maryland
health services
cost review commission

Regional Partnership Catalyst Program

Calendar Year 2022 Activities – Final Report

July 2023

P: 410.764.2605 ● 4160 Patterson Avenue | Baltimore, MD 21215 ● hscrc.maryland.gov

maryland
health services
cost review commission

Table of Contents

maryland
health services
cost review commission

Introduction

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

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

The Catalyst Programs are also an important tool to advance goals of health equity for Marylanders. Provision of wraparound services to address social determinants of health (SDOH) is core to Regional Partnership programming. Regional Partnerships deploy community health workers (CHWs), patient navigators, care managers, and others to screen participants for SDOH needs and connect participants to resources. Regional Partnerships recognize that addressing SDOH and treating the whole patient is crucial to preventing diabetes or helping diabetic patients manage their disease. Additionally, Regional Partnerships are intentional in the selection of community-based partners to reflect the culture, language, and demographics of target populations to customize marketing materials and outreach strategies to engage patients. These activities are critical to address long-standing health disparities in the State and have been highlighted and promoted by the Regional Partnership programs.

For the period January 2021 through December 2025, the HSCRC has awarded $157.6 million in cumulative funding through nine awards to eight Regional Partnerships.[1] The five-year cycle creates time to

[1] One Regional Partnership ended its participation in CY 2022.

build partnerships and infrastructure prior to implementing interventions. This report summarizes the activities in the second year of the five year cycle, CY 2022. As described in the enclosed report, Regional Partnerships have made significant progress in expanding service delivery in CY 2022 to stand up new programs across a large set of partners and different healthcare delivery systems. Although challenges continue to exist to recruit and maintain staff, navigate changing federal and state requirements, successfully implement billing and service reimbursement, and respond to the intensifying behavioral health needs of Marylanders, the Regional Partnerships cite an ongoing commitment to find creative solutions in order to improve health outcomes for participants in the respective programs. Importantly, Regional Partnerships will continue to promote provider awareness and build relationships with commercial insurers and Medicaid MCOs.

Overview

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

Subsequent to the Regional Partnership Transformation Grant Program's expiration in June 2020, the HSCRC established the Catalyst Program to enable hospital-led partnerships to continue to build infrastructure in support of the population health goals of the TCOC Model and SIHIS in a more focused manner. The Catalyst Program made awards under two funding streams: (1) diabetes prevention and management and (2) behavioral health crisis services. The Catalyst Program is based on the HSCRC philosophy of fostering collaboration among hospitals and community partners while creating infrastructure to disseminate evidence-based interventions.

Diabetes Prevention and Management Programs

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

This funding stream also supports implementation of Diabetes Self-Management Training (DSMT) and Diabetes Self-Management Education and Support (DSMES). DSMT/ES provides lifestyle change help and

diabetes management curriculum to patients to help better control their Type II diabetes. Regional Partnerships under the Catalyst Program were required to achieve American Diabetes Association (ADA) or American Association of Diabetes Education (AADE) accreditation for their respective DSMT and DSMES programs, or partner with an accredited program.

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

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

Behavioral Health Crisis Programs

The TCOC Model incentivizes reductions in unnecessary emergency department (ED) and hospital utilization. Across Maryland, hospitals cite opioid use disorder and inadequate access to acute mental health services as contributors to ED overcrowding. Maryland currently lacks sufficient infrastructure needed to divert behavioral health crisis needs from EDs and inpatient settings to more appropriate community-based care. Community-based organizations often do not receive reimbursement for crisis management services and struggle to provide the capacity needed in Maryland.

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

- **Air Traffic Control (ATC) Capabilities with Crisis Line Expertise.**[2] The ATC model is based on always knowing the location of an individual in crisis and verifying hand-offs to the next provider. The model creates a hub for deployment of mobile crisis services and access to other services such as crisis stabilization. The model’s essential components include qualified crisis call centers and 24/7 clinical coverage with a single point of contact for a defined region.

[2] ATC is also referred to as “Care Traffic Control” by one Regional Partnership.

- **Community-Based Mobile Crisis Teams**.[3] Mobile crisis services deploy real-time professional and peer intervention to the location of a person in crisis. They are intended to avoid unnecessary ED use and hospitalization.
- **Stabilization Centers**. Crisis stabilization services provide 24-hour observation and supervision at a sub-acute level to prevent or ameliorate behavioral health crises and/or address acute symptoms of mental illness. Settings are small and home-like relative to institutional care.

Summary of Awards

The HSCRC awarded a cumulative $157.6 million through nine awards to eight Regional Partnerships for the five-year period of January 2021 through December 2025. Five of the nine awards fall under the diabetes prevention and management funding stream. These awards total $78.5 million and involve 24 hospitals. They span Western, Central, and Southern Maryland as well as the Capital Region. Three of the nine awards fall under the behavioral health crisis services funding stream. These three awards total $79.1 million and involve 24 hospitals. They span Central Maryland, portions of the Capital Region, and the Lower Eastern Shore. A summary of awards is shown in Table 1 below.

[3] Mobile Crisis Teams (MCT) are also referred to as Mobile Response Teams (MRT).

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

	Regional Partnership	Counties/ Region	Award	Participating Hospitals
Diabetes Prevention and Management	**Baltimore Metropolitan Diabetes Regional Partnership**	• Baltimore City	$43,299,986	• JH Bayview Medical Center • Howard County General Hospital • Johns Hopkins Hospital • Suburban Hospital • UMMC • UMMS Midtown
	Western Regional Partnership	• Allegany • Frederick • Washington	$15,717,413	• Frederick Health • Meritus Medical Center • UPMC Western Maryland
	Nexus Montgomery[4]	• Montgomery	$4,121,123	• Holy Cross Germantown • Holy Cross Hospital • Shady Grove Medical Center • White Oak Medical Center
	Totally Linking Care (TLC)	• Charles • Prince George's • St. Mary's	$7,379,620	• Adventist -Fort Washington Medical Center • Luminis Doctors Community Hospital • MedStar St. Mary's • MedStar Southern Maryland • UM Capital Region Health • UM Laurel Regional Medical Center
	Saint Agnes and Lifebridge	• Baltimore City • Baltimore County	$5,962,333	• Ascension St. Agnes • Sinai Hospital • Grace Medical Center
	Full Circle Wellness	• Charles	$2,054,382	• UM Charles Regional Medical Center
Behavioral Health Crisis Services	**Greater Baltimore Region Integrated Crisis System (GBRICS)**	• Baltimore City • Baltimore County • Carroll • Howard	$44,862,000	• Bayview Medical Center • Carroll Hospital • Grace Medical Center • Greater Baltimore Medical Center • Howard County General • Johns Hopkins Hospital • Ascension St. Agnes • Sinai • MedStar Franklin Square • MedStar Good Samaritan • MedStar Harbor • MedStar Union Memorial • Mercy • Northwest • University Maryland Medical Center • UM Midtown • UM St. Joseph Medical Center

[4] Program participation ended in 2022.

	Totally Linking Care (TLC)	● Prince George's	$22,889,722	● Adventist Fort Washington Medical Center ● MedStar Southern Maryland ● UM Laurel Medical Center ● UM Capital Region Health
	Tri-County Behavioral Health Engagement (TRIBE)	● Lower Eastern Shore	$11,316,332	● Atlantic General Hospital ● TidalHealth - Peninsula Regional Medical Center
		Total Awards	**$157,602,911**	

Year Two Diabetes Prevention and Management Activities

DPP Referral, Enrollment, and Retention Strategies

During CY 2022, Regional Partnerships took a range of actions to promote DPP referral, enrollment, and retention. They made progress in expanding DPP capacity for underserved populations in particular, for example by targeting zip codes with no prior DPP, expanding cohorts at senior centers and assisted living facilities to engage older adults, and hiring bilingual coaches to expand Spanish-language DPP. Continued hiring of coaches, CHWs, and administrative support staff is a strategy reported by multiple Regional Partnerships.

Referral efforts are multipronged. Regional Partnerships are enhancing electronic health records (EHRs) to facilitate DPP referral and enrollment from within the hospital, for example with DPP referrals in after visit summaries and automated patient messages and provider prompts. In addition, Regional Partnerships work with community providers, and community-based organizations to identify participants and address barriers to care. This includes implementing technology solutions to reach community partners outside of the health system EHR. Outreach at community events and direct to consumer public marketing campaigns—including flyers, direct mail, media advertisements, and QR codes—are also referral sources, as are MCOs.

MCOs fulfill different roles in Regional Partnership referral processes. For some Regional Partnerships, MCOs are a key source of referrals, and they partner closely during outreach events to provide participant education. Other Regional Partnerships are in the process of building contracts with MCOs and understanding credentialing processes for DPP providers. Suggestions from Regional Partnerships include streamlining MCO credentialing processes. Table 2 shows CY 2022 MCO engagement with Regional Partnerships.

Table 2. CY 2022 MCO Engagement

Managed Care Organization (MCO)	Regional Partnerships Engaged
Aetna Better Health	3
Amerigroup	2
CareFirst	2
Jai Medical Systems	1
Maryland Physicians Care	3
Priority Partners	2

Source: Regional Partnership Annual Reporting, CY 2022

Regional Partnerships report that once individuals are identified and referred, enrollment proves challenging. Regional Partnerships deploy multiple touchpoints and different approaches to bridge the gap, for example shifting from phone calls to text messaging and purchasing smartphones for coaches to facilitate text communication. Individuals are reluctant to answer phone calls from unrecognized numbers.

During enrollment, Regional Partnerships engage participants in different formats depending on the preferences of the participant, with individual, group, in-person, and virtual methods. Regional Partnerships recognize that participants in virtual classes may fall outside of target zip codes.

To promote participant retention in DPP, coaches send encouraging messages and reach out to participants who miss classes. Participants are assessed for any barriers that might prevent participation. Regional Partnerships also provide participant incentives for reaching milestones. Examples include Weight Watchers memberships and functional tools such as scales and cooking equipment. Regional Partnerships make healthy food available to some participants, for example through Food as Medicine initiatives or grocery store raffles. Regional Partnerships are also focusing on retention of staff and coaches, for example through purposeful team communication and unification of mission. Regional Partnerships describe recruitment and retention of staff as a challenge. One Regional Partnership has successfully recruited staff from outside of Maryland through conference networking.

DPP Cohorts

Table 3 shows DPP Cohorts for CY 2021 – 2022. Regional Partnerships supported 163 total cohorts in 2022 that were either run by the hospital or partner community organizations. 119 cohorts began in 2022, while 44 cohorts that began in 2021 concluded. Two Regional Partnerships also ensured cohorts were more accessible to participants by providing interpreters and classes in English and Spanish. Cohort sizes can vary in size based on delivery format (i.e. in-person or virtual), location, and available staffing. In general, smaller cohort sizes allow for more personalized contact between lifestyle coaches and participants which supports program retention and maximizes patient success in the program.

Table 3. DPP Cohorts, CY 2021-2022

Regional Partnership	2022 (New Cohorts)	2021 (Cohorts Ending)
Baltimore Metropolitan Diabetes Regional Partnership	36	7
Full Circle Wellness	9	7
Saint Agnes and Lifebridge	8	6
Totally Linking Care (TLC)	24	17
Western Regional Partnership	42	7
Total	**119**	**44**

Source: Regional Partnership Annual Reporting, CY 2022

DSMT/ES Expansion Strategies

Regional Partnerships are focusing on referral and enrollment efforts as well as increasing the reach of classes to expand DSMT/ES. They cite success in participants meeting their goals for A1C improvement and self-selected behavioral goals.

Referral and enrollment strategies include strengthening relationships with referring providers. Regional Partnerships are increasing the presence of DSMT/ES educators in primary care and endocrinology practices to facilitate cross-referral and engaging participants in familiar settings. Another strategy is embedding DSMT staff in the population health team for integration between inpatient and ambulatory services. Regional Partnerships are targeting potential participants through the EHR and standardizing workflows among care management teams to address gaps in care. EHR enhancements facilitate participant identification, referral, care coordination, and resource navigation. Regional Partnerships are expanding their focus beyond Medicare, offering DSMT/ES as a standard of care for all patients particularly amidst transitions of care. In addition to encouraging provider referrals and EHR identification, Regional Partnerships are promoting DSMT/ES through community-based marketing and recruitment.

Despite these various strategies, engagement of participants in DSMT/ES continues to be challenging. Regional Partnerships cite low referral rates by providers, in addition to barriers such as cost-sharing faced by patients. For Medicare FFS beneficiaries, there is a cost share requirement which can become cost-

prohibitive for patients, particularly if DSMT is performed in a regulated setting.[5] [6] Patient financial responsibility depends on the location of where DSMT/ES is provided and any supplemental benefits the beneficiary may have in addition to Medicare coverage.

Regional Partnerships are expanding the number and nature of DSMT/ES classes, with more sites and larger spaces, in-person and virtual, one-on-one and group, and hybrid offerings. The expansion of classes allows for participants to receive education earlier in their diagnoses. Classes are being offered on evenings and weekends to meet the scheduling needs of participants under age 65 who balance work and caregiving activities. In addition, classes are offered in English and Spanish. DSMT/ES expansion has been facilitated by the hiring of new staff during CY 2022, including class teachers and registered dieticians to lead the nutrition components of DSMT and provide MNT.

Physician & Provider Engagement (DPP & DSMT/ES)

When a provider has a meaningful conversation with the patient about enrolling in DPP or DSMT/ES, the patient is more likely to participate. Accordingly, Regional Partnerships are continuing to conduct a range of physician and provider engagement activities for both DPP and DSMT/ES. Outreach methods differ for hospital-affiliated versus community-based providers. For hospital-affiliated providers, engagement activities center on EHR tools, regular outreach meetings, and messages from leadership. Some Regional Partnerships focus only on hospital-affiliated providers and MDPCP partners, for example by working with MDPCP managers to identify patients and collaborating with MDPCP to provide warm introductions and ongoing support to providers and CTOs. Other Regional Partnerships engage community-based providers with educational visits to offices, information about the CRISP referral tool, EHR optimization offerings, and the availability of paper referrals. In addition, Regional Partnerships offer educational road shows and CME modules for both categories of providers. Despite the various provider engagement efforts, Regional Partnerships note the challenges of recruiting hospital-affiliated and community-based providers to make referrals.

Impact Measures

DPP Referrals

HSCRC set a goal for Regional Partnerships to refer five percent of their prediabetic patient population to DPP in 2022. Referrals are measured in targeted ZIP codes that were self-selected by Regional Partnerships in their 2020 proposals. There is a significant number of referrals being generated outside of targeted ZIP codes that HSCRC does not give credit for in reporting since measurement is ZIP code-based.

[5] The deductible and coinsurance of 20 percent of the Medicare-allowed amount applies to DSMT.

[6] Centers for Medicare and Medicaid Services. *Medicare Learning Network Fact Sheet - Medicare Diabetes Self-Management Training*. May 2022. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DSMT-Fact-Sheet-909381.pdf

The numbers shown in Table 4 are therefore a lower-bound of referrals and actual performance exceeds the reported amounts.

In 2022, Regional Partnerships referred a total of 7,224 patients to DPP in designated ZIP codes. Referrals to DPP are inclusive of all-payers (Medicare, Medicaid, commercial, self-pay, uninsured) and are self-reported by Regional Partnerships monthly.

Table 4. All-Payer Referrals to Diabetes Prevention Programs, CY 2022

Regional Partnership	Target	Actual[7]	% of CY22 Target Achieved
Baltimore Metropolitan Diabetes Regional Partnership	1,969	2,976	151.1%
Full Circle Wellness	579	609.5	105.3%
Saint Agnes and Lifebridge	542	788	145.4%
Totally Linking Care (TLC)	1,911	1,634.5	85.5%
Western Regional Partnership	1,124	1,216	108.2%
Statewide Total	6,125	7,224	118%

Source: CRISP Regional Partnership Monitoring Dashboard, Hospital Self-Reported Data

HSCRC is continuing to use all-payer referrals as performance metric in CY 2023 and is monitoring Medicare and Medicaid claims to evaluate DPP enrollment. Progress to establish new billing processes for DPP has been slower than anticipated. All Regional Partnerships are expected to provide reports on billing progress this summer. Staff will be reviewing these plans and will ask for corrective action plans for Regional Partnerships where progress is still lacking.

On an all-payer basis, statewide cumulative enrollment in DPP has steadily increased since the Catalyst Program began in 2021 and is currently outpacing the nation (Table 5 and Figure 1). This data is based on CDC programmatic data that is provided to the State on a quarterly basis and is inclusive of all DPP in the State, not solely RP-attributed DPP. Based on data through January 2023, Maryland has experienced a 172.6 percent increase in DPP enrollments per 100k since 2018. This rate of change is faster than the nation overall, which has experienced a 96.4 percent increase over the same period.

Table 5. Cumulative DPRP Enrollment Rate per 100K Compared to National Average, 2018 - January 2023

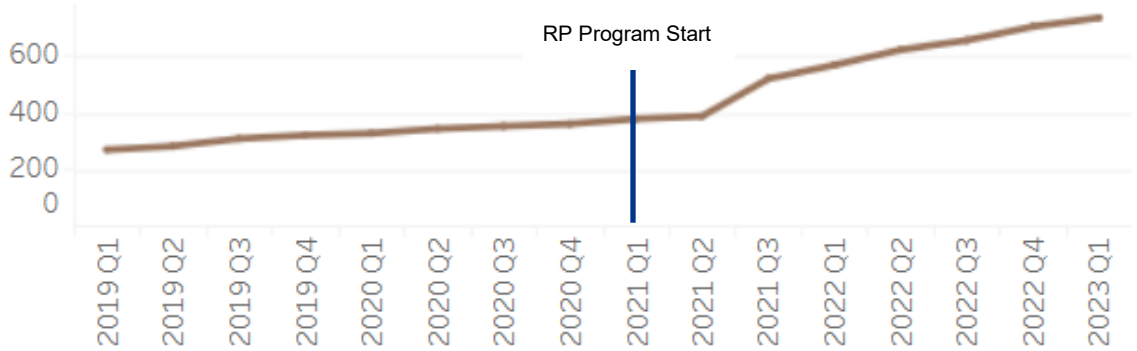
	2018 Baseline	Most Recent Rolling 12 Months	Percent Change	National Comparison Change

[7] Regional Partnerships that serve the same ZIP code split credit for referrals which accounts for 0.5 values.

Rates per 100K (MD)	269.9	735.7	172.6%	96.4%
Rates per 100K (Nation)	358.0	763.2	113.2%	

Source: CRISP SIHIS Directional Indicators Dashboard, CDC Programmatic Data

Figure 1. Cumulative DPRP Enrollment Rate per 100K Compared to National Average, 2018-January 2023



Source: CRISP SIHIS Directional Indicators Dashboard, CDC Programmatic Data

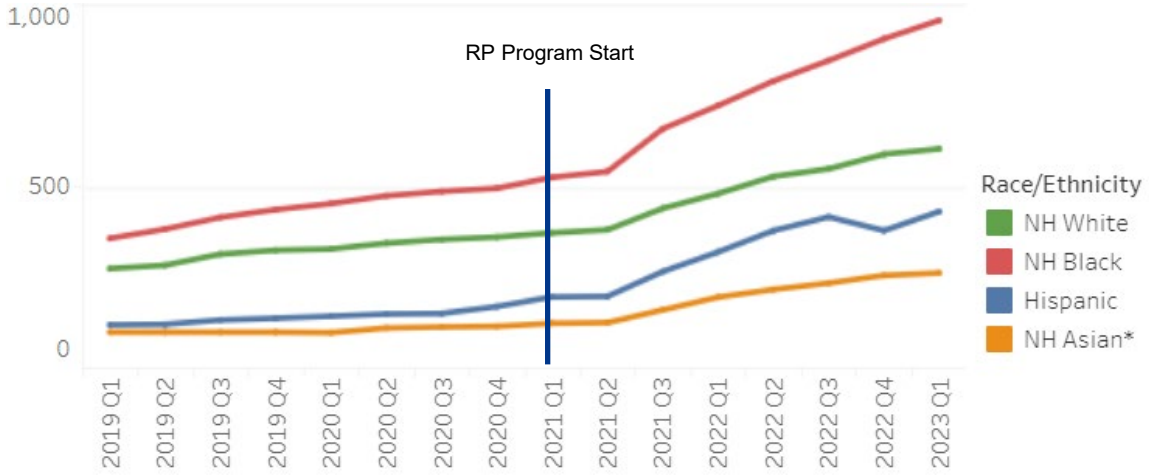
The State is also able to monitor DPRP enrollment by race and ethnicity, as shown in Table 6 and Figure 2, and is seeing marked improvements in enrollment across all races and ethnicities.

Table 6.Cumulative DPRP Enrollment Rates per 100K by Race/Ethnicity, 2018-January 2023

Race/Ethnicity	2018 Baseline	Most Recent Rolling 12 Months	Percent Change
NH White	276.2	604.1	118.7%
NH Black	359.0	955.8	166.2%
Hispanic	122.5	432.6	253.2%
NH Asian	102.1	264.2	158.7%
Statewide Total	269.9	735.7	172.6%

Source: CRISP SIHIS Directional Indicators Dashboard, CDC Programmatic Data

Figure 2. Cumulative DPRP Enrollment Rates per 100K by Race/Ethnicity, 2018-January 2023



Source: CRISP SIHIS Directional Indicators Dashboard, CDC Programmatic Data

As shown above, NH Black enrollment in DPP is outpacing NH White enrollment. There is room for improvement on DPP enrollment for the Hispanic and NH Asian population, although enrollment is growing faster for those populations than NH White.

DSMT/ES Participation

The HSCRC monitored Medicare DSMT claims in CY 2022 and found that volumes remained below initial expectations when the program launched. Many Regional Partnerships had not fully established billing operations for expanded DSMT programs in 2022 and were continuing to rebuild programs after DSMT volumes declined during the pandemic. Additionally, a great deal of DSMT/ES is reimbursed by commercial payers, but HSCRC does not currently measure commercial DSMT/ES claims and Medicaid does not provide coverage for DSMT/ES. Overall, DSMT claims for RP-attributed Medicare beneficiaries increased by 186 percent between CY 2021 and CY 2022 (Figure 3 and Table 7). Regional Partnerships are expected to aggressively grow their DSMT claims in CY 2023 as billing processes are put into place and volumes continue to rebound from 2020 lows due to the pandemic. Additionally, the Medicare cost-sharing requirement for patients continues to be a barrier to participation.

Figure 3. RP-Attributed Medicare Beneficiaries with DSMT Claims, CYs 2019-2022

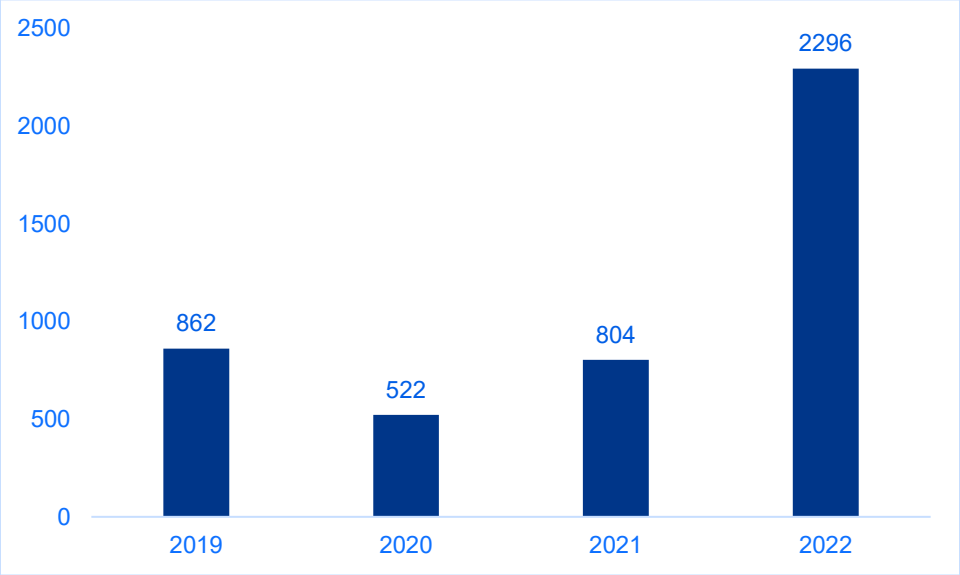


Table 7. RP-Attributed Medicare Beneficiaries with DSMT Claims, CY 2021-CY 2022

Regional Partnership	CY 2021	CY 2022	% Change 2021 to 2022
Baltimore Metropolitan Diabetes Regional Partnership	332	1513	356%
Full Circle Wellness	166	185	11%
Saint Agnes and Lifebridge	228	358	57%
Totally Linking Care (TLC)	68	85	25%
Western Regional Partnership	10	155	1450%
Statewide Total	804	2296	186%

Source: CCLF Data

The State also receives annual reports from the CDC on DSMES participation, based on data reported by the ADA and Association of Diabetes Care and Education Specialists (ADCES), as shown in Table 8. This data is inclusive of billed and non-billed DSMES. Since 2019, Maryland has seen 69 percent growth in DSMES participants through 2021, compared to 7 percent growth nationally.[8]

[8] 2022 DSMES Data will be available in late summer 2023.

Table 8. DSMES Participation Growth, Maryland vs. Nation, 2019-2021

State	2019 Encounters	2020 Encounters	2021 Encounters	Percent Growth
Maryland	11,403	11,705	19,270	69%
Nation	975,417	928,895	1,042,253	7%

Source: American Diabetes Association (ADA) and Association of Diabetes Care and Education Specialists (ADCES)

Billing & Sustainability (DPP & DSMT/ES)

The ability to bill Medicare and Medicaid for reimbursement of DPP and DSMT/ES creates a pathway to sustainability for Regional Partnerships. During CY 2022 Regional Partnerships made progress towards billing. In CY 2022, eight DPP suppliers billed Medicare and/or Medicaid, although the majority of Regional Partnership's DPP providers did not. One Regional Partnership plans on having an additional 21 DPP providers begin billing Medicare in 2023. One Regional Partnerships is also working on creating an administrative umbrella hub arrangement for billing—this approach accommodates DPP suppliers by not requiring a transfer of recognition to an umbrella hub provider organization.

Some Regional Partnerships' DSMT/ES providers have been billing Medicare and commercial payers for some time. All Regional Partnerships are committed to having all of their DSMT/ES providers billing Medicare in CY 2023. Regional Partnerships note that to be financially viable, programs need to bill payers beyond Medicare, and generate revenue from other services such as MNT and glucose monitoring. They also point to differences operating in regulated versus unregulated spaces, noting that regulated rates have associated cost-sharing for Medicare patients that can be cost-prohibitive.

Wraparound Services (DPP & DSMT/ES)

Provision of wraparound services to address social drivers of health (SDOH) is core to Regional Partnership programming. Regional Partnerships deploy CHWs, patient navigators, care managers, and others to screen participants for SDOH need and connect participants to resources. Support is available in English and Spanish. Regional Partnerships also screen participants for depression to connect them to resources as needed.

During CY 2022, Regional Partnerships offered the following wraparound services shown in Table 9 to DPP participants. These services that are supported by vendors and collaborators allow for participants' needs to be met and help remove barriers related to social determinants of health.

Table 9. CY 2022 Wraparound Services (DPP & DSMT)

Wraparound Service	Count of Regional Partnerships
Food Access	5
Transportation	5
Exercise	4
Medical Nutritional Therapy	4
Remote Patient Monitoring	2
Mobile Integrated Health	1
Medication Management	1
Financial Assistance	1

Source: Regional Partnership Annual Reporting, CY 2022

Regional Partnerships describe multiple efforts to address food access, starting with screening. Questions are now asked about "challenges purchasing *healthy* food" as opposed to "challenges purchasing food" to understand when participants lack physical or financial access to healthy food (even though fast food may be accessible). One survey showed that close to half of participants have trouble buying fruits and vegetables due to access or cost. From this survey, 56 percent of respondents having trouble getting food are African-American, pointing to health disparities.

Solutions to provide healthy food include food delivery to participants' homes, a virtual supermarket concept, and partnering with supermarkets and others on healthy food access programs. Regional Partnerships are also partnering with community- and faith-based organizations to provide cooking classes and demonstrations.

Regional Partnerships are addressing transportation through the provision of Lyft rides and connecting participants to existing non-emergency transportation providers. To promote exercise, Regional Partnerships offer participants gym memberships through the YMCA or County parks and recreation facilities, fitness instruction (including virtual), and Fitbit activity trackers.

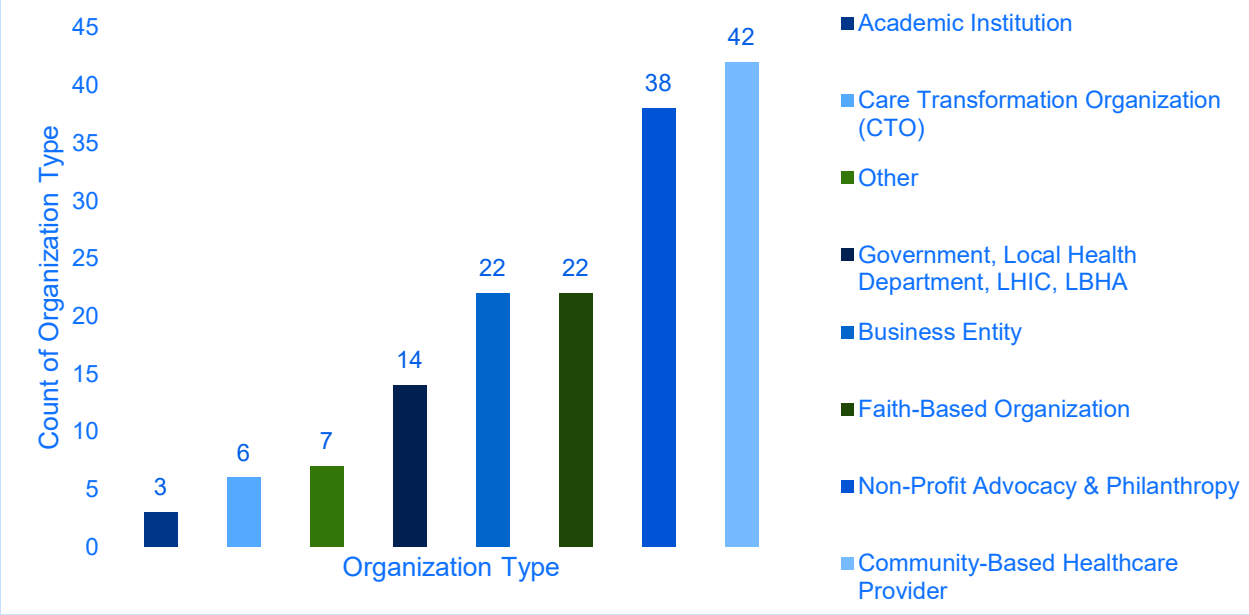
Diabetes Community Partner Collaboration (DPP & DSMT/ES)

The development of partnerships for long-term improvements in population health, and engagement and integration of community resources in the healthcare system are core goals of the Catalyst Program. During CY 2022, Regional Partnerships convened and attended community events with partners to reach potential participants outside of the healthcare setting who may be missed in other marketing efforts. The community events also enable Regional Partnerships to build relationships with other community attendees.
In CY 2022, Regional Partnerships also worked with community partners to provide ongoing education about diabetes prevention and management, and to establish in-person classes, for example at faith-based

organizations, apartment complexes, and senior settings. Regional Partnerships also worked closely with community partners to meet participants' SDOH needs, for example food access.

Figure 4 shows the breadth of Regional Partnerships' community partners for diabetes prevention and management. There are a total of 154 community partner organizations across the five Regional Partnerships. The two most common types of organizations are community-based healthcare providers and non-profit advocacy or philanthropy organizations.

Figure 4. CY 2022 Diabetes Program Community Partners



Source: Regional Partnership Annual Reporting, CY 2022

Year Two Behavioral Health Crisis Services Activities

Open Access and Crisis Center Activities and Progress

Regional Partnerships made significant progress on crisis center activities in Year Two. TRIBE opened both of its sites with Monday through Friday hours (8am to 8pm and 8am to 4:30pm). Crisis center visits increased monthly at both primary and secondary sites, and by the end of the calendar year both centers had a combined total volume of 1460 visits. Both sites integrate primary telehealth services as needed. Staff assess for and coordinate SDOH and substance use disorder needs. One of the two sites embeds peer support on site. The Regional Partnership continually monitors service delivery data to address priority needs. Given staff strain of walk-in hours with no scheduled times for intakes, the Regional Partnership is identifying better triage processes. The need for bolstered security was also addressed in CY 2022.

TLC projects to open its 23-hour Crisis Stabilization Center in the summer of 2023 with capacity to serve 16 individuals. During CY 2022 all contracts were signed and the Regional Partnership continues to meet regularly with key stakeholders to align with local and State requirements.

GBRICS is expanding access to immediate-need behavioral health services through its Open Access Pilot project, with two pilot cohorts of five and thirteen pilot sites. Both cohorts are now offering appointments. The project provides technical assistance, training, and seed funding to the sites to implement or expand open access appointments. In the last quarter of CY 2022, pilot sites received 155 patients. During CY 2022, a vendor was selected through competitive procurement to provide technical assistance. The Regional Partnership has worked with the care traffic control software to create an outpatient referral tool for the 988 Regional Call Center to send referrals to pilot sites for individuals in immediate need of outpatient behavioral health appointments which should grow patient volumes at Open Access pilot sites. The main source of referrals is each site's marketing efforts, as well as a widely shared resource guide and listing on the 988helpline.org website. An evaluation of the Open Access Pilot will provide information on why some sites have a low volume of referrals.

Care Traffic Control Activities and Progress

Significant progress was made on care traffic control and open access activities. The 988 Regional Call Center for Central Maryland went live in April 2023, establishing a regional Care Traffic Control system by implementing a single hotline for substance use and mental health crisis calls. It averages 55 calls per day, an increase from the number of calls to separate 988 operators prior to implementation. Work completed during CY 2022 included competitively procuring a vendor contract to operate the 988 Regional Call Center and negotiating the MOU. The contract is held by three organizations. It was challenging to identify and implement one phone system that worked for all three organizations, accommodating both cloud-based and hard-wired phone systems. An outpatient scheduling module was also completed. Dozens of staff have been trained in using the new system, including on risk assessments, mobile crisis team dispatch, and the bed registry. To market the new 988 Regional Call Center in preparation of its launch, GBRICS worked with over 100 community outreach partners to distribute marketing materials, disseminated materials and information through the 988helpline.org website, and had a paid media campaign across central Maryland.

Progress was made on enhancing the Prince George's County Response System via technology. During CY 2022, TLC implemented system integration between the 988 Call Center with the mobile response team dispatch module. To advance implementation, in October 2022 the Regional Partnership implemented the dispatch pilot with the Prince George's County Health Department serving as dispatchers to the mobile crisis team. In addition, a 911-988 diversion pilot was rolled out in Prince George's County in October 2022. This includes set-up protocols, call handling criteria, and outcomes measurement. The Regional

Partnership is currently developing standard operating procedures for referring crisis calls to mobile crisis teams.

Mobile Crisis Team Activities and Progress

Mobile crisis team response volume grew dramatically over CY 2022 to divert patients from the ED who do not require a high-level intervention. In Prince George's County, TLC is funding four operating mobile crisis teams. They work in close collaboration with law enforcement and EMS, with standard operating procedures around scene sharing and best practice protocols for the emergency crisis continuum. In October 2022 the Regional Partnership changed the mobile crisis team business model to be standalone, as opposed to part of the call center. This change was motivated by regulation and reimbursement requirements. The change also facilitated the mobile crisis team's increasing workforce. Incorporating dispatch into the mobile crisis team system increased coordination of services. The new standalone mobile crisis team can now receive calls directly instead of having to be routed through the 988 Call Center. After launching the new mobile response times in Fall 2022, in-person and virtual interactions with patients in crisis increased significantly. In CY 2022, monthly dispatches increased from 11 in January to 240 in December, totaling 1178 dispatches. A total number of 1751 patients were served by mobile response teams in CY 2022, growing from 52 in January to 432 in December.

In Central Maryland, several mobile crisis teams went live in May 2023, with more launching in summer 2023 as staff are hired. During CY 2022 GBRICS issued two awards to fund mobile crisis teams. This adds five teams: two shifts seven days per week plus a part-time shift for Baltimore City and Baltimore County coverage; and two shifts seven days per week plus a part-time shift for Howard and Carroll Counties plus additional coverage for Baltimore County. Additional work in CY 2022 included developing protocols on integrating peers into mobile response staffing, responding to third party callers, providing voluntary transportation for higher levels of care, and creating triage process around inclusion of medical or law-enforcement support.

Behavioral Health Sustainability

During CY 2022 Regional Partnerships advanced the sustainability of Catalyst Program behavioral health initiatives. Beginning in CY 2021, Regional Partnerships coordinated with the broad-based effort to establish a statewide mechanism to fund 988 in Maryland. The "Fund Maryland 988 Campaign" brings together more than 70 partner organizations to establish a Maryland 988 Trust Fund. The campaign advocated for legislation during the 2022 and 2023 General Assembly sessions to lay the groundwork for sustainable funding. In 2022, the General Assembly passed legislation to establish a 988 Trust Fund and appropriated $5.5 million for the 988 Lifeline in FY2023. During the 2023 Maryland General Assembly, legislators passed Senate Bill 3/House Bill 271 which require the Governor to appropriate $12 million for the

Trust Fund in the FY 2025 annual budget bill. With continued funding support, the 988 Trust Fund has the potential to financially support crisis services across the state in the long run.

Regional Partnerships are taking action to ensure the programs they implement are aligned with sources of funding for long term sustainability. For example, one 988 Regional Call Center structured its dispatch team to align with the bundled payment structure proposed by Maryland Medicaid to tap into a sustainable revenue source through claims reimbursement. Regional Partnerships are working on an ongoing basis to develop performance metrics for initiatives, ensuring accountability and fidelity to support sustainability.

Behavioral Health Community Partner Engagement

Regional Partnerships recognize the value of conducting meaningful, multi-sector input, as well as the significant dedicated effort it requires. They continued developing and expanding community partnerships in CY 2022. These relationships are vital to communicating the availability of new Catalyst Program services to the public. Regional Partnerships involve local government entities to ensure Catalyst Program efforts complement existing initiatives to develop behavioral health crisis service infrastructure. Key public entities included local government, public safety agencies, and LBHAs.

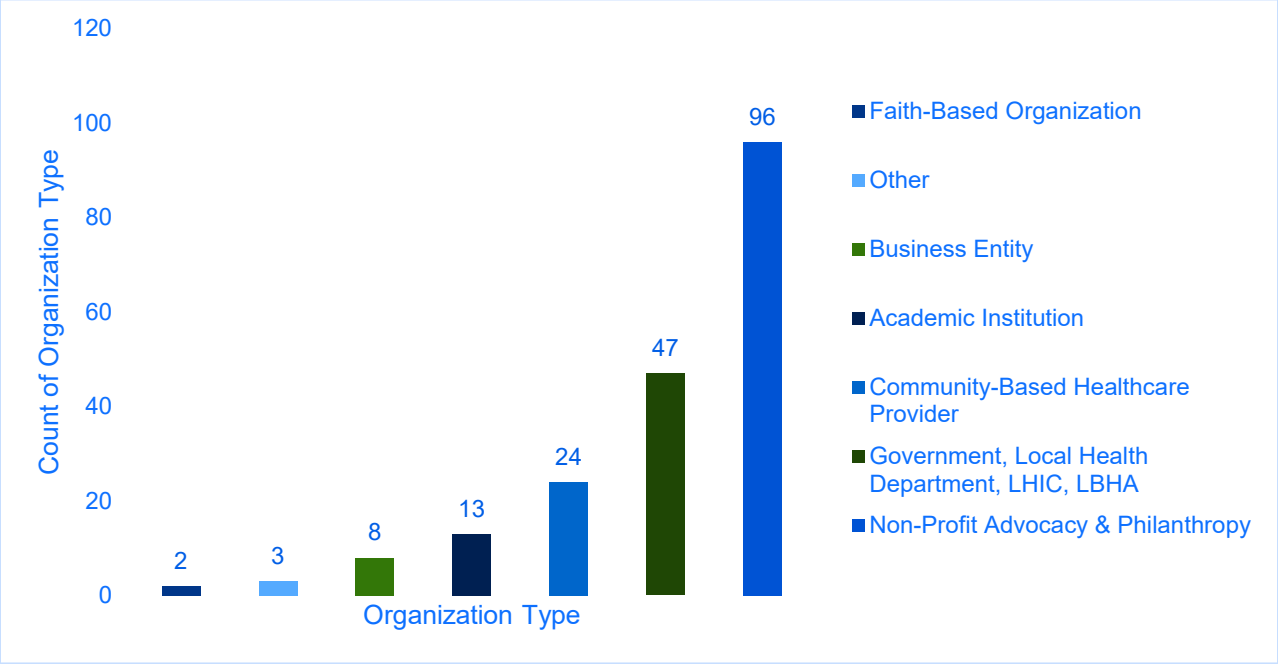
Regional Partnerships have formal governance entities intentionally structured to engage a diverse group of stakeholders in guiding the overall strategy, implementation, and sustainability of initiatives. Collaborations helped for example to achieve continuity of care with warm handoffs for patients in crisis, collaboration on individualized patient treatment plans, and support in develop of crisis stabilization center policies and procedures.

During CY 2022, one Regional Partnership issued a comprehensive community engagement report resulting from community roundtables and surveys. Key insights included the importance of overcoming skepticism toward the system of care and rebuilding trust with communities. This Regional Partnership also launched a 988 Community Ambassador program in CY 2022 to enlist community leaders in 988 education and outreach. Ambassadors represent leaders ranging from barbers to faith leaders.

Partner engagement also helped provide continuity of care amidst the changing behavioral health provider landscape. In CY 2022 a large mental health agency stopped providing services, creating treatment gaps. The Regional Partnership's crisis stabilization center worked with the LBHA to coordinate care and meet the needs of patients who had been left in the gap. Another example of collaborative partnership is between the Regional Partnership and the county school system and Board of Education to develop a referral pathway for high need students.

Figure 5 below shows the breadth of community partners in behavioral health crisis services Regional Partnerships. There were 193 community partners. The most prevalent category was 96 non-profit advocacy or philanthropy organizations. Local public entities comprised 47 community partners, followed by 24 community-based healthcare providers.

Figure 5. CY 2022 Behavioral Health Community Partners



Source: Regional Partnership Annual Reporting, CY 2022

Catalyst Program Budget and Expenditures Summary

Regional Partnership expenditures for CY 2022 are shown in Table 10. Total expenditures across all Regional Partnerships were approximately $27.4 million. The largest category was workforce, with approximately $12.3 million in expenditures. Approximately $9.7 million was spent on other implementation activities, operations, and indirect costs; approximately $1.3 million was spent on IT/technology, and approximately $2.1 million was spent on wraparound services.

Table 10. Regional Partnership CY 2022 Expenditures

	Regional Partnership	Expenditures by Category	Total Expenditures
Diabetes Prevention and Management	**Baltimore Metropolitan Diabetes Regional Partnership**	• Workforce expenditures: **$4,727,858** • IT services: **$114,411** • Wraparound services: **$126,501** • Other implementation activities, operations, and indirect costs: **$2,009,579**	**$6,978,349**
	Western Regional Partnership	• Workforce expenditures: **$2,436,061.71** • IT services: **$284,773.25** • Wraparound services: **$424,585.33** • Other implementation activities and indirect costs: **$323,768.34**	**$3,469,188.63**
	Totally Linking Care	• Workforce expenditures: **$257,218.67** • IT services: **$262,515** • Wraparound services: **$90,100.10** • Other implementation activities and indirect costs: **$662,398.84**	**$1,272,232.61**

	Saint Agnes and Lifebridge	• Workforce expenditures: **$552,894.52** • IT services: **$0** • Wraparound services: **$73,804.44** • Other implementation activities and indirect costs: **$41,652.39**	**$668,351.35**
	Full Circle Wellness	• Workforce expenditures: **$218,837.07** • IT services: **$708.56** • Wraparound services: **$62,180.86** • Other implementation activities and indirect costs: **$181,770.36**	**$463,496.85**
Behavioral Health Crisis Services	**Greater Baltimore Region Integrated Crisis System**	• Workforce expenditures: **$2,339,279.23** • IT services: **$326,000** • Wraparound services: **$964,169.35** • Other implementation activities and indirect costs: **$1,501,191**	**$5,130,639.58**
	Totally Linking Care	• Workforce expenditures: **$395,917.85** • IT services: **$202,312.71** • Wraparound services: **$343,620** • Other implementation activities and indirect costs: **$6,554,030.14**	**$7,495,880.70**
	Tri-County Behavioral Health Engagement (TRIBE)	• Workforce expenditures: **$1,350,597.49** • IT services: **$127,919.15** • Wraparound services: **$0** • Other implementation activities and indirect costs: **$406,523.96**	**$1,885,040.60**
		Total Expenditures	**$27,363,179.32**

Source: Regional Partnership Annual Reporting, CY 2022

HSCRC staff is in the midst of conducting financial audits of all Regional Partnership spending to verify expenditures. As with all other special funding programs, any unspent funds are removed from hospital rates.

Catalyst Program Health Equity Efforts

Both the diabetes and behavioral health Regional Partnerships intentionally keep health equity at the forefront of activities. Regional Partnerships are purposeful in the selection of community-based partners to reflect the culture, language, and demographics of target populations and gain insight on how to best customize materials and activities for different cultures. For example, one Regional Partnership's 988 Community Ambassador Program is designed to build community trust through partnership with key community leaders. Ambassadors provide essential feedback on CALL 988 marketing and promotion strategies, ensuring incorporation of representative imagery and messaging.

Screening for SDOH is a core element of the Regional Partnerships. As a routine part of intake and throughout program activities, participants are assessed for a variety of SDOH and connected to available resources via teams including nurses, social workers, CHWs, and peer recovery specialists. One Regional Partnership is partnering with local ethnic grocers to offer healthy food vouchers and assess risk.

Regional Partnerships weave equity considerations into staffing and procurement considerations, for example to recruit diverse and bilingual staff. An increasing number of Spanish-speaking diabetes

educators have been hired to offer more DPP and DSMT/ES classes in Spanish. Regional Partnerships provide interpreter services and services for individuals with hearing impairment. Staffing strategies included hiring more community health workers reflective of communities served, pursuing grant funding to hired behavioral health peer support specialist, and developing mobile crisis leadership and service providers who are diverse with respect to gender, race, ethnicity, and sexual orientation given that culture matching can mitigate stigma mitigation and help build rapport in crisis situations.

Staff trainings include topics such as motivational interviewing, cultural humility, and anti-racism. Regional Partnerships also described their efforts to promote diversity through procurement, for example prioritizing organizations with strong connections to their local communities that incorporate feedback from the people they serve into their quality improvement efforts, value the roles of people with lived experience, and include small and grassroots efforts. Selecting locally owned minority businesses was another strategy reported.

Regional Partnerships conduct analyses to identify the specific areas and communities experiencing health disparities. This involves working with community partners to understand the root causes of disparities. Regional Partnerships prioritize historically excluded and marginalized communities for marketing and outreach, for example with health fairs and a mobile integrated health visitation program. Regional Partnerships designed their tracking systems to stratify populations by a variety of parameters to facilitate understanding of how services are reaching different populations.

Other health equity efforts address different modes of service delivery. For example, DPP classes were designed to be held virtually to remove transportation barriers and are offered both day and evening to increase accessibility to different populations. Regional Partnerships promote wholistic well-being. Examples include delivery of behavioral crisis center services through a behavioral health visit within the primary care office. In addition, Diabetes 101 was offered by a Regional Partnership as a free community workshop on basic diabetes education targeting the un- and underinsured.

Conclusion

During CY 2022 the Regional Partnerships made significant progress in expanding service delivery. Regional Partnerships tackled the complexity of standing up new programs across a large set of partners and different healthcare delivery systems. Looking ahead, Regional Partnerships highlighted some challenges, the most significant of which is recruiting and maintaining staff. Other challenges include navigation of changing federal and state requirements, technical barriers to billing and service reimbursement, and the intensifying behavioral health needs among children and youth which requires a different type of expertise than adults. Regional Partnerships will continue to promote provider awareness and build relationships with commercial insurers and Medicaid MCOs.