Attachment A

FY21 Scope of Services & Deliverables

Totally Linking Care in Maryland, LLC (TLC-MD)

Totally Linking Care in Maryland (“Subrecipient” or “TLC-MD”) is a non-profit organization based in Prince George’s County, Maryland. TLC-MD is comprised of a team of more than 50 providers, outpatient services, local health departments, community organizations and residents – all focused on working together to identify solutions that help better coordinate medical care. Team members include: University of Maryland Capital Region Health; Doctors Community Hospital; Fort Washington Medical Center; MedStar Southern Maryland Hospital Center; Med Star St. Mary’s Hospital; Area Agencies on Aging; Maryland State Medical Society and Primary Care Providers; Prince George’s County Health Department; and Calvert County Health Department.

TLC-MD shall provide services under this Agreement to assist PreventionLink in fulfilling the goals outlined in requirements of the Innovative State and Local Public Health Strategies to Prevent and Manage Diabetes, Heart Disease, and Stroke, Grant Number 1817 from the Centers for Disease Control and Prevention (CDC) as follows:

1. Participate in the PreventionLink Community of Practice.
2. Expand new and existing CDC-recognized type 2 diabetes prevention programs.
3. Advise on modification and marketing of a hypertension app (CDC Strategy B7).
4. Enhance referrals, participation, and adherence for DSMES telehealth services.
5. Enhance referrals, participation, and adherence for cardiac rehabilitation services.

Specific Activities shall include the following:

Task 1: Participate in the PreventionLink Community of Practice
TLC-MD will send clinical and/or administrative representation to the PreventionLink Community of Practice (CoP) meetings to share best practices and lessons learned as the project progresses. The meeting schedule will be once a quarter (in-person) or via teleconference.

Task 2: Provide data and information from Health Systems and practices to support program planning and evaluation

A. Provide required monthly financial and PreventionLink reports on the first of each month and a biannual report at the middle and the end of the contract period.

Task 3: Provide access to hospital ambulatory systems and practices to implement project innovations and ensure completion of specific project deliverables by health systems partners.

A. Engage in bi-directional e-referrals (A1, A2, B6), by:
    a. Overseeing the training of hospital ambulatory systems and practices on how to increase referrals to the DPPs, DSMES telehealth and cardiac rehabilitation programs.
    b. Launching the DPPs and providing technical assistance.

Task 4: Oversee Community Health Worker (CHW) services related to the project, including training and integration of CHW services into hospital ambulatory systems. (A1, A2, A6, A7, B5, B6, B8)

A. Sub-contract with AccessHealth to leverage existing CHW organizations in the project area.
B. Ensure development of referral protocols for CHW services and oversee training of CHWs.
C. Ensure integration of CHWs into workflows at hospital ambulatory systems (including cardiac rehabilitation programs).
D. Assign CHWs to patients identified by the PreventionLink CRS (Central Referral System).
E. Collect and provide data to evaluators regarding the impact of CHW intervention.
F. Advise on development of CRISP-enabled case management technology and equip and train necessary providers with the program.

Task 5: Expand new and existing CDC-recognized type 2 diabetes prevention programs
Sub-contract with new and existing CDC-recognized type 2 diabetes prevention programs to expand services to cover areas identified as gaps in program planning.

Task 6: Lead all activities involving practice transformation of clinical practice among health system partners:

A. Implement systems to facilitate bi-directional e-referrals between practices, DSMES, cardiac rehabilitation and the National DPP lifestyle change programs. (A1)
    - Recruit second cohort of 20 practices to collaborate on bi-directional e-referrals to National DPP programs (HQI) by 9/28/21. (A1)
    - Monitor the feedback loop from the National Diabetes Prevention Program (National DPP) Lifestyle Change Programs (LCPs) to the 21 practices about the referrals the practices are making to the LCPs via the CRISP Unified Landing Page by 9/28/21. (A1)
B. Support organizations in increasing enrollment in existing CDC- recognized lifestyle change programs or establishing and sustaining new CDC recognized lifestyle change programs in underserved areas. (A2)
    - Establish annual funding priority and budget allocations; provide application materials and process for new DPPs to apply for funding; Implement systems to track and monitor enrollment of patient cohorts at the program level by 9/28/21. (A2)
    - Implement the virtual program. Assess contract performance with selected vendor in Year 3. Determine vendor effectiveness in increasing patients' timely access to National DPP enrollment; Determine if additional vendor is needed by 3/31/21. (A2)
    - Monitor and implement the approved VBP with the number of NDPPs LCPs by 9/28/21. (A2)
    - Procure a contractor to deliver virtual programming as a supplement to in-person classes within 30 days of contract signing by 03/31/2021. (A2)
C. Support advanced training for lifestyle coaches working at CDC-recognized lifestyle change programs to strengthen skills needed to engage and retain participants. (A4)
    - Provide advanced training courses for lifestyle coaches by 9/28/21. (A4)
    - Implement the training as determined by the capacity of the vendor(s) to deliver priority curriculum content by 9/28/21. (A4)
D. Explore and test innovative ways to eliminate barriers to participation and retention in CDC recognized lifestyle change programs for type 2 diabetes prevention and/or ADA-recognized/ADCES-accredited diabetes self-management education and support (DSMES) services for diabetes management among high burden populations. (A5)
    - Start a few programs at different times on different days of the week by 5/31/21. (A5)

- Provide DPP classes virtually (online or distance learning) as a supplement to in-person classes by 9/28/21. (A5)

E. Work with health care systems to establish or expand use of telehealth technology to increase access to ADA-recognized /ADCES-accredited DSMES programs for diabetes management and CDC recognized lifestyle change programs for type 2 diabetes prevention. (A6)
   - Confirm and engage second rural telehealth site by 2/28/21. (A6)
   - Offer broadcast DSMES classes with additional support from PGCHD by 5/31/21. (A6)

F. Increase adoption and use of clinical systems and care practices to improve health outcomes for people with diabetes. (A7)
   - Conduct outreach to targeted list of prospective practices by 9/28/21. (A7)

G. Explore and test innovative ways to enhance referral, participation, and adherence in cardiac rehabilitation programs in traditional and community settings, including home-based settings. (B8)
   - If feasible, support access to Home-Based Cardiac Rehabilitation (HBCR) cardiac rehab by 9/28/21. (B8)

Deliverables Schedule

1. Submit Biannual Reports by 4/30/21 and 10/15/21.
2. Recruit and engage a cohort of 20 clinical practices by 9/28/2021. (A1)
3. Identify potential practices to approach for engagement by 2/28/21. (A1)
4. Monitor the feedback loop from the National Diabetes Prevention Program (National DPP) Lifestyle Change Programs (LCPs) to the 20 practices to identify and/or address issues for quality improvement 9/28/21. (A1)
5. Conduct outreach to targeted list of prospective practices by 3/31/21. (A1)
6. Secure commitments of 10 practices to participate in PreventionLink by 6/30/21. (A1)
7. Secure commitments of an additional 10 practices to participate in PreventionLink by 9/28/21. (A1)
8. Participate as necessary with training practices on referral protocols by 2/28/21. (A1)
9. Support in assessing EMR features of enrolled practices to determine if/how primary care physicians utilize the EMRs to identify patients who are eligible for the National DPP by 3/31/21. (A1)
10. Support the continuing integration of CHWs into the bi-directional e-referral system workflow for the Year 3 cohort by 1/31/21. (A1)
11. Increase the number of Brick and Mortar National Diabetes Prevention Program Lifestyle Change Programs (NDPP LCPs) from 14 to 17 (an additional three DPPs) in Southern Maryland. (A2)
12. Monitor enrollment of patient cohorts at program level by 2/28/21. TLC-MD will collect data from the DPPs that will enable the project to compare enrollment vs. actual participation in DPPs. (A2)
13. Recruit one or more of the additional NDPP LCPs from St. Mary's, Charles, or Calvert Counties by 4/30/21. (A2)
14. Develop billing workflow by 2/1/2021. (A2)
15. Provide training and technical assistance to site staff on referral protocols and billing by 9/28/21. (A2)

16. Facilitate interaction and communication with NDPP LCPs through one-on-one check-ins, phone calls, emails, monthly group meetings to provide technical assistance, share best practices and address barriers by 9/28/21. (A2)
17. Monitor and assess the delivery of virtual programming for NDPP LCP by 5/31/21. (A2, A6)
18. Enroll 100 participants in the Eat Smart Move More Prevent Diabetes Program (ESMMPD) NDPP LCP online program by 9/28/21. (A2)
19. Participate in the implementation of NDPP LCP online program via RT web-based platform by 4/30/21. (A2)
20. Assess annual training needs of Lifestyle Coaches by 4/30/21. (A4)
21. Procure a Year 3 service agreement with provider for advanced Lifestyle Coach training by 3/31/21. (A4)
22. Implement the advanced training courses as determined by the needs and training priorities by 9/28/21. (A4)
23. Provide training and technical assistance to site staff on billing by 9/28/21. (A6)
24. Support DSMES telehealth services in one rural site by 6/30/21
25. Participate in the implementation of DSMES telehealth services via RT web-based platform by 9/28/21. (A6)
26. Confirm logistics for training and technical assistance by 3/15/21. (A6)
27. Provide training and technical assistance to site staff on the telehealth service protocols by 4/15/21. (A6)
28. Support in engaging practices, conducting preliminary assessments of EHR capabilities and connectivity to CRISP and confirm logistics for transformation activities by 4/30/21. (A7)
29. Support in implementing practice transformation activities by 9/28/21. (A7)
30. When feasible, support in conducting virtual interprofessional team rounds within the practices for selected high-risk patients by 9/28/2021 (B3)
31. When feasible, participate in virtual care teams when service delivery is by telephone or telehealth to ensure collaboration between the pharmacists, CHWs, and other members of the health care team to improve patient's medication adherence by 9/28/21. (B4)
32. Identify barriers and opportunities for CHW integration in Year 3 practice operations by 9/28/21. (B5)
33. Support in providing technical assistance to practices and CHWs on effective integration of CHWs in clinical workflows through the CoP by 9/28/21. (B5)
34.
35. Support alternative care models for CR by assisting CR programs in development and implementation of Home-based Cardiac Rehabilitation (HBCR) programs (if reimbursement available) or provide additional resources (i.e. educational materials and medical devices) for patients who choose to exercise at home. by 9/28/21. (B8)
36. Provide support to CR programs to increase referrals utilizing the Cardiac Rehabilitation Change Package and/or the Takeheart Initiative by 9/28/21. (B8)
37. Working with primary care practices, assist with the recruitment of 40 patients for the cardiac rehab program by 9/28/2021.
38. Ensure that CHWs support participants and provide resources in response to identified barriers. The referrals, participation and adherence will be tracked by the Central Referral System (CRS).
39. Advise on modification and marketing of a hypertension app (B7).

Deliverables Schedule (Access Health)

1. Conduct patient assessment to identify and track barriers to DPP participation by 3/31/21. (A5)
2. Receive e-referrals from practices by 9/28/21 and process (A5):
    a. Program Coordinator completes initial screening and assigns CHW.
    b. CHW conducts outreach, schedules home visit, and provides care coordination and resource connection to DPP and services.
    c. CHW provides ongoing support and motivation to clients, promoting appropriate health seeking.
3. Assist patients with addressing barriers by applying evidence-based pathways by 9/28/21. (A5)
4. Program Coordinator and CHWs document all contacts, encounters and visits in the Care Coordination System by 9/28/21. (A5)
5. Implement new strategies identified by the Community of Practice (CoP) and PL Project Team by 9/28/21. (A5)
6. Deploy Community Health Workers (CHWs) to conduct SDOH Risk Assessment to identify the patient's social and family risk factors, such as overweight, unhealthy diet, too much salt intake, alcohol use, low physical activity, smoking and stress by 9/28/21. (B3)
7. Implement the HTN pathway to provide health literacy education and motivational support to promote lifestyle changes to reduce risk factors by 9/28/21. (B3)
8. Connect patients to community resources by 6/30/21 to help reduce risk factors (B3), such as:
    a. Smoking Cessation
    b. Healthy Eating/Active Living Classes
    c. Exercise programs
    d. Stress reduction programs and activities.
    e. BP monitoring training
9. Document visit outcomes and patient contacts in care coordination system by 9/28/21. (B3)
10. Increase the number and percentage of patients receiving team-based care by 9/28/21. (B3)
11. Deploy CHWs to implement the pathway and assist MTM team with telehealth technology for the targeted patients by 9/28/21. (B4)
12. Document visit outcomes and patient contacts in care coordination system by 9/28/21. (B4, B5)
13. Deploy CHWs to implement the Pathways, identify patient barriers, develop care plans to address barriers and provide ongoing health literacy education and motivational support to promote lifestyle changes for managing hypertension and cholesterol by 9/28/21. (B5)
14. Achieve a fifty percent increase in the number and percent of patients within clinical and/or community settings that engage with CHWs or community navigators who link patients to community resources and additional health information and tools that promote management of high blood pressure and high cholesterol by 9/28/21. (B5)
15. Assign CHW to monitor the bi-directional e-referrals to ensure patients are connected with adequate resources and their social determinant needs are addressed by 9/28/21. (B6)
16. Deploy CHWs to implement the Pathways, identify patient barriers, develop care plans to address barriers and provide ongoing health literacy education and motivational support to promote lifestyle changes for managing hypertension and cholesterol by 9/28/21. (B6)
17. Continue to participate in virtual care teams when service delivery is by telephone or telehealth to ensure collaboration between the pharmacists, CHWs, and other members of the health care team to improve patient's medication adherence by 9/28/2021 (B4)