Developing Health IT Capacity for Successful Partnership with Health Care Entities
Speakers

• Beth Blair, Senior Research Associate, n4a
• Peter Eckart, Director, Center for Health and Information Technology, Illinois Public Health Institute
• Leigh Ann Eagle, Executive Director, Living Well Center of Excellence, MAC, Inc.
• Sue Lachenmayr, State Program Coordinator, Maryland Living Well Center of Excellence, a Division of MAC, Inc.
• Craig Behm, Maryland Program Director, CRISP
• Anne Montgomery, Deputy Director, Program to Improve Eldercare, Altarum Institute
The “Business Institute”

The mission of the Aging and Disability Business Institute (Business Institute) is to successfully build and strengthen partnerships between community-based organizations (CBOs) and the health care system so older adults and people with disabilities will have access to services and supports that will enable them to live with dignity and independence in their homes and communities as long as possible.

www.n4a.org/businessinstitute
ACL Business Acumen Grants

Learning Collaboratives for Advanced Business Acumen Skills (n4a)

• Organize and conduct 3-5 topically-based action learning collaboratives to address “next generation” issues; and to provide targeted technical assistance to networks of community-based aging and disability organizations.
  ▪ Trailblazers Learning Collaborative
  ▪ Health Information Technology Learning Collaborative
  ▪ Medicare Advantage Learning Collaborative

• Create knowledge and capture insights through these collaboratives to incorporate into future curriculum for national dissemination.
<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
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<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td>Provider availability</td>
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<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
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<td>Community engagement</td>
<td>Provider linguistic and cultural competency</td>
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<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
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<td>Discrimination</td>
<td>Quality of care</td>
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<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
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<td></td>
<td></td>
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<tr>
<td>Support</td>
<td>Walkability</td>
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</tr>
</tbody>
</table>

**Health Outcomes**
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Why the HITLC?

CBOs experience challenges with IT and data sharing with their health care partners

- 19% of respondents to a AAA survey on IT had systems to connect with their health partners (n4a and Scripps Gerontology Center, 2016)
- 66% reported that IT limitations are a significant barrier to their ability to develop a value proposition (n4a, 2018)
- 50.8% report receiving patient health outcome data through a contract with a health care partner (Business Institute, 2018)

“Data collection is very difficult. Each of our MCO partners requires we document and track client activity in their respective platforms. There is not one universal system to capture all the data…”

“The biggest issue we face is access to good, actionable data. We have very limited access to any information and most of that is not in actionable, reportable, manageable formats. It’s nothing more than general information, most often on hitting timeframes. This is one of the most critical problems facing CBOs related to contracting with MCOs and health systems.”

(Business Institute, 2018)
Challenges Faced by AAAs in Using IT

n4a and Scripps Gerontology Center, 2016, Information Technology in Area Agencies on Aging
Connecting Aging Services and Healthcare through Data for Better Care and Outcomes

NASUAD HCBS Conference
August 28, 2019
HITLC Goals

**Purpose:** Assist participants in making strategic decisions around investing in health information technology (HIT) systems to collect, manage and analyze service data and enhance program quality, client satisfaction, and service reimbursement.

**Key Outcome:** Successful implementation and use of administrative data systems to grow the capacity of CBOs.

**Deliverable:** Tools that can assist the larger field of CBOs with the making informed decisions around data systems.
Establishing the Learning Collaboration

- Application and review process
  - Criteria: maturity, readiness, scope of project
- Baseline knowledge
  - Project profiles
- Structure
  - Mix of opportunities
  - Work groups, full cohort, TA, 1-on-1
  - Activities that foster peer-to-peer sharing
Cohort Characteristics

**IT Project Maturity**
- Early investigation
- Selection
- Implementation and workflow redesign
- Active use

**Hiring IT Vendor?**
- Yes: 50%
- No: 20%
- Not yet: 30%
Cohort Characteristics

Data System Focus

- Evidence-based health promotion and disease prevention programs: 60%
- Care coordination/management/transitions: 40%

Organizational Structure

- Independent non-profit: 70%
- Other: 30%

Organization Size

- 1-10 FTEs: 2
- 10.5-21 FTEs: 1
- 21.5-36 FTEs: 0
- 36.5-79 FTEs: 2
- 79.5+ FTEs: 5
Sites Needs Vary Widely

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tr>
<td>Partner/Relationship Development</td>
<td></td>
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<tr>
<td>Case management systems</td>
<td></td>
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<tr>
<td>Collecting SDOH data</td>
<td></td>
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<tr>
<td>Legal: Consent, HIPAA</td>
<td></td>
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<tr>
<td>Data analysis, reporting, and visualization</td>
<td></td>
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<tr>
<td>Funding, Healthcare contracting</td>
<td></td>
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<tr>
<td>Vendor/software selection</td>
<td></td>
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<tr>
<td>Measuring outcomes</td>
<td></td>
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<tr>
<td>Health care quality measures</td>
<td></td>
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<tr>
<td>Integration with other systems (EMRs, HIEs, etc.)</td>
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</tbody>
</table>
Sample Project Goals Across Sites

- **Track delivery/impact of EBPs provided** to older adults with multiple chronic conditions and **notify referring entities of program outcomes**, cost savings, reduced healthcare utilization.

- **Establish a Health IT portal that is efficient and easy to use**, integrates with provider EHRs and member organizations’ existing platforms, and links to billing claims for ease in reimbursements for community services.

- **Transform data systems to an integrated data governance solution** that serves the agency for day-to-day management of services and long-term planning.

- **Identify ways to evaluate programs, data use, and data access** in order to leverage our services when forming partnerships with other key players addressing the health of seniors and adults with disabilities.
Content and Activities

Topics

• Partnering with Health Care – Health Systems and Payers
• Data Systems and Sharing between AAAs and Health Care
• Contracting with Health Systems and Plans
• Bi-directional E-referral Using RedCap
• Change Management

Optional Webinars

• Overview of Data Systems Selection Process
• Trailblazer Learning Collaborative Tools
• Epic Community Connect

Assignments

• Profile Profiles
• Project Workplan and Status Reports
• Community Presentations
• TA/SME Lessons Learned
• Evaluation of Existing Tools and Resources
• Input on Cohort Tools

• Peer-to-Peer
  • Consultancy, polling, project profiles, online community
What's new in N4a Health Information Technology Learning Collaborative (HITLC), Jenna?

Anna posted an update in the group 🌐 N4a Health Information Technology Learning Collaborative (HITLC) 9 days ago

Welcome to our online space for the N4a HITLC!

Our team has been enjoying the initial calls to get to know each team a bit more. Next week, we’ll post a document with short profiles of each site and an agenda that you can preview for the Kickoff Webinar on Wednesday, November 7 from 1:30 pm CT.

Peter posted an update in the group 🌐 N4a Health Information Technology Learning Collaborative a month ago

Well, everything is new in the n4a Health IT LC, cuz we’re just getting started!
Feedback Shared on Activities to Date

- The learning has been really helpful even if it is just confirming to know the issues are universal.
- Enjoyed info on building a data analytics team, will be discussing with our members.
- It was especially interesting to hear about the approach to creating and supporting a dedicated analytics dept (distinct from general IT)
- It was extremely helpful to hear about the process for selecting and implementing systems.
- Important to have a wide range of people representing different functions and agencies involved in change management efforts.
- Just have to say thank you for another great webinar!! In our conversation with healthcare the importance of closed loop and bi-directional communication have surfaced across all populations. We are seeing payment being driven based upon closed loop referrals and the technology to support that and the bi-directional communications.
What we’ve been learning; it’s a Process

Key elements of a data strategy

- **Define Purpose**
  Why you will do the work? What questions will answer and who will be at the table?

- **Engage Stakeholders**
  Who will do the work? Who will benefit from the work and what do they need?

- **Secure Resources**
  What funding, staff, and other resources will you need?

- **Govern Data Sharing & Use**
  How will you comply with privacy & security? How will data ownership be structured?

- **Identify Technical Solutions**
  What tools and infrastructure will support data uses?

- **Acquire & Analyze Data**
  What data sources, processes, and methods will you use to get, store, and make meaning from data?

- **Publish & Communicate Data**
  How will you report, interpret, and disseminate data, results, and information?
Aha Moments from Sites to Date: Partnerships

• **Stay persistent** in building relationships - both with internal champions and external organizations - and work to ‘speak the same language’ when pursuing health systems or plans.

• **Meet with a variety of staff** in different departments at health systems and plans to find your champion. Cultivate relationships at multiple levels.

• **Drive the timeline**: Having a solid workplan can help you drive the timeline when working with partners that may not have as much flexibility / momentum.
Aha Moments from Sites to Date: Data Systems

• **Define your use case:** One size does not fit all, different data systems may be needed for internal data management, analysis and reporting vs. for data that is shared with external entities (hospitals, payers, etc.)
  
  • Most have found there is no single software / vendor that can “do it all.” Understanding your requirements and the needs of your partners can help streamline your workflows and narrow down which system(s) can provide efficiencies and achieve your goals.

• **Navigating legal barriers** and consent management can be complicated. VPN is one solution to securely share data with health plans. Online training solutions exist for HIPAA compliance. All of it takes time. Nonetheless, important to get it right.

• **Software selection** and negotiations are an ever-evolving target, and even after many conversations, vendors may still slow or halt contracts. Collaborations with others who have purchased a software or engaged with the vendor are also helpful.
Project Spotlight 1: Sound Generations

**Project Enhance**: Evidence-based program offered nationwide to address chronic health conditions for those aging with and into disability

Goals:
- 1) Pilot a referral and EBP outcome feedback loop with health care provider
- 2) Review, assess and adopt best practices in demonstrating HIPAA-compliance and data security organization wide
- 3) Create standardized data sharing and BAA agreements
Different data matching processes for different payers

Kaiser: SG matches program participant data against a list of eligible policyholders supplied by Kaiser, and submits that list monthly

Silver&Fit: Sites generate a monthly attendance report which is then used for reimbursement

Data elements

- **Attendance**: Session-level, by participant
- **Participant Demographics**
- **Outcome Measures**: Varies by intervention: Functional fitness tests and/or validated survey questions captured at baseline and follow-up

Who are the programs reaching?
Are participants improving as a result of participation?
Closed Loop Referrals with Health Care

• Testing the impact of a closed loop referral system (NowPow) with a hospital and a network of primary care practices for adults on Medicare
• Includes EMR social determinant screen
• If patient is flagged for nutritional risk, they are referred to AgeOptions
• AgeOptions screens, refers for meals, follows up, and reports back through NowPow
Project Spotlight 3: Pima Council on Aging

PCO Is a AAA serving 28,000 Pima County, AZ residents

Opening a new Healthy Aging Center

Operate Pima Care at Home

Challenges addressing:
- Disparate data systems
- Move to better data analytics
- Contract with insurers/managed care
- HIPAA compliance

Data Flow Diagram
Project Spotlight 3: Pima Council on Aging (Cont’d)

Latest News:

1. After mapping workflows, outlining requirements, and viewing product demonstrations, they decided they will not purchase a new system and instead are concentrating on modifying the existing state-implemented system.

2. PCOA is working with the state to build the specifications together and will approach the vendor to discuss platform expansion.

3. Working to develop pilot project for data collection, data warehousing and visualization.
Project Spotlight 4: Western New York Integrated Care Collaborative

Shared Use of EHR

- WNYICC is contracting with a physician practice who will provide access to their EHR portal without having to pay an upfront cost.
- Physician practice provides clinical oversight on programs such as chronic care management and will handle the billing.
- WNYICC will provide the health coaching.
- Challenges: Takes time to develop HIPAA and data use policies and schedule meetings with the physician practice.
Project Spotlight 5: Oregon Wellness Network

- **OWN** is a division of Oregon Association of Area Agencies on Aging and Disabilities (O4AD) and serves as a network hub for the 17 Area Agencies on Aging (AAAs) in Oregon.

**Use of Solera in the Diabetes Prevention Program.**

- For the Diabetes Prevention Program they use Solera for data entry.
- People are signed up for this program by HealthInsight and Solera who refer people to OWN via email. OWN also does in-person and online sign-ups.
- OWN gets reports from Solera which are useful for them in terms of DPP and tells them participants have met program metrics. Solera produces a report in the DPP format.
Project Spotlight 5: Oregon Wellness Network

Solera payment and enrollment process

• Step 1: Participant identified, screened and enrolled in a workshop (done either online or call).

• Step 2: Participant enrolled through Solera portal for payer coverage.

• Step 3: Participant attends in-person DPP. Data is tracked in Solera portal.

• Step 4: As participant meets reimbursement milestones, OWN receives payment from Solera and passes on payment to local program supplier. An email is also sent to the participant informing them that they reached a certain milestone and receives an incentive for them.
HIT LC Tools – in Development

Partnering with Health Care: Key Takeaways
• Who to talk to / finding the right people at health systems plans
• What agreements around data sharing should be included in the contract

Software Vendor Grid
• Attributes and definitions

HIT Resource List
• Feedback on the utility of various resources shared by teams and facilitators over the course of the learning collaborative

AAA and CBO Strategic Software Investment Guide
• Specific considerations for CBOs/AAAs for identification, selection, and implementation
All In: Data for Community Health

100+ COMMUNITY COLLABORATIONS ARE ALL IN!
A Division of MAC, Inc.

Leigh Ann Eagle, Executive Director
Sue Lachenmayr, State Program Coordinator
Who We Are, What We Do

- Area Agency on Aging (AAA) for 4 rural counties on Maryland’s lower Eastern Shore
- Successful Implementation of the evidence-based Chronic Disease Self-Management Education resulted in transfer of statewide license and database from Maryland Department of Aging in 2015
- 2015/2018 CDSME Sustainability Grant and 2016/2019 Falls Sustainability Grant from the Administration for Community Living
- Established a statewide hub for licensing, training, technical assistance, data collection/reporting and quality assurance monitoring of evidence-based program implementation
- Partnership with Maryland AAAs
  - Contracts with 29 MD Hospitals
  - Collaboration with Chesapeake Regional Information System for Patients (CRISP) Maryland’s Health Information Exchange
Services

- Screening for Social Determinants of Health (SDoH) and referral to appropriate services and evidence-based programs
- Statewide calendar for registration/referral to evidence-based program workshops
- Living Well website with tools, resources, marketing materials for participants, leaders and coordinators, and health care providers
- Quarterly reports on patient activation, engagement, and long-term goals
- Participant satisfaction/engagement and quality assurance monitoring of leader fidelity and competency
- Collection individual and population health outcomes
- Tracking of pre-/post-clinical measures
## Matching Services to SDoH Needs

<table>
<thead>
<tr>
<th>Care Planning</th>
<th>Maryland Access Point (MAP) No Wrong Door Information &amp; Referral</th>
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</thead>
<tbody>
<tr>
<td><strong>Nutrition</strong></td>
<td>Nutrition counseling, education, and care planning; Meal programs: delivered to homes or senior centers; List of community food resources; Meal enhancements and nutritional supplements</td>
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<tr>
<td><strong>Financial</strong></td>
<td>Application for financial aid, including SNAP, Medicaid, the State Health Improvement Program (SHIP), energy-assistance programs, income-tax assistance, Medicare prescriptions, and Part B premiums; Medication and supplement grants</td>
</tr>
<tr>
<td><strong>In-Home Care</strong></td>
<td>Assistance with in-home care, sitters list, assisted living subsidies, Community First Choice; Telephone reassurance; Options Counseling</td>
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<tr>
<td><strong>Medical Conditions</strong></td>
<td>Medication management Assistance for dental, eye care, and hearing aids</td>
</tr>
<tr>
<td><strong>Social Support</strong></td>
<td>Senior centers (exercise, socialization); Support groups (Alzheimer, caregivers, stroke, renal); Lifelong learning; Volunteer opportunities; Senior employment</td>
</tr>
<tr>
<td><strong>Environmental Assistance</strong></td>
<td>Counseling on housing and assisted living; Education about local transportation systems; Training for assistive technology equipment &amp; adapted telephones; Ramp assistance</td>
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<tr>
<td><strong>Health and Wellness</strong></td>
<td>EBP Programs: Chronic disease, diabetes self-management; cancer thriving and surviving; Diabetes prevention program; Malnutrition workshop: Stepping Up Your Nutrition; Fall-prevention workshops Stepping ON, OTAGO; Depression care management: PEARLS</td>
</tr>
</tbody>
</table>
Partners Across Clinical and Nonclinical Services

The Maryland Living Well Center of Excellence (LWCE) at MAC, Inc. and Maryland’s Health Information Exchange - Chesapeake Regional Information System (CRISP)

- Track individuals across hospitalization, primary care providers, and community-based organizations (CBOs)
- Implement evidence-based programs and interventions to address social determinants of health
- Issue care alerts to providers and hospitals regarding CBO programs and services provided and clinical care services needed
- Demonstrate impact of evidence-based program and provision of non-clinical services on healthcare costs and participant quality of life
## 40 Organizations Offering CDSME Workshops at 500+ Locations

<table>
<thead>
<tr>
<th>MD Living Well Center of Excellence</th>
<th>MedStar St. Mary's Hospital</th>
<th>St. Mary's County AAA</th>
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<tbody>
<tr>
<td>Prince George's County AAA</td>
<td>MCVET</td>
<td>Carroll County AAA</td>
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<tr>
<td>Anne Arundel County AAA</td>
<td>Charles County Department of Health</td>
<td>Meritus Medical Center</td>
</tr>
<tr>
<td>Howard County AAA</td>
<td>Keswick Community Health</td>
<td>MedStar Montgomery Medical Center</td>
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<tr>
<td>UM Upper Chesapeake Health</td>
<td>Calvert Memorial Hospital</td>
<td>Charles County Dept of Community Services</td>
</tr>
<tr>
<td>MedStar Washington Hospital Center</td>
<td>UM St. Joseph Medical Center</td>
<td>MedStar Franklin Square Medical Center</td>
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<td>Frederick Regional Health System</td>
<td>Baltimore County AAA</td>
<td>UM Upper Chesapeake Hospital</td>
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<td>Cecil County AAA</td>
<td>Medstar Good Samaritan Hospital</td>
<td>Allegany County Health Department</td>
</tr>
<tr>
<td>Calvert County Health Department</td>
<td>UM Charles Regional Medical Center</td>
<td>Holy Cross Health</td>
</tr>
<tr>
<td>Washington County AAA</td>
<td>Allegany County AAA</td>
<td>Anne Arundel Medical Center</td>
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<td>Baltimore City AAA</td>
<td>Garrett County AAA</td>
<td>Howard County Health Department</td>
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<tr>
<td>University of Maryland Medical System</td>
<td>Medstar Harbor Hospital</td>
<td>Cecil County Health Department</td>
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<tr>
<td>Holy Cross Health</td>
<td>Howard County General Hospital</td>
<td>MedStar Southern Maryland Hospital Center</td>
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<tr>
<td>Hopkins Bayview</td>
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## 22 Organizations Offering Stepping On and/or EnhanceFitness

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
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<tr>
<td>MAC Inc</td>
<td>Frederick County Senior Services Division</td>
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<td>Washington County Health Department</td>
<td>University of Maryland Medical System</td>
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<td>Baltimore County AAA</td>
<td>Johns Hopkins Bayview</td>
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<td>Allegany County AAA</td>
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<td>Cecil County AAA</td>
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<tr>
<td>UM St. Joseph Medical Center</td>
<td>Meritus Medical Center</td>
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<td>Montgomery Co Dept of Health &amp; Human Svc</td>
<td>Cecil County Health Department</td>
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<td>Howard County AAA</td>
<td>Holy Cross Health</td>
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<td>Keswick Community Health</td>
<td>UM St. Joseph Medical Center</td>
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<td>UM Upper Chesapeake Health</td>
<td>Washington County Health Department</td>
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<tr>
<td>Washington County AAA</td>
<td>Prince George’s County AAA</td>
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</table>
Participant Activation and Self-Management Scores

- Self confidence: 2268
- Set and follow plan: 2363
- More motivated: 2494
- Understand how to manage symptoms: 2225

Responsiveness:

- Self confidence: 1008
- Set and follow plan: 909
- More motivated: 698
- Understand how to manage symptoms: 1013

Options:
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
Impact and Healthcare Cost Savings of SDoH Services/EBPs: Early data results of patient panel submissions for CDSME 12 months pre/post; Falls 6 months pre/post for 1 hospital

### Chronic Disease Self-Management Programs

<table>
<thead>
<tr>
<th>Patients with Pre visit</th>
<th>Patients with Post visit</th>
<th>Pre %</th>
<th>Post %</th>
<th>% of Change</th>
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<tr>
<td>52</td>
<td>44</td>
<td>71.2</td>
<td>60.3</td>
<td>-11.0</td>
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<tr>
<th>At least 1 visit Pre-/Post</th>
<th>Total Charges Pre</th>
<th>Total Charges Post %</th>
<th>Average Charge Post %</th>
<th>Ave $ reduction per patient</th>
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<tr>
<td>55</td>
<td>$435,834</td>
<td>$227,423</td>
<td>$5,169</td>
<td>-$3,212</td>
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### Falls Prevention Programs

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<th>Patients with Pre visit</th>
<th>Patients with Post visit</th>
<th>Pre %</th>
<th>Post %</th>
<th>% of Change</th>
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<td>17</td>
<td>16</td>
<td>3.1%</td>
<td>0</td>
<td>-3.1%</td>
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</table>

<table>
<thead>
<tr>
<th>At least 1 visit Pre-/Post</th>
<th>Total Charges Pre</th>
<th>Total Charges Post %</th>
<th>Average Charge Post %</th>
<th>Ave $ reduction per patient</th>
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<td>19</td>
<td>$208,480</td>
<td>$64,185</td>
<td>$4,012</td>
<td>-$8,251</td>
</tr>
</tbody>
</table>
Contact Information

- Leigh Ann Eagle, Executive Director
  Phone: 410-742-0505 X 136   E-mail: lae2@macinc.org

- Sue Lachenmayr, State Program Coordinator
  Phone: 908-797-5650   E-mail: bslach@earthlink.net
Maryland’s Health Information Exchange
About CRISP

Regional Health Information Exchange (HIE) serving Maryland, West Virginia, and the District of Columbia, and the State-Designated HIE in Maryland

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

Guiding Principles

1. Begin with a manageable scope and remain incremental.
2. Create opportunities to cooperate even while participating healthcare organizations still compete in other ways.
3. Affirm that competition and market-mechanisms spur innovation and improvement.
4. Promote and enable consumers’ control over their own health information.
5. Use best practices and standards.
6. Serve our region’s entire healthcare community.
In July 2019, Maryland and CMMI entered into a new initiative to improve quality and reduce the growth in health care spending:

- Modernized the 40-year-old Medicare Waiver by allowing policies and programs aimed at care redesign.
- Hospital global budgets set under an all-payer model are aligned with non-hospital settings and geographic populations.

Hospitals, physicians, and policymakers chose to invest in shared technology infrastructure:

- Existing state-designated Health Information Exchange leveraged and expanded upon.
- Shared tools, resources, and data encourage industry-led innovation and better care coordination.
1. **POINT OF CARE:** Clinical Query Portal & In-context Information
   - Search for your patients’ prior hospital records (e.g. labs, radiology reports, etc.)
   - Monitor the prescribing and dispensing of PDMP drugs
   - Determine other members of your patient’s care team
   - Be alerted to important conditions or treatment information

2. **CARE COORDINATION:** Encounter Notification Service (ENS)
   - Be notified when your patient is hospitalized in any regional hospital
   - Receive special notification about ED visits that are potential readmissions
   - Know when your MCO member is in the ED

3. **POPULATION HEALTH:** CRISP Reporting Services (CRS)
   - Use Case Mix data and Medicare claims data to:
     - Identify patients who could benefit from services
     - Measure performance of initiatives for QI and program reporting
     - Coordinate with peers on behalf of patients who see multiple providers

4. **PUBLIC HEALTH SUPPORT:**
   - Deploying services in partnership with Maryland Department of Health
   - Pursuing projects with the District of Columbia Department of Health Care Finance
   - Supporting West Virginia priorities through the WVHIN

5. **PROGRAM ADMINISTRATION:**
   - Making policy discussions more transparent and informed
   - Supporting Care Redesign Programs

### CRISP Services

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<th>Service</th>
<th>Typical Week</th>
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<td>Positive InContext Requests</td>
<td>525,000</td>
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<tr>
<td>Data Delivered into EMRs</td>
<td>1,400,000</td>
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<td>Patients Searched in Portal</td>
<td>62,000</td>
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<td>Patients Searched from EMR</td>
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</tr>
<tr>
<td>ENS Messages Sent</td>
<td>760,000</td>
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<tr>
<td>Clinical Documents Processed</td>
<td>350,000</td>
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<tr>
<td>Portal Users</td>
<td>40,000</td>
</tr>
<tr>
<td>Live ENS Practices</td>
<td>1,400</td>
</tr>
<tr>
<td>Reports Accessed</td>
<td>500</td>
</tr>
<tr>
<td>Report Users</td>
<td>600</td>
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</table>
Point of Care: Unified Landing Page & Snapshot

All CRISP applications in a single, secure site with one username and password

- Snapshot: View of critical patient data including care alerts, care teams, and prior visits with customizable widgets
- PDMP (authorized users only per State mandate)
- Health Records: Labs, radiology, images, and other clinical documents
Point of Care: InContext Data Delivery

- View of critical patient data, pulled from multiple repositories and embedded in the end user’s EHR
- Integrations can occur in EHR native app stores or through API queries
- CRISP delivers nearly 1.5M pieces of data per week through this method (and rising)
Care Coordination: ENS ProMPT

- Real-time or batch alerts to appropriate providers based on treatment and care management relationships
- User interface within CRISP secure portal or messages delivered into Direct or EHRs
Community Information Exchange

• Goal: To leverage existing technology to enable health care practitioners to connect with resources in the community

• Start by providing tools to fill gaps in the following overarching workflow:
  1. Identify appropriate interventions
  2. Select existing service providers
  3. Refer patient to selected resource
  4. Confirm patient enrollment
  5. Report on process and outcome measures
Program Referral Pilot
Contact and Resources

Training materials, recorded webinars, and patient education flyers can be found at:
https://crisphealth.org/resources/

A full user guide is available at:
https://userguide.crisphealth.org

**Craig Behm, Executive Director, CRISP Maryland**
- Office: 410.872.0823
- Cell: 410.207.7192
- Email: craig.behm@crisphealth.org
Questions for you

• Does your state unit currently collaborate with a Health Information Exchange to share data?
  • If yes, please share what you are doing
  • If no, please share barriers/challenges you’ve had in making the connection

• As the state unit, what do you see as the barriers to helping the aging network transition to outcomes-based reporting?

• Is your state unit considering making changes to IT systems to enable AAAs to better document services and programs that could be embedded into Medicare reimbursement?

• As a state unit, are you working with your network to coordinate standardization of assessing/reporting SDoH (HCBS or LTSS) services so outcomes/impact can be measured?

• Does your state currently or are you considering funding or other support to increase CBO/grantee capacity for data sharing, including and especially for the development of CBO-focused IT infrastructure?
Building IT Capacity for Home and Community Based Services (HCBS): Developing Successful Partnerships with Health Care Entities

Anne Montgomery, Deputy Director, Program to Improve Eldercare, Altarum
Health IT Capacity in HCBS

Challenge

Scant attention and little federal funding for IT has been directed to community-based providers (AAAs, CBOs) providing HCBS services.

2009 HITECH federal program that led to widespread adoption of electronic health records did not initially benefit HCBS.

Solution

February 2016 State Medicaid Director (SMD) letter begins to address gap by announcing need to link community-based systems to EHRs.

Partnership with providers encouraged to meet Meaningful Use (MU) objectives.
“One of the lessons learned from the MU EHR Incentive Payment Program is that just adopting EHRs via health IT incentives does not ensure interoperability. There are in fact many foundational components that need to accompany EHR adoption to develop out a **fully functioning health IT ecosystem** to accomplish the Medicaid program objectives. This includes **non-EHR considerations** such as robust identity management capabilities, provider directories which include **all HCBS providers**, and data analytics platforms functioning in real time using e-specified measures for the basis of quality and payment.”

Excerpted from ONC HCBS Toolkit:

https://www.healthit.gov/sites/default/files/5_HCBS_Health_IT_Toolkit_V1.pdf
CBOs Need Upgraded IT to Work with Medicaid, Medicare, HCOs Serving These Enrollees and Commercial Populations

All AAAs offer five core services under the OAA:

- **NUTRITION**
- **HEALTH & WELLNESS**
- **CAREGIVERS**
- **ELDER RIGHTS**
  - includes abuse prevention and long-term care ombudsman programs
- **SUPPORTIVE SERVICES**
  - Information and referral
  - In-home services
  - Homemaker & chore services
  - Transportation
  - Case management
  - Home modification
  - Legal services
Creating Data-Sharing Relationships for Care Transitions, Care Coordination, Supportive Services

Area Agency on Aging Case Management

- Hospitals
- Medical Providers
- Clinic
- Health Plans
- Fall Prevention
- Food
- Transportation
- Medication Reconciliation
- Home Modifications
- Caregiver Support
- Medication Reconciliation
State Medicaid Director letters & IT Funding

Medicaid Management Information Systems (MMIS) matching funds

**Federal / State Match**
- Develop – 90% / 10%
- Support – 75% / 25%

Availability of HITECH to Connect with Other Medicaid Providers

Use APD process for 90% / 10% match through 2021

SMD 10-016

SMD 16-003
State Medicaid Director Letters & IT Funding

**Leveraging Medicaid Technology to Address Opioid Crisis**
- Care Coordination
- Case Management
- Telehealth

**Delivery Systems for Adults with Mental Illness or Children with Emotional Disturbance**
- Wide range of waivers for federal IT funding

SMD 18-006  SMD 18-011
Medicare Advantage Plans Now Experimenting with Offering Limited LTSS

- Expanded supplemental benefit flexibility for MA plans takes effect in 2020

- Bipartisan Budget Act of 2018 authorizes supplemental optional benefits to improve, maintain health of chronically ill beneficiaries, which do not have to be “primary health related”

- AAAs/CBOs can ramp up efforts with Medicaid agencies for HCBS “use cases” that can be funded through APD process. Can also discuss with MA plans how to make IT investments that improve their ability to offer limited LTSS
LTSS Funding & Proposed Interoperability Rule (CMS-9115)

- eLTSS language may open up new federal funding opportunities for development and promotion of IT that is designed for sharing LTSS information.
Altarum’s APD Projects

<table>
<thead>
<tr>
<th>PROJECT NAME</th>
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<tbody>
<tr>
<td>Michigan Center for Effective IT Adoption (M-CEITA)</td>
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<tr>
<td>Michigan Center for Effective IT Adoption (M-CEITA) Long-Term and Post-Acute Care (LTPAC) Technical Assistance</td>
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<tr>
<td>Michigan Disease Surveillance System (MDSS)</td>
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<td>Michigan Syndromic Surveillance System (MSSS)</td>
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<td>Michigan Cancer Surveillance Program</td>
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<td>Michigan Birth Defects Surveillance Program</td>
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<td>Michigan Vital Records Program</td>
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<td>Newborn Screening (NBS) Critical Congenital Heart Disease (CCHD)</td>
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<td>Newborn Screening (NBS) Blood Spot</td>
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<tr>
<td>Newborn Screening (NBS) Early Hearing Detection and Interventions (EHDI)</td>
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<tr>
<td>Blood Lead Test Results and Workflow Analysis</td>
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<tr>
<td>MI Health Link Integrated Care Bridge Record (ICBR) Project</td>
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<tr>
<td>Michigan’s Dental Registry (MiDRSM)</td>
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</table>
MHL Demonstration Overview

- MI Health Link is a health care option for Michigan adults, ages 21 or over, who are enrolled in both Medicare and Medicaid, and live in one of four demonstration regions of Michigan.

- MI Health Link offers a broad range of medical and behavioral health services, pharmacy, home and community-based services, and nursing home care, all in a single program designed to meet individual needs.

- The MHL Demonstration kicked off March 1, 2015 and extends through December 31, 2020.
MI Health Link Care Plan

- **C-CDA Specification** – Care plan elements translated into HL7 standardized format to promote content sharing across payers and providers

- **Care Plan Viewer** – User friendly version of the Care Plan

- **Care Plan C-CDA Validator** – Ensures data quality when exchanging data across organizations

C-CDA: Consolidated-Clinical Document Architecture
HL7: Health Level 7 (international health standards organization)
Care Plan Viewer

- Provides a human readable view of the C-CDA data
- Ability to generate and print a customized view of the standardized Care Plan
- Ability to leverage the standardized C-CDA for reporting to MDHHS/CMS electronically
- Standardized Data & View for everyone
- User Customizable View
- Consolidated Data
- Attached Documents may be viewed from a consolidated location (e.g. PDF, WORD, ...)
- Work group consensus on the content and organization of the style sheet
Integrated Care Bridge Report

Member: Eve Betterhalf  D.O.B: May 1, 1975  Sex: Female  ICO Referral Number: renum1234  Document Intent Indicator:  Care Plan  PJHP L2A Record Number: PLRN5678

- Allergies
- Integrated Conditions Concerns Problems
- Integrated Care Team
- Signatures
- Initial Screening
- Most Recent Claims
- Likes and Interests
- Residential or Non Residential Setting Preferences
- Supports and Services
- Waiver Services
- Assessments and Reassessments
- Goals
- Concerns Goals Interventions

Level I Assessment
- Level II Assessment
- NFLOCD
- Social History
- Medications
- Health Status Summary
- Personal Preferences
- Attached Documents
- Personal Care Services
- Personal Care Assessment
- Risk Factors
- Interventions

Table of Contents

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- Show all
- Restore Layout
- Print Layout
Questions

Anne Montgomery, Deputy Director, Program to Improve Eldercare, Altarum