maryland
health services
cost review commission

Regional Partnership Catalyst Grant Program

Summary Form

Regional Partnership Name:
Trivergent Health Alliance (Western Regional Partnership)
Program Focus (Diabetes or Behavioral Health Crisis Services):
Diabetes Prevention and Management
Participating Hospitals (add rows as needed):
1. Frederick Health Hospital
2. Meritus Medical Center
3. University of Pittsburg Medical Center Western Maryland
Community Partners (add rows as needed):
1. Frederick County Health Department
2. Maintaining Active Citizens (MAC)
3. Maryland Living Well Center for Excellence programs
4. YMCA
5. Frederick Integrated Healthcare Network
6. Share Food Network
7. Frederick County Food Banks
8. Frederick City Housing Authority
9. Mission of Mercy
10. Commission on Aging (COA)
11. Washington County Health Department
12. Medication Assistance Center
13. Coordinated Approach to Child Health (CATCH)
14. Boys and Girls Club
15. Healthy Washington County (LHIC)
16. Maryland Area Health education Center West (AHEC West)
17. Allegany County Health Department
18. Associated Charities
19. Western Maryland Food Bank
20. Human Resources Development Commission
21. Allegany County Health Planning Coalition
22. Aramark

Program Summary:

The grant funds will be used to implement a full menu of wrap around assessment, culturally responsive engagement, social service navigation, and complementary medical services to increase recruitment and retention in the National Diabetes Prevention Program (DPP) and Diabetes Self-Management Training (DSMT). The primary interventions for the model are:
DPP and DSMT- (1) Increase number of certified leaders, participant recruitment and retention, and class offerings for DPP; (2) Rapidly expand virtual, in-person, and hybrid capabilities of DSMT.
Wrap around Services- (1) Implement and expand evidence-based nutrition and physical activity programs into current patient practice and coordinate with external partners; (2) Integrate mental health screenings into patient intake and recommended follow up in care plans; (3) Partner with Community-Based Organizations (CBOs) and deploy Community Health Workers (CHWs) to engage
communities in social needs screening and resource navigation.