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Regional Partnership Catalyst Program

Calendar Year 2023 Activities – Final Report

July 2024

P: 410.764.2605 ● 4160 Patterson Avenue | Baltimore, MD 21215 ● hscrc.maryland.gov

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Introduction

The Health Services Cost Review Commission (HSCRC) created the Regional Partnership Catalyst Program (Catalyst Program) to advance the population health and health equity goals of the Total Cost of Care (TCOC) Model and to encourage and support public-private partnerships that can create sustainable initiatives to improve the health of Marylanders. The Catalyst Program funds hospital-led teams to advance two population health priority areas that are part of the Statewide Integrated Health Improvement Strategy (SIHIS): (1) diabetes prevention and management and (2) behavioral health crisis services. Teams include neighboring hospitals and community organizations such as local health departments (LHDs), local behavioral health authorities (LBHAs), non-profit and social service organizations, and provider groups to develop and implement interventions. Goals of the Catalyst Program include:

- Partnerships and strategies that result in long-term improvement in the population health metrics of the TCOC Model;
- Increased number of prevention and management services for persons at risk for or living with diabetes;
- Reduced use of hospital emergency departments (EDs) for behavioral health and improved approaches for managing acute behavioral health needs;
- Integration and coordination of physical and behavioral health services to improve quality of care; and
- Engagement and integration of community resources into the transforming healthcare system.

The Catalyst Programs are also an important tool to advance goals of health equity for Marylanders. Provision of wraparound services to address social determinants of health (SDOH) is core to Regional Partnership programming. Regional Partnerships deploy community health workers (CHWs), patient navigators, care managers, and others to screen participants for SDOH needs and connect participants to resources. Regional Partnerships recognize that addressing SDOH and treating the whole patient is crucial to preventing diabetes or helping diabetic patients manage their disease. Additionally, Regional Partnerships are intentional in the selection of community-based partners to reflect the culture, language, and demographics of target populations to customize marketing materials and outreach strategies to engage patients. These activities are critical to address long-standing health disparities in the State and have been highlighted and promoted by the Regional Partnership programs.

For the period January 2021 through December 2025, the HSCRC originally awarded $165.4 million in cumulative funding through nine awards to eight Regional Partnerships. The five-year cycle was intended to allow time to build partnerships and infrastructure prior to implementing interventions. HSCRC made a difficult decision to discontinue diabetes funding in CY 2024, so final funding under the program to all eight Regional Partnerships will amount to $136.9 million. The Behavioral Health Crisis Services programs will

continue through the original program cycle which ends December 2025. This report summarizes the activities for all Regional Partnerships in CY 2023.

As described in the enclosed report, Regional Partnerships reported progress in expanding some areas of service delivery in CY 2023, implementing programs across a large set of partners and different healthcare delivery systems. Regional Partnerships cited an ongoing commitment to build effective, integrated teams and scale critical infrastructure. Importantly, Regional Partnerships will continue to promote community partnerships, improve provider awareness and build relationships with commercial insurers and Medicaid MCOs.

Challenges persisted in CY 2023 to recruit and maintain staff, navigate changing federal and state requirements, successfully implement billing and service reimbursement, manage construction delays, and respond to the intensifying behavioral health needs of Marylanders. Continued enrollment challenges within the diabetes prevention and management programs led to the decision to discontinue diabetes funding early.

Overview

The Catalyst Program builds on the HSCRC's Regional Partnership Transformation Grant Program, launched in 2015 to reduce potentially avoidable utilization and per capita costs and demonstrate a positive return on investment through increased Medicare savings. The Regional Partnership Transformation Grant Program funded fourteen hospital-led partnerships, involving 41 of Maryland's acute care hospitals. Interventions were diverse, spanning behavioral health integration, care transitions, home-based care, mobile health, and patient engagement/education strategies focused on high-need and high-risk Medicare patients.

Subsequent to the Regional Partnership Transformation Grant Program's expiration in June 2020, the HSCRC established the Catalyst Program to enable hospital-led partnerships to continue to build infrastructure in support of the population health goals of the TCOC Model and Statewide Integrated Health Improvement Strategy (SIHIS) in a more focused manner. The Catalyst Program made awards under two funding streams: (1) diabetes prevention and management and (2) behavioral health crisis services. The Catalyst Program is based on the HSCRC philosophy of fostering collaboration among hospitals and community partners while creating infrastructure to disseminate sustainable evidence-based interventions.

Diabetes Prevention and Management Programs

The diabetes prevention and management funding stream supported Regional Partnerships implementing the Centers for Disease Prevention & Control (CDC) recommended Diabetes Prevention Program (DPP). DPP has shown long-term success in helping to prevent the onset of diabetes and promote weight-loss for those with pre-diabetes. This funding stream also supported implementation of Diabetes Self-Management

Training (DSMT) and Diabetes Self-Management Education and Support (DSMES). DSMT/ES provides lifestyle change help and diabetes management curriculum to patients to help better control their Type II diabetes. Regional Partnerships under the Catalyst Program were required to achieve American Diabetes Association (ADA) or American Association of Diabetes Education (AADE) accreditation for their respective DSMT and DSMES programs, or partner with an accredited program.

Funding was available for wraparound services to bolster the impact of DPP and DSMT/ES. For example, Medical Nutrition Therapy (MNT) could be provided as a wraparound service for patients participating in DSMT/ES. It is provided by registered dietitians as an intensive, focused, and comprehensive nutrition therapy service. MNT delivered concurrently with DSMT/ES has been shown to increase the ability of patients to manage their diabetes. Additional wraparound services to support patient success in DPP and DSMT/ES include healthy food access, exercise programs, and transportation services to in-person classes.

DPP and DSMT/ES offer a pathway to sustainability via Medicare, Medicaid and/or commercial payer reimbursement. However, Medicare billing requires suppliers to make substantial investments in certification, training, and administration. Catalyst Program funding was intended to help build this infrastructure by supporting start-up costs, including recruitment, training, and certification.

Regional Partnerships were expected to meet different milestones over the five years of the program, with the final goal of having sustainable programs that would continue after the HSCRC funding ended. HSCRC staff found that CY 2023 performance fell short of program expectations which caused concerns about long-term program viability, leading staff to make the difficult decision to end diabetes funding early. Regional Partnership diabetes funding ended June 30, 2024, although Regional Partnerships may work through the end of CY 2024 to wind down their programs or shift towards more sustainable models. All Regional Partnerships have reported that they will continue to offer some form of diabetes programming without HSCRC funds.

Behavioral Health Crisis Programs

The TCOC Model incentivizes reductions in unnecessary emergency department (ED) and hospital utilization. Across Maryland, hospitals cite opioid and fentanyl use disorders, combined with inadequate access to acute mental health services as contributors to ED overcrowding. Maryland continues to lack sufficient infrastructure needed to divert behavioral health crisis needs from EDs and inpatient settings to more appropriate community-based care. Community-based organizations often do not receive reimbursement for crisis management services and struggle to provide the capacity needed in Maryland.

The behavioral health crisis services funding stream supports development and implementation of infrastructure and interventions consistent with the “Crisis Now: Transforming Services is Within Our Reach”

action plan developed by the National Action Alliance for Suicide Prevention. Regional Partnerships are implementing one or more of the following:

- **Air Traffic Control (ATC) Capabilities with Crisis Line Expertise.**[1] The ATC model is based on always knowing the location of an individual in crisis and verifying hand-offs to the next provider. The model creates a hub for deployment of mobile crisis services and access to other services such as crisis stabilization. The model's essential components include qualified crisis call centers and 24/7 clinical coverage with a single point of contact for a defined region.
- **Community-Based Mobile Crisis Teams**.[2] Mobile crisis services deploy real-time professional and peer intervention to the location of a person in crisis. They are intended to avoid unnecessary ED use and hospitalization.
- **Stabilization Centers**. Crisis stabilization services provide observation and supervision at a sub-acute level to prevent or ameliorate behavioral health crises and/or address acute symptoms of mental illness. Settings are small and home-like relative to institutional care.

Summary of Awards

The HSCRC awarded a cumulative $136.9 million through nine awards to eight Regional Partnerships. Five of the nine awards fall under the diabetes prevention and management funding stream. These awards total $57.8 million and involve 24 hospitals with funding through June 2024. They span Western, Central, and Southern Maryland as well as the Capital Region. Three of the nine awards fall under the behavioral health crisis services funding stream. These three awards total $79.1 million and involve 24 hospitals with funding through December 2025. They span Central Maryland, portions of the Capital Region, and the Lower Eastern Shore. A summary of awards is shown in Table 1 and 2 below.

Table 1. Summary of Diabetes Regional Partnership Catalyst Program Awards, CY 2021 – CY 2024

	Regional Partnership	Counties/ Region	Award	Participating Hospitals
Diabetes Prevention and Management	**Baltimore Metropolitan Diabetes Regional Partnership**	● Baltimore City	$32,730,418	● JH Bayview Medical Center ● Howard County General Hospital ● Johns Hopkins Hospital ● Suburban Hospital ● UMMC ● UMMS Midtown
	Western Regional Partnership	● Allegany ● Frederick ● Washington	$10,996,156	● Frederick Health ● Meritus Medical Center ● UPMC Western Maryland

[1] ATC is also referred to as "Care Traffic Control" by one Regional Partnership.
[2] Mobile Crisis Teams (MCT) are also referred to as Mobile Response Teams (MRT).

	Nexus Montgomery[3]	• Montgomery	$4,121,123	• Holy Cross Germantown • Holy Cross Hospital • Shady Grove Medical Center • White Oak Medical Center
	Totally Linking Care (TLC)	• Charles • Prince George's • St. Mary's	$4,463,519	• Adventist -Fort Washington Medical Center • Luminis Doctors Community Hospital • MedStar St. Mary's • MedStar Southern Maryland • UM Capital Region Health • UM Laurel Regional Medical Center
	Saint Agnes and Lifebridge	• Baltimore City • Baltimore County	$4,081,555	• Ascension St. Agnes • Sinai Hospital • Grace Medical Center
	Full Circle Wellness[4]	• Charles	$1,425,078	• UM Charles Regional Medical Center
		Total Awards	**$57,817,849**	

Table 2. Summary of Behavioral Health Regional Partnership Catalyst Program Awards, CY 2021 – CY 2025

	Regional Partnership	Counties/ Region	Award	Participating Hospitals
Behavioral Health Crisis Services	**Greater Baltimore Region Integrated Crisis System (GBRICS)**	• Baltimore City • Baltimore County • Carroll • Howard	$44,862,000	• Bayview Medical Center • Carroll Hospital • Grace Medical Center • Greater Baltimore Medical Center • Howard County General • Johns Hopkins Hospital • Ascension St. Agnes • Sinai • MedStar Franklin Square • MedStar Good Samaritan • MedStar Harbor • MedStar Union Memorial • Mercy • Northwest • University Maryland Medical Center • UM Midtown • UM St. Joseph Medical Center
	Totally Linking Care (TLC)	• Prince George's	$22,889,722	• Adventist Fort Washington Medical Center • MedStar Southern Maryland • UM Laurel Medical Center • UM Capital Region Health

[3] Revised award amounts are shown in Table 1. Nexus Montgomery participation ended in 2022 and all Diabetes Prevention and Management Regional Partnerships end June 30, 2024 with an additional 6- month winddown period to rollover unspent funds
[4] FCW is funded for DSMT activities only.

	Tri-County Behavioral Health Engagement (TRIBE)	● Lower Eastern Shore	$11,316,332	● Atlantic General Hospital ● TidalHealth - Peninsula Regional Medical Center
		Total Awards	**$79,068,054**	

Year Three Diabetes Prevention and Management Activities

Early Award Termination

The Regional Partnership Catalyst Program was created to fund the development of sustainable programs that support the State's population health goal to address diabetes burden. A key requirement for Regional Partnerships was to generate revenue through billing Medicare and Medicaid to create a sustainable funding source beyond HSCRC funding. Based on low claims volumes for DPP and DSMT in CY 2023, HSCRC was concerned about the long-term viability of the program. While there was growth in billable claims for Medicaid and Medicare, those volumes fell significantly below performance expectations established at the beginning of the Catalyst Program. Based on CY 2023 performance and the amount of funding issued, HSCRC staff determined that these programs were not on a path to sustainability and that the level of funding issued through the program was not commensurate with the number of patients served. Diabetes funding to Regional Partnerships ended June 30, 2024, although Regional Partnerships have through the end of CY 2024 to either wind down their programs or restructure to sustainable models to continue diabetes prevention and management activities in CY 2025 and beyond. All Regional Partnerships reported in early CY 2024 that they would continue some form of diabetes programming after HSCRC funding ended. Regional Partnerships will still be able to leverage the infrastructure and partnerships developed since 2021 when the program began.

DPP Referral, Enrollment, and Retention Strategies

During CY 2023, Regional Partnerships took a range of actions to promote DPP referral, enrollment, and retention. Strategies to support expansion of DPP capacity for underserved populations continued, with a focus on bi-lingual direct-to-consumer websites, access to translation services, building a more diverse staff workforce, access to multiple learning platforms and modalities (including both group and one-on-one offered in-person and virtually), extending hours to accommodate diverse schedules, and targeted programs to assess and address financial barriers. Continued hiring of coaches, CHWs, and administrative support staff was a strategy reported by multiple Regional Partnerships. While post-COVID returns to in-person activities were offered and were well received among some groups, distance learning and support options continued to be popular and addressed transportation and access barriers among other groups.

Regional Partnerships relied on offering both in-person and virtual options to encourage enrollment by meeting the varied needs of their diverse populations.

Health care provider multipronged referral efforts also continued and were reported as a key strategy to improve challenging enrollment trends. Regional Partnerships continued to enhance electronic health records (EHRs) to facilitate DPP referral and enrollment from within the hospital, for example with DPP referrals in after visit summaries and automated patient messages and provider prompts. In addition, Regional Partnerships worked with community providers, and community-based organizations to identify participants and address barriers to care. This included implementing technology solutions to reach community partners outside of the health system EHR. Outreach at community events and direct to consumer public marketing campaigns—including flyers, direct mail, media advertisements, and QR codes— were also effective referral sources. Despite these efforts, Regional Partnerships reported that some health care providers remained reluctant to make referrals. Financial constraints were identified as one barrier to enrollment. Regional Partnerships reported that co-insurance, deductibles, and requirements for pre-authorization contributed to enrollment challenges. Some Medicaid MCOs decline coverage DSMES/DSMT services and/or require a 'tedious' prior authorization process. One Regional Partnership introduced a 'no-cost' education option for referred patients as a way to mitigate some financial barriers to enrollment. Another Regional Partnership reported billing workflow improvements that led to better use of grant funds that reduced/eliminated patient out of pocket costs. To improve enrollment retention, Regional Partnerships regularly assessed social needs and other potential barriers to participation. During enrollment processes, Regional Partnerships continued to use supportive contact from coaches to engage participants in different formats depending on the preferences of the participant (employing individual, group, in-person, and virtual methods). Virtual methods of engagement were used by Regional Partnerships as a retention strategy. Partnerships report that the increase in convenience and ability to reach a wider range of current and potential enrollees resulted in higher retention rates relative to in-person counterparts. Regional Partnerships also continued to deploy multiple touchpoints and different approaches to support patients with different needs and preferences, for example shifting from phone calls to text messaging and purchasing smartphones for coaches to facilitate text communication. Individuals continue to be reluctant to answer phone calls from unrecognized numbers.

Regional Partnerships also leveraged community partnerships to offer wrap around supportive services that are provided based on patient eligibility and need. These wrap around services included: transportation (Lyft rides), food access and healthy meal enrollment support (including Moveable Feast, Meals on Wheels, Hungry Harvest, organized grocery store tours, grocery store gift cards), cooking classes and other healthy lifestyle support (YMCA Family Memberships, supportive meetings), and medication management and financial assistance support. Regional Partnerships also reported collaborations with faith communities as a mechanism to publicize program resources. Despite these efforts, below-target enrollment and retention

was reported as a continued challenge by Regional Partnerships. Partnerships did note, however, that enrollment and retention have improved and/or compare favorably to national trends.

Regional Partnerships supported 224 total cohorts in 2023 that were either run by the hospital or partner community organizations. 122 cohorts began in 2023, while 102 cohorts that began in 2022 concluded. Cohort sizes can vary in size based on delivery format (i.e., in-person or virtual), location, and available staffing. In general, smaller cohort sizes allow for more personalized contact between lifestyle coaches and participants which supports program retention and maximizes patient success in the program.

DSMT/ES Expansion Strategies

Regional Partnerships continued to focus on referral and enrollment efforts. Referral strategies included creating, maintaining and strengthening relationships with referring providers. Regional Partnerships continued to stress the presence of DSMT/ES educators in primary care and endocrinology practices to facilitate cross-referral and engage participants in familiar settings. Another strategy embedded DSMT staff in health care system population health teams to capture referral and enrollment opportunities found within the integration between inpatient and ambulatory services. Regional Partnerships noted that leveraging EHRs and existing care management workflows was an important method of targeting potential participants. In addition to encouraging provider referrals and EHR identification, Regional Partnerships continued to promote DSMT/ES through community-based marketing and recruitment.

Despite these various strategies, actual enrollment and engagement of participants in DSMT/ES continued to be challenging. All Regional Partnerships experienced enrollment rates well below targets. Financial barriers (such as cost sharing) were cited as a persistent barrier to participation. For Medicare FFS beneficiaries, there is a cost share requirement which can become cost-prohibitive for patients, particularly if DSMT is performed in a regulated setting.[5] [6] Medicaid MCOs may also decline coverage and/or require a burdensome pre-authorization process. Patient financial responsibility depends on the location of where DSMT/ES is provided and any supplemental benefits the beneficiary may have in addition to Medicare coverage. One Regional Partnership noted that eligible patients, despite appropriate referrals, simply choose not to enroll.

Regional Partnerships continued to expand the number and nature of DSMT/ES classes, with more sites and larger spaces, in-person and virtual, one-on-one and group, and hybrid offerings. The expansion of classes utilized a range of modalities, with a common goal for participants to receive education earlier in

[5] The deductible and coinsurance of 20 percent of the Medicare-allowed amount applies to DSMT.

[6] Centers for Medicare and Medicaid Services. *Medicare Learning Network Fact Sheet - Medicare Diabetes Self-Management Training.* May 2022. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DSMT-Fact-Sheet-909381.pdf

their diagnoses. Some Regional Partnerships noted that they expanded class offerings in response to growing wait times for new participants.

Physician & Provider Engagement (DPP & DSMT/ES)

Regional Partnerships continued to conduct a range of physician and provider engagement activities for both DPP and DSMT/ES. Outreach methods differed for hospital-affiliated versus community-based providers. For hospital-affiliated providers, engagement activities centered on EHR tools, regular outreach meetings, and messages from leadership. Regional Partnerships also engaged community-based providers with educational visits to offices, information about the CRISP referral tool, EHR optimization offerings, and the availability of a range of referral process methods. In addition, Regional Partnerships offered educational road shows and CME modules for both categories of providers.

Impact Measures

DPP Referrals

HSCRC set a goal for Regional Partnerships to refer ten percent of their prediabetic patient population to DPP in 2023. Referrals are measured in targeted ZIP codes that were self-selected by Regional Partnerships in their 2020 proposals. There is a significant number of referrals being generated outside of targeted ZIP codes that HSCRC does not give credit for in reporting since measurement is ZIP code-based. Statewide numbers therefore show a lower-bound of referrals and actual performance exceeds the reported amounts.

In 2023, Regional Partnerships referred a total of 11,459 patients to DPP in designated ZIP codes. Referrals to DPP are inclusive of all-payers (Medicare, Medicaid, commercial, self-pay, uninsured) and were self-reported by Regional Partnerships monthly. Despite large referral numbers, however, a much smaller percentage enroll in DPP. Enrollment is a preferable measure of financial sustainability and program participation since it captures not only actual patients served, but services that generated revenue through billing.

HSCRC began using DPP enrollment data using Medicare and Medicaid claims as an official performance metric in 2023. Regional Partnerships were expected to begin billing for DPP in 2023 which would be reflected in claims data. HSCRC set a goal for Regional Partnerships to enroll 2,244 Medicare and Medicaid beneficiaries into DPP statewide. Only 312 patients, 13.91 percent of the statewide goal, were identified through DPP claims data. Some Regional Partnerships were slow to stand up DPP billing operations which would therefore not capture any Medicare or Medicaid patients served in claims data.

Low participation in Medicare DPP has been a challenge nationally as well, so this experience is not unique to Maryland.[7]

Table 3. Regional Partnership All-Payer Referrals & DPP Enrollment, CY2023

Metric	Target	Actual Statewide Performance	% of CY 23 Target Achieved
All-Payer Referral	3,943	11,459	102%
DPP Enrollment (Medicare & Medicaid)	2,244	312	13.91%

Source: CRISP Regional Partnership Monitoring Dashboard, Hospital Self-Reported Data (through March 2024)

Regional Partnerships also reported serving non-Medicare and non-Medicaid patients, but not billing for those services provided. On an all-payer basis, statewide cumulative enrollment in DPP has steadily increased since the Catalyst Program began in 2021 and is currently outpacing the nation (Table 4). This data is based on CDC programmatic data that is provided to the State on a quarterly basis and is inclusive of all DPP in the State, not solely RP-attributed DPP. Based on data through January 2024, Maryland has experienced a 261 percent increase in DPP enrollments per 100k since 2018. This rate of change is faster than the nation overall, which experienced a 109.5 percent increase over the same period.

Table 4. Cumulative DPRP Enrollment Rate per 100K Compared to National Average, 2018 - January 2024

	2018 Baseline	Most Recent Rolling 12 Months	Percent Change	National Comparison Change
Rates per 100K (MD)	269.9	974.2	261%	109.5%

Source: CRISP SIHIS Directional Indicators Dashboard, CDC Programmatic Data

Despite this growth, DPRP enrollment as shown here does not reflect whether payers were billed for DPP services, which was a key implementation requirement for Regional Partnerships and informed the decision to terminate diabetes funding early, as discussed earlier in this report. Based on the low Medicare and Medicaid enrollment numbers shown in Table 3 and weighed against the $14.7 million issued in CY 2023, HSCRC staff determined that these programs were not on a path to sustainability and that the level of funding issued through the program was not commensurate with the number of patients served.

DSMT/ES Participation

The HSCRC monitored Medicare DSMT claims in CY 2023 and found that utilization remained below initial expectations when the program launched. Many Regional Partnerships had not fully established billing

[7] Centers for Medicare and Medicaid Services. MDPP Expanded Model Evaluation Report 2: Findings at a Glance. November 2022. https://www.cms.gov/priorities/innovation/data-and-reports/2022/mdpp-2ndannevalrpt-fg Accessed June 28, 2024.

operations for expanded DSMT programs in 2022 and were continuing to rebuild programs after DSMT volumes declined during the pandemic. Additionally, a great deal of DSMT/ES is reimbursed by commercial payers, but HSCRC does not currently measure commercial DSMT/ES claims and Medicaid does not provide coverage for DSMT/ES.[8] Regional Partnerships were expected to aggressively grow their DSMT claims in CY 2023 as billing processes were put into place and the volume of billable services continued to rebound from 2020 lows due to the pandemic. Additionally, the Medicare cost-sharing requirement for patients continued to be a barrier to participation. HSCRC set performance goals for initiating and retaining patients in DSMT. DSMT initiation reflects the count of Medicare[9] beneficiaries with at least one claim for DSMT services. DSMT retention is the count of Medicare beneficiaries with at least 10 units (approximately 30-minute sessions) billed for DSMT services. Multiple units can be included in a single DSMT claim.

Table 5. Regional Partnership Initiation and Retention of DSMT, CY2023

Metric	Cumulative Target	2023 Performance	% of Target
Initiation of DSMT	6,034	2,287	15.03%
Retention in DSMT	3,620	615	6.74%

Source: Medicare CCLF Data

The State also receives annual reports from the CDC on DSMES patient volumes based on data reported by the ADA and Association of Diabetes Care and Education Specialists (ADCES), as shown in Table 6. This data is inclusive of billed and non-billed DSMES. In 2022, Maryland saw a 44 percent decrease in DSMES participants from 2021, compared to a 7 percent decrease nationally. 2023 data is not yet available.

Table 6. DSMES Participation Growth, Maryland vs. Nation, 2019-2022

State	2019 Encounters	2020 Encounters	2021 Encounters	2022 Encounters	Percent Growth (since 2021)
Maryland	11,403	11,705	19,270	10,999	-44%
Nation	975,417	928,895	1,042,253	981,545	-7%

Source: American Diabetes Association (ADA) and Association of Diabetes Care and Education Specialists (ADCES)

As with DPP, DSMT performance fell short of program expectations as well. When considering the ongoing value of the diabetes funding stream, HSCRC considered the total patient volumes for both DPP and DSMT reported against the considerable size of the CY 2023 funding ($14.7 million).

[8] Some MCO reimburse for DSMT with prior authorization.
[9] Medicare Part A and B

Wraparound Services (DPP & DSMT/ES)

Provision of wraparound services to address social drivers of health (SDOH) has been important to Regional Partnership programming. Regional Partnerships deployed CHWs, patient navigators, care managers, and others to screen participants for SDOH needs and connected participants to appropriate resources as a way to encourage enrollment, program retention and improved clinical outcomes.

During CY 2023, Regional Partnerships offered the following wraparound services shown in Table 7 to DPP and DSMT participants. Services supported by vendors and collaborators allowed for participants' needs to be met and helped remove barriers related to social determinants of health.

Table 7. CY 2023 Wraparound Services (DPP & DSMT)

Wraparound Service	Count of Regional Partnerships
Food Access	5
Transportation	5
Exercise	4
Medical Nutritional Therapy	2
Remote Patient Monitoring	3
Mobile Integrated Health	1
Medication Management	2
Financial Assistance	2

Source: Regional Partnership Annual Reporting, CY 2023

Regional Partnerships described multiple efforts to address food access, identified through social determinants screening initiatives. Regional Partnerships routinely enrollees (and often potential enrollees) questions regarding their access to food types, where and how they obtain their food, and what they understand about the connection between their diabetes and nutrition.

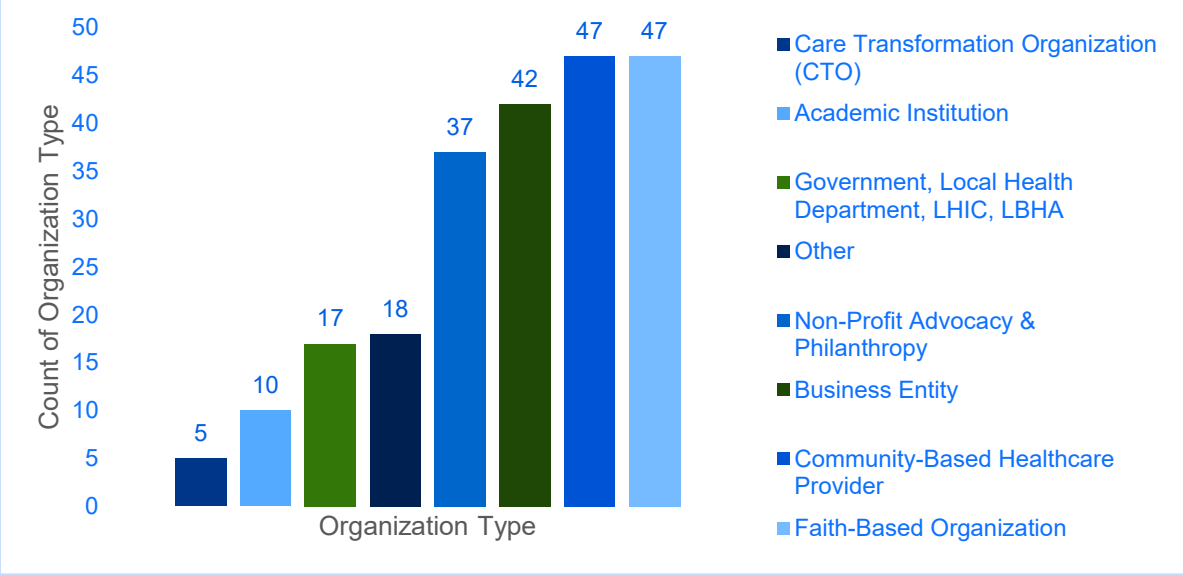
Solutions to provide healthy food included food delivery to participants' homes, virtual supermarket tours and descriptions, and partnering with supermarkets and others on healthy food access programs. Regional Partnerships are also partnering with community- and faith-based organizations to provide cooking classes and demonstrations.

Regional Partnerships addressed transportation through the provision of Lyft rides and connecting participants to existing non-emergency transportation providers. To promote exercise, Regional Partnerships offered participants gym memberships through the YMCA or County parks and recreation facilities, fitness instruction (including virtual), and/or by providing Fitbit activity trackers.

Diabetes Community Partner Collaboration (DPP & DSMT/ES)

The development of partnerships for long-term improvements in population health, and engagement and integration of community resources in the healthcare system are core goals of the Catalyst Program. During CY 2023, Regional Partnerships convened and attended community events with partners to reach potential participants outside of the healthcare setting who may be missed in other marketing efforts. The community events also enabled Regional Partnerships to build relationships with faith, cultural and other community groups that could extend message outreach by a variety of trusted community organizations. In CY 2023, Regional Partnerships also worked with community partners to provide ongoing education about diabetes prevention and management, and to establish in-person classes. Examples included programming and informational outreach conducted through faith-based organizations, apartment complexes, and senior settings. Regional Partnerships also worked closely with community partners to meet participants' SDOH needs; the most common was access to healthy food options. Figure 1 shows the breadth of Regional Partnerships' community partners for diabetes prevention and management. There are a total of 223 community partner organizations across Regional Partnerships. The two most common types of organizations are community-based healthcare providers and faith-based organizations.

Figure 1. CY 2023 Diabetes Program Community Partners



Source: Regional Partnership Annual Reporting, CY 2023

Year Three Behavioral Health Crisis Services Activities

Open Access and Crisis Center Activities and Progress

Regional Partnerships continued to make progress on crisis center activities in Year Three. Activities were focused on continuing to build community partnerships and expand site infrastructure to support an increased volume of patients through multiple care paths.

For the Maryland eastern shore, crisis protocols have been developed for both of TRIBE's sites (Tidal Health and Atlantic General Hospital/Chesapeake Health Care) which will support future growth. Both sites accepted referrals from walk-in patients in Year 3. TRIBE's TidalHealth center was open 7 days a week from 7am to 7pm. The TRIBE Regional Partnership reported a combined volume of 2,560 visits for CY 2023. TidalHealth created an EPIC dashboard to track relevant quality measures and completed SDOH screening for all patients during initial visits (and as needed during subsequent encounters). AGH transitioned its Behavioral Health service line to Chesapeake Healthcare (CHC), a Federally Qualified Health Center (FQHC), as of June 2023. This change will increase access to care by leveraging CHC's higher volume of licensed practitioners. AGH/CHC integrated its SDOH screening process into their EHR in year 3.

The Greater Baltimore Regional Integrated Crisis System (GBRICS) has continued to expand access to immediate-need behavioral health services. GBRICS also reported progress on the Open Access Project (formerly known as Same Day Access). Open Access has launched 50 percent of the clinical sites, with 17 of the planned 24 operational at the end of 2023. Open Access has been launched using phased cohorts, funding for Cohorts 1 and 2 ended as of 2023, though all but one site are still offering services after the end of these contracts. Cohort 3 (with 17 sites) will begin to receive funding in 2024, and plan to offer open access services by July 2024. Open Access clinics are located in Baltimore City, Baltimore County, Howard County and Carroll County.

Totally Linking Care has made steady progress towards opening a new crisis stabilization center, the Dyer Care Center, in Prince George's County. The Dyer Care Center will be the first-ever facility in Prince George's County to provide short-term personalized emergency crisis services to adults experiencing a mental health and/or substance use crisis. The Dyer Crisis Center will operate 24/7/365 and will accept not only walk-in patients but can accept patients directed by EMS and law enforcement. This approach ensures immediate, appropriate care to reduce the burden of public safety resources and the emergency department. Totally Linking care has led on-going workgroup meetings, and individual meetings with iMind and RI International to strengthen communications between 911, 988, mobile response teams, law enforcement, EMS, and the crisis stabilization center teams. The Dyer Center will open in August 2024.

Care Traffic Control Activities and Progress

During 2022, a partnership of three organizations – Baltimore Crisis Response, the Affiliated Sante Group and Grassroots – was selected to jointly operate a Regional 988 Helpline. The 988 operates as a cloud-based call center and utilizes the Behavioral Health Link (BHL) Care Traffic Control software. Implementation of the 988 Helpline occurred in April 2023, providing access to 100 counselors and 5 dispatchers. GBRICS reports a 988 Helpline call volume of 28,364 between May and December 2023. The 988 system is utilized by other Regional Partnerships as a basis for referrals.

The 988 Regional Call Center for Central Maryland went live in April 2023, establishing a regional Care Traffic Control system by implementing a single hotline for substance use and mental health crisis calls. Call volume was immediately high, averaging more than 100 calls per day. Moving forward, BHL will be used to track the source of call volume to 988 from other crisis lines. The 988 Helpline not only takes calls directly, but also serves as a referral from other existing systems (for example, the 211-1, the former crisis line operated by the State of Maryland and calls diverted from the 911 emergency system). This will help GBRICS understand the impact of its 988 marketing efforts. During 2023, GBRICS conducted final training of staff and continued to make system and report customization changes for Care Traffic Control. Other Regional Partnerships reported working to improve coordination, workflow processes and transfer of calls from the 911 and other systems to the newer 988 system. All Regional Partnerships reported receiving referrals from 988.

Continued progress was made on enhancing the Prince George's County Response System via technology. During CY 2022, TLC implemented system integration between the 988 Call Center with the mobile response team dispatch module. Calls from prior systems are still accepted and are routed to the new 988 call center. TLC reported a volume of 2,273 cases for Year 3. TLC-MD, Prince George's County Health Department, and the LBHA finalized standard operating procedures and workflows to make sure that the 988 system and the eight standalone Mobile Response Teams achieve seamless transfers of residents in crisis.

The TRIBE Regional Partnership reported working with the EMS services to identify and divert appropriate cases from emergency rooms to Crisis Centers.

Mobile Crisis Team Activities and Progress

Use of Mobile Crisis Team (MRT) response team continued to develop in CY 2023 as a strategy to divert patients from the ED who do not require a high-level intervention.
Based on continued needs assessments, Prince George's County increased its number of MRTs by two, for a new total of eight. Two person teams include a peer or technician paired with a mental health care professional. Overtime was necessary to staff the MRTs, as workforce shortages continued to be an ongoing challenge. TLC-MD funds four of these eight MRTs, in addition to supporting the development of

videos, marketing materials such as MRT informational cards, and first responder business card identifying the differences between the 988 and MRT services. TLC completed the full integration of the Behavioral Health Link (BHL) mobile response team into IMind (the MRT vendor) as of December 2023. TLC worked with IMind to create customized data collection. The mobile response teams' dispatchers continue to receive calls from community residents via outdated phone numbers, which will require ongoing efforts to improve referral modules. Utilizing the full integration of the BHL Mobile Response unit with the Prince George's County Behavioral Health Dashboard, TLC reported a total volume of 2,273 cases in CY 2023. These cases were referred from a wide range of sources including the 988 system, direct calls from social services, direct calls from the police/fire/EMS, schools, providers and participants. The majority of referrals came from either direct calls from Prince George's County residents or from unidentified referrals.

On the eastern shore of Maryland, TidalHealth reported a collaboration with the SWIFT (Salisbury-Wicomico Integrated First Care Team) to leverage their nurse-led mobile health team. This team utilizes a paramedic, nurse-practitioner, RN and CHW that respond to non-emergency 911 calls that can be addressed more effectively outside the emergency room.

In Central Maryland, several mobile crisis teams went live in May 2023, with more launching in summer 2023 as staff are hired. During CY 2022 GBRICS issued two awards to fund mobile crisis teams. This adds five teams: two shifts seven days per week plus a part-time shift for Baltimore City and Baltimore County coverage; and two shifts seven days per week plus a part-time shift for Howard and Carroll Counties plus additional coverage for Baltimore County. Challenges were reported in hiring staff for these programs. To support these expansions, a non-profit consultant (Dignity Best Practices or DBP) was hired to help resolve operational issues with MRT dispatch. DPT worked to develop common protocols for 988 Helpline to triage and dispatch MRTs. The protocols were reviewed and tested in 2023. Training of staff on final protocols is expected by the spring of 2024.

Behavioral Health Sustainability

Regional Partnerships continued to work toward the sustainability of Catalyst Program behavioral health initiatives. Beginning in CY 2021, Regional Partnerships coordinated with the broad-based effort to establish a statewide mechanism to fund 988 in Maryland. The "Fund Maryland 988 Campaign" brings together more than 70 partner organizations to establish a Maryland 988 Trust Fund. The campaign advocated for legislation during the 2022, 2023 and 2024 General Assembly sessions to lay the groundwork for sustainable funding. In May 2024, Governor Moore signed legislation that established a permanent funding source for the state's 988 helpline.

Regional Partnerships are taking action to ensure the programs they implement are aligned with sources of funding for long term sustainability. GBRICS has formed a Council to guide overall strategy, including plans for sustainability. The GBRICS Council, with 21 members, is internally structured to include key community

partners to guide and support sustainability planning. GBRICS also reports that, with all components of their project launched, their focus has turned to sustainability. In addition, final Medicaid regulations for coverage of mobile crisis services and Behavioral Health Crisis Stabilization Centers were posted in May 2024, providing a critical source of sustainable funding to support crisis services for Marylanders.

Behavioral Health Community Partner Engagement

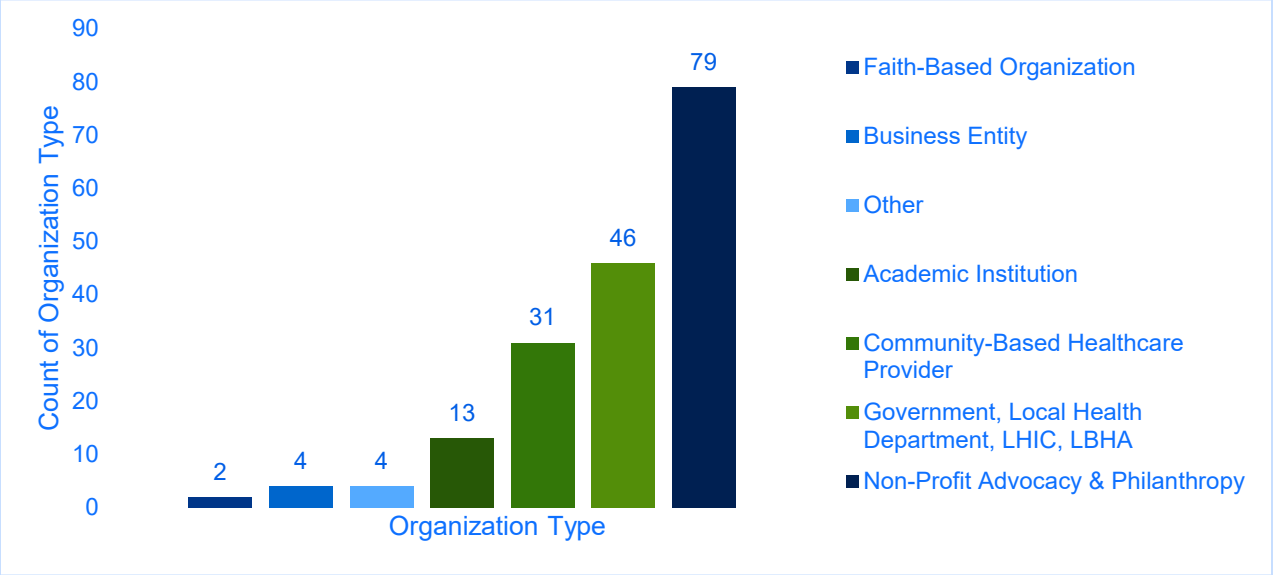
Regional Partnerships continue to recognize the value of conducting meaningful, multi-sector input, and are building on prior year progress. These relationships are vital to communicating the availability of new Catalyst Program services to the public. Regional Partnerships involve local government entities to ensure Catalyst Program efforts complement existing initiatives to develop behavioral health crisis service infrastructure. Key public entities included local government, public safety agencies, faith-based organizations, other health care providers and LBHAs.

Regional Partnerships have formal governance entities intentionally structured to engage a diverse group of stakeholders in guiding the overall strategy, implementation, and sustainability of initiatives. Collaborations helped for example to achieve continuity of care with warm handoffs for patients in crisis, collaboration on individualized patient treatment plans, support in develop of crisis stabilization center policies and procedures, and planning for longer term sustainability of services.

During CY 2023, Regional Partnerships reported the development and execution of MOUs with a range of community partners. MOUs function to ensure workflow, coordination of vendors and multiple partners, and clear accountability through detailed partnership agreements. One particular focus has been a focus on standardization of processes and procedures to ensure warm transfers and support callers in navigating to the most appropriate and timely level of care available under often new (and therefore unfamiliar) systems.

Figure 2 below shows the breadth of community partners for Regional Partnerships receiving behavioral health funding. There were 179 community partners. The most prevalent category was non-profit advocacy or philanthropy organizations, followed by local public entities, and community-based healthcare providers.

Figure 2. CY 2023 Behavioral Health Community Partners



Source: Regional Partnership Annual Reporting, CY 2023

Catalyst Program Budget and Expenditures Summary

Regional Partnership expenditures for CY 2023 are shown in Table 8. Total expenditures across all Regional Partnerships were approximately $31.7 million. The largest category was workforce, with approximately $18.3 million in expenditures. Approximately $9.3 million was spent on other implementation activities, operations, and indirect costs; approximately $1.9 million was spent on IT/technology, and approximately $2.3 million was spent on wraparound services.

Table 8. Regional Partnership CY 2023 Expenditures

	Regional Partnership	Expenditures by Category	Total Expenditures
Diabetes Prevention and Management	**Baltimore Metropolitan Diabetes Regional Partnership**	• Workforce expenditures: **$6,250,720.65** • IT services: **$755,774.07** • Wraparound services: **$229,976.21** • Other implementation activities, operations, and indirect costs: **$2,309,867.06**	**$9,546,337.99**
	Western Regional Partnership	• Workforce expenditures: **$2,942,747.71** • IT services: **$128,965.32** • Wraparound services: **$179,273.71** • Other implementation activities and indirect costs: **$265,284.26**	**$3,516,271**
	Totally Linking Care	• Workforce expenditures: **$182,647.35** • IT services: **$191,150** • Wraparound services: **$0** • Other implementation activities and indirect costs: **$444,324.65**	**$818,122**
	Saint Agnes and Lifebridge	• Workforce expenditures: **$747,786.19** • IT services: **$0** • Wraparound services: **$209,248.90**	**$967,060.75**

		• Other implementation activities and indirect costs: **$10,025.66**	
	Full Circle Wellness	• Workforce expenditures: **$273,230.25** • IT services: **$0** • Wraparound services: **$45,091.12** • Other implementation activities and indirect costs: **$78,208.33**	**$396,529.70**
Behavioral Health Crisis Services	**Greater Baltimore Region Integrated Crisis System**	• Workforce expenditures: **$5,467,373.55** • IT services: **$300,700** • Wraparound services: **$1,243,184.10** • Other implementation activities and indirect costs: **$1,701,016.53**	**$8,712,274.18**
	Totally Linking Care	• Workforce expenditures: **$328,567.51** • IT services: **$334,625** • Wraparound services: **$343,620** • Other implementation activities and indirect costs: **$3,754,685.69**	**$4,761,498.20**
	Tri-County Behavioral Health Engagement (TRIBE)	• Workforce expenditures: **$2,082,742.02** • IT services: **$187,886.44** • Wraparound services: **$0** • Other implementation activities and indirect costs: **$736,144.53**	**$3,006,772.99**
		Total Expenditures	**$31,724,866.81**

Source: Regional Partnership Annual Reporting, CY 2023

HSCRC staff is conducting financial audits of all Regional Partnership spending to verify expenditures. As with all other special funding programs, any unspent funds are removed from hospital rates.

Catalyst Program Health Equity Efforts

Both the diabetes and behavioral health Regional Partnerships continue to intentionally keep health equity at the forefront of activities. Regional Partnerships are purposeful in the selection of community-based partners to reflect the culture, language, and demographics of target populations and gain insight on how to best customize materials and activities for different cultures. Regional Partnerships reported leveraging the community engagement activities and partners to provide feedback and offer recommendations for improvements that support health equity.

Screening for SDOH remains is a core element of the Regional Partnerships. Regional Partnerships report that both MRT and 988 vendors provide language lines to assist callers who require another language or hearing-impaired services. As a routine part of 988 contact, as well as in intake and throughout program activities, participants are assessed for a variety of SDOH and connected to available resources via teams including nurses, social workers, CHWs, and peer recovery specialists. The TLC Regional Partnership reported that they routinely provide marketing and educational materials in Spanish.

Regional Partnerships weave equity considerations into staffing and procurement considerations, for example to recruit diverse and bilingual staff. Regional Partnerships continue to provide interpreter services and services for individuals with hearing impairment. Staffing strategies included hiring more community

health workers reflective of communities served, pursuing grant funding to hired behavioral health peer support specialist, and developing mobile crisis leadership and service providers who are diverse with respect to gender, race, ethnicity, and sexual orientation given that culture matching can mitigate stigma mitigation and help build rapport in crisis situations.

Regional Partnerships also described their continued efforts to promote diversity through procurement, for example prioritizing organizations with strong connections to their local communities that incorporate feedback from the people they serve into their quality improvement efforts, value the roles of people with lived experience, and include small and grassroots efforts. Selecting locally owned minority businesses was another strategy reported.

Regional Partnerships conduct analyses and are beginning to collect some data to identify the specific areas and communities experiencing health disparities. Regional Partnerships have developed strategies to target historically excluded and marginalized communities for marketing and outreach. Regional Partnerships designed their tracking systems to stratify populations by a variety of parameters to facilitate understanding of how services are reaching different populations.

Conclusion

For the Diabetes Prevention and Management Programs, while Regional Partnerships' best efforts resulted in growing referrals, they did not translate into sufficient patient volumes that could help build financially self-sustaining programs. The low patient volumes shown through DPP and DSMT claims led to the difficult decision to discontinue diabetes program funding early. Regional Partnerships can continue to leverage the infrastructure and groundwork laid over the last three years to continue offering these programs to pre-diabetic and diabetic patients, even though HSCRC funding ended June 30, 2024.

During CY 2023 the Regional Partnerships receiving behavioral health funding made significant progress in developing infrastructure and refining strategies and workflow with the collective goal of expanding service delivery. As programs have moved from planning to implementation, Regional Partnerships have shifted the efforts from design toward identifying and addressing challenges identified as programs are launched. Recruiting and staffing persist as sites seek to implement new programs. Regional Partnerships are also investing more in development and refinements to workflows and partner communications to support efficient and effective operations of their initiatives. Looking ahead, the program will focus on Regional Partnerships' Behavioral Health Crisis Service programs, all of which are providing growing services to an expanding population.