On behalf of the three partner hospitals,
Frederick Health Hospital,
Meritus Medical Center,
And
University of Pittsburgh Medical Center Western Maryland

Response to Request for Proposals

Regional Partnership Catalyst Grant Program

Funding Stream I: Diabetes Prevention and Management Programs

Presented to the
Maryland Health Services Cost Review Commission (HSCRC)

JULY 19, 2020

Section I: Scope of Work

1. Summary of Proposal

Hospital Applicant:	The Trivergent Health Alliance (Western Regional Partnership) consists of co-lead applicants: Frederick Health Hospital (FH), Meritus Medical Center (MMC), and University of Pittsburgh Medical Center Western Maryland (UPMC Western Maryland)
Hospital members:	FH, MMC, and UPMC Western Maryland
Health System Affiliations:	Trivergent Health Alliance, LLC.
Funding Track:	Funding Stream I: Diabetes Prevention and Management Programs
Total Budget Request:	$17,615,626

Target Patient Population
The Western Regional Partnership (WRP) will target populations in Allegany, Frederick, and Washington counties, including (1) Persons in geographic hotspots - Allegany County (21539, 21562, 21532, 21502), Frederick County (21701, 21702, 21703, 21704, 21705, 21709, 31520, 31521, 31522, 31527, 21788), and Washington County (21740, 21742); (2) Persons with pre-diabetes or diabetes; (3) African American and Latinx populations; (4) Persons with diabetes-related comorbidities.
Proposed Activities
We will use grant funds to implement a full menu of wrap around assessment, culturally responsive engagement, social service navigation, and complementary medical services to increase recruitment and retention in the National Diabetes Prevention Program (DPP) and Diabetes Self-Management Training (DSMT). The primary interventions for our model are: **DPP and DSMT-** (1) Increase number of certified leaders, participant recruitment and retention, and class offerings for DPP; (2) Rapidly expand virtual, in-person, and hybrid capabilities of DSMT. **Wrap around Services-** (1) Implement and expand evidence-based nutrition and physical activity programs into current patient practice and coordinate with external partners; (2) Integrate mental health screenings into patient intake and recommended follow up in care plans; (3) Partner with Community-Based Organizations (CBOs) and deploy Community Health Workers (CHWs) to engage communities in social needs screening and resource navigation.
Measurement and Outcomes
We will systematically monitor and assess progress towards our implementation and outcome goals. Our work will be grounded by evidence-based assessments of diabetes (DM) risks, co-occurring disorders, and social risks. We will engage clinicians in this new DM prevention and management system of care by creating electronic medical record (EMR) flags and automated reports that connect social risk data to clinical data. Clinician guides will support appropriate referrals to DM prevention, management, and wrap around services. In addition, our monitoring and evaluation model is based on best practice in identifying, engaging, and supporting patients to understand and learn to self-manage their health conditions. We seek to monitor high-risk and rising-risk patients across the continuum of services. The plans for hospital specific measurement and outcomes will be finalized in the first award year but we plan to measure: # of certified DPP Leaders & DSMT Facilitators; % of population with DM and Pre-DM referred to DPP and DSMT; Enrollment rate of referred population in DPP and DSMT; Completion rate of referred & enrolled populations in DPP and DSMT; # of DPP & DSMT participants referred to additional nutritional & physical activity support services; % of DPP & DSMT patients engaged in additional nutritional & physical activity support services; # of persons with

DM & pre-DM screened for BH and social needs; % of those screened referred to BH Specialist; % of those engaged with resolution of > one social need.
Scalability and Sustainability
Our year one investment in building and testing the infrastructure, systems, and partnerships to engage our target communities in DPP, DSMT and other evidence-based DM prevention and management interventions will provide a foundation for collective action. Resource sharing among our partners will facilitate greater cost-sharing and savings over time. In year two, we will develop a formal sustainability plan that will build on the Maryland Primary Care Program (MDPCP) and care transformation infrastructure. The MDPCP program incentivizes primary care practice transformation to improve health outcomes among persons with DM and co-occurring chronic disease. Requirements to risk stratify patients, increase access to care through alternative care strategies, provide comprehensive medication management, referral management, BH integration, and health-related social needs will strengthen and sustain the impact of our DM prevention and management programs. We will measure the ROI associated with all our strategies, including through reports generated through CRISP and we will continue to support programs that reduce the total cost of care after this program ends through global budgets, care transformation initiatives, billable services, and non-HSCRC grants.
Governance Structure
The governance structure establishing the Trivergent Health Alliance (THA) Board of Directors in July 2016, which is comprised of FH, MMC and UPMC Western Maryland CEOs will continue as documented in Appendix A. Each hospital will appoint two representatives to the THA Executive Committee (EC) to work together on the development and continuous improvement of the DM prevention and management programs and to coordinate execution of those programs. The EC will be the WRP advisory body. Decisions will be consensus based. Each hospital agrees to implement the activities planned in our proposal, which describes how we will use grant funds to partner with Local Health Improvement Coalitions (LHICs), Local Health Departments (LHDs), and Community Based Organizations (CBOs). Recommendations of the EC are subject to review and approval by all the hospitals, and each hospital will be responsible for executing those recommendations in its service area. In addition to the EC, the WRP will establish a regional DM committee that will meet monthly. The WRP DM committee will include at least two representatives of each county's DM teams who will manage Funding Stream I coordination, learning, and reporting. These WRP DM committee members will represent each hospital's county specific DM committees. Membership of the county specific DM committees will include each hospital's DM and care coordination leadership, consumers, and DPP and DSMT partners. On-the-ground teams will meet at least monthly to coordinate the development of high-functioning DM prevention and management ecosystems in Allegany, Frederick, and Washington counties.

Participating Partners and Financial Support List member hospitals/community collaborators and describe any resource sharing, financial support and/or in-kind support, if applicable.

DM committees that include each hospital's DM and care coordination leadership, consumers, and DPP and DSMT partners will manage county-specific implementation plans, budgets, partnerships and systems of care. Hospital staff will support outreach and engagement of partners who will work together on hot-spotting target populations and mapping of the existing care ecosystem to develop and implement interventions tailored to populations' needs. Most partners will receive financial or in-kind support from hospitals as detailed in the hospital budgets. Participating partners include:
FH- Frederick County Health Department, Maintaining Active Citizens (MAC)/ Maryland Living Well Center for Excellence programs, YMCA, Frederick Integrated Healthcare Network, Share Food Network, Frederick County Food Banks, Frederick City Housing Authority, and Mission of Mercy
MMC- YMCA, Commission on Aging (COA), Washington County Health Department, Medication Assistance Center, Coordinated Approach to Child Health (CATCH), Boys and Girls Club, Healthy Washington County (LHIC)
UPMC Western Maryland- Maryland Area Health Education Center West (AHEC West), Allegany County Health Department, Associated Charities, Western MD Food Bank, Human Resources Development Commission, Allegany County Health Planning Coalition, Aramark

Implementation Plan

We will begin implementing our work upon receipt of award and in year one, dedicated hospital and partner program staff will be recruited and on-boarded. We will convene partners in program launch events to generate excitement about our goals, discuss the roles of each partner, and present how all the services will come together. We will map an ideal DM prevention and management ecosystem, identify gaps in DM care, create plans for addressing these gaps, and begin recruitment and retention planning. Years two through five will focus on fully scaling activities to full performance and continuous process improvement to ensure desired outcomes are being achieved. We will refine our sustainability plan over the course of the work and will evaluate pilots and tests to make strategy adjustments to improve outcomes. Additionally, we will monitor progress towards goals and objectives and study root causes of deficiencies to adjust strategies.

Budget & Expenditures

Our summary costs by hospital and by year are shown below. This includes all the costs (workforce, IT/Technology, and enabling infrastructure) to implement the strategies.

Sponsor Hospital:	**CY 21**	**CY 22**	**CY 23**	**CY 24**	**CY 25**
FH	$956,465	$935,491	$918,218	$947,498	$932,896
MMC	$1,367,959	$1,391,044	$1,414,591	$1,438,609	$1,463,107
UPMC	$1,169,782	$1,169,991	$1,170,000	$1,169,982	$1,169,993
Regional Request by year:	**$3,494,206**	**$3,496,526**	**$3,502,809**	**$3,556,089**	**$3,565,996**

2. Target Population

The WRP convened hospital and community experts in DM prevention and management to analyze each county's demographic data, DM risk factor information, avoidable DM healthcare utilization and costs, and trend information to understand the best approach to reach bold DM prevention and management goals. We used a data-driven approach to pinpoint the greatest opportunities for improvement in our tri-county region and used this information to identify target populations and respective activities and services that will have a significant impact on these populations' healthcare cost, quality, and outcomes. The geographic scope of the WRP is the three counties that our hospitals and affiliated providers serve: Allegany, Frederick, and Washington counties. More than 455,000 Marylanders live in our region and will be reached through our efforts. The incorporated cities and towns, ZIP codes, and hospitals in the WRP target population included within the geo-political county boundaries are detailed below:

Table 1. Counties, incorporated cities and towns, ZIP codes, and hospitals within the WRP service area.

	Incorporated Cities & Towns	ZIP Codes	Hospitals
Allegany County	Cumberland, Frostburg, Barton, Lonaconing, Luke, Midland, Westernport	21521, 21524, 21502, 21529, 21530, 21532, 21766, 21539, 21540, 21542, 21543, 21545, 21555, 21557, 21562	University of Pittsburgh Medical Center (UPMC) Western Maryland
Frederick County	Brunswick, Burkittsville, Emmitsburg, Frederick City, Middletown, Mt. Airy, Myersville, New Market, Rosemont, Thurmont, Walkersville, Woodsboro	21710, 21703, 21714, 21716, 21717, 21718, 21727, 21701, 21702, 21705, 21754, 21755, 21758, 21762, 21774, 21769, 21770, 21771, 21773, 21777, 21778, 21780, 21788, 21790, 21704, 21793, 21798	Frederick Health Hospital
Washington County	Williamsport, Hagerstown, Clear Spring, Hancock, Boonsboro, Smithsburg, Funkstown, Keedysville, Sharpsburg	21711, 21713, 21722, 21733, 21734, 21740, 21742, 21746, 21750, 21719, 21756, 21767, 21779, 21782, 21783, 21781, 21795	Meritus Medical Center

There is an urgent need to strengthen community partnerships and collaborations to support persons at risk for developing DM and those already diagnosed with this disease to access the resources they need for healthier living and disease management. Allegany and Washington counties have a significantly higher percentage of the population living in poverty compared to the statewide percentage (16.4, 12.7, and 9.0 percent, respectively). The average person living in these counties is also significantly poorer than the statewide average median household income ($44,065 and $59,719 in Allegany and Washington counties respectively, compared to $83,242 in the state). All three counties also have older and aging populations, which will increase enrollment in Medicare. In the past year alone, Medicare enrollment increased by 5 percent and 3 percent in Washington and Frederick counties respectively, compared to a less than 2 percent increase statewide.

Table 2. Demographic information for population within the WRP service area.

		Allegany County	Frederick County	Washington County	Maryland
Population		71,977	248,472	149,811	6,042,718
Median Age		41.7	39.2	40.5	38.8
Total Medicare Enrollment		23.6%	16.9%	20.8%	17.1%
Employment Rate		47.8%	66.8%	55.7%	63.7%
Median Household Income		$44,065	$91,999	$59,719	$83,242
Poverty Rate		16.4%	7.1%	12.7%	9.0%
Race	**White**	88.2%	81.1%	82.7%	54.7%
	Black or African American	8.4%	9.4%	10.5%	30.0%
	Asian or Pacific Islander	0.9%	4.5%	1.9%	6.4%
	American Indian or Alaskan Native	0.1%	0.2%	0.2%	0.1%
	Some other race	0.3%	1.5%	1.0%	5.0%
	Two or more races	2.1%	3.3%	3.7%	3.7%
Ethnicity	**Hispanic or Latino**	1.8%	9.2%	4.8%	10.4%
	Non-Hispanic or Latino	98.2%	90.8%	95.2%	89.6%

Analyses of county-specific data show significant DM-related health and social needs.[1] Table 3 below summarizes these data to show the prevalence and mortality rate of top DM-related chronic conditions by county compared to the state, demonstrating the significant disproportionate chronic disease burden across counties. These findings are based on data from Community Health Needs Assessments (CHNAs), hospital data, and other national, state and regional sources.

Table 3. Diabetes and diabetes-related chronic conditions morbidity and mortality in WRP counties compared to state.

		Allegany County	Washington County	Frederick County	Maryland
Diabetes	**Prevalence (%)**	15%	14%	9%	12%
	ED visits (per 100,000 persons)	286.1	297.1	181.6	243.7
	Mortality (per 100,000 persons)	29.6	43.1	25.0	19.6
Food Insecurity	**Prevalence (%)**	15.1%	13.1%	8.9%	11.0%
Adult Obesity	**Prevalence (%)**	37%	36%	29%	31%

[1] Data sources include: Community Needs Assessments conducted by Frederick Regional Health System, Meritus Medical Center, and Allegany County (jointly performed by Western Maryland Health System and the county health department), the Health Services Cost Review Commission, U.S. Census, County Health Rankings (a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute), The Centers for Medicare & Medicaid Services (CMS) Chronic Condition Warehouse, Maryland Vital Statistics, the Maryland Department of Planning, and the Behavioral Health Risk Factor Surveillance System.

Physical Inactivity	**Prevalence (%)**	29%	27%	22%	22%
Hypertension	**ED visits (per 100,000 persons)**	453.3	318.1	214.3	351.2
	Mortality (per 100,000 persons)	140.8	206.5	122.2	129.3
Heart Disease	**Mortality (per 100,000 persons)**	257.0	244.4	203.5	163.5
Poor Mental Days	**Average (in the past 30 days)**	4.7	4.1	3.6	3.8

Across the western region, racial minorities carry a disproportionately greater burden of chronic disease relative to their population size within counties. Though African American and Latinx individuals represent less than 10 percent of the overall population within and across the counties, they have significantly higher healthcare utilization and mortality from DM than whites, who make up most of the population. In particular, the mortality rate of DM among African Americans in Allegany county is more than 50 percent higher than that for whites and the ED utilization rate among African Americans for DM across all counties is 3-5 times greater than that of whites.[2,3]. Similar disparities exist in the prevalence and healthcare treatment of underlying DM-related comorbidities like obesity, hypertension, physical inactivity, food insecurity, and poor mental health. In conjunction with the Maryland Hospital Association *Commitment to Racial Equity*[4,5], each hospital will be addressing these disparities through culturally responsive intervention adaptations and cultural competency training for program staff.

Prevention of costly DM-related comorbidities like hypertension, heart disease, and obesity is another high priority. Though the current average total cost of care per Medicare beneficiary for these conditions are comparable to the statewide average total cost of care per Medicare beneficiary, our counties have higher rates of single, expensive treatment events, such as hospitalizations and ED visits, than those of the overall state population. Thus, increasing preventive services will reduce the total cost of care for the older and aging population across the region. After reviewing the data, and particularly the findings from our respective CHNAs, we prioritized specific populations for outreach and engagement to achieve our impact goals, including:

- **Persons in geographic hotspots.** Allegany County: 21539, 21562, 21532, 21502; Frederick County: 21701, 21702, 21703, 21704, 21705, 21709, 31520, 31521, 31522, 31527, 21788; Washington County: 21740, 21742.
- **Individuals with pre-diabetes or diabetes.** Prediabetes- fasting glucose level of 100-125 or A1c5.7-6.4 or diabetes-fasting glucose > 126 on two occasions or ≥ A1c of 6.5.

[2] Centers for Disease Control & Prevention. 2018. Interactive Atlas of Heart Disease and Stroke. Retrieved from: https://nccd.cdc.gov/DHDSPAtlas/?state=County.
[3] Maryland Department of Health. 2017. SHIP Emergency Department Visit Rate Due to Diabetes 2008-2017. Retrieved from: https://opendata.maryland.gov/Health-and-Human-Services/SHIP-Emergency-Department-Visit-Rate-Due-To-Diabet/e6q8-2q3b
[4] Maryland Hospital Association. (June 20, 2020). Our Commitment to Racial Equity. Retrieved from: https://myemail.constantcontact.com/MHA-Toward-Better-Health-Newsletter---Our-Commitment-to-Racial-Equity.html?soid=1102624068989&aid=qsreQgQz_A8
[5] UPMC Western Maryland. (June 5, 2020). Addressing Racial Inequities in Health UPMC Western Maryland Service Area Action Plan.

- **Racial and ethnic minority populations.** African American and Latinx populations.
- **Persons with diabetes-related comorbidities**. Persons with Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Serious Mental Illness (SMI), depression, and/or social risks including food insecurity.

Our hospitals will build upon significant infrastructure built with 2015-2019 Regional Partnership (RP) funding to reduce readmissions associated with DM and chronic disease; however we believe that an approach focused on the DM prevention and management ecosystem that embeds continuous learning and sharing across the three hospitals and their partner communities will increase our collective impact in achieving the population health goals outlined in Maryland's Total Cost of Care (TCOC) model[6]. We expect that over five years we will significantly reduce avoidable costs associated with DM and pre-DM, and that persons who have multiple chronic conditions and those enrolled in Medicare and Medicaid will experience the greatest improvements. In addition, we expect broad benefits in hotspot communities from our improvements in the DM prevention ecosystems resulting from increased access to evidence based interventions, wrap around services, and full engagement of clinical and community partners. Consistent with the state's goals and the intent of the Catalyst Grant, our vision is to transform the community and healthcare system in the western region into one that provides coordinated, high-quality physical and behavioral health prevention and community-based social services to implement population health strategies that result in improved DM and pre-DM healthcare costs, quality, and outcomes.

3. Proposed Activities

Given the complex and intersecting DM-related health conditions and social circumstances our target populations face, we plan to use grant funds to implement a full menu of wrap around assessment, culturally responsive engagement, social service navigation, and complementary medical services to increase recruitment and retention in the National Diabetes Prevention Program (DPP) and Diabetes Self-Management and Training (DSMT). With our comprehensive approach, we seek to identify and change the drivers of poor physical and behavioral health at the person level while also addressing larger upstream factors associated with DM, ultimately promoting community-wide healthy lifestyles and DM prevention. We expect that our approach will most significantly impact our highest-need, highest-cost patients with unmanaged chronic comorbidities like obesity, hypertension, and heart disease, who will be the focus of our work. Our secondary, but equally important focus, are African Americans and Latinx, who are disproportionately burdened by unmanaged chronic condition comorbidities. Our initiatives integrate trained peers, who themselves are from geographic hotspot communities and can meet individuals "where they are". We will incorporate motivational interviewing to support patient engagement and behavioral change. Our work is grounded by evidence-based assessments of DM risks, co-occurring disorders and social risks. We will engage clinicians in this new DM prevention and management system of care by creating EMR flags and automated reports that connect social risk data to clinical data. Clinician guides will support appropriate referrals to DM prevention, management and wrap around services. The evidence-based interventions supported through the DPP and DSMT will enhance ongoing prevention and disease management processes and workflows, engage key community partners, and lower all-payer costs. We have defined core prevention and disease management interventions and wrap around service bundles. The two core interventions

[6] Maryland's Total Cost of Care Model. Maryland Health Services Cost Review Commission. Accessed July 14, 2020 from: https://hscrc.maryland.gov/Pages/tcocmodel.aspx.

are the DPP and DSMT programs that target pre-DM and DM patients, respectively. The three wrap around services will be bundled with DPP and DSMT to address larger upstream determinants and comorbidities of DM and DM-related conditions. These wrap around interventions were developed through review of population needs and barriers captured through our internal data, CHNA data, and CRISP reports. All interventions engage healthcare and social service partner organizations. Given our rural settings, and the changed landscape of in-person contact due to COVID-19, we will also focus on virtual engagement of our target groups. Our interventions are listed and described in further detail below.

Baseline Diabetes Prevention & Management Services	**1. Increase certified leaders, target population recruitment and retention, and access to the National Diabetes Prevention Program (DPP).**
	2. Expand in-person, virtual and hybrid access to Diabetes Self-Management Training (DSMT).
Wrap around Services	**3. Together with partners, expand evidence-based nutrition and physical activity programs.**
	4. Integrate mental health screenings into patient intake and recommended follow up in care plans.
	5. Expand the Community Health Worker (CHWs) workforce to engage target groups in social needs screening and resource navigation.

1. Increase certified leaders, target population recruitment and retention, and access to the National Diabetes Prevention Program (DPP)	
Description of Services	• Recruit DPP participants from prioritized groups • Provide DPP Lifestyle Change Program approved curriculum • Increase wrap around supports to achieve recruitment and retention goals • Train CHWs to support DPP participants in enrolling in, attending and completing the program (described in detail in Interventions 3 and 5) • Provide incentives for participants who complete program milestones • Provide self-management education- cooking demos, physical activity, and stress management
Target Population	• Persons in geographic hotspots • Persons with pre-DM (fasting glucose 100-125 or A1C 5.7-6.4) • African American and Latinx populations • Persons with CHF, COPD, CKD, SMI, depression, obesity, and/or social risks
Roles of Participating Partners	• Recruit and refer participants to the DPP • Provide certified DPP leaders, space for DPP classes, and incentives for recruitment and retention • Administer and report assessments • Provide wrap around services • Participate in county DM action planning and program improvement

Outreach & Planning	• Map DM hotspots, DPP and DSMT services to identify gaps in access and develop plans to address gaps • Host county kickoff events- present project visions, strategies, and partner interdependencies to create ideal DM prevention and management systems and secure commitments from partners for their respective roles • Develop partner MOUs for effective and streamlined referral processes, data sharing, space usage, etc. • Establish referral systems with clinical and social service partners • Plan, implement, and evaluate DPP pilots in each county • Assess centralized DPP billing options for program sustainability • Develop and implement social marketing strategies • Engage employers to incentivize employees to join DPP • Analyze data and establish quality improvement processes
Infrastructure & Workforce	• Expand certified DPP providers as needed to ensure access to accredited DPP • Hire DPP Coordinators to facilitate scheduling and engage community partners • Expand access to CHWs and lifestyle coaches to engage participants via online messaging, phone calls, and follow-up on missed classes • Enhance program Health Information Technology (HIT) infrastructure –to integrate flags, alerts and automated report functions to support DM referrals and seamless care • Promote use of centralized diabetes referral centers
Monitoring	• Interview completers and non-completers to understand barriers to DPP completion to make strategy mid-course adjustments • Establish quality improvement processes and monitor the measures detailed in subsection 4
2. Expand in-person, virtual and hybrid access to Diabetes Self-Management Training (DSMT)	
Description of Services	• Recruit persons with poorly controlled DM to the DSMT program modality right for them- in-person, virtual, or hybrid; group level or individual level • Provide DSMT with expanded evening and weekend classes, locations in hotpots, and time options to support program initiation and completion • Provide DSMT through interactive telehealth with on-demand education and links to community resources
Target Population	• Same as Activity 1 with one exception- target is persons who have poorly managed DM (fasting glucose $\geq$126 or > 6.4) which substitutes for persons with pre-DM
Roles of Participating Partners	• Recruit DSMT eligible patients • Provide licensed/certified DSMT facilitators • Collect and share data to inform county and regional DM action planning • Provide wrap around services to support DSMT referrals and participants' social needs (described in detail in Interventions 3 and 5) • Market and promote DSMT programs • Integrate DSMT in senior service programs • Provide care management and chronic disease support services
Outreach & Planning	• Host county kickoff events described in Activity 1 and engage partners to establish referral processes, care linkages, and DSMT standards of practice

	• Outreach eligible participants identified through MD Workshop Wizard, electronic health records (EHRs), CRISP • Develop and implement social media strategies • Expand DSMT sites, hours, days and modalities; implement virtual classrooms and establish accountability mechanisms • Create standard operating procedures (SOPs) and more efficient billing processes for DSMT • Obtain approval for staffing flexibilities to expand access to wrap around services • Analyze data and establish QI processes
Infrastructure & Workforce	• Recruit licensed DSMT providers, BH providers, and quality coordinators • Develop IT infrastructure for telehealth, referrals and data sharing • Expand telehealth capabilities for virtual and hybrid DSMT options
Monitoring	• Establish quality improvement processes and monitor the measures detailed in subsection 4
3. Together with partners expand evidence-based nutrition and physical activity program	
Description of Services	• Medical nutrition therapy (MNT) services, follow-up and performance tracking • Peer educators to augment DM interventions • Fresh Food prescription and distribution programs, i.e. *Food Farmacy*, a Geisinger program provided in collaboration with local churches and food pantries in Allegany and Frederick counties. Meritus will collaborate with Meals on Wheels in Washington County. • Complementary weight-loss programs, like Real Appeal in Frederick county, offered to hospital and local business employees through benefits plans • YMCA and gym memberships and fitness classes (including medically supervised classes for eligible patients) to support DPP and DSMT physical activity goals
Target Population	• Same as Activities 1 and 2
Roles of Participating Partners	• Set up nutrition and physical activity program referral mechanisms for DPP and DSMT participants, clinical practice patients • Promote services and recruit participants in service communities • Provide nutrition and physical activity services • Collect and share data
Outreach & Planning	• Establish coordinated referral processes and link to county Diabetes Action Plans • Increase dietitians providing MNT and clinicians' ability to order MNT • Expand wrap around support programs to increase access to fresh produce, weight loss and physical activity programs • Plan with DSMT provider organizations to ensure that food and lay education programs align with DPP and DSMT curricula
Infrastructure & Workforce	• Recruit dietitians and midlevel providers to establish a robust MNT program • Hire staff to coordinate wrap around services, obtain equipment and space for fitness classes, work with local churches and food pantries to ensure adequate infrastructure for nutrition services
Monitoring	• Establish quality improvement processes and monitor the measures detailed in subsection 4
4. Integrate mental health screening into patient intake and recommended follow-up in care plans	
Description of Services	• Depression screening and potential billing for persons with pre-DM and DM • Refer to BH specialists/BH integrated primary care as indicated

	• Consult with BH specialists to align chronic condition treatment plans
Target Population	• Same as Activities 1 and 2
Roles of Participating Partners	• Scale up community-based depression screening access points and refer persons with depression to appropriate care providers • Treatment planning, service delivery, and communication on patient progress
Outreach & Planning	• Plan referral processes and create mechanisms to share information • Strategize ways to align BH treatment and DM prevention and management
Infrastructure & Workforce	• Create shared documentation platform among clinicians, DPP and DSMT providers, and BH specialists • Expand DM care teams' access to BH professionals
Monitoring	• Establish quality improvement processes and monitor the measures detailed in subsection 4
5. Expand the Community Health Worker (CHWs) workforce to engage target groups in social needs screening and resource navigation	
Description of Services	• CHWs will outreach specific geographic, racial, and ethnic communities • Social needs screening will be a DPP and DSMT program enhancement. For those with social needs, CHWs will connect participants to benefit programs, and food, physical activity and other complementary resources
Target Population	• Same as Activities 1 and 2
Roles of Participating Partners	• Screening for social needs and referring to CHWs • Provide community resources • Provide chronic disease care coordination and supports • Provide support groups • Assist with medication access and affordability
Outreach & Planning	• Engage partners to establish screening and referral processes • Align services with state and county Diabetes Action Plans • Develop and expand community resource inventories • Assess potential for referrals from online databases
Infrastructure & Workforce	• Recruit, train (motivational interviewing and core competencies) and link CHWs to partner programs/practices • Develop or assess shared IT platforms to support collaboration
Monitoring	• Establish quality improvement processes and monitor the measures detailed in subsection 4

4. Measurement & Outcomes

We used population and program level data to identify target populations and set goals for improvements that are consistent with HSCRC's scale targets for the National DPP and DSMT. Overall, we expect our initiatives to decrease the prevalence of DM and DM risk factors in western Maryland, the rate of diabetes-related mortality, and the total cost of care for persons with DM and pre-DM in the region. We will systematically monitor and assess progress towards our implementation and outcome goals. Our evaluation model is based on DM self-management evidence-based practices among our target populations and will track progress in high and rising risk populations across the continuum of services. Finally, we will create a regional learning collaborative so that our staff and community

partners learn from each other and can share successes and challenges implementing these interventions in our rural, low resource communities. During year one, partners will engage in an iterative process to test whether hospital and partners' data sources and sharing agreements meet program evaluation needs. We will conduct interviews and focus groups among DPP and DSMT completers and non-completers to understand the best approaches to recruit and retain our target populations. We will also test our DPP and DSMT wrap around support bundles to inform our scaling strategies. We will develop performance measures to assess the following questions:

- Did we reach our target populations?
- Which target groups enrolled and completed DPP and DSMT?
- What wrap around supports were linked to program enrollment and completion?
- How did referrals work?
- Did we increase access to MNT and depression screening and treatment?
- What was the experience of program participants?

A further explanation of these goals, and how the partnership plans address them is detailed in the logic model below.

Strategy: Implement CDC approved diabetes prevention and ADA recommended diabetes management programs and related interventions	Goal: Reduce diabetes prevalence, morbidity, mortality and costs in Western MD

Inputs	Activities	Outcomes	
		Short Term (Capacity to Act)	Long Term (Community and Health Conditions)
• Regional Partnership (RP) funding and shared learning • Maryland Primary Care Program incentive structure • Care Transformation Organizations • State and County Diabetes Action Plans and LHICs • DPP and DSMT partners • Nutrition, physical activity and transportation resources • Businesses and faith community partners • Hospital DM committees and leadership • IT/EMR infrastructure • CRISP and HSCRC data • Clinician guides	• Engage and coordinate partners • Expand access to Diabetes Prevention Program (DPP) • Expand in-person, virtual and hybrid access to Diabetes Self-Management Training (DSMT) • Expand nutrition and physical activity wrap around programs • Integrate depression screenings into patient intake and provide follow up care • Provide MNT • Expand access to pharmacist supports • Increase CHWs for social needs screening/resource navigation • Assess and address data collection and sharing gaps • Test DPP and DSMT wrap around support bundles • Collect consumer feedback on barriers and facilitators to engagement in DPP and DSMT • Quality improvement processes • Scale telehealth infrastructure	• DPP and DSMT staffing to meet scale targets • MOUs and Business Agreements with partners • Documented commitment of partners to support DM prevention and management system • Target population engagement, recruitment and retention in DPP and DSMT • Increase in billed MNT services among eligible DPP and DSMT participants • Increase in billed depression screening and treatment among participants • Understanding of best financial incentive models • Understanding of the ROI associated with strategies • Increase engagement in weight-loss strategies and receipt of nutritious food from Food Farmacy • Increase social needs screenings among eligible DPP and DSMT participants	• Decrease in prevalence of DM and DM risk factors in the region • Improved Quality of Life among persons with DM and DM risk factors • Decrease in rate of DM-related morbidity and mortality • Decrease in total cost of care for persons with DM and pre-DM in the region • Sustainable financing for DM prevention and management system of care through global budgets, care transformation initiatives, billable services, and non-HSCRC grants • Reduction in avoidable costs associated with DM and pre-DM, especially for Medicaid and Medicare beneficiaries and those with multiple chronic conditions

In addition to the data provided through CRISP, we will collect the following data, stratified by race, ethnicity, gender, age and geography wherever possible:

1. Enhance number of certified leaders, participant recruitment and retention, and class offerings for the National Diabetes Prevention Program (DPP) – CY 2019 Baselines			
County	Allegany County	Frederick County	Washington County
Number of certified DPP leaders			
Data Source	CDC DPP Registry	CDC DPP Registry	CDC DPP Registry
Baseline Data	5	2	Pending accreditation
Expected Outcome	Increase to scale targets	Increase to scale targets	Increase to scale targets
Percent of pre-diabetes population referred to DPP			
Data Source	EMRs	EMRs	EMRs
Baseline Data	18	52	10
Expected Outcome	Increase to scale targets	Increase to scale targets	Increase to scale targets
Percent of referred patients enrolled in DPP			
Data Source	DPP provider data	DPP provider data	DPP provider data
Baseline Data	83.3% (15 out of 18) enrolled in 2019	58%	68% enrolled
Expected Outcome	Increase to scale targets	Increase to scale targets	Increase to scale targets
Completion rate of DPP enrolled and referred population			
Data Source	DPP provider data	DPP provider data	DPP provider data
Baseline Data	5 completed: 33.3% of enrolled, 27.7% of referred	23 completed: 77% of enrolled, 44% of referred	68%
Expected Outcome	Increase to scale targets	Increase to scale targets	Increase to scale targets
Clinical measures: A1c, weight loss, BMI, and Quality of Life surveys			
Data Source	EMRs	EMRs	EMRs
Baseline Data	No Baseline Data	No Baseline Data	4% avg. weight loss of participants
Expected Outcome	Increase to scale targets	Increase to scale targets	Increase to scale targets
2. Expand virtual, in-person, and hybrid capabilities of Diabetic Self-Management Training program for groups and individuals - CY 2019 Baselines			
County	Allegany	Frederick	Washington
Number of DSMT accredited providers by county			
Data Source	DSMT provider data	DSMT provider data	DSMT provider data

Baseline Data	1 multi-disciplinary accredited DSMT program with 2 certified DM care and education specialists	No Baseline Data	2
Expected Outcome	Increase the number of DSMT providers	Increase the number of DSMT providers	Increase the number of DSMT providers
Number and Percentages of eligible populations referred, enrolled and completing DSMT by location, target group and service modality			
Data Source	DSMT provider data	DSMT provider data	DSMT provider data
Baseline Data	151 referrals, 145 enrolled, 102 attended first meeting, 26 completed follow up class	No Baseline Data	1,087 enrolled, 380 completed
Expected Outcome	Increase in initiation, retention, and completion of program	Increase in initiation, retention, and completion of program	Increase in initiation, retention, and completion of program
Change in clinical measures, healthcare utilization and costs			
Data Source	EMRs	EMRs	EMRs
Baseline Data	No Baseline Data	No Baseline Data	No Baseline Data
Expected Outcome	Match change in clinical measures to DMST program goals, decrease healthcare utilization and costs	Match change in clinical measures to DMST program goals, decrease healthcare utilization and costs	Match change in clinical measures to DMST program goals, decrease healthcare utilization and costs
3. Implement and expand evidence-based nutrition and physical activity programs into current patient practice and coordinate with external partners - CY 2019 Baselines			
County	Allegany	Frederick	Washington
Percent of population engaging in services			
Data Source	Service provider data	Service provider data	Service provider data
Baseline Data	No Baseline Data	No Baseline Data	No Baseline Data
Expected Outcome	Increase engagement in services	Increase engagement in services	Increase engagement in services
Number of referrals from DPP/DSMT			
Data Source	DPP/DSMT provider data	DPP/DSMT provider data	DPP/DSMT provider data
Baseline Data	No Baseline Data	No Baseline Data	No Baseline Data
Expected Outcome	Increase referrals from DPP and DSMT	Increase referrals from DPP and DSMT	Increase referrals from DPP and DSMT
Percent of DPP/DSMT participants engaged in services			
Data Source	DPP/DSMT provider data	DPP/DSMT provider data	DPP/DSMT provider data

Baseline Data	100% Food Farmacy participants referred to DSMT	No Baseline Data	No Baseline Data
Expected Outcome	Increase percent of DPP/DSMT patients engaged in services	Increase percent of DPP/DSMT patients engaged in services	Increase percent of DPP/DSMT patients engaged in services
Number enrolled in weight-loss classes and receiving food from Food Farmacy			
Data Source	Class & Farmacy data	Class & Farmacy data	Class & Farmacy data
Baseline Data	31 active Food Farmacy participants	No Baseline Data	No Baseline Data
Expected Outcome	Increase number enrolled	Increase number enrolled	Increase number enrolled
Number billing for MNT			
Data Source	EMRs and provider billing claims	EMRs and provider billing claims	EMRs and provider billing claims
Baseline Data	42 patients billed for MNT	No Baseline Data	No Baseline Data
Expected Outcome	Increase number billing	Increase number billing	Increase number billing
4. Integrate mental health screening into patient intake and recommended follow-up in care plans - CY 2019 Baselines			
County	Allegany	Frederick	Washington
Number of DPP/DSMT participants screened for BH needs			
Data Source	DPP/DSMT provider data	DPP/DSMT provider data	DPP/DSMT provider data
Baseline Data	No Baseline Data	No Baseline Data	No Baseline Data
Expected Outcome	Increase screenings	Increase screenings	Increase screenings
Number of DPP/DSMT participants referred to BH services			
Data Source	DPP/DSMT provider data	DPP/DSMT provider data	DPP/DSMT provider data
Baseline Data	No Baseline Data	No Baseline Data	No Baseline Data
Expected Outcome	Increase referrals	Increase referrals	Increase referrals
Number of DPP/DSMT participants assisted by BH services			
Data Source	BH service provider data	BH service provider data	BH service provider data
Baseline Data	No Baseline Data	No Baseline Data	No Baseline Data
Expected Outcome	Increase patients assisted	Increase patients assisted	Increase patients assisted
5. Partner with Community-Based Organizations (CBOs) and deploy Community Health Workers (CHWs) to provide social needs screening and resource navigation - CY 2019 Baselines			
County	Allegany	Frederick	Washington
Number of persons screened for social needs			
Data Source	Aunt Bertha	Accountable Health Communities Screener	EMR
Baseline Data	359 patients screened	No Baseline Data	No Baseline Data

Expected Outcome	Increase screenings	Increase screenings	Increase screenings
Percent of DPP/DSMT patients screened for social needs			
Data Source	DPP/DSMT provider data	DPP/DSMT provider data	DPP/DSMT provider data
Baseline Data	82 diabetes patients screened	No Baseline Data	No Baseline Data
Expected Outcome	Increase screenings	Increase screenings	Increase screenings
Percent of screened patients who engage with a CHW			
Data Source	CHW data	CHW data	CHW data
Baseline Data	No Baseline Data	No Baseline Data	CHWs engaged 336 patients in 2019
Expected Outcome	Increase engagement with CHWs	Increase engagement with CHWs	Increase engagement with CHWs
Number and percent of patients engaged in resources, broken out by type			
Data Source	Aunt Bertha	AHC tracker	EMR
Baseline Data	No Baseline Data	No Baseline Data	No Baseline Data
Expected Outcome	Increase engagement with resources	Increase engagement with resources	Increase engagement with resources

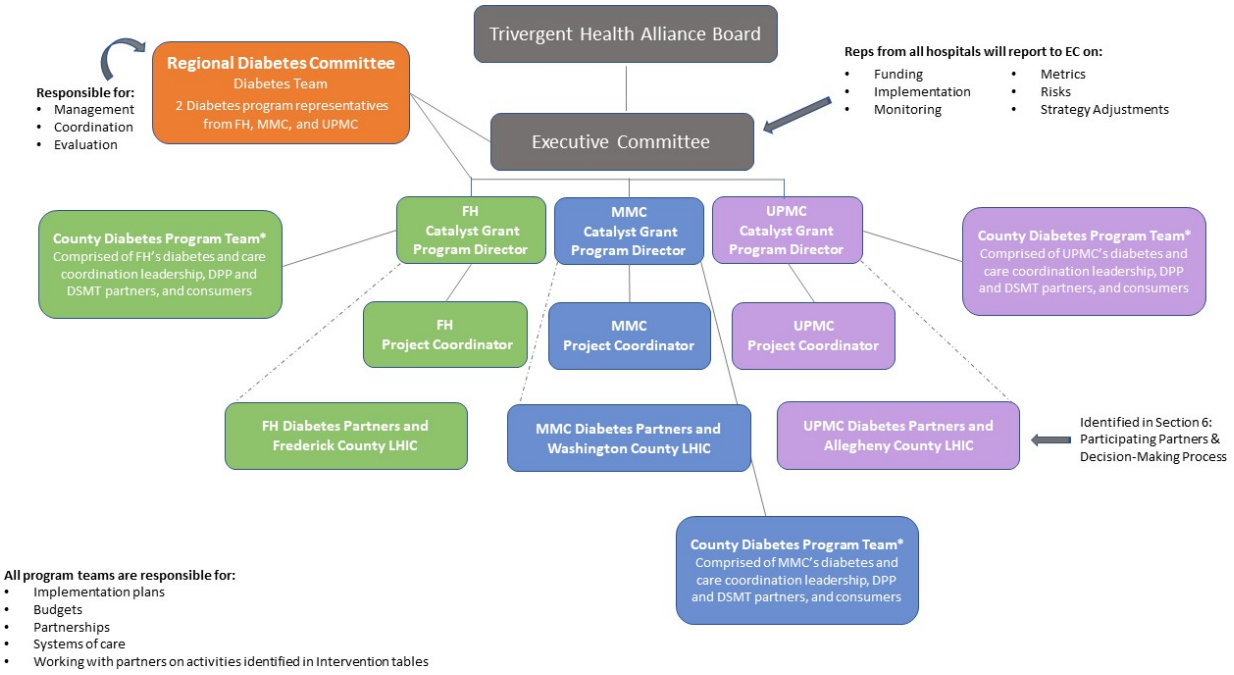
5. Scalability & Sustainability

Our year one investment in building and testing the infrastructure, systems, and partnerships to engage our target communities in DPP, DSMT and other evidence-based DM prevention and management will provide a foundation for collective action. Building on and leveraging the work of the Local Health Improvement Coalitions, Local Health Departments and community-based organizations will facilitate greater cost-sharing and savings over time. In year two, we will develop a formal sustainability plan that will build on the MDPCP and care transformation infrastructure. The MDPCP program incentivizes primary care practice transformation to improve health outcomes among persons with DM and co-occurring chronic disease. Requirements to risk stratify patients, increase access to care through alternative care strategies, provide comprehensive medication management, referral management, BH integration, and health-related social needs will strengthen and sustain the impact of our DM prevention and management programs. We will investigate the possibility of centralized billing for DPP services and obtain billing flexibilities for wrap around services, specifically for the MNT program. Additionally, given new flexibilities and guidance in telehealth billing and service delivery brought upon by COVID-19, we will explore how we can use these to further increase access to and sustainability of evidence-based services. We will oversee and evaluate financial incentive models for providers and community partners. The WRP hospitals provided the initial equity funding for the WRP and are committed to the scalability of the strategies defined here in support of our goals and mission. We will measure the ROI associated with all our strategies, including using CRISP cost reports. We will sustain successful strategies through global budgets, care transformation initiatives, billable services, and non-HSCRC grants.

6. Participating Partners & Decision-Making Process

The governance structure establishing the Trivergent Health Alliance (THA) Board of Directors in July 2016, which is comprised of FH, MMC and UPMC Western Maryland CEOs will continue. The draft THA Board resolution and THA hospital MOU is attached in Appendix A. Each hospital will appoint two representatives to the THA Executive Committee (EC) to work together on the development and continuous improvement of the DM prevention and management programs and to coordinate execution of those programs. The EC will be the WRP advisory body. Decisions will be consensus based. Each hospital agrees to implement the activities planned in our proposal, which describes how we will use grant funds to partner with LHICs, LHDs, and CBOs. Recommendations of the EC are subject to review and approval by all the hospitals, and each hospital will be responsible for executing those recommendations in its service area. In addition to the EC, the WRP will establish a regional DM committee that will meet monthly. The WRP DM committee will include at least two representatives of each county's DM teams who will manage Funding Stream I coordination, learning, and reporting. These WRP DM committee members will represent each hospital's county specific DM committees. Membership of the county specific DM committees will include each hospital's DM and care coordination leadership, consumers, and DPP and DSMT partners. On-the ground teams will meet at least monthly to coordinate the development of high functioning DM prevention and management ecosystems in Allegany, Frederick, and Washington counties.

Figure 1. WRP Regional Catalyst Grant Program governance structure.



In additional to strong internal team collaboration, each county hospital will work closely with the following partners:

Frederick Health Hospital

Name of Collaborator:	**Frederick County Health Department (FCHD)**
Type of Organization	Government
Amount and Purpose of Direct Financial Support	No financial support
Amount and Purpose of In-Kind Support	Provide in-kind support through marketing, recruitment of participants, referrals and potential use of space
Type and Purpose of Resource Sharing arrangements	Collaboration on development, recruitment and administration of DPP programs.
Roles and Responsibilities within the Regional Partnership (RP): Currently offer DPP; will work with partner to identify target opportunities for DPP expansion programs; additionally, will establish a strong referral system into wrap around services, including MNT, DSMT and Living Well programs w/the goal of longer-term patient/participant engagement	
Name of Collaborator:	**Maintaining Active Citizens (MAC) / Living Well Center for Excellence**
Type of Organization	Area Agency on Aging (AAA)
Amount and Purpose of Direct Financial Support	$9,200 for licenses and training of Diabetes Self-Management (English and Spanish) and Stepping Up Your Nutrition workshop facilitators, including course materials
Amount and Purpose of In-Kind Support	TBD
Type and Purpose of Resource Sharing arrangements	TBD
Roles and Responsibilities within the RP: Partner in comprehensive diabetes management program, trained DSMT facilitators who will refer and assist with participant recruitment for MNT and diabetes; Offer nutrition and physical activity workshops	

Name of Collaborator:	YMCA
Type of Organization	Non-profit
Amount and Purpose of Direct Financial Support	$10,000 discounted membership/physical activity classes
Amount and Purpose of In-Kind Support	TBD
Type and Purpose of Resource Sharing arrangements	TBD
Roles and Responsibilities within the RP: Currently offer DPP; will work with partner to identify target opportunities for DPP expansion programs; additionally will establish a strong referral system into wrap around services, including MNT, DSMT and Living Well programs with the goal of longer-term patient/participant engagement; Coordinate to offer physical activity classes or discounted memberships to targeted populations	
Name of Collaborator:	**Frederick Integrated Healthcare Network**
Type of Organization	ACO/Clinically Integrated Network
Amount and Purpose of Direct Financial Support	None
Amount and Purpose of In-Kind Support	TBD
Type and Purpose of Resource Sharing arrangements	TBD
Roles and Responsibilities within the RP: Will work closely with provider practices to identify and engage patients in appropriate services; promote recruitment and retention, develop a strong referral process for diabetic and pre-diabetic patients for DPP, DMST, MNT, Living Well and wrap around services and programs.	
Name of Collaborator:	**Frederick City and County Housing Authority**
Type of Organization	Government
Amount and Purpose of Direct Financial Support, if any	In-Kind; Will use the telehealth equipment in place via the behavioral health grant to support diabetes outreach, including DMST services
Amount and Purpose of In-Kind Support, if any	TBD
Type and Purpose of Resource Sharing arrangements, if any	TBD
Roles and Responsibilities within the RP: Provide support to engage clients living in subsidized housing with access to programs and services; significant opportunity to connect with targeted population	
Name of Collaborator:	**Share Food Network**
Type of Organization	Non-profit: Co-op to stretch grocery budget on healthy food choices
Amount and Purpose of Direct Financial Support	$8,372 (provide 364) healthy value packs to targeted population, including DPP, DMST and Living Well participants
Amount and Purpose of In-Kind Support	TBD
Type and Purpose of Resource Sharing arrangements	TBD
Roles and Responsibilities within the RP: Food distribution source – FH will commit funds to purchase Share boxes/value packages for participating clients – Share Food is a healthy economical food co-op; Monthly Value Packs include; 6-8 lbs of protein; 8-12 lbs of fresh fruit and vegetables; and other healthy food staples.	
Name of Collaborator:	**Frederick Food Bank (and local pantries)**
Type of Organization	Government and non-profit
Amount and Purpose of Direct Financial Support	None
Amount and Purpose of In-Kind Support	TBD
Type and Purpose of Resource Sharing arrangements	TBD

Roles and Responsibilities within the RP: Will participate in education regarding collection and distribution of health food items; will make referrals to the DPP and DSMT programs	
Name of Collaborator:	**Frederick County Chamber of Commerce – Healthy Business Committee**
Type of Organization	Government and non-profit
Amount and Purpose of Direct Financial Support	None
Amount and Purpose of In-Kind Support	TBD
Type and Purpose of Resource Sharing arrangements, if any	TBD
Roles and Responsibilities within the RP: Provide access to business community, including those who employ targeted populations, through whom we will partner to provide services and programs, i.e. DSMT and DPP.	
Name of Collaborator:	**Frederick County Health Improvement Coalition**
Type of Organization: (i.e., LHIC, Non-Profit, LBHA)	Non-profit
Amount and Purpose of Direct Financial Support, if any	None
Amount and Purpose of In-Kind Support, if any	Dissemination of information and collaboration, outreach to targeted populations to engage in services and programs
Type and Purpose of Resource Sharing arrangements, if any	TBD
Roles and Responsibilities within the RP: The LHIC will be used to identify linkages and opportunities to connect with County DM action plan; support outreach and referrals to programs and services; provide a collaborative forum for discussion across partners	
Name of Collaborator:	**The Mission of Mercy**
Type of Organization	Non-profit
Amount and Purpose of Direct Financial Support	None
Amount and Purpose of In-Kind Support	TBD
Type and Purpose of Resource Sharing arrangements	TBD
Roles and Responsibilities within the RP: Mobile primary and dental health clinic serving targeted population within the Frederick community; serve significant population of DM and pre-DM individuals; there is an established MOU between Mission of Mercy and FH to promote timely access and collaboration of services for shared patients – will expand existing collaboration to establish referrals into DPP and DSMT programs.	
Name of Collaborator:	**Frederick County Fire and Rescue**
Type of Organization	Government Emergency Management Services
Amount and Purpose of Direct Financial Support	None
Amount and Purpose of In-Kind Support	TBD
Type and Purpose of Resource Sharing arrangement	TBD
Roles and Responsibilities within the RP: Identify, recruit and retain participants	

Meritus Medical Center (MMC)

Name of Collaborator:	**YMCA**
Type of Organization	Non-profit – physical activity, nutrition, wellness; member of LHIC
Amount and Purpose of Direct Financial Support	$75,000 – Fund partial membership for completion of DPP and vouchers for classes for DSMT participants during participation time
Amount and Purpose of In-Kind Support	Marketing of YMCA programs

Type and Purpose of Resource Sharing	Partnering to share gym space and access to the pool; Provide healthy nutrition education, physical activity, CATCH classes in afterschool programs.
Roles and Responsibilities within the RP: MMC will partner with local YMCA chapters to provide participants of the DSMT and the DPP programs with discounted gym memberships, personal training, and exercise plans. YMCA will promote DPP and DSMT	
Name of Collaborator:	**Commission on Aging (COA)**
Type of Organization	Non-profit; wellness programs for seniors/persons with disabilities; member of LHIC (Healthy Washington county)
Amount and Purpose of Direct Financial Support	$12,000 – cost of Meals on Wheels home delivered meals for eligible DPP and DSMT participants referred by CHW.
Amount and Purpose of In-Kind Support	Marketing COA programs; oversight of grant-related contracts
Type and Purpose of Resource Sharing arrangements	Provide DPP classes and referrals; shared staff (CHWs), space for classes, outdoor fitness area at COA
Roles and Responsibilities within the RP: MMC will work with COA to develop wrap-around services to support DPP program recruitment and retention	
Name of Collaborator:	**Washington County Health Department (WCHD)**
Type of Organization	Government Organization; LHIC Lead organization
Amount and Purpose of Direct Financial Support	N/A
Amount and Purpose of In-Kind Support	TBD
Type and Purpose of Resource Sharing arrangements	Space for classes or workshops; collaboration on DPP teaching
Roles and Responsibilities within the RP: The website promotes DSME and DPP programs. Healthy Washington County will provide a single site for county resources (fitness, education, etc.).	
Name of Collaborator:	**Boys and Girls Club**
Type of Organization	Non-Profit Organization
Amount and Purpose of Direct Financial Support, if any	TBD
Amount and Purpose of In-Kind Support, if any	TBD
Type and Purpose of Resource Sharing arrangements, if any	TBD
Roles and Responsibilities within the Regional Partnership: MMC will supply referrals for children who are at risk to utilize the Boys and Girls Club.	

University of Pittsburgh Medical Center Western Maryland

Name of Collaborator:	**Maryland Area Health Education Center West (AHEC West)**
Type of Organization: (i.e., LHIC, Non-Profit, LBHA)	Non-profit; Member of LHIC
Amount and Purpose of Direct Financial Support, if any	$7,464 - $10,598 per year. Funds for DPP leaders and for coordination costs (est.$1866) per DPP group
Amount and Purpose of In-Kind Support, if any	UPMC Western Maryland will provide full access to Aunt Bertha (online directory and referral system for social needs); supplies- books and scales; billing support
Type and Purpose of Resource Sharing arrangements, if any	Existing BAA and MOU for Self-Management and Aunt Bertha. Will establish arrangement for billing services.

Roles and Responsibilities within the RP: AHEC West will coordinate DPP recognition program; provide DPP leaders; track DPP and submit billing; participate in County DM Workgroup; and recruit DPP and DSMT participants	
Name of Collaborator:	**Allegany County Health Department (ACHD)**
Type of Organization	Local health department; LBHA; Co-chair LHIC
Amount and Purpose of Direct Financial Support	$53,965 per year- 1 FTE contract position to focus on chronic disease prevention, screening and promotion, facilitate clinic intervention and referrals and connect to county Diabetes Action Plan
Amount and Purpose of In-Kind Support	Training; connection to Aunt Bertha and other appropriate sites.
Type and Purpose of Resource Sharing arrangements	Will need to establish an agreement for this grant. Currently have MOU for organization and operation of LHIC
Roles and Responsibilities within the RP: ACHD will facilitate LHIC connection; oversee county action plan for DM; screen for hypertension and DM at dental and BH clinics; and refer to DPP and DSMT	
Name of Collaborator:	**Associated Charities**
Type of Organization:	Non-profit; Member of LHIC
Amount and Purpose of Direct Financial Support	$60,000 per year to support medications related to diabetes when not covered by insurance, and a 1.0 FTE resource navigator to be onsite and increase rapid response to the prescription and emergency assistance needs of people with diabetes
Amount and Purpose of In-Kind Support	Office space for staff and access Aunt Bertha and other appropriate sources. Will have access to grant funds to support identified needs outside of their scope.
Type and Purpose of Resource Sharing arrangements	Existing BAA and MOU for Self-Management, Merck, SunLife, Aunt Bertha. Need to update agreement for this grant (Space & funds).
Roles and Responsibilities within the RP: Associated Charities will screen and support DM patients with pharmaceutical assistance and social needs and make referrals to programs	
Name of Collaborator:	**Western Maryland Food Bank (and local food pantries)**
Type of Organization	Non-profit; Member of LHIC
Amount and Purpose of Direct Financial Support	$ 10,000 per year for food and items such as Glucerna
Amount and Purpose of In-Kind Support	Access to and support of Aunt Bertha
Type and Purpose of Resource Sharing arrangements	Existing BAA and MOU for SunLife and Aunt Bertha
Roles and Responsibilities within the RP: WMFB will support food purchase and distribution via food pantry and Food Farmacy; meet supplement needs; and make referrals to programs.	
Name of Collaborator:	**Human Resources Development Council (HRDC)**
Type of Organization	Nonprofit-Community Action Agency, LHIC member, Mobility Management
Amount and Purpose of Direct Financial Support	$20,000 per year for transportation
Amount and Purpose of In-Kind Support	Full access to Aunt Bertha and UPMC support of transportation system
Type and Purpose of Resource Sharing arrangements	Existing BAA and MOUs for Aunt Bertha, Self-Management, SunLife, and Transportation
Roles and Responsibilities within the RP: HRDC will refer to DPP, DSMT; provide facilitators for DSMT and the Stanford Chronic Disease Self-Management Program (CDSMP); support outreach to Senior Centers and Meals on Wheels; and coordinate transportation.	
Name of Collaborator:	**Aramark**
Type of Organization	Contracted Vendor and Food Service Provider

Amount and Purpose of Direct Financial Support	Between $85,288-$105,432 each year for Food Farmacy food and classes, and mileage for deliveries.
Amount and Purpose of In-Kind Support, if any	In-kind-coolers and shelving for offsite Food Farmacies
Type and Purpose of Resource Sharing arrangements, if any	Aramark has an existing contract, but amendment needed for grant.
Roles and Responsibilities within the RP: Aramark will provide budget friendly medically tailored meals for classes; provide the vehicle and drivers to transport healthy foods to Food Farmacies; and work with WMFB and HRDC to increase access to healthy foods.	
Name of Collaborator:	**Allegany County Health Planning Coalition**
Type of Organization	LHIC
Amount and Purpose of Direct Financial Support	N/A
Type and Purpose of In-Kind Support	UPMC Western Maryland staff will continue to co-chair the LHIC and assist with coordination of various partners
Type and Purpose of Resource Sharing Arrangements	LHIC has an existing MOU
Roles and Responsibilities within the RP: LHIC will: Identify linkages and opportunities with County Diabetes Action Plan, Support outreach and referrals for both diabetes and behavioral health, and Provide a forum for discussion among community partners	

7. Implementation Plan

See attached PDF titled “Trivergent Implementation Plan – Diabetes Management” for Implementation Plan

Section II. Financial Projections

1. Budget and Expenditures

Hospital/Applicant:	**Frederick Hospital**					
Funding Track:	**Diabetes Management**					
Total 5-year Budget Request:	**$4,690,568**					
Workforce/Type of Staff	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Consultant - Regional Coordination	Data collection and management, Report writing for Regional Partnership, staged training of Program Coordinator transition who will assume responsibility in year 3.	$115,000	$28,750	$0	$0	$0
Program Coordinator	1.0 FTE salary and fringe; responsible for overall program implementation and management of the project	$94,348	$96,234	$98,159	$100,122	$102,125
RN CDE or RD	1.0 FTE prorated 80% for yr 1, will be hired in 3rd month	$79,872	$112,170	$114,413	$116,701	$119,035
Admin/data support	0.5 FTE to support DM Team activities, including scheduling & set up of meetings/events, minutes, assist with supports, outreach coordination, etc. Prorated at 75% yr 1; 2% increase annually	$23,410	$31,812	$32452	$33,108	$33,776
Social worker	Provides ongoing support and intervention to participants based on PHQ2&9 depression screening, community referrals and service coordination	$75,479	$94,348	$96,235	$98,159	$100,122
Community Health Workers	3.0 FTE; social determinant screening, referrals and coordination of services; outreach to targeted populations; recruitment/retention for programs; 80% year 1; 2% increase years 2-5	$94,350	$122,700	$125,154	$127,627	$130,180
Nurse Practitioner	1.0 NP - Certified in Diabetes Care - based in Care Clinic clinical needs of high risk/vulnerable target populations and or those with limited or poor provider access; and engage patients/clients in wrap around services	$149,385	$149,386	$152,374	$155,421	$158,530
Care Clinic and Ambulatory pharmacy support/leadership	Responsible for oversight and implementation of grant components within the Care Clinic and ambulatory pharmacy services; support optimization of medication therapies/DM Clinic	$149,385	$152,373	$155,420	$158,529	$161,699
DPP Recognition	Leaders and coordination time. $1866. Leaders will do 3 DPP in year 1, Yr2&3 3 per year; Years 4&5 4 per year	$5,598	$5,598	$5,598	$7,464	$7,464
Total		**$786,827**	**$793,371**	**$779,805**	**$797,131**	**$779,155**
IT/Technologies	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**

Shared Village	Social Determinant screen; license and new module/assessment	$1,200	$1,200	$1,200	$1,200	$1,200
Total		**$1,200**	**$1,200**	**$1,200**	**$1,200**	**$1,200**
Wrap-Around Services	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Food Supports/resources for workshops *	Support for DSME and DPP groups ($15meal in class) and (2-$20 take home meals) and ($23 Monthly Share Food Network); Based on 4 groups of each DSME and DPP, 8 people participating in group. Stanford Living Well Diabetes Self-Management and Stepping Up Your Nutrition 6 workshops x 10 participants years	$23,576	$35,364	$35,364	$47,152	$47,152
Supplies	Books/binders, bands, bags and food for DSME and DPP workshops	$6,400	$6,400	$9,600	$9,600	$12,800
Maintaining Active Citizens (MAC) / Living Well Center for Excellence	Stanford Living Well Diabetes Self-Management workshop; Step up Your Nutrition workshops; Recruitment source for DPP and DSME	$9,200	$9,200	$9,200	$9,200	$9,200
Transportation (Transit/Roundtrip/Uber/Cab)	Rides to DPP, DSMT, DSME (Stanford Living Well English and Spanish Diabetes Self-Management workshops); Care Clinic for NP visit or wrap around services	$12,000	$12,000	$12,000	$12,000	$12,000
FH Discharge Pharmacy; community pharmacy	Funds to support prescription medication related to diabetes, when not covered by insurance	$15,000	$15,000	$15,000	$15,000	$15,000
Summit- Training	Funding to host learning session with grant partners, community member and patients, at both local and regional level	$2,000	$0	$0	$0	$0
Certified Health Coach training	Health Coach/Chronic Care Professional Certification through Health Sciences Institute an evidence-based model which includes motivational interviewing, client driven assessments, goal setting, etc.	$8,370	$4,185	$4,185	$4,185	$4,185
YMCA	Partner to offer physical education activities to targeted populations; discounted memberships to engaged participants; collaborate to expand DPP programs	$10,000	$10,000	$10,000	$10,000	$10,000
CDE Certification	2 new certifications annually	$3,200	$3,200	$3,200	$3,200	$3,200
Total • **Bolded items represent partner resource sharing**		**$89,746**	**$95,349**	**$98,549**	**$110,337**	**$113,537**
Other Indirect Costs	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Financial Support	.5 FTE Billing/financial counseling for DPP, DSME and MNT; Bilingual; prorate 50% yr. 1; address participation barriers and support billing/collections for sustainability	$22,015	$23,836	$23,836	$23,836	$23,836
Printing	Copying of education materials for classes and individual sessions	$4,800	$4,800	$4,800	$4,800	$4,800
Furniture/Equipment	Cooler, educational flip charts, food models, for mobile classroom	$3,000	$0	$0	$0	$0

Phones and Laptops	Mobile phone/service plan and laptop for: Program Coordinator, Admin, Social Worker, 2.0 CHWs, Pharmacist, NP	$33,848	$6,720	$6,720	$6,720	$6,720
Mileage	Facilitator/leader mileage to workshop	$3,000	$3,150	$3,308	$3,474	$3,648
Consultant Travel and Mileage	Travel and mileage for Regional Consultants Reduce by 50% in year 2	$11,929	$5,965	$0	$0	$0
Accreditation fees	$100 multisite fee and $1100 accreditation renewal during year 2	$100	$1,100	$0	$0	$0
Total		**$78,692**	**$45,571**	**$38,664**	**$38,830**	**$39,004**
Total Expenses & Investments		**$956,465**	**$935,491**	**$918,218**	**$947,498**	**$932,896**

Hospital/Applicant:	Meritus Medical Center (MMC)					
Funding Track:	Diabetes Management					
Total 5-year Budget Request:	$7,834,642					
Workforce/Type of Staff	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
1.0 Quality Coordinator	Meritus Employee- Activity 2	$111,267	$113,492	$115,762	$118,077	$120,439
1.0 Program Coordinator	Meritus Employee- Activity 1	$65,000	$66,300	$67,626	$68,979	$70,358
2.0 Diabetes Educator- RD	Meritus Employee- Activity 1-2	$208,000	$212,160	$216,403	$220,731	$225,146
1.0 Diabetes Educator- RN	Meritus Employee- Activity 1	$110,500	$112,710	$114,964	$117,263	$119,609
1.0 Pharmacist	Meritus Employee- Activity 5	$121,500	$123,930	$126,409	$128,937	$131,516
4.0 Community Health Workers	Meritus Employee- Activity 1-5	$237,952	$242,711	$247,565	$252,517	$257,567
1.0 Behavioral Health Therapist (LCSW-C)	Meritus Employee- Activity 1	$92,040	$93,881	$95,758	$97,674	$99,627
1.0 Multi-Lingual Translator	Meritus Employee- Activity 1-2	$78,000	$79,560	$81,151	$82,774	$84,430
1.0 Technology Specialist	Meritus Employee- Activity 1-2	$84,500	$86,190	$87,914	$89,672	$91,466
1.0 Community Navigator	Meritus Employee- Activity 5	$45,500	$46,410	$47,338	$48,285	$49,251
Total		**$1,154,259**	**$1,177,344**	**$1,200,891**	**$1,224,909**	**$1,249,407**
IT/Technologies	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Virtual Classroom and Learning Management System	Startup costs and maintenance for the program Camera/microphone/speaker system, wall mount, wall monitor, laptop per site.	$15,000	$15,000	$15,000	$15,000	$15,000
Glooko Subscription and transmitters	Activity 2	$24,000	$24,000	$24,000	$24,000	$24,000
Total		**$39,000**	**$39,000**	**$39,000**	**$39,000**	**$39,000**
Wrap-Around Services	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Meals on Wheels	Help address food insecurity for the vulnerable population.	$12,000	$12,000	$12,000	$12,000	$12,000
Stipend for Ophthalmologist and Podiatrist	Present 30-60 minutes per class series	$57,600	$57,600	$57,600	$57,600	$57,600
Three Month Gym Memberships	Purchase of memberships for class participants	$75,000	$75,000	$75,000	$75,000	$75,000
Workshops in community	Fee for venue space	$1,000	$1,000	$1,000	$1,000	$1,000
Food Vouchers	Vouchers for healthy fruits/ veggies for participants	$1,600	$1,600	$1,600	$1,600	$1,600
Transportation for participants	Transportation vouchers	$2,000	$2,000	$2,000	$2,000	$2,000
Total		**$149,200**	**$149,200**	**$149,200**	**$149,200**	**$149,200**
Other Indirect Costs	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Office Supplies	Educational texts, misc. office supplies	$15,000	$15,000	$15,000	$15,000	$15,000

Staff Education and training	Activity 1-2	$4,000	$4,000	$4,000	$4,000	$4,000
DPP Master Training	Activity 1	$2,000	$2,000	$2,000	$2,000	$2,000
Life Coach Training	Activity 1	$1,500	$1,500	$1,500	$1,500	$1,500
Mileage	Mileage for Employees	$3,000	$3,000	$3,000	$3,000	$3,000
Total		**$25,500**	**$25,500**	**$25,500**	**$25,500**	**$25,500**
Total Expenses & Investments		**$1,367,959**	**$1,391,044**	**$1,414,591**	**$1,438,609**	**$1,463,107**

Hospital/Applicant:	**UPMC Western Maryland**					
Funding Track:	**Diabetes Management**					
Total 5-year Budget Request:	**$5,849,748**					
Workforce/Type of Staff	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Consultant - Regional Coordination	Data collection/management/ report writing	$136,930	$79,465	$26,733	$26,733	$26,733
Project Liaison/Outreach Coordinator	1.0 FTE salary and fringe	$48,672	$49,645	$50,637	$51,650	$52,683
Multidisciplinary Team DSME (Admin support, RD, CDCES, Well Coach, Pharmacist)	Teaching DSMES group and individual. Avg. 20 DSMT per year minus existing 12 groups	$2,867	$5,736	$5,736	$7,170	$7,170
Administrative Assistant	1.0 FTE to support Diabetes Care Team	$40,763	$54,350	$55,437	$56,546	$57,677
Diet Tech	0.4 FTE to support off site Food Farmacy and distribution	$18,853	$19,230	$19,614	$20,006	$20,406
Certified Diabetes Educator	1.0 FTE salary and fringe	$75,036	$100,048	$102,049	$104,090	$106,172
Dietitians	1.5 FTE, Prorated for 75% in year one, 2% increase yrs.2-5	$85,176	$113,568	$115,839	$118,156	$120,519
DPP Leaders from UPMC	Cost per DPP class	$1,158	$3,474	$3,474	$4,632	$4,632
ACHD	1.0 FTE Chronic Disease Coordinate screening and referral	$53,965	$53,965	$53,965	$53,965	$53,965
AHEC West	Manage DPP Recognition Program DPP class- 2 leaders and coordination time.	$10,598	$8,598	$8,598	$7,464	$7,464
Certified Medical Technician	Cert. Med Tech in CCR- liaison, referrals and screening	$41,912	$42,750	$43,605	$44,477	$45,367
Diabetes Care Managers	1.0 FTE (post Merck) to assist with expanded caseload and DSME classes & care management	IK	IK	$100,048	$102,049	$104,090
Community Health Workers	3.0FTE to address social needs and back fill time Care Managers	$97,344	$129,792	$132,389	$135,037	$137,738
Associated Charities- Med support	1.0FTE Case Manager to be housed at UPMC from AC	$40,000	$40,000	$40,000	$40,000	$40,000
Team Lead	Oversight of diabetes components	$0	$0	$67,152	$68,495	$69,865
BH professional for diabetes care team	1.0 FTE to be integrated as part of Diabetes Care Team	$62,400	$62,400	$62,400	$62,400	$62,400
Total		**$715,674**	**$763,021**	**$887,676**	**$902,870**	**$916,881**
IT/Technologies	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
IT costs for EMR and AB connection	Vendor cost for connection between Aunt Bertha and clinical system (ECW or EPIC)	$10,000	$0	$0	$0	$0
Smart TV Package	Equipment for remote training	$5,000	$0	$0	$0	$0
Total		**$15,000**	**$0**	**$0**	**$0**	**$0**
Wrap-Around Services	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Food Farmacy	Food support for DSME groups	$82,296	$94,792	$94,078	$104,440	$104,440

Nutrition support for DPP	Pilot restaurant option for 4 DPP classes	$6,000	$9,000	$9,000	$0	$0
Supplies	Books/bands for DSME, DPP book, Food	$8,200	$13,700	$10,950	$4,200	$4,600
HRDC- Transportation	Rides to DPP, DSMT	$20,000	$20,000	$20,000	$20,000	$20,000
Associated Charities	Funds to support prescription medication	$20,000	$20,000	$20,000	$20,000	$20,000
WM Food Bank	Food support for patients	$10,000	$10,000	$10,000	$10,000	$10,000
Summit- Training	Funding to host learning session partners/ patients/ community	$25,000	$10,000	$10,000	$5,000	$5,000
Total		**$173,496**	**$177,492**	**$174,028**	**$163,640**	**$164,040**
Other Indirect Costs	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Financial Services	Billing DPP, DSME and MNT 0.25 FTE year 1/ increase to 0.50 FTE Y2-5	$11,918	$23,836	$23,836	$23,836	$23,836
Printing	Printing/copying	$8,000	$8,000	$4,800	$4,800	$3,000
Furniture/Equipment	Cooler, shelves, table and chair, Desk/chair- 9 staff x$850	$22,150	$0	$0	$0	$0
Phones and Laptops	Phone and mobile service and laptops for staff	$17,000	$3,000	$3,000	$3,000	$3,000
Mileage	Mileage to/from food sites, weekly Food Farmacy travel	$10,715	$11,277	$11,277	$11,936	$11,936
Rent	Lonaconing and Church of Nazarene, yr 1 $1500 to prep space	$3,900	$2,400	$2,400	$2,400	$2,400
Consultant Travel and Mileage	Travel and mileage for Regional Consultants Reduce by 50% in year 2	$11,929	$5,965	$2,983	$2,500	$2,900
Engagement Campaign	Culturally sensitive campaign w/ County Diabetes Action Plan	$160,000	$160,000	$50,000	$45,000	$32,000
MISC Patient Assistance	Funds to support social needs	$20,000	$15,000	$10,000	$10,000	$10,000
Total		**$265,612**	**$229,478**	**$108,296**	**$103,472**	**$89,072**
Total Expenses & Investments		**$1,169,782**	**$1,169,991**	**$1,170,000**	**$1,169,982**	**$1,169,993**

2. Budget and Expenditures Narrative

Each of the three lead hospitals request approximately 45 percent of the .75 percent of each hospital's GBR in grant funding for Funding Stream I. Each hospital will use this annual increase in rates between January 1, 2021 and December 31, 2025 to generate funds that together with hospital resources we will each use to implement our proposal. These funds will increase staffing to implement DPP and DSMT and complementary supportive services. The budget request also includes allowable enhancements to IT infrastructure, wrap around supports, partner fees and project management costs. Line itemed budgets specify each hospital's funding allocations by numbers of FTEs and other program costs. Bolded items in the budgets represent resources that will be shared with community collaborators.

Staffing

All three hospitals will hire, train and support expanded intervention workforces: Program coordinators, multi-lingual outreach staff, clinicians, dietitians, DPP and DSMT leaders and class support staff, peer workforce, MNT providers, BH clinicians and others. Nurse practitioners certified in diabetes care will link patients in community clinics to DPP and DSMT interventions. Because many persons with pre-diabetes and diabetes have co-occurring conditions and take many medications, community pharmacists will assist patients to access affordable medications, to understand choices in medications, and to manage side effects and interactions. Behavioral health specialists will address co-occurring behavioral health disorders. Community Health Workers (CHWs) will screen program participants to identify social needs and assist in navigating community resources.

Hospitals have budgeted for training and development of staff including motivational interviewing, client driven assessments, goal setting, etc. They have also budgeted for staff to obtain and maintain professional certifications.

Hospitals budgets include program coordination and management costs to engage partners, develop processes and workflows, document and track data and outcomes.

Each hospital's gaps and opportunities to improve diabetes prevention and management systems are different as specified in line item budgets. Salaries and fringe costs are included. Year 2-5 budgets allow for projected salary and fringe increases.

IT Infrastructure

Hospitals plan to enhance existing electronic health record infrastructure to provide flags, alerts and automated reports to enable clinicians to support DSMT and DPP recruitment and retention and to connect patients to wrap around behavioral health services, MNT, food access and physical activity programs. Hospitals also plan to integrate social risk screening information and have budgeted for new module and assessment licenses as needed. MMC budgeted for startup costs and maintenance for the virtual classroom DSMT program, including cameras, microphones, speaker systems, wall mounts, wall monitors and laptops.

DPP and DSMT Direct Costs

In addition to direct staffing costs, hospitals have budgeted for DPP, Stanford Living Well Diabetes Self-Management and Stepping Up Your Nutrition workshop costs and books/binders, bands, bags and food for DSME and DPP workshops. Costs also include materials copying and funds to provide materials and

services in Spanish. They will provide coolers, educational flip charts, and food models for mobile classrooms. In Washington county, stipends will be provided for an ophthalmologist and podiatrist to present to each DM program class.

Wrap Around Services

Hospitals will provide funding for healthy meals at DSME and DPP classes to reinforce and demonstrate class lessons. Some hospitals have also budgeted for take home food and monthly food sharing memberships to further support healthy eating among very low-income participants.

Two hospitals will provide funds for prescription medications to improve diabetes management, when not covered by insurance.

Many wraparound services are provided by partners. Hospitals' budgets include shared resources to increase access to gyms and physical activity intervention. They also include significant funding for food vouchers and resources provided through partners given the deep poverty experienced by many in the hospital target population. MMC will partner with Meals on Wheels to provide home delivered meals for eligible persons who are food insecure. All three hospitals will assist with transportation costs when this is a barrier to DSMT or DPP participation.

Project Management and Program Performance Measurement and Improvement

Hospital have budgeted to host meetings and events with grant partners and community members

Other Indirect Costs

Other indirect costs include financial oversight and management of partner contracts and hospital budgets. They also include printing for reports and presentation documents, allowable program related furniture and equipment, phones and laptops for diabetes program staff, intervention related mileage, consultant travel and mileage, and accreditation fees.

TRIVERGENT HEALTH ALLIANCE, LLC

RESOLUTION OF THE BOARD OF MANAGERS AUTHORIZING FORMATION OF COMMITTEE FOR REGIONAL CARE TRANSFORMATION

WHEREAS, since 2016, Meritus Medical Center ("Meritus") and Frederick Health Hospital, Inc. ("Frederick"), together with UPMC Western Maryland Health System ("UPMC-WMHS") (collectively the "hospitals"), have collaborated as a regional partnership to participate in the State of Maryland's Transformation Grant Program sponsored by the Health Services Cost Review Commission (HSCRC);

WHEREAS, Meritus and Frederick are members of Trivergent Health Alliance, LLC ("Trivergent") and UPMC-WMHS is a former member;

WHEREAS, the hospitals wish to continue their collaborative relationship for improving population health in their combined service areas by participating in the HSCRC's successor Regional Partnership Catalyst Grant Program (the "Catalyst Grant Program") for the five-year period from January 1, 2021 through December 31, 2025;

WHEREAS, to facilitate the collaborative relationship of the hospitals, the Board of Trivergent (the "Board") has determined that it would be advantageous to create an advisory committee for planning related to population health strategies to achieve the goals of the Catalyst Grant Program;

NOW, THEREFORE, IT IS HEREBY RESOLVED THAT:

1. The Board hereby establishes an advisory committee to be known as the Regional Care Transformation Executive Committee (the "Committee");

2. The Committee shall include representatives from each of the hospitals;

3. The Committee shall be responsible for recommending population health strategies to achieve the goals of the Catalyst Grant Program and coordinating the planning and execution of those strategies by the hospitals;

4. The Committee's role shall be advisory only--the Committee shall not have decision-making authority for any hospital or for Trivergent;

5. The recommendations of the Committee shall be subject to review and approval of each hospital, and execution of those recommendations shall be the responsibility of each hospital acting individually, but with the intention that the hospitals will coordinate their activities so as to achieve the goals of the Catalyst Grant Program in an effective and efficient manner;

6. Each hospital shall be requested to commit to the goals of the Committee by signing a memorandum of understanding substantially in the form of Exhibit A to this resolution setting forth the terms of participation on the Committee;

7. Trivergent shall provide coordinating assistance to the Committee with respect to its meetings and minutes, but shall not be responsible for funding with respect to the activities of the Committee;

8. The Board retains the discretion to change these directives at any time, based upon developments.

ADOPTED this__ day of_____ , 2020

_____
Secretary

ATTACHMENT:

Exhibit A- Regional Partnership Catalyst Grant Program, Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding (this "MOU"), effective on the date of signature of the last signatory to this MOU (the "Effective Date"), is entered into by and among **Trivergent Health Alliance, LLC**, a Maryland limited liability company ("Trivergent"), **Frederick Health Hospital, Inc**. ("Frederick"), **Meritus Medical Center** ("Meritus"), and **UPMC Western Maryland Corporation** ("UPMC-WMHS"). Frederick, Meritus, and UPMC-WMHS are each a nonprofit, non-stock Maryland corporation and are referred to herein as a "Hospital" or the "Hospitals." (Trivergent and the Hospitals are also referred to individually as a "Party" and collectively as "the Parties.")

RECITALS

WHEREAS, in July 2016, the Maryland Health Services Cost Review Commission (HSCRC) awarded a "Transformation Grant" to Trivergent, on behalf of its member hospitals, which provided funding through 2020 for the implementation of regional care transformation strategies in the combined service area of those hospitals;

WHEREAS, since the award of the grant to Trivergent in 2016, Meritus, Frederick, UPMC-WMHS have utilized Trivergent as their shared decision-making governance structure for implementation of Transformation Grant Program activities;

WHEREAS, Meritus and Frederick are members of Trivergent and UPMC-WMHS is a former member;

WHEREAS, the Hospitals wish to participate in the HSCRC's successor Regional Partnership Catalyst Grant Program (the "Catalyst Grant Program") for the five-year period from January 1, 2021 through December 31, 2025, and to continue utilizing Trivergent to provide a governance structure for shared decision making in satisfaction of the HSCRC Catalyst Grant Program Requirements;

WHEREAS, to facilitate the shared decision-making process, Trivergent has created an advisory committee (the "Regional Care Transformation Executive Committee" or the "Committee") to act as a steering committee for planning related to achievement of the goals of the Catalyst Grant Program;

WHEREAS, the Parties wish to confirm their commitment to participation on the Committee as described in this MOU;

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

1. Terms of Commitment

(a) The Hospitals commit to the goals of the Catalyst Grant Program, including:

a. Partnerships and strategies that result in long term improvement in the population health metrics that are part of the new Maryland Total Cost of Care (TCOC) Model;
b. Increased number of prevention and management services for persons with potential for or living with diabetes;
c. Reduced use of hospital emergency departments and improved approaches for managing acute behavioral health issues;
d. Integration and coordination of physical and behavioral health services for improved quality of care; and
e. Engagement and integration of community resources into the transforming healthcare system.

(b) Each Hospital agrees to follow the Regional Partnership Catalyst Grant Program Proposal (**Exhibit A**), which describes how the Hospitals will use the Catalyst Grant Program funds to work in collaboration with Local Health Improvement Coalitions, Local Health Departments, and community-based organizations,

(c) Each Hospital agrees to appoint **[two]** representatives to the Committee to collaborate with representatives of the other Hospitals on the development of population health strategies for achieving the goals of the Catalyst Grant Program and coordinating execution of those strategies;

(d) Decisions of the Committee shall be on a consensus basis; each Hospital acknowledges that any recommendations of the Committee are subject to review and approval by all of the Hospitals, and each Hospital remains responsible for execution of those recommendations in its respective service area;

(e) The Committee shall function as the shared decision-making governance structure for purposes of the Catalyst Grant Program, consistent with past practice under the Transformation Grant Program;

(f) Trivergent shall assist the Committee and the Hospitals with respect to coordination of Committee meetings, preparation of minutes, and maintenance of Committee records, but Trivergent shall not be responsible for funding with respect to any of the activities of the Committee;

(g) Trivergent is authorized to make arrangements with third parties for assistance in the preparation of reports required under the Catalyst Grant Program for measuring progress towards scale targets, subject to approval of the Committee. Initially, Trivergent expects to utilize staff resources at Meritus for the preparation of such reports. Any funding required by Meritus with respect to report preparation will be subject to the mutual

agreement of Meritus (or a successor selected by the Committee) and the participating Hospitals.

2. Term of MOU. This MOU will commence on the Effective Date and will remain in effect for the term of the Catalyst Grant Program.

3. Termination. A Hospital may terminate its participation in this MOU upon reasonable prior written notice to the other Parties and subject to fulfillment of any requirements imposed on the withdrawing Hospital under the Catalyst Grant Program. Further, any termination of the Catalyst Grant Program by the HSCRC will result in the automatic termination of this MOU, except that the arrangement will continue following such termination for the time period reasonably necessary to complete any reporting requirements under the Program.

4. Notices. Any notice required or permitted to be given pursuant to this MOU shall be given in writing and shall be deemed effective on the date of delivery if delivered by hand, or one business day after mailing by a commercial overnight delivery service, or three (3) business days after being deposited in the United States certified mail and properly addressed to:

Trivergent:

Trivergent Health Alliance, LLC
1 Frederick Health Way
Frederick , MD 21701
Attn: Chief Executive Officer

Hospitals:

Frederick Health Hospital, Inc.
400 West Seventh Street
Frederick, MD 21701
Attn: Chief Executive Officer

UPMC Western Maryland Corporation
12500 Willowbrook Road
Cumberland, MD 21502
Attn: Chief Executive Officer

Meritus Medical Center
11116 Medical Campus Road
Hagerstown, MD 21742
Attn: President and Chief Executive Officer

A Party may change its address for notice by providing written notice to the other Parties in accordance with this Section.

5. No Assignment. No Party may assign this Agreement or any of its rights or obligations hereunder without the prior written consent of each other Party. Notwithstanding the foregoing,

a Party may assign this Agreement (i) to any subsidiary or parent corporation, now or hereinafter existing, or (ii) to a successor organization in the event of a merger or consolidation, or the sale of all or substantially all of its assets to the successor organization; provided, however, that (a) the assigning Party provides the other Parties with prompt written notice of such sale, merger or consolidation, and (b) the assignee agrees to be bound by all terms and conditions set forth by this Agreement. For purposes of this Section, "assignment" shall include any assignment by operation of law and any change in control of the Party.

6. Governing Law. This MOU will be governed by and construed in accordance with the laws of the State of Maryland without regard to its conflicts of laws principles. **The Parties waive the right to a trial by jury in any action, proceeding, or counterclaim arising out of or related to this MOU.**

7. Public Announcements. Each Hospital agrees that no public or private announcements, media releases, press conferences, advertising or similar publicity in any form relating to Trivergent will be made without the prior written consent of Trivergent, which may be provided or withheld in their sole and absolute discretion.

8. Use of Logos. Hospitals shall not use the name, service marks, trademarks, trade names or logos of Trivergent, subsidiaries or any variation or acronym thereof, for any purpose, without the prior written consent of Trivergent, which may be provided or withheld in their sole and absolute discretion.

9. Entire Agreement; Amendment. This MOU constitutes the entire agreement among the Parties with respect to the subject matter hereof, and supersedes all prior agreements, understandings, and discussions, written or oral, between or among the parties related to their collaboration in the HSCRC Catalyst Grant Program. The Parties acknowledge that additional terms and conditions may be imposed on each Party by HSCRC pursuant to the HSCRC Catalyst Grant Program. This Agreement may not be modified, amended or otherwise changed in any manner except by a written instrument executed by all of the Parties.

10. Counterparts; Electronic Transmission. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument. Executed copies of this Agreement may be delivered by email, facsimile, or other comparable means.

[The remainder of this page intentionally left blank.]

IN WITNESS WHEREOF, this MOU has been executed by the duly authorized officers of the Parties.

Trivergent Health Alliance, LLC
By:_____
Print Name:_____
Title:_____
Date:_____

UPMC Western Maryland Corporation
By:_____
Print Name: _____
Title:_____
Date: _____

Meritus Medical Center
By:_____
Print Name:_____
Title:_____
Date:_____

Frederick Health Hospital, Inc.
By:_____
Print Name: _____
Title:_____
Date: _____

Exhibit A - Regional Partnership Catalyst Grant Program Proposal

Key		
		Planning
		Implementation
		Monitoring

RP Project Management		Year 1 - 2021											
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Monthly Trivergent Health Association/Western Regional Partnership (WRP) Executive Committee meetings	All Hospitals	Monthly Planning, Implementation and Monitoring											
Monthly WRP Diabetes (DM) Committee meetings													
Monthly hospital/county DM committee meetings													

Target Population Planning and Analysis		Year 1 - 2021											
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
In Frederick and Allegany, map DM hotspots and high- risk populations	All Hospitals												
In Allegany, Frederick,and Washington counties, map clinical access points for target communities and populations													
Map community access points for wrap around supports – Food banks, faith-based organizations, YMCAs, community pharmacists													
Map ideal WRP DM prevention and management ecosystem and identify gaps in DM care system													
Create plans for addressing county specific gaps in crisis services in each county													
Plan, implement and evaluate DPP pilots in each county that provide comprehensive wrap around supports and incentives in hot spot communities													

Activities Service Planning and Development		Year 1 - 2021											
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Plan approach to reach DPP and DSMT recruitment and retention goals with partners	All Hospitals												
Create standard operating procedures and MOUs to connect DM system of care elements													
Establish referral systems													
Enhance multi-disciplnary care teams													
Sponsor county DM partners kick off events													
Develop policies to waive co-payments through financial assistance policies													
Assess partnership opportunities with VA to provide DPP and/or DSMT for persons jointly insured by Medicare and Tri-Care in project out years													

National DPP		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Assess existing DPP program performance and study opportunities to recruit and retain higher risk populations through wrap around servcie enhancements	All Hospitals												
As needed, increase # of licensed group leaders in all counties													
Expand partnerships with county health department clinics for recruiting high risk persons (dental clinic in Allegany is a strategic target)													
In Washington county, increase access to DPP through centralized class schedules, referrals, patient engagement, and marketing at MMC, COA, and WCHD													
Continue to provide or partner with DPP providers in all three counties													
Expand access to fresh vegetables and fruits through partners Food Farmacy in Allegany and Frederick Counties													
Expand access to physical activity resources through free or discounted memberships - YMCAs, etc.													

DSMT Program		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Assess existing DSMT program performance and study opportunities to recruit and retain higher risk populations, including virtual and/or hybrid DSMT	All Hospitals												
Provide DSMT services													
In Washington County, develop telehealth capabilities for "virtual classroom"													
Continue and expand CDSMP Living Well services													
Expand certified DSMT educators (if needed)													
Get approval from ADA to expand DSMT to new sites													

Wraparound Services		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Continue and expand MNT	All Hospitals												
Continue and expand Bridges lay health educator program in Frederick													
Recruit CHWs from high burden communities													
Expand access to healthy food through Food Farmacy program													
Expand access to healthy food through food pantries													
Continue and expand medically supervised fitness classes, as well as unsupervised physical activity programs													
Continue and expand depression screening and treatment													

Partner Engagement and Management		Year 1 - 2021											
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Update partner/ collaborator list if needed	All Hospitals												
Notify partners and collaborators of project launch													
Plan and hold county level kick- off events with DM system of care partners													
Provide funding and in-kind services for partners documented through business agreements													
Collaborate with business and faith community partners to integrate diabetes education classes into their employee wellness and faith-based programs.													
Engage LHICs and create mechanism for on-going communication, updates and alignment with Diabetes Action Plan strategies													
Market and promote services to hospital ED and floor nursing staff, clinical practices, community pharmacists, community-based organizations, the public, others TBD													

Infrastructure & Workforce Development		Year 1 - 2021											
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Recruit initiative staff (program coordinators, CHWs, BH specialists)	All Hospitals												
Provide trainings for staff and partners in DM interventions and motivational interviewing													
Integrate social risk screening into EMRs													
Create EMR flags and automated reports to provide real time information to clinicians about patients' status and plans													
Obtain approval for MNT ordering flexibilities													

Data Collection & Monitoring		Year 1 - 2021											
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Establish data collection and management SOPs	All Hospitals												
Test systems for collecting, linking and managing demographic, social needs and medical information													

Identify gaps and barriers for Year 2 Implementation Plan	Hospitals												
Collect and analyze performance measurement data													

	Year 2 - 2022				Year 3 - 2023				Year 4 - 2024				Year 5 - 2025			
RP Project Management	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
RP DM Committee Meetings	**Monthly Planning, Implementation and Monitoring**															
Monthly hospital-specific DM Committee meetings																
Other county-level diabetes committee meetings																
	Year 2 - 2022				Year 3 - 2023				Year 4 - 2024				Year 5 - 2025			
Proposed Activities Service Implementation & Delivery	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
National DPP with Wraparound Services																
Recruit target populations																
Integrate BH screening and treatment into intake and care plans																
Flag and refer screened patients to BH specialist																
CHWs screen patients for social needs																
CHW resource navigation to connect patents with resources and benefits																
DPP Enrollment																
Create and implement a patient outreach plan to ensure outreach is growing																
Provide in-person DPP classes and retain participants for 12 months																
Build DPP into existing wrap around services																
Connect participants to Food Farmacy program in Allegany and Frederick counties																
Connect participants to SHARE Food Network																
Promote and offer Real Appeal weight loss program in Frederick County																
Offer free gym or reduced gym memberships and personal training for program participants																
Provide medically supervised physical activity for eligible participants																
DPP Outcomes																
Medicare and Medicaid claims for first sessions																
Claims for 9 core sessions																
Claims indicating 5% or 9% bodyweight loss																
DSMT Program with Wraparound Services	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Recruit target populations through clinical and community partners																
Provide in-person, hybrid and virtual DSMT program modalities																
Provide wrap around services - MNT, depression screening, access to food and physical activity programs																
Engage partners in DSMT service continuum plans and improvements																
Assess and continuously improve performance to scale targets																
DSMT Outcomes																
Medicare claims for DSMT services																
2.5% reduction PQI93 rate																
5% reduction PQI93 rate																
	Year 2 - 2022				Year 3 - 2023				Year 4 - 2024				Year 5 - 2025			
Partner Engagement and Management	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Engagement of primary care practices and hospital clinicians in DM program recruitment and retention																
Engagement of DSMT and DPP community partners																
	Year 2 - 2022				Year 3 - 2023				Year 4 - 2024				Year 5 - 2025			
Infrastructure & Workforce Development	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Expansion of Walnut Street class site in Washington county																
Expansion of MMP North class site																
Assess DPP centralized billing options																
	Year 2 - 2022				Year 3 - 2023				Year 4 - 2024				Year 5 - 2025			
Data Collection & Monitoring	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Collect and analyze performance measure data																
Review and analyze CRISP and HSCRC data																
	Year 2 - 2022				Year 3 - 2023				Year 4 - 2024				Year 5 - 2025			
Reporting and Oversight	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
THA Executive Committee Review of program milestones and progress to scale targets																

Key	
	Planning
	Implementation
	Monitoring