Catalyst Diabetes Project

Expanding Delivery Capacity and Demand for DPP and DSMT Programs while Improving Participant Enrollment and Retention

Date: July 18, 2020

Submitted By:

NEXUS MONTGOMERY

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SECTION I: Scope of Work

1. Introduction and Summary of Proposal

Nexus Montgomery Regional Partnership is pleased to submit this proposal to work with local community resources to build capacity for and utilization of the Diabetes Prevention Program (DPP) and Diabetes Self-Management Training (DSMT), both well-researched, evidence-based approaches.

Nexus Montgomery Regional Partnership, a collaboration among Montgomery County's six hospitals, works with community partners to promote health, reduce hospital utilization and manage total cost of care for our shared community in ways that no single hospital could achieve on its own. For four years, Nexus Montgomery has successfully managed programs together with community-based organizations and local county government. Nexus Montgomery operationalizes the decisions of its Board of Managers through a local 501c3 organization founded in 1993, the Primary Care Coalition (PCC). During the original Regional Partnership grant period, ~70% of grant funds were expended through financial arrangements with multiple community and local government partners with the hospitals providing in-kind support.

The Nexus Montgomery Diabetes Project will focus on twelve ZIP Codes in Montgomery County that represent nearly 500,000 residents and a significant portion of the Nexus Montgomery hospitals' diabetes-related admissions. Targeting these ZIP Codes creates achievable scale targets and, given the racial and ethnic demographics of these areas, provides opportunities to close long-standing disparities.

The Nexus Montgomery Diabetes Project will be implemented through collaboration with a wide range of community partners serving as DPP or DSMT providers and referral or outreach partners. DPP or DSMT provider partners will receive intensive support for start-up of new programs or expansion, including stipends to offset initial, un-reimbursable costs, contingent on ongoing process improvement participation. The Diabetes Project shall have three other key implementation partners: a public outreach partner attuned to the input of the diverse audience, a centralized referral and case management partner, and the Brancati Center for its technical assistance and expertise in DPP programming.

We have designed our program activities to address and overcome challenges to:

- **The supply of DPP and DSMT programs** (e.g. building interest in being a DPP or DSMT provider, adapting curricula to meet diverse linguistic and cultural needs, data infrastructure for program providers to report on and measure their DPP or DSMT program, coordination with local community organizations, and assistance with obtaining ongoing funding/billing); and
- **The demand for DPP and DSMT programs** (e.g. public outreach and referral generation)
- **The enrollment and retention process for DPP and DSMT programs** to match diverse populations with appropriate, accessible programs and support participant retention, which can be difficult to maintain over multi-month and multi-year programs.

Our strategy is to address these challenges through an innovative system of centralized supports, while maintaining decentralized diabetes education program (DPP & DSMT) provision through community partners. To enhance the supply of DPP and DSMT programs, we will offer **capacity support and process improvement** services for program providers. To promote demand, we will conduct **public outreach** and

coordination of referral sources. To increase enrollment and retention, we will provide **referral and case management** services to match new patient demand with increased program supply, and support high-risk patients to improve program completion. Centralized data collection will facilitate more robust outcomes monitoring. It also will enable analysis of the gap between reimbursements and costs to support development of sustainable payment structures.

Table 8 provides the Summary of Proposal.

2. Target Population

This Diabetes Program is a program of and will be governed by the Nexus Montgomery Regional Partnership, with its six hospital members and shared service area. However, this application for a grant award is by four hospitals only. MedStar Montgomery Medical Center and Suburban Hospital are not participants in the application. The hospital applicants are therefore: Holy Cross Hospital, Holy Cross Germantown Hospital, Shady Grove Medical Center, and White Oak Medical Center.

Montgomery County is large in population (1.05M residents) and geographic area (507 sq. miles), with areas of great density juxtaposed with low-density agricultural reserve. The region has transportation constraints including traffic congestion and limited cross-county (East-West) corridors. These factors create challenges for prevention-focused programs to provide adequate accessible geographic coverage. Because of this distribution, the county could benefit considerably from geographically focused efforts to increase access to and participation in diabetes prevention and management activities. Further, the distribution of diabetes disease burden and avoidable admissions is not even across Montgomery County. This uneven distribution of risk offers an opportunity to focus on priority ZIP Codes for scale up that meet the areas of greatest need. **This Diabetes Project will target a geographic area of twelve ZIP Codes (Table 1) in Montgomery County.** Two of these ZIP Codes partially overlap with incorporated Rockville (20850) and incorporated Gaithersburg (20878).

2a. Target Population Health Needs: Montgomery County has the third-highest diabetes disease burden in Maryland, according to the U.S. Centers for Disease Control and Prevention; an estimated 60,000 diabetic residents[1] in the county of 1.05 million[2] or 5.7 percent of the population. Of those, 4,000 were newly diagnosed in 2016.

For affected individuals and their families, diabetes can be costly to control and result in disability and reduced life expectancy. Diabetic patients also account for significant costs to the health care system. The more than 32,000 Medicare Performance Adjustment (MPA)-attributed beneficiaries with diabetes at Nexus Montgomery hospitals in 2018 had an average of 523 emergency department (ED) visits per 1,000 patients and an average of 368 inpatient (IP) visits per thousand. Though physician and outpatient facility costs were also significant, roughly a third of the costs for MPA-attributed patients with diabetes were for short-term hospital care. The average monthly cost for these patients was $1,368 with roughly 9.3 avoidable diabetes-related admissions per thousand overall admissions among MPA-attributed patients;[3] much of the cost associated with hospital care for diabetic patients may be preventable.

[1] CDC Diabetes Atlas, 2016.
[2] Census.gov Population Estimate as of July 1, 2019
[3] Based on CRISP extract

2b. Geographic Scope and Population Demographics: Nexus Montgomery proposes a program with a geographic scope (Figure 1) focused on 12 ZIP Codes[4] that represent nearly 500,000 residents[5] and a significant portion of diabetes-related admissions.

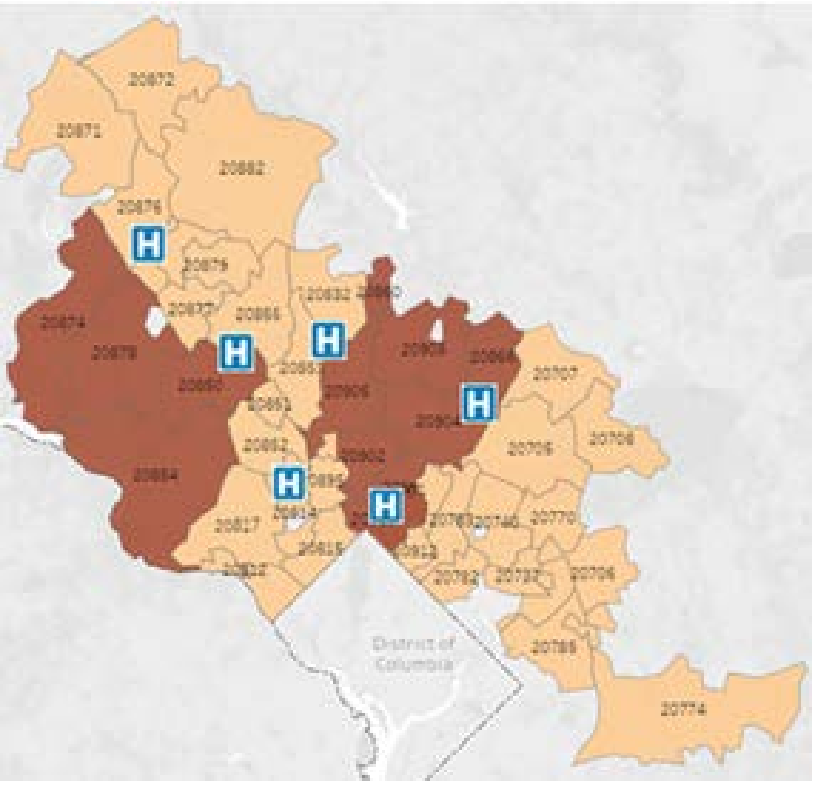


FIGURE 1. TARGET GEOGRAPHIC AREA

To determine the target areas, we analyzed diabetes-related admissions data for all hospitals in Montgomery County and demographic data for all ZIP Codes in the Nexus Montgomery hospitals' shared service area, specifically for age and income.

We prioritized ZIP Codes most likely to have a large volume of patients with poorly controlled diabetes (based on hospital admissions data) and large populations of people at risk of developing diabetes (based on age and income as a proxy for diabetes risk). We also reviewed racial and ethnic demographics, ensuring that the target area represents the diverse region and provides opportunities to close long-standing disparities.[6]

Three ZIP Codes house the patients who are most likely to be admitted to a hospital in Montgomery County for diabetes-related treatment: 20906 (Aspen Hill/Wheaton), 20874 (Germantown), and 20904 (White Oak/Colesville).[7]

Of the ZIP Codes analyzed, ZIP Code 20910 had the third-highest Prevention Quality Indicator (PQI) rate and the highest readmission rate among diabetes chronic care flags. ZIP Code 20901 had the third-highest number of PQI-associated Medicaid MCO claims and the second-highest charges per visit under diabetes chronic care flags. These two ZIP Codes (20910 and 20901) shared the second-longest length of stay under diabetes chronic care flags.[8]

The geographic target area includes the three ZIP Codes with the highest numbers of African American admissions (20874, 20904, 20906), the top two ZIP Codes for longest length of stay per visit (20878 and

[4] Included in the 12 targeted Zip Codes are 10 administrative Zip Codes: 20849, 20859, 20875, 20883, 20885, 20918, 20914, 20916, 20907, & 20911. These administrative zip codes may be used by some patients living in the targeted geographic areas, so will be included for claims-based analyses."
[5] 2010 Census data
[6] The Maryland Diabetes Plan points to poverty, low educational attainment, and being a member of a minority racial/ethnic group as risk factors for diabetes.
[7] Based on CRISP extract
[8] Based on CRISP extract

20854), the three highest charges per visit (20854, 20878, 20901), the three highest charges per patient (20860, 20878, 20901), and the three highest overall charges (20874, 20904, 20906).[9] It also includes five of the ten ZIP Codes with the highest Hispanic populations in the Nexus Montgomery service area and five service area ZIP Codes with large populations earning low incomes (top three ZIP Codes where large numbers of residents have adjusted gross income below $25,000, and the top four ZIP Codes where residents have adjusted gross income between $25,000 and $50,000).[10,11] Compared to the overall Montgomery County population within the Nexus Montgomery service area, the targeted ZIP Codes overrepresent residents from racial and ethnic minorities, as well as residents earning low incomes.

The twelve target ZIP Codes also account for a disproportionate share of all uninsured in the County, roughly 16% of residents in the targeted ZIP Codes are uninsured, more than twice the uninsured rate for the County.[12] The concentration of uninsured residents is closely correlated with lower incomes and uncertain immigration status.[13]

TABLE 1. TARGET ZIP CODES VERSUS MONTGOMERY COUNTY ZIP CODES WITHIN THE NEXUS MONTGOMERY SERVICE AREA

Demographic Data[14]								
Targeted Diabetes Track	Black or AA	Hispanic / Latino	Asian/ Pacific Islander	Average Income	Income <$50K	25-49 years	50-64 years	65+ years
20850	0.9%	3.3%	0.9%	N/A	N/A	22.0%	37.8%	15.3%
20854	6.6%	11.1%	6.6%	$119,578	38.7%	32.5%	21.5%	15.8%
20860	18.8%	33.8%	18.8%	$54,719	64.1%	38.4%	17.5%	10.9%
20866	24.4%	22.6%	24.4%	$68,044	55.5%	38.6%	19.1%	10.2%
20874	22.7%	20.3%	22.7%	$65,584	55.7%	40.5%	17.0%	5.3%
20878	20.7%	37.5%	20.7%	$44,969	70.8%	39.7%	15.8%	10.6%
20901	24.1%	24.4%	24.1%	$54,306	62.0%	39.4%	18.8%	8.9%
20902	9.4%	11.7%	9.4%	$102,781	43.4%	36.8%	21.9%	8.3%
20904	21.9%	24.4%	21.9%	$60,540	58.3%	38.6%	20.3%	6.0%
20905	1.2%	5.0%	1.2%	N/A	N/A	24.5%	26.2%	18.9%
20906	22.6%	17.9%	22.6%	$66,715	53.6%	43.9%	16.9%	5.3%
20910	6.7%	7.5%	6.7%	$115,367	39.4%	29.0%	26.9%	10.3%
Targeted Diabetes Track	18.3%	21.8%	14.4%	$72,548	55.6%	38.6%	19.1%	8.8%
Montgomery County[15]	17.7%	17.6%	13.8%	$100,170	51.1%	36.3%	19.9%	12.3%

[9] Based on CRISP extract
[10] 2010 US Census data
[11] 2013 Internal Revenue Service data
[12] US Census, American Community Survey. Characteristics of the Uninsured.
[13] Ibid
[14] 2010 Census data and 2013 Internal Revenue Service data
[15] The shared Montgomery County service area of the Nexus Montgomery hospitals (42 ZIP Codes)

3. Proposed Activities

DPP and DSMT programs face a web of interrelated supply- and demand-side problems that limit greater utilization. For instance, recruiting motivated participants for these programs is a significant challenge. Many programs have contacts with a single organization as a referral source, conduct direct outreach through community contacts or "in-reach" to an existing population. Since both the DSMT and DPP programs require a long-term commitment, ensuring that participants are prepared for the programs requires an additional step of pre-screening, often through informal motivational interviewing. In addition, the DSMT program requires a clinician referral. This scattershot recruitment through individual entities across a community limits the ability to start new group cohorts. Once programs have enrolled patients into DPP or DSMT, the long-term nature of both programs requires ongoing engagement and follow-up to retain participants.

A best practice for education programs is to offer services at convenient community-based sites.[16] However, each additional site adds substantial administrative coordination costs that are a barrier to smaller program providers. In addition, the requirements for reporting, billing, and administration for these programs are significant, especially for the DPP program, which may be offered by non-clinical organizations unaccustomed to medical billing. Finally, the reimbursement rates for the programs simply do not cover the costs of administrative services and care coordination.

These are substantial barriers to entry for organizations that would otherwise be interested in offering these programs (the supply-side challenge), with no cohesive recruitment and retention effort across a community (the demand-side challenge). Hence the existing capacity for CDC-approved prevention programs is relatively low: there are only a few active cohorts of the Diabetes Prevention Program (DPP) offered each year in the target area for this program (ranging between 6 to 8 cohorts). And, while all Montgomery County hospitals offer some level of Diabetes Self-Management Training (DSMT), all hospitals in the County combined have only provided DSMT/DSME services to 330 diabetic Medicare recipients in the last three years (2016-2019).[17]

This Diabetes Project is designed to address both the supply and demand challenges of the local service model by creating centralized services at key inflection points in the program pipeline. These interventions solve structural problems limiting program growth among community-trusted providers while ensuring enough service volume to create economies of scale. Together, these interventions will support a network of independent, community-trusted providers capable of meeting the needs[18] of a diverse patient population increasingly motivated to participate in diabetes prevention and management education.

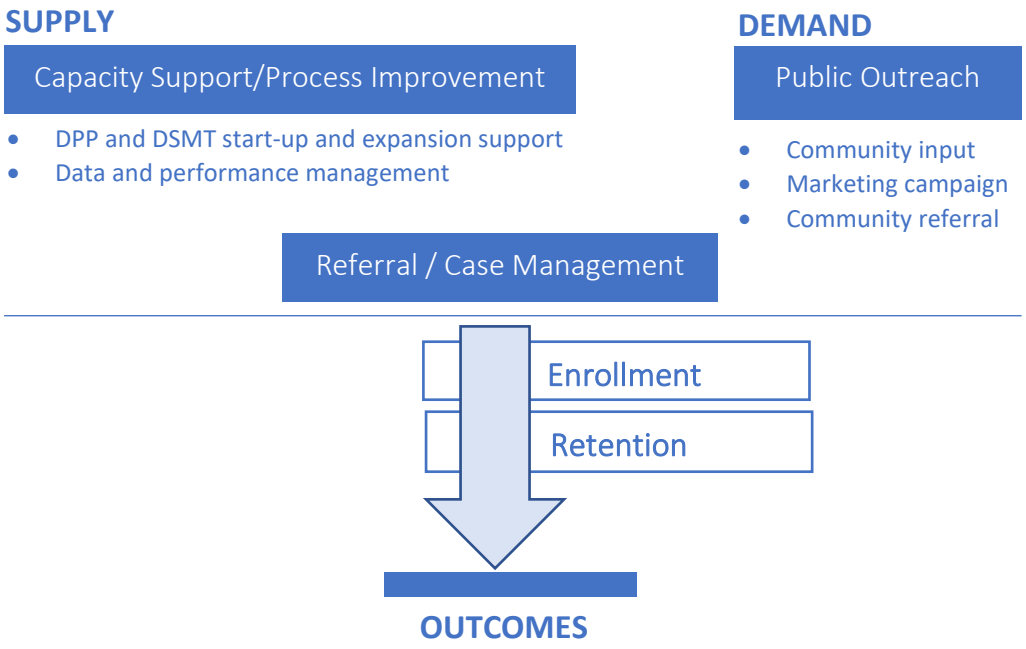
Figure 2 illustrates our project framework, with three centralized supports as key interventions: **capacity support and process improvement, public outreach, and referral/case management.** Referral and case management services ensure that supply and demand are not just rising but efficiently matched, so that programs are operating near capacity while interested participants are directed to a genuinely accessible program option. See Table 8: Summary of Proposal for the DPP and DSMT targets this framework will achieve.

[16] Diabetes Prevention in the Real World: Effectiveness of Pragmatic Lifestyle Interventions for the Prevention of Type 2 Diabetes and of the Impact of Adherence to Guideline Recommendations. Dunkley et al. Diabetes Care Apr 2014, 37 (4) 922-933; DOI: 10.2337/dc13-2195.

[17] Based on CRISP extract

[18] Needs include physical accessibility (location, transportation, hours) as well as linguistic and cultural fit.

FIGURE 2. PROJECT FRAMEWORK



3a. Improving the Supply of DPP & DSMT Providers and Programs

Increasing the availability of diabetes prevention and management programs in the community requires addressing not just the number of DPP and DSMT programs offered, but also their fit with the target population. This Diabetes Project will establish new or expanded programs in community locations that are convenient and familiar to the patient population.

Capacity Support and Process Improvement

A distributed, community-based network of providers will be best suited to meet the geographic, cultural and language needs of our target audience. For such a network of new and expanded diabetes education providers to be effective, we will provide a variety of support services. Training and coordination support will be provided to new programs and programs expanding to new sites. Building upon Nexus Montgomery's successful Skilled Nursing Facility (SNF) Alliance model, we will create and support learning collaboratives so programs can share challenges and successes and build best practices together. Given Montgomery County's high degree of ethnic and racial diversity, we will devote time to adapting existing curricula to meet diverse linguistic and cultural patient profiles. To improve ease of accessing programs, we will pilot web-based, remote program delivery methods. This will make the program time commitment less prohibitive for otherwise willing participants by eliminating the need to commute to and from the program location.[19]

[19] The COVID-19 shift to telehealth by the health clinics in the PCC-administered Montgomery Cares network, which provides comprehensive health services to uninsured and immigrant adults earning low incomes in ZIP Codes which overlap with the Diabetes Program target areas, demonstrated a decrease in patient "no shows" and, an increase in behavioral health visits (virtual). This experience indicates these patients can access and use more technologically dependent health management strategies and that telehealth tools are an important option to maximize access to services.

Over the course of the grant period, a focus on monitoring and performance enhancement will be critical to improving the efficiency of service delivery and to achieving our targets. Data infrastructure will be built for outcome measurement and reporting from multiple partners for multiple payers/funders and accreditation partners. Recognizing that valuable partner programs may be small, financially fragile, and operate with limited infrastructure, our work plan includes an intensive support process for new programs, including stipends to offset initial, un-reimbursable costs and efforts, contingent on continued process improvement participation. This is a strategy PCC has used extensively on quality improvement programs, with consistently high demonstrated results. All providers will participate in data reporting and in a learning collaborative to identify ongoing challenges and refine the system. We will also work with providers to develop individualized sustainable program models, including necessary infrastructure and funding streams.

Target population/audience: Local organizations providing DPP and DSMT services or interested in providing them. (see provider column in Table 2). During implementation we will work to expand the provider list to include non-traditional providers with strong community connections.

Workforce: The Primary Care Coalition (PCC), the local nonprofit that is the management entity for Nexus Montgomery, serves as the Nexus project team, will providing staffing support, learning collaborative meetings management, and data analytics/reporting for partner DPP or DSMT providers. The Brancati Center for Advancement of Community Care will provide technical assistance to DPP providers establishing new sites or expanding their service footprint and participate in DPP learning collaborative meetings.

Technology: Participating programs will be required to sign data-sharing agreements with Nexus Montgomery/PCC. Tableau and secure servers will be utilized for central data management. Providers shall utilize the Chesapeake Regional Information System for our Patients (CRISP) tool being developed by CRISP and the HSCRC.

Partners:

- Brancati Center for the Advancement of Community Care, for its experience setting up non-clinical DPP programs, will provide technical assistance for DPP program expansions.
- Provider partners will implement DPP and/or DSMT programming. For preliminary participants, see Table 2: Community Partners, under DPP or DSMT Provider.

Monitoring: Nexus Montgomery staff will collect and analyze data on DPP and DSMT program referral, enrollment, and retention for the DPP and DSMT programs. These data will be reviewed and monitored by the Nexus Montgomery Board though its PPIC (Partnership Programs Intervention Committee). The Nexus Montgomery staff will work closely with individual DPP and DSMT providers to resolve any barriers to recruitment, enrollment, and retention. In addition, the team will review DPP participants' outcome data: self-reported physical activity and recorded weight. Along with recruitment and retention, these data will also be reviewed at quarterly learning collaborative meetings of providers, with a focus on process improvement. DPP programs will also submit bi-annual reports to the CDC in fulfillment of their certification requirements. These reports may be prepared by Nexus Montgomery project staff or prepared by the provider and shared with the project upon submission.

3b. Increasing the Demand for DPP and DSMT Programs

To have a meaningful effect on slowing the progression of diabetes and reducing the total cost of care associated with diabetes, we will need to engage a large number of participants from vulnerable, hard-to-reach populations. Demand-side interventions will include an ongoing 1) public input campaign to ensure the messaging and programs motivate engagement and long-term lifestyle change in diverse

communities, and 2) public outreach campaign to raise awareness of the programs among residents of our target geographic area who have high incidence of diabetes or prediabetes.

TABLE 2. COMMUNITY PARTNERS

Community Partners*			
Organization Name	Clinical Network	DPP or DSMT Provider	Community Engagement
One Quality Health CTO	√	√	
Holy Cross Health CTO	√	√	
MedStar Accountable Care	√		
Potomac Physicians Associates	√	√	
Privia Health	√	√	
Maryland Collaborative Care	√	√	
Kaiser Permanente	√	√	
Johns Hopkins Medicine Alliance	√		
YMCA		√	
Bethesda *NewTrition*		√	
Health Care Dynamics Inc		√	√
Giant Food		√	
Montgomery County DHHS		√	√
MD Nat'l Capital Park and Planning Commission			√
AARP			√
American Diabetes Association			√

*Includes both committed partners and those in discussion to participate

Public Outreach

Planning: Before launching the outreach campaign, we will further obtain feedback and input from the target patient population to understand the motivations and barriers to participation in diabetes prevention programming. PCC is a member of the Healthy Montgomery (LHIC) Steering Committee, for which reduction in Type 2 Diabetes ED usage is a goal. Where possible, actions based on target population feedback on diabetes prevention and management needs will be aligned with the County's Community Health Improvement Planning (CHIP) and the Nexus Montgomery hospitals' Community Health Needs Assessment activities.

We will collaborate with existing health promotion programs, such as the County's Minority Health Initiatives, and conduct market research to inform the creation of messages and outreach strategies appropriate to our audiences. Based on the information collected, we will develop multi-lingual marketing materials for print and electronic distribution. Public outreach activities will raise awareness about the DPP and DSMT programs, provide consumer resources including tools for patients to self-screen for DPP-eligible risk factors, and promote direct referral to the DPP program.

Target population: Individuals with diabetes or prediabetes.

Workforce: Nexus staff (PCC) will oversee outreach activities and contract with the public outreach/communications partner.

Technology: Our goal is to create mechanisms that link community partner and website referrals directly with CRISP, though the Nexus team will manage data transfers to our centralized referral and case management partner if we cannot develop a tool for CRISP integration.

Monitoring: Nexus staff will monitor progress on deliverables by the communications partner using website analytics, impression rates for electronic outreach, and CRISP-linked referral records, as feasible, to estimate the impact of these investments.

Partners:

- Communications firm to lead the market research, messaging strategy, and collateral production
- Montgomery County Department of Health and Human Services (DHHS, inclusive of LHIC and Minority Health Initiatives) to advise on their health promotion program experience.
- Community organizations (identified in Table 2 under Community Engagement) to distribute messages and materials among their communities, host speakers, share collateral, and/or refer potential participants to the centralized referral management service.

3c. Ensuring Diabetes Outcomes

To simultaneously build program supply and demand – and maintain that growth – newly interested participants must connect with new program providers by design, not chance. For some participants, moreover, that initial point of connection will not be enough to maintain the engagement necessary to realize DPP or DSMT outcomes. That is why our model relies on a single, centralized structure that manages the connection between programs and participants.

Referral and Case Management

Centralized referral and case management services are at the heart of the intervention, ensuring that:

- Patients are referred to the appropriate type of program (DPP, DSMT, or other program outside the grant scope), and are well-distributed among available DPP/DSMT sites considering their location, transportation, or language needs.
- Patients receive extra support if clinical indicators put them at high risk of developing diabetes or diabetes complications, or if their low program attendance indicates underlying unmet needs.

Through this approach, we will direct our resources to serving patients with the highest need and greatest potential for improvement while providing every patient who meets referral criteria with a good service fit. These centralized referral and case management services are the fulcrum on which system resources and patient needs balance – having both roles performed by the same partner organization adds efficiency to the process.

Planning: We will establish clear referral criteria for the DPP and DSMT programs, outline referral workflows, and ensure regular communication for planning and process improvement purposes among the centralized referral and case management partner, the clinical referral partners, and the Nexus Montgomery team.

The centralized referral and case management service is a key element of long-term continuation and scalability of the DPP and DSMT provider and referral network. Successful enrollment of new participants requires dedicated referral coordination in addition to routine screening and referral. The centralized case management team will coordinate with the Nexus Montgomery team and individual providers to ensure that participants at risk of dropping out receive additional support. Success in these

programs requires a high level of motivation and long-term behavioral change. Effective implementation of health coaching and change management support will be critical.

Target population:

- Individuals with diabetes or prediabetes
- Clinical and community referral partners

Workforce: A community partner organization will provide the referral and case management workforce, with an estimated scale up from 3.7 FTEs in the first year to 7.5 FTEs by year five. Nexus staff will provide process improvement training to clinical referral partners and oversee the partner organization's contractual scope of work.

Technology: The community partner organization providing the service will develop a case management solution that connects to CRISP to pull clinical referrals from CRISP for follow up. We aim to link website and community partner referrals through CRISP; if that is ultimately not possible, these referrals will be managed by Nexus Montgomery project staff and shared with the case management partner for further action.

Monitoring: The case management partner will maintain and report data on participants referred, including their participation in DPP or DSMT programs and resulting clinical indicators. Nexus Montgomery will use this information to conduct screening process improvement with clinical referral partners and review case management data to determine additional supportive services to improve participant adherence to the program.

Partners:

- A community partner, selection to be finalized, will be the central referral and case manager, working through a call center to connect referrals to programs and provide additional assistance to patients with high risk profiles or low program attendance.
- Clinical networks and community organizations will provide referrals to the program. See Table 2: Community Partners for a list of these organizations.

4. Measurement and Outcomes

The measures we will use to evaluate program effectiveness include the key indicators of interest for Maryland's CMS waiver agreement, as well as measures of interest to the broader payer mix - necessary for sustainability funding discussions that will maintain this robust diabetes prevention and management program in our community. Detailed measures of hospital utilization costs are included to quantify cost savings associated with the program and determine how levels of care (e.g. ED and inpatient) contribute to these savings. Complete cost data will be a key component for any future payment discussions, particularly for any service elements that are not reimbursable under existing payer arrangements, such as services for uninsured residents. We will also stratify outcome data based on race/ethnicity, language, and geography to ensure equitable program reach and identify any groups for whom services could be better targeted.

Table 3 provides the DPP measures. Table 4 provides the DSMT measures. See Summary of Proposal, Table 8, for the cumulative DPP and DSMT targets.

TABLE 3. DPP MEASURES

DPP Measures						
Target	Logic	Numerator	Numerator Data Source	Denominator	Denominator Data Source	Evidence-Based Target
DPP Capacity	Program implementation requires qualified providers offering multiple cohorts of the DPP program.	Total number of fully accredited DPP cohorts that are completed.	Internal tracking/ community partners	N/A	N/A	Year 1: 4 Year 2: 29 Year 3: 69 Year 4: 164 Year 5: 279
Percent of prediabetic residents referred to DPP	Prediabetic individuals are more likely to participate in DPP programs if they are referred by a medical provider or other trusted community member.	Number of referrals to the DPP program.	CRISP as well as reports from community partners	Total prediabetic population in target areas: 37,763	BRFSS prediabetic prevalence (10.5%) x Adult population (359,647)	Year 1: 0.7% Year 2: 2.8% Year 3: 6.0% Year 4: 10.2% Year 5: 15%
Success rate for referral follow-up	Centralized referral follow-up will increase enrollment rates and generate greater confidence & commitment from referral partners.	Number of residents that complete at least one DPP session after follow-up from referral management partner.	Internal tracking	Number of residents who receive follow-up from referral management partner	Internal tracking	Year 1: 40% Year 2: 45% Year 3: 50% Year 4: 55% Year 5: 60%
Percent of prediabetic residents that began DPP program	Achieving economies of scale to sustain programming requires a minimum rate of referral and enrollment.	Medicare claims for a first session or bridge payment AND Medicaid claims for a first session (in-person or virtual) or milestone 1 (virtual).	Medicare/ Medicaid claims Quarterly internal DPP reporting	Total prediabetic population enrolled in Medicare/ Medicaid: 9,441	Prediabetic adults (37,763) x estimated Medicare/ Medicaid enrollment (25%)	Year 1: 0.3% Year 2: 1.9% Year 3: 5.0% Year 4: 10.3% Year 5: 16.4%
Success rate for case management	Intensive case management to residents identified as high-risk will improve retention rate for DPP.	Number of residents that complete at least nine DPP sessions after case management from referral management partner.	Internal tracking	Number of residents who receive ongoing case management from referral management partner	Internal tracking	Year 1: 30% Year 2: 35% Year 3: 40% Year 4: 45% Year 5: 50%

Percent of prediabetic residents that completed 9+ sessions of DPP program	Programs will not achieve prevention outcomes without substantial long-term client retention.	Medicare patients completing 9 session and Medicaid patients completion 5-9 sessions & milestone 3	Medicare/ Medicaid claims Quarterly DPP reports	Total prediabetic population in Medicare/ Medicaid: 9,441	Prediabetic adults (37,763) x estimated Medicare/ Medicaid enrollment (25%)	Year 1: 0.02% Year 2: 0.3% Year 3: 1.6% Year 4: 4.5% Year 5: 8.2%
Percent of prediabetic residents that achieved 5% or 9% weight loss in DPP program	DPP certification depends on achieving target weight loss outcomes. Weight loss is closely associated with reduced incidence of diabetes.	Medicare and Medicaid patients that have reached weight loss benchmark of 5% or 9%.	Medicare/ Medicaid claims Quarterly DPP reports	Total prediabetic population in Medicare/ Medicaid: 9,441	Prediabetic adults (37,763) x estimated Medicare/ Medicaid enrollment (25%)	Year 1: 0.01% Year 2: 0.1% Year 3: 0.6% Year 4: 2.0% Year 5: 4.2%
Percent reduction in the diabetic rate compared to the expected rate	Completion of DPP programming will reduce the expected incidence of diabetes among program participants.	Reduction in the diabetes rate of participants compared to expected rate.	Survey of participants, 18-24 after program completion	Expected diabetic incidence of program participants	Internal review of risk factors and analysis	Year 3: 10% reduction Year 4: 15% reduction Year 5: 20% reduction

TABLE 4. DSMT MEASURES

DSMT Measures						
Target	Logic	Numerator	Numerator Data Source	Denominator	Denominator Data Source	Evidence-Based Target
DSMT Capacity	Program implementation requires qualified providers offering multiple cohorts of the DSMT program.	Number of DSMT cohorts offered in the targeted geographic areas by accredited DSMT programs	Internal tracking/ community partners	N/A	N/A	Year 1: 30 Year 2: 130 Year 3: 280 Year 4: 450 Year 5: 620
Percent of diabetic Medicare recipients referred to DSMT	Program enrollment requires a clinical referral.	DSMT referrals	Internal tracking	Total Medicare beneficiaries with diabetes diagnosis: 8,352	Medicare claims	Year 1: 5.4% Year 2: 21.0% Year 3: 41.3% Year 4: 64.1% Year 5: 86.8%
Success rate for referral follow-up	Centralized referral follow-up will increase enrollment rates and generate greater	Number of residents that complete at least one DSMT session after	Internal tracking	Number of residents who receive follow-up from referral	Internal tracking	Year 1: 50% Year 2: 55% Year 3: 60% Year 4: 65%

	confidence & commitment from referral partners.	follow-up from referral management partner		management partner		Year 5: 70%
Percent of diabetic Medicare recipients enrolled in DSMT with at least one claim	Program enrollment should be high enough to support DSMT provider viability.	Total patients in denominator with at least 1 Medicare claim for DSMT services	Medicare claims	Total Medicare beneficiaries with diabetes diagnosis: 8,352	Medicare claims	Year 1: 2.9% Year 2: 12.5% Year 3: 26.8% Year 4: 43.1% Year 5: 59.4%
Percent of diabetic Medicare recipients enrolled in DSMT with at least five claims	Programs will not achieve prevention outcomes without sufficient client retention.	Total patients in denominator with 5 or more claims for DSMT	Medicare claims Internal tracking/ community partners	Medicare beneficiaries with diabetes diagnosis: 8,352	Medicare claims	Year 1: 1.2% Year 2: 6.0% Year 3: 14.6% Year 4: 26.1% Year 5: 38.7%
Percent of diabetic Medicare recipients enrolled in DSMT with at least ten claims	Ten sessions is the standard on which outcome goals are based.	Total patients in denominators with 10 or more claims for DSMT	Medicare claims	Medicare beneficiaries with diabetes diagnosis: 8,352	Medicare claims	Year 1: 0.1% Year 2: 0.9% Year 3: 2.3% Year 4: 4.6% Year 5: 7.7%
Reduction in avoidable diabetes-related admissions	Improved diabetes management should decrease diabetes burden and associated avoidable hospital utilization in the target areas.	PQI-93 rate	CRISP	Baseline PQI-93 rate: 16%	CRISP	Year 3: 2.5% reduction Year 4: 3.75% reduction Year 5: 5% reduction

5. Scalability and Sustainability

This program provides support, funding and key infrastructure for start-up and scaling of DPP and DSMT programs and participants. DPP and DSMT scale-up targets over the five-year grant period are in Table 8, Summary of Proposal, Measurement and Outcomes Goals section. The majority of savings from the Diabetes Project programming will be health care system-wide savings due to reduced/delayed incidence of diabetes. The majority of these savings are realized in years three to ten after an individual completes their diabetes education program, though savings continue well beyond that.[20] The Nexus Montgomery Diabetes Project will collect evidence for its efficacy and share with stakeholders to determine mechanisms, such as outcomes-based credits, that can invest these future savings into the core activities in a present time to continue to reduce the incidence of diabetes in the community.

The decentralized education programs (DPP and DSMT) and centralized system support must have sufficient funding to sustain the model after the grant period ends. Yet, DPP and DSMT providers report the current rates of reimbursement are not sufficient to sustain large-scale DPP or DSMT programs, especially when accounting for the case management and administrative burden of follow-up and retention. We intend to share learnings for best practices and identify economies of scale that can mitigate this. One key to sustainability will be determining the appropriate size of central service infrastructure to maintain and further scale service delivery within a sustainable cost structure.

The grant period will accumulate data to model solutions to two key sustainability questions:

- What **level of centralized services** should be maintained long-term to ensure CDC completion rates consistent with ongoing certification and to maximize administrative economies of scale for both the DPP and DSMT programs? What are the costs of these centralized services?
- What is the **gap between available reimbursement rates and sustainable program income** through public or private insurance billing? Which payers are most likely to reap the benefits of investing in a robust system, and what will encourage their investment?

Figure 3 outlines the timeline for activities that answer these questions.

In grant year three, project staff will discuss the impacts and benefits of DPP with health insurance companies and self-insured employers. In order to reach population health goals and in order to be sustainable, DPP must be available to privately insured residents. Expanding reimbursement sources alone will not make the services sustainable, but it is a crucial step in closing the gap between reimbursement revenue and program sustainability. By the end of year four, we anticipate that 50% of participants will be privately insured, consistent with the projected coverage types for people with prediabetes in Montgomery County.

We shall also analyze the impact of the centralized service model, its contribution to the creation or expansion of program providers, the demand by patients for the programs, and the retention of those patients through DSMT or DPP program completion. In the later years of the project, we explore:

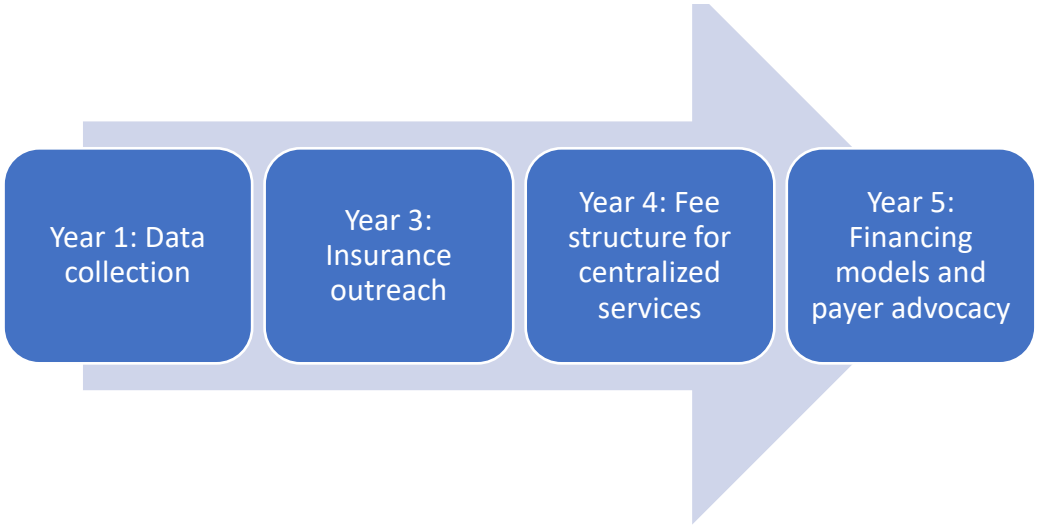
- What is the ongoing level of coordination needed between community partners and referral partners, as both ingrain the processes?

[20] Long-term effects of lifestyle intervention or metformin on diabetes development and microvascular complications over 15-year follow-up: The Diabetes Prevention Program Outcomes Study. (2015). The Lancet Diabetes & Endocrinology, 3(11), 866-875.

- What is the level of investment in marketing and outreach needed to ensure a steady flow of new patient referrals? Is there a tipping point where word of mouth and engagement with community leaders is largely sufficient?
- How intensive do referral follow-up and case management wraparound support services need to be to ensure program entry and completion?

Because this community-serving, centralized delivery model is innovative, we will study the data and our experiences of the first three years of the project to arrive at the answers to these questions. A portion of the centralized services may ultimately be returned to individual DPP or DSMT providers, if economies of scale are not crucial. Providers with lower in-house administrative capacity will continue to need a centralized system offering a full slate of shared services, while larger organizations may support their own referral coordination, outreach, etc. Defining the ongoing central service model impacts the level of revenue needed for DPP and DSMT network sustainability.

FIGURE 3. SUSTAINABILITY TIMELINE



In grant year four, we will build out a fee structure for centralized services, considering a model in which the providers might pay for these services, from reimbursed revenue, after the close of the grant period.

By the beginning of year five, we will have defined the gap between the total cost of program services and projected reimbursement revenues, and will finalize a plan for sustainable financing. Research on DPP efficacy suggests a reduction of diabetes incidence of up to 58%,[21] significantly reducing health care spending. The Nexus Montgomery Diabetes Project will prevent over 2,200 diabetic person years, generating $6 million in long-term savings, as detailed in Table 5. At year five scale of implementation, Nexus Montgomery-developed DPP programming can prevent or delay over 1,000 diabetic person years for each additional year of activity.

[21] The Diabetes Prevention Program. The Diabetes Prevention Program (DPP) Research Group, Diabetes Care Dec 2002, 25 (12) 2165-2171

TABLE 5. NEXUS MONTGOMERY DPP LONG-TERM SAVINGS

Nexus Montgomery DPP Long-term Savings

		Year 1 DPP Cohorts	Year 2 DPP Cohorts	Year 3 DPP Cohorts	Year 4 DPP Cohorts	Year 5 DPP Cohorts	Program TOTAL
Nexus Montgomery participants that complete DPP (9+ sessions)		5	60	240	550	690	**1,545**
2021-2025	Reduced diabetic person-years	2.7	24.2	61.0	63.8	17.9	**169.7**
	Health care savings	$7,305	$64,745	$162,824	$170,410	$47,918	**$453,202**
2026-2030	Reduced diabetic person-years	2.7	35.4	150.0	360.8	441.6	**990.5**
	Health care savings	$7,278	$94,553	$400,650	$963,697	$1,179,514	**$2,645,692**
2031-2035	Reduced diabetic person-years	1.9	25.7	114.2	280.0	361.6	**783.4**
	Health care savings	$5,008	$68,752	$305,135	$747,746	$965,727	**$2,092,368**
2036-2039	Reduced diabetic person-years	-	2.6	26.9	102.3	191.1	**323.0**
	Health care savings	$0	$7,051	$71,796	$273,243	$510,508	**$862,599**
TOTAL	Reduced diabetic person-years	7.3	88.0	352.1	806.9	1,012.2	**2,266.5**
	Health care savings	**$19,592**	**$235,101**	**$940,406**	**$2,155,096**	**$2,703,666**	**$6,055,958**

The fundamental question is which organizations realize those savings enough to justify program investment, including for the cost of uninsured participants. We will build an advocacy case using available calculations of the long-term savings of DPP and DSMT programs for different potential payers/funders.

Financing models are likely to include public funding from local governments, philanthropic investments, hospital community benefit funds, and shared savings from the health care system – particularly where we are able to demonstrate both a significant long-term health care cost savings and a relatively modest funding gap. With detailed cost data for the local market, we may advocate for increased reimbursement rates.

The initial five-year Catalyst grant support for this project is essential for long-term scalability by investing in the development and refinement of a centralized service infrastructure, as well as in practical guidance for new program partners and a means to drive the patient volume necessary for sustainable operations.

It is clear from our conversations with existing DPP experts and providers that many commercially-viable program models rely on some degree of selection bias, which ultimately limits their community impact. One advantage of our centralized approach is that we may be able to create systems that "follow" patients who would benefit from DPP participation but are not yet ready to commit to it, providing them with bridge connections until they are ready for the DPP leap. Our aim with this approach is to introduce a new variation that balances the business realities of a high-participation model with the community health goal of widespread reach.

6. Participating Partners and Decision-Making Process

TABLE 6. LISTING OF REGIONAL PARTNERSHIP COLLABORATORS[22]

Name of Collaborator:	Brancati Center for Advancement of Community Care
Type of Organization:	Non-profit organization (under Johns Hopkins Division of Internal Medicine)
Amount and Purpose of Financial Support:	$99,000 for technical assistance for implementation of DPP at providers, and centralized DPP support services.
Type and Purpose of In-Kind Support:	N/A
Type and Purpose of Resource Sharing arrangements:	To share DPP curricula, policies and procedures, etc. developed by Brancati Center in fulfillment of their mission to improve the health of communities – locally and nationally.
Roles and Responsibilities within the Regional Partnership:	
Based on their experience setting up non-clinical DPP programs, Center staff provide technical assistance on work plan development for establishing new and expanded DPP programs. Center staff will also review DPP curricula and participate in learning collaborative meetings for DPP providers.	

Name of Collaborator:	DPP & DSMT Providers/Sites (see Table 2: Community Partners)
Type of Organization:	Largely non-profit organizations and medical providers
Amount and Purpose of Financial Support:	$1,200,650: Stipends for DPP & DSMT programs re: participant engagement $115,500: Scholarship for uninsured DPP participants $440,550 Stipends to DPP & DSMT site host organizations
Type and Purpose of In-Kind Support:	N/A
Type and Purpose of Resource Sharing arrangements:	N/A
Roles and Responsibilities within the Regional Partnership:	
To start and expand DPP and DSMT programs in the target ZIP Code communities:	

Name of Collaborator:	Centralized Referral and Case Management Community Partner, TBD[23]
Type of Organization:	Non-profit organization
Amount and Purpose of Financial Support:	$2.7 million for centralized referral and case management services
Type and Purpose of In-Kind Support:	N/A
Type and Purpose of Resource Sharing arrangements:	N/A
Roles and Responsibilities within the Regional Partnership:	

[22] Note: Amount of Financial Support is total for the five-year grant. See Budget for amounts by year.
[23] JSSA (Jewish Social Services Agency) provided the referral and case management design and pricing for proposal development. However, following Nexus Montgomery Finance policies, an RFP will be let after program award.

The community partner will create and staff the call center that manages all DPP and DSMT referrals submitted by CRISP or by other partners. The center will be responsible for creating the case management infrastructure necessary and maintaining communication with community, clinical referral, and DPP/DSMT provider partners.

Name of Collaborator:	Primary Care Coalition (PCC)
Type of Organization:	Non-profit organization
Amount and Purpose of Financial Support:	$6.67 million for project implementation, data analytics, governance support, and contracting with other project partners
Type and Purpose of In-Kind Support:	Grant seeking/writing services: for program sustainability and to meet project needs not covered under Catalyst grant Advocacy facilitation services: to local county government and philanthropy
Type and Purpose of Resource Sharing arrangements:	N/A
Roles and Responsibilities within the Regional Partnership:	
PCC serves as the staff for Nexus Montgomery and provides decades of connection to other community service providers and vulnerable populations. The Nexus Montgomery staff are responsible for administration and management of the Diabetes program, in accordance with decisions of the Nexus Montgomery governance structure. Duties include managing program data and quality improvement efforts, contracting with and overseeing program subcontractors, and conducting sustainability analysis.	

The **public outreach partner** has not been selected as of proposal submission. The amount of financial support is ~$1 million over the five-year grant.

6a. Governance Structure: The Nexus Montgomery Regional Partnership (NMRP LLC), the regional collaborative of the six hospitals located in Montgomery County, is governed by a Board of Managers with representatives from each of the six hospitals and the ability to expand its membership. An Operating Agreement defines the NMRP LLC charter elements and key aspects of governance (committees, board seats, officers, voting rights). Data sharing agreements are in place among the hospitals, NMRP LLC and the Nexus Montgomery management entity, PCC. The Board meets monthly, and has a four-year history of productive decision-making, good governance practices, and collaborative engagement with community partners for population health programming in support of Total Cost of Care Model goals.

The Nexus Montgomery Board takes recommendation from its two standing committees, which also meet monthly, the Partnership Program Intervention Committee (PPIC) and the Finance Committee. The Board maintains a regular cycle of program partner attendance at Board meetings for reporting and discussion, and utilizes a metrics dashboard to regularly review progress and outcomes. In addition, the Board has a Stakeholder Engagement Plan detailing the many stakeholders in this population health work (e.g. local and state executive and legislative agencies, payers, physician groups, community groups) and defines regular interactions for input and feedback.

The Nexus Montgomery Board shall continue its strong governance practices with the Diabetes Project added to its scope of programs. This structure for joint discussion and decision-making will be key for ensuring public outreach and messaging are clear and consistent across all hospitals, and referrals best

meet the needs of the prediabetic and diabetic individuals in this shared community of 12 ZIP Codes. On Board actions specific to Diabetes Program funding from the HSCRC Catalyst award, the MedStar Montgomery Medical Center and Suburban Hospital representatives on the Nexus Montgomery Board, PPIC, and the Finance Committee will abstain.

Nexus Montgomery operationalizes its shared capacity through a local 501c3, the Primary Care Coalition of Montgomery County MD Inc. (PCC), which has over 25 years of community convening and program administration experience in Montgomery County.

6b. Incorporation of Perspectives and Shared Decisions:

The Nexus Montgomery Board has final decision-making authority on the top level programmatic and budgetary items related to the Catalyst Diabetes grant funds, as is appropriate to the hospitals' role as the HSCRC grantee. The Board regularly meets with its implementation partners to learn their perspectives, challenges and needs. At the project implementation level, community partners (DPP/DSMT providers and referral partners) share in improving the overall program through a learning collaborative and process improvement activities. Program recipients (DPP and DSMT participants) have forums to shape the program through the public outreach design activities, and feedback gained through experience surveys and central referral and case management activities. (Letters of support from community partners are included as Appendix A.)

6c. Funding: The applicant hospitals shall contribute their grant funds as an equal percentage of Global Budget Revenue. This places each applicant hospital as an equal contributor in relative proportion to its revenue.

TABLE 7. FUNDING BY HOSPITAL

Hospital	FY20 Approved Net Revenue plus Markup	Percent of Total Net Revenue	Grant Contribution (5 yr Total)
Holy Cross Health	$ 533,205,200	36.8%	$ 4,729,959
Holy Cross Germantown Hospital	$ 119,315,200	8.2%	$ 1,058,422
Shady Grove Medical Center	$ 483,252,749	33.4%	$ 4,286,841
White Oak Medical Center	$ 312,802,114	21.6%	$ 2,774,807
Total	**$ 1,448,575,263**	**100%**	**$ 12,850,029**

TABLE 8. SUMMARY OF PROPOSAL

Hospitals/Applicants	Four Lead Applicants: Holy Cross Hospital, Holy Cross Germantown Hospital, Shady Grove Medical Center, White Oak Medical Center
Hospital Members (of RP)	Holy Cross Hospital, Holy Cross Germantown Hospital, MedStar Montgomery Medical Center, Shady Grove Medical Center, Suburban Hospital, White Oak Medical Center
Health System	Hospital — Health System Affiliation Holy Cross Hospital — Holy Cross Health Holy Cross Germantown Hospital — Holy Cross Health Shady Grove Medical Center — Adventist HealthCare White Oak Medical Center — Adventist HealthCare
Funding Track:	Diabetes Prevention & Management Programs
Total Budget Request	$12,850,029 (over five years)

Target Patient Population

This Diabetes program will focus on individuals in the 12 Montgomery County ZIP Codes that are home to nearly half of the county's population and a substantial portion of its diabetes-related hospital admissions. This targeted geography responds to the challenge of the county's large population and land area by serving a concentrated population with a demonstrated risk of diabetes-related utilization. The 12 ZIP Codes represented 2,016 patients in Diabetes Composite Performance Quality Indicators (PQIs) from January 2016 – December 2019 and more than $28 million in charges. These target ZIP Codes also reflect contextual factors like poverty and race/ethnicity that shape risk for diabetes and its sequelae. The 12 ZIP Codes are: 20850, 20854, 20860, 20866, 20874, 20878, 20901, 20902, 20904, 20905, 20906, 20910.

Proposed Activities

We propose three interventions that create a systemic approach to addressing the related problems of inadequate DPP and DSMT program supply and under-developed program demand from individuals who would benefit from these services, with fidelity to the established evidence-based DPP and DSMT models.

1. Capacity support and process improvement for new and expanding DPP & DSMT providers
   a. Start-up support: training and coordination support
   b. DPP provider learning collaboratives
   c. Culturally-competent curricula adaptation for DPP & DSMT programs
   d. Data reporting support
2. Public outreach to potential participants in the target ZIP Codes
   a. Engagement and training with clinical partners to routinely screen and refer to DPP & DSMT
   b. Print and online materials for DPP & DSMT marketing campaigns
   c. Community partnerships for program promotion and DPP screening/referral
3. DPP & DSMT referral coordination and case management
   a. Referral process and process improvement to support provider DPP & DSMT referrals
   b. Case management for high-risk populations

Measurement and Outcomes Goals

Measures to evaluate program effectiveness, including measures of interest to potential payers – necessary for sustainable funding discussions – are in Table 3 and Table 4. Measures of hospital utilization costs will be used to determine which level of care – ED versus inpatient – contributes the bulk of hospital utilization savings. Cumulative program outcome targets are below.

Cumulative DPP Targets: Rates

Targets	Year 1	Year 2	Year 3	Year 4	Year 5

Number of accredited DPP cohorts	4	29	69	164	279
Percent of prediabetic residents referred to DPP	0.7%	2.8%	6.0%	10.2%	15.0%
Percent with Medicare/ Medicaid enrolled into DPP (one claim)	0.3%	1.9%	5.0%	10.3%	16.4%
Percent with Medicare/ Medicaid that completed 9+ sessions of DPP	0.02%	0.3%	1.6%	4.5%	8.2%
Percent that lost 5% or 9% of bodyweight	0.01%	0.1%	0.6%	2.0%	4.2%

Cumulative DSMT Targets: Rates

Targets	Year 1	Year 2	Year 3	Year 4	Year 5
Number of accredited DSMT cohorts	30	130	280	450	620
Percent diabetic Medicare residents referred to DSMT	5.4%	21.0%	41.3%	64.1%	86.8%
Percent with at least 1 DSMT claim	2.9%	12.5%	26.8%	43.1%	59.4%
Percent with at least 5 DSMT claims	1.2%	6.0%	14.6%	26.1%	38.7%
Percent with at least 10 DSMT claims	0.1%	0.9%	2.3%	4.6%	7.7%

Scalability and Sustainability

This program provides support, funding and key infrastructure for significant scale-up of DPP and DSMT programs and participants (see outcomes section above). In addition, the program will build a centralized package of services that could support scale up of programs in ZIP Codes not targeted in this grant.

Sustainability is approached by using data and process improvement to maximize efficiency within individual DPP and DSMT programs and define the most cost-effective centralized service package or package options. We will work with program providers to incorporate the costs of centralized services into the program's reimbursement rate, establishing a long-term plan to share revenue. After optimizing the costs of the programming and central support, we will define the gap between available reimbursement rates for these programs and the actual cost of providing them. We will identify payer sources for gap funding, including seeking increased reimbursement.

The majority of savings are realized in years four to ten after an individual completes their diabetes education program, though savings continue well beyond that. The Nexus Montgomery Diabetes Project will prevent over 2,200 diabetic person years, generating $6 million in long-term savings. At year five scale of implementation, Nexus Montgomery-supported DPP programming can prevent or delay over 1,000 diabetic person years for each year of activity. This will generate $2.7 million in long-term savings for each year of continued program delivery at year five scale. We will share data with stakeholders to determine mechanisms, such as outcomes-based credits, that can invest these future savings into the core prevention activities to continue to reduce incidence of diabetes.

Governance Structure

This project builds on Nexus Montgomery's four-year history of productive decision-making, good governance practices, and collaborative engagement of the six member hospitals with community partners for population health programming in support of Total Cost of Care Model goals. The Nexus Montgomery Board has final decision-making authority for top-level programmatic items related to the Catalyst Diabetes program. As appropriate to hospitals' role as the HSCRC grantees, only the four applicant hospitals shall vote on Board actions specific to Diabetes Program funding.

The Board regularly meets with its implementation partners to hear their perspective, challenges and needs. At the project implementation level, community partners (DPP/DSMT providers and referral partners) share in improving the overall program through a learning collaborative and process

improvement activities. Program recipients (DPP and DSMT participants) have forums to shape the program through the Public Outreach design activities, and feedback gained through experience surveys and central referral and case management activities.

Participating Partners and Financial Support

Lead applicant hospitals: Holy Cross Hospital, Holy Cross Germantown Hospital, Shady Grove Medical Center, and White Oak Medical Center. The grant award will financially support the program activities through partners. The hospitals contribute significant in-kind support including management time for governance, grants management and reporting.

Partners on implementation and central support: Brancati Center, the referral/case management partner and public outreach partner (tbd). Brancati Center has resources to share including DPP curricula, policies and procedures.

Collaborators for the clinical referral network include CTOs and large physician groups. DPP or DSMT provider partners include CTOs, medical practices, American Diabetes Association and community groups.

Implementation Plan

We will use the pre-award period for initial outreach to community partners and creation of data-sharing agreements that will support coordinated work. We will also use this time to explore additional DPP community sites and adapt materials for our diverse residents. This schedule for completing key ramp-up work before the grant begins will allow implementation of all major activities beginning in year one, including:

- Setting up the screening and referral processes for a centralized flow of patients into new programs (subsequent years feature additional training and process improvement to ensure the system is achieving maximum impact and is well embedded within the culture of clinical referral partners)
- Designing public outreach materials and strategies.
- Beginning new cohorts for both existing and new DPP and DSMT providers, supported by learning collaborative meetings, case management services for DPP participants at high-risk of diabetes or low rates of participation, billing process creation, and stipends for uninsured patient participation and newly-offered programs.

We will begin identifying the long-term scope of centralized services in year three, and begin evaluation of the impact of the main interventions. This timeline allows for the identification of areas for potential process improvement or service adjustments with enough time remaining in the five-year grant to assess their effectiveness on program processes and scale targets.

Budget & Expenditures

The targets of this program are ambitious and will require significant work force effort to bring to fruition. Efforts include recruitment, training, coordination and maintenance of the network of medical and community-based referral partners; development, training and support of new and expanding diabetes education providers, both DPP and DSMT; the operation of the referral coordination/case management central function; and project management, data analytics and governance support functions.

Other expenditure categories of size are: the public outreach; start-up stipends, relative to engagement of participants, for new diabetes education providers; remuneration to sites hosting the education classes; and training costs for screening and referral. The total budget over five years is $12,850,029.

7. Implementation Work Plan

	Pre-award	Year 1				Year 2				Year 3				Year 4				Year 5			
	10/20-12/20	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Screening & Referral Initiation & Preparation																					
Establish data-sharing agreements for screening & referral partners with the centralized referral management partner.																					
Establish health informatics & EHR integration between CRISP referral portal and centralized referral management partner.																					
Engage with stakeholders focused on diabetes education programs outside of the Catalyst grant (e.g., DSMP). Incorporate feedback into screening process to ensure that patients are referred to appropriate program.																					
Finalize workplan for referral process to DPP & DSMT with clinical referral partners.																					
Screening & Referral Ongoing Activities																					
Train clinical referral partners on DPP & DSMT screening & referral protocols, track progress, and follow-up to support routine referrals.																					
All referred clients receive follow-up from centralized referral management partner.																					
Outreach to additional clinical referral partners, targeting high-risk populations (Medicare diabetic, obese & prediabetic, and women with gestational diabetes)																					
Screening & Referral Sustainability																					
Routinely report to clinical referral partners on related outcomes & impact of referrals.																					
With clinical referral partners, review the screening & referral processes & identify opportunities to institutionalize routine screening.																					

	Pre-award	Year 1				Year 2				Year 3				Year 4				Year 5			
	10/20-12/20	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
DPP & DSMT Capacity & Support Initiation & Preparation																					
Establish data-sharing agreements with DPP & DSMT providers, collecting all program participation & outcome metrics.																					
Develop reporting & data analytics tools for DPP that meets program requirements for the HSCRC, CDC, and other funders.																					
Identify community sites to host DPP & DSMT programming linking with existing certified providers in Year One																					
Develop & adapt curricula for DPP & DSMT programs, based on language/cultural needs and possible long-term shift to web-based remote programs.																					
DPP & DSMT Capacity & Support Ongoing Activities																					
Currently certified DPP & DSMT provider partners begin new cohorts.																					
Newly certified DPP & DSMT provider partners begin new cohorts.																					
Coordinate placement of new DPP & DSMT cohorts at community sites.																					
Provide intensive assistance to new DPP & DSMT provider partners with program startup, training, & data management.																					
Track referrals & enrollment into programs, coordinating with referral coordination partner to ensure appropriate capacity.																					
High-risk & low participation DPP participants receive additional case management support from the centralized referral management partner.																					
Conduct all data analysis & reporting for the DPP & DSMT provider partners.																					
Stipends for diabetes education programs, front-loaded for new programs (that either cannot receive reimbursements or have high startup costs) with incentives for performance improvement.																					
Lead quarterly learning colloboratives with DPP provider partners, providing ongoing training while identifying challenges in the referral & retention processes.																					

	Pre-award	Year 1				Year 2				Year 3				Year 4				Year 5			
	10/20-12/20	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
DPP & DSMT Capacity & Support Sustainability																					
Establish a billing process for each of the DPP partners, either building capacity internally or linking with a third party billing organization.																					
Establish a scholarship program, reimbursing programs for self-pay patients or with insurance that does not yet cover DPP.																					
Develop minimally-viable model of centralized DPP & DSMT support. Review the potential & limitations for revenue-sharing from reimbursements.																					
Estimate impact on diabetes hospital visits and diabetes incidence. Report on potential long-term savings to health care system.																					
Advocacy and engagement with health insurance companies to reimburse for DPP; investigate & advocate for revenue for self-pay DPP patients.																					

	Pre-award	Year 1				Year 2				Year 3				Year 4				Year 5			
	10/20-12/20	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Public Outreach & Promotion Campaign Initiation & Preparation																					
Engage with health outreach & promotion programs in the targeted region to receive input on strategic plan.																					
Market Research on targeted geographic area and population at risk to develop diabetes.																					
Design website targeting awareness of diabetes & prediabetes in English & Spanish. Incorporate a self-assessment test for the DPP program, linking to the centralized referral management partner for client follow-up.																					
Develop and print collateral to recruit for the DPP and DSMT programs. Review & update based on language & cultural needs.																					
Public Outreach & Promotion Campaign Ongoing Activities																					
Develop and implement a speaker's bureau to coordinate attendance at community events, promoting the program.																					
Engage with community organizations in targeted hotspot, sharing collateral.																					
Recruit individual community organizations to systematically screen & refer clients/participants to DPP programs.																					
Implement marketing campaign for DPP, incorporating social media as well as bus-stop advertisements and other components based on market research.																					
Public Outreach & Promotion Campaign Sustainability																					
Estimate impact of marketing campaign on referrals & enrollment to the programs.																					
Engage with local health department and other stakeholders to determine components of health outreach campaign needed to match new program capacity.																					

SECTION II: Financial Projections

1. Budget

Hospital/Applicant:	Four Lead Applicants: Holy Cross Hospital, Holy Cross Germantown Hospital, Shady Grove Medical Center, White Oak Medical Center
Regional Partnership Members:	Holy Cross Hospital, Holy Cross Germantown Hospital, MedStar Montgomery Medical Center, Shady Grove Medical Center, Suburban Hospital, White Oak Medical Center
Funding Track:	Diabetes Prevention and Management
Total Budget Request:	$12,850,029

Workforce/Type of Staff	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Nexus Montgomery Director	Overall Nexus oversight, strategy, & governance	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	
Program Director Diabetes Track	Oversight of diabetes track activities, supervises staff & manages subcontracts	1	1 FTE	1 FTE	1 FTE	1 FTE	
Program Manager Diabetes Track	Manages recruitment, training, coordination, and outreach activities.	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	
Provider Recruitment Manager	Provides support to provider recruitment and training on referrals & support	0.35 FTE	0.35 FTE	0.35 FTE	0.35 FTE	0.35 FTE	
Diabetes Education Partners Manager	Recruitment, coordination, & support of diabetes education partners	0.3 FTE	0.3 FTE	0.3 FTE	0.3 FTE	0.3 FTE	
Health Informatics	Data sharing agreements, interfaces (e.g. EMRs, CRISP), Referral tracking system and data management	1.2 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	
Director of Outcomes	Develops reports for program management and outcomes	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	
Data Manager	Maintain interface with CRISP, conduct data analysis for programs	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	
Data Analyst	Conducts data analysis and reporting for all DPP programs	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	
Program Coordinators	Administrative support Nexus activities, diabetes-track meetings, trainings, and learning collaboratives	2 FTE	2 FTE	2 FTE	2 FTE	2 FTE	
Communications Specialist	Support to outreach & public health promotion	0.2 FTE	0.2 FTE	0.2 FTE	0.2 FTE	0.2 FTE	
Referral Program Management (RN)	Oversee and manage referral tracking program and referral tracking coordinators	1.2 FTE	1.2 FTE	1.2 FTE	1.2 FTE	1.2 FTE	
Referrral Coordinator/Case Manager	Perform referral tracking, case coordination	1.5 FTE	2.0 FTE	3.0 FTE	5.0 FTE	6.0 FTE	
Total Loaded Labor Costs		$1,481,231	$1,439,643	$1,560,655	$1,768,188	$1,902,902	$8,152,620

IT/Technologies	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Interfaces	Linkages to EMRs and CRISP systems.	55,000	55,000	27,500	27,500	27,500	192,500
Total IT/Technologies Costs		**55,000**	**55,000**	**27,500**	**27,500**	**27,500**	**192,500**

Wrap Around Services	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
N/A							
Total Wrap Around Services		$ -	$ -	$ -	$ -	$ -	$ -

Other Implementation Activities	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
DPP Advisory Consultants	Expert TA on DPP program design & expansion	$26,400	$24,200	$22,000	$13,200	$13,200	$ 99,000
Translation & Cultural Review	Translation and community review	$27,500	$16,500	$16,500	$11,000	$5,500	$ 77,000
Public Outreach	Public engagement and marketing campaign	$220,000	$198,000	$181,500	$192,500	$198,000	$ 990,000
DPP & DSMT Provider Start-up	Stipends to providers	$42,900	$174,350	$223,850	$408,650	$350,900	$ 1,200,650
Stipends to DPP & DSMT sites	Stipend to organizations hosting programs	$4,950	$36,300	$61,050	$156,750	$181,500	$ 440,550
Self-pay coverage for DPP	Scholarships for uninsured DPP participants	$3,300	$9,900	$19,800	$33,000	$49,500	$ 115,500
Training	Training on screening/referral processes	$44,000	$66,000	$99,000	$99,000	$66,000	$ 374,000
Learning Collaborative & Meeting Costs	Regular meetings and learning collaboratives	$11,000	$13,200	$16,500	$19,800	$19,800	$ 80,300
Rent/Facilties Costs	For Project Labor: rent, parking, utilities	$72,832	$75,382	$78,020	$80,751	$83,577	$ 390,561
Mileage, parking, & transportation	For Project labor: project related travel	$7,970	$7,970	$7,970	$7,970	$7,970	$ 39,848
Equipment & supplies	Equipment, tool, and technological support	$17,600	$13,200	$11,000	$6,600	$6,600	$ 55,000
Total Other Impl. Activities		**$478,452**	**$635,001**	**$737,189**	**$1,029,220**	**$982,546**	**$ 3,862,409**

Other Indirect Costs	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Hospital Administrative Fee	5% of grant award amount	$106,036	$112,086	$122,386	$148,679	$153,313	$ 642,501
Total Other Indirect Costs		$106,036	$112,086	$122,386	$148,679	$153,313	$ 642,501

Total Expenses & Investments							
		$2,120,719	**$2,241,731**	**$2,447,731**	**$2,973,588**	**$3,066,261**	**$ 12,850,029**

2. Budget and Expenditures Narrative

Introduction

The member hospitals of Nexus Montgomery recognize that collaboration with community partners will drive the growth of DPP and DSMT services in our community, promote the engagement and retention of program participants, and foster long-term sustainability through local development of centralized services. The majority of the grant funds will be directed to local community organizations, with the hospitals retaining 5% as an administrative fee for grants management and indirect support of the in-kind hours hospital staff will spend in program governance, planning, implementation and oversight.

All expenditures will be in accordance with the annual Program budget approved by the Nexus Board. The Nexus Board, through its data-driven Partnership Programs Intervention Committee (PPIC), sets program metrics and regularly monitors progress towards measurable outcomes. The annual budget and all contract agreements at values over $50,000 are reviewed in advance by the Nexus Board Finance Committee for compliance with Board-determined conditions and existing law.

Section I.5, Scalability and Sustainability, discusses a plan and actions to develop revenue streams to sustain the education and referral provider networks and the centralized supportive services. The budget requested is to cover 100% of the proposed project activities, which includes activities to develop funding streams that sustain what the project has built after grant end.

Work Force:

The budget describes each position type/category with number of FTE. The workforce budget of $8,152,620 across all five years of the grant supports the following.

- Program implementation, capacity support, and process improvement (five-year total: $5,460,279. Nexus staff at the Primary Care Coalition (PCC) support program governance (e.g. Nexus Board, PPIC), data analytics, outcomes measurement and reporting, quality improvement, and contracts management with partners and vendors. Staff lead the development of the provider and referral networks to expand both size and effectiveness. For diabetes education providers, staff conduct recruitment, coordination and support including connecting with technical assistance resources. Staff recruit clinical providers and other referral sources and provide training. Over the grant years, staff are responsible for growing these networks, and strengthening education providers to achieve the grant outcomes.

- Referral tracking and case management function (five-year total: $2,692,341). Staff at the partner program will build up the referral coordinator/case management program starting with 1.5 FTE referral coordinators in the first year to 6.0 FTE referral coordinators in the fifth year as the number of referrals to DPP and DSMT programs increase. Health informatics FTE is higher in the first year to ensure the needed infrastructure is operational.

IT/Technologies

The budget includes $192,500 across the five years to cover costs related to establishing functional linkages between different data systems: electronic medical records, case management tools, CRISP, and other reporting tools.

Wrap Around Services

The Program does not budget for structured wrap around services with separate scale targets. The Program provides for support to participants through the referral follow-up & case management central hub and the Program will encourage greater linkages between related social services. Those services are addressed under *Other Implementation Activities*.

Other Implementation Activities

Other program implementation activities ($3,862,409 over five years) includes:

DPP Advisory Services:
Technical assistance and advisory services from the Brancati Center for the Advancement of Community Care (estimate of up to 150 hours per year) to develop individual work plans for diabetes education providers to start new or expand existing DPP programs, establish a library of DPP resources including curricula and other tools, and provide strategic guidance and expert technical assistance in establishing centralized support to multiple DPP providers.

Translation and Cultural Review:
Translate curricula, recruitment material, and other communications to multiple languages, including cultural review using community partners to translate materials to Spanish, French, Amharic, Chinese, Korean, and Vietnamese. The majority of translation and cultural review will occur in the early years of the grant.

Public Outreach
The public outreach partner will engage in community review and program design ($20,000/month for 4 months), and outreach implementation ($15,000/month for 20 months). Ongoing activities will range between $10,000-to-$15,000/month, including updates to the engagement plan, advertisements, and maintaining online infrastructure and collateral.

Support to Diabetes Education Providers and Sites

The first years of programming for DPP and DSMT are financially challenging due to the initial start-up costs and low level of reimbursements, especially for DPP programs that are not yet fully accredited. Nexus Montgomery will provide a startup stipend, relative to engagement of participants. These stipends will focus on community-based organizations to enable new programs and the expansion of existing ones. The Nexus team will work closely with clinical providers that plan to recruit patients internally for these programs, ensuring that stipends meet compliance guidelines and meet the goal of creating new DPP and DSMT capacity.

For DPP programs we anticipate an average payment of $400 per participant in first year cohorts, tapering to $250 per participant in second year cohorts. After each new DPP program's second year, the program will not receive stipends. New DSMT sites will receive a stipend based on attendance, averaging $100 per participant in cohorts in the programs' first year. Since multiple DSMT cohorts can be offered in a single year, we anticipate that new DSMT providers will have improved processes to maximize reimbursements after their first year.

Support for Uninsured Patients

The budget assumes that 10% of all participants will be uninsured or otherwise self-pay, establishing a pool of funds to act as a scholarship for these participants at $400 per uninsured participant. The Nexus team will work closely with DPP providers to ensure that scholarships for uninsured participants meet compliance guidelines and can be managed with minimal administrative burden for participants.

Training & Learning Collaboratives
Nexus Montgomery staff will directly engage with health care providers to promote routine screening and referral to DPP and DSMT. In addition, Nexus Montgomery staff will provide training support to clinical and non-clinical organizations who seek certification in DPP or DSMT. The estimated average cost is $1,000 for each training,

including the training site fees, costs for relevant CEUs if available, and training materials. The team aims to provide 40 to 90 trainings each year.

In addition to training new partners, the Nexus Montgomery Team will host a quarterly Learning Collaborative for DPP providers, as well as small group meetings with partners that require additional assistance with recruitment or retention. The budget for these meetings increases with the number of partners, increasing from an average of $2,500 per quarter to $4,500 per quarter.

Facilities, Travel, & Supplies
The costs for office space for the program management and implementation team, and program travel (mileage and parking) is based on the number of FTEs. Rent escalates 3.5% per year.

Other Indirect Costs

The applicant hospitals retain 5% of grant award (five-year total: $642,501) to offset extensive involvement of management and line staff in Program activities, governance, grant management and reporting.

Other Budget Notes

Fringe benefit and/or General & Administrative fees of program partners are included in the budget estimates where applicable. Labor rates assume a 3% cost of living inflation each year.

Program investments made with partners are expensed to the grant in the grant year in which the contract with the partner is executed and the funds paid to the partner, though the partner may have contractual obligations that cross program years.

Appendix A. Letters of Support

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Marc Elrich
County Executive

Raymond L. Crowel, Psy.D.
Director

July 17, 2020

Ms. Katie Wunderlich, Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Wunderlich:

The Montgomery County Department of Health and Human Services (DHHS), Public Health Services (PHS), is in support of the Catalyst Diabetes proposal submitted by the Nexus Montgomery Regional Partnership, the collaboration among the hospitals in Montgomery County. The Nexus Montgomery Regional Partnership proposal to expand the number and uptake of Prevention Program (DPP) and Diabetes Self-Management Training (DSMT) programs in Montgomery County's areas of greatest need aligns with the goals of DHHS/PHS and our Local Health Improvement Coalition (Healthy Montgomery).

The growing incidence of Type 2 Diabetes is one of the greatest long-term public health challenges in Montgomery County. Three of the core measures of Healthy Montgomery are closely related to Diabetes: Diabetes Mortality, Diabetes Emergency Room Visits and incidence overweight/obese Body Mass Index. The Community Health Improvement Plan details strategies to increase access to preventive care, promote greater physical activity and strengthen connections between services. By increasing utilization of DPP and DSMT, Nexus Montgomery's programming will support Healthy Montgomery's goals to drive down the incidence of diabetes and improving control among those with diabetes.

We are pleased to offer our support for this proposed program and look forward to working with the Nexus Montgomery Regional Partnership, the Primary Care Coalition and other stakeholders as this program is implemented.

Sincerely,

Travis A. Gayles

Travis A. Gayles, M.D., Ph.D.
Montgomery County Health Officer
Chief, Public Health Services

TG:ss

JOHNS HOPKINS
UNIVERSITY

The Brancati Center for the Advancement of Community Care
Department of Medicine, Division of General Internal Medicine
2024 East. Monument Street / Room B-303
Baltimore, MD 21205 USA
410-614-6441

July 13, 2020

Katie Wunderlich
Executive Director
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Re: Commitment for Diabetes Prevention Program with Nexus Montgomery

Dear Ms. Wunderlich:

On behalf of the Johns Hopkins Brancati Center for the Advancement of Community Care, I am writing to express full support for the proposal for Diabetes Prevention Program (DPP) and Diabetes Self-Management Training (DSMT) services being submitted by the hospitals of Montgomery County to the Health Services Cost Review Commission. As a leader of community-based DPP education, we are well aware of the structural challenges to new program development. The Nexus Montgomery Regional Partnership-led scale up promises to address the context of service provision and create new mechanisms to support sustainable program engagement.

By simultaneously addressing the challenges in expanding DPP programs and increasing program recruitment, the Regional Partnership presents a critical opportunity to build robust referral and support systems for diabetes prevention program delivery. The proposed project's centralized support mechanism is key to making the system work for patients and providers alike. Funding from the Regional Catalyst Grant Program would support the start-up phase of this centralized system, generating key information to determine the best scope of centralized services to ensure long-term program effectiveness.

At the Brancati Center, our mission is to expand access to the DPP across Baltimore City and the State of Maryland. While the program is proven to prevent type 2 diabetes, it has rigorous requirements including attendance at the program's sessions for 12 months, self-monitoring of physical activity, and 5% weight loss. In partnering with community-based organizations to deliver these programs, we have found that we can increase access and participation, provide skills training for our community coaches, develop community-based approaches to healthier living, and reduce diabetes risk. More than 100 people have enrolled in the Brancati Center's year long in-person program; have attended more than 80% of sessions; and have lost an average of 5.6% of their initial weight.

We are pleased to offer our support for this project and are committed to working with the Nexus Montgomery Regional Partnership, the Primary Care Coalition, and other stakeholders as a technical advisor for the set up and support of new DPP programs.

Sincerely,

Nisa Maruthur, MD, MHS
Director of Community Partnership, Johns Hopkins Brancati Center
Associate Professor of Medicine, Epidemiology, and Nursing
Division of General Internal Medicine

jssa

Candace G. Kaplan
President

Todd Schenk, M.Ed, MBA
Chief Executive Officer

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F 703.204.9590

July 17, 2020

Katie Wunderlich
Executive Director
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Re: Commitment for Diabetes Prevention Program with Nexus Montgomery

Dear Ms. Wunderlich:

On behalf of the Jewish Social Services Agency (JSSA), I am writing to express full support for the proposal for Diabetes Prevention Program (DPP) and Diabetes Self-Management Training (DSMT) services being submitted by the hospitals of Montgomery County to the Health Services Cost Review Commission. The Nexus Montgomery Regional Partnership promises to address new service provisions and create mechanisms to support sustainable program engagement. As a provider of services to community members and health care professionals, we are proud to partner in this work.

By simultaneously addressing the challenges in expanding DPP programs and increasing program recruitment, the Regional Partnership presents a critical opportunity to build robust referral and support systems for diabetes prevention program delivery. The proposed project's centralized support mechanism is key to making the system work for both patients and providers. Funding from the Regional Catalyst Grant Program would support the start-up phase of this centralized system, generating key information to determine the best scope of centralized services to ensure long-term program effectiveness.

At JSSA, our mission is to empower individuals and families to achieve well-being across their lifespan. We have extensive experience with complex case management that addresses physical, emotional, and functional health. As part of this depth of experience, we actively coordinate with other community providers including community physicians, hospitals and a wide breadth of other health care organizations. We are in favor of partnerships that join hospitals and community-based providers, as they represent a significant opportunity to address social determinants of health and provide the opportunity to bend the cost curve for managing chronic illness within our community.

We are pleased to offer our support for this project and are committed to working with the Nexus Montgomery Regional Partnership, the Primary Care Coalition, and other stakeholders. We look forward to this opportunity for improving health in our community.

Sincerely,

Amy Schiffman, MD, MHS
Chief Medical Officer
Jewish Social Service Agency

Adventist HealthCare
Adventist Medical Group
820 West Diamond Avenue, Suite 600
Gaithersburg, MD 20878
AdventistMedicalGroup.org

July 15, 2020

Ms. Katie Wunderlich
Executive Director
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Re: Commitment for Diabetes Prevention and Management with Nexus Montgomery

Dear Ms. Wunderlich:

On behalf of Adventist HealthCare Adventist Medical Group, I am writing to express full support for the proposal for Diabetes Prevention Program (DPP) and Diabetes Self-Management Training (DSMT) services being submitted by the hospitals of Montgomery County to the Health Services Cost Review Commission. Existing systems limit our availability to connect more patients with these evidence-based health improvement programs. The Nexus Montgomery Regional Partnership-led scale up promises to address the context of service provision and create new mechanisms to support sustainable program engagement.

By simultaneously addressing the challenges in expanding DPP programs and increasing program recruitment, the Regional Partnership presents a critical opportunity to build robust referral and support systems for diabetes prevention and management education. The proposed project's centralized support mechanism is key to making the system work for patients and providers alike. Funding support from the Regional Catalyst Grant Program would support the start-up phase of this centralized system, generating key information to determine the best scope of centralized services to ensure long-term program effectiveness.

Our organization works to improve the health and well-being of people and communities through a ministry of physical, mental and spiritual healing. Among our patient and community populations, diabetes has been identified as a priority area of focus. However, the need goes beyond education alone. A centralized system that provides program support and wrap around services to address social needs is critical to moving the needle on diabetes prevention and management in our community. We look forward to working with Nexus to establish referral streams for our patients to access these crucial resources.

We are pleased to offer our support for this project and are committed to working with the Nexus Montgomery Regional Partnership, the Primary Care Coalition, and other stakeholders to maximize referrals to diabetes education programming and to increase capacity for DSMT and

DPP activities. We look forward to expanding the reach of DSMT and DPP programs in our community.

Sincerely,

Mary Ward, PhD
Vice President of Operations
Adventist HealthCare/Adventist Medical Group

HOLY CROSS HEALTH

1500 Forest Glen Road
Silver Spring, MD 20910-1484
301-754-7000
www.holycrosshealth.org

July 15, 2020

Katie Wunderlich
Executive Director
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Re: Commitment for Diabetes Prevention and Management with Nexus Montgomery

Dear Ms. Wunderlich:

On behalf of Holy Cross Health Partners at Asbury Methodist Village and Holy Cross Health Partners in Kensington, I am writing to express full support for the proposal for Diabetes Prevention Program (DPP) and Diabetes Self-Management Training (DSMT) services being submitted by the hospitals of Montgomery County to the Health Services Cost Review Commission. Existing systems limit our availability to connect more patients with these evidence-based health improvement programs. The Nexus Montgomery Regional Partnership-led scale up promises to address the context of service provision and create new mechanisms to support sustainable program engagement.

By simultaneously addressing the challenges in expanding DPP programs and increasing program recruitment, the Regional Partnership presents a critical opportunity to build robust referral and support systems for diabetes prevention and management education. The proposed project's centralized support mechanism is key to making the system work for patients and providers alike. Funding support from the Regional Catalyst Grant Program would support the start-up phase of this centralized system, generating key information to determine the best scope of centralized services to ensure long-term program effectiveness.

Holy Cross Health Partners is committed to patient-centered, coordinated care that supports access, communication and patients' involvement in addressing their individual needs and goals to achieve a better quality of life. We see firsthand in our practices, the impact that diabetes can have on individuals and their loved ones in terms of cost, disability and reduced life expectancy. Evidence-based programs like DPP and DSMT have made a positive difference in the lives of our patients who have participated in these programs; however, lack of support for patients in finding classes and fully engaging in these programs prevents many from participating who would otherwise benefit. The Nexus Montgomery diabetes project will help address and overcome these challenges.

We are pleased to offer our support for this project and are committed to working with the Nexus Montgomery Regional Partnership, the Primary Care Coalition, and other stakeholders to maximize

referrals to diabetes education programming and to increase capacity for DSMT and DPP activities. We look forward to expanding the reach of DSMT and DPP programs in our community.

Sincerely,

Rhonique Shields, MD, MHA, FAAP
Vice President, Medical Affairs and Practice Operations
Holy Cross Health Network