maryland
health services
cost review commission

Regional Partnership Catalyst Program

Calendar Year 2021 Activities - Final Report

October 2022

maryland health services cost review commission

Table of Contents

Introduction 1

Overview of the Regional Partnership Catalyst Program 1

- Diabetes Prevention and Management Programs 2
- Behavioral Health Crisis Programs 2
- Summary of Awards 3

Year One Diabetes Prevention and Management Activities 6

- DPP Infrastructure Development 7
- DPP Referral Strategies and Enrollment 8
- DSMT/ES Infrastructure Development 9
- DSMT/ES Referral Strategies and Initiation 9
- Diabetes Billing and Sustainability 10
- Diabetes Community Partner Engagement 11

Year One Behavioral Health Crisis Services Activities 12

- Overarching Behavioral Health Crisis Services Infrastructure Development 12
- Care Traffic Control (CTC) Activities and Progress 13
- Mobile Crisis Team Activities and Progress 13
- Crisis Center Activities and Progress 13
- Behavioral Health Sustainability 14
- Behavioral Health Community Partner Engagement 15

Catalyst Program Budget and Expenditures Summary 16

Catalyst Program Health Equity Efforts 17

Impact of COVID-19 on Regional Partnerships 19

Conclusion 19

Introduction

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

Goals of the Catalyst Program include:

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

For the period January 2021 through December 2025, the HSCRC is issuing $165.4 million in cumulative funding through nine awards to eight Regional Partnerships. The five-year cycle creates time to build partnerships and infrastructure prior to implementing interventions. This report summarizes activity for the first year of funding, Calendar Year (CY) 2021.

Overview of the Regional Partnership Catalyst Program

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

Subsequent to the Regional Partnership Transformation Grant Program's expiration in June 2020, the HSCRC established the Catalyst Program to enable hospital-led partnerships to continue to build

infrastructure in support of the population health goals of the TCOC Model and SIHIS. The Catalyst Program made awards under two funding streams: (1) diabetes prevention and management and (2) behavioral health crisis services. The Catalyst Program is based on the HSCRC philosophy of fostering collaboration among hospitals and community partners while creating infrastructure to disseminate evidence-based interventions.

Diabetes Prevention and Management Programs

Maryland needs significantly more diabetes prevention and management resources for the State's pre-diabetic population. The diabetes prevention and management funding stream supports Regional Partnerships implementing the Centers for Disease Prevention & Control (CDC) recommended Diabetes Prevention Program (DPP). DPP has shown long-term success in helping to prevent the onset of diabetes and promote weight-loss for those with pre-diabetes.

This funding stream also supports implementation of Diabetes Self-Management Training (DSMT) and Diabetes Self-Management Education and Support (DSMES). DSMT/ES provides lifestyle change help and diabetes management curriculum to Medicare beneficiaries to help better control their Type II diabetes. Regional Partnerships under the Catalyst Program must receive American Diabetes Association (ADA) or American Association of Diabetes Education (AADE) accreditation for their respective DSMT and DSMES programs.

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

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

Behavioral Health Crisis Programs

The TCOC Model incentivizes reductions in unnecessary emergency department (ED) and hospital utilization. Across Maryland, hospitals cite opioid use disorder and inadequate access to acute mental

health services as contributors to ED overcrowding. Maryland currently lacks sufficient infrastructure needed to divert behavioral health crisis needs from EDs and inpatient settings to more appropriate community-based care. Community-based organizations often do not receive reimbursement for crisis management services and struggle to provide the capacity needed in Maryland.

The behavioral health crisis services funding stream supports development and implementation of infrastructure and interventions consistent with the "Crisis Now: Transforming Services is Within Our Reach" action plan developed by the National Action Alliance for Suicide Prevention.[1] Regional Partnerships are implementing one or more of the following:

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

Summary of Awards

The HSCRC awarded a cumulative $165.4 million through nine awards to eight Regional Partnerships for the five-year period of January 2021 through December 2025. Six of the nine awards fall under the diabetes prevention and management funding stream. These six awards total $86.3 million and involve 24 hospitals. They span Western, Central, and Southern Maryland as well as the Capital Region. Three of the nine awards fall under the behavioral health crisis services funding stream. These three awards total $79.1 million and involve 24 hospitals. They span Central Maryland, portions of the Capital Region, and the Lower Eastern Shore. A summary of awards is shown in **Table 1**.

[1] National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc. Available at: https://theactionalliance.org/sites/default/files/crisisnow.pdf

[2] Also referred to as "Care Traffic Control" by Regional Partnerships implementing this element of the Crisis Now Model.

Table 1. Summary of Regional Partnership Catalyst Program Awards, CY 2021 – CY 2025

	Regional Partnership	Counties/ Region	Award	Participating Hospitals
Diabetes Prevention and Management	**Baltimore Metropolitan Diabetes Regional Partnership**	• Baltimore City	$43,299,986	• JH Bayview Medical Center • Howard County General Hospital • Johns Hopkins Hospital • Suburban Hospital • UMMC • UMMS Midtown
	Western Regional Partnership	• Allegany • Frederick • Washington	$15,717,413	• Frederick Health • Meritus Medical Center • UPMC Western Maryland
	Nexus Montgomery	• Montgomery	$11,876,430	• Holy Cross Germantown • Holy Cross Hospital • Shady Grove Medical Center • White Oak Medical Center
	Totally Linking Care (TLC)	• Charles • Prince George's • St. Mary's	$7,379,620	• Adventist -Fort Washington Medical Center • Luminis Doctors Community Hospital • MedStar St. Mary's • MedStar Southern Maryland • UM Capital Region Health • UM Laurel Regional Medical Center
	Saint Agnes and Lifebridge	• Baltimore City • Baltimore County	$5,962,333	• Ascension St. Agnes • Sinai Hospital • Grace Medical Center
	Full Circle Wellness	• Charles	$2,214,862	• UM Charles Regional Medical Center

Behavioral Health Crisis Services	**Greater Baltimore Region Integrated Crisis System (GBRICS)**	• Baltimore City • Baltimore County • Carroll • Howard	$44,862,000	• Bayview Medical Center • Carroll Hospital • Grace Medical Center • Greater Baltimore Medical Center • Howard County General • Johns Hopkins Hospital • Ascension St. Agnes • Sinai • MedStar Franklin Square • MedStar Good Samaritan • MedStar Harbor • MedStar Union Memorial • Mercy • Northwest • University Maryland Medical Center • UM Midtown • UM St. Joseph Medical Center
	Totally Linking Care (TLC)	• Prince George's	$22,889,722	• Adventist Fort Washington Medical Center • MedStar Southern Maryland • UM Laurel Medical Center • UM Capital Region Health
	Tri-County Behavioral Health Engagement (TRIBE)	• Lower Eastern Shore	$11,316,332	• Atlantic General Hospital • TidalHealth - Peninsula Regional Medical Center
		Total Awards	**$165,428,698**	

An overview of Catalyst Program activities by Regional Partnership is shown below in **Table 2**. The table is inclusive of current and planned activities through the duration of the program. The diabetes prevention and management activities emphasize community partnership building and infrastructure expansion to expand DPP and DSMT/ES services, as well as wrap-around services to support engagement. The behavioral health crisis activities focus on increasing immediate access to behavioral health care through implementing elements of the CrisisNow Model.

Table 2. Overview of Catalyst Program Activities by Regional Partnership

Regional Partnership	Catalyst Program Activities

Diabetes Prevention and Management	**Baltimore Metropolitan Diabetes Regional Partnership**	● Establish centralized management services for DPP and DSMT/ES ● Build partnerships with community stakeholders including faith-based organizations, senior citizen centers, and community engagement centers ● Expand DSMT/ES sites beyond hospital outpatient clinics ● Integrate social needs wrap-around services, including food security and transportation. ● Build technology infrastructure for information transfer throughout the State
	Western Regional Partnership	● Increase DPP certified leaders, participant recruitment and retention, and classes ● Rapidly expand virtual, in-person, and hybrid DSMT/ES capabilities ● Implement and expand evidence-based nutrition and physical activity programs into current patient practice and coordinate external partners ● Integrate mental health screenings into patient intake ● Partner with community-based organizations and deploy community health workers for social needs screening and resource navigation
	Nexus Montgomery	● Improve the supply of DPP and DSMT/ES providers and programs by increasing capacity support and process improvement ● Increase the demand for DPP and DSMT/ES programs through public outreach campaigns to raise program awareness ● Ensure diabetes outcomes through referral and case management
	Totally Linking Care	● Expand the number of DPPs and DSMT/ES operating in the target region ● Expand outreach, screening, and referrals to DPPs and DSMT/ES ● Expand wrap-around services to support DPP and DSMT/ES engagement, retention, and completion ● Establish training and technical assistance for healthcare and social service providers to support DPP and DSMT/ES programs
	Saint Agnes and Lifebridge	● Expand evidence-based diabetes education and DPP by recruiting, training, and supporting twelve Certified DPP LifeStyle coaches within the community ● Improve access to healthy food for individuals with prediabetes/diabetes by expanding virtual supermarket access to food insecure patients
	Full Circle Wellness	● Expand DSMT/ES services by hiring a full-time RN CDCES and a full-time dietician ● Offer wrap-around services including MNT, home visits, telehealth, pulmonary exercise, transportation, patient support groups, and medication delivery ● Utilize community health workers, lifestyle coaches, nurse navigators, and pharmacist technicians to provide social support for patients, increasing participation and engagement

Behavioral Health Crisis Services	**Greater Baltimore Region Integrated Crisis System**	● Establish a regional Care Traffic Control system by implementing a single hotline for substance use and mental health crisis calls ● Expand mobile crisis teams to divert patients from the ED who do not require a high-level intervention ● Expand access to immediate-need behavioral health services by piloting the Same Day Access program
	Totally Linking Care	● Enhance Prince George's County Response System via technology ● Expand mobile crisis teams throughout Prince George's County ● Establish a crisis receiving facility to accept individuals in crisis 24/7/365 on a walk-in self-referred basis
	Tri-County Behavioral Health Engagement (TRIBE)	● Increase behavioral health crisis care for individuals by establishing a regional behavioral healthcare urgent care center ● Centralize and regionalize two mobile crisis programs with the behavioral healthcare urgent care center

Year One Diabetes Prevention and Management Activities

The HSCRC recognizes CY 2021 as an initial period of planning, relationship building, and infrastructure development for the five-year program cycle. Regional Partnerships started at different points: some already operated DPPs, some established new collaborations with existing DPPs, and others began creating entirely new DPPs. Achievements for CY 2021 include the creation of 32 new DPP cohorts supported by the Catalyst Program as well as expansion of DSMT/ES programs. All six Regional Partnerships met the two diabetes CY 2021 scale targets. For diabetes prevention, this was having at least one preliminary, pending, or full CDC-recognized program in its service area with qualification in a payment program. For diabetes management this was ADA DSMT accreditation or AADE DSMES accreditation.

DPP Infrastructure Development

Regional Partnerships undertook DPP infrastructure development and capacity building activities in CY 2021. Those in the early stages of DPP development conducted research and analysis to identify and target community needs and available capacity. Inputs to these analyses included prevalence of diabetes, obesity, poverty, and other demographic factors overlayed with existing community referral points and resources. Stakeholder interviews also provided information on needs and barriers.

Other Regional Partnerships formed governance and executive operating structures, and conducted staff recruitment, hiring, and onboarding. This included hiring of administrative staff such as program coordinators as well as DPP coaches. Training and support for personnel was another major set of activities in CY 2021. Regional Partnerships provided direct support for diabetes educators through the launch of

learning collaboratives and symposiums. One Regional Partnerships offered stipends to DPP educators for new programs and for those serving uninsured patients. Educational forums and training in motivational interviewing were also held to onboard new community health workers.

During CY 2021 Regional Partnerships planned and implemented outreach to clinical providers to generate referral workflows. Outreach took the form of mail, email, in-person presentations, and the development of continuing medical education (CME) modules on DPP eligibility and referral processes. Regional Partnerships developed public media campaign strategies and materials—this was completed internally in some cases, and with procurement of an external vendor in others. Formalization of collaborative relationships was another key activity in CY 2021, discussed below in Community Partner Engagement.

Health Information Technology (HIT) was another key element of infrastructure development. Efforts included electronic health record (EHR) reporting enhancements and data management, engagement with CRISP around the referral module development, and work to map social risk screening workflows into CRISP eReferrals in CY 2022.

Two Regional Partnerships reported activities to launch wrap-around services supportive of DPP. One Regional Partnership is working with five food partners to provide medically tailored meals and produce. In this model, all enrolled participants are assessed for food access programs. Another Regional Partnership added transportation services, medication delivery, and other services to support DPP. Social determinant of health (SDOH) support is provided by community health workers, nurse navigators, and others.

While one Regional Partnership relocated to a larger, more central space to increase DPP capacity, other Regional Partnerships pivoted to provide virtual and asynchronous options amidst COVID-19, in addition to continue offering in-person resources.

DPP Referral Strategies and Enrollment

The Regional Partnerships have a broad reach of engagement with community-based organizations, faith-based organizations, and clinical providers. During CY 2021, Regional Partnerships developed infrastructure and processes for receiving and managing referrals from community partners, Medicaid MCOs, clinical providers, and directly from patients' self-referral.

Regional Partnerships reported on their efforts to automate identification of patients for DPP within their EHRs. This included mining EHR data to retroactively identify patients for referral, creating eligibility flags, and creating enrollment registries for patients with diabetes and prediabetes. For example, EHR tools

included automated after-visit summaries with referrals to DPP, patient messages, DPP intake and patient document flowsheets, and new outreach reports capturing referral navigation work.

Technical work also focused on establishing clinical workflows and interface screens to track DPP referrals with the CRISP web-based provider referral and registration process. All of these new tools required the Regional Partnerships to deliver education and training to providers and staff. Notification of referrals were provided back to community health workers and diabetes educators.

Regional Partnerships worked to establish their essential roles in centralized DPP referral management and follow-up. Some Regional Partnerships provided this internally, while at least one other selected and onboarded an external referral management partner to track direct referrals as well as those received via CRISP.

Some Regional Partnerships had already-operational DPPs at the start of the funding cycle, while others were building completely new DPPs. Enrollment during the first year reflects this variation in the maturity of programs. Several of the Regional Partnerships launched multiple DPP cohorts in CY 2021, ranging from seven to twelve. Others were still focused on planning and infrastructure development during this first year and did not enroll participants.

DSMT/ES Infrastructure Development

As was the case for DPP, Regional Partnerships embarked on DSMT/ES capacity building activities in CY 2021. Most Regional Partnerships were already providing DSMT/ES services in CY 2021 in group cohorts and individual sessions, including virtually and telephonically. Thus, CY 2021 efforts focused on expansion to enable patients to receive education earlier in their diagnoses. Activities included:

- Providing technical assistance and one-on-one support to revive a dormant DSMT/ES program at one hospital;
- Fostering new partnerships with already-accredited DSMT/ES providers, and facilitating virtual and hybrid telehealth options;
- Hiring of staff, including a number of certified diabetes care and education specialists (CDCES) and a dietician as well as administrative coordinators and support staff;
- Relocating DSMT/ES to a larger physical space to accommodate a greater number of patients; and
- Planning activities also focused on expanding to sites within local communities.

Direct support was provided to diabetes education providers delivering DSMT/ES, for example with training and participation via learning collaboratives, support for DSMES accreditation, and provision of start-up stipends to help cover the costs of new programs.

Regional Partnerships conducted research and analysis to identify community needs based on the prevalence of diabetes, obesity, poverty, and other demographic variables. This information along with hospital diabetes-related ED and inpatient claims was integrated with existing community referral points and resources to understand community need and how to align providers and services. Another Regional Partnership procured expertise of a consultant to analyze potential DSMT/ES model options for ambulatory practice.

HIT was another key element of DSMT/ES infrastructure development. Like DPP, efforts included EHR reporting enhancements and data management, new EHR tools for referrals, and provider training on EHR enhancements and referral processes.

DSMT/ES Referral Strategies and Initiation

Regional Partnerships reported on the challenge of obtaining a consistent volume of provider referrals to DSMT/ES. During CY 2021, Regional Partnerships conducted outreach with clinical providers to build on the formal referral avenues already in place with partner hospitals. To engage and educate providers, one Regional Partnership developed CME course credits on diabetes education with information on DSMT/ES. A variety of other community outreach initiatives targeted patients as well as the community at large to promote diabetes education. Regional Partnerships worked to align their outreach campaigns with local county-led diabetes programs.

As was the case for DPP, the Regional Partnerships play essential roles in centralized DSMT/ES referral management and follow-up. This required technical work during CY 2021, for example setting up referral pathways through EHRs.

Regional Partnerships also reported on a number of innovations as part of DSMT/ES service expansion in the first year of the funding cycle. One Regional Partnership is embedding CDCES educators within primary care settings to fill a traditional gap in services. Another Regional Partnership established MNT as a new outpatient service at the end of CY 2021; all patients completing DSMT/ES are referred to MNT. Other Regional Partnerships continued working on integration of wrap-around services and supports for patients. As described above, most of the Regional Partnerships already provided DSMT/ES at the start of the program.

Diabetes Billing and Sustainability

The ability to bill Medicare and Medicaid for reimbursement of DPP creates a pathway to sustainability for Regional Partnerships. HSCRC has required that all Regional Partnerships DPP billing be fully established by January 2023. The rates of billing in CY 2021 reflect the different starting points for DPP across the Regional Partnerships. Four of the Regional Partnerships reported that a cumulative total of six DPP provider partners billed for Medicare and/or Medicaid during the year, with continued work to refine existing billing processes. Regional Partnerships must also bill for DSMT/ES in CY 2023 as well.

Additional Regional Partnerships made progress during the year to prepare for DPP billing in CY 2022. For example, an additional DPP provider submitted its application to Medicare. At the state level, Regional Partnerships worked with Maryland Medicaid officials to set up billing processes as well as coordinate billing processes with Maryland Medicaid MCOs. Regional Partnerships worked to ready their internal billing teams. They evaluated payment model sustainability for different clinical practice settings. Several described their efforts to support additional DPPs with credentialing for Medicare and Medicaid reimbursement. Regional Partnerships also worked to extend the reach of Medicare and Medicaid revenue streams by becoming umbrella billing entities for community partners.

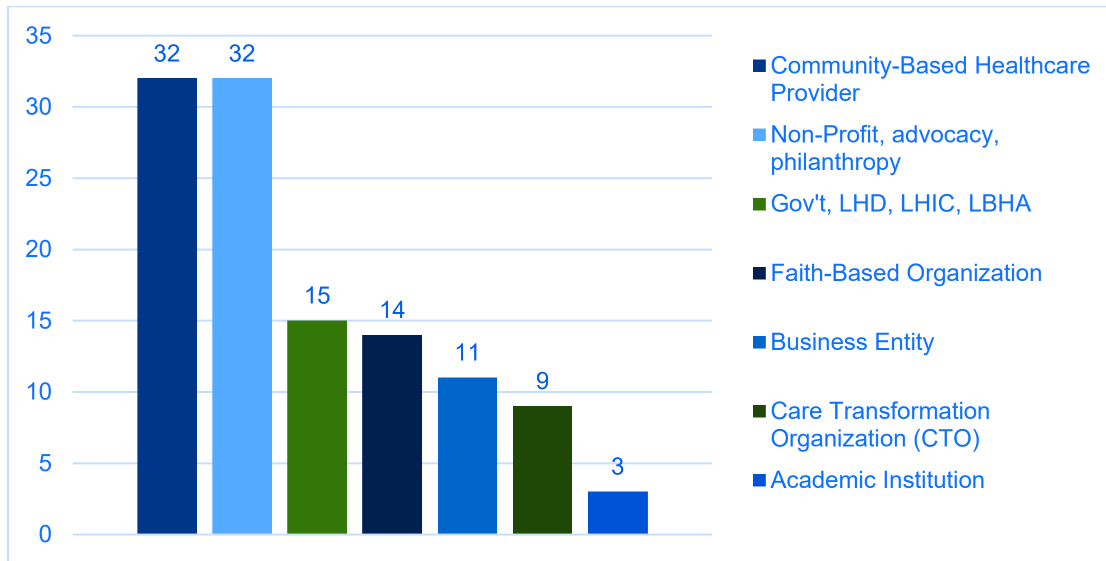
In addition to pursuing Medicare and Medicaid reimbursement to support sustainability, Regional Partnerships reported additional sources of revenue. Some of the DPP cohorts operating in CY 2021 were supported by funds outside of the Catalyst Program. Regional Partnerships reported private payer reimbursement and some modest amounts of non-Catalyst Program funding.

Diabetes Community Partner Engagement

The development of partnerships for long-term improvements in population health, and engagement and integration of community resources in the healthcare system are core goals of the Catalyst Program. Community partner engagement was one of the main activities undertaken in CY 2021. For both DPP and DSMT/ES, Regional Partnerships met with partners individually and held summits to understand needs—such as Spanish-language DPP and DSMT/ES services—and collect information on baseline participation. These interactions were also opportunities to learn about prior successes and challenges, and brainstorm implementation strategies for the future. During CY 2021 Regional Partnerships formalized their relationships with partners, for example through the development of MOUs and collaborative agreements as they identified community hosts for DPP and associated activities. For DSMT/ES, Regional Partnerships worked with community partners on strategies to access populations not otherwise reached through existing marketing efforts.

Figure 1 shows the breadth of Regional Partnerships' community partners for diabetes prevention and management. There are a total of 116 community partner organizations across the six Regional Partnerships. The two most common types of organizations are community-based healthcare providers and non-profit advocacy or philanthropy organizations.

Figure 1. Diabetes Program Community Partners



Regional Partnerships provide different types of support to community partners, including direct financial support, in-kind support, and resource sharing. In CY 2021, the diabetes Regional Partnerships provided approximately $580,000 in direct financial support to community partners, and $246,000 in in-kind support. Some Regional Partnerships provided additional in-kind support without tracking its monetary value, so it is not reflected in the $246,000. One also reported providing resource sharing to community partners in CY 2021.

Year One Behavioral Health Crisis Services Activities

During CY 2021, the three Regional Partnerships under the behavioral health crisis services funding stream focused on infrastructure planning and development as well as relationship building. All Regional Partnerships met the three behavioral health scale targets, which included having: (1) five-year development and business plans for crisis services, (2) MOUs with community partners, member hospitals, and local emergency services, and/or (3) crisis protocols for services indicated in the application/award letter. CY 2021 produced the following major achievements: a CTC software vendor was procured, mobile

crisis team providers began responding to calls, and groundwork was laid to open crisis centers in the first half of CY 2022.

Overarching Behavioral Health Crisis Services Infrastructure Development

The three Regional Partnerships undertook a number of activities as part of infrastructure planning and development during CY 2021. This included establishing formal structures for governance, accountability, meeting cadence, and sub-groups that included representation of a wide array of stakeholders. Regional Partnerships built administrative capacity to manage day-to-day project implementation and finances. Efforts included recruiting and hiring new staff and bringing on external expertise via competitive procurements. Significant time was devoted to the development and execution of competitive procurement processes.

Regional Partnerships worked with consultants to conduct needs assessments through market research, interviews with providers and other stakeholders, and tours of existing facilities. This provided an understand of gaps between the current state of services and best practices, and barriers to implementation. Information gathered informed the identification of workflows and standard protocols to support patients.

Care Traffic Control (CTC) Activities and Progress

The Catalyst Program is funding two Regional Partnerships to develop CTC capabilities as a hub for deployment of mobile and other crisis services. The model includes open access clinical care. CY 2021 coincided with ongoing planning for the national launch of the 988 Crisis and Suicide Lifeline. Consequently, Regional Partnership decisions regarding implementation of CTC were dependent on progress of the national 988 system.

With guidance from the Maryland Department of Health (MDH) and collaboration between the two Regional Partnerships, the same vendor—Behavioral Health Link—was procured by both Regional Partnerships in CY 2021. The vendor provides software in support of the comprehensive call center as well deployment and coordination of crisis services in real time.

One Regional Partnership reported that the launch of the open access pilot was delayed due to the complexity of determining call center software, and the need to gather extensive feedback from partners to draft the open access pilot RFP.

Mobile Crisis Team Activities and Progress

Two Regional Partnerships are engaged in developing mobile crisis teams. A major focus of CY 2021 was development of mobile crisis team standards in collaboration with stakeholders. Standards were incorporated into the process to procure and expand service providers for CY 2022. Mobile crisis team service launch coincides with CTC call center launch.

One Regional Partnership awarded contracts to mobile crisis team service providers. After extensive training, the providers began responding to community calls in the last quarter of CY 202**1**. The other Regional Partnership worked on its procurement in the last quarter of CY 2021. Challenges to implementation included the need to align the mobile crisis team scope with community needs, hiring delays, and the length of time needed for the procurement process.

Crisis Center Activities and Progress

Two Regional Partnerships reported on activities to develop crisis centers in CY 2021. One Regional Partnership is developing two crisis stabilization center sites: a primary site which opened in May 2022 and a secondary site which opened in January 2022. Both sites are across from EDs to facilitate alternative access to emergency care. During CY 2021 progress was made on centralizing existing crisis response services and the following activities:

- Building infrastructure;
- Renovating buildings, including instituting safety and risk assessment recommendations;
- Recruiting, hiring, and training staff, including a full-time on-site psychiatrist at the primary center and additional general and pediatric tele-psychiatry providers;
- Developing policies and procedures;
- Securing necessary IT and medical equipment; and
- Creating and deploying a marketing strategy and community outreach campaign.

The other Regional Partnership contracted a national leader in crisis services and reported on efforts to secure an appropriate facility and address regulatory and reimbursement requirements for commercial payers and Medicaid. The Regional Partnership awarded a separate contract for the provision of wrap-around services to reduce behavioral health readmissions.

Behavioral Health Sustainability

The three Regional Partnerships were in the early stages of achieving sustainability in CY 2021. Efforts during the year included engaging in statewide and national convenings to increase knowledge of best

practices, collaborating with community partners and local and State government to identify standards, and advocating for policy reforms needed to support local development of the crisis care continuum and sustain behavioral health crisis services.

Regional Partnerships coordinated with the broad-based effort to establish a statewide mechanism to fund 988 in Maryland. The “Fund Maryland 988 Campaign” brings together more than 50 partner organizations to establish a Maryland 988 Trust Fund with an initial $10 million investment to support crisis call centers across the state. The campaign advocated for legislation during the 2022 General Assembly session. The campaign website www.fundmd988.org is a source for information sharing and partner mobilization.

In addition, Regional Partnerships worked with the (MDH) Behavioral Health Administration (BHA) to identify potential funding sources through grants and Maryland Medicaid reimbursement to enhance Catalyst Program funds. Insurance reimbursement requirements for Medicaid, such as billing codes, are also applicable to the work Regional Partnerships did to explore commercial insurance reimbursement. Regional Partnerships reported on the need to amend the Maryland Medicaid program to cover mobile crisis services and receiving centers. Regional Partnerships reported involvement with BHA’s stakeholder engagement activities related to the drafting of regulations. Additionally, Regional Partnerships reported on the need to develop commercial payer reimbursement for mobile crisis services and crisis stabilization centers. Efforts included working with stakeholders and the State legislature to explore requiring all insurers to cover crisis services. Since the submission of the annual reports, Medicaid received a planning grant to develop a state plan amendment (SPA) to provide qualifying community-based mobile crisis intervention services and will reimburse for mobile crisis care. In addition, Medicaid will reimburse stabilization services at crisis stabilization centers, a critical component of the crisis care continuum and a significant milestone in sustainably funding behavioral healthcare in Maryland.

Other State-level needs identified by Regional Partnerships include addressing the social stigma surrounding crisis services and identifying locations for centers. There is also a need to address behavioral health workforce shortages within the industry.

Regional Partnerships also undertook activities directly tied to sustainability. For example, one Regional Partnership reported on creation of a dashboard to monitor results from crisis center sites. In another instance, the introduction of wrap-around services was found to reduce hospital readmissions of program participants by 55 percent.

Behavioral Health Community Partner Engagement

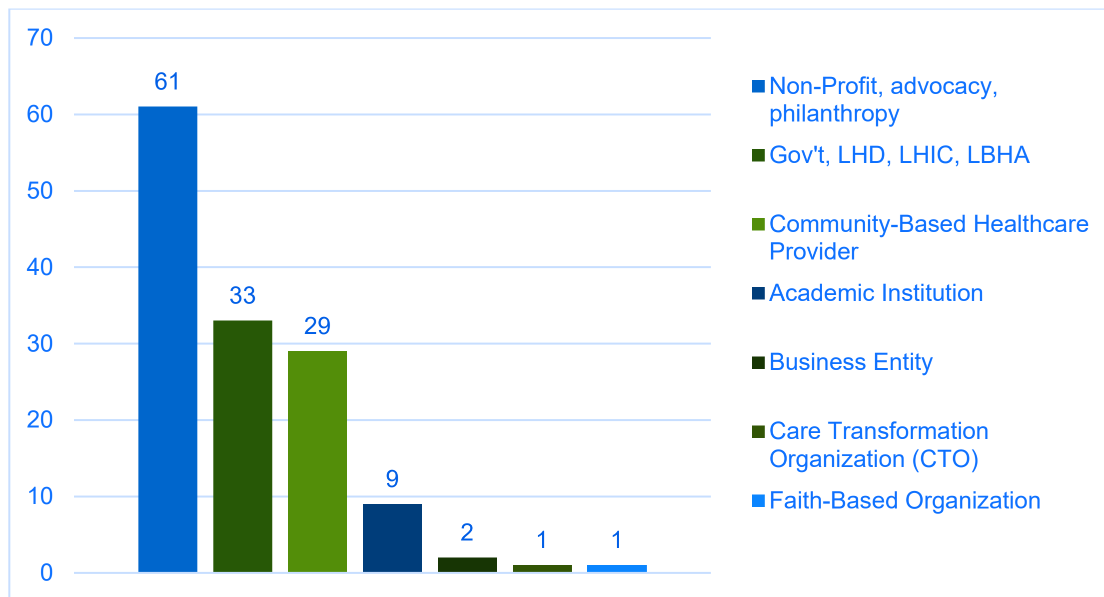
The Regional Partnerships devoted significant effort to solidifying strong working relationships with community partners. Regional Partnerships described these relationships as vital to their planning and operationalization activities. New governance structures include community partners and other stakeholders at their foundation to ensure a diversity of voices and perspectives.

Regional Partnerships involved local government entities to ensure Catalyst Program efforts complemented existing initiatives to develop behavioral health crisis service infrastructure. Key public entities included local government, public safety agencies, and LBHAs. Consultant deliverables funded by the Catalyst Program were shared widely to support coordination. Regional Partnerships also collaborated among one another, for example coordinating receiving center plans.

Regional Partnerships invested in market research to determine how best to communicate the value of behavioral health crisis services to the general public, promoting awareness and access.

Figure 2 below shows the breadth of community partners in behavioral health crisis services Regional Partnerships. There were 136 community partners. The most prevalent category was non-profit, advocacy, or philanthropy organizations. Local public entities comprised 33 community partners, followed by 29 community-based healthcare providers.

Figure 2. Behavioral Health Community Partners



Regional Partnerships provide different types of support to community partners, including direct financial support, in-kind support, and resource sharing. In CY 2021, the behavioral health Regional Partnerships provided approximately $830,000 in direct financial support to community partners. The Regional Partnerships provided additional in-kind support without tracking its monetary value. One Regional Partnership reported providing additional resource sharing to community partners in CY 2021.

Catalyst Program Budget and Expenditures Summary

Regional Partnership expenditures for CY 2021 are shown in **Table 3**. Total expenditures across all Regional Partnerships were approximately $9.3 million. The largest category was workforce, with approximately $5.6 million in expenditures. Approximately $2.1 million was spent on other implementation activities, operations, and indirect costs; approximately $990,000 was spent on IT/technology, and approximately $590,000 was spent on wrap-around services.

Table 3. Regional Partnership CY 2021 Expenditures

	Regional Partnership	Expenditures by Category	Total Expenditures
Diabetes Prevention and Management	**Baltimore Metropolitan Diabetes Regional Partnership**	● Workforce expenditures: **$1,807,453** ● IT services: **$36,920** ● Other implementation activities, operations, and indirect costs: **$221,226**	**$2,065,599**
	Western Regional Partnership	● Workforce expenditures: **$1,449,103** ● IT services: **$15,223** ● Wrap-around services: **$81,755** ● Other indirect costs: **$183,209**	**$1,729,290**
	Nexus Montgomery	● Workforce expenditures: **$680,699** ● Wrap-around services: **$60,434** ● Other implementation activities and indirect costs: **$201,809**	**$942,942**
	Totally Linking Care	● Workforce expenditures: **$122,313** ● IT services: **$62,804** ● Wrap-around services: **$102,519** ● Other implementation activities and indirect costs: **$292,889**	**$580,525**
	Saint Agnes and Lifebridge	● Workforce expenditures: **$399,283** ● Wrap-around services: **$117,459** ● Other implementation activities: **$3,379**	**$520,121**
	Full Circle Wellness	● Workforce expenditures: **$217,584** ● IT services: **$6,257** ● Wrap-around services: **$1,658** ● Other implementation activities and indirect costs: **$28,554**	**$254,053**
Behavioral Health Crisis Services	**Greater Baltimore Region Integrated Crisis System**	● IT services: **$326,000** ● Other indirect costs: **$484,880**	**$810,880**
	Totally Linking Care	● Workforce expenditures: **$224,957** ● Wrap-around services: **$229,080** ● Other implementation activities and indirect costs: **$494,195**	**$948,232**

	Tri-County Behavioral Health Engagement (TRIBE)	● Workforce expenditures: **$725,154** ● IT services: **$543,603** ● Other implementation activities and indirect costs: **$209,398**	**$1,478,155**
		Total Expenditures	**$9,329,797**

HSCRC staff is in the midst of conducting financial audits of all Regional Partnership spending to verify expenditures. As with all other special funding programs, any unspent funds are removed from hospital rates. Due to the impact of COVID-19 on the first year of the program, HSCRC staff allowed Regional Partnerships to request a one-time rollover of CY 2021 funding that was unspent due to the impact of COVID-19. Regional Partnerships were required to provide a fixed dollar amount and justification for their request. HSCRC staff reviewed written requests and approved the rollover of $11.2 million of the $23 million awarded in CY 2021. This was a one-time exception due to challenges posed by the pandemic and HSCRC staff does not intend to allow funding to roll over in future years of the program.

Catalyst Program Health Equity Efforts

Both the diabetes and behavioral health Regional Partnerships had multi-pronged approaches to addressing health equity. They intentionally kept health equity at the forefront of activities. For example, the governance committee of one Regional Partnership adopted the theme of advancing equity through policy and systems change as the foundation of its guiding principles.

Regional Partnerships conducted analyses to identify the specific areas and communities experiencing health disparities. This involved working with community partners to understand the root causes of disparities. Regional Partnerships prioritized historically excluded and marginalized communities for outreach and inclusion in the stakeholder engagement process. Regional Partnerships also designed their tracking systems to stratify populations by a variety of parameters. This will enable them to understand how services are reaching different populations.

Screening for social determinants of health (SDOH) was an element described by most of the Regional Partnerships. They are assessing a variety of SDOH and connecting clients to available resources. In some cases, one Regional Partnership directs certain patients to care coordination teams to address SDOH in lieu of directly referring to DPP or DSMT/ES. This approach acknowledges that DPP or DSMT/ES may not necessarily be a successful intervention for a patient if other underlying issues impacting their health remain unaddressed.

Health equity considerations were also woven into practices around staffing and procurement. Staffing strategies included hiring more community health workers (CHWs) reflective of communities served, pursuing grant funding to hire behavioral health peer support specialists, and developing diverse mobile crisis leadership and service providers with respect to gender, race, ethnicity, and sexual orientation. Staff training included topics such as motivational interviewing, cultural humility, and anti-racism. Regional Partnerships also described their efforts to promote diversity through procurement, for example prioritizing organizations with strong connections to their local communities and reflective of the culture, language, and demographics of the area the serve. Selecting locally-owned minority businesses was another strategy reported.

Other health equity efforts addressed different modes of service delivery. For example, DPP classes were designed to be held virtually to remove transportation barriers and were offered both day and evening to increase accessibility to different populations. Regional Partnerships promoted wholistic well-being. Examples include a mobile integrated health visitation program and delivery of behavioral crisis center services through a behavioral health visit within the primary care office.

Regional Partnerships also highlighted the needs of different populations. Three of the diabetes Regional Partnerships addressed plans to provide cohorts in Spanish. In addition, Diabetes 101 was offered by a Regional Partnership as a free community workshop targeting the un- and underinsured. For behavioral health, Regional Partnerships raised the need to target the LGBTQIA population, Deaf and Hard of Hearing communities, and to address racial biases inherent in the criminal justice system.

Impact of COVID-19 on Regional Partnerships

The COVID-19 pandemic created a range of challenges for Regional Partnerships in CY 2021. A primary challenge was the redeployment among local community partners and clinical staff to pandemic-related needs. This delayed implementation, for example pushing back the timing for training healthcare providers on diabetes referral systems. Regional Partnerships also reported difficulty hiring due to pandemic-related workforce shortages, affecting clinical and wrap-around services.

Regional Partnerships responded to COVID-19 by pivoting to virtual formats—for example for community engagement and diabetes programs. However, some diabetes patients lacked technology or were less engaged in virtual formats. Because diabetes patients had fewer visits to primary care during the pandemic, Regional Partnerships reported poorer diabetes management and lower rates of referrals to DPP and DSMT/ES. Some active participants dropped out of diabetes prevention and management programs because of disruptions in their lives stemming from COVID-19.

Regional Partnerships reported a number of pandemic-related delays, including to CTC software set-up and to community marketing campaigns as public health messaging prioritized vaccination efforts. Supply chain delays were also an issue.

Given the impact of COVID-19 on implementation, Regional Partnerships underspent Catalyst Program funds. As discussed in the expenditures section of this report, HSCRC staff allowed Regional Partnerships to request a one-time rollover of CY 2021 funding that was unspent due to the impact of COVID-19. HSCRC staff reviewed written requests and approved the rollover of $11.2 million of the $23 million awarded in CY 2021.

Conclusion

During CY 2021 the eight Regional Partnerships made significant progress in infrastructure development and began to expand service delivery for diabetes prevention and management, as well as behavioral health crisis services. Regional Partnerships recognized the complexity of standing up new programs across a large set of partners and different healthcare delivery systems. They also recognized importance of conducting meaningful, multi-stakeholder engagement to achieve sustainable change. Regional Partnerships also worked in earnest to respond to the challenges of the pandemic which impacted implementation activities and program resources. Looking ahead, Regional Partnerships will continue to scale their DPP enrollment efforts and provision of DSMT services, through strategies such as promoting provider awareness and building relationships with payers. Regional Partnerships receiving behavioral health funding will continue to execute on their implementation plans, build additional community partnerships, and scale up services implemented in 2022. HSCRC will continue to monitor to Regional Partnership performance through written reporting, regular meetings with individual Regional Partnerships on implementation progress, and data monitoring through CRISP.