinate messaging around medical services and outcomes. The salary for the project is estimated at \$11,250 Year 1, \$11,925 Year 2, and \$12,640 Year 3; calculated at a 6% increase each year.

Director of Quality Assurance will use 5% of his total time on the project to conduct, oversee, and direct data collection and analysis. The salary for the project is estimated at \$6,500 Year 1, \$6,890 Year 2, and \$7,303 Year 3; calculated at a 6% increase each year.

Complete the table below to show the breakout of FTEs by position type, type of support provided to this grant program, and an indication of the number of FTEs already hired and number of FTEs that still need to be hired. Insert additional rows in table as needed.

In Example 1 below, 6 individuals are assumed to work as a Community Health Worker, the position is budgeted for 5 FTEs (i.e., 4 full-time and 2 part-time individuals), and all 6 individuals will provide direct patient care services to the grant program. In Example 2 below, 1 individual is assumed to work as a Program Manager, the position is budgeted for 0.5 FTEs (i.e., 1 part-time), and will provide support to the grant program.

Position Type	Type of Support Provided	Total Program FTEs	FTEs Hired to date	FTEs to be hired
Project Lead	Oversee and coordinate all project activities	.1	.0	0
Director of Communications	Oversee, direct, create, internal and external partner collaborations on all messaging; assist with outreach events	0.5	0.5	0
Director of Community Outreach	Direct Community Outreach	.2	.2	0
Director of Medical Affairs & Medical Director	Internal collaboration on messaging	.05	.05	0
Director of Quality Assurance	Internal coordination of data collection and analysis	.05	.05	0

**Personnel Fringe Benefits**

Provide in the [Schedule 2 CHRC Funding Request Budget Template](#) a fringe benefits amount of up to 25% of overall personnel salaries. The fringe benefits percentage of overall personnel salaries of W-2 employees is automatically calculated on the Budget Template.

If the applicant requests **more than 25% of salary costs for fringe benefits**, the applicant will be required to provide a compelling rationale for exceeding this amount in this **Budget Narrative Template** in the text box below and provide other supporting documentation.

Fringe benefits for all FTEs is calculated at 18%, as reported by XXX's finance and accounting team. XXX is not requesting any fringe benefits be covered by MCHRC grant funding,

**Equipment/Furniture/IT & Telecom/Minor Infrastructure Improvements/Vehicle(s)**

Provide in the **Schedule 2 CHRC Funding Request Budget Template** the applicable line items associated with any Equipment, Furniture, IT & Telecom, Minor Infrastructure Improvements, and/or Vehicle(s) costs (purchase or rental costs not included in indirect costs rate).

Provide in this **Budget Narrative Template** in the text box below a brief description of any Equipment, Furniture, IT & Telecom Renovations, and/or Vehicle(s) costs with an explanation for the use of the item(s) to be purchased with grant funding in support of this project. Expenses budgeted in this category should align to one of the five-line items on the budget template: 1) Equipment, 2) Furniture, 3) IT & Telecom, 4) Minor Infrastructure Improvements, and 5) Vehicle(s).

To help offset IT/telecom needs to produce quality podcasts and videos, XXX is requesting MCHRC grant funding of 80% of the total It/telecom budget line. The request Year 1 = \$4,800, Year 2 = \$3,600, and Year 3 = \$2,400.

XXX does not anticipate any equipment, furniture, minor infrastructure improvements, or vehicles will be required to successfully complete the project.

**Supplies**

Provide in the **Schedule 2 CHRC Funding Request Budget Template** the overall supply costs to be used during the grant period. The supply costs do not need to be listed on separate line items in the Budget Template.

In this **Budget Narrative Template** in the text box below, list out all supply types and related costs and provide an explanation for each supply type.

The Project Lead and other key staff are requesting MCHRC funding of less than 43% of the total supplies line item for each of the three years. \$10,000 Year 1 = less than 43% of the total, \$10,000 Year 2 = less than 41% of the total, and \$10,000 Year 3 = less than 36% of the total.

### **Travel/Mileage/Parking**

Provide in the **Schedule 2 CHRC Funding Request Budget Template** on separate line items the total costs for program participants and for applicant employees.

In this **Budget Narrative Template** in the text below, identify costs and reasons for travel that are applicable to grant specific activities for program participants and employees providing services under the grant (i.e., attending health fairs, community events, services provided under grant etc.).

XXX is requesting no MCHRC grant funding for mileage and parking reimbursements. The total estimated project expenses for mileage and parking reimbursement reflects Year 1 = \$5,700 for patients and \$11,400 for staff totaling \$17,100, Year 2 = \$6,200 for patients and \$12,400 for staff totaling \$18,600, and Year 3 = \$6,700 for patients and \$13,400 for staff totaling \$20,100. These expenses will offset mileage reimbursement at the Federal allowable per mile rate for respective years for community outreach events and activities for patients and/or family members or caregivers as well as XXX staff. This benefits economic factors within social determinants of health for patients and caregivers.

### **Staff Trainings/Development**

Provide in the **Schedule 2 CHRC Funding Request Budget Template**, the overall staff trainings/development costs. These costs do not need to be listed on separate line items in the Budget Template.

In this **Budget Narrative Template** in the text box below, identify the type of training, position types that will receive the training, and costs related to the training. Explain how this training will benefit the project. This category includes travels costs related to employee training including employee certifications required to provide services under the grant and employee travel related costs (lodging, meals, transportation, parking, etc.) to conferences, training sessions, etc. Expenses budgeted in this category **should exclude salaries** paid to employees attending the training, as those amounts **should be included in the Personnel Salary expenses section of the budget**.

XXX is cordially requesting that staff training and development for the three years (estimated at a total of \$60,000) be covered by MCHRC grant funding at 90% each year.

The request for 90% of the total line item is based on the fact that other fundraising campaigns, events, and appeals are not as successful for staff training and development as donors do not grasp the immediate impact of these necessary activities and tend to partner more with contributions for services.

**Contractual**

In the **Schedule 2 CHRC Funding Request Budget Template** on separate line items, list contractual arrangements over \$5,000 and the related costs. For contractual arrangements less than \$5,000, input costs in All Other Contractual Arrangements < \$5K line items. This section should not include W-2 employees of the applicant.

In this **Budget Narrative Template** for each contract more than \$5,000, identify each individual vendor/contractor, the cost of the total contract, and a brief description of what type of service the contract is providing.

Individual Vendor/Contractor	Total Cost	Description of Service Contract Being Provided
<b>Part-time contract faith community liason (40 hrs/mnth x \$40 hr Yrs 1 &amp; 2, 20 hrs/month x \$40 hr Yr 3))</b>	\$48,000 (\$19,200 Yr 1 & 2, (\$9,600 Yr 3)	This role is crucial to creating marketing and services materials that speak to the sensitive or underserved populations with appropriate language and graphics, as well as locations of outreach to maximize connections in these communities. This significantly reduces barriers to prevention and management of chronic disease and communication barriers, directly resulting in positive impacts on at least three determinants of health.
<b>Consultant - community outreach materials development (sensitive populations)</b>	\$91,000 (\$38,000 Yr 1 & 2, \$15,000 Yr 3)	This role is crucial to designing content and graphics for specific populations that are harder to reach through traditional community outreach messaging. This significantly reduces barriers to prevention and management of chronic disease and communication barriers, directly resulting in positive impacts on at least three determinants of health.

XXX is requesting 100% of the contractual expenses to be covered by MCHRC grant funding.

**Program Marketing Related Expenses**

Provide in the **Schedule 2 CHRC Funding Request Budget Template**, the overall program marketing related costs. These costs do not need to be listed on separate line items in the Budget Template.

In this **Budget Narrative Template** in the text box below, list out all marketing related costs (i.e., marketing, advertising, promotional materials/communications/ handouts related to the grant program, etc.) and provide an explanation for each marketing related cost type.

Program marketing is the overarching objective of the project. XXX community outreach efforts must reach the culturally sensitive and underserved residents in our communities. The only option is to speak to these populations - whether one-on-one, in groups, through printed materials, or digital content – by eliminating language barriers and debunking myths about the prevention and management of chronic disease including heart and lung diagnoses, calming fears of the unknown about hospice and palliative care, and correcting the thought that chronic disease care and end-of-life planning is not just for cancer patients.

To achieve the goals and implement tactics necessary to increase prevention and management engagement, quality targeted marketing is vital. Succinct yet educational materials need to be produced and distributed along multi-pronged channels over a strategic timeline, with robust follow-up. Implementing these tactics across the MCHRC and XXX service areas requires funding to develop, and develop right the first time.

XXX is seeking funding support for marketing initiatives at approximately 88% of the total Year 1, 76% of the total Year 2, and 43% of the total Year 3.

The request for significant percentages of each years’ totals for the marketing line item is based on the fact that other fundraising campaigns, events, and appeals are not as successful for staff training and development as donors do not grasp the immediate impact of these necessary activities and tend to partner more with contributions for services.

**Other Expenses**

Provide in the **Schedule 2 CHRC Funding Request Budget Template**, the overall other costs.

In this **Budget Narrative Template** in the text below, identify in sufficient detail any other expenses that do not fit in any of the other direct expense categories outlined above. Expenses associated with employee background checks and finger printing (if applicable) should be included in this category.

XXX is not seeking MCHRC grant funding support for any expenses not fitting into the other categories.

**Indirect Costs**

Indirect costs are for activities or services that may benefit more than one project. **Examples of indirect costs include utilities, insurance, rent, audit and legal expenses, equipment rental, and administrative staff.** The applicant should have internal controls in place to ensure expenses reported in the direct costs categories are not a duplication of reported indirect costs.

Provide in the **Schedule 2 CHRC Funding Request Budget Template** indirect costs amount of up to 15% of overall direct costs. The indirect costs percentage of overall direct costs is automatically calculated on the Budget Template (direct costs = total costs minus indirect costs).

The CHRC will closely examine grant applications for potential duplicate funding, including an assessment of the applicant’s request for indirect costs. Applicants may not request direct funding for any activities that are typically included in the organization’s indirect cost pool/indirect rate. The CHRC will accept an indirect rate of **up to 15%** of direct costs related to the grant program (unless the applicant qualifies for a higher indirect pursuant to Md. Code Ann., State Finance and Procurement § 2-208(c)), while also requiring applicants to describe activities to be covered within their indirect rate.

Please provide in the table below types (dollar breakdown not required) of expenses included in your indirect costs request. **Any Indirect Costs associated with staffing expenses should include the name of the position type.** Insert additional rows in the table as needed.

Administrative Staff positions that are typically included in indirect costs are clerical, accounting, compliance, human resources, general IT, Senior level positions of the organization, (CEO, Executive Director, Medical Director, Operations leader, etc.), etc. **Any Administrative Staff positions not included in the indirect cost rate but are included in the budget as salaries, must perform duties directly required by the grant. Applicant must have controls to document time spent on the grant and the positions should not already be included in the indirect costs.**

**Categories of Indirect Costs (list out position type for staffing costs)**

XXX is not seeking MCHRC grant funds to help offset Indirect Costs associated with this project.

**Individuals to be Served for Overall Grant Period**

Provide in the **Schedule 2 CHRC Funding Request Budget Template** the overall unduplicated individuals to be served (new patients only) under this CHRC grant program. **There is no action on your part to input the total cost per unduplicated individuals to be served. This will automatically be calculated in the budget template.**

Provide in the **Schedule 2 CHRC Funding Request Budget Template** the overall number of existing patients to be served (existing patients receiving new services) under this CHRC grant program. **There is no action on your part to input the total cost per existing patients to be served (existing patients receiving new services). This will automatically be calculated in the budget template.**

**There is no action on your part to input the overall number of new and existing patients to be served and the total cost per overall number of new and existing patients to be served. This will automatically be calculated in the budget template.**



## LOGIC MODEL – FY 2025 CALL FOR PROPOSALS

Organization name: XXXXXXXX xx xxx XXXXXXXXXXX (XXX)

Program name: Addressing Chronic Disease (Heart and Lung Diseases) through Expanded Targeted Community Outreach and Services

Amount requested: \$571,300.00

Area of focus: Addressing Chronic Disease Prevention and Management

<b>INPUTS▶</b>	<b>ACTIVITIES▶</b>	<b>OUTPUTS▶</b>	<b>SHORT- &amp; LONG-TERM OUTCOMES▶</b>	<b>IMPACT</b>
To accomplish the activities listed we will need the following: (e.g., staff, equipment, partner organization participation)	To address our problem or asset we will accomplish the following activities:	We expect that once accomplished these activities will produce the following evidence or service delivery:	We expect that if accomplished these activities will lead to the following measurable changes in 1-3 years:	We expect that if accomplished these activities will lead to the following changes in 5 years:
<i>Project Lead; Chief Medical Officer; Directors of Community Outreach, Communications, Quality Assurance; Board of Directors; Advisory Committees Organizational Leadership; Staff; volunteers (optional)</i>	<i>Catalyze and support community outreach to actively and effectively address chronic disease (cardiac and lung) prevention and management in meaningful ways throughout the communities XXX serves; improve community outreach and quality to inform programs and initiatives in chronic disease prevention and management</i>	<i>Residents (patient, caregivers, family members) and partner development/brokering; consultation support from faith and community leaders to reach sensitive populations; staff and partner education and training</i>	<i>Comprehensive education, outreach, and training to address chronic disease prevention and management (internally and externally) to effect long-term care where patients call home, as well as funding assistance for the project.</i>	<i>Better informed residents, especially sensitive populations, because of targeted materials and events, reaching populations who traditionally shun or avoid conversations around life-limiting illness and end-of-life services.</i>
Director of Community Outreach; Project Lead; technology	Community Outreach – Item A	Produce (separate) heart and lung disease prevention and management podcasts, quarterly Year 1, monthly years 2 & 3	General and targeted resident audiences throughout the community will benefit by being able to make informed decisions about their own care or that of a loved one diagnosed with heart and/or lung disease. Community and professional partners will gain valuable tools for working with XXX and within the community. These benefits will	Sustained cost-savings and patient/caregiver supports, as well as staff development, positively impact these determinants of health:  *Economic stability for families and healthcare providers *Access to quality and reliable healthcare education for the prevention and management of chronic diseases and related information for comorbidities



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To accomplish the activities listed we will need the following: (e.g., staff, equipment, partner organization participation)	To address our problem or asset we will accomplish the following activities:	We expect that once accomplished these activities will produce the following evidence or service delivery:	We expect that if accomplished these activities will lead to the following measurable changes in 1-3 years:  result in improved care, and cost-efficiencies for patients, caregivers, family members, and service providers.	We expect that if accomplished these activities will lead to the following changes in 5 years:  *Access to high-quality healthcare *Economic stability boosts local, regional, and state economies *Underserved and sensitive populations are provided crucial disease and services information by trusted community partners/faith leaders in their neighborhoods
Administrative support from Community Outreach and Communications Teams; supplies; volunteer support (optional)	Community Outreach – Item B	Print and distribute at least 1000 XXX branded copies each of Years 1, 2, & 3: National Partnership of Healthcare and Hospice Innovation (NPHI) Patient and Caregiver Guide	General and targeted resident audiences throughout the community will benefit by being able to make informed decisions about their own care or that of a loved one diagnosed with heart and/or lung disease. Community and professional partners will gain valuable tools for working with XXX and within the community. These benefits will result in improved care, and cost-efficiencies for patients, caregivers, family members, and service providers.	Sustained cost-savings and patient/caregiver supports, as well as staff development, positively impact these determinants of health:  *Economic stability for families and healthcare providers *Access to quality and reliable healthcare education for the prevention and management of chronic diseases and related information for comorbidities *Access to high-quality healthcare *Economic stability boosts local, regional, and state economies



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<p>To accomplish the activities listed we will need the following: (e.g., staff, equipment, partner organization participation)</p>	<p>To address our problem or asset we will accomplish the following activities:</p>	<p>We expect that once accomplished these activities will produce the following evidence or service delivery:</p>	<p>We expect that if accomplished these activities will lead to the following measurable changes in 1-3 years:</p>	<p>We expect that if accomplished these activities will lead to the following changes in 5 years:</p> <ul style="list-style-type: none"> <li>*Underserved and sensitive populations are provided crucial disease and services information by trusted community partners/faith leaders in their neighborhoods</li> </ul>
<p>Director of Community Outreach; Project Lead; technology; administrative support from Community Outreach and Communications Teams; supplies; volunteer support (optional)</p>	<p>Community Outreach – Item C</p>	<p>Produce and post monthly videos for social media for cardiac and lung disease prevention and/or management for local and/or targeted audiences, Years 1, 2, &amp; 3</p>	<p>General and targeted resident audiences throughout the community will benefit by being able to make informed decisions about their own care or that of a loved one diagnosed with heart and/or lung disease. Community and professional partners will gain valuable tools for working with XXX and within the community. These benefits will result in improved care, and cost-efficiencies for patients, caregivers, family members, and service providers.</p>	<p>Sustained cost-savings and patient/caregiver supports, as well as staff development, positively impact these determinants of health:</p> <ul style="list-style-type: none"> <li>*Economic stability for families and healthcare providers</li> <li>*Access to quality and reliable healthcare education for the prevention and management of chronic diseases and related information for comorbidities</li> <li>*Access to high-quality healthcare</li> <li>*Economic stability boosts local, regional, and state economies</li> <li>*Underserved and sensitive populations are provided crucial</li> </ul>



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To accomplish the activities listed we will need the following: (e.g., staff, equipment, partner organization participation)	To address our problem or asset we will accomplish the following activities:	We expect that once accomplished these activities will produce the following evidence or service delivery:	We expect that if accomplished these activities will lead to the following measurable changes in 1-3 years:	We expect that if accomplished these activities will lead to the following changes in 5 years: disease and services information by trusted community partners/faith leaders in their neighborhoods
Directors of Community Outreach, Education, and Communications; Project Lead; part-time faith consultant	Community Outreach – Item D	Under the consultancy of faith leader(s), develop marketing content for targeted underserved and/or sensitive groups/residents to ensure saturation of community awareness of cardiac and lung disease prevention and management	<p><b>SENSITIVE POPULATIONS WILL HAVE UNDERSTANDABLE, TRUSTED INFORMATION AND ENGAGEMENT.</b></p> <p>General and targeted resident audiences throughout the community will benefit by being able to make informed decisions about their own care or that of a loved one diagnosed with heart and/or lung disease. Community and professional partners will gain valuable tools for working with XXX and within the community. These benefits will result in improved care, and cost-efficiencies for patients,</p>	<p>Sustained cost-savings and patient/caregiver supports, as well as staff development, positively impact these determinants of health:</p> <ul style="list-style-type: none"> <li>*Economic stability for families and healthcare providers</li> <li>*Access to quality and reliable healthcare education for the prevention and management of chronic diseases and related information for comorbidities</li> <li>*Access to high-quality healthcare</li> <li>*Economic stability boosts local, regional, and state economies</li> <li>*Underserved and sensitive populations are provided crucial disease and services information by trusted community</li> </ul>



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To accomplish the activities listed we will need the following: (e.g., staff, equipment, partner organization participation)	To address our problem or asset we will accomplish the following activities:	We expect that once accomplished these activities will produce the following evidence or service delivery:	We expect that if accomplished these activities will lead to the following measurable changes in 1-3 years: caregivers, family members, and service providers.	We expect that if accomplished these activities will lead to the following changes in 5 years: partners/faith leaders in their neighborhoods
Director of Community Outreach and Team; Business Development team (optional); supplies	Community Outreach – Item E	Attend at least six (6) community events during each of Years 1, 2, & 3 to engage the community and increase awareness of cardiac and lung disease prevention and awareness with printed materials and/or one-on-one engagement	General and targeted resident audiences throughout the community will benefit by being able to make informed decisions about their own care or that of a loved one diagnosed with heart and/or lung disease. Community and professional partners will gain valuable tools for working with XXX and within the community. These benefits will result in improved care, and cost-efficiencies for patients, caregivers, family members, and service providers.	Sustained cost-savings and patient/caregiver supports, as well as staff development, positively impact these determinants of health: *Economic stability for families and healthcare providers *Access to quality and reliable healthcare education for the prevention and management of chronic diseases and related information for comorbidities *Access to high-quality healthcare *Economic stability boosts local, regional, and state economies *Underserved and sensitive populations are provided crucial disease and services information by trusted community partners/faith leaders in their neighborhoods



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To accomplish the activities listed we will need the following: (e.g., staff, equipment, partner organization participation)	To address our problem or asset we will accomplish the following activities:	We expect that once accomplished these activities will produce the following evidence or service delivery:	We expect that if accomplished these activities will lead to the following measurable changes in 1-3 years:	We expect that if accomplished these activities will lead to the following changes in 5 years:
Director of Community Outreach and Team; part-time faith consultant; Business Development team (optional); volunteers (optional); mileage and parking reimbursement; supplies	Community Outreach – Item F	Attend at least eight (8) community events during each of Years 1, 2, & 3 to engage SPECIFIC and targeted underserved and/or sensitive population and increase awareness of cardiac and lung disease prevention and awareness with printed materials and/or one-on-one engagement	General and targeted resident audiences throughout the community will benefit by being able to make informed decisions about their own care or that of a loved one diagnosed with heart and/or lung disease. Community and professional partners will gain valuable tools for working with XXX and within the community. These benefits will result in improved care, and cost-efficiencies for patients, caregivers, family members, and service providers.	Sustained cost-savings and patient/caregiver supports, as well as staff development, positively impact these determinants of health: *Economic stability for families and healthcare providers *Access to quality and reliable healthcare education for the prevention and management of chronic diseases and related information for comorbidities *Access to high-quality healthcare *Economic stability boosts local, regional, and state economies *Underserved and sensitive populations are provided crucial disease and services information by trusted community partners/faith leaders in their neighborhoods
Chief Medical Officer; Project Lead; Directors of Education and	Community Outreach – Item G	Develop and provide XXX-specific education events and/or	Increase XXX's capacity to serve and grow cardiac and lung	Increased capacity positively the scaling up of services, numbers



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<p>To accomplish the activities listed we will need the following: (e.g., staff, equipment, partner organization participation) Community Outreach; Business Development (optional)</p>	<p>To address our problem or asset we will accomplish the following activities:</p>	<p>We expect that once accomplished these activities will produce the following evidence or service delivery: curriculum for community and medical professional partners, including approved professional develop-related credits focusing on chronic disease prevention and management – at least 2 in Year 1, 4 each of Years 2 &amp; 3</p>	<p>We expect that if accomplished these activities will lead to the following measurable changes in 1-3 years: disease care for underserved communities through new partnerships, sustained partnerships, value-adds for partners</p>	<p>We expect that if accomplished these activities will lead to the following changes in 5 years: of community members reached, and partnerships strengthened</p>
<p>Project Lead; Director of Chesapeake Life Center and team; supplies; mileage and parking reimbursement; volunteers (optional)</p>	<p>Community Outreach – Item H</p>	<p>Caregiver support events – multiple educational and self-care activities throughout Years 1, 2, &amp; 3</p>	<p>Increased caregiver supports, in the short- and mid-term addresses many social determinants of health: *Reduce stress *Help eliminate financial burdens for patients, caregivers, and family members *Sustain and improve familial and social relationships *Improves and sustains their loved one's access to high-quality healthcare and related services</p>	<p>Increased caregiver supports, in the long-term, addresses many social determinants of health: *Reduce stress *Help eliminate financial burdens for patients, caregivers, and family members, boosting local, regional, and state economies *Sustain and improve familial and social relationships *Improves and sustains their loved one's access to high-quality healthcare and related services</p>



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To accomplish the activities listed we will need the following: (e.g., staff, equipment, partner organization participation)	To address our problem or asset we will accomplish the following activities:	We expect that once accomplished these activities will produce the following evidence or service delivery:	We expect that if accomplished these activities will lead to the following measurable changes in 1-3 years:	We expect that if accomplished these activities will lead to the following changes in 5 years:
Directors of Communications and Community Outreach and teams; technology	Community Outreach – Item I	Consistently and regularly utilize social media platforms (3-4 monthly posts per platform) during Years 1, 2, & 3 to inform patients, caregivers, family members, and the community about chronic disease prevention and management	General and targeted resident audiences throughout the community will benefit by being able to make informed decisions about their own care or that of a loved one diagnosed with heart and/or lung disease. Community and professional partners will gain valuable tools for working with XXX and within the community. These benefits will result in improved care, and cost-efficiencies for patients, caregivers, family members, and service providers.	Sustained cost-savings and patient/caregiver supports, as well as staff development, positively impact these determinants of health: *Economic stability for families and healthcare providers *Access to quality and reliable healthcare education for the prevention and management of chronic diseases and related information for comorbidities *Access to high-quality healthcare *Economic stability boosts local, regional, and state economies *Underserved and sensitive populations are provided crucial disease and services information by trusted community partners/faith leaders in their neighborhoods
Director of Communications; Chief Medical Officer; technology	Community Outreach – Item J	During Year 1, develop a cardiac and lung disease prevention and	General and targeted resident audiences throughout the	Sustained cost-savings and patient/caregiver supports, as



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<p>To accomplish the activities listed we will need the following: (e.g., staff, equipment, partner organization participation)</p>	<p>To address our problem or asset we will accomplish the following activities:</p>	<p>We expect that once accomplished these activities will produce the following evidence or service delivery: management page on XXX's website, including resources</p>	<p>We expect that if accomplished these activities will lead to the following measurable changes in 1-3 years: community will benefit by being able to make informed decisions about their own care or that of a loved one diagnosed with heart and/or lung disease. Community and professional partners will gain valuable tools for working with XXX and within the community. These benefits will result in improved care, and cost-efficiencies for patients, caregivers, family members, and service providers.</p>	<p>We expect that if accomplished these activities will lead to the following changes in 5 years: well as staff development, positively impact these determinants of health: *Economic stability for families and healthcare providers *Access to quality and reliable healthcare education for the prevention and management of chronic diseases and related information for comorbidities *Access to high-quality healthcare *Economic stability boosts local, regional, and state economies *Underserved and sensitive populations are provided crucial disease and services information by trusted community partners/faith leaders in their neighborhoods</p>
<p>Director of Quality Assurance; Project Lead; Director of Community Outreach</p>	<p>Community Outreach – Item K</p>	<p>Consistently and regularly track and evaluate focused community outreach activities for chronic disease prevention and management within XXX</p>	<p>Ensure the systematic collection and analysis of information about the project to generate credible information used to make decisions about the project to</p>	<p>Comprehensive data collection and analysis contribute to the success of the project, ensure maximum capacity is utilized internally and externally, and</p>



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<b>INPUTS▶</b>	<b>ACTIVITIES▶</b>	<b>OUTPUTS▶</b>	<b>SHORT- &amp; LONG-TERM OUTCOMES▶</b>	<b>IMPACT</b>
To accomplish the activities listed we will need the following: (e.g., staff, equipment, partner organization participation)	To address our problem or asset we will accomplish the following activities:	We expect that once accomplished these activities will produce the following evidence or service delivery: operations quarterly in Years 1, 2, & 3, including community and partner feedback	We expect that if accomplished these activities will lead to the following measurable changes in 1-3 years: evaluate success, make necessary adjustments, and create sustainability	We expect that if accomplished these activities will lead to the following changes in 5 years: develop transparency and trust with funders, partners, and the community
Chief Medical Officer; Directors of Education, Community Outreach, and Quality Assurance; Project Lead	Community Outreach – Item L	To better serve the communities, ongoing staff training and education for chronic disease (cardiac and lung) prevention and management will be conducted at least quarterly and as needed throughout Years 1, 2, & 3	Internal professional development is crucial to high-quality medical care. It reduces staff turnover, increases organizational capacity, instills trust throughout the community, and creates cost efficiencies for the healthcare provider.	Internal professional development is crucial to high-quality medical care. It reduces staff turnover, increases organizational capacity, instills trust throughout the community, and creates cost-efficiencies for the healthcare provider, contributing to resident employees remaining in the community, a sustained workforce, and ongoing high-quality healthcare, all vital to growing and thriving communities.

# MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION - RFA FY 2025 Work Plan Template



**Organization Name:** XXXXXXXX XX XXX XXXXXXXXXXXX

**Project Name:** Addressing Chronic Disease (Heart and Lung Diseases) through Expanded Targeted Community Outreach and Services

**Project Purpose:** XXXXXXXX XX XXX XXXXXXXXXXXX seeks to significantly increase the number of residents accessing high-quality information and care for chronic heart and lung disease diagnoses, focusing on sensitive and/or underserved populations through comprehensive, multi-pronged community outreach.

1. **GOAL:** A measurable, expected project outcome (i.e., what the project seeks to achieve in each operational area of the project plan).
2. **OBJECTIVE:** What needs to be achieved to attain the goal.
3. **KEY ACTIVITIES/ACTION STEPS:** These are the measurable ways the project will achieve the corresponding objective(s). **NOTE: CHRC recommends using the S.M.A.R.T. tool to formulate Goals and Objectives.**
4. **EXPECTED OUTCOME (TARGET):** These are the measures of what is expected to occur to demonstrate that the objective is achieved (i.e., your measure of success).
5. **DATA EVALUATION AND MEASUREMENT:** How will progress towards achieving the goal be measured?
6. **DATA SOURCE(S) AND BASELINE MEASURES:** What data and/or other information will demonstrate that the objective and goal are achieved?

**(1) GOAL: Identify and prioritize populations for targeted community outreach, including sensitive and/or underserved populations in the XXX's service area.**

Objective(s)	Key Activities/Action Steps	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	Person/Group Responsible	Timetable for Achieving the Objective
<i>List objective(s), one per line, that when achieved will attain the goal.</i>	<i>Define all actions/steps necessary to achieve the objective. List each activity/action step on its own row.</i>	<i>Define an outcome for each activity/action step</i>	<i>Identify the process and measure(s) to be used to determine if the outcome has been achieved.</i>	<i>Define where the data will come and what baseline data will be used to measure change.</i>	<i>Identify the person(s) and/or organization(s) primarily responsible</i>	<i>When will the activity/action step be completed?</i>
Identify and prioritize populations for community outreach, including sensitive and/or underserved populations.	Analyze historical and current internal and external data to identify groups and geographical areas in which community outreach will be expanded or launched.	Provide quantitative data for anticipated population, neighborhood, congregant, or region size. Quantify all qualitative data possible. (Ex. numbers in age groups, ranges of age groups, numbers of heart and/or lung disease diagnoses, anticipated number of participants, total population of targeted constituency)	All appropriate data categories will be assigned to project staff to ensure comprehensive baseline information is recorded for successful analysis throughout the project.	The baseline data will be collected from historical internal sources and obtained from recent external studies, and reports from local, state, and federal entities. Comparisons of the baseline data, participation, attendance, feedback, and more will determine the scale and scope of change (e.g., increases in specific census data, increases in sensitive population engagement, etc.)	Directors of Quality Assurance, Accounting and Finance (census tracking); Project Lead	This activity will be completed within the first year of the funding period.
	Develop a timeline for the identified groups and geographical areas for expansion or launch of community outreach activities.	Develop an estimated timeline for Years 1, 2, & 3 to initiative and reevaluate this data.	Key staff and partners develop the timeline by the assigned date.	The baseline data will be the timeline confirmed on the project and organizational calendars, with progress and completion being monitored to ensure ongoing success.	Project Lead, Directors of Community Outreach and Communications	This activity will be completed within the first month of the funding period.

**(2) GOAL: Develop marketing materials for the newly identified populations or those not previously targeted with language- and semantic-appropriate content and design.**

Objective(s)	Key Activities/Action Steps	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	Person/Group Responsible	Timetable for Achieving the Objective
<i>List objective(s), one per line, that when achieved will attain the goal.</i>	<i>Define all actions/steps necessary to achieve the objective. List each activity/action step on its own row.</i>	<i>Define an outcome for each activity/action step</i>	<i>Identify the process and measure(s) to be used to determine if the outcome has been achieved.</i>	<i>Define where the data will come and what baseline data will be used to measure change.</i>	<i>Identify the person(s) and/or organization(s) primarily responsible</i>	<i>When will the activity/action step be completed?</i>
Create an inventory of current and desired marketing materials best suited for the identified groups and geographical areas in Goal 1.	List all current content that can be repurposed for this project; list and describe all new content that needs created.	Determine what the scope of what needs to be created to estimate when new materials will be ready for launch and tentatively outline event and activity calendars.	A comparison of all materials needed will verify those needing to be created while helping to set reasonable creation deadlines.	Each new material will be assigned a deadline and progress tracked to completion; the same process will ensure the editing of existing documents is completed on time.	Project Lead, Directors of Community Outreach and Communications, faith community (sensitive populations) liaison(s)	All existing content will be edited, and initial new content will be created by the end of the third month of the funding period.
Develop sensitive population-focused marketing materials that do not already exist in the inventory.	Design and create content for all new marketing materials; edit existing marketing materials.	Determine what the scope of what needs to be created to estimate when new materials will be ready for launch and tentatively outline event and activity calendars.	A comparison of all materials needed will verify those needing to be created while helping to set reasonable creation deadlines.	Each new material will be assigned a deadline and progress tracked to completion; the same process will ensure the editing of existing documents is completed on time.	Project Lead, Directors of Community Outreach and Communications, faith community (sensitive populations) liaison(s)	All existing content will be edited, and initial new content will be created by the end of the third month of the funding period.

**Organization Name:** XXXXXXXX XX XXX XXXXXXXXXXXX

**Project Name:** Addressing Chronic Disease (Heart and Lung Diseases) through Expanded Targeted Community Outreach and Services

**Project Purpose:** XXXXXXXX XX XXX XXXXXXXXXXXX seeks to significantly increase the number of residents accessing high-quality information and care for chronic heart and lung disease diagnoses, focusing on sensitive and/or underserved populations through comprehensive, multi-pronged community outreach.



1. **GOAL:** A measurable, expected project outcome (i.e., what the project seeks to achieve in each operational area of the project plan).
2. **OBJECTIVE:** What needs to be achieved to attain the goal.
3. **KEY ACTIVITIES/ACTION STEPS:** These are the measurable ways the project will achieve the corresponding objective(s). **NOTE: CHRC recommends using the S.M.A.R.T. tool to formulate Goals and Objectives.**
4. **EXPECTED OUTCOME (TARGET):** These are the measures of what is expected to occur to demonstrate that the objective is achieved (i.e., your measure of success).
5. **DATA EVALUATION AND MEASUREMENT:** How will progress towards achieving the goal be measured?
6. **DATA SOURCE(S) AND BASELINE MEASURES:** What data and/or other information will demonstrate that the objective and goal are achieved?

**(3) GOAL: Develop and launch a comprehensive community outreach agenda, including anticipated audiences, resources, and communications vehicles/platforms.**

Objective(s)	Key Activities/Action Steps	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	Person/Group Responsible	Timetable for Achieving the Objective
<i>List objective(s), one per line, that when achieved will attain the goal.</i>	<i>Define all actions/steps necessary to achieve the objective. List each activity/action step on its own row.</i>	<i>Define an outcome for each activity/action step</i>	<i>Identify the process and measure(s) to be used to determine if the outcome has been achieved.</i>	<i>Define where the data will come and what baseline data will be used to measure change.</i>	<i>Identify the person(s) and/or organization(s) primarily responsible</i>	<i>When will the activity/action step be completed?</i>
Confirm a variety of community outreach events and activities appropriate for the target populations, ensuring saturation service areas.	List all possible types of events appropriate for project, along with (desired) dates and locations.	Proven by and for planning purposes, compile an inventory of community and partner events at which community outreach for this project may be conducted, as well as identify internal and fundraising events appropriate for this project's outreach.	A quarterly review of event and activity opportunities that were attended, are registered for, and newly identified opportunities will be conducted.	The original list will be the baseline for all community and partner activities and events for outreach opportunities.	Project Lead, Directors of Communications, Quality Assurance, and Community Outreach, Chief Medical Officer; volunteers (optional)	The quarterly review ensures all appropriate events and activities are included in the XXX outreach initiatives.

**(4) GOAL: Consistently and regularly track and evaluate qualitative and quantitative feedback and data on participation.**

Objective(s)	Key Activities/Action Steps	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	Person/Group Responsible	Timetable for Achieving the Objective
<i>List objective(s), one per line, that when achieved will attain the goal.</i>	<i>Define all actions/steps necessary to achieve the objective. List each activity/action step on its own row.</i>	<i>Define an outcome for each activity/action step</i>	<i>Identify the process and measure(s) to be used to determine if the outcome has been achieved.</i>	<i>Define where the data will come and what baseline data will be used to measure change.</i>	<i>Identify the person(s) and/or organization(s) primarily responsible</i>	<i>When will the activity/action step be completed?</i>
Ensure all project goals and objectives are being met and/or are on schedule.	Identify overarching goals and objectives as well as all requirements in funding agreements.	All internal and external expectations and requirements are met in a timely manner.	Consistent and regular review and analysis of project description, data on completed tasks, and qualitative feedback	The baseline is the original project description of goals and objectives, anticipated activities, and engagement of partners and staff.	Project Lead, Director of Quality Assurance	All stated and agreed upon goals will be met on or before the expected deadlines during Years 1, 2, & 3
Ensure any pivots that need to be made during the funding period are accommodated.	Identify overarching goals and objectives as well as all requirements in funding agreements.	All internal and external expectations and requirements are met in a timely manner, accomplishing such with any necessary project adjustments.	Consistent and regular review and analysis of project description, data on completed tasks, and qualitative feedback	The baseline is the original project description of goals and objectives, anticipated activities, and engagement of partners and staff.	Project Lead, Director of Quality Assurance	All stated and agreed upon goals will be met on or before the expected deadlines during Years 1, 2, & 3

**(5) GOAL: Produce podcast(s) and videos for social media platforms for community outreach and educational purposes.**

Objective(s)	Key Activities/Action Steps	Expected Outcome (TARGET)	Data Evaluation and Measurement	Data Source(s) and Baseline Measures	Person/Group Responsible	Timetable for Achieving the Objective
<i>List objective(s), one per line, that when achieved will attain the goal.</i>	<i>Define all actions/steps necessary to achieve the objective. List each activity/action step on its own row.</i>	<i>Define an outcome for each activity/action step</i>	<i>Identify the process and measure(s) to be used to determine if the outcome has been achieved.</i>	<i>Define where the data will come and what baseline data will be used to measure change.</i>	<i>Identify the person(s) and/or organization(s) primarily responsible</i>	<i>When will the activity/action step be completed?</i>
Produce podcasts with aligned guests for educational and engagement purposes of sensitive and/or underserved populations.	Produce podcasts with aligned guests for educational and engagement purposes of sensitive and/or underserved populations.	Significantly increased engagement throughout targeted populations; scaled up partnerships	Comparison of expected percentages of increase to actuals through qualitative and quantitative data	The baseline in the original and/or updated expected increases in engagement.	Project Lead, Director of Quality Assurance	All stated and agreed upon goals will be met on or before the expected deadlines during Years 1, 2, & 3
Produce videos for educational and engagement purposes of sensitive and/or underserved populations.	Produce videos for educational and engagement purposes of sensitive and/or underserved populations.	Significantly increased engagement throughout targeted populations; scaled up partnerships	Comparison of expected percentages of increase to actuals through qualitative and quantitative data	The baseline in the original and/or updated expected increases in engagement.	Project Lead, Director of Quality Assurance	All stated and agreed upon goals will be met on or before the expected deadlines during Years 1, 2, & 3



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Organization Information

1. LEGAL NAME OF ORGANIZATION

[Redacted]

2. ADDRESS

[Redacted]  
Waldorf, Maryland 20603  
United States

3. ORGANIZATION EMAIL

info@[Redacted].org

4. ORGANIZATION PHONE

(301) [Redacted]

5. WEBSITE

https://www.[Redacted].org/

6. EIN #

52-[Redacted]

7. YEAR ORGANIZATION WAS ESTABLISHED

1983

8. PLEASE SELECT THE YEARS YOU HAVE RECEIVED PRIOR GRANTS FROM CHARLES COUNTY CHARITABLE TRUST.

- FY24 Grant Amount
- FY24 Purpose (30 word limit)
- FY23 Grant Amount
- FY23 Purpose (30 word limit)
- FY22 Grant Amount
- FY22 Purpose (30 word limit)

FY24 GRANT AMOUNT

20000

FY24 PURPOSE (30 WORD LIMIT)

Grief, Greenery, and Gardens funding supported expanding and retooling grief and bereavement services for all Charles County residents experiencing the loss of a loved one.

FY23 GRANT AMOUNT

50000

FY23 PURPOSE (30 WORD LIMIT)

Addressing the unmet health care needs of the growing Charles County population by expanding hospice care, support services, and introducing palliative care for our community.

FY22 GRANT AMOUNT

40000

FY22 PURPOSE (30 WORD LIMIT)

Addressing the unmet health care needs of the growing Charles County population by expanding hospice care, support

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services, and introducing palliative care for our community.

9. PLEASE SELECT THE YEARS YOU HAVE RECEIVED GRANTS OR FUNDING DIRECTLY FROM CHARLES COUNTY GOVERNMENT, IN ADDITION TO OR INSTEAD OF GRANTS FROM THE CHARLES COUNTY CHARITABLE TRUST.

10. UPLOAD YOUR IRS 501(C)(3) DETERMINATION LETTER (PDF FORMAT)

- [IRS-Determination-Letter-HOC-combined-letters.pdf](#)

11. ORGANIZATION RESUME

[REDACTED] ([REDACTED]) is a community-based 501(c)(3) nonprofit with a mission to provide compassionate hospice and supportive care for individuals who are living with advanced, life-limiting illnesses. We also provide support services for families, caregivers, and additional community members who are grieving a loss. Opening in 1983 as an all-volunteer organization, [REDACTED] has evolved as a professionally led and trusted provider serving any county resident in need of care, regardless of age, race, religion, gender, sexual orientation, diagnosis, or inability to pay.

The affiliation with [REDACTED], since its Autumn 2020 acquisition, brought an investment of resources that positions [REDACTED] for significant expansion in our community. The impact of our growing capacity is already demonstrated by a 44% increase in hospice patients. Additional accomplishments include:

- Census increased to 662 hospice patients in 2023
- Addition of key clinical staff to support expanded/new services was part of employing 47 full-time staff
- Expanded provider partnerships, including University of Maryland Charles County Regional Medical Center and Sagepoint Senior Living
- Renovations to HOCC headquarters improving the inpatient care center, adding a new Supportive Care outpatient clinic, and creating bereavement counseling space
- Strengthened and expanded community/professional education via social media, Webex meetings for community groups including "Grief and Veterans" for vet centers throughout MD/DC area, sessions for County schools' guidance counselors on children/teens' grief
- Educational presentations reaching over 665 County residents employed at Federal agencies, including Andrews AFB, Dept. of Agriculture, and Pentagon
- Monthly bereavement support group series provided in assisted living facilities, and educational presentations to area churches on grief and loss support
- Developed state-of-the-art skills training lab for clinical staff

As part of Hospice of the Chesapeake's family, HOCC has been selected as part of the federal CMS GUIDE Model Program, an

12. NUMBER OF FULL-TIME STAFF

47

13. NUMBER OF PART-TIME STAFF

13

14. NUMBER OF VOLUNTEERS, INCLUDING BOARD MEMBERS

91

IS THIS NUMBER AN ESTIMATE?

No

15. NUMBER OF VOLUNTEER HOURS IN THE MOST RECENT FISCAL YEAR

1916

IS THIS NUMBER AN ESTIMATE?

No

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16. BOARD OF DIRECTORS, TITLES, AND AFFILIATIONS OR FORMER AFFILIATIONS (PDF FORMAT)

- [REDACTED]-Fdn-Boards-of-Directors-FY2024.pdf

17. PURPOSE OF PROPOSED PROGRAM (30 WORD LIMIT)

Healthcaring: Care Collaboration for Patients, Caregivers, Family Members, and the Community with a focus on expanded dementia initiatives and increased services to assist caregivers

18. NUMBER OF INDIVIDUALS TO BE SERVED IN CHARLES COUNTY

2285

IF YOU ENTERED ZERO, PLEASE PROVIDE AN EXPLANATION (30 WORD LIMIT)

N/A

19. AMOUNT OF GRANT REQUEST (MAX. \$65,000)

65000

20. PROGRAM SUMMARY

Healthcaring is not just a concept. [REDACTED] ([REDACTED]) implements a spectrum of hospice and supportive care, including dementia services for patients and caregivers. [REDACTED] continues to expand innovations along our continuum of healthcaring through augmented convenience, greater efficiencies, diversity of services provided, and targeted memory care programs that include community outreach. A crucial component of healthcaring also includes recruiting and retaining the most experienced and dedicated workforce through competitive wages, innovative benefits, and state-of-the-art simulated training labs.

Conveniently located in Waldorf for all residents of Charles County, the [REDACTED] ([REDACTED]) inpatient facility and grounds provide state-of-the-art care for patients and community outreach space. Because navigating the journey of life-limiting illness is multi-pronged, the scope of services for this grant includes: 1) older adults living with advanced, chronic health conditions, multiple comorbidities, or with a diagnosis of a life-limiting illness, 2) their family members and caregivers, 3) older adults throughout our community who are grieving the loss of a loved one and in need of support, and 4) enhanced capacity to provide dementia-focused care, including training for [REDACTED] staff, patient families, and caregivers. Many whom we serve in all (including) rural communities in Charles County often require customization of care, translation services for care visits, discussions about their health, and other accommodations. Valuable funds will support those who are un/underinsured and cannot afford the total cost of care or services, as well as required services that exceed the level of Medicare reimbursement. As part of [REDACTED]'s family, [REDACTED] has been selected as part of the federal CMS GUIDE Model Program, an eight-year program for dementia care, including a significant focus on caregivers to reduce caregiver fatigue and reduce costs of care.

Many of these individuals living in Charles County can benefit from the reduced symptoms and increased comfort, safety, and resilience offered by “whole person” hospice, supportive, and dementia care, as with [REDACTED]'s healthcaring services.

21. NEED

Across Maryland, older adults represent the fastest-growing segment of the population. Ensuring their quality of life is essential not only to individual wellbeing, but also to the long-term sustainability of our healthcare systems and the strength of local and regional economies. Expanding access to high-quality, patient-centered care is critical to supporting healthy aging and maintaining vibrant, economically resilient communities. Maryland's State Plan on Aging projects that Maryland will have over 1.6 million individuals aged 60+ by 2030. This age group is steadily increasing its share of the region's total population. Currently, over half of this population is living longer with the disabling symptoms of advanced disease and late-stage illness, resulting in reduced quality of life for many. As medicine continues to advance, extending life expectancy for this age group, there is an ongoing need for increased caregiving, long-term services, and improved

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management of chronic disease and illness. [REDACTED]'s healthcaring ingenuities focus on improving access to and quality of care, education, training, and support services.

The impacts of life-limiting illness and dementia elude few families in Charles County. Dementia is a leading cause of death in the US, with Maryland leading the country in new dementia diagnoses (per capita), and even more significantly in our service area. [REDACTED] understands it is crucial that patients and unpaid caregivers have access to quality, multi-faceted, ongoing support beginning with the diagnosis through end-of-life planning. Recently, Johns Hopkins University researchers found that a staggering 97% to 99% of patients and caregivers have unmet dementia-related care needs. Although the research and evidence are scalable across the country, it is noteworthy that the research was conducted with constituents in our region.

## 22. OBJECTIVES AND OUTCOMES

Our primary goals include:

1. Provide comprehensive hospice care and supportive services for older adults and their families and caregivers who are in need, including those unable to pay
2. Continue and expand telehealth and other innovations of care for convenience and efficiencies of care
3. Expand and strengthen provider and residential facility partnerships
4. Implement short- and long-term strategies to address systemic staffing challenges
5. Maintain service procedures and resources to comply with COVID-19 regulations and guidelines
6. Implement dementia program in all four (4) counties of our service area

Anticipated outcomes and results include:

1. Improved management of symptoms, increased comfort for patients over a longer period
2. Increased access to hospice care for underserved seniors in all geographical areas of service
3. Increased access to supportive services) for more seniors
4. Improved care management and quality of life for those needing primary care services
5. Increased access to clinical care and supportive services, including bereavement support, for those who cannot pay the full cost of care
6. Improved efficiency of services and greater convenience through telehealth and virtual engagement opportunities
7. Provide comprehensive dementia training through the Dementia Live resource
8. Provide caregiver support for family members with loved ones in HOCC care, as well as family members with patients living in assisted care facilities.
9. Create community outreach focused on living with and caring for loved ones with dementia, including developing end-of-life and dementia care training program

## 23. PARTNERSHIPS

This broad effort addressing hospice, supportive, dementia, and bereavement healthcaring throughout Charles County will be facilitated through our network of important provider partnerships, including:

- Charles County Public Schools
- Sagepoint Senior Living Services
- Washington, Southern MD Hospitals and Health Partners
- Members of our Charles County Advisory Group providing community perspective to our Board of Directors
- Clergy, churches, and related religious and spiritual organizations
- Civic groups
- Social media and digital communication platforms

## 24. KEY PROGRAM STAFF (PAID AND/OR VOLUNTEER)

Vice President, Care Continuum, Brian Berger, LCSW-C, APHSW-C: Oversees the strategic aspects and goals of

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█, including marketing existing services, supporting community and professional partnerships specific to bereavement services, program development and sustainability, and maximizing the operational efficiencies; Interprets operational indicators detecting census changes and increases or decreases in volume that could impact staffing levels, revenues, or expenses; Leads community programming through collaboration and development of community partnerships supporting the advanced serious illness continuum of care.

Nurse Practitioner, Rachel E. Sherman, MSN, FNP-BP: Treats patients with advanced chronic illness or dementing/debilitating diseases in hospitals, patient residences, and Supportive Care Clinic; assesses/manages symptoms, crafts treatment plans, assists patients to reduce symptoms, advanced care planning.

Clinical Social Worker, CSC, Caroline Burkart, BSW, MSW, LMSW: Provides supportive care psychosocial assessments and community resources recommendations.

**25. TIMELINE**

Although Healthcaring services are offered year-round, the timeline for this funding is July 1, 2024 - June 30, 2025.

The (federal) CMS GUIDE Model participation is an eight-year project.

**26. SCALABILITY**

YES

**EXPLANATION (30 WORD LIMIT)**

█ strategically plans multi-pronged scaling processes (i.e., serving our communities). By scaling services and human resources, █ maintains the capacity to meet the growing needs more closely.

**27. SUSTAINABILITY**

YES

**EXPLANATION (30 WORD LIMIT)**

█ is managed by an executive team including a Chief Executive, Medical, Financial, and Advancement Officers. █ is financially sound, retaining an investment portfolio designed for long-term growth.

**Financial Information**

**28. START DATE OF CURRENT FISCAL YEAR**

01/01/2024

**29. CURRENT FISCAL YEAR BUDGET VS. ACTUALS (PDF OR EXCEL FORMAT)**

- █FY24-YTD-Budget-v-Actuals.pdf

**30. PRIOR FISCAL YEAR OPERATING BUDGET VS ACTUALS (PDF OR EXCEL FORMAT)**

- █Charles-County-Budget-v-Actuals-FY23-with-PL-FY22.pdf

**32. PROPOSED PROGRAM BUDGET (PDF OR EXCEL FORMAT)**

- █-Budget-for-HOCC-FY25-grant.pdf

**33. SOURCE OF OTHER PROGRAM FUNDING**



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rmiller@[REDACTED].org

(443) 837-1504