Nexus Montgomery Regional Partnership
Diabetes Catalyst Grant – Referral Case Management
Request for Consulting Proposals

The Nexus Montgomery Regional Partnership (NMRP) is pleased to send this request for proposals (RFP) to procure a Referral Management partner for diabetes education programs. This initial 18-month project aims to provide immediate referral coordination, while also developing and implementing a new model for more intensive risk assessment, case management, and ongoing support to diabetes education partners. This model will be assessed as a workplan for the following three years as the program scales-up. This RFP provides key background information, a starting framework, and requested requirements for a proposal.

If you have questions or require additional information, please contact, Shawn Sullivan, Shawnda_Sullivan@primarycarecoalition.org

Background:

Nexus Montgomery Regional Partnership (NMRP)

NMRP is a collaborative of all six hospitals in Montgomery County, Maryland working with community partners to promote health, reduce hospital utilization and manage total cost of care for our shared community in ways that no single hospital could achieve on its own.
. The hospitals, representing four health systems are: Shady Grove Medical Center and White Oak Medical Center (Adventist Health Care), Holy Cross Hospital and Holy Cross Germantown Hospital (Holy Cross Health), MedStar Montgomery (MedStar), and Suburban Hospital (Johns Hopkins). Funded initially through a competitive award from the Health Services Cost Review Commission (HSCRC), in 2021 NMRP was awarded a Catalyst grant to expand access the Diabetes Prevention Program (DPP) for prediabetic residents and Diabetes Self-Management Training (DSMT) for residents with a diagnosis of diabetes. NMRP has a management contract with the Primary Care Coalition (PCC) which provides the staff and resources to support the collaborative.

Diabetes Programs
Between 2021 and 2025, the NMRP will expand participation in the DPP program to reach over 20% of the estimated prediabetic population while also recruiting over 50% of Medicare beneficiaries with diabetes hospitalization into the DSMT program. Currently, only a handful of county residents participate in these programs.
These diabetes education programs are intensive, with DPP lasting 12-to-24 months and DSMT offering up to 10 hours of education in the first twelve months. One of the primary challenges for diabetes educators is recruitment and retention. It is difficult for educators to find patients ready to commit to the program and to maintain participation throughout.
NMRP will support community-based providers to expand existing DPP and DSMT programs, develop new programs, improve outcomes for participation, and establish a consistent flow of residents to participate in the programs. A key component for this work will be a system of centralized referral management, directed and executed by the Referral Management partner. Rather than expecting referral sources such as community physician practice, community-based service providers to know the details of program availability, scheduling, and locations for dozens of diabetes education programs, they will only have to refer to Nexus Montgomery Diabetes Program. Clinical referrals will be received through the CRISP eReferral portal. Community referral may be received via secure email/fax or other method and require the Referral Management partner to input the referral into the CRISP eReferral portal. The Referral

Management partner will follow-up with each referred resident to confirm eligibility, assess which diabetes education program is most appropriate for them and ensure that the resident is connected to the appropriate community education provider for enrollment in the education programs.
As the program grows, the NMRP team expects to work with the Referral Management partner to develop and implement new tools to support patient recruitment and retention. After the first eighteen months, NMRP will renew a contract for referral management for the final three years based on the program structure developed.

Suggested Activities & Timeline:

CY2021 : July 2021-December 2021

- Provide immediate follow-up support for all referrals to DPP and DSMT. Contact referred patient to confirm eligibility and review class options. Determine best option based on language, referral source, and patient schedule.
  Expected volume: 100-to-200 referrals/month from clinical partners using CRISP

- Coordinate community-based referrals that are not entered into CRISP. Residents who recruited for DPP and DSMT outside of the clinical environment will need referral management.
  Expected volume: 50-to-100 referrals/month

- Communicate back to the referral source by updating the CRISP Unified Landing Page for each referred patient at initial acceptance or rejection into a program and upon completion of referral management.

- Provide monthly activity reports to the NMRP team.
  Include the following data: referrals received, follow-up status, stratified by referral source, zip code, and payer. Develop new reports as requested.

- Work with NMRP team to develop a referral guide for local DPP and DSMT programs as well as related services (DSMP, food assistance, cardiovascular health education, support groups, etc.).
  Integrate referral guide into patient engagement process.

- Develop and pilot risk assessment tool for patients referred to DPP, identifying social barriers and priorities for long-term follow-up.
  Integrate risk assessment into referral management process.

- Meet regularly with NMRP Staff to review progress, identify barriers and challenges, and update resource lists.

CY2022: January 2022-December 2022

- Scale-up referral management activities as the program grows.
  Expected volume: 350-to-500 CRISP referrals per month and 100-250 community-based referrals per month.
  If the program scales at a faster or slower pace, review staffing plan to maintain appropriate case load for referral management.

- Throughout the scale-up, continue to implement the referral guide and risk assessment process, updating as needed.

- With input from DPP health coaches and NMRP team, develop a model for centralized case managers to provide retention support for high-need DPP participants. This may include motivational interviewing, links to services to address barriers to care, and other support to DPP patients.

- Continue to provide monthly reports and meet regularly with NMRP staff to review progress and plan for program growth.

Qualifications:

- Demonstrated capacity to provide referral management and case management services to a diverse population.
- Experience in or commitment to health education, chronic disease management, and chronic disease prevention.
- Demonstrated experience managing protected health information.
- Has staff available or infrastructure in place to readily engage staff to provide direct referral management.
- .

Proposal Requirements and Timing:

- Legal name of firm and key contact information
- Description of firm's history and qualifications
- Listing of all key individuals that will be on the project including role, resume, and expected participation (hours or percent of time)
- Expected case load for referral managers to provide referral support.
- Detailed articulation of the firm's approach to the project.
- Proposed scope of work, work plan, and budget, including proposed approach to flexing up staffing based on referral volume.
- Combined page limit for narrative, workplan, staffing plan, and budget not to exceed 8 pages.

Please submit proposals via email on or before June 30, 2021 to Shawnda_Sullivan@primarycarecoalition.org.