Saint Agnes and LifeBridge Health Diabetes Collaborative

HSCRC Regional Partnership Catalyst Grant Program
Funding Stream 1
Proposal

Submitted July 17, 2020

Section I: Scope of Work

Summary of Proposal

Saint Agnes and LifeBridge Health Diabetes Collaborative	
Hospital/Applicant	Grace Medical Center, Saint Agnes, Sinai Hospital
Hospital Members	Saint Agnes, Sinai Hospital, Grace Medical Center
Health System Affiliations	Ascension, LifeBridge Health
Funding Track	Funding Stream I: Diabetes Prevention & Management Programs
Total Budget Request	$7,848,228

Target Patient Population
Our community of West Baltimore—with the State's highest rates of diabetes and prediabetes—needs a focused, sustained, community-centered approach to better manage diabetes and prediabetes to create long term improvements in our community's overall health. West Baltimore needs resources to significantly grow diabetes prevention and management resources to provide this service to all of our community in need. Ascension Saint Agnes and LifeBridge Sinai Hospital and Grace Medical Center are partnering together to provide diabetes and prevention services to the West Baltimore community through the HSCRC's Funding Stream I Regional Partnership Catalyst Grant Program. Together we form the **Saint Agnes and LifeBridge Health Diabetes Collaborative**. Our partnership—across two health systems serving the same community—demonstrates our commitment to working together for our shared community. In developing our target population, we aimed for zip codes that are 1) adjacent to our facilities, 2) high need based on disease incidence, and 3) amassing a large enough population to make measurable impacts on the overall health of Baltimore City. We selected to target five zip codes in Baltimore City adjacent to our hospitals: 21215, 21229, 21207, 21216, 21223. With a total population of 210,000, 8.8 percent of patients from these zip codes visiting a Maryland hospital have diabetes. This is nearly double the statewide rate of 4.8 percent.[1] NIH studies show that prediabetes impacts about 35 percent of adults in the US. Our community, with the high obesity and hypertension rates, certainly have a greater prediabetes disease burden than the national estimates. We also find high rates of poverty (over 50 percent are under 200 FPL) and high food insecurity in our community. In addition, West Baltimore is considered a Healthy Food Priority Areas (commonly known as food deserts). Through our proposed activities, we will serve approximately 5,000 individuals across the five-year grant.
Proposed Activities
Diabetes and prediabetes prevention and management require both knowledge and access. An individual recently diagnosed with diabetes or prediabetes needs to have an understanding of the disease, learn about needed treatment such as medications, and know the importance of lifestyle changes needed to manage the disease. In addition, diabetes and prediabetes prevention and management requires the individual to have access to the necessary medical care, healthy foods, and safe spaces to exercise to engage in the necessary health and lifestyle changes.

[1] Based on CRISP Reporting Services analysis of HSCRC's Case Mix data for patient visits in 2018 and 2019.

The Saint Agnes and LifeBridge Health Diabetes Collaborative will work with our community to develop and foster diabetes and prediabetes prevention and management knowledge and access. Together, we will engage in two major grant activities. We will build upon two successful evidence-based diabetes education activities, National Diabetes Prevention Program (DPP) and ADA-Approved Diabetes Self-Management, to efficiently bring to scale the diabetes prevention and management services needed in West Baltimore. As a second major grant activity, we will engage with our community partners to improve access to healthy food, currently a barrier to successful diabetes and prediabetes prevention and management activities. In the following table, we outline the Saint Agnes and LifeBridge Health Diabetes Collaborative proposal, including key points:

- **We are community focused.** We are the community hospitals located in our five target zip codes; two hospital systems are partnering to serve our community. This proposal leverages the significant experience of Saint Agnes with implementing the National DPP to make diabetes prevention available in West Baltimore. We are not starting from the beginning; but instead, working to bring a small, successful program to scale. We are bringing into this effort strong community-based partner organizations.
- **Most grant resources are deployed outside the hospital.** This is a true community partnership investing in people, such as our National DPP coaches and educators. The coaches, individuals from the community, build the workforce of the communities served.
- **West Baltimore is a high need area with limited resources.** Our community has one of the highest rates of diabetes and pre-diabetes. We are a food desert. We have a high incidence of obesity, diabetes, and other chronic diseases and have little access to safe exercise space.

Proposed Activities Expand Evidence-Based Diabetes Education and Improve Access to Healthy Food Through Collaboration with Community Partners for a Healthier West Baltimore

Expanding evidence-based diabetes education and improving access to healthy foods is challenging, but the Saint Agnes and LifeBridge Health Diabetes Collaborative is well positioned to foster lasting changes in our community by expanding on smaller, successful programs and using this grant's funding to bring these programs to the scale necessary to make an impact across the population.

The Saint Agnes and LifeBridge Health Diabetes Collaborative proposes two major activities:

1. **Expand Evidence-Based Diabetes Education**
    - Expand National Diabetes Prevention Program (DPP) provider capacity. Establishing and credentialing a National DPP program takes time. Fortunately, Saint Agnes has already invested resources to initiate and credential this program. Therefore, the grant funding will begin making an impact in Year 1. We will recruit, train, and support twelve Certified DPP LifeStyle coaches with recruitment coming from within the West Baltimore community.
    - Expand ADA-Approved Diabetes Self-Management Training (DSMT) and move this resource from hospital settings and into the community. Providing more resources in the community allows to greater access to services to more affordable services when and where our community needs them.
2. **Increase Access to Healthy Foods**
    Access to healthy foods and supporting behavioral change are critical wrap around services to support patients with diabetes. With this grant, we will leverage existing food resources to support the behavioral and social changes necessary to improve health. Grant funding will expand:
    - Baltimarket, a virtual supermarket, with a site coordinator and funds for ordering and delivery.
    - Food Rx to all eligible individuals discharged from our hospitals.
    - Food as Medicine.

- Promoting Behavior and Lifestyle Changes Through a Social Media Campaign.
- Partnering with Baltimore City LHIC to Address Food Insecurity.

Measurement and Outcomes

Because we are building on a strong foundation of diabetes education programs, our proposal already meets Year 1 and 2 targets for establishing programs and setting up billing mechanisms. Our proposal is scaled to meet the targets included in the RFA for reaching the population in our target area. We have proposed outcomes and process measures for strategies to address food insecurity.

Scalability and Sustainability

By building on existing infrastructure of experienced diabetes education programs, our proposal quickly increases the capacity of diabetes education coaches and providers. With systems already in place to bill Medicare and Medicaid for both National DPP and DSMT, we are able to quickly access third party revenues to further increase the scale of the program. Grant funds are needed to build these programs because current third-party payments are inadequate to fund the capacity that is needed in West Baltimore and Statewide. With Statewide leadership and collective organizational commitments to diabetes education, we hope to encourage coordinated funding and with the total cost of care savings that will result from the scale of these investments, we have a foundation to build sustainable programs.

The investments we are proposing in food insecurity are foundational efforts that should have a lasting and multi -generational impact on communities and improve access to health foods in West Baltimore. The Food as Medicine component is designed to focus on sustainability strategies by attracting different funding models for food investments and related educational programs that have improved health outcomes.

Governance Structure

We are proposing a governance structure that builds on the collective strengths and existing resources of Saint Agnes and LifeBridge Health in a true collaboration. Our governance structure engages our community partners and consumers with a voice in the Collaborative's operations and decision-making.

Participating Partners and Financial Support

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

Supporting our Community Partners and Moving Services into the Community are best practices

We are proposing a robust partnership with our community partners. Our governance structure and funding proposal reflects this commitment with over 80% of requested funds being distributed to community partners or deployed resources with our community partners. All together, we name 12 community partners with committed roles and responsibilities and plan to incorporate other partners as our project gets underway.

Implementation Plan

We have developed an implementation plan that paces implementation so that we can be successful and build the program incrementally to meet the scale needed in West Baltimore.

Budget & Expenditures

The proposal requests a total o [redacted] million over the 5-year grant. We assume [redacted] in total expenditures and [redacted] in revenues from reimbursement for National DPP and DSMT.

2. Target Population

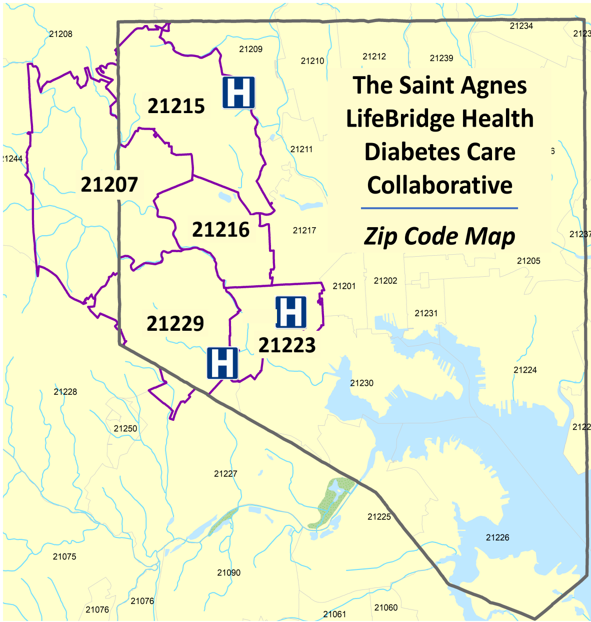
West Baltimore has one of highest diabetes and pre-diabetes prevalence in Baltimore City and in Maryland. When ranking Maryland zip codes by diabetes prevalence, over half the top ten zip codes are in West Baltimore. Further the area is considered a Healthy Food Priority Area, commonly known as food desert, lacking access to healthy food options essential to effectively preventing and managing diabetes. In developing our target population, the teams at Saint Agnes and LifeBridge Health aimed to identify zip codes that are:

- Adjacent to our facilities
- High need based on disease incidence
- Amassing a large enough population to make measurable impacts on the overall health of Baltimore City

In this proposal, we are targeting the five West Baltimore zip codes with the greatest need for expanding evidenced-based diabetes education and improving access to healthy food. We selected the zip codes: 21215, 21229, 21207, 21216, 21223. Our focus is largely in Baltimore City; however, one zip code (21207) includes both the City and County.

Selecting Zip Codes Adjacent to the Partner Hospitals Provides Community Connectivity

We selected five zip codes adjacent to our hospitals to optimize community connectivity. Additionally, Saint Agnes and LifeBridge Health hospitals hold substantial market share for these zip codes making us well positioned to engage with the community in our target areas. The map, displayed here, shows the selected zip codes and the three Collaborative hospitals.



West Baltimore, with High Poverty and Diabetes Incidence, Has Great Need and Low Resources

Our West Baltimore community has a high burden of illness. The statistics are striking. Patients visiting Maryland hospitals from these zip codes show twice the rate of diabetes as is seen statewide. For example for patients visiting a Maryland hospital in 2018 and 2019, 8.8 percent of patients from our target zip codes have diabetes. The statewide rate is only 4.8 percent. We see the same pattern for hypertension—a diabetes and prediabetes indicator—with 20.0 percent of patients from our target zip codes having a diagnosis of diabetes while the statewide rate is 11.5 percent. NIH estimates that 35 percent of people in the US have prediabetes. Our community, with high rates of hypertension and obesity, likely also has a higher rate of prediabetes than the overall population of the US.

Social and economic factors also make the needs of our target population great. West Baltimore has high rates of poverty (over 50 percent of individuals live with incomes less than 200 FPL). Food insecurity

is common. In addition, West Baltimore is considered a Healthy Food Priority Areas (commonly known as food deserts).

Significant health disparities exist due to structural discrimination, racism, poverty, and historical practices of exclusion, and health disparities are a reason for the 20-year difference in average lifespan between the wealthiest and poorest Baltimore City neighborhoods.[2] The Baltimore Neighborhood Indicators Alliance *Vital Signs 18* documented that Southwest Baltimore was one of three neighborhoods with the lowest life expectancy (66.4 years) in the City.[3] The Collaborative intends to work with our community better our overall community's health.

We built our program with an eye to make real and sustainable impact on Baltimore City. We are touching a large area—the population in these zip codes selected amounts to about one third of Baltimore City's population. As described in more detail below, through our proposed activities, we will serve about 5,000 individuals across the five-year grant for diabetes education, many of whom will also receive food assistance. The per person costs of our initiatives are well below the cost of an unplanned admission for diabetic complications. Our intent is to impact a greater population than the people directly served. As meals and fitness activities are shared among family members, the changes in diet and exercise could impact a wider population and create generational change.

3. Proposed Activities

With this award, we propose to create the Saint Agnes and LifeBridge Health Diabetes Collaborative (Collaborative). Along with our community-based organization partners, this proposal builds on the collective experience and expertise of Saint Agnes and LifeBridge Health to focus on two major activities:

- Expanding Evidence-Based Diabetes Education and Diabetes Prevention programs; and
- Improving Access to Healthy Food for individuals with diabetes or pre-diabetes.

The Collaborative will significantly expand diabetes prevention and management resources in West Baltimore by expanding Saint Agnes' National Diabetes Prevention Program (National DPP) and building the capacity of the ADA-Approved Diabetes Self-Management Training (DSMT). The proposal also strengthens wrap-around services essential to making healthy foods available and accessible to individuals with diabetes and pre-diabetes. The Collaborative will coordinate with community partners to deliver diabetes education and access to healthy foods, improving awareness about the resources.

The Collaborative will build on existing administrative infrastructures and work with CRISP to improve referrals among health providers and community partners. The Collaborative has developed planning, implementation, and monitoring strategies to ensure effective and efficient implementation of proposed activities and the ability to adjust efforts to maximize performance.

Why Saint Agnes and LifeBridge Health Diabetes Collaborative?

- Brings existing, accredited National DPP
- Community hospitals with community focus
- Relationships with community partners to provide space and support
- Fitness program developed that are vital to diabetes education success
- A high need population

[2] Available at: https://health.baltimorecity.gov/state-health-baltimore-winter-2016/state-health-baltimore-white-paper-2017

[3] Available at: https://vital-signs-bniajfi.hub.arcgis.com/app/c908cfc5ba9742ae8e10b5c95fe69d51

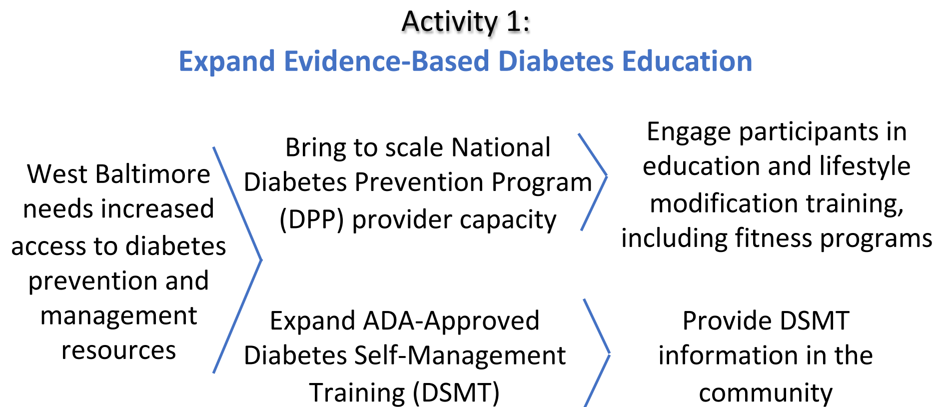
Activity 1: Expanding Evidence-Based Diabetes Education

The Collaborative proposes to expand two diabetes-focused education programs: National DPP and DSMT. For both efforts, the Collaborative will move services into more accessible community sites and non-hospital clinical settings.

Expand National Diabetes Prevention Program (DPP) Provider Capacity

With this grant, the Collaborative will leverage Saint Agnes's experience as a fully recognized CDC National DPP provider to efficiently increase the number of the Certified DPP Lifestyle Coaches expanding comprehensive National DPP services to 600 individuals annually (by Year 2).

The National DPP is an evidence-based model that works with communities to prevent Type 2 diabetes. A key aspect of the model is the CDC-recognized lifestyle change program. The interventions enable participants to support one another and build connections for lifelong help: encourage weight loss, increase physical activity, and increase knowledge of nutrition, stress management, and other elements of healthy living. Participants in National DPP engage in a year-long teaching and coaching program, beginning with intense weekly services for 26 weeks. National DPP also includes an optional second year maintenance cohort to further solidify the lifestyle changes. Through this award, the Collaborative will expand our National DPP model to include the important second year maintenance cohorts, which is reflected in our budget documents.



Saint Agnes' Experience Allows for Efficient Expansion of National DPP

Saint Agnes began offering DPP in 2015, achieving full recognition status by the CDC in 2018. This is the oldest program in Baltimore and the only program in our target area. More importantly, Saint Agnes has the only community based National DPP program in West Baltimore, a best practice in the delivery of prevention services.

National DPP is a structured model that takes time to implement successfully and achieve full recognition by the CDC. Further, maintaining CDC recognition requires programs to meet ongoing performance and reporting standards. The Collaborative is choosing to build on Saint Agnes' experience with National DPP to efficiently train, hire, and support the DPP Certified Lifestyle Coaches, contract with fitness programs and engage the community partners to build a robust community-based National DPP program that is broadly available in West Baltimore.

This proposal further builds on the partnership that Saint Agnes already has with the Maryland Office of Minority Health and Disparities to support DPP cohorts in West Baltimore. Lack of adequate resources

for diabetes prevention is a major barrier to addressing health disparities and the success of this partnership has led to a second year of funding. The funding through the Office of Minority Health and Disparities only provides partial support with Saint Agnes funding the administrative infrastructure and reporting requirements.

COVID-19 Approach

Saint Agnes has established approaches to maintain continuity of National DPP services with COVID-19. Visits in clinical and community sites are held in-person, telephonically, or virtually as appropriate. Certified diabetes educators, registered dietitians and certified DPP lifestyle coaches conduct one-on-one sessions telephonically. Certified diabetes educators utilize a HIPAA compliant platform to conduct virtual patient visits and we continue to utilize virtual visits as needed during the grant period. Fitness instructors have developed web-based fitness classes which are deployed to participants utilizing google meet or zoom platforms. These classes are utilized for small group fitness sessions. The ongoing cohorts will continue in-person class sessions when COVID-19 social distancing requirements are lifted.

While the need in West Baltimore for effective diabetes prevention programs is great, the supply of Certified DPP Lifestyle Coaches is currently small. A major focus of this grant effort will be to recruit, train, and certify the DPP Certified Lifestyle Coaches necessary to serve new 20 cohorts annually, reaching 600 individuals annually. Saint Agnes currently has four active Certified DPP Lifestyle Coaches who serve about 160 people annually in the target area. With this grant, our efforts to serve an additional 20 new cohorts each year or 600 individuals will expand its capacity by almost four times its current level. This important step towards life-long change and improved health in the community.

The Collaborative will use this grant to sponsor qualified individuals to become certified DPP Lifestyle Coaches, utilize them to teach classes, compensate them for teaching, and support ongoing mentoring of DPP Lifestyle Coaches to expand their knowledge and skills. We intend to support in person classes—as well as small group virtual classes—with live instruction from Lifestyle Coaches. Every effort will be made to ensure that Lifestyle Coaches are recruited from the target areas of the grant to assure cultural literacy and intercultural competence.

Fitness is an integral component of the National DPP program. Saint Agnes' experience to date with National DPP is that West Baltimore has unique challenges for the community to find safe options for exercise. Therefore, Saint Agnes provides fitness instruction as component of National DPP. This has helped participants meet the 150 hours of exercise needed to maintain full program recognition, a status critical for program billing of Medicare and Medicaid and key to sustainability.

With this grant, the Collaborative will pay for fitness classes in conjunction with the National DPP education classes. We plan to provide fitness classes at a new YMCA currently under construction on the Saint Agnes campus, as well as coordinating with other programing and support provided by the YMCA. Additionally, Saint Agnes Healthcare offers access to a small facility center and fitness classes on campus at a very low cost to the community.

Expansion of National DPP Will Rely on Strong Community-Based Partnerships

The Saint Agnes National DPP program has successfully built on a model of partnering with community-based organizations to provide National DPP services. Partnering with LifeBridge Health will expand the reach of community-based partners and relationships. Meeting individuals in the communities where they live and work has been essential to recruiting cohorts of patients and keeping them engaged in the long lifestyle changes necessary to prevent type 2 diabetes development. Currently we have 4 community sites and plan to expand to 10 additional sites with support from this grant.

Churches and senior housing partners provide space to conduct National DPP and fitness classes in a safe and comfortable environment using fellowship halls and community rooms for a small fee or honorarium to be funded by this grant. Community space is limited in West Baltimore which has made strong community partnerships an important component of the National DPP. These organizations are trusted partners, are in touch with community and individual needs, and are effective referral sources linking participants with the program.

Grant Funds Will Support Expansion and Success of National DPP

The Collaborative will allocate grant funds for the following National DPP efforts:

- Recruit, train, and support 12 Certified DPP LifeStyle coaches, serving 20 new cohorts per year or about 600 people.
- Fitness Instruction for 600 individuals annually.
- Hire a Diabetes Education Manager to manage the program, lead outreach efforts and track compliance to maintain CDC compliance and certification. This position will also support DSMT discussed below.
- Engage new community settings for training. The goal would be to expand to 10 new community settings over the 5-year grant.
- Program expenses include training materials, laptops, potential travel, printing and incentives for patients to complete services.

Expand ADA-Approved Diabetes Self-Management Training (DSMT)

In addition to our focus on the National DPP, the Collaborative will also expand the availability of ADA-Approved Diabetes Self-Management Training (DSMT). A key aspect of our proposed expansions is that we will deploy these professionals outside of hospitals where the services are more accessible and affordable and more likely to meet the needs of patients newly diagnosed with diabetes.

When patients are diagnosed with diabetes, they are often overwhelmed by the changes they will need to make to manage their chronic disease. Failure to successfully support patients at this critical time has significant consequences in addressing preventable disability and complications. West Baltimore lacks an adequate supply of accessible providers certified to help newly diagnosed patients learn to manage their diabetes and the consequences are expensive in terms of unnecessary hospitalizations and preventable disability. The Diabetic Composite PQI for West Baltimore is some of the highest in the State in part due to the lack of community resources for individuals with diabetes.

DSMT is a recognized evidence-based model to support patients with diabetes manage their disease. It is best provided by a multidisciplinary team of health professionals with experience and expertise in diabetes. It is an on-going service that is incremental, building knowledge, self-management skills, and a comfort level for patients in managing their disease. The gold standard for diabetes educators is the Diabetes Care and Education Specialist (DCES) credential. Formerly known as the Certified Diabetes Educator (CDE), diabetes care and education specialists provide comprehensive care including assessment of education needs, self-management goals and the educational and behavioral interventions to support patients in managing diabetes.

The DCES is highly qualified to guide patients in diabetes self-management as they bridge the gap between clinical care and daily self-management. These clinicians are board certified clinical professionals who are technically proficient and have a whole person-centered approach that supports

patient's gaining knowledge, skill and responsibility and control over their disease to prevent disability and complications. Aspiring diabetes educators must be licensed professionals with experience in diabetes care and pass a board exam. There are significant start-up costs, mentoring, and training required to support providers through this certification process.

Building a Pipeline of Clinical Experts on a Strong Foundation Will Improve Diabetes Management

The Collaborative will build the systems and strategies to recruit, retain, and maintain a pipeline of clinical experts in diabetes care that serve the West Baltimore community and improve the supply of providers certified to provide DSMT throughout the State. We will fund 2 new DCESs annually, 10 over the 5-year program, using a blend of Registered Nurses and Registered Dieticians. West Baltimore is the ideal place to create a training program given the high rates of diabetes and social factors that make training more challenging given lack of access to health foods, income insecurity and lack of transportation.

In addition to the DCESs, we propose adding a Licensed Clinical Social Worker and a Care Coordinator to provide comprehensive supports to patients in DSMT. The Licensed Clinical Social Worker will focus on providing behavioral health therapy to patients in managing diabetes related distress and helping patients improve self-management skills. Care Coordinators will be used to provide support for social determinants of health impacting diabetes and referrals for resources and care.

Saint Agnes, Sinai, and Grace all provide DSMT services. Both organizations are already accredited by the American Diabetes Association (ADA) and actively billing for services, well ahead of the RFA's Year 1 and 2 targets. Building on existing programs and making them available in the community is an efficient strategy to expanding the capacity of DSMT statewide.

DSMT in Community Settings Will Make the Service More Accessible

DSMT services have traditionally been provided in the acute hospital. In West Baltimore, patients are often receiving a diabetes diagnosis in the emergency room or inpatient setting due to a lack of primary care. An effective handoff from the acute care setting to on-going, accessible diabetes care is essential to effectively managing the disease and preventing disability and complications. Through this grant, the providers certified to provide DSMT will help manage these handoffs along with the Diabetes Education Referral Coordinator (described below) and Licensed Clinical Social Worker and Care Coordinator.

Offering DSMT services in an acute hospital setting continues to be needed but creates access challenge that this grant seeks to address. DSMT has a 20 percent Medicare copayment and when the service is provided in acute hospitals, the 20 percent copayment requirement is three to five times higher than if offered in a community setting. The patient responsibility is insurmountable for individuals with low income or older adults with fixed income. When the higher co-payment is considered in the context that DSMT is an on-going service that requires patients to engage with providers in small incremental learning opportunities over the course of months and in different arrangements, it is clear why making DSMT community based is essential to accessibility and affordability. By moving DSMT services outside of the regulated environment we will be creating change in the system which will encourage more patients to complete the 10 hours in the first year and ongoing care during future years. Grant funds are included to support these community-based clinical sites.

Saint Agnes is already underway in an initiative to move DSMT service delivery into community clinical settings. Through a partnership with Catholic Charities and funding from the Maryland Community Health Resources Commission, Saint Agnes is locating a primary care clinic at My Brothers' Keeper (MBK), which begins seeing patients in September 2020. Funding from this grant will build on that work and expand the capacity of DSMT at MBK with more DCESs. Similarly, LifeBridge will further expand DSMT services at Grace Medical Center in unregulated space. The grant will support the Collaborative to identify other community clinical settings where DSMT can be provided and provide resources for start-up costs such as staffing, space, food props, and training materials.

COVID-19 Approach

Approaches to maintain continuity of services during COVID 19. are already place. Certified diabetes educators utilize a HIPAA compliant platform to conduct virtual patient visits and we continue to utilize virtual visits as needed during the grant period.

Grant Funds Will Support Expansion and Success of Community Setting DSMT

The Collaborative will allocate grant funds for the following DSMT efforts:

- Grant funds will be used to hire a multi-disciplinary team of DCESs, supporting recruitment, mentoring, training, and certification. By the beginning of year five of the grant, we anticipate adding 10 new DCESs training about 2,000 additional individuals over 5 years.
- A Diabetes Education Manager will be hired to manage the program and lead the engagement with community- based clinical sites to deliver DSMT. This position will also support National DPP discussed above.
- A Licensed Clinical Social Worker to provide behavioral health therapy services to supporting patients in managing diabetes related distress and helping patients develop improved self-management strategies and skills.
- Care Coordinators will be used to provide support for social determinants of health impacting diabetes and referrals for resources and care. We anticipate adding 1 care coordinator in year one and a second in year two bringing the total care coordinators to 2.
- Training and certification funds will be available for RN and RD's needing specialized training in Diabetes Education
- Funds will be used to address social determinants of health, incentivize patients and improve compliance including providing transportation using Lyft, patient incentives (recipe books and cooking supplies and produce coupons) and home scales.
- Patient education materials required by program
- Resources for start-up in non-hospital clinical settings and funds to offset costs of rent and utilities for community sites hosting programs

Activity 2: Improve Access to Healthy Foods

Access to healthy foods and supporting behavioral change are critical wrap around services to supporting patients with diabetes in managing their chronic illness and helping patients with pre-diabetes halt the progression of disease. With this grant, the Collaborative will leverage existing assets in the City that are working to address food insecurity and support the behavioral and social changes necessary to create both policy and personal changes necessary to improve health for individuals with diabetes or pre-diabetes.

We estimate that there are about 16,000 individuals in the target area that with diabetes or pre-diabetes with a food insecurity. This is because West Baltimore is an extreme food desert. Affordability

is only one barrier to healthy food, with some individuals with SNAP benefits or able to afford on their own, while others lack benefits or the resources to purchase foods. Aside from affordability, healthy foods are largely inaccessible in the target areas because of a lack of grocery stores, the inability to prepare foods, and the population's reliance on inefficient public transportation. Fast foods or expensive corner markets are often the only source for foods and typically lack healthy options. This proposal includes strategies that address both affordability and accessibility of healthy foods to maximize the use of SNAP benefits.

Our strategy is to make investments to address food insecurity through this grant because food is such a foundational concept to diabetes prevention and supporting diabetic self-management. The proposed strategies build on our experience from our prior work and organizational commitment to addressing food insecurity in West Baltimore. Saint Agnes developed and launched a suite of programs under the name Food Rx. These programs, described below, are developed more fully and collaboratively with LifeBridge Health. Sinai, through its service provider Metz Culinary Management, has held farmers markets for Sinai staff, patients, and visitors several times a month to help individuals access fresh and healthy food options (prior to COVID). Sinai Community Development staff have also worked with area partners to support food access for community residents, including coordinating food delivery for seniors in partnership with Civic Works, deliveries of groceries and produce with Park Heights Renaissance, and distribution of medical information including COVID awareness materials through Langston Hughes weekly food pantries.

The strategies proposed in this grant build on these promising pilots as well as strategies that have been successfully adopted in other jurisdictions, and coordinate with citywide partners, including the Baltimore City LHIC and other Regional Partnership Applicants. We will focus on five specific strategies: 1) Expansion of Baltimarket, 2) Food Rx, 3) Food as Medicine, 4) promoting behavior and lifestyle changes through a social media campaign, and 5) Partnering with the City to Address Food Insecurity.

Expansion of Baltimarket Virtual Supermarket

The proposal will support expansion of the Baltimore City Health Department's Baltimarket Virtual Supermarket program. The Virtual Supermarket Program is an innovative approach to address Healthy Food Priority Areas (commonly known as food deserts). The Baltimarket uses online grocery ordering and delivery to bring food to neighborhoods with low vehicle ownership and inadequate access to healthy foods. It enables residents to order groceries at their local library, senior/disabled housing, or

from a designated site. Baltimarket accepts SNAP benefits to ensure this important federal benefit translates into access to healthy food options. The City has a strong partnership with Shopright, which is one of the few grocery stores in the target area. This grant will build on this existing collaborative relationship.

It is the mission of Baltimarket to work with communities and grocery stores to facilitate access to healthy foods. The staff and Neighborhood Food Advocates of Baltimarket teach Baltimore residents online grocery shopping and community organizing skills to encourage ownership of their local food environments as well as healthy eating. Outreach funds are included to fund neighborhood food advocates who are trained community members whose mission is to generate community-driven approaches to increase food access.

Participants of the both National DPP program and recipients of DSMT will be referred to the Virtual Supermarket as a resource for accessing healthy foods based on identified need through social determinants of health screening conducted by clinical staff in these communities.

With Baltimarket's demonstrated value, the. Collaborative will use grant funds to support groceries' participation in the program by 1) funding their costs of fulfilling orders and delivery, and 2) supporting an additional Program Coordinator at the Baltimore City Health Department. The Program Coordinator will recruit new Baltimarket sites with the goal of doubling the numbers of sites to scale up this program. The Coordinator will work with the 10-15 new sites, recruit volunteers to operate, and oversee the operation and marketing of service to communities.

COVID-19 Approach

The food delivery model is particularly valuable to ensure the safety of customers during the COVID-19 pandemic. Baltimarket makes grocery delivery available to a population not well served by general grocery delivery models. Understanding the importance of food delivery, Food Rx programs continue delivering meal and food, while taking contact precautions.

Food Rx

Saint Agnes developed the Food Rx program to address systemic inequities in access to healthy food and improve nutrition for chronically and medically complex patients at high risk for hospital readmission.
Through this grant, the Collaborative will fully implement Food Rx. This implementation will provide healthy meals in individuals' homes after discharge from the Collaborative hospitals, serving a large population of individuals with or at risk for developing diabetes. The 8-week intervention is designed to improve health outcomes, expand access and understanding of healthy meal options and reduce expensive readmissions for this vulnerable population. Additionally, Food Rx serves as a proof of concept to inform policy makers, insurance carriers, and State Medicaid officials for future product plan design and waivers.

Hospital patients will be identified and referred to Food Rx based on targeted screenings for social determinants of health that are positive for lack of access to healthy foods and are diagnosed with diabetes or at high risk of developing diabetes. For those patients who intend to return home, a Saint Agnes, Sinai, or Grace Medical Center care coordinator completes a social determinants of health screening and connects those identified with food insecurity with the best food intervention that meets their needs.

The grant will support Food Rx's engagement with the following four key food programs:

(1) Meals on Wheels: The requested funds would enable [illegible] individuals over five years to newly receive eight weeks of meal delivery from Meals on Wheels of Central Maryland. Meals on Wheels serves people who are homebound and unable to shop for their food or prepare their own meals, on a permanent or temporary basis. The service includes daily delivery of a hot lunch main meal and a cold second meal. Additional wraparound services are available.
(2) Moveable Feast: The requested funds would enable [illegible] individuals over five years to newly receive eight weeks of food and services from Moveable Feast. Each week, the delivered food consists of up to 18 healthy meals, including a bag of up to five services of fresh produce per week and a bag of "safety net" food staples delivered the last week of the month. The delivery from the Moveable Feast visitor also helps to alleviate isolation.
(3) Hungry Harvest Rx Produce Delivery: The requested funds would enable [illegible] individuals over five years to receive eight weeks of Harvest Rx Produce Delivery. Harvest Rx is a "prescription" for home deliveries of fresh produce that help encourage healthy eating, home cooking, and a greater sense of independence. Delivery provides enough produce for eight meals per week.
(4) Hungry Harvest Rx: The requested funds would enable [illegible] individuals over five years to receive eight weeks of Harvest Rx produce at Saint Agnes' weekly year-round "Produce in a SNAP" farmers market. Harvest Rx increases community access to affordable, healthy food, and provides health education for participants.
(5) Grassroots organizations such as UMempower The Food Project: The requested funds would enable grassroots organizations to support delivery of healthy foods to individuals and create job opportunities for youth who are learning culinary skills in the targeted area (see discussion below in Section 6. Participating Providers).

Food as Medicine

The Collaborative will launch a Food as Medicine initiative. The concept of Food as Medicine is trying to prevent chronic illnesses such as diabetes, or even reverse disease progression by prescribing nutritional changes and/or launching initiatives to remove barriers to healthy foods. Our proposal is modeled on DC Greens Produce Rx Program in Washington, DC. The DC initiative allows medical professionals to prescribe fresh fruit and vegetables to patients experiencing diet-related chronic illnesses with additional support for patients living in poverty. DC Greens partners with local grocery stores to accept a prescription for healthy foods from a medical professional. This referral, along with a $20 coupon for healthy foods and wrap around nutritional counseling on-site at the store is supported by DC's Medicaid MCOs.

The Saint Agnes LifeBridge Health Diabetes Care Collaborative proposes to develop and advocate for a similar model where health care providers can write a prescription for healthy foods and a nutritional counselor is available on-site at the grocery store to support their selection of healthy foods. The **Food Insecurity Programs Project Manager** funded by the grant (described below) will also launch the Food as Medicine initiative, develop the community partnerships and work with Medicaid MCOs, Medicare Advantage and other payers to reimburse the costs of healthy foods. The grant will also include technical assistance support from the Partnership for a Healthier America. This is the organization that launched the program in DC and a small investment in consulting will ensure that West Baltimore can scale up the model and learn from their practical experience. On an on-going basis, the Partnership for a Healthier America will also provide a wide array of nationwide best practices, including food as medicine programming, engaging small and large- format food retailers as partners, and using effective messaging to promote the consumption of fruits and vegetables.

Promoting Behavior and Lifestyle Changes Through a Social Media Campaign

The Saint Agnes LifeBridge Health Diabetes Care Collaborative will partner with the Baltimore Metropolitan Diabetes Regional Partnership (BMDRP) to support a citywide social media campaign to promote lifestyle changes and healthy eating. This proposal includes 20% of the total budget of $375,000 needed annually for a campaign of this scale and impact. Funds will be used to hire a public relations firm in Year 1 and develop and implement strategies over the 5-year period of the grant for large-scale and regionwide public health campaigns for National DPP and DSMT aimed at promoting healthy eating. Other communications strategies will be considered, including hospital partner and National DPP and DSMT site specific campaigns (e.g. pamphlets, videos on plasma screens in hospitals and clinical waiting areas). The remaining 80% of the costs are to be funded by the BMDRP. We will coordinate with the BMDRP, the vendor and other stakeholders to create and implement the public health campaign.

Partnering with Baltimore City LHIC to Address Food Insecurity

The Collaborative will provide funding to the Baltimore City Health Department to onboard a Food Policy Analyst to support the Local Health Improvement Coalition. This position will be hired through the Baltimore Corps, a nonprofit organization that recruits highly talented, mission-driven professionals and connects them to full time social and health-related impact projects. The grant will support for a full-time person hired through Balt. Corps. This LHIC Analyst will report to the LHIC Director.

The LHIC Director and Analyst, along with the Collaborative Director (described below) and Diabetes Education and Food Insecurity Mangers will lead efforts to engage other partners, policymakers and payers and to advocate for changes needed to build sustainable healthy environment to improve care and resources for individuals with diabetes and pre-diabetes. This includes focusing on how to sustain efforts to improve access to health foods and make effective diabetes education broadly available.

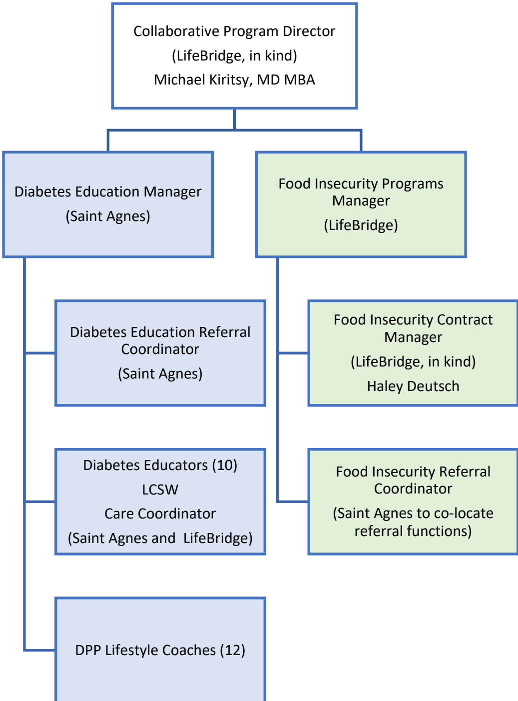
Grant Funds Will Support Expansion of Pilot Efforts to Address Food Insecurity and Citywide Partnership

The Collaborative will allocate grant funds for the following efforts:

- Support Baltimore City Health Department to recruit and hire a Virtual Supermarket Program Coordinator at the, recruit 10-15 new Supermarket sites, reaching over 1,000 new customers. The Coordinator will manage the ongoing operations of the Virtual Supermarket Program;
- Compensate grocery stores for their on-going fulfillment and delivery costs under the Baltimarket -- Virtual Supermarket;
- Provide food delivery or purchase through the Food Rx partners (Meals on Wheels, Moveable Feast, Hungry Harvest Rx and other grassroots organizations) to provide healthy foods to over [illegible] individuals;
- Hire a Food Insecurity Manager to oversee the Collaboratives Food Initiatives (discussed below in Planning, Foundation Building, and Referral Systems)
- Nutritional counseling and coupons for healthy food purchases as part of Food as Medicine, serving [illegible] individuals annually.
- Funding for the Partnership for a Healthier America to help launch the Food as Medicine program
- Support a Citywide Public Health Campaign with the Baltimore Metropolitan Diabetes Regional Partnership
- Provide financial support to Baltimore City to recruit and LHIC Policy Fellow

Planning, Foundation Building, and Referral Systems

Saint Agnes and LifeBridge Health will launch these proposed activities on a strong foundation of existing administrative infrastructure and on-going planning (see staffing chart below). The proposal will leverage CRISP as a tool to improving the management of referrals for diabetes education and wrap-around food programs. Michael Kiritsy is already on staff as the **Collaborative Program Director**. He will oversee implementation of all the grant activities and report to the Steering Committee. Funding for his will be provided in-kind by LifeBridge Health. Dr. Kiritsy is an MD and MBA trained in Emergency Medicine with experience in value-based care and population health. Dr. Kiritsy is already leading collaborative planning among the population health teams from both Saint Agnes and LifeBridge Health. Informal teams for Diabetes Education and Food Insecurity are already in place and coordinating on programming and partnering with the Baltimore City Health Department. These committees would be directly overseen by the Dr. Kiritsy.



In addition to the Collaborative Program Director, four positions will be support implementation and oversight. A **Diabetes Education Manager** will be hired through Saint Agnes to lead the expansion of the diabetes education efforts, including both National DPP and DSMT. A **Food Insecurity Programs Manager** will be hired through LifeBridge Health to lead the initiatives to improve access to health foods and coordinate with Citywide efforts and lead the Food as Medicine Initiatives. An additional in-kind staff, **Contracts Manager**, will be provided by LifeBridge Health to manage contracting with food programs. A **Diabetes Education Referral Coordinator** and a **Food Insecurity Referral Coordinator** will be hired by Saint Agnes and LifeBridge, respectively, to oversee and manage referrals (scheduling and enrollment) to National DPP, DSMT and food programs. These referral positions will be co-located and cross-trained so that they can backfill and maximize their efficiency.

Saint Agnes and LifeBridge Health are working with CRISP to use the referral tools that CRISP has created to simplify and streamline referral processes. CRISP is already piloting a closed loop referral tool available through the Unified Landing Page. This tool allows CRISP users to make a referral to community-based programs to address social determinants of health. CRISP has already established connections with Meals on Wheels and Moveable Feast, two of the providers of food programs under this proposal. The CRISP referral tool can easily be used by Saint Agnes and LifeBridge Health as well as their community based clinical partners to leverage this tool. The Collaborative will work with CRISP to add connections to the CRISP tool, including Hungry Harvest, and the Saint Agnes Diabetes Education Referral Coordinator for both the National DPP program and DSMT. CRISP has expressed a willingness to work to embed this referral tool in hospital and non-hospital EMRs to improve workflows and efficiency.

CRISP also expressed interest in leveraging technology available to non-clinical users to provide a simplified system for community-based organizations to make referrals for the National DPP program and food programs. Unlike DSMT, these programs do not require a referral from a physician. Typically, CRISP tools are only available to HIPAA covered entities; however, as part of their response to COVID, CRISP has developed a tool available to non-HIPAA covered entities. The goal is to use this technology which is already in place to let community-based organizations make a referral to diabetes education programs or food insecurity initiatives. This leverages the identify management tools at CRISP, while blocking access any personal identity or health information to non-clinical users. The CRISP referral tools and the community health module in the Saint Agnes EMR will function as the registration system for National DPP and will track participant data including all data needed for the CDC file and for the CMS crosswalk file. The Saint Agnes and LifeBridge Health EMRs will manage referrals for DSMT and manage the tracking of participants.

Grant Funds Will Support Effective Management and Oversight

The Collaborative will allocate grant funds to hire the following management staff:

- Diabetes Education Manager
- Food Insecurity Program Manager
- Diabetes Education Referral Coordinator
- Food Insecurity Referral Coordinator

Outreach

Saint Agnes and LifeBridge will use multiple strategies to outreach and create awareness about the services provided and improve the delivery of diabetes care in West Baltimore. Strategies will include engaging community partners that have established trusted relationships with the target population; direct outreach to individuals with diabetes of pre-diabetes; and engaging with physicians and clinics to improve the delivery of care to individuals with diabetes and pre-diabetes and expand referrals to prevention and education resources. By engaging with community partners and directly with consumers, as well as a robust governance model, we have mechanisms to get feedback from the consumers served, understand their needs and adjust programs to improve the delivery of services.

Engaging Community Partners

The Collaborative Program Coordinator will build on existing relationships with trusted community partners as well as forging new relationships. Saint Agnes will build on the work that it already has underway with its National DPP program. Since the acquisition of Grace Medical Center by LifeBridge Health, LifeBridge has been making concerted efforts to enhance community partnerships through existing organizations such as Unity Properties Inc. Our work with trusted community partners will include telephonic and in person outreach to on-site program directors at targeted senior housing sites and outreach to faith-based partners to provide announcements in church bulletins, newsletters, fliers in vestibule, etc.

Direct Outreach

Outreach to individual participants will build on strategies already in use and include a strengthened website, use of social media tools, personal contacts with community partners and distribution of materials. These efforts will be led by the Collaborative Program Director. Fliers with information on the availability of National DPP will be distributed in targeted senior housing centers. Participation in community health fairs such as those offered by the Office of Minority Health or back to school fairs are

an important opportunity to offer the CDC Prediabetes Risk Test as a referral source as well as share general educational materials. Information will also be provided at the weekly Produce in a SNAP market on campus at Saint Agnes and Sinai Hospital and Grace Medical Center as well as through other community health programming offered by both organizations and their many community partners.

Engaging Physicians and Clinics

The proposal will include targeted efforts with community-based physicians and clinics to provide resources and training on diabetes care and increase awareness about the availability of National DPP and strengthened electronic referral processes. The Collaborative Program director will lead development of content and materials that will be distributed through existing efforts. St. Agnes is applying to become a CTO and already engaging 43 MD PCP practices and LifeBridge Health is already a CTO and participating with 27 MD PCP providers with established practice liaisons in place.

A small amount of grant funds will be used to provide a stipend to the ADA to make their *Diabetes is Primary* Education Program locally available. This training program provides 6 Continuing Education credits free of charge. The training has demonstrated results that the program has helped providers improve their practice and awareness in diabetes care. As part of MD PCP, these practices are already incentivized to improve quality of care.

Grant Funds Will Support Coordinated Outreach

The Collaborative will allocate grant funds to:

- Development and distribution of outreach materials
- Stipend for ADA for *Diabetes in Primary* delivered locally

Implementation and Monitoring

The Saint Agnes LifeBridge Health Diabetes Care Collaborative's Implementation Plan, provided in Section 7, describes a robust process for planning and implementation. These efforts coupled with a strong Governance Structure, described in section 6, will provide systems for monitoring implementation efforts and mechanisms to make adjustments as necessary in order to successfully achieve the goals of the program.

4. Measurement and Outcomes

The HSCRC has indicated they will be working with CRISP to assess a variety of scale and outcome measures, which the St. Agnes LifeBridge Health Diabetes Care Collaborative will separately track using one or more internal reporting systems. Our strategy would be to import EMR, CRISP, and any referral data tracked elsewhere into LifeBridge's enterprise data warehouse (EDW). Once the data is centralized in the EDW, a unified dashboard of all metrics will be created using available analytics platforms and will be accessible for review or distribution by appropriate Collaborative participants.

Based on available CRISP public health data and the RFP's prediabetes prevalence data, it is estimated that approximately 22,254 patients of the 233,155 people in our target zip codes are living with prediabetes. Moreover, the participating hospitals saw 11,580 patients in its acute care, observational, and emergency facilities in 2018 and 2019. This represents a majority of the 18,684 patients who were

seen in any Maryland hospital over the same period. Given that the Collaborative has operating DPP and DSME programs, we have already met the goals for the first year of the program. This provides us with additional opportunity to scale and engage patients in the Baltimore community. In addition to the measures proposed in the RFP document, the Collaborative will also track several other metrics to ensure expansion is successful and are improving outcomes. As part of this, we will be tracking enrollment rates and attrition rates for both DPP and DSMT programs at the cohort level. This will help the collaborative ensure we meet or exceed the HSCRC's goals as well as give us the opportunity for continued feedback and process improvement activities. For those patients enrolling in DPP, we will also track whether patients progress to diabetes or not, even beyond the grant period. This will allow us to assess whether our expansion programs are having an effect on the long-term total cost of care and will help demonstrate an ROI on the program. For those enrolling in DSMT, we will also track Hemoglobin A1c% on a yearly basis for each patient to assess the efficacy of our expansion efforts and to help demonstrate an ROI on expanding the programs. Specifically, we will track if each enrolled patient's A1c is greater or less than 8%, as is consistent with most value-based care quality measures.

In addition to the proposed metrics in assessing efficacy and outcomes for the education programs, the Collaborative will also be implementing several process and outcome measures for our healthy food access programs, as it is a large part of the overall program. We propose tracking the following measures during the course of the program:

1. Percent of SDOH screened patients referred to a healthy food access program
    a. This is a process measure that will allow us to track how well the screening and referral process for healthy food programs is functioning and provide opportunities for us to improve over the course of the program. We would split this measure out by food program allowing us to track progress toward scale targets
2. Percent of eligible patients able to access healthy food access programs
    a. This is a process measure allowing us to understand how well our community partners are able to provide access to healthy foods for those patients referred to them. It will allow us to identify and fix any workflow challenges experienced by our partners. This measure would be split out by program allowing us to track progress toward scale targets
3. Percent of eligible patients receiving food as medicine prescriptions
    a. This is also a process measure meant to assess how well community providers are engaging with this food access program. It will allow us to identify and fix any workflow challenges and ensure continued tracking toward our scale target.
4. Percent of enrolled patients achieving any form of bodyweight loss (as defined in the HSCRC DPP outcome measure)
    a. This is an outcome measure that will allow us to assess whether expanding access to healthy food improves outcomes in our prediabetic and diabetic populations. This will help us demonstrate an ROI on the program and support continuation of such efforts after the grant period.
5. Percent of enrolled patients with controlled diabetes (A1c<8%).
    a. This is also an outcome measure similar to the proposed outcome measure for diabetes education initiatives. It will enable us to detect if these initiatives improve health outcomes for the population and to demonstrate an ROI on the program.

5. Scalability and Sustainability

Preventing the progression of diabetes among individuals with pre-diabetes and supporting individuals with diabetes manage their chronic disease has tremendous opportunity to reduce long term health consequences of diabetes and reduce total cost of care. Both National DPP and DSMT are billable services; however, third party reimbursement alone is inadequate to build the programs to the scale necessary to meet the needs in West Baltimore. Grant funding is needed to develop the capacity of these programs and Medicare and Medicaid funding is only available when and if patients fully complete education requirements and meet outcome goals. Over time, program retention rates and reporting should improve, improving reimbursement potential.

Both Saint Agnes and LifeBridge Health bill for DSMT services now and have the on-going systems to maintain billing. Saint Agnes has years of experience with National DPP, having achieved full recognition status by the CDC in 2018 which is necessary for billing. Establishing the billing processes for National DPP takes time and Saint Agnes is currently working on Medicaid MCO contracting and Medicare billing provider certification. Saint Agnes will begin billing by the Fall of 2020, well in advance of the Year 3 Target included in the RFA. This established billing infrastructure enables the Collaborative to move quickly to scale National DPP capacity.

Our budget assumes significant revenues from third party billing of DSMT and by year 5 of the grant, reimbursement is more than double what is proposed to be funded through the grant. Similarly, our budget assumes revenues from third party payers for patients' completion of National DPP training, but historic reimbursement models suggest that the majority of funds will be needed to be supported by the grant in year 5.

Over the 5-year life of this grant and with Statewide leadership, we are confident that the education programs will demonstrate value and bring third party payers to the table to contribute because they will have reduced costs once these programs are scaled more fully. While Medicare, Medicaid and potentially commercial reimbursement for diabetes education is important to on-going sustainability, it is still likely to be below the levels needed to fully sustain the programs. Once the programs are grown to scale, there is a greater opportunity to recognize the total cost of care savings through reduced diabetes prevalence and complications and the GBR payment models incentives for population health improvement.

The grant also makes early investments in strategies to reduce food insecurity. Demonstrating an ROI in food investments should build support for the concept of food as medicine and encourage other funding. The investments in a public health campaign has the potential to create lasting behavioral change. The Program Director, LHIC and Food Insecurity Manager will be working together to support comprehensive health and educational strategies.

6. Participating Providers and Decision-Making Process

Governance Proposal

The governance structure is designed to support meaningful collaboration among key community organizations while giving each stakeholder the ability to contribute to the decision-making process, as well as provide feedback on all parts of the process. The structure is also designed to ensure

contributions from all partners who would receive funding from the grant while remaining small enough to not be unwieldly.

Steering Committee

The regional partnership steering committee will provide strategic guidance and administrative support to ensure the goals for the program are met. The steering committee will also be responsible for approving strategic and implementation decisions proposed by the Diabetes Education Committee, the Healthy Food Access Committee, and any workgroups convened by any of these three formal committees.

The structure will be as follows:

- One chair of the steering committee, to be nominated and elected by majority vote of the other members of the steering committee.
- Two seats to be held by a member of each participating hospital system.
- Two seats to be held by primary care providers located in the target service area. One would a provider employed by St. Agnes, and one would be a provider employed by LifeBridge Health
- One seat for a representative from the Baltimore City Health Department (BCHD).
- Three seats to be held by each major partner, specifically the American Diabetes Association (ADA), Healthcare for the Homeless, and My Brother's Keeper/Catholic Charities of – Baltimore.

Program Director: Michael Kiritsy, MD, MBA

Reporting to the steering committee will be a designated collaborative program director who will be responsible for managing the implementation of the proposal, tracking the status of the project, and addressing any challenges and barriers to implementation. He will also oversee the Diabetes Education and Healthy Food Access committees

Diabetes Education Committee

The Diabetes Education Committee will oversee the expansion and implementation of the diabetes education programs set forth in the grant. It will ensure that the programs adhere to the budget of the program, and it will be responsible for tracking performance metrics to be reported to the steering committee, all partnership members, and the HSCRC. It will also engage additional resources and workgroups as needed to meet the sustainability and implementation goals of the partnership.

The structure will be as follows:

- One committee chair to be nominated and elected by majority vote of the other committee members
- Two seats held by leading diabetes educators from each hospital system
- One representative from the BCHD
- Two seats to be held by community providers practicing in the target zip codes
- Two seats to be held by community partners, Baltimore Medical System and Enterprise Properties

Healthy Food Access Committee

The Healthy Food Access Committee will oversee the expansion and implementation of food access programs for the grant, including negotiating contract terms with community partners (subject to steering committee approval). It will ensure that each partner program adheres to the budget outlined in this proposal. It will be responsible for reporting all performance metrics to the steering committee,

partnership members, and the HSCRC. It will also engage additional resources and workgroups as needed to meet the goals of the proposal.

The structure will be the following:

- One committee chair to be nominated and elected by majority vote of the other committee members
- Two seats held by administrators from each hospital system.
- One representative from the BCHD
- Three seats to held by each major community food partner, specifically Hungry Harvest, Meals on Wheels, and Moveable Feast
- Other community partner positions may be added as determined by the steering committee

Implementation responsibilities

Given the scope of this proposal and the respective expertise of each hospital system, the majority of implementation work, to be overseen by the respective committees and the steering committee, will be divided to reflect the respective resources of each health system and their preexisting partner relationships. St. Agnes will be largely responsible for expanding diabetes education programs, training, and hiring additional diabetes educators and any associated staff required. LifeBridge will oversee the expansion of programs that will address food insecurities, including hiring of any necessary staff, managing any required contracts, and implementing a robust screening and referral process. LifeBridge and St. Agnes will be working together with CRISP to ensure a robust referral process is implemented for all aspects of the program. Both systems will also partner equally to provide education to community providers on these resources as well as on any required performance tracking and auditing.

Regional Partnership Collaborators

The St Agnes and LifeBridge Health Diabetes Care Collaborative will work closely with our non-hospital community partners to meet the goals of the grant. The grant proposes to allocate over 80% of funds to be allocated to community partners, either through direct funding or deploying staff or consultants on site with our partners. The multidisciplinary workforce of diabetes educators hired through this grant are often more efficiently hired through as part of a clinical organization with appropriate credentialing and clinical oversight.

<table>
<tr><td>Name of Collaborator (1):</td><td>Catholic Charities /My Brother's Keeper (MBK)</td></tr>
<tr><td>Type of Organization:</td><td>501(c) (3) social service provider</td></tr>
<tr><td>Amount and Purpose of Direct Financial Support, if any</td><td>None</td></tr>
<tr><td>Type and Purpose of Resource Sharing arrangements, if any</td><td>DCES funded by grant deployed on site at new primary care clinic</td></tr>
<tr><td colspan="2">Roles and Responsibilities within the Regional Partnership:</td></tr>
<tr><td colspan="2">MBK operates targeted prevention programs and will be a site for the National DPP and Diabetes Self-Management and Training (DSMT) when their current cardiovascular program concludes. MBK will also be a referral site for National DPP. MBK will be member of the Partnership's Diabetes Education Committee.</td></tr>
</table>

Name of Collaborator (2):	Baltimore Medical System (BMS)
Type of Organization:	FQHCs

Amount and Purpose of Direct Financial Support, if any	None
Type and Purpose of Resource Sharing arrangements, if any	DCES funded by grant deployed on site

Roles and Responsibilities within the Regional Partnership:
This grant will develop the capacity of NDPP to take more patient referrals from BMS. The grant will also develop the capacity of the food programs to take referrals from BMS and provide nutrition education. BMS also refers patients to the Saint Agnes high-risk pregnancy clinic which includes many pregnant women with type 1, type 2 and gestational diabetes. This program will provide referrals to NDP, DSMT and the food programs. BMS will be member of the Partnership's Education Committee.

Name of Collaborator (3):	Healthcare for the Homeless (HCH)
Type of Organization:	FQHC
Amount and Purpose of Direct Financial Support, if any	None
Type and Purpose of Resource Sharing arrangements, if any	DCES funded by grant deployed on site

Roles and Responsibilities within the Regional Partnership:
This grant will develop the capacity of National DPP and DSMT to take more patient referrals from HCH. The grant will also develop the capacity of the food programs to take referrals from HCC and provide nutrition education. HCH will be member of the Partnership's Steering Committee.

Name of Collaborator (4):	Baltimore City Health Department
Type of Organization:	Local Health Department
Amount and Purpose of Direct Financial Support, if any	Baltimarket: [illegible] LHIC: [illegible]
Type and Purpose of Resource Sharing arrangements, if any	Grant to support to support administrative costs to the grocers and food delivery costs, and 1 project coordinator at the LHD and LHIC

Roles and Responsibilities within the Regional Partnership:
Baltimore City Health Department is a key partner Saint Agnes and LifeBridge. They have been a part of the grant planning and development and will participate on both Partnerships Committees.

Name of Collaborator (5):	Meals on Wheels
Type of Organization:	501(c) (3) food provider
Amount and Purpose of Direct Financial Support, if any	[illegible]
Type and Purpose of Resource Sharing arrangements, if any	Funded partner to provide meal delivery

Roles and Responsibilities within the Regional Partnership:
Meals on Wheels is already working with the Food Rx program to provide meal delivery to homebound individuals. This service will be expanded through the grant and Meals on Wheels will sit on the Food Insecurity Committee.

Name of Collaborator (6):	Moveable Feast

Type of Organization:	501(c) (3) food provider
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of Resource Sharing arrangements, if any	Funded partner to provide meal and grocery delivery
Roles and Responsibilities within the Regional Partnership: Moveable Feast manages a range of programs including home delivered meals, community partner meals, medical nutritional therapy, and limited transportation services. Moveable Feast has a long-standing relationship with Food Rx and is already a contracted partner. This service will be expanded through the grant and Moveable Feast will sit on the Food Insecurity Committee.	

Name of Collaborator (7):	Hungry Harvest
Type of Organization:	Social Entrepreneurship Company
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of Resource Sharing arrangements, if any	Funded partner to provide meal and grocery delivery
Roles and Responsibilities within the Regional Partnership: Hungry Harvest is a social entrepreneurship company with a mission of ending food waste and eliminating hunger. They have a long-standing partnership with the Food Rx program to deliver fresh produce and they operate a farmers' market on the campus of Saint Agnes. Due to the COVID 19. Pandemic, the farmers market is using a delivery model. The grant will expand these two programs.	

Name of Collaborator (8):	Northwest Faith Based Partnership
Type of Organization:	501(c)3 Social Service Provider
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of Resource Sharing arrangements, if any	Funded partner to provide space for hosting DPP classes and referring patients
Roles and Responsibilities within the Regional Partnership: Northwest Faith-Based Partners (NWFBP) is a coalition of churches and other partners that plans and implements faith-based initiatives that make a difference in northwest Baltimore. Through their network of churches and parishioners as well as ongoing outreach and events with community members, the NWFBP is well positioned to help reach and inform individuals, host classes in churches, and also refer potential patients to DPP programs and resources.	

Name of Collaborator (9):	Comprehensive Housing Assistance Incorporated
Type of Organization:	501(c)3 Social Service Provider
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of Resource Sharing arrangements, if any	Funded partner to provide space for hosting DPP classes and referring patients
Roles and Responsibilities within the Regional Partnership: Comprehensive Housing Assistance Inc. (CHAI) is a nonprofit community development organization with a historic presence in northwest Baltimore. This grant would support CHAI host DPP classes, utilize their existing network and relationships with community members to advertise programing, as well as allow CHAI to refer patients to our DPP programs.	

Name of Collaborator (10):	Central Baptist Church
Type of Organization:	501(c)3 Social Service Provider
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of Resource Sharing arrangements, if any	Funded partner to provide space for hosting DPP classes and referring patients
Roles and Responsibilities within the Regional Partnership: Central Baptist Church is a Baptist Christian congregation in West Baltimore with a long relationship with St. Agnes. It has an active Health Ministry which partners with Saint Agnes to host numerous chronic disease management and health related programs including the National DPP and the CVD Prevention Programs and other screening events. This grant would allow us to host more classes in their facility and help them to refer patients to the DPP program.	

Name of Collaborator (11):	Enterprise Community Development
Type of Organization:	501(c)3 organization
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of Resource Sharing arrangements, if any	Funded partner to provide space for hosting DPP classes and referring patients
Roles and Responsibilities within the Regional Partnership: Enterprise Community Development is a non-profit residential property development organization with a long-standing commitment to providing affordable housing to families in need. This grant would allow us to host more classes in their facility and support them as a referral partner.	

Name of Collaborator (12):	UEmpower of Maryland "The Food Project"
Type of Organization:	501(c)3 organization
Amount and Purpose of Direct Financial Support, if any	Amount TBD
Type and Purpose of Resource Sharing arrangements, if any	Funded partner to provide healthy food access for patients with food insecurity
Roles and Responsibilities within the Regional Partnership: UEMPOWER of Maryland's "The Food Project" brings culinary skills, job opportunities, sustainable food sources, mentorship & hope to the youth of South West Baltimore. With your support we can empower futures together.	

The Collaborative is already engaged with other community partners, and may potentially expand these through the grant:

- Fayette Street Outreach, a non-profit in West Baltimore could be a potential new site for the Baltimarket or National DPP and referral partner.
- Paul's Place, a homeless service provider, could be a site for National DPP and referral partner
- Bon Secours Community Works can also serve as a referral partner and potential sites for National DPP.
- Coppin State University is also a potential partner. With a campus site in 21216, we will explore partnering with them to provide DSME at their clinic.

- Food programs such Plantation Farm, Green Street Academy, First Fruit's Farm, Langston Hughes, and Black Yield Institute are potential partners for referrals and food delivery sites.

7. Implementation Work Plan (See Appendix A)

8. Budget Narrative (Separate Budget Included in Appendix B)

The St. Agnes LifeBridge Health Diabetes Care Collaborative has developed a proposed budget to address the three priority areas delineated in Section 3, in the amount of [redacted] over five years. It was developed using available data from CRISP and other resources from each organization and ensures that a majority of funds or employed resources (70%-87%) are utilized at partner sites. It is anticipated that funds will be distributed to both St Agnes and LifeBridge Health based on the requested amount in the attached budget through an increase in hospital rates. It is expected that funds for DPP and DSMT expansion will go to Saint Agnes through rate increases, amounting to over [redacted] over 5 years. It is expected that funds for Healthy Food Access Expansion Programs will go to LifeBridge through rate increases, amounting to [redacted] over 5 years.

Priorities 1 and 2: Expand National Diabetes Prevention Program Provider Capacity and ADA-approved Diabetes Self-Management Training Programs

Given the research showing the health outcomes and healthcare cost benefits of diabetes prevention education, the St Agnes LifeBridge Health Diabetes Care Collaborative is committed to expanding access to diabetes prevention education. We are seeking to do by ensuring more than 80%-98% of the proposed funds go to community partner organizations or deployed in community organizations. Over the first four years of the program we will be adding 12 Diabetes Prevention Lifestyle Coaches (3 per year). We have allocated [redacted] per educator in training costs for years 1-4 to meet this goal. As outlined elsewhere, St. Agnes currently operates a CDC NDPP program, which we will be expanding upon. As outlined in the implementation plan, we anticipate being able to begin providing expanded services beginning in July 2021.

We assume that each group class accommodates 30 people, and based on historical data, approximately 1/2 finish the program. We also assume that each class takes 3 hours to account for setup and cleanup, and each educator is paid at a rate of [redacted]. In terms of required hours, we assume each group meets weekly for the first 6 months, has 10 sessions for the second six months, and meets monthly for the year of maintenance education, a new service we plan to provide. We also include 50 minutes of fitness instruction per week for each group, reimbursed at [redacted] for 2 hours total (including setup and cleanup time) at each session. Lastly, we assume that we will enroll patients at the same rate each year beginning in year 2, which will allow us to meet the defined outcome measure of 12.2% enrolled by the end of year 5.

In year 1, we request [redacted] in salary for providing Diabetes prevention education, [redacted] for providing DPP fitness instruction classes, and $1,500 in education of new diabetes prevention lifestyle coaches. This would expand to [redacted] in years 2-5 for DPP classes and [redacted] for fitness instruction. In addition, we assume that we will need to contribute approximately [redacted] per cohort per year for spaces to perform these activities. This amounts to [redacted] in year 1, and [redacted] in years 2-5. We also

request in computer equipment for the new diabetes educators, in year one only, DPP education materials at per patient, and patient incentives in the amount of $50 per patient. These incentives would be one item with a e and to purchase produce. In aggregate, the DPP Expansion budget would be We would offset some of this with DPP billing revenues, which we assume are approximately per patient cohort, for a net 5 year budget o .

The St. Agnes LifeBridge Health Diabetes Care Collaborative is also committed to expanding Diabetes Self-Management Training (DSMT), and is proposing funding to support significant expansion in these areas. Over the course of the program, our goal is to hire and fund 10 additional Diabetes Care Education Specialists (DCES's), 5 of whom would be registered nurses (RNs), and 5 of whom would be registered dieticians (RDs). All would be employed by St. Agnes, and all are planned to be deployed in community partner clinic sites. We assume that salary and fringe for each and fringe for each St. Agnes employed RN is with 25% for fringe and each RD is with 25% fringe and increases at 2% per year. Our goal is to have all proposed expansion staff employed by the beginning of year 5. In addition, we are requesting per educator to take the basic DCES certification exams and preparation, continued education every year for existing certified educators, amounting to over the course of the program. Moreover, we also request per year as honorarium to be paid to the ADA in support of their Diabetes as Primary education service, which we will have providers complete as part of MD PCP. We also are requesting to add one LCSW to behavioral health therapy to help diabetes patients manage adjustment to disease and diabetes related distress beginning in year 1 (. In addition to the CDE staff, we also request , beginning in year 2, to assist in expansion costs for clinic sites where DSMT may be offered, including in community partner clinics such as -My Brother's Keeper clinic and Healthcare for the Homeless. In addition, we request funding to support the cost of education materials, per patient. To assist patients in navigating the complex health system we also would add two care coordinators, one in year 1, and another hired halfway through year and r.

To help support expansion of these programs, we also are proposing funding to assist in operating these expanded education programs. We are proposing one program coordinator at), who will assist in connecting referred patients to the programs, enrolling them, arranging any required transportation, and assisting patients and staff. We also request per year to help subsidize transportation costs ( ) for approximately 15 patients per DCES. Lastly, we request per year in order to provide marketing materials intended to drive outreach and referrals to these programs through community partners. This makes for a total budget of n year 1, and a 4 in year 5, for a total of . 59%-86% of these funds would be directly contributed to referral partners. We also plan to offset these costs with revenue from DSMT billing, resulting in a net 5-year total requested budget of

Priority 3: Expand Access to Healthy Foods

Knowing that access to healthy food is a key barrier to improving health outcomes in diabetic and prediabetic patients, the regional partnership is devoting significant funding to bolster Baltimore City's and Community organizations ability to provide healthy food to these patients. The proposed budget reflects three key tactics to expand access: expansion of Baltimarket, expansion of subsidized food access, implementation of a food as medicine program, and support of BCHD's LHIC and public

education campaign. Over 5 years, we are proposing funding of , of which approximately 78%-88% each year would be distributed to community partners.

Our efforts to support expansion of BCHD's Baltimarket would amount to over 5 years and would include per year for a program coordinator employed by BCHD, per year, increasing to per year, to support outreach efforts by BCHD, and funding to support expansion costs incurred by Baltimarket's vendor, Shoprite. This funding would begin at and increase to per year in year 2. This funding is to help Shoprite with delivery costs and additional personnel costs that may be required. Our goal would be to reach approximately two thousand additional eligible patients through this program.

In addition to expanding Baltimarket, we also would seek to help expand the ability of several key community organizations, Moveable Feast, Meals on Wheels, Hungry Harvest Rx Produce Delivery, and Hungry Harvest Rx, and potentially others, to provide access to healthy food for those patients with identified food insecurity and inability to pay for healthy foods. These programs would provide food to eligible patients for an 8-week period. This would assist in expanding these programs to serve and additional 1,100 patients per year in our service areas. This would amount to over 5 years. In addition, we would also provide some funding to grass-roots organizations seeking to expand access to healthy foods, such as The Food Project. The total amount of this funding would be over 5 years.

Continuing to provide subsidized access to healthy food is an important service in enabling our expanded education programs to be successful in improving health outcomes and decreasing the total cost of care in our target population. However, we must also work to make this expanded service sustainable beyond the scope of this program. Drawing on inspiration from Washington, DC's ProduceRX program, we would seek to implement a similar program in Baltimore, in partnership with BCHD and our other key food access partners. In year 1 we would hire a Food Insecurity Project Manager to help with launching this program in year 2. This role would is estimated at $. In order to ensure patients are able to access these services, we also propose funding for another referral coordinator at $). Our initiatives will also be supported by a contracted group, the Partnership for a Healthier America, who will assist us with food access expansion and sustainability strategies, specifically for the Food as Medicine initiative. This contract work would be over the duration of the program, or per year. In addition, we would also fund direct food subsidies in the form of coupons to be provided to any eligible patient who has a prescription from a Maryland healthcare provider. Our funding is based on providing weekly coupons to patients per year in year 2, and patients per year in year 3. This amounts to $

The final part of our wrap around budget proposal includes supporting BCHD in their LHIC and education campaign efforts, which is predominately being led by Johns Hopkins and UMMS. The St. Agnes LifeBridge Health Diabetes Care Collaborative would support this work by funding the LHIC Analyst position, per year as estimated by BCHD, as well as providing per year in support of BCHD's social media education campaign.

Appendix A: Diabetes Prevention Program Implementation Plan

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Operations and Planning
Establish Partnership Entity
Establish Governance Board
Establish Operations Committees
Develop Implementation Work Plan
Policy Advocacy Support
Analytics & Reporting Activities
Audit Activities
Community Outreach and Support
Provider education on DPP and DSME resources for patients
Develop 5 year education marketing campaign in collaboration BCHD
Work with BCHD LHIC to improve diabetes education and care
Implement/expand current BCHD marketing campaign
Implement/expand BCHD LHIC efforts
Diabetes Prevention Programs
Identify existing resources for expansion
Identify sites for expansion
Apply for NPP expansion sites
Establish referral system
Ready facilities to be able to provide services
Begin training DPP lifestyle coaches
50% of target DPP coach staff
75% of target DPP coach staff
100% of target DPP coach staff
Begin billing for services
Evaluation of DPP programs and accessibility/expansion as deemed necessary
Diabetes Self Management Training
Identify existing resources for expansion
Identify sites for expansion
Apply for DSME expansion sites
Establish referral system
Ready facilities to be able to provide services
Begin training and hiring DCES Staff
60% of target DCES staff
80% of target DCES staff
100% of target DSME staff
Begin billing for services
Evaluation of DSME programs and accessibility/expansion as deemed necessary
Healthy Food Access Expansion Programs
Begin formalizing community partnerships/expansion plans for existing partnerships
Expand deployment of SDOH screening tools to determine eligibility of service
Develop/enhance screening criteria for eligibility for food services
Create/implement and expand referral system for healthy food access
Begin expansion of Baltimarket in collaboration with BCHD
50% of target expansion delivery sites for Baltimarket
100% of target expansion delivery sites for Baltimarket
Additional 400 patients provided with subsidized healthy food access
Additional 800 patients provided with subsidized healthy food access
Additional 1100 patients provided with subsidized healthy food access
Strategy and Implementation Planning of Food as Medicine
Launch of Food as Medicine Initiative
50% of target eligible patients able to access food as medicine
75% of target eligible patients able to access food as medicine
100% of target eligible patients able to access food as medicine
[illegible]
Payer Reimbursement of Food as Medicine Begins
Evaluation of access to healthy food programs and pursuit of new partners as needed

Appendix B: HSCRC Regional Partnership Catalyst Grant
DPP/DSMT Proposed Budget

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