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Erin Schurmann
Center for Payment Reform & Provider Alignment
Maryland Health Services Cost Review Commission
erin.schurmann@maryland.gov

July 17, 2020

Re: Project Title: Full Circle Wellness for Diabetes in Charles County (FCW4D)

Dear Ms. Schurmann:

On behalf of University of Maryland Charles Regional Medical Center (UM CRMC), I am pleased to submit the enclosed grant application to the Maryland Health Services Cost Review Commission (HSCRC) for the Regional Partnership Catalyst Grant Program (CY 2021 - CY 2025). The application is for funding Stream I: "Diabetes Prevention & Management Programs".

If the project is selected for funding, University of Maryland Charles Regional Medical Center is committed to fulfilling all of the commitments made in the grant application.

I hereby authorize Mary Hannah, to act as the key contact for this project, and all correspondence concerning the grant application will be directed to Ms. Hannah at [redacted].

Respectfully,

Albert Zanger
Chief Financial Officer
University of Maryland Charles Regional Medical Center

[redacted]

Section I: Scope of Work

1. Summary of Proposal (3 Pages)

Hospital/Applicant:	University of Maryland Charles Regional Medical Center (UM CRMC)
Hospital Members:	
Health System Affiliations:	University of Maryland Medical System (UMMS)
Funding Track:	Funding Stream I: Diabetes Prevention & Management Programs
Total Budget Request:	$2,526,347

Target Patient Population
As of 2019, 163,257 residents resided in Charles County. Approximately 60% of Charles County residents live in the greater Waldorf-La Plata area. The project aims to reduce the prevalence of diabetes and diabetes risk factors among County residents. Approximately, 10.8% (14,262) of Charles County's residents have physician diagnosed diabetes, ranking 14th highest in the state. Additionally, 3 out of 4 residents are overweight or obese. The project service area spans 458 square miles and covers 37 communities across 25 zip codes. The regional partnership will also serve Prince George's County residents living along the northern border of Charles County and St. Mary's County residents living along the southeastern border of the county for Diabetes Self-Management Training (DSMT) and Diabetes Prevention Program (DPP) services. The associated zip codes are: 20604, 20695, 20603, 20611, 20612, 20616, 20617, 20622, 20625, 20632, 20637, 20643, 20640, 20646, 20645, 20658, 20661, 20664, 20662, 20675, 20677, 20682, 20693, 20602, and 20601.
Proposed Activities
Full Circle Wellness for Diabetes in Charles County (FCW4D) 1. Expand Diabetes Self-Management Training services by hiring a full time RN CDCES and full time Dietician. Relocate the Center for Diabetes Education to a space that allows for growth of additional staff and services. 2. Offer wrap around services including medical nutrition therapy, home visits, telehealth, pulmonary exercise, on demand transportation, patient support groups, and medication delivery. 3. UM CRMC and the Charles County Department of Health partner to expand Diabetes Prevention Services by seeking program accreditation, and listing UM CRMC as a subsidiary partner. Train three additional lifestyle coaches to increase the number of patients served. Offer services insured, uninsured, and low-income residents. 4. Create [redacted] tool to make referrals and enrollment easier for providers and patients. 5. Utilize Community Health Workers, Lifestyle coaches, nurse navigators and pharmacist technicians to provide social support for patients, increase participation and engagement. 6. Partner with Greater Baden Medical Services, Health Partners, and United Way of Charles County to provide uninsured or underinsured patients diabetes education and prevention services, and increase public awareness and outreach. Partner with the leaders of the faith-

based community to reach residents disconnected from healthcare and those that live in geographically hard to reach areas.

Measurement and Outcomes
The partnership will utilize Workshop Wizard, workshop enrollment rosters, [redacted], and a custom [redacted] report [redacted] to evaluate progress towards the scale targets. Additional program measures are: • 25 Percent volume growth of the DPP program annually; • 15 Percent volume growth of the DSMT program annually; • Participants in DSMT workshop have a 25% gain in knowledge of diabetes and management techniques from their pre-workshop survey; and • Ratings of good to very good on 90% of workshop surveys completed.
Scalability and Sustainability
The partnership will use a variety of methods to sustain the program: CTIs, billable services from DSMT, DPP, and MNT; non-HSCRC grants; expansion of the partnership to include more members; and based on return on investment incorporating grant funded positions into the global budget. The project features extensive collaboration and sharing of resources to provide services not normally available in rural communities, and to expand access to services.
Governance Structure
A formal governance structure will not be used for the Full Circle Wellness for Diabetes in Charles County Regional Partnership. UM CRMC has an MOU with the Charles County Dept. of Health for shared funding and resources, and informal and verbal agreements with the other partners. Quarterly meetings will be held to assess lessons learned and program adjustments. Annual meetings will assess program outcomes and changes to strategy. A representative from each partner will be invited.

Participating Partners and Financial Support List member hospitals/community collaborators and describe any resource sharing, financial support and/or in-kind support, if applicable.
University of Maryland Charles Regional Medical Center will provide additional staffing to support DSMT, DPP, IT enhancements, and general program administration. University of Maryland Medical System will connect patients to telehealth supports, provide system wide program support, and coordinate with CRISP to develop enrollment/ recruitment tools.

Charles County Dept. of Health will lead the DPP program, manage accreditation, and list UM CRMC as a subsidiary. Provide DPP facilitators/ lifestyle coaches. Charles County Mobile Integrated Health will provide community health nurses, community health workers for medication management home visits.

Greater Baden Medical Services, Health Partners, University of Maryland Medical Group Endocrinologists and Primary Care Physicians will disseminate materials and refer patients. Each will have a partnership lead.

United Way of Charles County and the FLINT team will host/co-host community events for outreach and leverage partnerships with faith-based leaders for diabetes education classes in nonclinical settings. Lyft will provide on-demand transportation to support patients with transportation needs.

Implementation Plan

- Task 1: Planning Period will focus on finalizing agreements, hiring staff, defining program details, and developing workshop schedules and curriculum. (1/1/2021-12/31/2021)
- Task 2: Focuses on creating and deploying the IT Infrastructure for patient Identification and program enrollment, and providing training to the partners. (1/1/2021-12/31/2021)
- Task 3- 5: Focus on expanding the DSMT and DPP programs and wrap around services. Year 1 will be used to hire and train new staff. Services will become fully operational in year 2. A Registered Nurse CDCES and Registered Dietitian CDCES will be hired for DSMT and three lifestyle coaches will be trained for DPP. (1/1/2021-12/31/2025)
- Task 6: Consumer Outreach and Engagement focuses on providing community benefit programs, diabetes support groups, reaching patients through marketing and public awareness, and assessing patient satisfaction and behavioral changes. (1/1/2021-12/31/2025)
- Task 7: Partner Engagement and Stakeholder Meeting outlines the structure for communication and quarterly/ annual partnership meetings. (1/1/2021-12/31/2025)
- Task 8 and 9: Focus on data collection, analysis of outcomes, financial and performance reporting, and closeout during the final year of the project. (1/1/2021-12/31/2025)

Budget & Expenditures

Year 1	Year 2	Year 3	Year 4	Year 5	5- Year Total
$499,874	$481,972	$493,505	$509,206	$541,790	$2,526,347

2. Target Population

Geographic Area Served

UM Charles Regional Medical Center (UM CRMC) is a regional, not for profit, integrated health system that serves Charles County and southern Maryland residents. UM CRMC is one of thirteen University of Maryland Medical System (UMMS) affiliated hospitals. The UM CRMC main campus in La Plata, MD is a 98-bed acute and preventative care outpatient medical pavilion. In 2019 it had 6,049 admissions and 51,592 emergency department visits. About 7% of visits were uninsured. The regional partnership also includes the Charles County Department of Health (CCDoH) and not for profit, Federally Qualified Health Centers Greater Baden Medical Services and Health Partners. All three organizations provide primary and preventive care services to low income and uninsured patients.

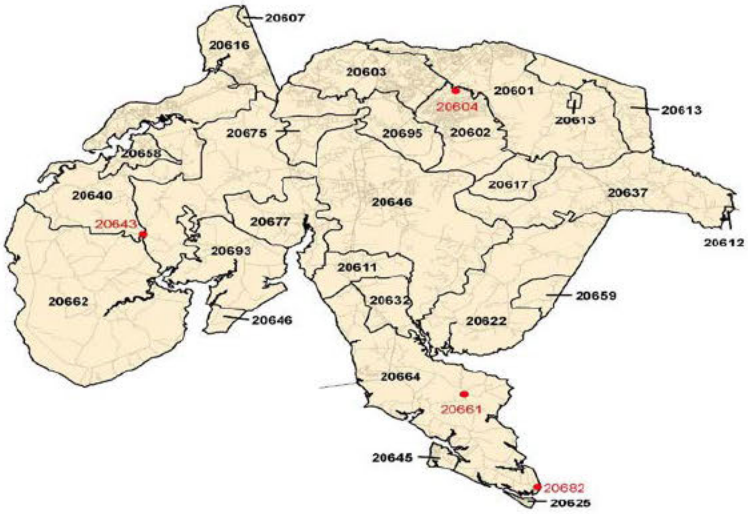
As of 2019, 163,257 residents resided in Charles County. Approximately 60% of Charles County residents live in the greater Waldorf-La Plata area. The project service area spans 458 square miles and covers 37 communities across 25 zip codes. Services will be provided to residents in the towns of Indian Head, La Plata (county seat), and Port Tobacco Village; census designated communities of Bensville, Bryans Road, Bryantown, Cobb Island, Hughesville, Pomfret, Potomac Heights, Rock Point, Saint Charles, and Waldorf; and the following unincorporated cities: Bel Alton, Benedict, Dentsville, Faulkner, Glymont, Grayton, Ironsides, Issue, Malcolm, Marbury, Morgantown, Mount Victoria, Nanjemoy, Newburg, Pisgah, Popes Creek, Port Tobacco, Pomonkey, Ripley, Rison, Swan Point, Welcome, and White Plains. The regional partnership will also serve Prince George's County residents living along the northern border of Charles County and St. Mary's County residents living along the southeastern border of the county for Diabetes Self-Management Training (DSMT) and Diabetes Prevention Program (DPP) services. The associated zip codes are: 20604, 20695, 20603, 20611, 20612, 20616, 20617, 20622, 20625, 20632, 20637, 20643, 20640, 20646, 20645, 20658, 20661, 20664, 20662, 20675, 20677, 20682, 20693, 20602, and 20601.

Charles County Health Needs

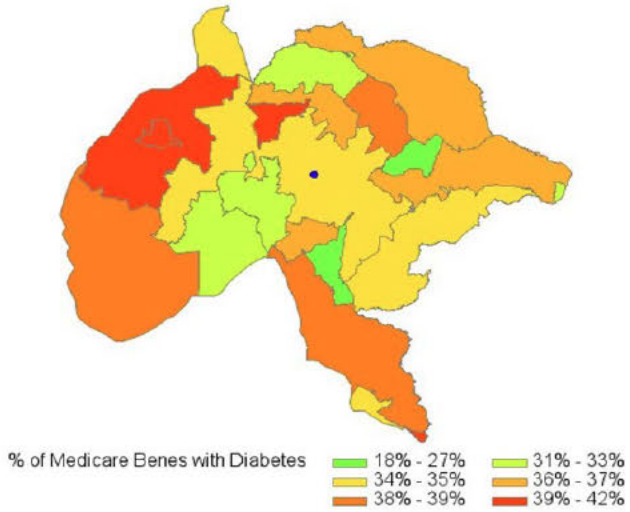
DSMT and DPP services expanded through this partnership aim to lower the prevalence of diabetes county-wide. According to the 2018 Maryland Behavioral Risk Factor Surveillance System data 10.8% (14,262)[1] of Charles County's residents have physician diagnosed diabetes, ranking 14th highest in the state. Graphic 2 illustrates a higher prevalence of diabetes among Medicare recipients in the western and southern regions of the county and along the Prince George's County Border (5th highest in state)[1].

1. Behavioral Risk Factor Surveillance System, Maryland Department of Health, Age Adjusted Diabetes Prevalence, 2014,2016,2018 All Counties

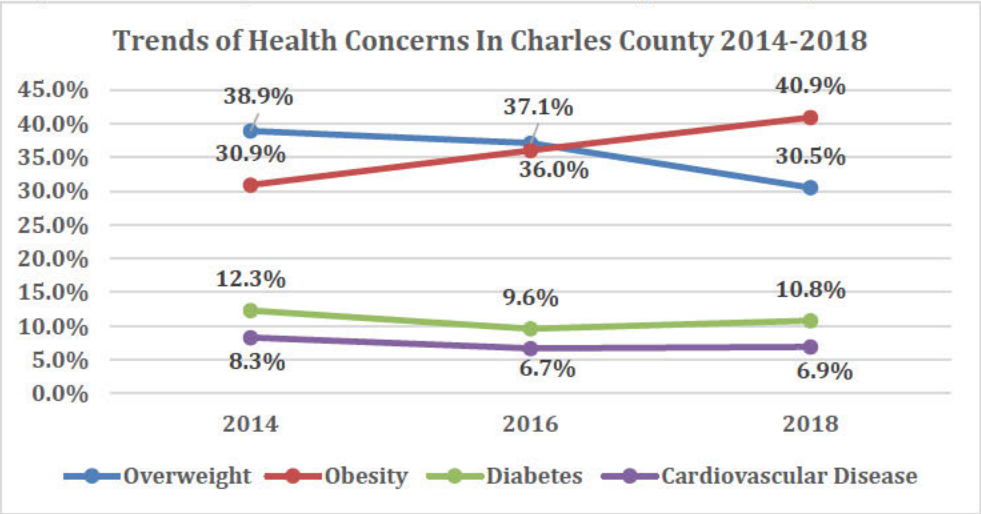
Graphic 1: Charles County Map by Zip Code[2]



Graphic 2: Charles County % Medicare Beneficiaries w. Diabetes 2017 [3]



A rising number of residents are also impacted by prediabetes, a condition where blood sugar levels are higher than normal, but not high enough to be considered diabetes. Almost 8 out of 10 residents have risk factors for prediabetes which include eating less than 5 or more fresh fruits and vegetables each day (78%), eating fast food frequently (20%) , rarely participating in daily physical activity (76%)[4], and/or being overweight with a Body mass index between 25-29.9 (30.5%) or obese with a mean body mass index over 30 (40.9%)[5]. Charles County obesity prevalence is 10% higher than the state average, but varies by ethnicity. Within the county, about 39% of white residents are obese compared to 42.8% of African Americans. Most alarming is the percentage of residents that have transitioned from overweight to obese between 2014 and 2018 [5]. The upward trend, shown in graphic 3, may be in part explained by county-wide population growth, and Black and Hispanic residents representing a greater portion of the population than in previous years. As of 2019, the racial breakdown of Charles County is 41.6% White, 50.1% Black or African American, and 6.3% Hispanic.[6]



2. MD Dept of Planning, 2015-2016 Charles County Map by Zipcode
https://planning.maryland.gov/MSDC/Documents/zipcode_map/2015/charzc15.pdf
3. Prevalence of Diabetes in Charles County for Medicare recipients, 2017, prepared by HQI Solutions

Residents also face multiple barriers to care stemming from the rurality of Charles County that impede healthy outcomes in the diabetic population such as geographic isolation, lack of transportation, and limited access to health care services such as endocrinology and nutrition programs. At least 5 areas within Charles County are designated medically under-served areas (MUA) by the Health Resources & Services Administration because they have too few primary care providers. Additionally, as of 2018, 8.2 % of residents lacked health insurance[7] and 7.2% reported being unable to see a doctor in the past 12 months because of the cost[7]. The partnership includes collaboration with community partners to provide round-trip transportation to training and medical appointments, telemedicine, access to free and low-cost physical activity programs, and prepared meals to address social determinants of health.

Without education, support, and medical intervention, diabetes can lead to frequent emergency department visits and more serious, potentially life-threatening conditions which include cardiovascular disease (i.e. heart disease, heart attack, stroke, and heart failure), kidney disease, nerve damage, urinary tract infections, foot ulcers, gum disease, and death. In 2018, 217 Charles County deaths were attributed to cardiovascular disease. As in previous years, heart disease remained the leading cause of mortality within Charles County with a rate of 166.7/ 100,000 residents[8]. An additional 47 deaths were attributed to Diabetes mellitus. The 2016-2018 mortality rate for diabetes mellitus increased to 26.3/ 100,000 residents, up from 22.4 between 2015-2017. The current rate is higher than Calvert County (25.5) and the state average (19.8), but not St. Mary's County (29.8)[8].

3. Proposed Activities

An Evidence-Based Approach

Every three years UM Charles Regional Medical Center (UM CRMC), in partnership with the Charles County Department of Health (CCDoH), conducts the Charles County Community Health Needs Assessment (CHNA). The CHNA identifies the health needs of individuals living in Southern Maryland and outlines strategies to improve community health. The 2018 CHNA utilized 5 different sources of data: a long online survey and a short paper survey to collect Charles County residents' perceptions of health and health behaviors; 5 focus groups with community leaders, citizens, and stakeholders; 9 key informant interviews on behavioral health; and a quantitative data analysis of secondary, published data. Data collection occurred between July 2017 and February 2018, and 77% of respondents lived within the County. Across all data sources some of the biggest issues to emerge were obesity, diabetes, chronic disease, and access to care.

Out of 846 respondents of the long online survey, approximately three out of four reported traveling outside the County for medical care. Out of those respondents 59% travelled outside for specialty care; 20% said they travelled because services were not available; and 39% believed that better care was available outside of the County[4]. When asked what problems prevent them from getting the care they

4. Charles County Community Health Needs Assessment and Implementation Plan. (2018) UM Charles Regional Medical Center and Charles County Department of Health.

5. Behavioral Risk Factor Surveillance System, Maryland Department of Health,2014,2016,2018 Weight Classification, All Counties

6. US Census Bureau, Quick Facts, pulled 7/10/2020
https://www.census.gov/quickfacts/fact/table/charlescountymaryland,US/PST045219

need, common concerns were not being able to get an appointment when needed, lack of transportation, and "the doctor is too far away from my home". Respondents most likely to have transportation and healthcare access challenges were older adults, those with low-income, and residents that live in towns outside of Waldorf and La Plata. Within the focus groups of 128 health professionals, a majority also identified healthcare access, obesity, and chronic disease management as some of the biggest issues facing the county, in addition to physician recruitment, retention, and reimbursement.

Using the Hanlon Method to prioritize the most critical health needs in the CHNA, the Charles County Community Health Needs Assessment Committee identified three priority areas, of which two will be addressed by the Regional Partnership: Chronic Disease Prevention and Management and Access to Care. Within Chronic Disease Prevention and Management, health topics include Diabetes, Heart Disease, Obesity, and Hypertension using Education and Community based programs that are evidence-based. Under Access to Care, the topics include Physician Recruitment and Retention, Social Determinants of Health, and Unnecessary Hospital Utilization. Aligned with the results of the CHNA Improvement Plan, UM CRMC's 2018-2022 strategic plan includes significant investments in programs that target chronic disease including diabetes prevention and treatment, fitness, and social determinants of health. Focus groups identified new programs developed in response to the 2015 CHNA, such as outpatient diabetes education, chronic disease self-management classes, mobile integrated healthcare, and a diabetes prevention program as a strength.

Numerous studies highlight the benefits of implementing DSMT, DPP, and wrap around services in counties with similar health and social needs as Charles County, yet as of 2016, 62% of rural counties across the United States did not have a Diabetes Self-Management Program[9]. A 2006 study of 12 Diabetes Self-Management Programs in rural Arkansas published in Preventing Chronic Disease found diabetes management programs empower people to manage diabetes through education about nutrition, medication and insulin therapy, stress management and preventive foot and eye care. Specifically, preventive care practices improved: daily blood glucose monitoring increased from 56% to 67%, and daily foot examinations increased from 63% to 84%[10] . In Charles County we are seeing similar results at the UM Charles Regional Medical Center for Diabetes Education. Since opening in Fall of 2016, the Center has had a total of 3,003 patient visits, demonstrating strong community interest in this service. To share a few case studies: One patient started with an A1C of 11.9%, and ended the 2-month program with 100% of her fasting blood sugars within target. Another patient dropped his A1C from 7.9% to 6.9%. What that means for these patients is that they are healthier now, with a lower risk for developing the devastating complications of diabetes. There is also strong evidence that diabetes prevention programs work. Randomized clinical trials and real-world implementation studies have proven that structured lifestyle change programs, like DPP, can help prevent or delay type 2 diabetes by 60% in people with prediabetes. Complementary improvements to the physical environment such as increasing availability of healthy food choices and opportunities for physical activity were also found to help participants make healthier choices. Without moderate weight loss and increased physical activity, 15 to 30 percent of people with prediabetes will develop type 2 diabetes within 5 years[11].

7. Behavioral Risk Factor Surveillance System, 2018 Maryland Department of Health, Healthcare Access reports
8. 2018 Maryland Vital Statistics Annual Report, Mortality Maryland Department of Health TABLE 48. Deaths from Selected Causes by region and political subdivision, Maryland, 2018.
9. Diabetes Self-Management Education Programs in Nonmetropolitan Counties — United States, 2016; Surveillance Summaries / April 28, 2017 / 66(10);1–6
10. Barriers to Diabetes Self-management Education Programs in Underserved Rural Arkansas: Implications for Program Evaluation; Preventing Chronic Disease, 14 Dec 2005, 3(1):A15 PMID: 16356368 PMCID: PMC1500958

Medical Nutrition Therapy, a new program offered as part of the expansion, is based on decades of medical research on the relationship between diet, nutrition, and health outcomes. It's vastly different from nutrition education, because it instructs individuals on how they can adjust their diet to best support their medical conditions. According to the American Diabetes Association, Improvements in A1C and systolic and diastolic blood pressure were statistically significant for patients who received Medical Nutrition Therapy at uniform 3-month intervals through 1 year. At the 1-year follow-up, A1C reduction was –0.8% (P <0.01), systolic blood pressure reduction was –8.2 mmHg (P <0.01), and diastolic blood pressure reduction was –4.3 mmHg (P <0.05)[12]. The article concluded that although low-income individuals encounter a variety of barriers that reduce their capacity for success with and adherence to MNT, provision of nutrition therapy services by a registered dietitian experienced in addressing these barriers can be an effective addition to the existing medical components of type 2 diabetes care.

Because Charles County is a smaller county, with medically underserved areas, and access to fewer local resources for funding, developing strategies that allow organizations to share and leverage resources is a cornerstone of the project model. This approach aligns with the CHNA and the Strategic plan outlines efforts to work collaboratively with key community stakeholders such as Partners for a Healthier Charles County. The focus groups stated that "Charles County is known for its ability to collaborate. Agencies communicate well and are willing to move outside of their silos to work together to address issues. All partners are "at the table." The partnership can incorporate services such as home visits, transportation, telehealth visits, and training in settings like churches, which have been found to be effective in maintaining program participation rates, and improving health outcomes.

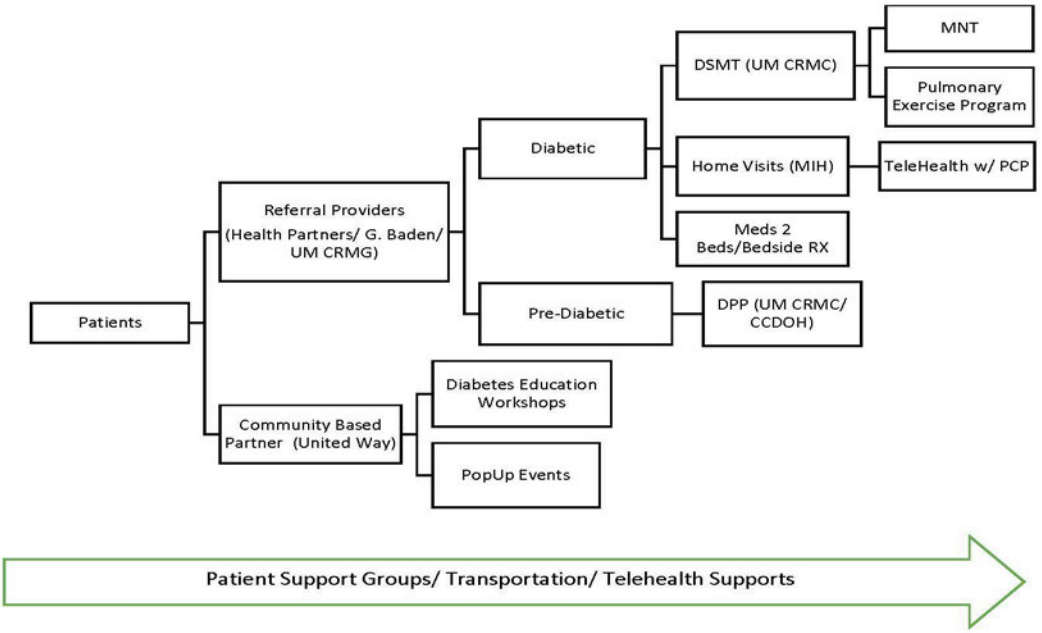
Services and Interventions

The proposed project model, services offered, and partnership collaborations are designed to address the health needs identified in the most recent community health needs assessments and state and county health data. Using an evidence-based approach and strategies outlined in the 2020 MD Dept. of Health Diabetes Action Plan, the model incorporates proven diabetes interventions for rural populations, especially those with disproportionate rates across ethnicities, like Charles County. The goal of Full Circle Wellness for Diabetes in Charles County (FCW4D) is to improve Charles County residents with diabetes ability to manage their condition and achieve optimal health by increasing access to new and expanded DSMT services and wrap around services, and reduce the number of new diabetes diagnoses within the County by expanding diabetes prevention services and increasing programs that help residents maintain a healthy weight. University of Maryland Charles Regional Medical Center and the Charles County Dept. of Health will facilitate the DSMT and DPP programs. Participants will be referred for services by provider partners using the EPIC and CRISP referral tools, outlined under Technologies and Program Innovations. A Community Health Worker will be hired to coordinate referral, patient outreach, and scheduling. Diabetes education workshops for the general public will be available to all residents, at no cost, and be coordinated with community partner Charles County United Way FLINT Team.

11. How Effective Are Diabetes Prevention Programs? CDC Expect Series on Medscape Podcast; Ann Albright, PhD, RD August 13, 2014

12. Effect of Medical Nutrition Therapy for Patients with Type 2 Diabetes in a Low-/No-Cost Clinic: A Propensity Score–Matched Cohort Study; Diabetes Spectrum 2018 Feb; 31(1): 83-89. https://doi.org/10.2337/ds16-0077

The graphic below provides a schematic of the Full Circle Wellness for Diabetes in Charles County (FCW4D) services provided to a patient, based on their medical needs.



Diabetes Self-Management Training and Wrap-Around Supports

Diabetes Self-Management Training Program: Charles County residents with a diagnosis of diabetes will have access to a 2 to 3-month Diabetes Self-Management Training Program workshop offered at the UM CRMC Center for Diabetes Education in LaPlata, MD. The program received AADE accreditation by the Association of Diabetes Care and Educational Specialists (ACDES) in 2016. The renewal application is due in August 2020. The workshop provides 10 hours of diabetes education training: 1 hour for individual training and four, biweekly group sessions each lasting 2- 3 hours each. There are about 10 patients per class. The workshop is covered by Medicare, Medicaid, and some private insurers. Training will be facilitated by a Registered Dietician Nutritionist (RDN) and a Registered Nurse both with Certified Diabetes Care and Education Specialist certifications. To be eligible for the program patients must: 1) be age 18 or older; 2) have medical insurance, 3) be diagnosed with Type 1, Type 2, or Gestational diabetes, and 4) be referred by a provider partner or primary care provider, OB/GYN, or endocrinologist.

DSMT training covers the following topics: Blood sugar meter training, Individual evaluation and diabetes instruction, insulin instruction and injection training, diabetes nutrition instruction and weight management. Course content is based on the AADE 7 Self Care Behaviors (healthy eating, being active, monitoring, taking medication, problem solving, reducing risks, and health coping). Patients receive written material on every subject for future reference. Participants will also receive incentives for program completion including diabetes starter kits (glucometer, 30-day supply of testing supplies, educational pamphlets) and giveaways which include Calorie King books, telescopic mirrors, pill dividers, resistance bands, and food journal log books.

Grant funding will enable the partnership to expand the DSMT program by hiring additional staff to teach the class, which will increase the number of classes offered. For Fiscal Year 2018-2019, the UM CRMC Center for Diabetes Education had 899 total visits, a 21% increase in patient visits from 2017-2018. Currently, DSMT sessions are routinely at maximum capacity, and there is a two month wait list. Expansion will allow for newly diagnosed patients to get education early in their diagnosis,

leading to improved health outcomes. During the project planning phase in Year 1 the Center for Diabetes Education will be relocated to a larger space, centrally located near the medical center's entrance for easier patient access. The space will accommodate individual training for two patients at the same time, and one patient in the waiting area. Each of the patients can have up to one designated support person accompany them to training. The previous space could only accommodate training one patient at a time. Group training will be held in meeting rooms at the UM CRMC LaPlata campus. DSMT is currently staffed by two RN Certified Diabetes Care and Education Specialists (CDCES). With grant funding, the Project Director will hire a full-time RN CDCES who will serve as the overall project coordinator and DSMT facilitator, and a Full-Time registered dietician CDCES to teach the nutrition portion of the workshop and to provide individual medical nutrition therapy consultations. Once hired, there will be four educators on staff to teach up to 200 group classes per year starting Year 2. (Refer to Tasks 1 and 3 in Workplan)

As part of this grant, the partnership would also like to provide a shorter, community-based workshop for uninsured and underinsured residents with diabetes. The workshop will not be DSMT accredited, but will cover some basics of diabetes education. The workshops will be offered in unregulated space- either UM CRMC's offsite classroom space or in community partner spaces. Patient outreach and enrollment will be coordinated with faith-based partners, Greater Baden La Plata office, and Health Partners for uninsured or underinsured patients. The partnership plans to offer a class at least monthly if not more often. Participants may attend several workshops if they need to have information reinforced and if the class size allows.

Diabetes Management Wrap Around Supports

Diabetes Education and Disease Management Home Visits: Home visits will be used to monitor patients with diabetes at risk for readmission due to chronic illness, and to connect patients with community resources, which improves health outcomes, reduces repeated trips to the emergency room, and reduces calls to 9-1-1. This service is available through the Charles County Mobile Integrated Health Program, an integral partnership between the Charles County Department of Health, University of Maryland Charles Regional Medical Center, and the Department of Emergency Services. To be eligible patients must be Charles County residents meeting the following criteria: 1) deemed high risk for hospital readmission and admitted to the Emergency Department more than 3 times in 3 months, 2) have made 3 or more 911 calls in 3 months, and/ or 3) have chronic conditions and need health education and service referrals to improve medication adherence and health outcomes. Priority will be given to home visits for medication management, insulin administration, and setting up pill divider boxes weekly.

Program participants will receive weekly home visits from a registered community health nurse who facilitates health visits, checking of vital signs, and diabetes education. The MIH nurse also provides and sets up equipment for video telehealth medical appointments with the patient's physician, as needed. Patients also receive support from a community health worker who provides the "high touch" needed to keep the patients engaged in the program and out of the emergency department. The CHW will refer patients to community resources and programs and follow up to increase participation.

Providing home visits will improve medication adherence and A1C levels for patients struggling with blood testing with glucometers and/or medications due to health literacy or other social barriers. Approximately 60% of MIH patients have diabetes. Looking at 3-month pre and post MIH data for the first 95 participants of the pilot: ED utilization dropped by 56% from 234 ED visits to 99 ED visits, inpatient admissions dropped 67% from a total of 84 inpatient admissions 3 months prior to MIH to 28 inpatient admissions, 30-day

readmissions dropped by 90%. Home visits and telehealth appointments are currently operational and the MIH program recently completed a 3-year pilot program funded by the Community Health Resources Commission. The Charles County MIH Program was recognized in July 2019 as a Model Practice by the National Association of City and County Health Officials and also received the 2018 Maryland Governor's Customer Service Award. Funding under this grant will help sustain these services for the diabetic population.

Medical Nutrition Therapy: Medical Nutrition Therapy will be a new out-patient service established with the Regional Partnership grant. MNT is used as a support for patients completing the DSMT program. The MNT program will offer each patient a comprehensive nutrition assessment and one-to-one counseling to discuss the patient's nutritional diagnosis, goals, care plans, and specific nutrition interventions to help the patient better manage or treat their condition. Typically, the therapy stays in place until the initial goal is achieved or the nutrition-related diagnosis is resolved. However, the plan can be adjusted as needed by the RDN and the patient's medical team. The MNT has the same eligibility criteria as the DSMT program, and patients that complete that program will be referred for MNT. MNT sessions will be scheduled by the CHW or Population Health Office Specialist and facilitated by the Registered Dietician. MNT sessions are usually 30 to 60 minutes in length. Patients are usually eligible for 2 hours total. The service is covered by Medicare, and other patients will have availability based insurance coverage. Initially, the RDN will provide MNT services two days per week and teach DSMT education three days per week. MNT availability will be adjusted over the project period to meet changes in demand, as monitored by the program coordinator. Additional details of the program will be defined during the Year 1 planning period by the regional partners, and upon further needs assessment. MNT sessions will begin in Quarter 1-Year 2.

Medication Delivery: Meds to Beds, a partnership between UM CRMC and La Plata Pharmacy, is a medication delivery service that launched at UM CRMC in December 2018. After in-patient hospitalization, patients with a new or existing diabetes diagnosis will be offered the option to have their medications delivered to their bedside, by La Plata Pharmacy, prior to leaving the hospital. This is a free service other than the cost of prescription or co-pays. Meds to Beds is a beneficial wrap around service because it saves the patient time and an extra trip to a pharmacy. It also ensures the patient has an adequate supply of their medication and that they receive medication counseling improving medication adherence and reducing drug-related complications that lead to hospital readmissions. Meds to Beds is currently underutilized because there is not a coordinated referral process. The nursing staff must refer and complete paperwork while also handling patient discharge activities. As a result, Meds to Beds is often an overlooked step. To expand the use of Meds to Beds for patients with diabetes, especially newly diagnosed a pharmacy technician will be hired to set-up Meds to Beds deliveries when patients agree to the service, to provide diabetes kits to newly diagnosed patients, and to help the patient address medication related barriers with the UM CRMC pharmacist. The UM CRMC Director of Pharmacy will hire the pharmacy technician in Year 1 and the expanded services will be fully operational by Year 2.

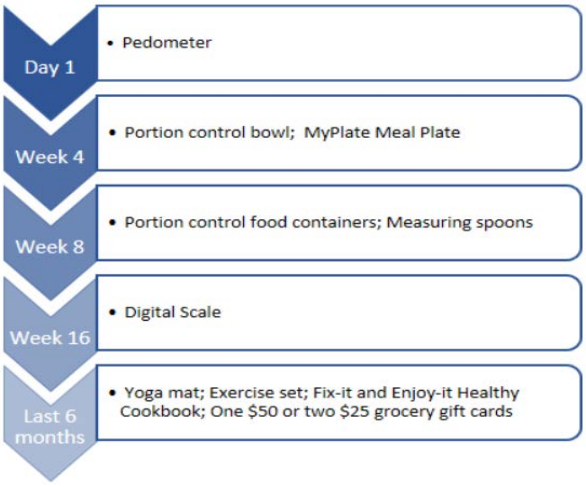
Diabetes Prevention

Diabetes Prevention Program: Prevent T2 is a Centers for Disease Control and Prevention (CDC) recognized DPP service administered by the Charles County Department of Health (CCDoH). Prevent T2 is a 1-year program for low income and uninsured Charles County residents that provides diabetes education and coaching to patients diagnosed with pre-diabetes or with diabetes risk factors like obesity and hypertension. The program has a pending CDC accreditation for the in-person format and recently applied for online training. Once accreditation is approved, UM CRMC will be included as a subsidiary so

that workshops can be held at UM CRMC or CCDoH. To be eligible, patients must meet all of the following criteria: 1) Be at least 18 years old , 2) Be overweight (Body Mass Index ≥25; ≥23 if Asian), 3)Not be pregnant, 4) Have no previous diagnosis of type 1 or type 2 diabetes, and 5) Have a blood test result in the prediabetes range within the past year: Hemoglobin A1C: 5.7–6.4% or fasting plasma glucose: 100–125 mg/dL. The program is free to residents and currently funded by a 5-year Prevention Link grant from the CDC which ends in 2023.

The goal is to prevent the onset of type 2 diabetes by helping patients increase physical activity and lose 5-7% of body weight. Key components of the program include: 1) CDC-approved curriculum with lessons, handouts, and other resources to help patients make healthy changes, and 2) A lifestyle coach, specially trained to help patients learn new skills, set and meet goals, and stay motivated in a fun and engaging program model with support groups. All CDC-recognized lifestyle change programs follow a CDC-approved curriculum and discuss the same topics over the year. However, the lifestyle coach will adapt the sessions to match each group's background, interests, and needs. Support group topics include how to prepare healthy versions of popular local or ethnic foods; tips for eating healthy during cultural holidays or events; healthy eating without giving up all the foods you love; getting back on track if you stray from your plan—because everyone slips now and then; and how to add physical activity to your life, even if you don't think you have time. Group discussion is encouraged.

Program incentives have been used by health plans and other organizations to increase program retention and completion rates. Incentives are complementary to the DPP curriculum, scaled, and similar to those outlined in Figure 4, which were used in the Maryland Medicaid MCO demonstration project.



The partnership has the opportunity to expand the delivery of in-person and virtual DPP classes by seeking accreditation, adding UM CRMC as a subsidiary, and training three additional lifestyle coaches through a master trainer. The CCDoH began three DPP cohorts in FY20 with 55 participants enrolled, and the FY21 DPP program will also have three cohorts. The ideal cohort is 25 attendees maximum. The demand for the class exceeds the current capacity, so many residents are placed on a wait list. Other times, cohorts have been extended to 35 students, but this is not ideal. With additional lifestyle coaches trained the partnership will be able to host training at the medical center, and add additional cohorts. Expansion will also include providing diabetes prevention education at local churches, in partnership with the United Way FLINT team to reach a wider population. Details will be refined in Year 1 and revisited at quarterly and annual partnership meetings. (Refer to Task 1 and 4)

In Year 1 the three selected staff will enroll in the Diabetes Training and Technical Assistance Center (DTTAC) Lifestyle Coach Training. The training is a 2-day, in person training to prepare for facilitation of CDC DPP programs. During the class, participants review the DTTAC Lifestyle Coach Training Workbook, diabetes basics, the background of the national DPP, and guiding principles of the Lifestyle Change Program. Participants have hands-on activities, like creating a food log, which replicate what DPP students complete. Participants are tested on their facilitation skills, and are assigned a DPP module to learn and teach the other students. This helps them gain experience teaching others, and they receive feedback on areas of improvement. At the end of the training, participants receive a Lifestyle Coach Training Guide, DTTAC Lifestyle Coach Workbook, Participant guide, a Calorie King guide, a certificate of completion, and access to the DTTAC website for additional DPP materials.

Additional Wrap Around Services

Transportation: UMMS has an existing Business Associate Agreement with Lyft that provides reliable and cost-effective transportation for patients requiring follow up appointments and services. Expansion of this partnership will provide transportation to DPP, MNT, and DSMT services offered at UMMS affiliated hospital and community partner sites. Rides will also be provided to wrap around services, such as follow up appointments and rides to food banks/grocery stores. A letter of commitment is attached in the Appendix.

Endocrinologist Tele-visits: A delivery barrier identified in the most recent UMMS system-wide needs assessment was access to endocrinologists among those eligible for referral. The University of Maryland Diabetes and Endocrine Center, housed within UMMC Midtown Campus, will serve as a centralized system hub for endocrinologist referral among UMMS affiliated sites. Telehealth consultations will be available for UMMS providers to address complex patients with multiple physical and social problems.

Diabetes Exercise Program: This is a structured exercise class offered through UM CRMC's Pulmonary Rehabilitation Program, and directed by a board-certified pulmonologist. The program helps participants increase their quality of life through exercise, education, and empowerment. The program works similar to a gym membership allowing patients to pay monthly to exercise two to three times a week. Each exercise session is supervised by a registered nurse and/or an exercise physiologist with advanced cardiac life support (ACLS) certification. The program is available to all patients with diabetes. Under the HSCRC Regional Partnership grant, UM CRMC will be able to provide ten DSMT program participants access to the class, at no cost. Eligibility for this program will be determined during the planning period of Year 1 and enrollment will begin in Year 2.

Diabetes Support Groups: Under the Regional Partnership grant, UM CRMC will offer no-cost Diabetes Support Group meetings twice a month at the UM CRMC campus in LaPlata, MD for residents with Type 2 diabetes or prediabetes. In 2019, nine support group meetings were conducted, one session was offered in the daytime and one in the evening per month. A total of 109 people with diabetes and their guests or caregiver attended. Subjects covered included: Celebrate Summer with barbecue menu and taste tests, Continuous Glucose Monitors (CGM's), Healthy Holiday Eating, Weight Loss, Stress management, and Fast Food. In FY19, a Type 1 Support Group was offered, but was discontinued due to low attendance. Under this grant, the Center for Diabetes Education will offer eight Type 2 Diabetes Support Group meetings with each subject offered in an evening session and an afternoon session.

Technology and Program Innovations

The goal of IT infrastructure enhancements is to make it easier for referral providers to identify patients

that are eligible for services, streamline the referral process, and automate enrollment. The current system for referrals relies on manual faxes from referral providers. Processing referrals by fax is time-intensive, and there is a greater chance a referral will be missed because they are not correctly sent or received by the machine. The new infrastructure proposed under this grant will [redacted]

EPIC is the electronic health record system used to track referrals and charting for all patients enrolled in the UM CRMC services. EPIC allows providers to receive real-time notifications when a patient under their care is treated at a participating UMMS-affiliated location; access to patient information and clinical data in real time including lab, imaging and test results hospital admissions and discharge summaries; and consultation notes and emergency department encounter notes. Patients can also use this portal to access their own medical record information. UM CRMC's IT department will build [redacted]. Modifications to the system will occur in Year 1. The Charles County Department of Health utilizes Workshop Wizard, a website managed by the Maryland Department of Health that residents can use to find DPP and DSMT classes. Training providers use Workshop Wizard to track enrollments and body weight changes, and share the data with the CDC.

As a partner with UMMS, this project will be supported by a referral and registration process that community providers will utilize to refer overweight, obese and pre-diabetic patients to DPP and DSMT services. The tools enable Maryland residents to have greater access to workshops across the state. The tools also provide the necessary infrastructure for sustainability within the Maryland healthcare system. UMMS and CRISP will develop [redacted] EPIC is only available to the hospitals and doctors' offices that use this software for their electronic health record. [redacted] Referral providers in the Regional Partnership will be educated and trained on the enrollment process and the benefits of using the IT innovations during partnership meetings. (Task 2)

DSMT and DPP workshops will be offered in-person and virtually. Three UMMS hospitals, the University of Maryland St. Joseph's Medical Center (UM SJMC) the University of Maryland Medical Center (UMMC) and University of Maryland Upper Chesapeake (UM UCMC) Medical Center, are accredited by the Centers for Disease Control and Prevention (CDC) to deliver DPP in traditional classroom settings or virtually. During the recent COVID-19 crisis, health education and health consultation appointments were delivered successfully via virtual telehealth capabilities. Moving forward, this methodology will be deployed to deliver health education safely and to broaden access. The pre-diabetic and diabetic populations have increased risk of adverse outcomes from COVID-19, so this will be especially important for this patient population.

<u>Consumer Outreach and Engagement Strategies</u>

This project will implement tested and successful consumer outreach and engagement strategies for program recruitment, retention, public awareness, and program improvement. Many of which are recommended in the 2020 Diabetes Action Plan. To recruit consumers into the programs the

partnership will spread awareness using partner websites, public marketing, expanded outreach to physicians and endocrinologists not in the network for referrals, and by attending community events. Patients with insurance will receive marketing materials from their doctor's office, or a direct referral through the referral systems. Uninsured, low-income, hard to reach, and Asset Limited, Income Constrained, employed (ALICE) residents will be reached through Health Partners, Greater Baden Medical Services, and United Way. Health Partners has medical/ dental offices in Waldorf and Nanjemoy, and Greater Baden has offices in La Plata and Brandywine. Both will provide patients in need diabetes resources and supply giveaways, and help the partnership stay up to date on community needs.

Community events and diabetes workshops will be hosted/ co-hosted with United Way of Charles County at community centers and places of worship as a way to reach residents in a non-clinical environment. Recently, United Way of Charles County and UM CRMC cohosted Pumpkins on the Potomac in Indian Head, Maryland, and a health fair in Bryans Road, Maryland. Both events were in the Western side of the county in medically underserved areas and food deserts. United Way events often have over 500 attendees. At the event's healthy snacks, water, masks, nutrition information, and rack cards and flyers for the diabetes services are distributed. In addition, interactive workshops that focus on healthy eating, fitness and weight loss will be offered.

The partnership with the United Way Faith Leaders Impacting Needs Together (FLINT) Team is also essential to reaching residents who are disconnected from healthcare due to mistrust or other barriers. Faith leaders are trusted members within their neighborhoods and they are in a unique position to shape and communicate the purpose behind the initiatives. The partnership will leverage FLINT's connections to establish diabetes education classes in or near places of worship. CCDoH has recently hosted Living Well with Chronic Disease classes at churches, church halls, and community centers. The results were increased attendance, and the classes helped to reach residents living in geographically isolated and underserved areas. Diabetes and Pre-diabetes support groups engage residents, introduce them to diabetes management concepts, and provide social support without concerns about cost or commitment to a formal program. The free workshops offered act as a gateway to the formal DPP and DSMT services, and encourage word-of-mouth referrals.

Once patients have enrolled the common question among diabetes educators is "How do you get patients to come back?". Evidence suggests providing tiered incentives and giveaways positively impact enrollment and program completion rates. To help patients adopt behaviors and lifestyle changes, patients select their learning goals and objectives during the first workshop or training session. During each class patients will report on their progress towards meeting their goals and any challenges or barriers they have encountered. The RD, RN CDCES, or Lifestyle coach will address their concerns and questions, and provide encouragement to foster growth achievement. Peer to peer discussion in group workshops also aid in goal achievement. The patient is also encouraged to bring one caregiver or supporter to training, which promotes accountability. An added benefit is the supporter also gains knowledge about diabetes prevention and risk factors during the process. To evaluate outcomes statistics are maintained on goal achievement for patients who complete at least 3 of the 5 sessions for the DSMT. Weight loss is tracked for DPP. A pre and posttest will also be given to each participant. The goal is at least a 25% or better increase in knowledge gained on the post survey.

The partnership will collect formal feedback on direct services and wrap around support through usage reports and satisfaction surveys, and informal feedback from discussions with the patient. Feedback will be discussed at the quarterly and annual partnership meetings, and inform course schedules, topics, and program expansion. The partnership will also reassess the program based on feedback in the FY 2021 and

FY 2023 Community Health Needs Assessments. To incorporate feedback from diverse stakeholders, the partnership will leverage an existing relationship with the Partnerships for a Healthier Charles County Access to Care Coalition (ACC) team. The ACC team discusses barriers to healthcare access and identifies solutions. Partner organizations include the Charles County Department of Health, Department of Social Services, Tri-County Council, Health Partners, Greater Baden Medical Services, and many other community agencies. The ACC team has over 100 members in their directory.

4. Measurement and Outcomes

In addition to monitoring and assessing program outcomes using reports provided by HSCRC and CRISP, progress towards scale targets will be tracked and measured using workshop rosters for DSMT and DPP; Enrollment, patient charting, and billing data from [redacted]; and the Maryland Department of Health Workshop Wizard. Data collected will be refined in Year 1 to allow for internal evaluation of the scale targets. A logic model is in the Appendix.

Scale Target	Alt. Data Source	Baseline	Partnership Outcomes
Medicare/ Medicaid Initiation of DPP Services	EPIC/ Maryland Workshop Wizard, Billing.	FY 2019- 55 patients, 3 cohorts 189 Participants since 2017 <u>Age Breakdown</u> 18-44 (6%), 44-49(6%), 55-59 (15%), 60-64 (17%), 65-69 (21%), 70-74 (10%), 75-79 (8%), 80-84 (2%)	Yr 5: 100 to 120 patients initiate DPP services per year. Approx. 5-6 cohorts per year.
Medicare/ Medicaid Initiation of DSMT Services	EPIC, Center for Diabetes Education class roster	FY 2019/ 2020- [redacted] Patients	Yr 5: 15% increase in patient volume
Medicare/ Medicaid Retention in DPP	# of classes completed, class roster	See Diabetes Prevention Program Baseline Data Table	Y5: 12.4% of participants with prediabetes complete 9 core sessions 60% of participants will attend at least 9 sessions during months 1-6 and at least 60% of its participants attending at least 3 sessions in months 7-12 (DPRP Standards 2018)
Medicare/ Medicaid Retention in DSMT	# of classes completed, class roster	Out of [redacted] patients in 2018-2019, 59% completed 3 out of 5 classes	50% of patients complete 3 out of 5 classes.

Medicare/ Medicaid DPP participant Body weight loss	Maryland Workshop Wizard	See Diabetes Prevention Program Baseline Data Table	By Year 5, 1.8% of the participants achieved or maintained 5%-7% weight loss by the end of the program or 9%-bodyweight through submission of Medicare/Medicaid claims
Medicare/ Medicaid PQI93 Rate by hospital participating in each RP (DSMT)	CRISP and UMMS Finance Team Reports	For FY 20 UM CRMC had [redacted] of PQI in the all payor PAU data for the Diabetes PQI Case Trending Averaging [redacted] cases/month	By year 5, decrease diabetes related PQI cases by 10% or 19 cases annually

An example of the patient roster for the DSMT program is outlined below. FY 2019-2020 completions were impacted by COVID-19.

UM Charles Regional Medical Center Center for Diabetes Education A Comparison of 3 Fiscal Years			
	2017/2018	2018/2019	2019/2020**
New Patients (Pre, T1, T2)	[redacted]		
New Gestational Diabetes (GDM) Dr. Barry left, and the other OBG office stopped their OBG practice)			
TOTAL New Patients			
Total Completions			
Total Patient Visits	744	899	751

The partnership will also collect data on: number of referrals to DPP and DSMT by referral source, number of patient visits to DPP and DSMT, number of classes considered a community benefit by UM CRMC for uninsured and underinsured patients, number of medical nutrition therapy visits, number of UM CRMC staff trained in DPP, number of exercise program participants under charity care, number of Community Events attended to market the DPP, MNT and/or DSMT programs, number of diabetes prevention and management support group sessions, number of quarterly partner meetings, number and type of wrap around service provided, patient satisfaction ratings, and patient knowledge gained based on pre and post workshop assessments.

Additional Program Outcomes are:

- 25% Percent volume growth of the DPP program annually.
- 15% Percent volume growth of the DSMT program annually.
- Participants in DSMT workshop have a 25% gain in knowledge of diabetes and management techniques from their pre-workshop survey
- Ratings of good to very good on 90% of workshop surveys completed.

Diabetes Prevention Program Baseline Data 2018-2020

CDC Standard[10]					Rule 5		Rule 6	Rule 7	Rule 8	Rule 9
Description	Workshop Is Complete	# Month Data	Total Participants	Attendance-Eligible Participants [1]	Session Attendance in Months 1-6[5]	Session Attendance in Months 7-12[5]	Weights Recorded [6]	Activity Recorded [7]	Weight Loss[8]	Blood Test or GDM Eligibility [9]
Target					60%	60%	80%	60%	5%	35%
[redacted]	Yes		22	[redacted]	96%	60%	100%	65%	3.9%	100%
[redacted]	No	[redacted]	20		72%	50%	100%	40%	2.5%	85%
[redacted]	No	[redacted]	23		51%	22%	100%	34%	1.0%	87%
[redacted]	No	[redacted]	25		80%	54%	100%	82%	2.1%	84%
[redacted]	Yes		21	[redacted]	99%	94%	100%	82%	6.1%	82%
[redacted]	Yes		21	[redacted]	94%	90%	100%	88%	3.4%	60%
[redacted]	No	[redacted]	27		79%	40%	100%	69%	2.6%	56%
[redacted]	No	[redacted]	10		61%	40%	99%	55%	2.4%	50%
[redacted]	No	[redacted]	20		58%	0%	100%	39%	3.2%	70%
Charles County Department of Health			64	[redacted]	96%	86%	100%	82%	4.4%	75%

[1]A participant is "Attendance-Eligible" if they have (1) attended at least 3 sessions during months 1-6 of the workshop, and (2) the time from the first session they attended to the last session they attended is at least 9 months.

It's important to keep this requirement in mind when looking at rules 5-9 in the table because IF A WORKSHOP IS COMPLETE then a participant is NOT CONSIDERED if they are not attendance-eligible. Another way of saying this is that if a participant is not attendance-eligible, they will be treated as if they had never registered for or attended the workshop when calculating the percentages for rules 5-9.

[5]At least 60% of participants must attend at least 9 sessions in months 1-6 and also attend at least 3 sessions in months 7-12.

[6]The participant weight must be recorded for least 80% of participant-sessions.

[7]The participant activity level must be recorded for at least 60% of participant-sessions.

[8]The average weight loss for participants must be at least 5%.

[9]At least 35% of participants must be eligible for the workshop due to a blood test or a history of GDM. (The remaining 65% can be eligible based on the CDC Prediabetes Screening Test or the ADA Type 2 Diabetes Risk Test.)

[10]For these rules, see Table 3 in the March 1, 2018 version of the CDC and DPRP Standards and Operating Procedures.

5. Scalability and Sustainability

Sustainability: The DPP and MNT programs will be new billable services for UM CRMC, and revenue generated will sustain the role of the dietician and increase CDCES educator hours. UM CRMC will work to integrate the grant funded positions and new programs into future operational global budgets. Future costs of promotional/marketing and educational materials and giveaways may be supported through the UM CRMC foundation's fundraising efforts. Another way to sustain and expand the DSMT, DPP and MNT programs includes applying for Non-HSCRC grants. UM CRMC has recently been successful in obtaining grants from the Rural Maryland Council to provide non-emergency medical transportation to patients, and the Charles County Charitable Trust for COVID-19 relief funding. The hospital's foundation contributes to required matching funds and grant writing support. Evaluation of financial and health outcomes (enrollments, revenue generated, reduction in hospitalizations, etc.) will demonstrate a return on investment that will support future grants and integration into global budgets. Finally, during the 5-year period, the partners will actively seek community/hospital partners for continued expansion and support of population needs.

Scalability: Scalable components of this project include the partnership with the local health improvement coalition, and extensive collaboration. Often, hospitals and local health organizations do not partner to build DSMT and DPP services which can lead to competition for patients, resources, and funding. Partnering is a good way to address rural communities' needs, while recognizing that a greater impact can be made when resources are shared. To that point, leveraging the resources of larger healthcare organizations is also a scalable model of care. As part of the University of Maryland System, UM CRMC can link residents to services that are not typically available in rural communities. Last, data gathered on the partnership with Lyft for on-demand transportation can provide a proof of concept and lessons learned on how to provide ride-share services in areas that are typically underserved and geographically hard to reach.

6. Participating Partners and Decision-Making Process

Shared Decision-Making Process

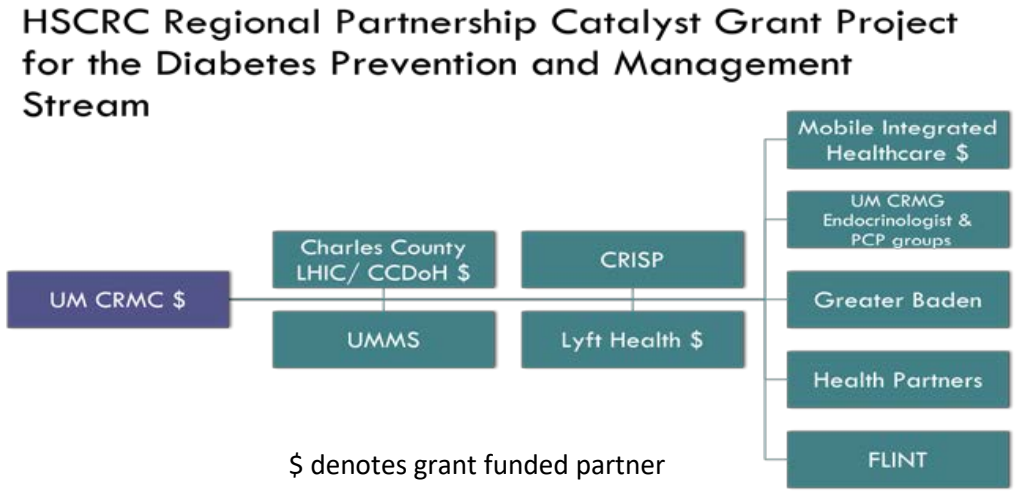
Task 1: Planning Period outlines the decision-making activities in Year 1, and Task 7: Partner Engagement and Stakeholder Meetings outlines the activities for the shared decision-making process throughout the project period. Partnership meetings will be led by Mary Hannah, Project Director and Manager of Population Health Management at UM CRMC and Cynthia Adams, Project Manager and Diabetes Educator. In the first four months of the project the partners will hold a partnership kickoff meeting and smaller roundtables to refine delivery and referral process for DSMT, DPP, and Wrap-around support services. During the remainder of the project period, starting in Year 2, partner meetings will be held quarterly to discuss implementation planning, lessons learned, and goals. Annual planning meetings with the partner lead will be scheduled to evaluate outcomes metrics and evolution of programs. When changes to the programs are suggested they will be voted by the partnership representatives.

The identified project leads at the time of the application are:

- [redacted], Project Director, Manager of Population Health Management at UM CRMC
- [redacted], RN CDCES, Project Manager and Diabetes Self-Management Training Educator
- [redacted], MPH Epidemiologist, Charles County Department of Health and Project lead for Mobile Integrated Health

- [redacted] CHES, CWWS, Diabetes Prevention Program Community Health Educator Charles County Department of Health
- [redacted], Office Manager from UM CRMG Endocrinologist
- [redacted], Office Manager from UM CRMG PCP
- [redacted], Population Health Project Manager from UMMS
- [redacted], Director of Community Projects from United Way Charles County/ FLINT
- [redacted], Population Health Manager, Greater Baden Medical Services
- [redacted], Executive Director, Health Partners
- Albert Zanger, CFO, UM CRMC Finance
- Joseph Moser, CMO, UM CRMC Executive Management

A formal governance structure will not be used for the Full Circle Wellness for Diabetes in Charles County Regional Partnership. The graphic below depicts the flow of funding and the structure of the partnership. UM CRMC has an MOU with the Charles County Dept. of Health for shared funding and resources, and informal and verbal agreements with the other partners. Most of the partners work together on other initiatives like Mobile Integrated Health, Transportation to Wellness, and the ACC Team, to name a few.



Name of Collaborator (1):	University of Maryland Charles Regional Medical Center, Applicant
Type of Organization:	Non-Profit Medical System
Amount and Purpose of Direct Financial Support, if any	None provided. Funding requested for hiring staff, administration, as outlined in the budget ([redacted].
Type and Purpose of In-Kind Support, if any	In-kind Staffing support: 100hrs IT infrastructure development, two DSMT educators, 3 staff to serve as DPP Lifestyle coaches, Center for Diabetes Education to house the present DSMT program total [redacted]3 annually, DSMT incentives through UM CRMC Foundation
Type and Purpose of Resource	UM CRMC to become subsidiary on CCDoH DPP program

Sharing arrangements, if any	
Roles and Responsibilities within the Regional Partnership:	
Oversight of program administration, grant requirements, and finances/billing. Management and Hiring of DSMT staff and programming, project lead, coordinate with community and referral partners. Staffing for DPP programs, diabetes support groups, and community events. Coordinate IT innovations and training.	

Name of Collaborator (2):	University of Maryland Medical System (UMMS)
Type of Organization:(i.e. LHIC, Non-Profit, LBHA)	Non-Profit Medical System
Amount and Purpose of Direct Financial Support, if any	None
Type and Purpose of In-Kind Support, if any	Shared leadership support though the Waiver Maximization team, shared contracts for Lyft services through a system wide agreement
Type and Purpose of Resource Sharing arrangements, if any	Aligning shared partners when appropriate, system wide oversight of projects and progress towards goals
Roles and Responsibilities within the Regional Partnership:	
Part of shared governance allows for more resources and shared partnerships for UMMS hospitals. This builds potential with sustainability and monitoring of appropriate grant operations. Lead for financing and developing referral and enrollment tools with CRISP.	

Name of Collaborator (2):	Charles County Department of Health Diabetes Prevention Program
Type of Organization:(i.e. LHIC, Non-Profit, LBHA)	Local Health Department (LHD)
Amount and Purpose of Direct Financial Support, if any	No financial support provided [redacted], requested to market DPP and for Incentives
Type and Purpose of In-Kind Support, if any	DPP educators and Lifestyle coaches, staff for DPP data entry.
Type and Purpose of Resource Sharing arrangements, if any	CCDoH will list UM CRMC as a DPP subsidiary
Roles and Responsibilities within the Regional Partnership:	

Diabetes Prevention Program leads for administration and marketing. Will submit accreditation paperwork, hold license with the CDC, and submit data for accreditation renewals. All materials will have shared CCDOH and CRMC logos. DPP facilitators lead diabetes education and support groups throughout the county. Provide a representative for Partnership meetings.

Name of Collaborator (3):	Greater Baden Medical Services
Type of Organization:(i.e. LHIC, Non-Profit, LBHA)	Non-Profit
Amount and Purpose of Direct Financial Support, if any	None
Type and Purpose of In-Kind Support, if any	Member for partnership meetings
Type and Purpose of Resource Sharing arrangements, if any	None
Roles and Responsibilities within the Regional Partnership:	
Provide a representative for Partnership meetings. Refer insured, underinsured, and uninsured patients to DSMT and DPP programs. Distribute program materials and giveaways.	

Name of Collaborator (3):	Health Partners
Type of Organization:(i.e. LHIC, Non-Profit, LBHA)	Non-Profit
Amount and Purpose of Direct Financial Support, if any	None
Type and Purpose of In-Kind Support, if any	Member for Partnership meetings
Type and Purpose of Resource Sharing arrangements, if any	None
Roles and Responsibilities within the Regional Partnership:	
Provide a representative for Partnership meetings. Refer insured, underinsured, and uninsured patients to DSMT and DPP programs. Distribute program materials and giveaways.	

Name of Collaborator (4):	Charles County United Way FLINT (Faith Based Leaders in the Community)

Type of Organization:(i.e. LHIC, Non-Profit, LBHA)	Non-profit
Amount and Purpose of Direct Financial Support, if any	None
Type and Purpose of In-Kind Support, if any	Member for Partnership Meetings
Type and Purpose of Resource Sharing arrangements, if any	Space for diabetes education events
Roles and Responsibilities within the Regional Partnership:	
Provide a representative for partnership meetings. Leverage connections with faith-based leaders to promote services, educate the public, disseminate resources, and coordinate opportunities to provide diabetes workshops at churches and similar locations.	

Name of Collaborator (5):	Charles County Mobile Integrated Healthcare (MIH) Team
Type of Organization:(i.e. LHIC, Non-Profit, LBHA)	Partnership of Health Dept, EMS, and UM CRMC
Amount and Purpose of Direct Financial Support, if any	None Provided. [redacted] requested to fund MIH nurse
Type and Purpose of In-Kind Support, if any	● CCDoH will provide funding to cover the time and resources committed to the MIH program by the Epidemiologist; salary, fringe, and associated resources of the Community Health Worker (1) and MIH paramedic required to support the MIH program. ● CCDOH will provide funding to cover office, medical, and other supplies, cell phone and hotspot monthly costs, telehealth equipment, and telehealth services platform subscription. ● CCG will provide funding for the MIH team vehicle, medical equipment, medical supplies, office space and other related items needed to perform duties.
Type and Purpose of Resource Sharing arrangements, if any	MOU in place for the shared funding and roles
Roles and Responsibilities within the Regional Partnership:	
Provide a representative for partnership meetings. Conduct home visits for medication management and support of diabetic patients. Provide equipment and time to facilitate telehealth videos with the patient's physician. Community health workers will connect patients to resources and provide social support to increase engagement and participation. Track program outcomes.	

Name of Collaborator (6):	University of Maryland Charles Regional Medical Group CRMG Endocrinologist and Primary Care Physician Group
Type of Organization:(i.e. LHIC, Non-Profit, LBHA)	For profit, Physician Group
Amount and Purpose of Direct Financial Support, if any	None
Type and Purpose of In-Kind Support, if any	3 endocrinologists at the practice are available to provide program guidance and support, as needed. Partnership member.
Type and Purpose of Resource Sharing arrangements, if any	None
Roles and Responsibilities within the Regional Partnership:	
Provide a representative for Partnership meetings. Refer insured patients to DSMT and DPP programs. Distribute program materials and giveaways.	

Name of Collaborator (7):	Lyft Health Concierge Services
Type of Organization:(i.e. LHIC, Non-Profit, LBHA)	For Profit, rideshare
Amount and Purpose of Direct Financial Support, if any	None provided. [redacted] requested for ride-shares services provided as needed under UMMS agreement.
Type and Purpose of In-Kind Support, if any	None
Type and Purpose of Resource Sharing arrangements, if any	None
Roles and Responsibilities within the Regional Partnership:	
Wrap around support for patients with transportation barriers. Will provide on-demand transportation for patients to and from DSMT and DPP services, and to follow-up medical appointments.	

Section 7: Project Implementation Work Plan (Timetable and Milestones)

Applicant: University of Maryland Charles Regional Medical Center Project Title: Full Circle Wellness for Diabetes in Charles County (FCW4D) January 1, 2021- December 31, 2025				
Task 1: Planning Period				
Key Activities	Measurement of Accomplishment	Data Source/ Measure	Person Responsible	Expected Completion
Finalize referral process with Greater Baden Medical Services and Health Partners to reach uninsured or underinsured patients.	Process Established	N/A	Project Director	1/1/2021-6/2021
Finalize partnership agreement with FLINT Team at the Charles County United Way	Verbal Agreement	N/A	Project Director/ United Way	1/1/2021-4/2021
UM CRMC joins the Charles County Dept. of Health as a subsidiary partner for the DPP program. Create joint branded marketing materials	UM CRMC as subsidiary	CDC website, Accreditation approval	Program Coordinator/ CCDoH	1/1/2021-6/31/2021
Partnership kickoff meeting and roundtables. Refine criteria for DSMT, DPP, and Wrap-around support services	Planning meetings/ Partner Participation	Meeting notes	Project Director/ CRMC Regional Partners	1/1/2021-4/31/2021
Hire and train new staff to expand/ create Diabetes Prevention and Management services. (RN CDCES/Program Coordinator, RDN CDCES, Pharmacy Technician, CHW)	New Hire/ Orientation	3 new staff hired and trained.	Project Coordinator/ Project Director/ Director of Pharmacy	1/1/2021-6/1/2021
Add additional workshops, create schedule, and finalize training topics for DSMT and DPP services	Schedule established and posted	N/A	UM CRMC/ CCDoH, Project Director/ Coordinator	1/1/2021-6/2021
Task 2: Create and Deploy IT Infrastructure for Patient Identification and Program Enrollment				
Key Activities	Measurement of Accomplishment	Data Source/ Measure	Person Responsible	Expected Completion
[redacted]	[redacted]	EPIC	UM CRMC IT/ Program Director	1/1/2021-1/1/2022
Train staff on systems. [redacted]	Referral Reports	EPIC	UM CRMC IT/ Program Director	1/1/2022-9/1/2025

UMMS and CRISP create referral report that enables hospitals in UMMS network to refer to DSMT, MNT and DPP service	UMMS Referral Report	# of referrals/ referral reports	UMMS/ CRISP	1/1/2021-1/1/2022
Providers enroll patients [redacted]. Facilitators Notified	# of Enrollments In UMMS/ CRISP report	[redacted]	UM CRMG/ UMMS	1/1/2022-6/30/2025
Build scheduling, billing, and documentation into [redacted] to improve sustainability	Revenue generated	[redacted]	UM CRMC IT	1/1/2021-1/1/2022
Task 3: Expand and Implement Diabetes Self-Management Program				
Key Activities	Measurement of Accomplishment	Data Source/ Measure	Person Responsible	Expected Completion
Relocate the Center for Diabetes Education for program expansion	Renovation Completed	N/A	Project Coordinator/ Project Director	1/1/2021
Host in-person and virtual DSMT classes for patients with Type 1 and Type 2 diabetes	275 Individual trainings/yr. 200 group training /yr.	# people trained, # sessions	Project Coordinator/ Nurse CDCES/ RDN	1/1/2021-12/31/2025
Host in-person and virtual diabetes management education classes for uninsured/ underinsured patients.	18 classes/year	Enrollments, Workshop roster	Project Coordinator/ Nurse CDCES/ RDN	1/1/2021-12/31/2025
High risk patients with diabetes receive diabetes education and disease management home visits/ telehealth visits	up to 50% MIH patients served p/year	MIH patient census	CCDoH lead/MIH Nurse/ CHW	1/1/2021-12/31/2025
Task 4: Expand and Implement Diabetes Prevention Program				
Create Community Education (for the uninsured and underinsured) and DPP space at 8 Kent Ave 1st floor Population Health conference rooms	18 classes community classes/year	schedule for Kent Space	Population Health Manager	1/1/2021-12/31/2025
UM CRMC staff trained as DPP Lifestyle coaches	3 UM CRMC staff trained	course certifications	UM CRMC Community Health Education Specialist	1/1/2021-1/1/2022
Host DPP Workshops for pre-diabetes and high-risk patients at UM CRMC and CCDoH	3 additional classes/ year	Workshop roster, enrollments	CCDoH, RDN, RN CDCES	1/1/2021-12/31/2025
Task 5: Implement Wrap Around Services				

Key Activities	Measurement of Accomplishment	Data Source/ Measure	Person Responsible	Expected Completion
Host Medical Nutrition Therapy workshops for patients with diabetes.	up to 2 hours/patient	Enrollment/ Completion Reports	RDN CDCES	1/2022-12/31/2025
Provide diabetes starter kits (glucometer, 30-day supply of testing supplies, education DSMT info)	100 kits/year	Pharmacy data	UM CRMC Pharmacy /CHW	1/1/2021-12/31/2025
DPP program incentives	180 program incentives/annually	DPP data	UM CRMC/CCDoH	1/1/2021-12/31/2025
Provide patients access to mobile app for dietary guidance and exercise tracking	# patients participating	N/A	UM CRMC	1/1/2022-12/31/2025
Provide Medication Delivery to diabetes patients before discharge	# patients participating	Pharmacy Data	Pharmacy Technician	1/1/2022-12/31/2025
Offer exercise program to DSMT patients and offset the out of pocket costs of enrollment	Fund 10 participants/year	# of participants	UM CRMC C/P Rehab	2/1/2021-12/31/2025
Task 6: Consumer Outreach and Engagement				
Key Activities	Measurement of Accomplishment	Data Source/ Measure	Person Responsible	Expected Completion
Community Health Workers (CHWs) contact patients on the registry for follow up and referrals to classes	# contacted per month	CHW metrics	Program Coordinator/CHW	1/1/2022-12/31/2025
Create and provide marketing materials and Diabetes self-management starter kits to UM CRMG PCP and Endocrinology practices	# of kits supplied to practices/month	Marketing Data	Community Health Specialist	1/1/2021-12/31/2025
Update Website with new services	Website updated annually	Marketing Data	UM CRMC	1/1/2021-12/31/2025
Partner with the United Way of Charles County for community events	Join 2-3 community outreach events annually	Community Events Calendar	Program Director/ UM CRMC staff	1/1/2021-12/31/2025
Offer free Diabetes Support Groups at UM CRMC	8 support groups/year	Roster, Attendance	RN CDCES	1/1/2021-12/31/2025
Task 7: Partner Engagement and Stakeholder Meetings				
Key Activities	Measurement of Accomplishment	Data Source/ Measure	Person Responsible	Expected Completion
Partner meetings to discuss implementation planning, lessons learned and goals	4 meetings/year	Meeting Notes, Agenda	Project Director/ Partnership leads	1/1/2021-12/31/2025
Annual Planning meetings to evaluate outcomes metrics and evolution of programs	1 meeting/year	Meeting Notes, Agenda	Program Director/ Program	1/1/2022 1/30/2026

			Coordinator, Partnership leads	
Task 8: Data Collection, Program Evaluation and Analysis, and outcome reporting				
Key Activities	Measurement of Accomplishment	Data Source/ Measure	Person Responsible	Expected Completion
Reassessment of diabetes program needs via the Charles County Health Needs Assessment	Updates to Strategic Plan/ Improvement Plan	CHNA survey/ assessment	CCDoH, UM CRMC Population Health/ Program Director	12/2021 and 12/2024
Monthly reviews of the program outcomes from the DSMT, DPP and MNT programs.	Enrollment, Attendance, wait times, and completion rates	DSMT, DPP, and MNT data reports	Program Director/ Program Coordinator	12/1/2021-1/30/2026
Annual reviews of the patient outcomes from the DSMT, DPP and MNT programs.	A1C percentage decrease, weight loss, and goals completed	DSMT, DPP, and MNT data reports	Program Director/ Program Coordinator	12/1/2021-1/30/2026
Annual Performance Reporting to HSCRC	Performance targets set by HSCRC, Annual	CRISP reporting	Program Director/ Program Coordinator	12/1/2021-1/30/2026
Financial Reporting to HSCRC	Actual expenses meet budgeted expenses, Annual	Finance Data	Program Coordinator/ UM CRMC Finance	12/1/2021-1/30/2026
Task 9: Project Closeout				
Key Activities	Measurement of Accomplishment	Data Source/ Measure	Person Responsible	Expected Completion
Final performance and financial reports to close out the grant	Performance targets set by HSCRC	CRISP reporting	Project Director and Program Coordinator	12/1/2025-1/30/2026

Applicant: University of Maryland Charles Regional Medical Center Project Title: Full Circle Wellness for Diabetes in Charles County (FCW4D)
January 1, 2021- December 31, 2025

	Year 1: CY2021				Year 2: CY2022				Year 3: CY2023				Year 4: CY2024				Year 5: CY2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Finalize referral process with Greater Baden Medical Services and Health Partners to reach uninsured or underinsured patients.	■	■																		
Finalize partnership agreement with FLINT Team at the Charles County United Way	■	■																		
UM CRMC joins the Charles County Dept. of Health as a subsidiary partner for the DPP program. Create joint branded marketing materials	■	■																		
Partnership kickoff meeting and roundtables. Refine criteria for DSMT, DPP, and Wrap-around support services	■	■																		
Hire and train new staff to expand/ create Diabetes Prevention and Management services.	■	■																		
Add additional workshops, create schedule, and finalize training topics for DSMT and DPP services	■	■																		
Integrate UM CRMC into [redacted]	■	■	■	■																
Train staff on systems. Automatic notifications go to community health worker	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
UMMS and CRISP create referral report that enables hospitals in UMMS network to refer [redacted]	■	■	■	■																
Providers enroll patients into [redacted] Facilitators Notified					■	■	■	■	■	■	■	■	■	■	■	■	■	■		
Relocate the Center for Diabetes Education for program expansion	■																			
Host in-person and virtual DSMT classes for patients with Type 1 and Type 2 diabetes	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Host in-person and virtual diabetes management education classes for uninsured/ underinsured patients.		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
High risk patients with diabetes receive diabetes education and disease management home visits/ telehealth visits	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Create Community Education (for the uninsured and underinsured) and DPP space at 8 Kent Ave 1st floor Population Health conference rooms	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
UM CRMC staff trained as DPP Lifestyle coaches	■	■	■	■																
Host DPP Workshops for pre-diabetes and high-risk patients at UM CRMC and CCDoH	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Host Medical Nutrition Therapy workshops for patients with diabetes.					■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Provide diabetes starter kits (glucometer, 30-day supply of testing supplies, education DSMT info)	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
DPP program incentives	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Provide patients access to mobile app for dietary guidance and exercise tracking					■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Provide Medication Delivery to diabetes patients before discharge					■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Offer exercise program to DSMT patients and offset the out of pocket costs of enrollment		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

Applicant: University of Maryland Charles Regional Medical Center Project Title: Full Circle Wellness for Diabetes in Charles County (FCW4D)
January 1, 2021- December 31, 2025

	Year 1: CY2021				Year 2: CY2022				Year 3: CY2023				Year 4: CY2024				Year 5: CY2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Community Health Workers (CHWs) contact patients on the registry for follow up and referrals to classes																				
Create and provide marketing materials and Diabetes self-management starter kits to UM CRMG PCP and Endocrinology practices																				
Update Website with new services																				
Partner with the United Way of Charles County for community events																				
Offer free Diabetes Support Groups at UM CRMC																				
Partner meetings to discuss implementation planning, lessons learned and goals																				
Annual Planning meetings to evaluate outcomes metrics and evolution of programs																				
Reassessment of diabetes program needs via the Charles County Health Needs Assessment																				
Monthly reviews of the program outcomes from the DSMT, DPP and MNT programs.																				
Annual reviews of the patient outcomes from the DSMT, DPP and MNT programs.																				
Annual Performance Reporting to HSCRC																				
Financial Reporting to HSCRC																				
Final performance and financial reports to close out the grant																				

Section II. Financial Projections

Hospital/Applicant:	University of Maryland Charles Regional Medical Center
Regional Partnership Members:	● University of Maryland Medical System ● Charles County Dept. of Health ● Health Partners ● Charles County United Way FLINT Team (Faith Based Leaders in the Community) ● Greater Baden Medical Services ● Charles County Mobile Integrated Healthcare (MIH) ● University of Maryland Charles Regional Medical Group (CRMG) Endocrinologist Group ● University of Maryland Charles Regional Medical Group (CRMG) Primary Care Physician Group
Funding Track:	Diabetes Prevention & Management Programs
Total Budget Request:	$2,526,347

Workforce/Type of Staff	Description	Amount
Pharmacy Technician (UM CRCM)	Provide support for Meds 2 Beds medication delivery	[redacted]
RN Care Manager (MIH)	Provide home medication and disease management visits to diabetic patients.	[redacted]
Registered Clinical Dietician (UM CRMC)	Provides nutrition instruction for DSMT workshops, diabetes support groups, and MNT sessions	[redacted]
Nurse CDE/Program Coordinator (UM CRMC)	Program coordinator, project management, DSMT and DPP lead and facilitation	[redacted]
Community Health Worker (UM CRMC)	Coordinate patient enrollments into DPP and DSMT services, and facilitate use of wrap around services	[redacted]
Population Health Lead (UM CRMC)	Serves a project director, and lead for grant financial and performance management.	[redacted]
Fringe Benefits	[redacted] of annual salaries	[redacted]
Total	5 year totals with 3% assumed inflation	[redacted]

IT/Technologies	Description	Amount
Diabetes App Support	Yearly app memberships for DPP patients(weight/fitness)	[redacted]
Surface 3 Laptop	5 computers for new staff to assume duties	[redacted]
Spectra Link Phones	5 phones for new staff to assume duties	[redacted]
Printers	5 printers for new staff to assume duties	[redacted]

Total	5-year total	$201,555

Wrap Around Services That are not captured above)	**Description**	**Amount**
Marketing for the DPP	Newspaper ads, postcards, RX tear pads	[redacted]
Marketing for DSMT, and MNT	Marketing packages, ads, and possible billboard ad	
Lyft Concierge Rides to PCP, Classes, etc	Transportation to workshops and medical appointments for patients in need	
Educational materials/ giveaways	Program incentives	
Scales	Digital food and weight scales	
Faux food and A1C models	Teaching items	
Diabetes Exercise Program	Pulmonary Exercise program for 10 charity patients	
Diabetes Starter Kits	Kits with essential items for diabetes management, given to newly diagnosed	
Total	5 Year Total	$[redacted]

Other Indirect Costs	**Description**	**Amount**

DPP staff training classes/travel expenses	Diabetes Prevention training expenses for 3 lifestyle coaches	[redacted]
Supplies	Office supplies, workshop snacks, water, etc.	[redacted]
Continuing Education	Continuing education costs for 4 employees/ year	[redacted]
Building Renovation (Center for Diabetes Education)	Relocate the Centers for Diabetes education to larger space	[redacted]
Renovation Depreciation	Depreciation cost for renovations/ 15 years	[redacted]
Equipment Depreciation	Equipment cost/ 5 years	[redacted]
Total	5-year total	[redacted]
Total Expenses & Investments	Yr1: $499,874; Yr 2: $481,972; Yr3: $493,505; Yr4: $509,206; Yr5: $541,790	$2,526,347.00

In-Kind Investments from Partners: UM CRMC expenses yearly for the Center for Diabetes Education [redacted]. UM CRMC will continue to fund this program and will only use the new HSCRC funding to expand upon the efforts that are already existing. UMMS IT: [redacted] Foundation: Funds charity glucometers, scales, pill dividers and Calorie King books. [redacted]. CCDoH partners on the MIH program and funds the current DPP efforts. For the salaries of the Community Health Worker for the MIH program [redacted], and the Community Education Specialist that plans and teaches the DPP classes and tracks data [redacted].

Full Circle Wellness for Diabetes in Charles County (FCW4D) Budget and Expenditures Narrative

Workforce/Type of Staff	Itemization	Year 1	Year 2	Year 3	Year 4	Year 5	5 Year Total
Pharmacy Technician (UM CRMC)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
RN Care Manager (MIH)							
Registered Clinical Dietician (UM CRMC)							
Nurse CDE/Program Coordinator (UM CRMC)							
Community Health Worker (UM CRMC)							
Population Health Lead (UM CRMC)							
[redacted]							
[redacted]							

[redacted]

[redacted]

IT/ Technologies	Itemization	Year 1	Year 2	Year 3	Year 4	Year 5	5 Year Total
Diabetes App Support							
Surface 3 Laptop							
Spectra Link Phones							
Printers							
Total							

Diabetes App Support: The exact app to be used is still being determined.

Surface 3 Laptop: Computer for new staff to accomplish duties; **Spectra Link Phones:** Phone for new staff to accomplish duties ; **Printers:** Printers for new staff to accomplish duties

Wrap Around Services	Itemization	Year 1	Year 2	Year 3	Year 4	Year 5	5 Year Total
Educational Materials and Giveaways							
Lyft Concierge Rides to PCP, Classes, etc	$800/month						
Diabetes Management Educational materials/ giveaways							
Diabetes Prevention Educational materials/ giveaways							
Scales							
Faux food and A1C models							
Diabetes Exercise Program							
Diabetes Starter Kits							

[redacted]

Other Indirect Costs	Itemization	Year 1	Year 2	Year 3	Year 4	Year 5	5 Year Total
DPP staff training classes/travel expenses	[redacted]	[redacted]			[redacted]		[redacted]
Supplies		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Continuing Education		[redacted]					[redacted]
Building Renovation (Center for Diabetes Education)		[redacted]					[redacted]
Renovation Depreciation	$ [redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Equipment Useful Life Depreciation	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total		$ [redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]

DPP staff training classes/travel expenses: Planning to have 3 staffed trained from UM CRMC for the CDC DPP class educator role. Funds can be used to pay for class registration, hotel costs and/or mileage fees.
Supplies: Office supplies (e.g. print cartridges, paper, pens, notebooks, file folders, folders, etc.) granola bars, waters, other class snacks, etc.
Continuing Education: Continuing education including registration, travel costs and mileage for 4 employees/year that are hired for the functions of the grant. All education would be appropriate to the role of the employee.
Building Renovation (Center for Diabetes Education): This is for renovations depreciation annually . Total cost/ 15 years.
Equipment Useful Life Depreciation: Calculated by dividing the total value of purchased equipment by 5 program years.

Year 1	Year 2	Year 3	Year 4	Year 5	5- Year Total
$499,874	$481,972	$493,505	$509,206	$541,790	$2,526,347

Total Requested: $2,526,347 100% of project costs for expansion requested.

In-Kind Investments from Partners: UM CRMC expenses yearly for the Center for Diabetes Education $[redacted]. UM CRMC will continue to fund this program and will only use the new HSCRC funding to expand upon the efforts that are already [redacted] CRMC Foundation: Funds charity glucometers, scales, pill dividers and Calorie King books. [redacted] CCDoH partners on the MIH program and funds the current DPP efforts. For the salaries of the Community Health Worker for the MIH program $[redacted], and the Community Education Specialist that plans and teaches the DPP classes and tracks data [redacted].

Full Circle Wellness for Diabetes in Charles County (FCW4D) Diabetes Program Prevention Logic Model

Inputs	**Intervention Activities**	**Outputs**	**Short-Term Outcomes (Y1)**	**Intermediate Outcomes (Y2-3)**	**Long-Term Outcomes (Y4-5)**
Staff time Local hospital admins System admins UM CRMG Diabetes & Endo IT Community partners grant funding system funding Face to Face and virtual DPP Delivery Existing CCDoH Coaches UM CRMC staff Lay Health Workers Participation incentives IT: EMR referral support Community partner space Hospital space Hospital conference rooms	Face-to-face delivery of DPP by community partners using scaled incentives Online delivery of DPP to community centers by system hub using scaled incentives Online delivery of DPP to individual participants by system hubs using scaled incentives App based coaching/texting • Adherence strategies based on behavioral theory (SCT, TTM & HBT) and best practices • Nutritional support • Physical activity support • Transportation support • Scaled incentives - scales, measuring devices, lunch bags, etc. EMR referral process created Partnership meetings Governing board meeting minutes Annual evaluation report	% population w/ prediabetes in service area referred to national DPP (HSCRC target) Enrollment rate of referred population (HSCRC target) Retention rate (HSCRC target) % of population with prediabetes in service area enrolled in national DPP (HSCRC target) Completion rate of referred population (HSCRC target) – online and virtual % of population in service area completing national DPP (HSCRC target) # classes attended – virtual and in-person # classes offered – virtual and in-person # of Incentives delivered # Lifestyle coaches trained # partners engaged	At least 1 preliminary, pending or full CDC-recognized program in service area with a letter of support indicating qualification in a payment program (MDPP or Medicaid)	***Referrals through CRISP*** Y2: 10% of adult population with prediabetes in service area zip codes Y3: 20% of adult population with prediabetes in service area zip codes ***Y3 Enrollment***: 2% of adult population with prediabetes in service zip codes through submission of Medicare/Medicaid claim for first session.	***Y4 Enrollment***: 6% of adult population with prediabetes in service zip codes through submission of Medicare/Medicaid claim for first session ***Retention*** Y4: 2.1% of adult population with prediabetes indicating 9 core sessions complete via Medicare/ Medicaid claims Y5: 12.4% of adult population with prediabetes indicating 9 core sessions complete via Medicare/ Medicaid ***Health Outcomes Y5***: 1.8% of the adult population achieved or maintained 5% or 9% bodyweight through submission of Medicare/Medicaid claims.

Full Circle Wellness for Diabetes in Charles County (FCW4D) Diabetes Self-Management Training Logic Model

Inputs	**Intervention Activities**	**Outputs**	**Short-Term Outcomes (Y1)**	**Intermediate Outcomes (Y2-3)**	**Long-Term Outcomes (Y4-5)**
Staff time • Local hospital admins RD and RNs • System admins • UM CRMG Diabetes & Endo • IT Community partners Planning time – CY 2021 grant funding System funding DSMT delivery via Onsite at UM CRMC or telehealth Adherence incentives EMR referral support Referral from community partners (Epic and CRISP) Eligible telehealth originating sites Hospital space Conference rooms	Face-to-face delivery of DSMT by UM CRMC RD, RNs Telehealth delivery of DSMT by UM CRMC RD, RNs Face-to-face endocrinologist consults at UM CRMG Telehealth consults by endocrinologists Adherence strategies based on behavioral theory Transtheoretical Model (TTM) /best practices/community needs assessment Q3yr Bedside education Nutritional support Physical activity support Transportation support	Initiation of DSMT services (HSCRC target) DSMT completion rate (HSCRC target) DSMT retention rate (HSCRC target) # app/text based messages sent # sessions attended – telehealth and in-person # classes offered – telehealth and in-person #, $ Incentives delivered # partners engaged Bedside education videos created Annual evaluation report Governing board meeting minutes	AADE Accreditation	***Initiation of DSMT Services*** Y2: 15% of diabetes population in hospitals' service area have at least one Medicare claim for DSMT services Y3: Y2: 25% of diabetes population in hospitals' service area have at least one Medicare claim for DSMT services ***Retention Y3***: 15% of diabetes population in hospitals' service area have at least 5 or more Medicare DSMT claims ***Y3 Health Outcome:*** 2.5% reduction in PQI93 rate by hospital participating in RP	***Retention Y4:*** 20% of diabetes population in hospitals' service area have at least 5 or more Medicare DSMT claims ***Y5 Completion Rate:*** 5% of diabetes population in hospitals' service area have at least 10 or more claims for DSMT ***Y5 Health Outcome:*** 5% reduction in PQI93 rate by hospital participating in RP

Brandon Neiswender, COO
CRISP Health
7160 Columbia Gateway Drive
Suite 100
Columbia, Maryland 20146

6/5/2020

Tequila Terry
Deputy Director, Center for Payer Reform and Provider Alignment
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Tequila,

On behalf of CRISP, please accept this letter in support of the University of Maryland Medical Center (UMMC) and its affiliate hospitals' grant applications for the 2021 Regional Partnership Catalyst Grant Program. As a partner with UMMC, we have agreed to support the development of a referral and registration process that community providers would utilize to refer overweight, obese and pre-diabetic patients to Diabetes Prevention (DPP) Program and Diabetes Self-Management Training (DSMT) course offerings.

This partnership will allow for the expansion of diabetes prevention and management programming across the State and will build the necessary infrastructure for sustainability within the Maryland healthcare system. We expect this to result in significant improvements in pre-diabetes and diabetes related health outcomes.

If you have any further questions about our support of UMMC and its affiliate hospitals, or our contribution to the regional partnerships, please do not hesitate to contact me at brandon.neiswender@crisphealth.org

Thank you,

Brandon Neiswender
5C1C681037A2D871F93BD5CFCB7B6C42 contractworks.

Brandon Neiswender

COO

Charles County Department of Health

Tequila Terry

Deputy Director, Center for Payer Reform and Provider Alignment

Health Services Cost Review Commission

4160 Patterson Avenue

Baltimore, Maryland 21215

Dear Ms. Terry,

On behalf of the Charles County Department of Health, please accept this letter in support of the University of Maryland Charles Regional Medical Center (UM CRMC) for their grant application for the 2021 Regional Partnership Catalyst Grant Program. As a partner with UM CRMC, we have agreed to partner to provide patients with the Diabetes Prevention (DPP) Program. This partnership will allow for the expansion of diabetes prevention programming in Charles County and will build the necessary infrastructure for sustainability within the Maryland healthcare system. We expect this to result in significant improvements in pre-diabetes and diabetes related health outcomes.

If you have any further questions about our support of UM CRMC, or our contribution to the regional partnerships, please do not hesitate to contact Angela Deal, 301-609-6885 or Amber Starn, 301-609-5748.

Thank you,

Suzan Lowry, MD MSHI FAAP

Health Officer

Charles County Department of Health

Jill Angelone, Manager Healthcare Partnerships
Lyft Business
185 Berry Street Ste 5000
San Francisco, CA **94107**

7/6/2020

Tequila Terry
Deputy Director, Center for Payer Reform and Provider Alignment
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Tequila,

On behalf of Lyft, please accept this letter in support of the University of Maryland Charles Regional Medical Center (CRMC) and the Charles County Partnership for the 2021 Regional Partnership Catalyst Grant Program. As a partner with CRMC and the Charles County Partnership, we have agreed to serve as a regional partner in the community to expand the Diabetes Prevention Program (DPP) and Diabetes Self-Management Training (DSMT). Our partnership will benefit program participants by providing reliable and cost effective transportation for them to access wrap around services, such as follow up appointments and rides to food banks and/or grocery stores.

This partnership will assist CRMC and the Charles County Partnership increase program adoption, retention and completion rates by providing the necessary support for participants to successfully achieve the required health outcomes. We expect this to result in significant reductions in prediabetes and PQI93 rates among the communities served.

If you have any further questions about our support of CRMC and the Charles County Partnership, or our contribution to the regional partnerships, please do not hesitate to contact me at jangelone@lyft.com.

Thank you,

Jill Angelone

Jill Angelone
Manager, Healthcare Partnerships