

SECTION I

1. Summary of Proposal (Appendix “D”)

Hospital/Applicant	Totally Linking Care in Maryland, LLC
Hospital Members	University of Maryland Capital Region Health MedStar Southern Maryland Hospital MedStar St. Mary’s Hospital Adventist HealthCare Fort Washington Medical Center Luminis Doctors Community Hospital
Health System Affiliations	University of Maryland Medical System MedStar Health Adventist HealthCare Luminis Health
Funding Track	Diabetes
Target Patient Population	
Residents of Charles, Prince George’s and St. Mary’s counties who are: <ul style="list-style-type: none"> • Adults aged 18 and older who are at risk for developing type 2 diabetes or • Adults aged 65 years and older who are diagnosed with type 2 diabetes 	
Proposed Activities	
<p>Activities Targeting Patients:</p> <ul style="list-style-type: none"> • Outreach and Screening • Bidirectional referral to DPP and DSMT services for persons aged 18 and over • Wraparound services – Care Coordination (CC); Medication Therapy Management (MTM), Medical Nutrition Therapy (MNT) and Community Health Worker (CHW) services including linkage to services that mitigate social determinants of health (SDOH) <p>Activities Targeting Health System Providers</p> <ul style="list-style-type: none"> • Technical Assistance and Training around screening, bidirectional referral, and quality diabetes prevention, care, and treatment 	
Measurement and Outcomes	
By 12/31/25 the TLC-MD RP will achieve these outcomes for the target population with pre-diabetes: <ul style="list-style-type: none"> • 40 % of the population will be referred to a National DPP • 12 % of the population will enroll in a National DPP • 6.6% of the population will complete a National DPP • 100 % of DPPs & DSMTs in Service Area able to bill Medicaid, Medicare, and other insurers • 5% reduction in the PQI93 Rate for each hospital participating in TLC RP 	
Scalability and Sustainability	
The RP’s sustainable elements are local health department infrastructure that includes a bi-directional e-referral system accessible to clinical and health-related non-clinical service providers; regional coordination inputs from the Local Health Improvement Coalitions (LHICs) ; and ongoing monitoring and evaluation by the local health departments (LHDs). The RP will also provide training and technical assistance (TTA) to DPPs and DSMTs so that they are eligible for reimbursement from Medicare,	

Medicaid, and other payers. Finally, CRISP patient panel data showing reductions in the total cost of care (TCOC), readmissions, potentially avoidable utilization (PAU), and specific hospital PQI ratings (related to this patient population) will be used to make the case for payer reimbursement (via ROI models) of wraparound services needed to remove barriers to enrollment and completion of DPP and DSMT services. Hospital partners are also committed to use community benefit dollars to cover the cost of screening and DPP and DSMT enrollment for persons who cannot obtain insurance.

Governance Structure

The TLC-MD RP’s Hospital Partners will serve as the fiscal agent and have corporate oversight of the Partnership. The TLC-MD Executive Director will report directly to the hospitals. An Advisory Board will provide additional guidance on RP operations. A three-person Steering Committee composed of the TLC-MD Executive Director, an LHIC Regional Planning Coordinator, and a LH Lead Evaluator, will oversee day-to-day RP operations.

Participating Partners and Financial Support

<i>TLC RP Members</i>	<i>Resource Sharing</i>	<i>Financial Support</i>	<i>In-Kind Support</i>
University of Maryland Prince George's Hospital Center	DSMT, DPP, Medical Nutrition Therapy	Based on % GBR contribution	Determined based on hospital contribution minus cost of services = In-kind support provided/Community Benefit contribution will also be factored in
MedStar Southern Maryland Hospital	DPP, DSMT, Medical Nutrition Therapy	Based on % GBR contribution	Determined based on hospital contribution minus cost of services = In-kind support provided/Community Benefit contribution will also be factored in
MedStar St Mary’s Hospital	DPP, DSMT	Based on % GBR contribution	Determined based on hospital contribution minus cost of services = In-kind support provided/Community Benefit contribution will also be factored in
Adventist HealthCare Fort Washington Medical Center	DSMT, Medical Nutrition Therapy	Based on % GBR contribution	Determined based on hospital contribution minus cost of services = In-kind support provided/Community Benefit contribution will also be factored in

Luminis Doctors Community Hospital	DPP, DSMT, Medical Nutrition Therapy	Based on % GBR contribution	Determined based on hospital contribution minus cost of services = In-kind support provided/Community Benefit contribution will also be factored in
Implementation Plan			
<p>Expansion of DPPs and DSMTs- In addition to brick-and mortar expansion of existing and creation of new DPPs and DSMTs, the RP will promote mobile services that go to where clients live and/or work. If policy changes to support virtual service delivery, the RP will encourage the creation of virtual services. All DPPs and DSMTs in the target area will receive TTA to improve the quality of their services and be eligible for Medicare, Medicaid, and other payer reimbursement.</p> <p>Outreach-The RP will conduct a provider education campaign to raise clinicians’ awareness of diabetes screening guidelines and improve diabetes screening rates; aid providers to engage in bi-directional e-referral; and participate in diabetes care and treatment quality improvement efforts. The RP will launch a social marketing campaign to promote consumer awareness of pre-diabetes and diabetes to prompt residents to seek screening.</p> <p>Screening- The RP’s participating providers will screen patients according to uniform screening guidelines and make bi-directional referrals of persons testing positive to the RP. RP nurses will review patient clinical and service utilization data that are available through the bi-directional e-referral system to assess the need for CC, MTM and/or MNT. RP CHWs will screen for SDOH and identify patients’ need for health-related social needs support provided by wraparound services.</p> <p>Wraparound services –. The RP will offer patients CC, MTM, MNT and/or CHW services-referral and linkage to resources that mitigate SDOH and provide care plan and medication adherence support.</p> <p>TTA to Providers- <i>Clinicians</i> will receive TTA to enhance their adherence to diabetes screening guidelines; facilitate use of the bi-directional e-referral system; improve their use of SDOH assessment data; and improve the quality of the diabetes prevention and treatment services they offer. <i>DPPs and DSMTs</i> will receive TTA so that they become eligible for reimbursement from Medicare, Medicaid and other payers and know how to use the bi-directional e-referral system.</p>			
Budget and Expenditures			
Our (cumulative 5-year total) budget will consist of 7 tasks			
Task 1: Intervention Support: meetings with LHICs, LHDs, CRISP, and our Advisory Board to ensure alignment across all stakeholders for the project			
Task 2: Expansion of DPPs and DSMTs: TTA to DPPs and DSMT program to support use of bi-directional e-referral system and expansion to reach enrollment targets.			
Task 3: Clinical Provider Outreach: outreach, creating and delivering training materials & programs to providers, including training on the CRISP e-referral tool			
Task 4: Patient Outreach: designing and implementing a comprehensive social marketing campaign using social media and grassroots community outreach strategies			
Task 5: Screening: comprehensive “practice reform” to assist physician practices in collecting and “mining” data to measure pre-diabetes, facilitate bi-directional referrals to DPP/DSMT programs and improve screening rates			

Task 6: Wraparound services CC, MTM, MNT, and CHW services assigned according to patient risk and designed to mitigate SDOH and provide care plan and medication adherence support	
Task 7: Monitoring, Evaluation, Overhead to include periodic meetings with the HSCRC to review progress to goals, designing/tracking measures for success, development of regional data collection and submission protocols, continuous clinical data analysis via a care coordination software platform integrated with CRISP, all supported by back office resources for billing, contract review, and administration	

2. Target Patient Population

The Totally Linking Care in Maryland, LLC (TLC-MD) Regional Partnership (RP) will operate in Charles, Prince George’s, and St. Mary’s counties. The TLC-MD RP hospitals and their health system affiliations are the University of Maryland Capital Region Health (Prince George’s Hospital Center and Laurel Medical Center, University of Maryland Medical System); Southern Maryland Hospital and St Mary’s Hospital (MedStar); Fort Washington Medical Center (Adventist HealthCare); and Doctors Community Hospital (Luminis). Table 1 below presents basic demographic data for the target counties.

Table 1: Demographic Data¹ for TLC-MD RP Target Counties

Demographic Category	Target Counties		
	Charles	Prince George’s	St Mary’s
African Americans	49%	64%	15%
White Alone	39%	13%	74%
Hispanic/Latinx	6%	19%	5%
Other	6%	4%	6%
Age			
Persons aged 18 to 64	63%	65%	63%
Persons aged 65 and over	13%	13%	13%

Prince George’s is primarily urban, whereas Charles is a mix of urban, suburban, and rural, and St Mary’s is primarily rural. The list of targeted zip codes and incorporated cities is: **Charles County**- 20603 Waldorf; **Prince George’s County** – 20607 Accokeek ; 20743 Capitol Heights; 20744 Fort Washington; 20745 Oxon Hill;; 20748 Temple Hills; 20783 Hyattsville; 20784 Hyattsville; 20785 Hyattsville; ; 20735 Clinton; 20740 College Park; 20715 Bowie; and **St. Mary’s County**- 20650 Leonardtown; 20653 Lexington Park; and 20659 Mechanicsville. TLC-MD selected these zip codes because they have a high prevalence of diabetes and are currently underserved by DPPs and DSMTs and they are also where TLC-MD member hospitals have existing physician relationships and substantial patient volume and investments.

The portion of the adult population diagnosed with Type 2 diabetes is 14% in Prince George’s and 11% in both Charles and St Mary’s, respectively.² The TLC-MD RP is taking a lifespan approach to diabetes

¹ Data in Table 1 are from US Census QuickFacts <https://www.census.gov/quickfacts>

² CDC US National, State and County Diabetes Data <https://www.cdc.gov/diabetes/data/index.html>

prevention and treatment in the region, and therefore, focuses on personal health behaviors and social determinants of health (SDOH) that are associated with the development of diabetes and indicators of suboptimal diabetes management such as emergency department (ED) visits due to diabetes.

Receiving early prenatal care is important to prevent the onset of gestational diabetes.³ Being overweight or obese at any age can lead to the onset of diabetes and regular moderate or vigorous physical activity aids in attaining and maintaining appropriate weight.⁴ Use of tobacco products puts users at higher risk for developing diabetes and leads to complications in persons who already have the disease.⁵ Having health insurance and a regular primary care provider (PCP) and receiving annual check-ups are essential for maintenance of good health, the early detection of conditions leading to diabetes, and the effective management of diabetes.⁶ However, target population data shown in Table 2 highlight various patterns and disparities that warrant intervention. For example, all the targeted counties have

Table 2: TLC-MD Target Population Diabetes Risk Factors⁷

Jurisdiction	% of Adults who are Overweight or Obese				% of Persons Engaging in regular Physical Activity			
	All	African Americans	Latinx	Whites	All	African Americans	Latinx	Whites
Charles	72	24	--	28	47	45	--	47
Prince George's	75	21	25	32	50	50	45	50
St Mary's	75	--	--	25	50	57		49
Maryland	67	--	--		51	48	43	53
Jurisdiction	ED visit rate due to diabetes				% of adults using tobacco			
Charles	245	349	--	151	15	--	--	16
Prince George's	229	264	148	91	10	--	--	13
St Mary's	300	750		217	19	9	--	21
Maryland	244	454	178	144	14	--	--	--

overall rates of adult overweight and obesity that surpass the state's rate. None of the counties have regular physical activity rates approaching the Healthy People 2020 goal of 67%.⁸ African Americans have a disproportionately high rate of ED visits compared to other races/ethnicities. The data on adults' tobacco use are spotty, but what are available compare negatively to the state's rate.

Only 39% of Latinx in Prince George's report having a regular PCP. The low rate of linkage to a PCP among Latinx in Prince George's may be explained by the fact that 20% of the county's Latinx adults between the

³ Ryan DK, Haddow L, Ramaesh A et al. Early Screening and Treatment of Gestational Diabetes in High-Risk Women Improves Maternal and Neonatal Outcomes: A Retrospective Clinical Audit. *Diabetes Res Clin Pract.* 2018 Oct;144:294-301

⁴ Kirwan JP, Sacks J, & Nieuwoudt S. The Essential Role of Exercise in the Management of Type 2 Diabetes. *Cleve Clin J Med.* 2017 Jul;84(7 Suppl1): S15-S21

⁵ Roderick P, Turner V, Readshaw A et al. The global prevalence of tobacco use in type 2 diabetes mellitus patients: A systematic review and meta-analysis. *Diabetes Res Clin Pract.* 2019 Aug;154:52-65.

⁶ Zhang X, Bullard KM, Gregg EW et al. Access to Health Care and Control of ABCs of Diabetes. *Diabetes Care* 2012 Jul; 35(7): 1566-1571.

⁷ Data are from Maryland State Health Improvement Process <https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx>

⁸ Healthy People 2020 Physical Activity Objectives Accessed at <https://www.healthypeople.gov/2020/topics-objectives/topic/physical-activity/objectives>

ages of 18 and 65 are uninsured in comparison to 11% in Charles and 11% in St Mary's⁹. Prince George's has a relatively high (19%) Latinx population, many of whom are undocumented and hence unable to obtain insurance. This finding may also explain the relatively low ED visit rate due to diabetes reported for Latinx in Prince George's. A similar pattern of racial/ethnic disparities in access to care with respect to Latinx is observed in the data on prenatal care. Particularly noteworthy are Charles County where only 41% of Latinas access early prenatal care and Prince George's where only 51% of Latinas do so. Late entry into prenatal care delays the prevention of gestational diabetes.¹⁰

3. Proposed Activities

Target Populations – Our target patient population consists of adults aged 18 and over residing in Charles, Prince George's or St Mary's counties who are at risk for developing Type 2 diabetes; and adults aged 65 and older who have been diagnosed with diabetes. We will also target the health care providers of both groups of patients. We are targeting these populations for the following reasons. Firstly, we wish to build upon but not duplicate the efforts of *PreventionLink of Southern Maryland*, a CDC-funded chronic disease prevention initiative, led by the Prince George's County Health Department (PGCHD), and operating in Calvert, Charles, Prince George's and St Mary's counties. PreventionLink seeks to increase the number of DPPs in the target area but given the high demand for this service, the RP can safely engage in DPP expansion without duplicating PreventionLink's efforts. Secondly, PreventionLink is expanding DSMES availability via telehealth but is not focusing on DSMT. Therefore, the TLC-MD RP will target persons aged 65 and older with diabetes and ensure their access to DSMT.

Proposed Interventions

TLC-MD will use RP funding to provide the following services- expansion of the number of DPPs and DSMTs operating in the target region; outreach and screening and referral to DPPs and DSMTs; wraparound services to support engagement and retention in and completion of DPP or DSMT programs; and training and technical assistance (TTA) to health care and social service providers to support the activities mentioned above. Our approach to the delivery of these services is guided by several factors.

Firstly, the HSCRC requires regional partnerships to collaborate with the Local Health Improvement Coalitions (LHICs) and Local Health Departments in their target area. TLC-MD began this collaboration by seeking input from these entities while preparing the present proposal and fully intends for these relationships to continue should TLC-MD be awarded a regional partnership grant. Secondly, the TLC-MD-RP builds on PreventionLink which began in 2018, with TLC-MD as a key implementing partner, and has established most of the infrastructure needed to support the proposed RP's aims. However, PreventionLink is a CDC innovation demonstration project that focuses on diabetes (DPPs and DSMES) and cardiovascular disease. It is designed to capture information on the process of DPP and DSMES uptake and does not have numerical patient enrollment targets as does the RP. Furthermore, CDC as a federal funder has not required PreventionLink to consider Maryland's Total Cost of Care Model or State Diabetes Health Plan or to involve the LHICs and local health departments as fully as TLC-MD intends with its RP. The RP will align with these priorities while leveraging and enhancing PreventionLink's infrastructure assets and applying, where feasible, lessons learned and best practices from PreventionLink, to maximize economies of scale and avoid duplication of effort.

⁹ County Health Rankings Data Uninsured Adults in Maryland. Accessed at <https://www.countyhealthrankings.org/app/maryland/2014/measure/factors/3/data>

¹⁰ Ibid

Expansion of DPPs and DSMTs

TLC-MD staff will assess existing DPPs and DMSTs for their expansion potential and vet entities wishing to establish new programs. Currently there are 13 DPPs and 11 DSMTs serving the RP target area; annually they serve approximately 390 persons (DPPs) and 330 persons (DSMTs). TLC-MD understands that HSCRC will finalize expansion targets with each grantee. However, for the purposes of budgeting for the proposed RP, we calculated rough estimates as follows. The total population of adults aged 18 and over in the RP target zip codes is 319,635 of which 10.5% or 33,562 have pre-diabetes. The RP will refer 40% of that number or 13,425 to a DPP. Based on our experience with PreventionLink, we expect that 18% of referred persons or 2,416 will have enrolled in a DPP by the end of the five-year HSCRC funding period. Year 1 is devoted to planning, so assuming a 15% attrition rate among DPP enrollees we propose annual enrollment targets as noted in Table 3 below.

Table 3: Estimated DPP Expansion Enrollment Targets

Year 1	Year 2	Year 3	Year 4	Year 5
0	103	411	1,208	2,416

Table 4 presents rough estimates of targets for DSMT enrollment. These estimates were computed by calculating the total number of patients (8,268) with a type 2 diabetes diagnosis that presented to TLC-member hospitals from December 2018 to December 2019 and then the applying the following estimated scale targets: 0% year 1, 15% year 2, 25% for each of years 3-5.

Table 4: Estimated DSMT Expansion Enrollment Targets

Year 1	Year 2	Year 3	Year 4	Year 5
0	1,240	2,067	2,067	2,067

Given that the current CMS waivers allowing DPPs and DSMTs to offer virtual services may only last until the end of the federal public health emergency declaration, TLC-MD will focus its expansion efforts on the creation of new brick-and-mortar services and mobile service delivery that take DPPs and DSMTs to where prospective clients are; for example, conducting DPP or DSMT sessions in the common room of a senior apartment residence or at worksites of large employers, thereby increasing service accessibility without requiring clients to travel to providers’ facilities. Through our work on PreventionLink, TLC-MD is aware of CDC’s strong interest in promoting virtual DPP and DSMES services. This interest is echoed by residents of the target area who have been surveyed by PreventionLink and has intensified given the disruption of in-person services due to the COVID-19 social distancing and shelter-in-place mandates. Therefore, if awarded an HSCRC grant, TLC-MD will monitor the status of the CMS waivers and should they become permanent during the performance period, we will definitely promote the establishment of virtual services in the RP’s target area.

TLC-MD currently serves as the DPP/DSMES coordinator on PreventionLink. As such, TLC-MD staff recruit DPPs and DSMESs to enroll PreventionLink participants. The TLC-MD staff also delivers TTA to providers so they can become eligible for Medicare, Medicaid, and other insurance reimbursement. Additional TTA addresses DPP and DSMES infrastructure, for example, connecting providers to the bi-directional e-referral system. Given TLC-MD’s solid working relationships with the DPPs and DSMES¹¹ in the RP target area, we do

¹¹ These providers also offer DSMT services.

not anticipate that the RP's *DPP/DSMT Expansion Coordinator* will encounter any opposition relative to proposed service expansion. An added incentive for providers to participate in the project is the fact that the expansion costs will be covered by RP funds.

The Coordinator will begin the engagement with a DPP/DSMT that agrees to participate in the project by conducting a complete organizational assessment to gauge organizational capacity to deliver quality services. Then, based on the assessment, the Coordinator will work with the provider to create a TTA plan that addresses reimbursement eligibility; technological infrastructure; human resources, for example, the capacity of the program's lifestyle coaches; outreach and marketing strategies; and data collection capacity. Typically, most programs can attain their capacity building objectives after 12 months of TTA.

Outreach and Screening

The RP will need to conduct outreach to clinicians and to patients. The following discussion focuses on clinical provider outreach first.

Providers: Many persons who have pre-diabetes or diabetes are not aware of their condition. This is partly due to a lack of screening by their healthcare providers¹². Therefore, the RP will promote routine screening of patient populations that the literature identifies as being at higher risk for diabetes. TLC-MD understands that consumers access healthcare differently, therefore, we will foster a "no wrong door" approach to screening in the region. In other words, any provider that can screen a patient for diabetes during the delivery of routine care will be encouraged to do so for patients who fit a certain risk profile. For example, ophthalmologists should know who among their patients fall into the risk category for pre-diabetes and diabetes and offer them a dilated eye exam that can detect the disease.

TLC-MD research indicates that there are approximately 350 healthcare providers who are likely to interact with the target population of our RP. These include health care providers in the following specialties- Emergency Medicine, General Practice, Family Medicine, Internal Medicine, Obstetrics and Gynecology, Cardiology, Ophthalmology. TLC-MD will implement a *provider education campaign* targeting all providers in these specialties practicing in the RP's target area and using materials from the American Diabetes Association (ADA) and the Centers for Disease Control and Prevention (CDC).

As stated earlier in this narrative, the TLC-MD RP builds on the Prevention Link (PL) project that is currently conducting outreach to 40 providers in the TLC-MD RP target area. Therefore, so as not to duplicate efforts, the TLC-MD RP *Practice Liaison* will coordinate with the PreventionLink staff responsible for provider outreach. Additionally, based on challenges encountered in our PreventionLink provider outreach efforts, TLC-MD is opting to include MedChi, the Maryland State Medical Society, to assist with the RPs provider outreach effort. MedChi will leverage its longstanding relationships with the physician community and its work with CRISP, the Maryland Primary Care Program (MDPCP), and the Maryland Department of Health to offer specific guidance to the RP on the strategies that are most likely to be effective in engaging providers.

The purpose of the campaign is to raise providers' awareness of the importance of screening patients for pre-diabetes and diabetes and referring them to the appropriate community resource. To this end the RP will align its efforts with MDPCP provider outreach initiatives that assist providers to identify at risk patients. Given the high proportion of Black and Latinx residents in the RP's target area, two racial/ethnic minorities with disproportionately high type 2 diabetes incidence rates, the campaign will encourage providers to screen annually all patients 40 and older as well as younger patients with major risk factors

¹² Gopalan A, Lorincz IS, Wirtalla C, Marcus SC, Long JA. Awareness of Prediabetes and Engagement in Diabetes Risk-Reducing Behaviors. *Am J Prev Med.* 2015;49(4):512-519. doi:10.1016/j.amepre.2015.03.007

such as member of a racial/ethnic group with disproportionately higher diabetes incidence rates, obesity or overweight, family history of type 2 diabetes, high cholesterol, history of gestational diabetes, hypertension, sedentary lifestyle, polycystic ovary syndrome, glucose intolerance, sleep disorders, such as sleep apnea, in the presence of glucose intolerance. This screening guideline is provided by the American Academy of Family Physicians and merges guidelines of the US Preventive Service Task Force and the American Diabetes Association, respectively.¹³

The campaign will include:

- Information on the *current screening guidelines* mentioned above, *the clinical markers that warrant a patient's referral to either a DPP or DSMT*, and *how the region's chronic disease Central Referral System (CRS) that is integrated with the regional bi-directional e-referral system*, established by PreventionLink, can facilitate such referrals.
- *An invitation to all providers to receive technical support so that they can connect to the state health information exchange, CRISP, that houses the bi-directional referral system.* CRISP links to provider electronic health records (EHRs) as well as the intake systems of health-related social services in the target area. When a health care provider refers a patient to, for example, a DPP, the referral is sent electronically to the CRS and then to the DPP via CRISP. The DPP, which is also connected to CRISP, can then send periodic updates to the provider on the patient's status. For example, has the patient enrolled in services; if yes, is the patient attending DPP sessions regularly, etc.? These updates allow the provider to monitor patient's progress and make additional referrals and/or adjust the patient's care plan accordingly. The bi-directional e-referral system eliminates the need for providers to rely on often inaccurate patient self-reports on the status of referrals and makes accurate patient data readily available to providers, thereby improving the quality of care. Another advantage of providers' participating with CRISP is that it facilitates their involvement in other regional healthcare efforts that involve data sharing.
- *Information on how SDOHs can affect access to diabetes prevention and management services and the ability to effectively self-manage prediabetes or diabetes.* The campaign will inform providers about how they can use CRISP's bi-directional referral system to refer patients for SDOH screening by the RP and referrals to community service providers (e.g., food banks, housing programs) that mitigate SDOH.
- An invitation to participate in the RP's *quality improvement efforts* (described later in this narrative in the section entitled "Training and Technical Assistance to Providers").

Community: Residents of the RP's target area access healthcare differently and some do so rarely. However, through the RP we hope to empower residents to take proactive control of their health. Therefore, we will design and implement a social marketing campaigns promoting awareness of pre-diabetes and prompting residents to self-screen. The campaign will focus on three high risk groups– Blacks, Hispanics, and pregnant women, and will disseminate the following messages:

- All persons aged 18 and over should take one or both of the following consumer-friendly diabetes screeners – from the CDC <https://www.cdc.gov/prediabetes/takethetest> or from the ADA <https://www.diabetes.org/risk-test>. If self-screening indicates the taker might have pre-diabetes or

¹³ Pippitt K, Li M, Gurgle HE. Diabetes Mellitus: Screening and Diagnosis [published correction appears in Am Fam Physician. 2016 Oct 1;94(7):533]. *Am Fam Physician*. 2016;93(2):103-109.

diabetes then the person should contact his/her health care provider, or if (s)he does not have a PCP then the individual should contact the RP which will coordinate linkage to a PCP.

●Pregnant women should seek prenatal care if they are not already doing so. Women who do not have a prenatal care provider should contact the RP which will coordinate linkage to a PCP. Women should talk to their prenatal care provider about being screened for gestational diabetes if they have one or more of the following risk factors: are overweight or obese; have a family history of diabetes; have given birth to a baby weighing more than 9 pounds; are older than 25; are a racial/ethnic minority; have already been diagnosed with pre-diabetes and/or with hypertension.

TLC-MD's Outreach Coordinator will consult with health literacy experts from the University of Maryland to develop consumer outreach materials that are culturally, linguistically and literacy-level appropriate and uniform in tone and appearance. We will partner with the local health departments' and other RP partners' outreach efforts to disseminate our messages via print, radio, television, social media and in-person contacts (social distancing permitting). These partners include but are not limited to:

- The *health outreach and education programs* of all partner hospitals
- All *ambulatory practices affiliated with TLC-MD member health systems* serving the target area
- *Street outreach* undertaken by programs such as the University of Maryland's *Health Advocates In-Reach and Research (HAIR): Mobilizing Barbershops and Salons for Health and Wellness Project*
- *Casa de Maryland the largest Latinx and immigrant serving organization in the four-county region*
- *Giant Foods and other grocery retailers* that offer community nutrition services
- All *local health department clinics and programs*, including Women's Infants and Children (WIC) programs, smoking cessation services and tobacco quit-lines
- *Managers of public housing and large private apartment complexes*
- *Alumni chapters of Greek organizations* – sororities and fraternities to reach African American residents
- *Public libraries*
- *Local public transit* such as the Bus in Prince George's
- *PSAs on local public access television channels and radio programming*
- *Faith-based organizations* as a means of reaching Black and Latinx residents, for whom spirituality is often an important aspect of health^{14,15}

Screening

The RP's participating providers will follow the diabetes screening guidelines publicized during the provider education effort to identify patients who are at risk for diabetes or who have diabetes. Then, they will use CRISP to make bi-directional electronic referrals of persons testing positive. Providers who participate in the RP's TTA efforts will receive specific assistance to improve their screening for pre-diabetes and diabetes. This work will build on MDPCP data mining algorithms that analyze EHR data to identify patients with elevated A1C levels and those who have not had an A1C measurement in the past 12 months, as well as

¹⁴ Brintz CE, Birnbaum-Weitzman O, Llabre MM, et al. Spiritual well-being, religious activity, and the metabolic syndrome: results from the Hispanic Community Health Study/Study of Latinos Sociocultural Ancillary Study. *J Behav Med.* 2017;40(6):902-912. doi:10.1007/s10865-017-9858-7

¹⁵ Choi SA, Hastings JF. Religion, spirituality, coping, and resilience among African Americans with diabetes. *J Relig Spiritual Soc Work.* 2019;38(1):93-114. doi:10.1080/15426432.2018.1524735

persons with comorbidities, polypharmacy, and other indicators of risk. The RP has engaged a clinical data analysis contractor who previously worked with the MDPCP in a similar role to assist with data mining for at risk patient identification.

Once RP providers identify a patient that is eligible for DPP, DSMES or DSMT services they will make a bi-directional referral using CRISP. The electronic referral will go to the regional CRS. The CRS will first scan the current DPP and DSMT patient database to ensure that the person is not already being served by PreventionLink or another DPP/DSMT in the region. Then, the CRS will triage persons as follows: Persons with pre-diabetes will be connected to an RP DPP partner¹⁶; persons between the ages of 18 and 64 with diabetes will be referred to the PreventionLink project which will facilitate their entry into DSMES; and persons aged 65 and over with diabetes will be referred to a RP DSMT partner. A copy of the referral will be sent automatically to the RP's Care Coordination Unit (CCU), based at TLC-MD, that will monitor and track DPP and DSMT outcomes. Because the referrals are bi-directional, the referring provider and the CCU will receive updates via CRISP from the DPP/DSMT regarding whether the patient has enrolled in the DPP or DSMT to which (s)he was referred.

TLC-MD has learned from PreventionLink that patients need to enroll and receive services as quickly as possible after they have been referred and while their motivation to seek services is at its highest. Therefore, all RP DPP/DSMT partners will be required to contact each prospective client within 48 business hours of the referral, and preferably while the patient is still at the provider's office. During this initial contact, the DPP/DSMT will review the services it offers and the enrollment procedure and respond to any questions that the client might have. The DPP/DSMT will document this and all other client contacts in the CRS, which is accessible to the CCU. Then, within 72 business hours an RP CCU Community Health Worker (CHW) will follow-up with the client to ensure that the DPP/DSMT has made contact, to facilitate completion of the referral and to conduct the SDOH screening for wraparound services that are described next.

Wraparound Services

The RP recognizes that due to a variety of SDOH enrolling and completing a DPP or DSMT program may prove challenging for some clients, and that busy clinical practices may not have the time to follow up with patients even if they receive information from CRISP that the patient has not enrolled or is not attending the DPP/DSMT regularly. Therefore, the RP CCU will monitor all referrals using client follow-up data submitted by the DPPs/DSMTs via CRISP. If a newly referred client fails to enroll in services within 3 business days of referral to a DPP or DSMT program provider or an enrolled client's attendance becomes irregular the CCU will follow-up with the client directly and keep the PCP and the DPP/DSMT abreast of the outcomes. The CCU will contact the patient to ascertain the reasons for the lack of follow through on the referral; assess the patient for barriers to engagement and retention and offer wrap-around services to assist the patient to overcome the barriers.

TLC-MD has learned from its own care coordination experience under the first RP and from PreventionLink that unaddressed SDOH can prevent some patients from enrolling or remaining in services. Therefore, the CCU CHWs will assess patients' SDOH with the *Accountable Health Communities Health-Related Social Needs Screening Tool*¹⁷. The tool covers five core domains: Housing instability; Food insecurity;

¹⁶TLC-MD will ask DPP and DSMT partners to stagger the start dates of their service cohorts so that there is always at least one DPP or DSMT cohort poised to start within two weeks of any referral date.

¹⁷ Billioux, A., MD, DPhil, Verlander, K., MPH, Anthony, S., DrPH, & Alley, D., PhD. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. National

Transportation; Utility assistance; and Personal safety; and eight supplemental domains: Financial strain; Employment; Family and community support; Education; Physical activity, Substance use; Mental health and Disabilities.

The CCU staff includes registered nurses who will access the patients' medical records via CRISP to determine whether the patient could benefit from care coordination, medication therapy management (MTM), medical nutrition therapy (MNT), and/or CHW services. Their assessment will involve a review of clinical and service utilization markers such as: Frequent ED visits and/or hospital readmissions; presence of comorbidities; and patients with diabetes complications. The CCU staff will enter the assessment findings into a risk algorithm that calculates risk based on multiple factors including the number of unaddressed SDOH so as to determine the type and intensity of the wraparound services that the patient will be offered. The principal components of TLC-MD's wraparound service model are Care Coordination, MTM, MNT and CHW services. A description of these services follows.

Care Coordination may be provided by a registered nurse and CHW (all high-risk patients); a registered nurse with occasional CHW intervention (moderate risk); or a RN only (low risk). As the name implies, care coordination services are designed to coordinate the health and health-related social services that a patient needs, including care transitions and exchanges of information among PCPs and specialty care providers and inpatient and outpatient services. The Care Coordination effort must also address the SDOH that could prevent patient's enrollment and completion of a DPP/DSMT. PreventionLink conducted research to identify the most commonly experienced SDOH in the RP target area. They are:

Financial: - As noted earlier in this narrative, a significant proportion the region's Latinx are unable to obtain insurance. There are also insured persons whose insurance does not cover DPP or DSMT services or who have high co-payments, deductibles, or out-of-pocket limits. For these persons, paying for a DPP or DSMT out-of-pocket may be prohibitive. In Prince George's County, the PGCHD in collaboration with the LHIC has created *Health Assures*, a fund that covers the cost of care for persons who are unable to obtain insurance. *Health Assures* funds cover the cost of DPP and DSMT services for Prince George's County residents who are unable to obtain insurance. Currently, Charles and St. Mary's counties do not offer programs similar to *Health Assures*; therefore, the RP has allocated funding to cover the cost of DPP and DSMT participation for residents of these counties.

Transportation- TLC-MD has learned from PreventionLink that the lack of reliable transportation options is a barrier to DPP/DSMT attendance, particularly in rural communities and those without readily accessible public transportation. Therefore, we will map the locations of existing DPPs and DSMTs and only support the creation of new services in areas with high need and less access to these services. Where there are sufficient number of prospective clients with transportation challenges and residing in relatively close proximity to each other, we propose to take the DPP or DSMT to them- making arrangements to conduct the program in the community room of an apartment complex or a senior housing facility; a worksite of a large employer; or at neighborhood FBO facility. In cases where the options just mentioned are not feasible, the RP has allocated funds to cover health-related transportation provided by our medical transportation, in addition to MetroCard's and ride services operated by local faith-based (FBO), senior housing, and community-based organizations (CBOs) and Uber Health and Lyft. The list of collaborators at the end of this narrative includes all of the RP partners' that will accept referrals to assist clients with other SDOH such as food insecurity, housing, and utility assistance that may that take precedence over

Academy of Medicine Perspectives, 1-9. <https://nam.edu/wpcontent/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf>.

DPP/DSMT attendance for some patients.

Health Literacy- PreventionLink has conducted extensive research on what constitute culturally and linguistically appropriate health education materials for a diverse group of clients, including persons who have low educational attainment, are unfamiliar with the American health care system, or for whom English is a second language. The RP will use these research findings to select, and where necessary adapt, CDC and ADA patient materials for our target populations. The proposed materials will be available in English and Spanish at a minimum and possibly other languages, based on LHIC feedback. The materials will assist clients to better understand pre-diabetes and diabetes and the importance of prompt and sustained, evidence-based self-management efforts. We will supplement these materials with a guide to the American healthcare system and how the RP's DPP and DSMT partners integrate with the system. This resource will also be available in the languages primarily spoken in the project area.

Medication Therapy Management (MTM)- Medication Therapy Management (MTM)- Pharmacists will accept RP referrals to offer MTM to support the primary care management of patients with Type 2 diabetes. Pharmacist's staff in collaboration with the RP's clinical provider TTA partner, will give participating RP providers the clinical criteria that warrant a referral for P3 MTM. Providers will make referrals using the bi-directional referral system.

The pharmacist will collect baseline clinical and behavioral measures including: 1) a comprehensive medication list, 2) HgA1c, 3) refill rates of diabetes medication, and 4) medical visits compliance. In addition, a comprehensive review of the patient's medications (OTC, Rx, and herbals) will be performed to assess safety, appropriateness, and effectiveness of drug therapy based on information received from the patient and their health care provider. The pharmacist will also assess patient's' knowledge and behaviors including adherence to medications, proper device use, smoking status, acute care utilization and environmental triggers.

The pharmacists will deliver MTM services in-person or by telephone or telehealth. They will work as a team with the RP CCU's CHWs, PCPs and other providers and community pharmacies to improve patient's medication adherence, making referrals to patient drug assistance programs through various pharmaceutical companies as necessary, and to optimize the patient's medication management. P³ pharmacists will also serve as a resource on drug information to the DPP and DSMT programs participating in the RP to ensure that patients are receiving coordinated and interprofessional care while receiving state of the art pharmacy services.

The pharmacist will document each patient encounter in the HIPAA- compliant system, which links to the bi-directional e-referral system. The documentation system supports the collection and analysis of drug related problems and supports quality assurance reviews of the MTM services by combining clinical, behavioral and medication adherence data in one system. It also tracks the time pharmacists spend on MTM or direct patient interventions through the use of MTM CPT codes to facilitate billing under Medicare Part D. Expected outcomes of the MTM services are improved medication adherence, improved disease management as indicated by improved clinical measures, reduced emergency room utilization, decrease hospitalizations and decreased complications.

Medical Nutrition Therapy (MNT) - The nutrition departments of the RP hospitals will provide MNT which is covered by Medicare for persons with diabetes, non-dialysis kidney disease, and/or who are 36 months post kidney transplant when they are referred by a physician, and when MNT is provided by an registered dietician nutritionist (RDN) who is enrolled as a Medicare Provider. PreventionLink does not provide MNT, but it has emerged as a critical need across the project's target population. Therefore, RDNs at the RP hospitals will jointly develop standard MNT referral criteria that RP providers will employ. The RDNs will receive referrals via the bi-directional e-referral system. They will conduct comprehensive nutrition assessments of referred patients, collaborate with patients to create tailored care plans that include nutrition intervention(s), and transmit updates on patients' progress via the bi-directional referral system.

CHW Services- TLC-MD's CCU Manager, a registered nurse, and the CHW provider's LCSWC will supervise the CHWs and deliver care coordination in collaboration with them. The CHWs' main responsibilities will be: conducting community outreach; conducting baseline and follow-up SDOH screening; assessing for health literacy using the *Rapid Estimate of Adult Literacy in Medicine (REALM)* short form and the *Diabetes Numeracy Test (DNT)* short version; following up on client service referrals; capturing SDOH ICD10 Z Codes for monitoring and reporting; ensuring patients understand how to properly store and take medications and how to monitor glucose levels; providing insurance and social benefit application assistance; and assisting clients to follow their individualized care plan through actions such as motivational coaching to prompt adherence, issuing appointment and medication reminders, and assistance in navigating the health and social service systems in the region. The CHWs will also work to improve client's health literacy and self-management capacity relative to diabetes.

The RP CCU CHWs will use the evidence-based *Pathways Community Coordination* model¹⁸ to create individualized care plans based on assessment findings. The care plan will include a Pathway for each need the client presents. Each Pathway constitutes a series of clearly defined, measurable action steps that must be followed to resolve a specific need. The Pathway will be closed when the interventions are completed, the need is met or the client disenrolls from the program. Over time new Pathways may be opened and added to the care plan in response to newly identified needs that emerge during ongoing client needs assessment. In many cases, patients need referrals to a variety of community resources that address basic social needs such as food, housing, education, transportation, and support along with insurance navigators to assist clients with obtaining health insurance. Guided by TLC-MD's experience on PreventionLink, the RP has partnered proactively with agencies that address a variety of SDOH needs as shown by the collaborators list at the end of this narrative.

Training and Technical Assistance to Providers

Clinicians - The RP's approach to clinical provider recruitment for TTA is informed by TLC-MD's experience recruiting providers for PreventionLink's TTA. We have invited MedChi and MDPCP to partner with us on this RP task so that we can leverage their longstanding ties with the provider community. Doing so will also minimize duplication with MDPCP provider capacity building services but instead build mutual reinforcement of our respective efforts.

The RP *Practice Liaison* will meet with target providers to make a presentation on the project and the TTA aims, in the context of the Total Cost of Care model, and how participation in TTA can improve the quality of

¹⁸ Redding S, Conrey E, Porter K et al. Pathways community care coordination in low birth weight prevention. *Matern Child Health J.* 2015 Mar;19(3):643-50.

the services the provider offers and have a positive effect on the practice's bottom line. The Liaison will also provide testimonials from local providers that have successfully participated in similar practice transformation efforts undertaken by PreventionLink. The Liaison will coordinate closely with PreventionLink so that the providers already targeted by that project are not also enrolled in the RP.

TLC-MD has selected PreventionLink's practice transformation partner to serve as our Provider TTA partner. This partner will deliver a combination of virtual and in-person quality coaching, virtual group education and performance data feedback to help providers increase the proportion of patients who are screened for prediabetes and diabetes, increase the proportion of patients with diabetes who have diabetes under control as measured by hemoglobin A1c value, connect to CRISP for referring patients to DPP and DSMT, and increase the number of patients who are referred for DPP and DSMT.

Services include assistance using EHRs to identify patients who need to be screened and implementing reminder systems. In addition, this partner will provide implementation support; for example, guidance on revising workflows to ensure that screening and testing occur consistently and that results trigger appropriate actions. Other services include the analysis of claims, EHR and other data to generate practice-level reports that displayed improvement over time on both process (e.g., screening) and outcome (e.g., hemoglobin A1c level) measures.

Provider Engagement- After practices have been recruited by the RP Practice Liaison, they will be onboarded by their assigned Quality Improvement Advisor (QIA). The QIA serves as the practice's single point of contact for improving performance on diabetes management and self-management education referrals. As part of onboarding, the QIA will assess the practice's use of EHR and CRISP functionalities, their current approach to population health management (including diabetes), their baseline performance on the hemoglobin A1c measure NQF#0059, and the nature and extent of their clinical-community connections.

In experience, about 75% of the practices engaged in PreventionLink TTA did not use workflows or care plans. A similar proportion did not have experience using a data collection tool or using run charts to visualize performance improvement over time. None had experience using registries or population health management tools. As a result, the initial assessment will incorporate questions about experience with these common strategies for improving patient outcomes and practice efficiency. QIAs will provide education and training to close skill and knowledge gaps prior to implementing DPP/DSMT screening and referrals and before adopting diabetes care models.

QIAs will ask each practice to identify current needs and priorities, so that their action plan for improving diabetes/prediabetes management can be addressed. For example, if the practice has lost revenue as a result of COVID-19 and needs help establishing telehealth, the QIA will help them establish telehealth and pilot its use for follow-up visits with patients with newly diagnosed diabetes or recent changes to diabetes medications.

As an added incentive, each quarter, QIAs will incorporate strategies to restore the joy in primary care practice.

sets and pre-visit labs. This approach responds not only to the increasing pressure under which primary care providers operate, but also to the needs of practices that are stretched thin.

QIAs will visit each practice quarterly to review performance data and modify improvement strategies, and ensure alignment with other projects, so that the practice is receiving the best value from the program. QIAs will also hold virtual meetings with practices on a monthly basis, so that momentum is kept in-between in-person visits. QIAs remain responsive to practice's needs, sending new tools and resources as available and other helpful information, such as quality reporting updates. If a practice becomes unresponsive or misses a scheduled check-in, the QIA will contact the practice each week, varying the type of touch, from email to telephone calls until they are able to reengage the practice.

Identifying Prediabetes and Diabetes- QIAs will help practices establish reliable systems and consistent processes for conducting diabetes screening for all patients 40 years old and over, as well as younger patients with major risk factors. This includes teaching practices how to implement the American Diabetes Association (ADA) Prediabetes Risk Assessment, an evidence-based tool endorsed by the CDC, the American Medical Association (AMA), and the ADA. Patients can independently complete this assessment in 60 seconds without the need for a blood test (i.e., glucose or A1c). Patients qualifying as prediabetic are recommended for participation in a DPP if they score a 5 or higher. QIAs will also assist practices in adopting the ADA's criteria for testing for diabetes and prediabetes in asymptomatic adults using an A1c, fasting plasma glucose, or an oral glucose tolerance test.

Diabetes/Prediabetes Management and Educational Referrals- QIAs will assist practices to use EHR-based disease registries to manage prediabetics and diabetics to ensure quality patient education upon initial diagnosis, timely lab work, and coordination of care with other healthcare and community resource providers. QIAs will also assist practices to establish an EHR alert based on a patient's A1c value that suggests the appropriate educational referral (DPP, DSMT), and establish a workflow for using the RP's bi-directional e-referral system to make and track referrals. QIAs will ensure that practices know how to use CRISP and are uploading patient panels regularly, as our experience on PreventionLink indicates many practices lack this capacity and do not understand how to keep their patient information up to date within CRISP.

DPPs and DSMTs -One of TLC-MD's primary responsibilities on PreventionLink is recruiting and supporting DPP and DSMT project partners. In this capacity, TLC-MD has observed that a significant challenge to DPP and DSMT viability is the inability of some programs to bill for reimbursement from Medicare, Medicaid, and private insurers. This affects their sustainability since they typically do not attract a sufficiently large number of clients able to pay for services out-of-pocket. For DPPs, the ability of an organization to bill for services is based on the organization's CDC-recognition. To bill for services through Medicaid, a DPP with Pending CDC-recognition must apply and be approved to be a Medicaid supplier and then contract with at least one of the nine Managed Care Organizations in Maryland. To bill for services through Medicare, a DPP with Preliminary or Full CDC-recognition must apply and be approved to be a Medicare supplier. To obtain reimbursement, DSMT providers must have American Diabetes Association (ADA) recognition and/or American Diabetes Care and Education Specialist (ADCES)-accreditation and be an approved Medicare supplier.

The RP's *DPP/DSMT Expansion Coordinator* will deliver TTA to CDC-recognized DPPs so that they can obtain and/or maintain full recognition by increasing participant enrollment, engagement, and retention, which are major factors in the CDC analysis to determine program recognition status.

The RP’s *DPP/DSMT Expansion Coordinator* will provide all existing and newly formed DPPs/DSMTs with the TTA they need to establish systems for claims, billing, and coding so that they can be eligible for reimbursement from all payers that cover DPP and DSMT services for Maryland residents. The Coordinator will also train DPPs and DMSTs on how to use the RP’s bi-directional e-referral system. Finally, should the CMS virtual service waivers become permanent, the Coordinator will adapt the PreventionLink DSMES Telehealth Training Program and a Toolkit to assist DSMT providers to deliver DSMT services virtually.

4. Measurement and Outcomes

From our care coordination work that was funded by the first HSCRC Regional Partnership, TLC-MD has learned the importance of creating patient panels, in collaboration with CRISP, to support the assessment of the impact of care coordination and other wraparound services on readmissions, potentially avoidable utilization (PAU), and PQIs to demonstrate TCOC savings. CRISP patient panels will play a key role in RP performance measurement (via the CRISP pre/post reports). CRISP and TLC’s population health software platform will greatly facilitate patient panel creation and allow TLC-MD to measure the effect of the RP’s wraparound services on the program’s desired outcomes in reducing total cost of care (TCOC), reductions in readmissions, PAU, and specific PQI indicators related to this patient population. These data are critical for the RP’s sustainability as they will be used to make the case for payer reimbursement (via ROI models) of wraparound services needed to remove barriers to enrollment and completion of DPP and DSMT services.

The PGCHD’s Office of Assessment and Planning (OAP), the PreventionLink evaluator, will also serve as the RP evaluator. PGCHD OAP will work with the RP’s clinical data analysis contractor to combine DPP and DSMT data to inform patient panel analyses. The RP Evaluator will also work with CRISP to leverage the practice management data that physician practices currently send to CRISP as part of the MDPCP program, since CRISP has already created custom interfaces to accommodate the various systems that providers use.

The RP will need to provide the LHICs with data on the prevalence of various SDOH to inform the LHICs’ policy agendas as they relate to chronic disease prevention and treatment in general and diabetes in particular. Therefore, we propose to track additional performance measures relative to the uptake and impact of the RP’s wraparound services. The source of these data will be CRISP and CRS that houses the regional bi-directional e-referral. We will also track the number and proportion of providers who receive TTA to improve their diabetes screening rates and deliver quality diabetes care and treatment, as these measures capture the capacity of regional providers to deliver screening and treatment and can be used to show the connection between improved provider capacity and DPP and DSMT referrals. These additional performance measures are presented in Table 5 below.

Table 5. Additional TLC-MD RP Performance Measures

Target	Logic	Numerator	Denominator
Persons receiving care coordination	Care coordination (CC) enables persons to enroll and complete DPP and DSMT services	# of DPP enrollees receiving CC	# of persons who enroll in a DPP
		# of DSMT Enrollees receiving CC	# of persons who enroll in a DSMT
Number of SDOH that are resolved	Solving SDOH barriers facilitates DPP & DSMT enrollment & completion	# of CC Pathways for DPP clients that are closed	Total # of CC Pathways for DPP clients ever opened
		# of CC Pathways for DPP clients that are closed	Total # of CC Pathways for DPP clients ever opened

Target	Logic	Numerator	Denominator
Types of SDOH that are resolved	Some types of SDOH may require policy changes to resolve	N/A	N/A
Number of persons receiving MTM	MTM can improve medication adherence leading to improved health outcomes	# of patients on diabetes medication who are enrolled in DSMT and who receive MTM	# of patients on diabetes medication who are enrolled in DSMT
		# of patients on diabetes medication who are enrolled in DSMT and MTM who achieve HgA1c <9	# of patients on diabetes medication who are enrolled in DSMT
Quality Improvement # of clinical providers improving quality of diabetes screening & management	Following screening guidelines increases the number of persons who are diagnosed with pre-diabetes and assisted to avert developing diabetes	# of primary care providers (PCPs) who complete screening TTA	# of PCPs in the region
	Delivering treatment according to guidelines improves clinical outcomes for patients with diabetes	# of PCPs who complete quality treatment TTA	# of PCPs in the region

5. Scalability and Sustainability

The TLC-MD RP will be sustainable and scalable after the funding period because its infrastructure is built on public health utilities; specifically, the bi-directional e-referral system and CRS as well monitoring and evaluation support that reside in the local health departments and the LHICs. By building on the foundation already laid by PreventionLink, the RP will learn from that project's successes and failures and move expeditiously towards expanding what works while avoiding the pitfalls encountered in PreventionLink's implementation. Additional RP design elements that promote sustainability and scalability include the assignment of a Regional Planning Coordinator to collaborate with the LHICs to ensure that the RP remains in programmatic and fiscal alignment with the region's priorities. The RP is also leveraging the experience of the PGCHD OAP, the PreventionLink evaluator, to serve as the RP evaluator. The OAP epidemiologists understand how to assess projects that integrate public health and primary care in a population health framework, as they already provide the LHICs with data they use in their deliberations. Over the course of the project they will provide the RP with data needed to inform mid-course adjustment, refine RP operations, and increase the likelihood of sustainability. By the end of the HSCRC funding period we will accomplish three goals that will ensure sustainability:

- 1) All DPPs and DSMTs operating in the target area will be certified to bill Medicare, Medicaid, and other payers for their services.
- 2) We will have robust cost data demonstrating the cost effectiveness of the core wrap around services for consumers in terms of their impact on ambulatory sensitive hospitalizations, ED visits, and hospital readmissions. We are confident that when presented with these data payers will be willing to cover the cost of wrap around services.

3) Should the CMS virtual service waivers prove permanent, all DPPs and DSMTs will have received TTA to be able to operate virtually, thereby expanding their reach.

Finally, the RP's hospital partners have pledged to use a portion of their community benefit dollars, in the future, to cover the cost of screening and DPP and DSMT enrollment for persons who are unable to obtain insurance.

6. Participating Partners and Decision-Making Process

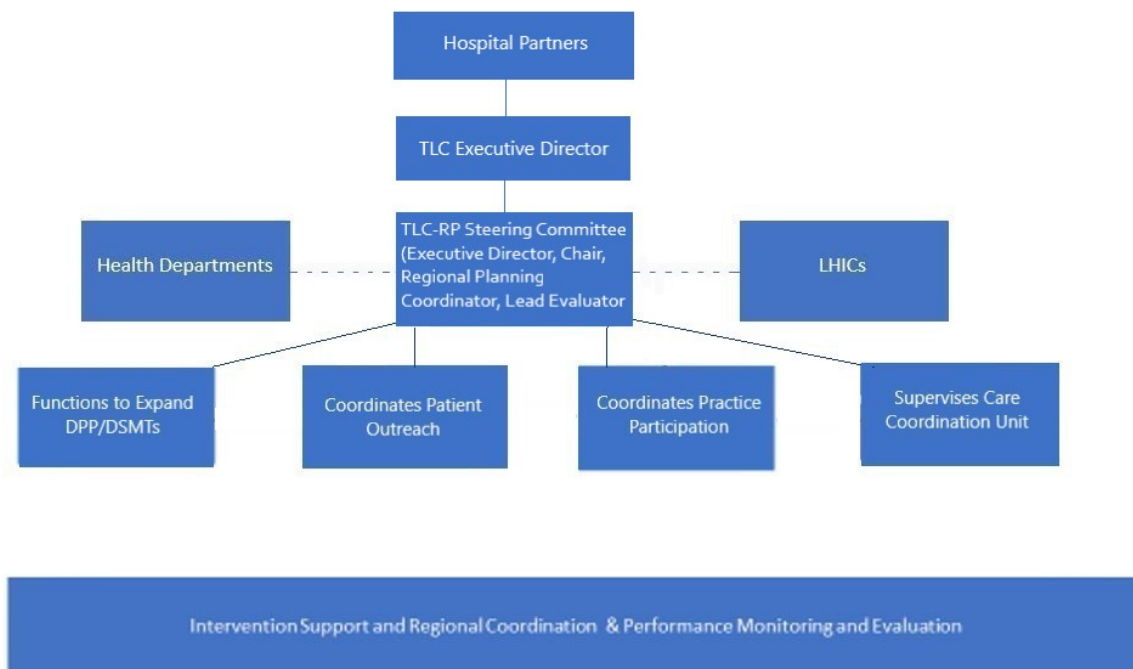
The TLC-MD RP's Hospital Partners will serve as the RP's fiscal agent and corporate overseer. The partner hospitals have created a Fiscal Oversight Committee consisting of one representative from each hospital as well as the TLC-MD Executive Director. This Committee will address financial decisions including creating budgets, vetting vendors, and authorizing payments. Representatives from each hospital will vote on the decisions the Committee proposes to make. One of the partner hospitals will function as the "finance department" and will oversee bank accounts, financial reporting, and accounts payable.

Initial Capital Contributions. The Initial Capital Contribution shall be the funding amount included in each partner hospitals' GBR revenue by HSCRC for the initial year of operation in connection with the RP. The funding amount shall reflect the anticipated revenue to be collected by the hospital from the gross revenue amount of the Grant ("Net Collections") for each hospital (the "Required Initial Contribution"). The Required Initial Contributions shall be made monthly in advance. The capital investment will be adjusted annually prospectively in the event any partner hospital is unable to contribute the full grant amount awarded (net of Mark Up included in the Grant) by reason of inability to collect the full amount of Global Budgeted or Total Patient Revenue in the given year, with any underage to be paid in the following year.

Annual Capital Contributions. The partner hospitals have agreed that each will make annual capital contributions to the RP of an amount equal to the Net Collections of the Grant amount added to rates in any year by the HSCRC as part of the Grant program (the "Required Annual Contribution," and with the "Required Initial Contribution," the "Required Capital Contributions").

The TLC-MD Executive Director will report directly to the hospitals. The RP will have an Advisory Board composed of representatives from the County Health Departments, the Hospital Partners, and the LHICs. We will request that the LHICs include at least two patients with diabetes among the representatives that they assign to the Board. The Board will have rotating co-chairs with the positions being held by Health Department, LHIC and Hospital Partner representatives. The Board will meet quarterly, and its primary role will be to provide direction aimed at making the project fully responsive to regional needs and to explore project sustainability strategies. Figure 1 presents the RP's organizational chart. A three-person Steering Committee, composed of the TLC-MD Executive Director, an LHIC Regional Planning Coordinator, and a Local Health Department Lead Evaluator, will oversee day-to-day RP operations. The specific responsibilities of each Steering Committee member are discussed next.

Figure 1: TLC-MD RP Organizational Chart



The **TLC-MD-Executive Director (1FTE)** will serve as the liaison between the hospital partners and the RP. He will meet monthly with hospital partners to solicit their feedback and report on RP operations. The *Executive Director* will be the RP’s point of contact with the HSCRC and facilitate communication between HSCRC and other RP staff and consultants, as necessary. The *Executive Director* will be responsible for compiling all financial and programmatic reports-based on input from the relevant staff and submitting them as required by HSCRC. The *Executive Director* will also directly supervise the *DPP/DSMT Expansion Coordinator*; the *Patient Outreach Coordinator*; the *Practice Liaison*; and the *Care Coordination Unit Manager*.

The **LHIC Regional Planning Coordinator (1FTE)** will deliver intervention support around the selection and planning of the various activities that the RP will implement. This Coordinator will be hired by the LHICs but paid for with RP funds. The Coordinator will:

- set uniform standards for all RP interventions, e.g. requiring that all RP CHWs receive the same training; collaborate closely with QIAs to implement quality assurance activities so that across the RP there is a core menu of evidence-based interventions that reflect the latest science but allows for customization by individual clinical partners;
- solicit feedback from the LHICs and the county health departments on how RP activities should align with regional and county-level priorities; operationalize this feedback into actionable steps; and
- work with TLC-MD and clinical partner staff to integrate the steps into RP activities. This approach will lead to the regional, multi-system, multi-disciplinary integration of chronic disease prevention and management services rather than siloed activities undertaken by disparate projects.

As our current experience with COVID-19 underscores clearly, public health priorities can change overnight; therefore, the Coordinator will maintain regular communication with the LHICs, the county health departments, and the RP hospital partners to facilitate the (re)alignment of RP activities over time. This effort will be greatly facilitated by Coordinator's attendance at LHICs' hospital workgroup meetings to discuss current and future RP implementation plans and how these fit within the broader public health context.

The **Lead Evaluator**, a PGCHD OAP epidemiologist, will head the RP's monitoring and evaluation efforts that assess the RP's progress towards the HSCRC enrollment benchmarks and the effectiveness of the wraparound services and the provider TTA. OAP will also transmit evaluation findings to the LHICs and assist them to interpret their implications for regional chronic disease prevention and management. For example, where evaluation data indicate that progress is not being made due to gaps in services or policies that hinder patient access to needed services, the OAP will present these data to the LHICs so that they can formulate effective responses at the county or even regional level. The OAP Team will present RP process and outcome data at regularly specified intervals to the LHICs so that the latter can assess the RP's alignment with regional health priorities and use the data to inform the selection of future regional chronic disease priorities. This approach continues the current custom of the OAP team presenting community health needs assessment data to the PGC LHIC which then uses these data to refine the County's Population Health model. The LHIC Hospital Workgroups will have access to RP health system performance data that they can use to promote county and region wide quality improvement in chronic disease prevention and treatment. Additionally, the OAP will respond to ad hoc data requests from the LHICs, the local health departments, and/or the RP clinical partners.

The OAP will collect and analyze RP process data from the bi-directional e-referral system to inform understanding of the pattern of observed outcomes. As PGCHD employees, the OAP staff have ready access to the IT consultants and system engineers that maintain the system. OAP staff also have a close working relationship with CRISP, which collaborates with PGCHD contractors to implement and maintain CRISP. OAP staff are intimately familiar with the system's functionalities and can advise TLC-MD on its capabilities and limitations and how to collect data in a manner that leverages the system's assets. OAP will also be able to monitor data quality and, make recommendations to the RP on data collection protocols and to CRISP administrators on the network's data management, storage, and retrieval functions as they relate to RP needs.

Decision making: The *Steering Committee* will meet weekly to review progress towards work plan goals and objectives; devise action plans; forecast needed resources; and proactively identify potential problems and brainstorm solutions. Problems that cannot be resolved by the Steering Committee will be referred to the monthly Hospital Partner meeting attended by the TLC-MD Executive Director.