



Making an Impact on Population Health: Utilizing a State-wide Health Information Exchange to Promote the National Diabetes Prevention Program

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Maryland Medicaid

Fiscal Impact

- Approximately \$13.5 billion in state and federal funds
- Typically accounts for about 24% of State budget

Reach

- Provides benefits for approximately 1.7 million people
 - 1.47 million (86%) are enrolled in HealthChoice
 - 427,356 adults are enrolled as a result of the ACA Medicaid expansion

Maryland Medicaid Managed Care Organizations (MCOs)

Under HealthChoice, Maryland requires most Medicaid beneficiaries to enroll in 1 of 9 participating MCOs (including individuals with disabilities and children in foster care):

Aetna Better Health of Maryland

AMERIGROUP Community Care

CareFirst Blue Cross BlueShield Community Plan of Maryland

Jai Medical Systems

Kaiser Permanente

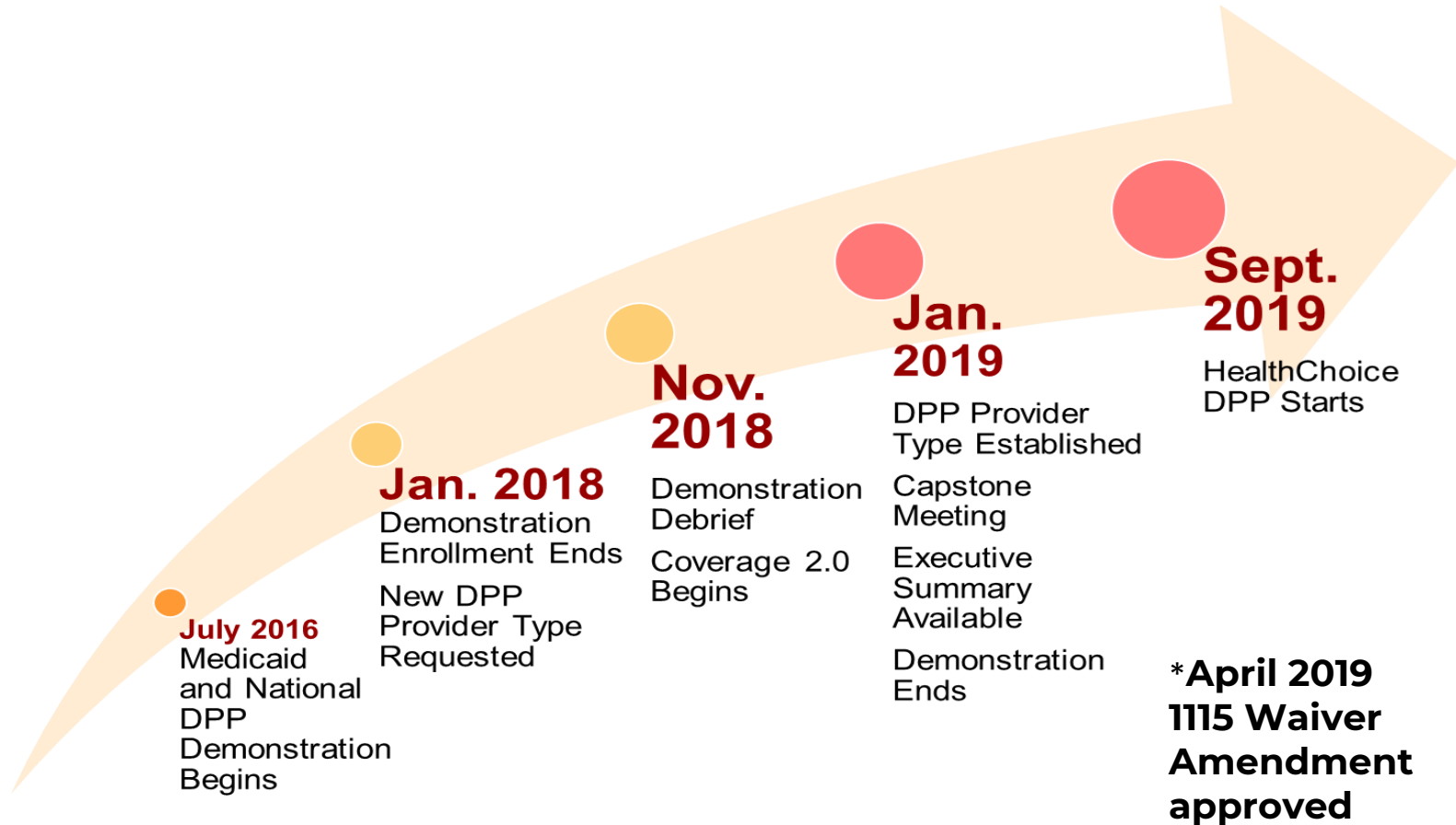
Maryland Physicians Care

MedStar Family Choice

Priority Partners

UnitedHealthcare

Demonstration to Coverage Timeline



HealthChoice DPP

Statewide implementation of the National DPP through HealthChoice MCOs

Required changes to Maryland Medicaid regulations

Built into MCO capitation rates

Aligns with CDC Diabetes Prevention Recognition Program (DPRP) eligibility criteria

Closely aligns with the Medicare Diabetes Prevention Program (MDPP) Expanded Model

Includes both in-person and virtual CDC-recognized organizations

Effective Date: September 1, 2019

Statewide Goals Across Three Domains



Hospital Quality



Total Population Health



Care Transformation Across the System

Hospital Quality

- Reduce avoidable admissions
- Improve Readmission Rates by Reducing Within-Hospital Disparities

Care Transformation Goals

- Increase the amount of Medicare TCOC or number of Medicare beneficiaries under value-based care models*
- Improve care coordination for patients with chronic conditions

Statewide Goals Across Three Domains



Hospital Quality



Total Population Health



**Care Transformation
Across the System**

Total Population Health Goals

- Priority Area 1 (Diabetes): Reduce the mean BMI for adult Maryland residents
- Priority Area 2 (Opioids): Improve overdose mortality
- Priority Area 3 (Maternal and Child Health Priority Area):
 - Reduce severe maternal morbidity rate
 - Decrease asthma-related emergency department visit rates for ages 2-17



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Maryland
DEPARTMENT OF HEALTH

Domain 3: Total Population Health

Priority Area 1: Diabetes

- Identified as a statewide priority by Maryland State Secretary of Health & the statewide ***Diabetes Action Plan*** is now available on MDH website
-

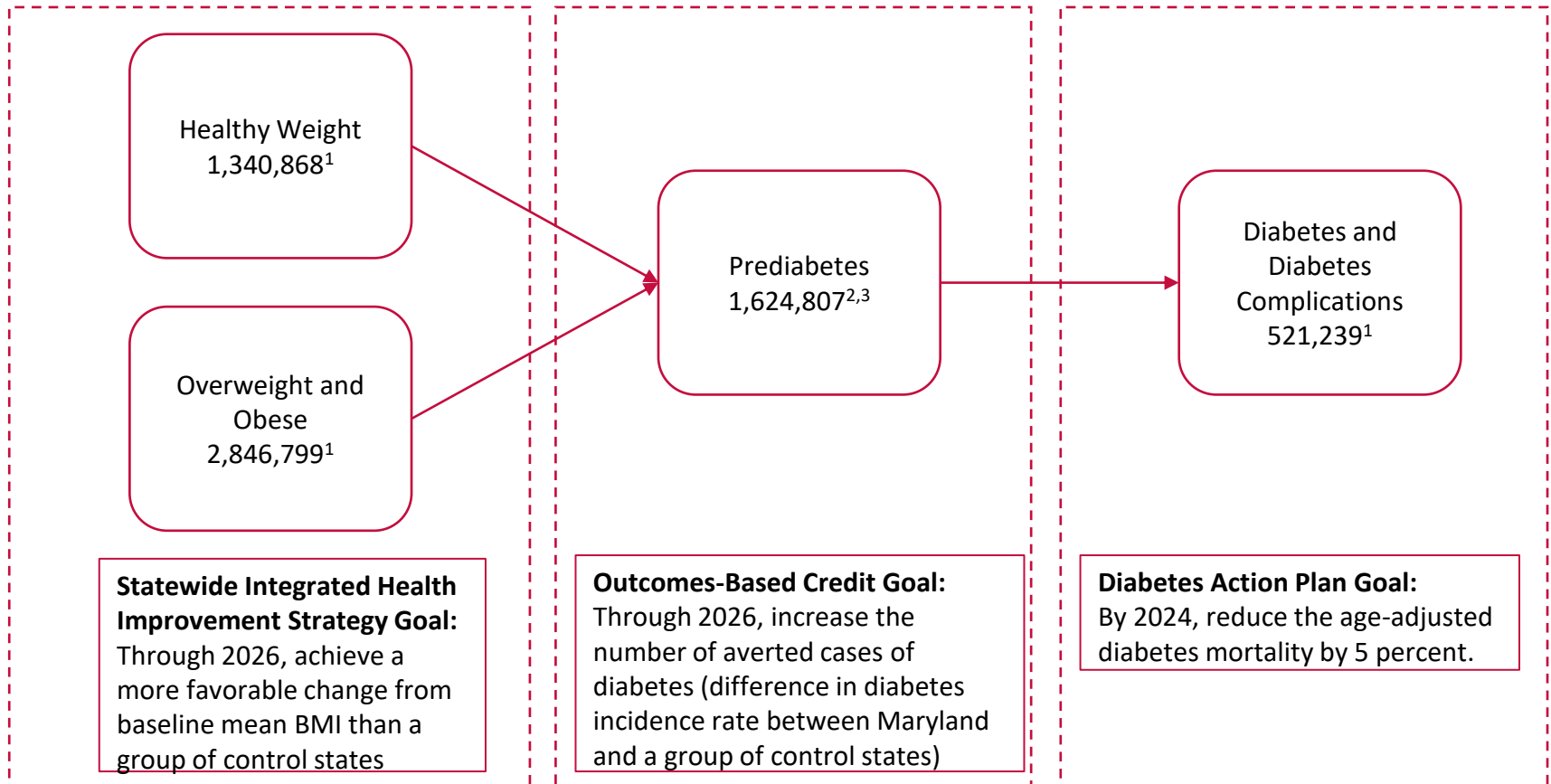
Priority Area 2: Opioids

- Identified as a statewide priority by Lieutenant Governor through the Maryland Heroin and Opioid Emergency Task Force in 2015
 - State of Emergency declared by Governor Hogan in 2017
-

Priority Area 3: Maternal & Child Health

- Maternal and Child Health identified as a SIHIS recommendation by the Maternal and Child Health Task Force formed by House Bill 520/Senate Bill 406

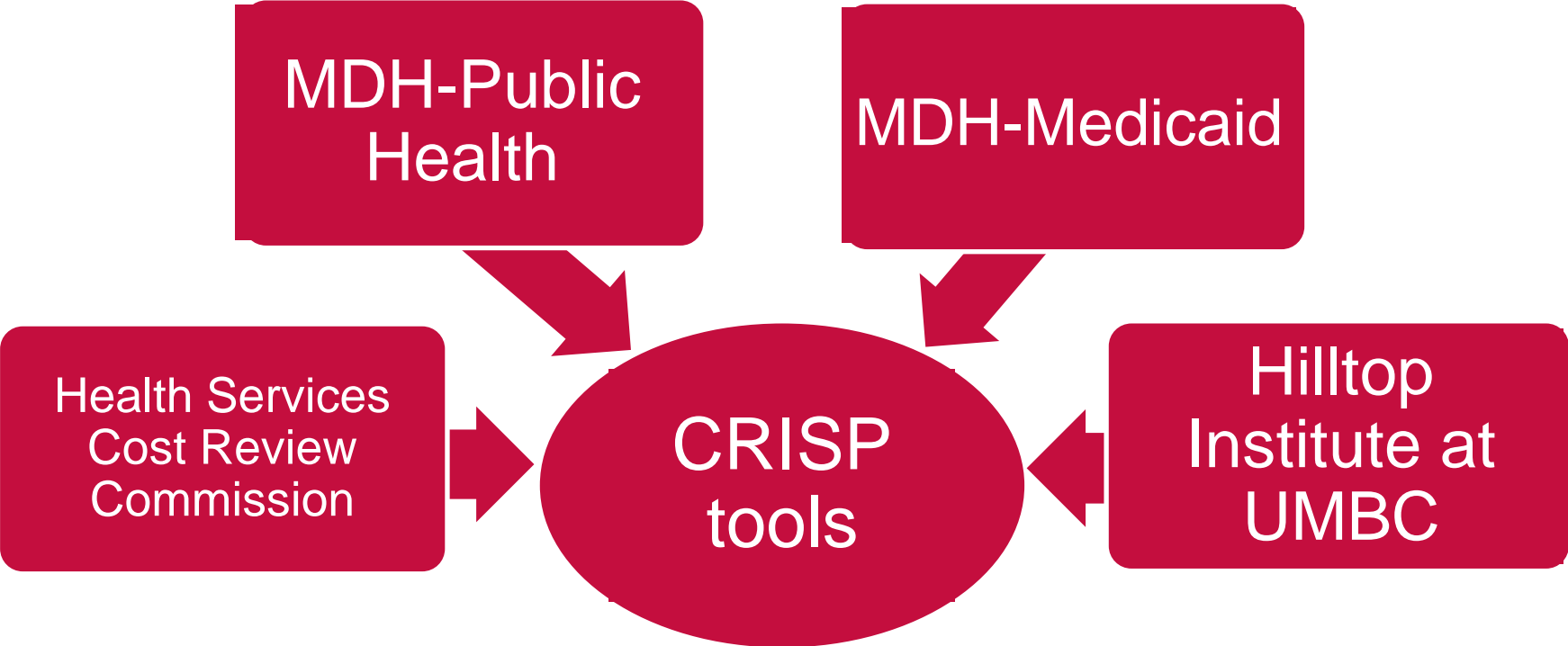
Diabetes Impact



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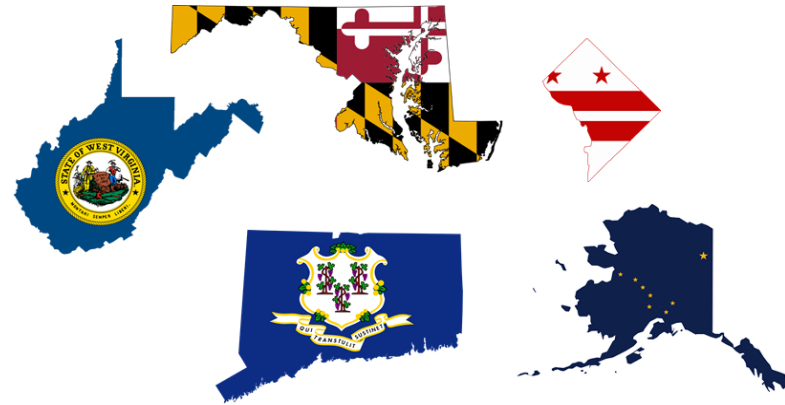
State Agency Collaboration: Prediabetes Flag



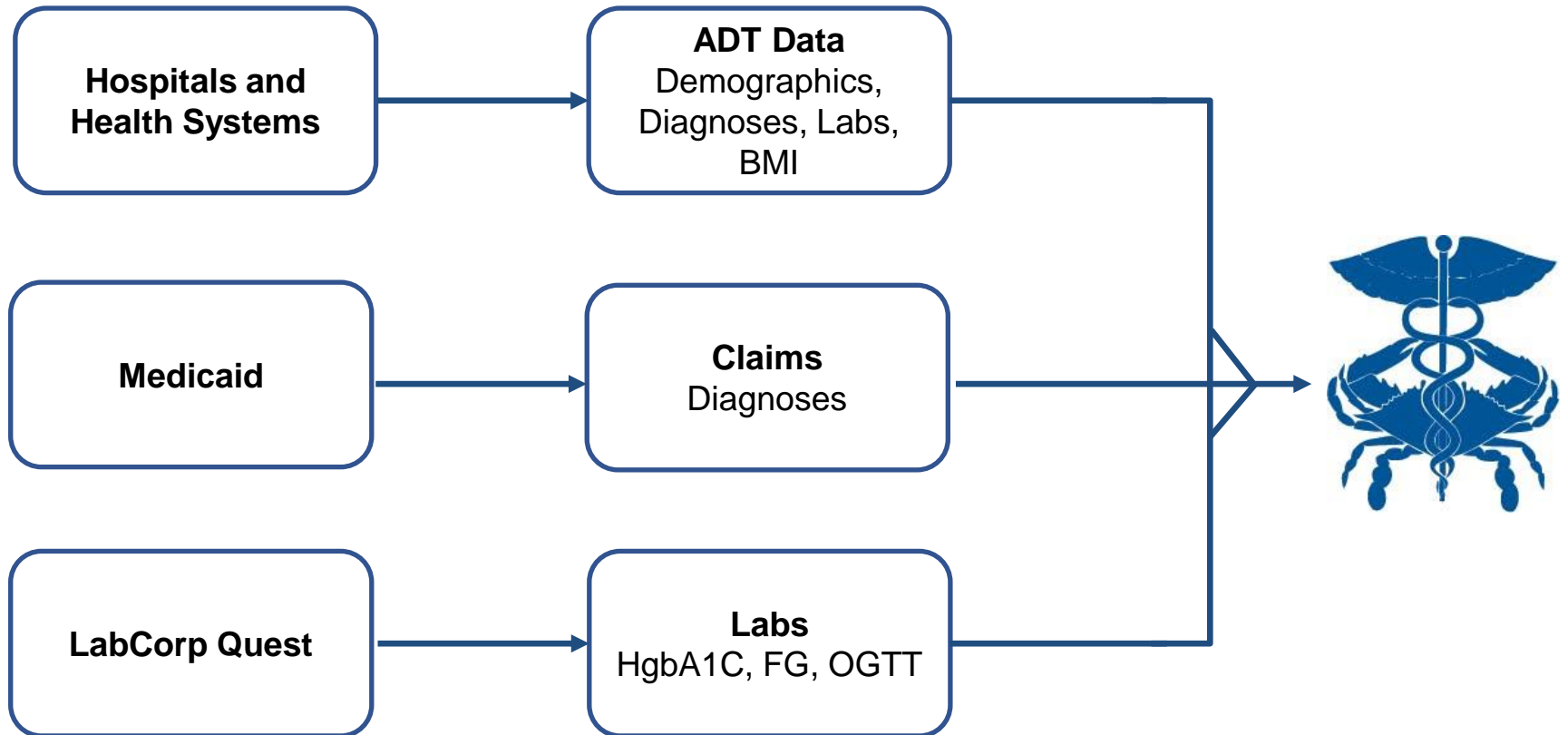
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Regional Health Information Exchange (HIE) serving Maryland, West Virginia, the District of Columbia, Connecticut, and Alaska

Vision: To advance health and wellness by deploying health information technology solutions adopted through cooperation and collaboration.



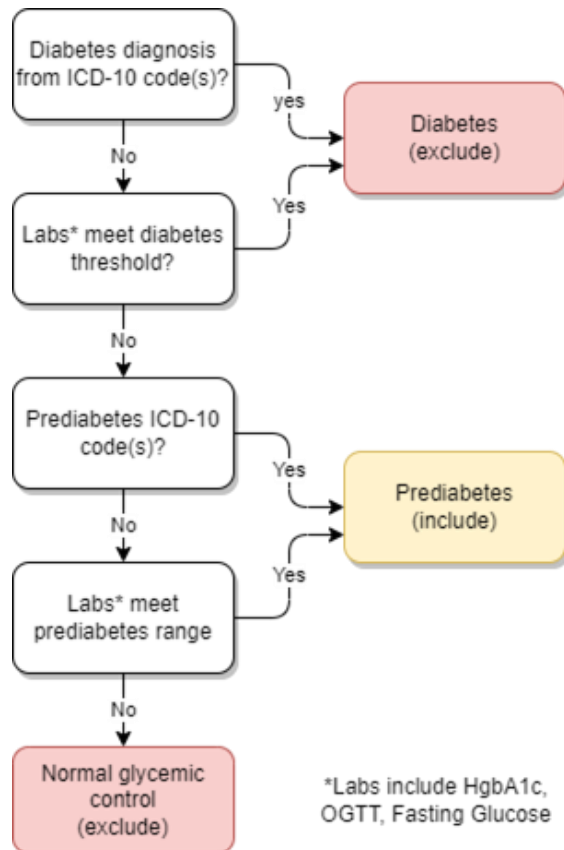
CRISP Data Sources



Identifying Eligible Populations

- **Goal:** Use the available data sets to identify patients who are likely eligible for health choice DPP and ensure appropriate members of the care team know who they are.
- **How:**
 - Two-tiered process:
 - Tier 1: Identify Prediabetes
 - Tier 2: Apply HealthChoice DPP eligibility

Identify Prediabetes and GDM



- Apply American Diabetes Association guidelines to available data
- Gestational Diabetes (GDM) identified using diagnosis codes

Tier 2

Apply HealthChoice DPP Eligibility

HealthChoice DPP adds a layer of eligibility aligned with National Diabetes Prevention Program

- Age
- BMI
- Lab timing



Two distinct populations

- Tier 1 and 2 criteria met
 - Medicaid DPP Eligible
- Tier 1 criteria only
 - Medicaid DPP Eligible Missing Data

Care Alerts

Care Alerts

MEDICAID (2021-05-04)



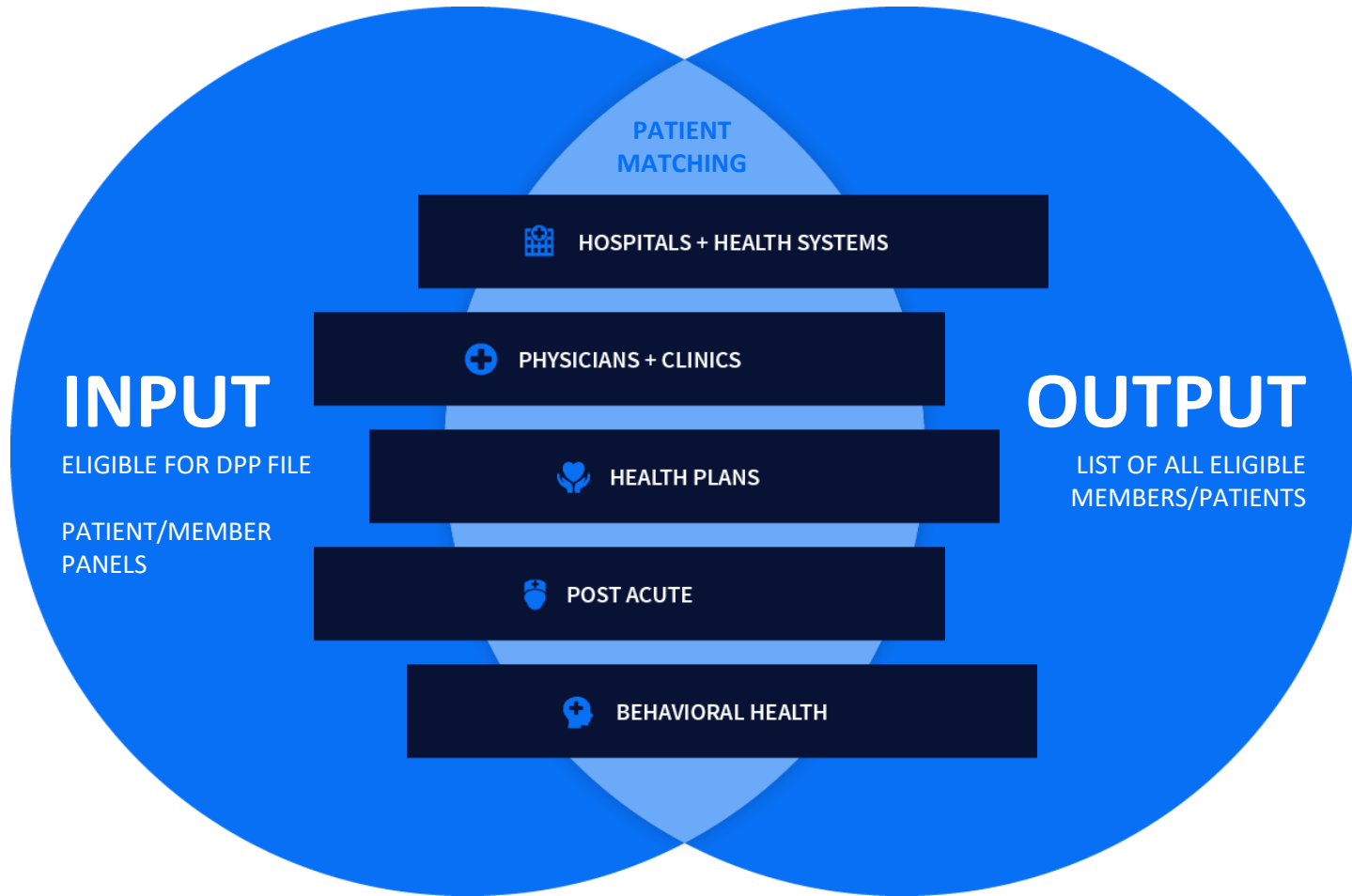
Medicaid DPP Eligibility: This patient likely meets eligibility criteria for the National Diabetes Prevention Program, an evidence-based year-long lifestyle change program designed to prevent or delay the onset of type 2 diabetes. Please note that pregnancy is an exclusion for DPP programming. You may refer this patient by contacting [MCO_name] (<https://mmcp.health.maryland.gov/Pages/HealthChoice-DPP.aspx>), or through the CRISP referral tool. The MCO will help the patient enroll. Please encourage your patient to participate in the program.

CLOSE



Informing the Care Team

ENS - SmartAlerts



Actionable Data

June 2021 went live

~75,000 initially identified

~86,500 active alerts as of
12/31/21

7 MCOs receiving
SmartAlerts

- During the last quarter of 2021, Care Alerts were generated for members of all 9 MCOs as follows:
 - Members who have received a new DPP likely eligible alert: 909
 - Members who have received a new DPP likely eligible but missing data alert: 1750
- Subscribing MCOs receiving monthly, continuously updated SmartAlerts

Actionable Data

Extensible technology like Care Alerts and ENS-SmartAlerts can help identify high priority patient populations

- Leverage existing data sets
- Other Smart Alerts
 - Population health management
 - HIE can help identify populations and send to the most appropriate member of the care team to take action



CRISP e-Referrals

- CRISP identified a need to create a referral system that notifies providers of their patient's program enrollment

Referrals Workgroup

- MDH Center for Chronic Diseases
- Maryland Medicaid
- Health Services Cost Review Commission (HSCRC)
- Maryland Primary Care Program (MDPCP)



DPP Intermediaries

Manual Workflow

Regional Partnerships

- Baltimore Metropolitan Diabetes Regional Partnership
- Nexus Montgomery
- Western Regional Partnership
- Saint Agnes and Life Bridge Diabetes Health Collaborative
- Full Circle Wellness for Diabetes in Charles County
- Totally Linking Care

Medicaid MCOs

- Aetna Better Health of Maryland
- AMERIGROUP Community Care
- CareFirst BCBS Community Plan of Maryland
- Jai Medical Systems
- MedStar Family Choice
- Priority Partners
- UnitedHealthcare

Automated Workflow

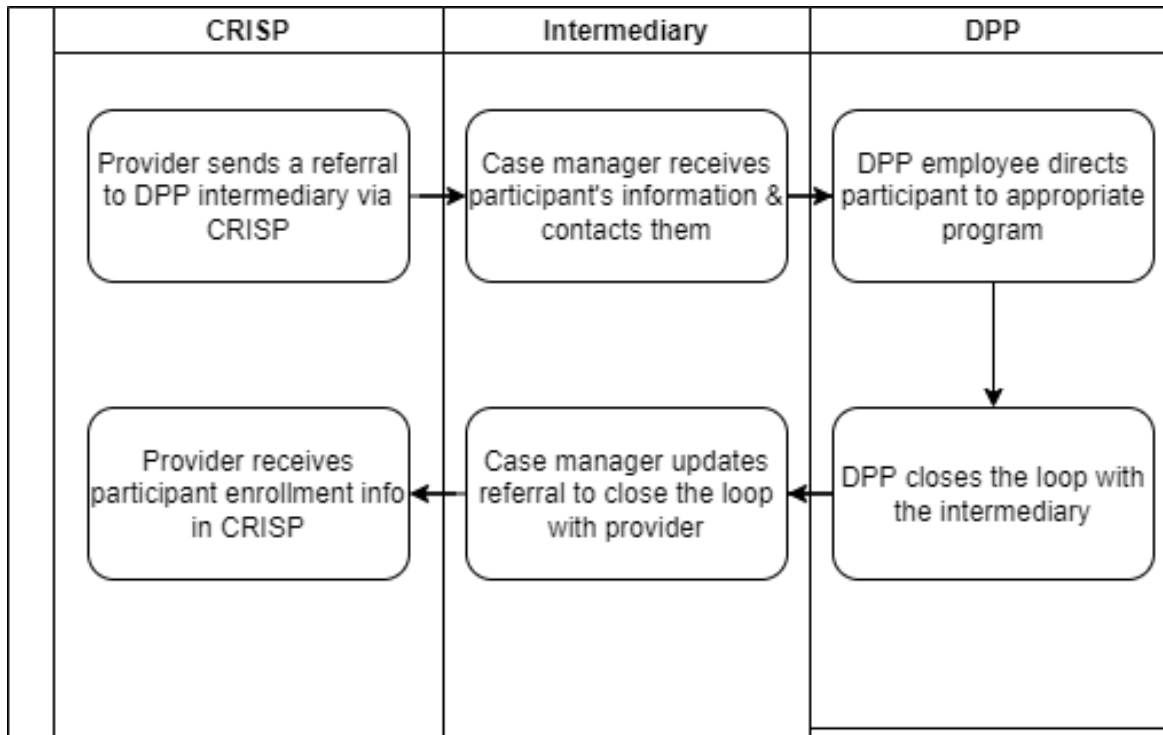
Workshop Wizard Integration



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Manual Workflow



Manual Workflow

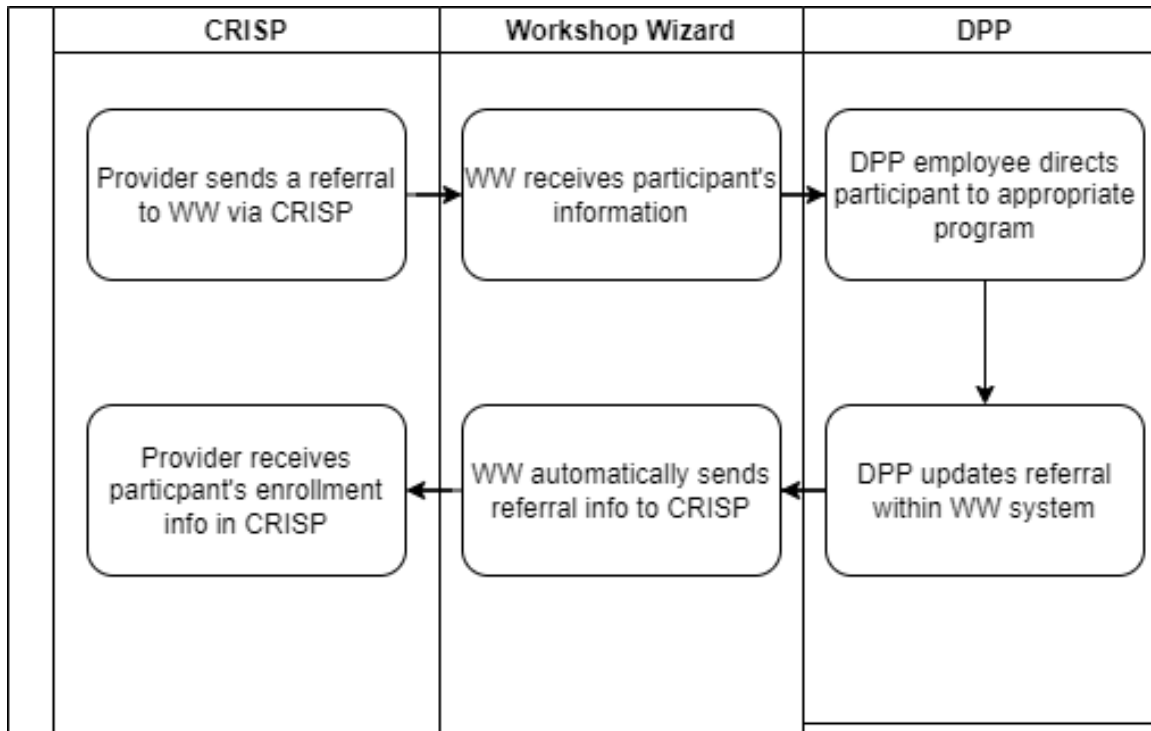
- Manual workflow for intermediary involves case manager working with individuals with prediabetes
- Case manager identifies appropriate program to send individuals to
- Case manager works with DPP to close the loop to referring clinician



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Automated Workflow - Workshop Wizard



What CRISP Sends to WW

- Participant's name, address, contact info
- Provider notes

What WW Sends Back to CRISP

- Enrollment status
- Workshop leader info



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Send Referral to Intermediary

CRISP Program Referral

Patient Information

* First Name: Patone Middle Name: Last Name: Integrations

* Date of Birth (Format MM/DD/YYYY): 01/01/2001

* Home Address 1: 18204 Crisp St * Phone Number: 3015555555 * Type: Mobile

Home Address 2: Alternate Phone Number: Type:

* City: Germantown * State: MD * Zip: 20874 Email: patone.integrations@crisp.st

Patient Vitals

BMI: 31 HbA1c: Blood Pressure: 170/110

Cholesterol: Fasting Glucose: 123 mg/dL

Referring Physician

* Name: Dr. Jones

Referral Program

* Organization: Medicaid DPP - Aetna Better Health of Mary * Programs: Diabetes Prevention Program

Referrals Webform

- Referral Webform captures patient demographics and clinical information
 - BMI
 - HbA1c
 - Blood pressure
 - Cholesterol
 - Fasting glucose
- Intermediary identified



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Intermediary Manages Referral

Auto Reject

Referrals Overview

Look up Referral

Name (last, first)	Gender	DOB	Doctor	Health Org.	Ref. Date ↓	Referral Status
GRAPE, GILBERT		Jan 1, 1984	Tiffany Younger	CRISP Internal Users - Break Glass	May 17, 2022	Pending
GRAPE, GILBERT		Jan 1, 1984	Tiffany Younger	CRISP Internal Users - Break Glass	May 13, 2022	Pending
GRAPE, GILBERT		Jan 1, 1984	Shreyash Shrivastava	CRISP Internal Users - Break Glass	May 13, 2022	Pending
PIMRTester, Referral		Oct 1, 2001	Tiffany Younger	CRISP Internal Users - Break Glass	May 13, 2022	Pending
GRAPE, GILBERT		Jan 1, 1984	Shreyash Shrivastava	CRISP Internal Users - Break Glass	May 12, 2022	Pending
GRAPE, GILBERT		Jan 1, 1984	Samit Desai	Saint Agnes Hospital	May 11, 2022	Pending

Intermediary Worklist

- Intermediary tracks incoming referrals via their Worklist queue
- Intermediary closes the loop to referring providers via their CBO portal



E-Referral Tool

Referrals Overview

Look up Referral

Name (last, first)	Gender	DOB	CBO	Ref. Date ↓	Referral Status	Accepted Date	Programs
GRAPE, GILBERT		Jan 1, 1984	Crisp Internal Use ONLY	May 20, 2022	Pending		0 / 0 / 1
GRAPE, GILBERT	M	Jan 1, 1984	Crisp Internal Use ONLY	May 20, 2022	Accepted	May 20, 2022	0 / 1 / 1
GRAPE, GILBERT	M	Jan 1, 1984	Crisp Internal Use ONLY	May 11, 2022	Accepted	May 17, 2022	0 / 1 / 1
GRAPE, GILBERT		Jan 1, 1984	Crisp Internal Use ONLY	May 10, 2022	Pending		0 / 0 / 1
GRAPE, GILBERT	M	Jan 1, 1984	Crisp Internal Use ONLY	May 9, 2022	Accepted	May 9, 2022	0 / 1 / 1
GRAPE, GILBERT		Jan 1, 1984	Crisp Internal Use ONLY	May 2, 2022	Pending		0 / 0 / 1
GRAPE, GILBERT		Jan 1, 1984	Crisp Internal Use ONLY	Apr 29, 2022	Pending		0 / 0 / 1

Referrals Portal

- Referring clinicians are able to track their patient's enrollment info via CRISP



Referrals History

ANNA CADENCE
Female | Nov 16, 1981

CONDITIONS REFERRAL HISTORY

Referral History

Date of Referral	Program Name	Status	Last Updated
2021-11-18	Meals on wheels	Pending	2021-11-18
2021-11-24	DPP	Pending	2021-11-24
2021-11-24	Moveable Feast Medical Nutrition Program	Pending	2021-11-24
2021-11-24	HCAM	Pending	2021-11-24
2021-11-24	Prescription assistance	Pending	2021-11-24

Referral History
Community Health Worker
Date Updated: 2021-11-18

Referral Sender
Referring Provider: Betty Test
Referring Provider Organization: CRISP Primary Care
Referring Provider Phone: Not Provided
Referring Person: Doctor Who
Referring Person Organization: Cheasapeake Regional InformationSystem for our Patients
Referring Person Email: referrals@crisphealth.org

Referral Recipient
Organization: Priority Partners
Program: Diabetes Prevention Program
Program Description: Generic Program Description 8
Referral Coordinator: Evan
Referral Coordinator Phone: 333-555-5555
Referral Coordinator Email: solange@crisp.org

Referral Recipient Updates
Date: 2021-11-18
Note : Test referral data 1

Referrals History Subtab

- Any member of this participant's care team can view their referral history information under the Social Needs tab in CRISP
- Will also display referrals that originate outside of CRISP once ingested



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At a Glance

- **13 DPP intermediaries managing diabetes referrals in the tool**
 - 7 Managed Care Organizations
 - 6 Regional Partnerships
 - Workshop Wizard
- **Average of 100 referrals/week in 2022**
- **Scale Targets**
 - RPs targeted to receive 33,000 referrals in 2022



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Key Medicaid Resources

National DPP Program

- [CDC Diabetes Prevention Program](#)

Maryland Program

- [HealthChoice Diabetes Prevention Program](#)

Program and Policy Guidance

- [Policy Transmittal 09-20 Coverage of National Diabetes Prevention Program for HealthChoice Enrollees \(Last Updated 09.30.19\)](#)
- [HealthChoice Diabetes Prevention Program Manual](#)
- [Frequently-Asked Questions - HealthChoice DPP Implementation](#)



Contact

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