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

Sandy Kick, MSPH, Maryland Department of Health, Senior Manager, Office of Innovation, Research and Development
Marc Rabner, MD, MPH, CRISP, Director, Clinical Applications
Kerron Richards, Project Manager, CRISP

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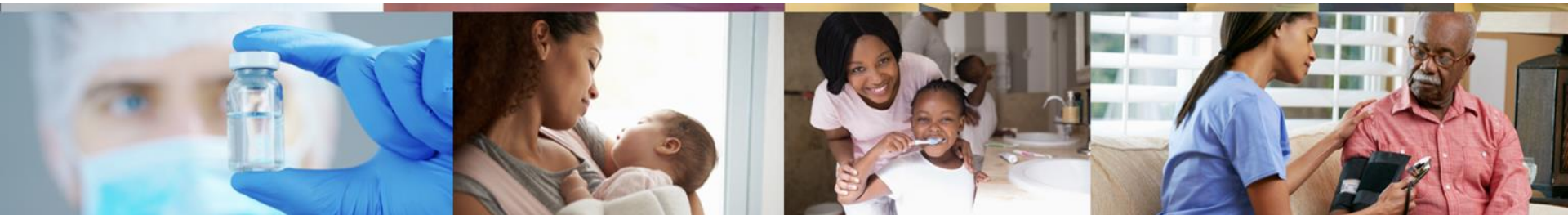

May 2022

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

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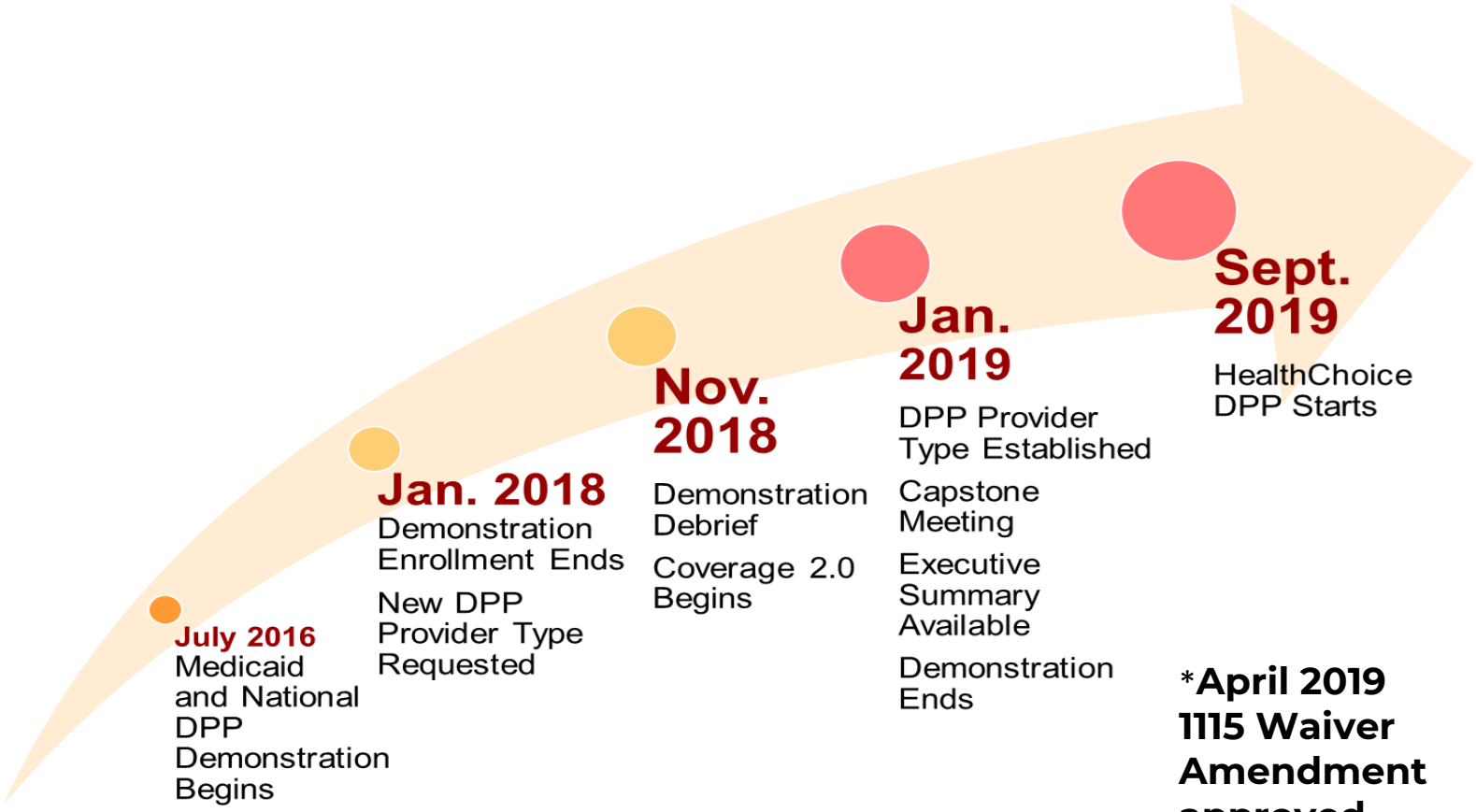
Maryland Medicaid Managed Care Organizations (MCOs)

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



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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

- 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

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Statewide Goals Across Three Domains

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

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

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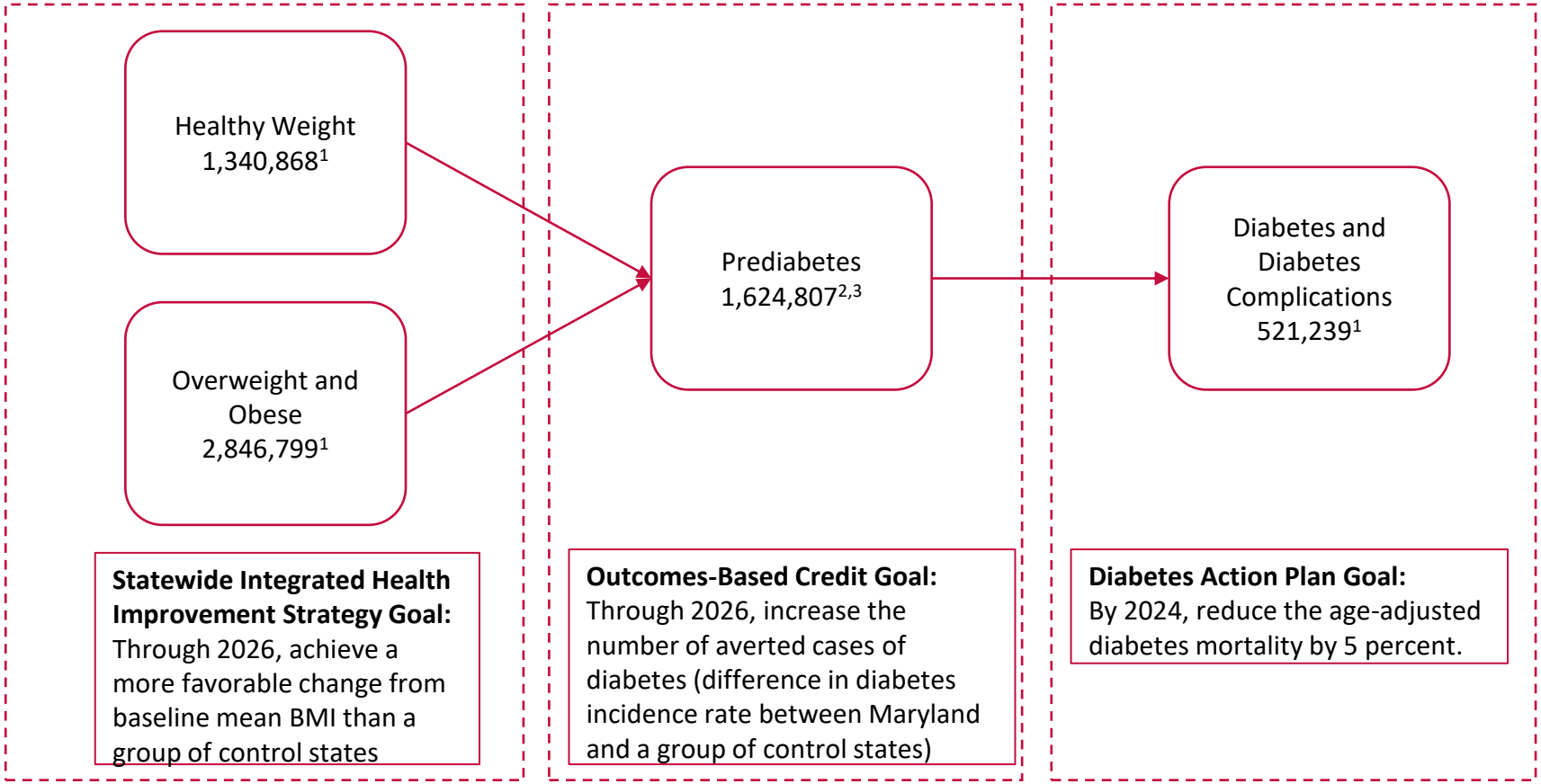
Diabetes Impact



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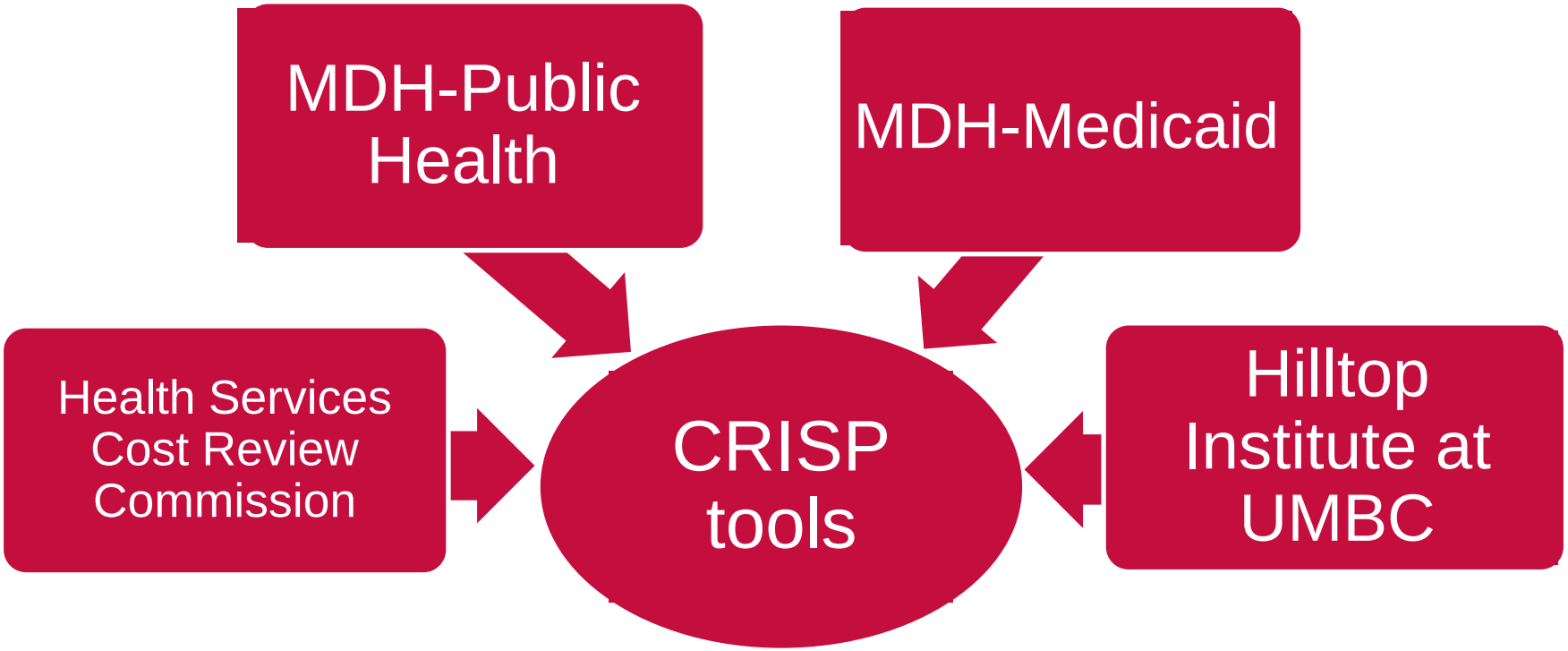
State Agency Collaboration: Prediabetes Flag



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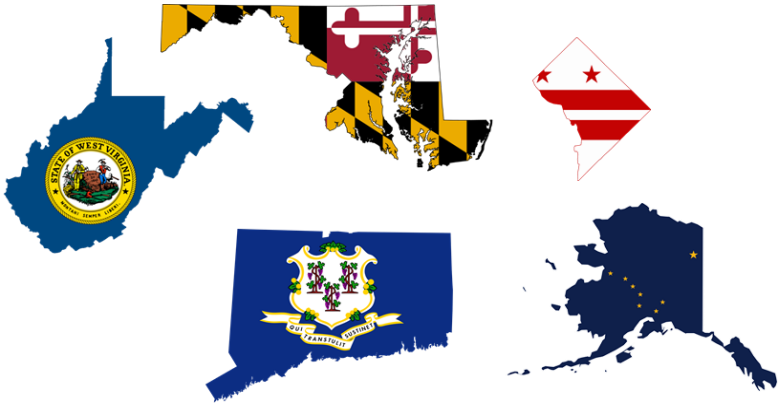
CRISP

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.



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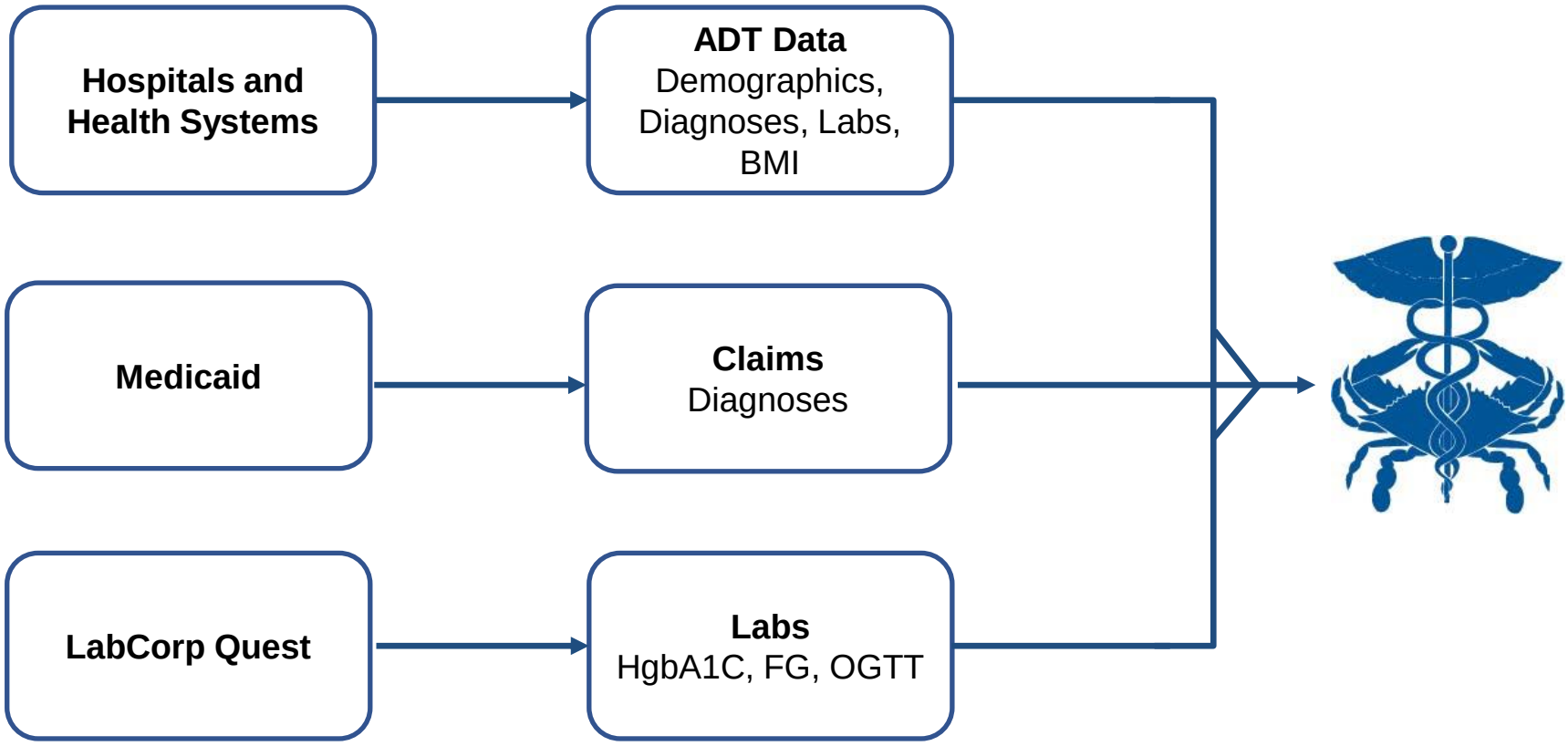
CRISP Data Sources

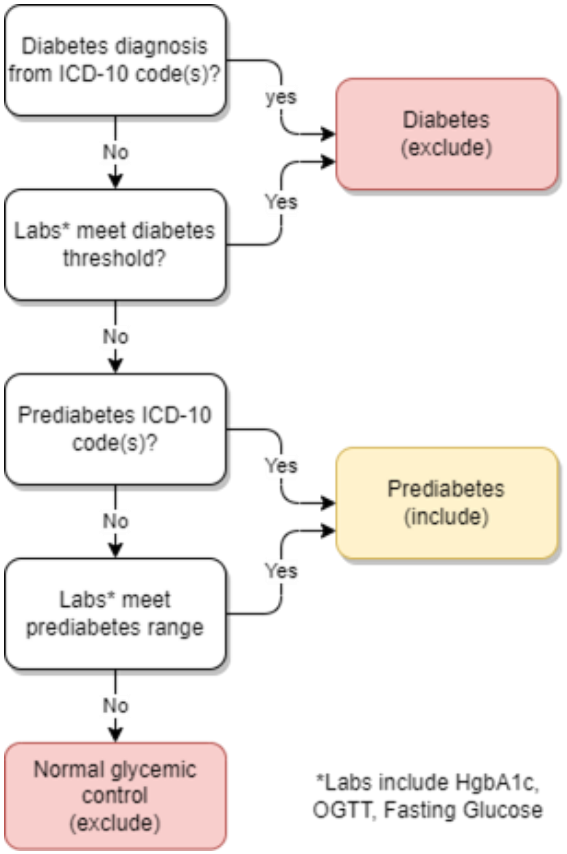


Identifying Eligible Populations

- **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

Tier 1

Identify Prediabetes and GDM



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

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Tier 2

Apply HealthChoice DPP Eligibility

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

- Age
- BMI
- Lab timing

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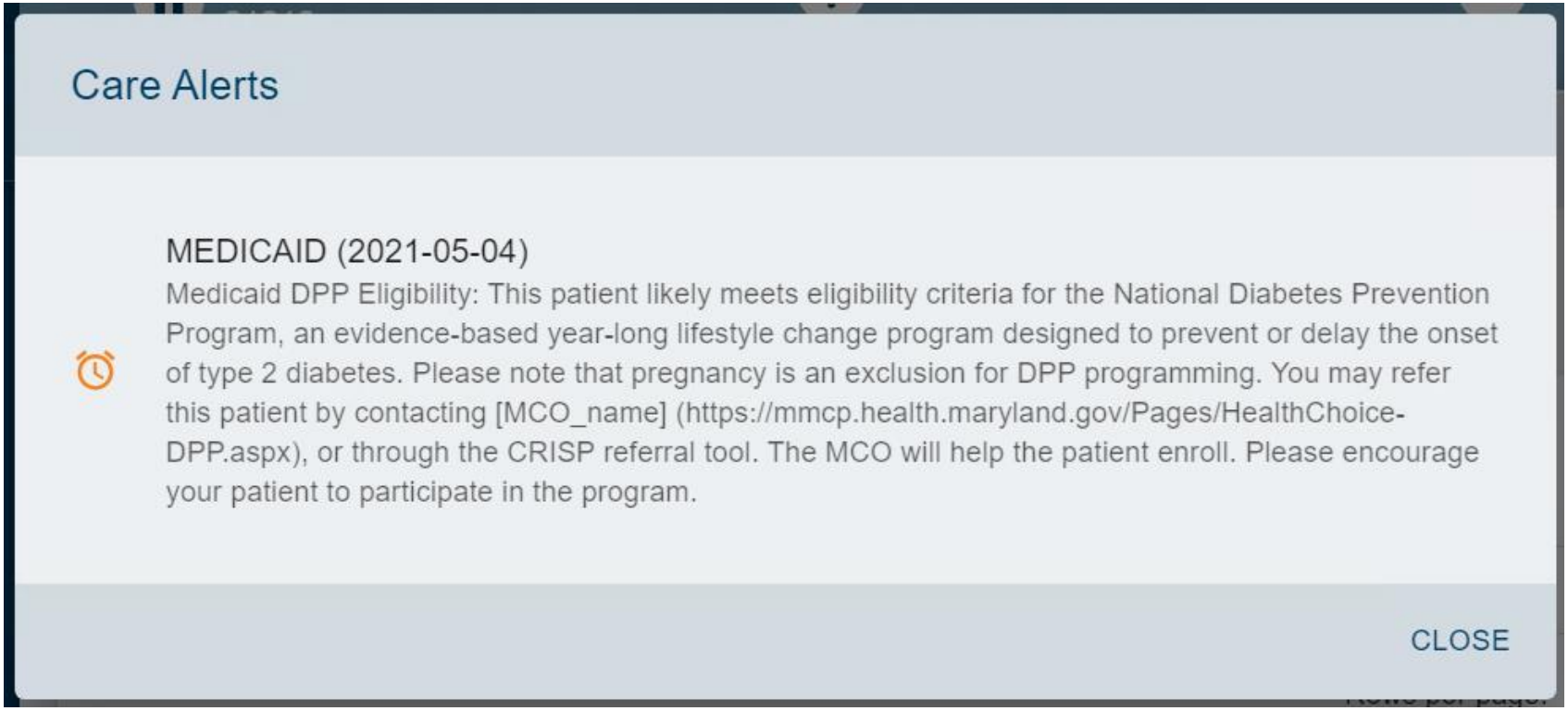
Two distinct populations

- Tier 1 and 2 criteria met
  - Medicaid DPP Eligible

- Tier 1 criteria only
  - Medicaid DPP Eligible Missing Data

Care Alerts



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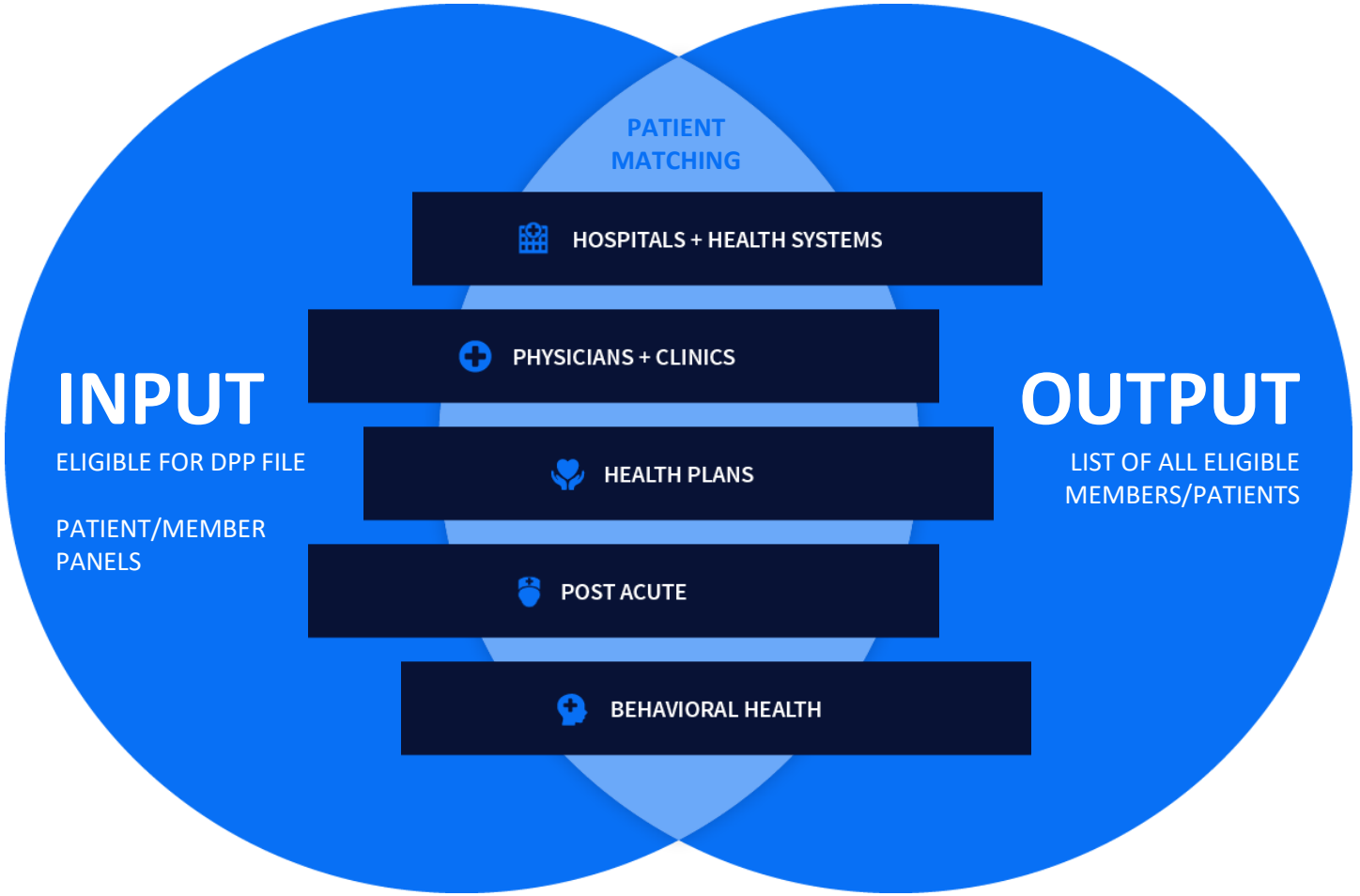
ENS - SmartAlerts



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

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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)

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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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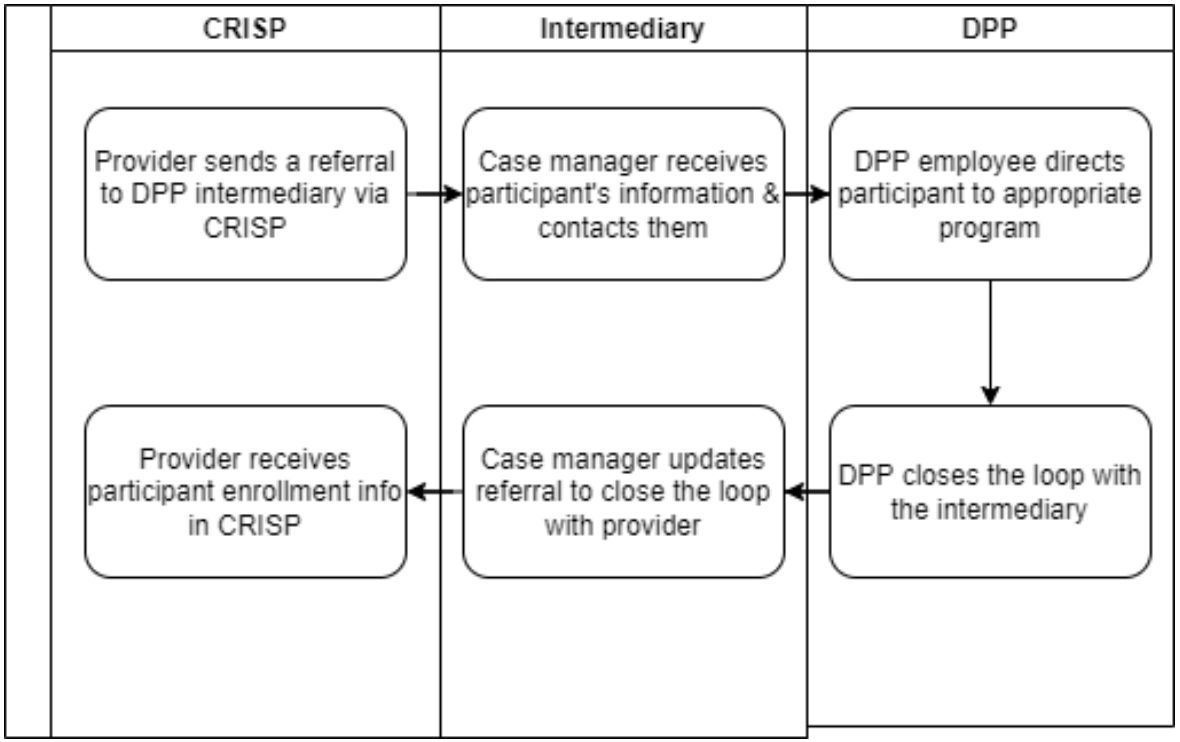
Manual Workflow



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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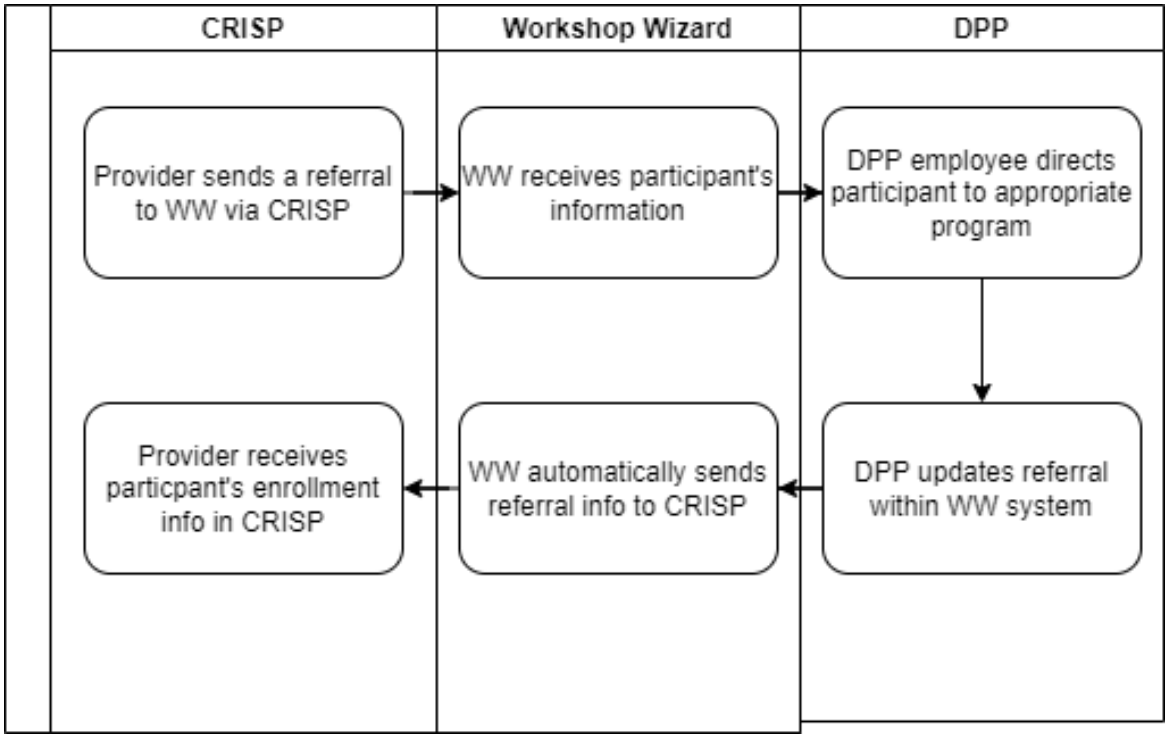
Automated Workflow - Workshop Wizard



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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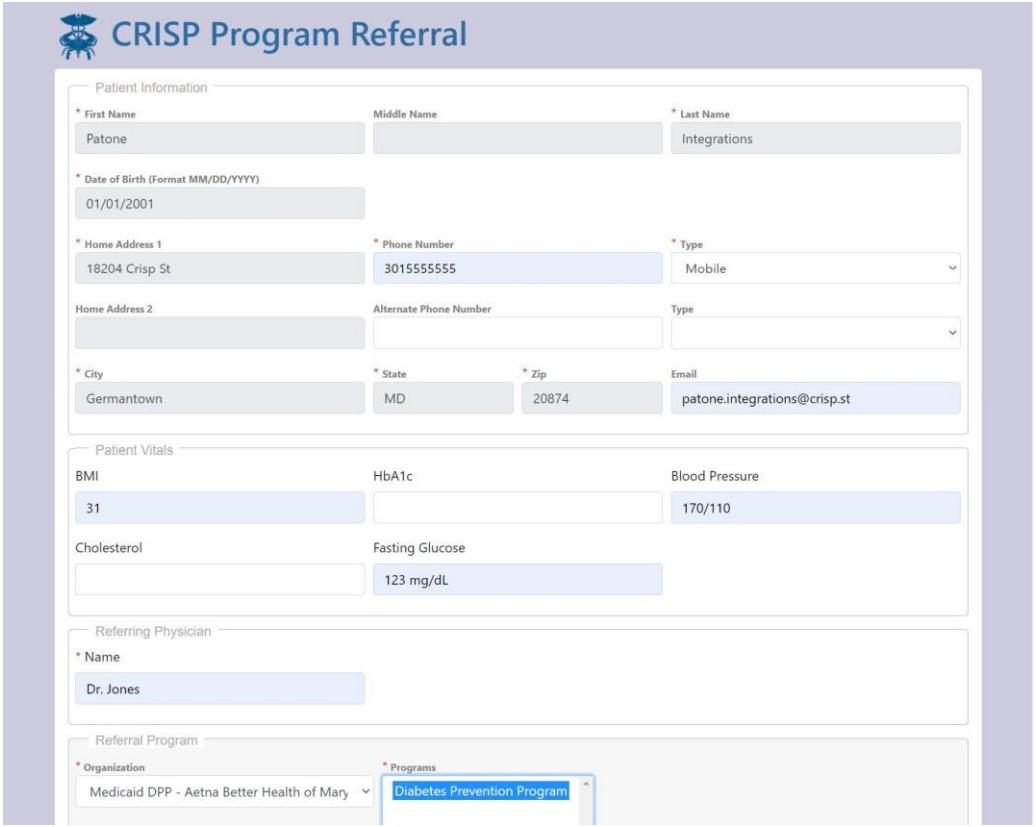
Send Referral to Intermediary



Referrals Webform

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

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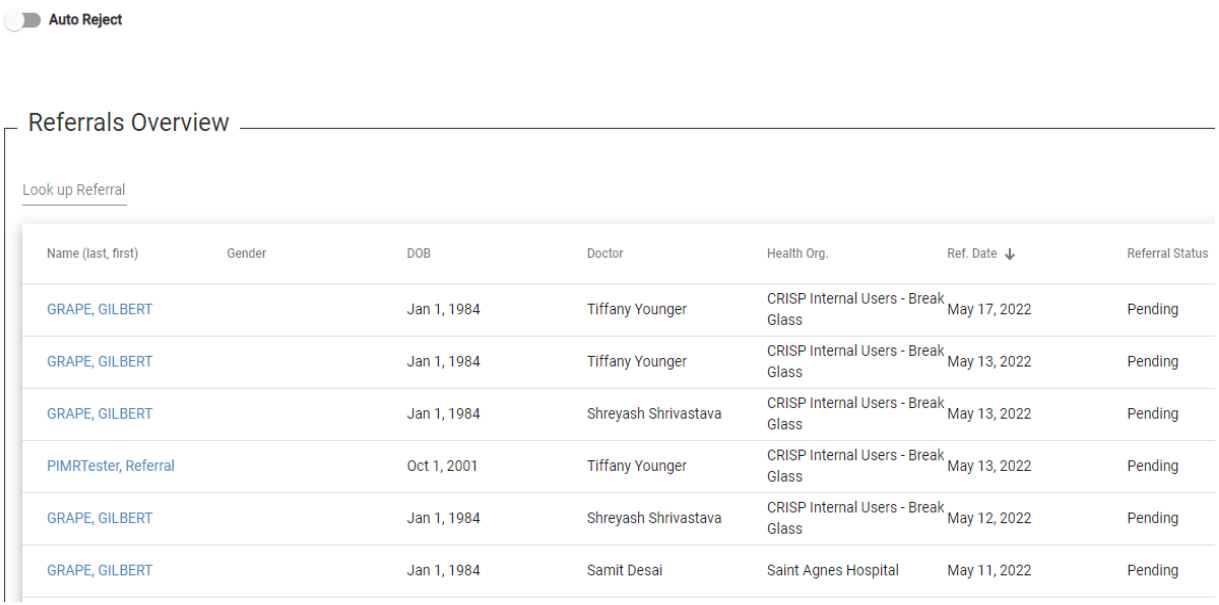
Intermediary Manages Referral



Intermediary Worklist

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

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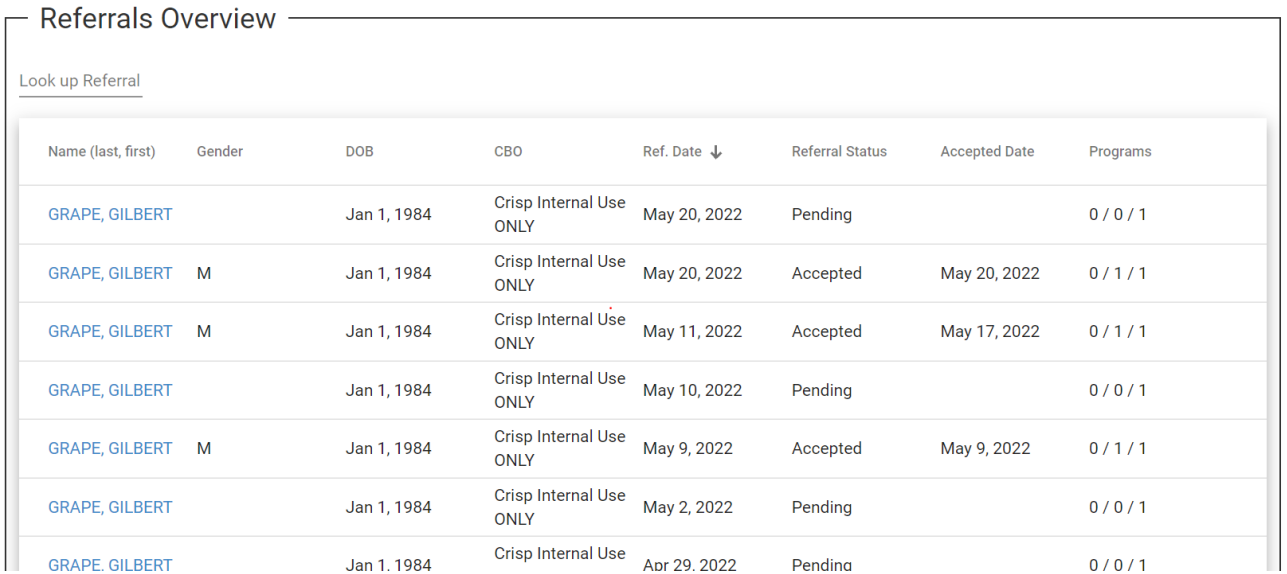
E-Referral Tool



Referrals Portal

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

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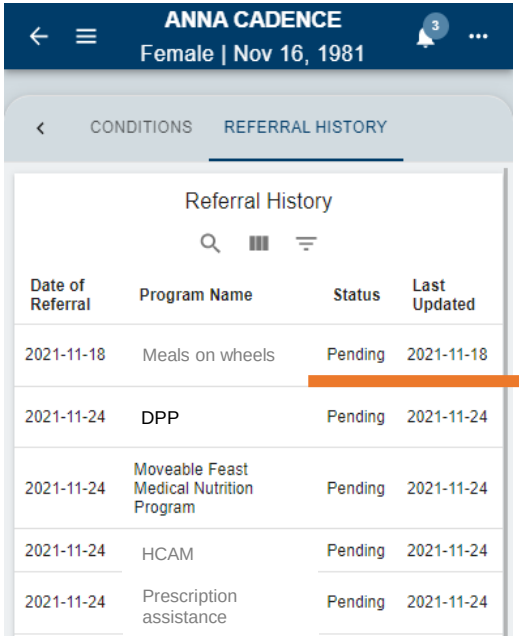
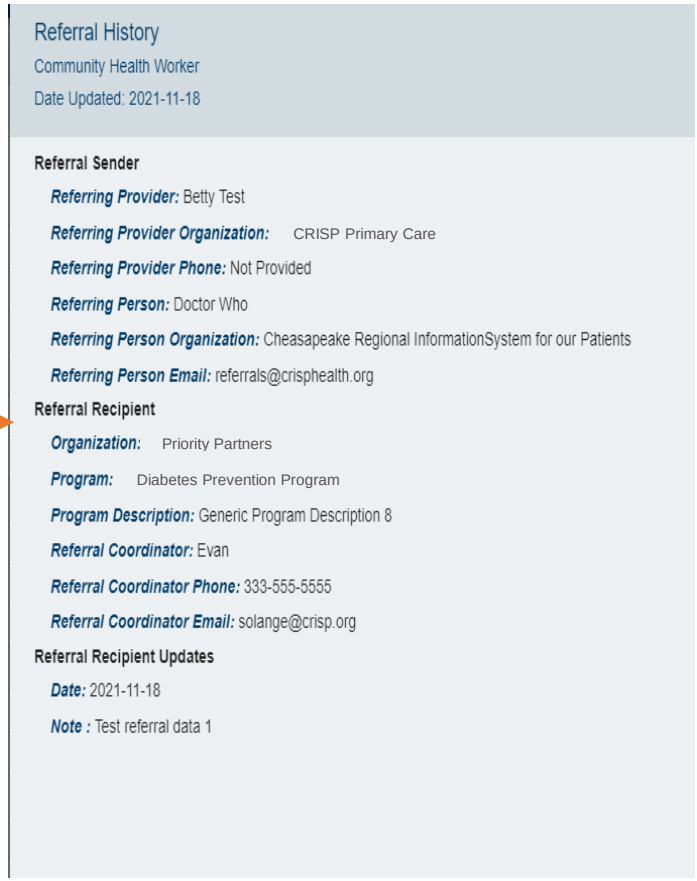
Referrals History





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

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Contact

Speaker Contacts:

Sandy Kick, Sandra.kick@maryland.gov

- **Medicaid DPP Mailbox:** mdh.medicaiddpp@maryland.gov

Marc Rabner, MD, marc.rabner@crisphealth.org

Kerron Richards, Kerron.Richards@crisphealth.org

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