Maryland Commission
on Public Health
March 7, 2024 | 2:00 PM – 5:00 PM

Baltimore County Dept of Health
Google Meet joining info
Video call link: https://meet.google.com/whc-wzpa-osc
Or dial: (US) + 1 314 474-3289
Pin: 228 226804#
More phone numbers: https://tel.meet/whc-wzpa-osc?pin=9675008149300

Agenda

I. **Call to Order**

II. **Adoption of the Agenda**

III. **February Minutes Review**

IV. **Special Guests**

V. **Presentation: CRISP State-Designated Health Information Exchange (HIE) - Overview and Services**
Craig Behm, MBA
CEO, Chesapeake Regional Information System for our Patients (CRISP)

VI. **Presentation: Behavioral Health**
Alyssa Lord, MA, MSc
Deputy Secretary of Behavioral Health, Maryland Department of Health

VII. **Break**

VIII. **Workgroup Updates**
   a. General
   b. Workgroups and Data Needs
      i. Communications & Public Engagement
      ii. Data & Information Technology
      iii. Funding
      iv. Governance & Organizational Capabilities
      v. Workforce

IX. **Old Business**
   a. LHD Site Visits and Regional Public Meetings

X. **New Business**
   a. Update from Indiana site visit
   b. Workgroup leadership change

XI. Announcements

a. Next meeting: April 4, 2024, 2-5PM at Baltimore County Dept of Health with virtual option

XII. Adjournment

MARYLAND COMMISSION ON PUBLIC HEALTH

Thursday, February 1, 2024 | 2:00 PM - 5:00 PM
Baltimore County Dept of Health | Virtual

Commissioners present in person or virtually:

Camille Blake Fall
Gregory W. Branch
Christopher Brandt
Meenakshi Brewster
Nilesh Kalyanaraman
Boris Lushniak
Olutosin Olateju
Fran Phillips
Nicole Rochester
Maura Rossman
Michelle Spencer
Allen Twigg

Commissioners absent:

Heather Bagnall
Jean Drummond
Ariana Kelly
Alyssa Lord

Workgroup members present in person (others joining virtually):

Stephanie Ajuzie
Sanmi Areola
Cynthia Baur
Craig Behm
Roselie Bright
Barbara Brookmyer
Julie Cady-Reh
Brian Castrucci
Saniya Chaudhry
Angela Cochran
Kassie Coulson
Kisha Davis
Jennifer Dixon Cravens
Negin Fouladi
Tonii Gedin
Joan Gelrud
Isis Gomes
Christina Gray
Stephanie Harper
Roger Harrell
Rebecca Jones
Michelle Kong
Maggie Kunz
Vanessa Lamers
Sylvette La Touche-Howard
Lisa Nelson
Isabel Rodriguez
Chloe Scott
Gena Spear
Earl Stoner
Bill Webb
Randi Woods

I. **Call to Order**
   a. Presiding co-chair M. Brewster called meeting to order. All consent to be recorded by remaining on call. Further questions or comments by workgroup members can be sent to md.coph@maryland.gov.
   b. Commissioner Roll call – Quorum met

II. **Adoption of the Agenda**
   a. A motion was made to adopt February agenda.
   b. Agenda unanimously adopted

III. **January Minutes Review**
   a. A motion was made to approve the minutes from January 4, 2024 CoPH virtual public meeting; the motion was seconded.
      i. There were two name corrections mentioned and approved as amended.

IV. **Special Guests**
   a. In addition to presenters, Dr. Judy Monroe, Megan Roney from CDC Foundation were introduced

V. **New Business (Discussion/Motions)**
   a. Revised timeline for CoPH
      i. Meeting in Annapolis, Senate was pro forma, so meeting was hybrid. In attendance, Delegate Mark Chang (Appropriations Committee), a representative from Senator Kelly's office, Representatives from Maryland Health Resources Commission, Maryland Healthcare Commission, support staff, and 5 Commissioners attended. The participants presented concerns: timeline, funding staffing, timeline
         1. Timeline
            a. 3 proposed timelines for final report: as-is with report due December 2024; 6-month extension with final report due June 2025, 1-year extension with final report due December 2025. December 2025 proposed because a legislative session is not until 2026, so June 2025 deadline leaves a 6-month gap. A 6-month gap gives time to rally and gain support, however, there's the opportunity for the report to lose pertinence. A report would still be given December 2024 for the next legislative session, however, it would not be called the "final report."

b. A motion was made for June 2025 deadline; that motion was seconded.
    i. 9 ayes, 1 nay
    ii. Motion was carried

b. Public meeting regions/hosts
    i. Legislation requires 3 public meetings. 4 locations in different regions approved by commission (western MD – Washington County, Eastern Shore – Talbot County, central MD – Howard County, southern MD – St. Mary's County). Geographic representation is not a stipulation; this was something the co-chairs decided on. Commission may decide to do more but will need to take into account timeline and assessment period.
    ii. Last meeting, a suggestion for second central Maryland location due to concerns about representation: Baltimore City, Montgomery County, Prince George's County. All 3 health departments were interested; however, 2 options today based on feasibility from a timeline logistics perspective: Baltimore City and Montgomery County.
    iii. Montgomery County per 1 million residents: 40% white, split Latino, African American. Economic disparity (perceived as a rich county but a lot of poverty); many different languages represented. Health Department has experience with public meetings.
    iv. A motion was made for Commission to delegate to co-chairs to make decision; motion was seconded and granted unanimously.

c. Data and IT workgroup co-chair change
    i. Bill Webb has to step down; Matthew Levy offered to be a new co-chair.
    ii. A motion was made to adopt and seconded; motion granted unanimously.

VI. Presentation: Overview of Maryland's State Public Health Infrastructure (available on website)

Nilesh Kalyanaraman, MD, FACP Deputy Secretary of Public Health Services Maryland Department of Health

*Presenter introduced by B. Lushniak

a. About the Maryland Department of Health
b. Vision, Mission and Core Values
c. MD Dept of Health Org Chart
    i. Secretary Laura Herrera Scott oversees department with 5 different units with deputy secretaries

d. Leadership
    i. Maryland Health Secretary – Laura Herrera Scott
    ii. Public Health Services Administration Deputy Secretary – Nilesh Kalyanaraman
    iii. Development Disabilities Administration (DDA) Deputy Secretary – Marlana Hutchinson
    iv. Behavioral Health Administration (BHA) Deputy Secretary – Alyssa Lord
    v. Health Care Financing and Medicaid Administration Deputy Secretary – Ryan Moran
    vi. Operations Administration Deputy Secretary – Bryan Mroz
e. Capabilities of the Maryland Department of Health
f. Funding and Budget
    i. MDH 5-Year Trends
        1. 2024 $19.6B in funding (~1/3 of the state's budget)
    ii. MDH FY 2024 Appropriations
        1. Public Health Services FY 2024 Appropriations
    iii. Federal Stimulus and Dedicated Purpose Account
g. Public Health Services Administration
    i. About
    ii. Guiding Principles
    iii. Commitment to Equity
    iv. Operational Units
h. Local Health Departments
    i. About
    ii. Programs in Local Health Departments
i. Prevention and Health Promotion Administration
    i. PHPA Units
        1. Maternal and Child Health Bureau
            a. Programs
                i. Work is focused on how we are supporting families with young children and giving them the best start to life and improving their health.
        2. Environmental Health Bureau
            a. Programs (regulatory, programs focused on environmental effects on health, violence and injury prevention)
        3. Cancer and Chronic Disease Bureau
            a. Programs
                i. Cancer Prevention and Control

1. A lot of this work is focused on filling in in gaps in insurance, access, public health services
ii. Chronic Disease Prevention and Control
iii. Tobacco Prevention and Control
iv. Oral Health
v. Maryland Kidney Disease Program
4. Infectious Disease Epidemiology and Outbreak Response Bureau
    a. Does not include STIs/HIV/HBV/HCV
    b. Programs
5. Infection Disease Prevention and Health Services Bureau
    a. Programs

j. PHS Administration (mostly administered at state level)
    i. Office of Preparedness and Response
        1. Programs
    ii. Office of Health Care Quality
        1. Programs
    iii. Office of the Chief Medical Examiner
        1. Programs
    iv. Vital Statistics Administration
        1. Data currently only available as pdf. No dashboard
        2. Programs
    v. Laboratories Administration
        1. Programs
    vi. Office of Provider Engagement and Regulation
        1. Programs
            a. Office of the Prescription Drug Monitoring Program
            b. Office of Controlled Substances Administration
    vii. Office of Population Health Improvement
        1. Programs
    viii. State Anatomy Board
    ix. Public Health Workforce & Infrastructure Office
        1. Priorities
k. Public Health Service Initiatives
    i. MDH Accreditation by the Public Health Accreditation Board
    ii. Public Health Infrastructure Grant
    iii. Public Health Workforce Development

1. Workforce Development Internship Program
iv. Data Modernization: Goals and Associated Outcomes
1. Public Health Datasets, Applications & Systems

l. Questions from Group
i. B. Lushniak: How to define workforce? To LHDs, what are your problem areas (recruiting, retaining, expertise)? There was ample discussion regarding recruiting, retaining, and expertise.
1. A participant proposed SWOT analysis, comparing with other states, and addressing it at another meeting.
2. N. Kalyanaraman: Currently going through state assessments, will have measures and comparisons to other state as part of state health improvement plan in April or May. MD doesn't have good state data about healthcare workforce. VA provides good model for how to look at trends. Office of Population Health improvement bringing together stakeholders to develop picture of healthcare workforce.
3. F. Phillips: Other things going on a MDH that are germane to PH but not part of PHPA, like behavioral health. There are health policy decisions made outside MDH. Health Services Cost Review Commission

VII. Break

VIII. Presentation: Public Health System Assessments and Transformation Approaches (available on website)

Reena Chudgar, MPH Senior Director, Public Health Systems and Services Public Health Accreditation Board
Jessica Solomon Fisher, MCP Chief Operating Officer Public Health Accreditation Board

*Guests introduced by O. Olateju

a. About PHAB
i. 1 of 3 national partners funded to support the public health infrastructure grant work.

b. Foundation Setting around Public Health Transformation
i. Foundational Public Health Services (this adheres to national model)
1. Foundational Areas
2. Foundational Capabilities

3. One commissioner noted behavioral health is currently not considered a foundation of public health services, but that might need to be reconsidered services but that might need to be reconsidered.
    a. J. Solomon Fisher: Model meant to be broad to cover all health departments, so there is variation and more can be included on a state level. We do not rank states
4. This framework embedded in the field at a national level, and more than a dozen states have adopted this framework to try to better define what governmental public health ought to be
5. Another commissioner noted 21st century learning community with the 18 states that are doing this work. In 2021, de Beaumont Foundation, put out workforce shortages nationally. Found that for foundational capabilities *only,* they were 80,000 workers short. These were pre-covid numbers and did not account for the rest of that model
6. This is the framework against which the commission can make recommendations for foundational capabilities and areas

ii. Accreditation and Recognition
1. During accreditation process, departments have the framework for communicating what public health is and what it does
2. Assures that all parts and whole of the departments are working to deliver comprehensive public health services based on national peer-reviewed standards
3. Quality improvement process
4. Identifies areas for continued improvement
5. 12 of 24 LHDs in MD are accredited
6. In many states, accreditation is a key driver in transformation

c. 21st Century (21C) Approaches to Transformation
i. PHAB 21st Century Learning Community (18 states)
1. Statewide systems including state health department, local health departments, other public health-related organizations
2. These states are implementing work similar to Commission's work

3. Working in various ways to build the foundation of public health services
4. Learn, share, contribute, and support each other

ii. Systems Approach to Transformation
1. Begins with developing a vision and adopting a framework (FPHS Model)
2. Begins with assessment of current foundational public health services and cost. If there is a gap, that may go to legislators as a funding request
3. Public Health Infrastructure Grant
   a. From CDC. Over $5B (for 5 years) in flexible funding to support infrastructure to support all the things that don't usually get supported in public health
   b. Maryland a recipient as well as Baltimore City directly. 40% of funding meant to go to other LHDs.

d. Assessment Tools

i. PHAB Tools for Transformation
1. PHAB FPHS Capacity and Cost Assessment
   a. Found it's best to assess state-wide, not just at individual health department level
2. PHAB Readiness Assessment
3. Public Health Workforce Calculator
   a. Currently, limitations on health department size to use tool: Depts that serve a population of under 500,000
   b. B. Lushniak: Do we know if any MD LHDs have used this calculator?
   c. How do you map Maryland's activities to the operational definitions that exist? What else are you looking to assess?
4. 21C Examples
   a. Missouri, Wisconsin, Ohio
   b. Oregon and Washington

e. Recommended Approaches for Assessment

i. Statewide Capacity and Cost Assessment

ii. Considerations for Recommendations

f. PHAB Supports & Q&A

i. Question O. Olateju: Has Ohio's mandatory accreditation been effective? R. Chudgar: Ohio has a mandate for PHAB

accreditation. Currently working on impact evaluation, so will have a better idea in June when that's completed.

ii. Question from M. Rossman: Maryland currently undergoing reaccreditation. Are these tools being utilized during this process?
    1. R. Chudgar: Readiness assessment would not have been available for accreditation application

IX. Workgroup Updates

a. General
   i. CDC Foundation collaborating with MACHO to provide funding for support staff and support staff directly from CDC Foundation
      1. UMD and Morgan State University are mobilizing to help with student interns

b. Workgroups
   i. Communications & Public Engagement
      1. N. Rochester: First meeting Jan 25, introductions and discussion around reasons for joining workgroup. Trust, dis/mistrust. Messenger is as important as message. Meet people where they are. Collaboration, importance of bidirectional communication, accessible language, utilizing other methods of distribution like social media and texting, relevance of information (accurate, culturally relevant). Public engagement: shift in power dynamics that currently exist between community and providers and that everyone is part of public health. Timing important, not waiting until crisis. Reaching populations such as seniors, disabled, those without internet access, and those with language barriers
   ii. Data & Information Technology
      1. C. Brandt: Met Jan 24; discussed data needs and possible barriers; identified need for information on data systems enhancements, deciding what sort of assessment to conduct; integration: public health data system as well as clinical delivery data system; data to action: what to do with it; funding: staffing for assessment work, how to deliver services; capacity and workforce development; equity, delivery; legal barriers
   iii. Funding

1. L. Polsky: Overview of PH in MD, highlighted funding issues structurally across the nation (compared to other countries, US spends the lowest on public health prevention); discussion about how MDH and LHDs are funded: often through year-long, restrictive grants, which does not provide enough time for planning or effective use; LHDs often provide the clinical services that the private sector cannot generate profit from. The revenue received does not match the cost of providing the services; core funding: a shared responsibility between state and counties, heavily contingent on broader economy and restrictive, therefore not dependable; community health benefit dollars: preliminary discussion about how funds could be better used to address social determinants of health across the state, these funds are predictable, recession proof, available across the state; action items for members: research add'l areas of public health funding that may be used in other states and possibly other experts in the field

iv. Governance & Organizational Capabilities
1. F. Phillips: Met in January, meeting again early February and then will have regular meetings; will be looking at quantitative measures, many qualitative measures around assessment of governance and organization. Clarification: this is not organizational administration in a health department, rather focusing on local and state health department org chart; would like to conduct interviews and would like ideas about surveys, about how to structure qualitative measures, would like input from commission on who to talk to. Recommendations from workgroup won't likely be as simple as checking a box

v. Workforce
1. B. Lushniak: Met on Jan 23, will meet the first Tuesday of every month; discussion on defining public health workforce; should recommendations be achievable or aspirational since legislators need also need to be able to take action; considerations of funding since it's needed for hiring; hiring process: hiring based on degrees, experience level, needs?; quality, adequacy of staffing workforce; will be

examining Public Health Workforce and Needs Survey from de Beaumont; action items for workgroup members to find other useful surveys and datasets

X. **Announcements**

a. Next meeting: March 7, 2024, 2-5PM at Baltimore County Dept of Health with virtual option

XI. **Adjournment**

a. Meeting was adjourned at 5:02pm upon motion of O. Olateju, motion was seconded

Craig Behm
CEO, Chesapeake Regional Information System for our Patients (CRISP)

As President and CEO, Craig is the lead executive responsible for developing and executing the strategic plan as well as ensuring strong financial controls and high-quality services. His focus is on driving interoperability and innovation by expanding Health Data Utilities through CRISP and member Health Information Exchanges across the country. He manages the senior team with an emphasis on fostering collaboration while advocating for the mission, vision, and values of both CRISP and CRISP Shared Services.

Previously, Craig has been an instructor at the University of Maryland Baltimore County Master's program in Health Information Technology. He also led the start-up and operations of three physician-led, Advance Payment Medicare Shared Savings Program Accountable Care Organizations. He has a Master of Business Administration from Loyola University.

State-Designated HIE Overview and Services

7160 Columbia Gateway Drive, Suite 100
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

About CRISP

State Designated Health Information Exchange (HIE) and Health Data Utility serving Maryland, and in affiliation through a shared services model with the HIEs in West Virginia, the District of Columbia, Connecticut, Virginia, and Alaska.

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.

About CRISP

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

Health Information Exchange (HIE)

- State-designated independent non-profit serving Maryland, and in affiliation with the HIEs in West Virginia, the District of Columbia, Connecticut, Virginia, and Alaska through CRISP Shared Services

Health Data Utility (HDU)

- HB1127 required the State-Designated HIE to operate as an HDU, advancing equity and wellness by linking data across the public health system and enabling secure, appropriate access beyond traditional health information users.

Implementation Timeline

2006 · 2008 · 2010 · 2012 · 2014 · 2016 · 2018 · 2020 · 2022

First Steps

CRISP begins at a meeting between John Erickson and the CIOs of Maryland's three largest hospital systems, asking how to make medical records for seniors available when they visit the hospital.

Getting Connected

CRISP is named Maryland's designated statewide HIE through a competitive process and the first provider organizations connect. The HSCRC awards a grant and CRISP wins federal Regional Extension Center funding.

Utilizing Services

Every hospital in Maryland is connected. Clinicians begin using the Query Portal, and the team develops the Encounter Notification Service.

Expansion

Claims-based reports are produced, the Prescription Drug Monitoring Program and Health Benefits Exchange provider directory go live, the first Washington D.C. hospital connects, and health plans begin accessing records through a specialized portal, and CRISP begins routing CCDAs at hospital discharge.

Supporting Partnerships

The initial research use case goes live. Program Administration to support care redesign programs begins and patient-level Medicare claims become available. The InContext app goes live in Epic. CRISP partners with the West Virginia Health Information Exchange (WVHIN) to share infrastructure.

Essential Infrastructure

DC Medicaid claims data is made available. New open source HIE stack is implemented (June) first county EMS are connected (Oct) CRISP begins responding to national network queries. Connecticut's HIE, Connie, partners with CRISP.

Health Data Utility

Real-time hospital utilization reports are launched, COVID testing reports and notifications are introduced, immunization tools go live, and new data types are shared through the HIE. The Insights data lake and analytics are leveraged extensively.

Technology Components

Health Department Systems of Record

- Immunization Registry
- Vital Statistics (Mortalities)
- Reportable Conditions

Hospital, Medicare, & Medicaid Claims

Hospitals, Clinics, EMS (Participant Data)

National Exchange Networks

Conversion & Normalization

Core Supporting Infrastructure

Master Person Index

Consent Utility

Secure User Portal

FHIR APIs

Push Notifications

Reports

Flat Files

HITRUST
Health Information Trust Alliance

EHNAC

Data Quality

In January 2024, we transformed 16.6M inbound ADTs for analytics in Azure with the following completeness by data element:

- Race = 95%
- Ethnicity = 93%
- Gender = 100%
- Address = 99%
- PCP = 70%
- Diagnosis = 38%

Category	1/14/2024	1/7/2024
ADT-based Metrics		
Admit Reason	64 %	62 %
Diagnosis	33 %	34 %
Diagnosis Timeliness	95 %	92 %
Diagnosis Description	34 %	34 %
Discharge Summary Timeliness	68 %	65 %
PCP NPI	52 %	52 %
Next of Kin	60 %	60 %
Address	99 %	99 %

Data Quality Dashboard

Date: 12/1/2023 – 12/31/2023

HIE: All

Source Code	Facility	ADTs	Admit Reason	PCP NPI	Next of Kin	Race	Ethnicity	Language	Address	Phone	Encounters	Dx Codes
MMC	Meritus Medical Center	1,795,474	39 %	84 %	42 %	95 %	98 %	100 %	99 %	99 %	122,090	80 %
JHH	Johns Hopkins Hospital	1,711,482	93 %	59 %	65 %	98 %	95 %	100 %	99 %	99 %	84,902	97 %
CCHS	Christiana Care Health System	1,241,430	80 %	61 %	71 %	95 %	96 %	100 %	99 %	99 %	175,276	57 %
MS_MPP	Medstar Physician Partners	1,058,394	54 %	0 %	50 %	92 %	50 %	100 %	100 %	100 %	453,089	0 %
AAMC	Luminis Health - Anne Arundel Medical Center	888,047	44 %	63 %	62 %	96 %	92 %	100 %	99 %	98 %	106,890	55 %
ENS_PRIVIA	Privia Health	886,440	0 %	3 %	62 %	94 %	94 %	100 %	100 %	100 %	644,705	0 %
JHCPA	Johns Hopkins Home Care Group - RPM	881,893	76 %	74 %	61 %	93 %	88 %	100 %	97 %	97 %	165,645	99 %
MHS	Mercy Medical Center (No Auditable Contacts or Assets)	745,962	36 %	83 %	47 %	99 %	99 %	100 %	99 %	99 %	336,796	38 %
WMHS	UPMC - Western Maryland	622,451	98 %	75 %	98 %	99 %	93 %	100 %	100 %	99 %	26,038	10 %
JHH_BVIEW	Johns Hopkins Bayview Medical Center	584,103	93 %	62 %	68 %	99 %	96 %	100 %	100 %	100 %	31,704	95 %
MEDSTAR_FSH	Medstar Franklin Square Medical Center	408,641	100 %	39 %	91 %	99 %	94 %	100 %	100 %	98 %	33,874	21 %
JHH_HH	Johns Hopkins Home Health	396,081	5 %	57 %	57 %	85 %	77 %	100 %	92 %	92 %	1,990	84 %
HCGH	Johns Hopkins Howard County Medical Center	374,645	91 %	69 %	75 %	96 %	93 %	100 %	99 %	99 %	16,972	95 %
HCH	Holy Cross Health Center - Silver Spring	345,858	86 %	36 %	83 %	83 %	62 %	100 %	96 %	96 %	17,497	85 %
GBMC	Greater Baltimore Medical Center	334,945	70 %	69 %	48 %	83 %	82 %	100 %	97 %	87 %	57,567	26 %
FMH_ID	Frederick Health	334,587	93 %	0 %	89 %	98 %	94 %	99 %	98 %	99 %	26,186	98 %
AGH	Atlantic General Hospital	320,718	97 %	77 %	5 %	98 %	94 %	100 %	100 %	98 %	18,825	0 %

CRISP Services

1. POINT OF CARE: Clinical Query Portal & InContext Information
   - Search for your patients' prior health records (e.g. labs, radiology reports, etc.)
   - Determine other members of your patient's care team
   - View external records in a SMART on FHIR app inside your EHR
2. CARE COORDINATION: Event Notification Delivery
   - Be notified when your patient is hospitalized in any regional hospital
   - Enhance workflows across multiple care settings and teams
3. POPULATION HEALTH REPORTS: CRISP Reporting Services (CRS)
   - Use administrative and clinical data to design and measure interventions
4. PROGRAM ADMINISTRATION:
   - Making policy discussions more transparent and informed
   - Disseminating evidence-based best practices and technology
5. HEALTH DATA UTILITY:
   - Deploying services in partnership with health officials
   - Providing information and reports to state and local health departments
   - Linking, analyzing, and sharing data across the continuum

Service	Typical Week
Portal Queries	75,000
EHR Application Launches	150,000
Automated API Calls	1.5 mil
Outbound Event Notifications	3.5 mil
Inbound ADTs	3.0 mil
Inbound ORUs	1.7 mil
Participating Organizations	2,200
Active Users	27,000

Point of Care: InContext Data Delivery

- View of patient data, pulled from multiple repositories and sources, embedded in the end user's EHR
- Integrations can occur in EHR native app stores or through API queries
- CRISP is FHIR compliant and moving to USCDI+ and TEFCA

HIE InContext

FRODO BAGGINS

Male | May 6, 1989 | Probable

34121 RING LANE, COLUMBIA, MD 21045

Infection Control Alerts VIEW

Next of Kin VIEW

HEALTH RECORDS | ENCOUNTERS | STRUCTURED DOCUMENT

LABORATORY | RADIOLOGY | CLINICAL NOTES

Health Records

Date	Source	Description
2021-03-04	BAMLANREF	Referral for further care
2020-01-24	MHS	TYPE AND SCREEN
2019-05-10	UMMS_UMMC	Functional Brain MR
2019-02-08	UMMS_UMMC	URINE ANALYSIS
2017-12-19	UMMS_UMMC	Discharge Summary

Rows per page: 25 1-5 of 5

Important Additional Data

- Data is combined across sources to reveal critical information

HIE InContext

MEDICATION MANAGEMENT
CLINICAL DATA
CARE COORDINATION
SOCIAL NEEDS DATA
DATA FROM CLAIMS
HIE PORTAL

GILBERT GRAPE

Male | Jan 1, 1984 | Probable

4145 Earl C Adkins Dr. River, WESTMINSTER, WV 26000 | No Infection Control Alerts | Next of Kin | VIEW

ADVISORIES | PDMP

93	Average Daily MME THRESHOLD: 1+ DAYS OVER 90	5	Overlapping Opioid & Benzos THRESHOLD: 3
14	Overlapping Opioids THRESHOLD: 3	2/2	Total Prescribers/Pharmacies THRESHOLD: 5/5

Detailed medications data available VIEW PDMP

Powered by CRISP

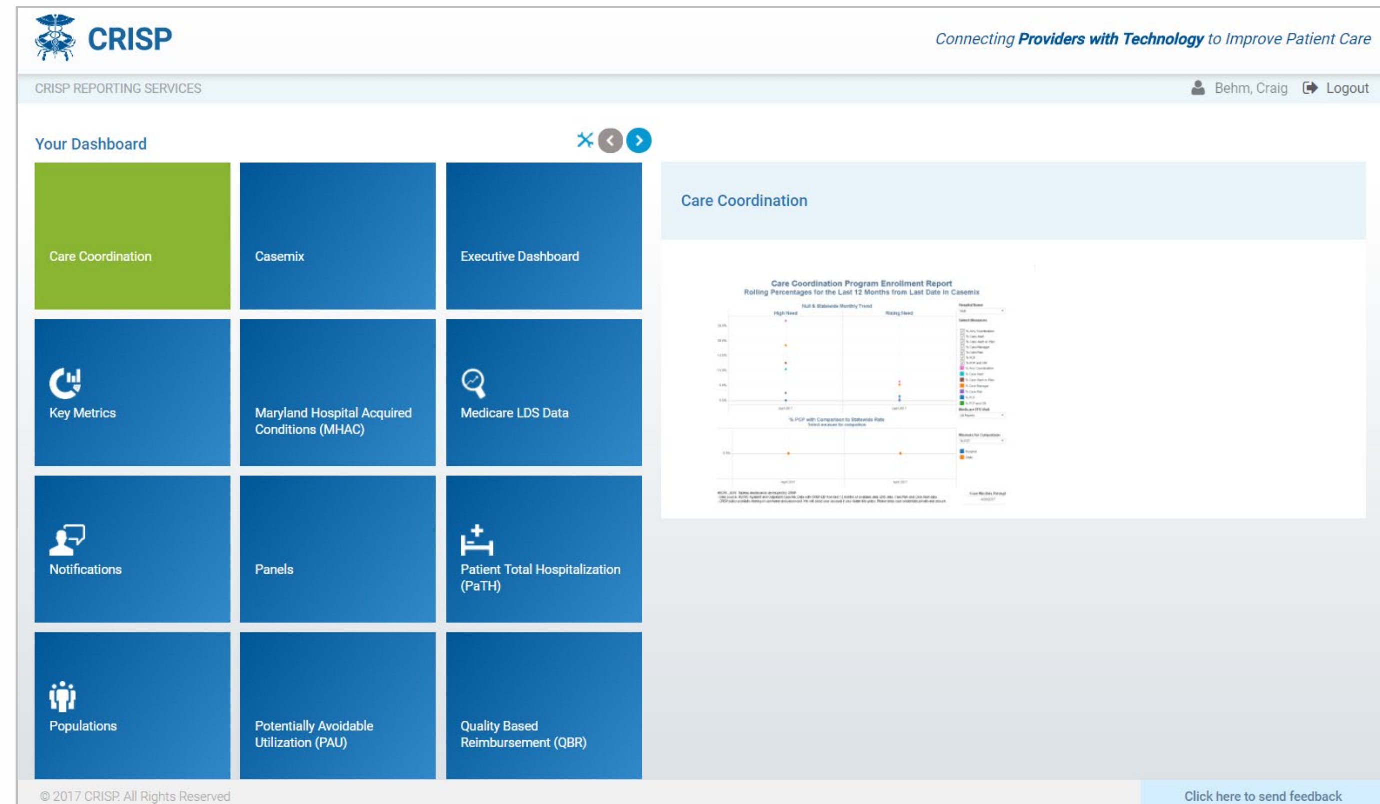
1 Clinical Alerts

BSB (2019-07-25)

Patient may have experienced a controlled substance related event on 2019-07-25 at Bon Secours Hospital. Discharge Diagnosis: T40.2X1A (Poisoning by opium, intentional, initial) (Patient may have experienced an overdose even on 2019-01-20 20:30 at BSB.). Admit Reason: Overdose on Controlled Dangerous Substance. There is no longer a training requirement to obtain a waiver to prescribe buprenorphine for treatment of OUD; please visit Maryland Addiction Consultation Services (https://www.marylandmacs.org/New-HHS-Practice-Guidelines/) for more information.

Population Health: CRISP Reporting Services

- Dashboards from administrative data to support high-needs patient identification, care coordination, and progress reporting
- Primary data sets are hospital casemix and Medicare claims and claim line feed (CCLF)
- Different levels of patient data available for hospitals based on HSCRC payment requirements and Total Cost of Care Model participation
- There are over **600 active users** viewing **85 reports** over **2,000 times per month**



Public Health Dashboard

- Designed for individuals working on population health and public health, who want a deeper understanding of their community's health
- Users can define a population of interest that will persist through the report to better understand that population's characteristics
- The dashboard hosts interactive maps of Maryland to drill down into utilization by county or zip code and view areas of excess

Health Related Social Needs HIE Tools

Screening Assessments

Obtain Data

- Direct Entry Screening Tool
- Screening data via data feeds

Share Data

- InContext: Social Needs display
- Assessments: history of patient's SDOH assessment created and/or shared with HIE
- Z-codes: Social, environmental, and economic conditions from ICD-10 codes in parsed CCDs

Referral Tools

1. Search Community Programs
    - Enables users to easily search and select community-based programs
    - Searches external community databases like 211s
2. Create Referral
3. Manage Referral

Display in Point of Care

- Referral History view: Allows members of the patient's Care Team to view the patient's referral history

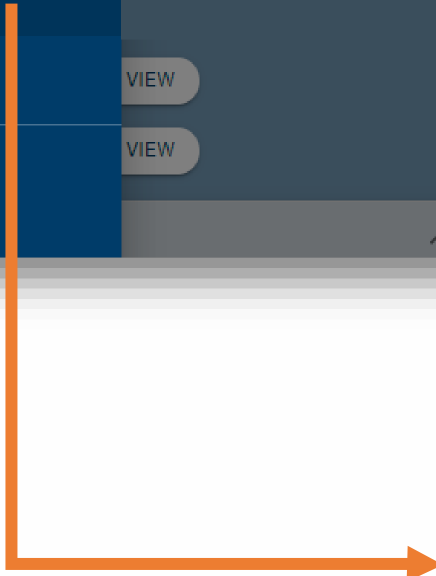
Interoperability for Assessments

ontext

MEDICATION MANAGEMENT
CLINICAL DATA
CARE COORDINATION
SOCIAL NEEDS DATA
DATA FROM CLAIMS
HIE PORTAL

Probable

VIEW
VIEW



HIE InContext

GILBERT GRAPE

Male
Jan 1, 1984
Probable

4145 Earl C Adkins Dr, River, WV 26000

80 Infection Control Alerts VIEW

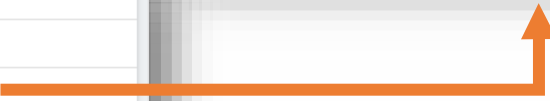
4 Next of Kin VIEW

ASSESSMENTS CONDITIONS REFERRAL HISTORY

Assessments

Date	Source	Description
2021-03-19	JHHREL	AHC Screening
2021-03-19	JHHREL	CMS Screening
2020-02-15	JHHREL	AHC Screening
2020-02-15	JHHREL	CMS Screening

Rows per page: 25 1-4 of 4



AHC Screening
2020-02-15

Housing

What is your living situation today?

I have a steady place to live

Think about the place you live. Do you have problems with any of the following?

Mold
Lead paint or pipes

Food

Transporation

Direct Data Entry

HOME

Search Applications & Reports

Reports & Applications

- Panel Processor
- Screening
- RealTime
- Clinical Information Staging
- Search Programs
- MyDirectives for Clinicians
- Snapshot Staging
- InContext
- Reports Role Manager
- PopHealth
- DC VAC

Direct Entry Screening Tool

Name: GILBERT GRAPE | Gender: male | DoB: 1984-01-01 | Phone: home: 7889007666

Available Questionnaires: Show Date

Search

- Meritus SDOH Screening Questionnaire
- The Accountable Health Communities Health-Related Social Needs Screening Tool
- Maryland MOM Social Determinants of Health Screening

The Accountable Health Communities Health-Related Social Needs Screening Tool

Name	Value	Units
Housing Instability/Homelessness		
What is your living situation today?	Select one	
Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY	Select one	
Food Insecurity		
Within the past 12 months, you worried that your food would run out before you got money to buy more.	Select one	
Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	Select one	
Transportation Insecurity		
In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living?	Select one	
Inadequate Housing		
In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	Select one	
Interpersonal Violence		
How often does anyone, including family and friends, physically hurt you?	Select one	
How often does anyone, including family and friends, insult or talk down to you?	Select one	

Creating and Sending Referrals

1: Select a Patient, choose the program

2: Create referral

3: Complete the form (pre-populated)

4: Receive confirmation and email notification

Referral Confirmation

HIE Referrals
To Naureen Elahi
2:30 PM

Thank you for using CRISP Referral Services. Your referral submission has been sent to the following program(s):

Referral Program: Fitness & Exercise
Program Description: The Richard A. Henson Wellness Center at MAC offers a wide variety of programs and services targeted toward addressing the health concerns and needs of older adults. The centers goal is to enable and to empower members to be physically active and to maintain and enhance their level of independence. Gym offerings include in-person and virtual classes, equipment and personal training. Membership fees are paid monthly and scholarships are available.

Confirmation Number: 2879bbf9-43eb-41a7-99fd-5ca78005bb58

Sincerely,
CRISP - Health Information Exchange

Managing Referral Worklist

Community Based Organizations view a sortable referral worklist to identify, select, accept/reject, and share notes for the individual

CBO WorkList

Filter results

Name	Gender	Date of Birth	Referring Provider	Referral Date	Referral Status	Last Updated	Organization	Program Name
ULPThree UnifiedLandingP	M	2003-03-03	Janelle Thomas	2024-01-22 11:07:11 AM	Pending	2024-01-22 11:07:11 AM	Test Organizations	Diabetes Self-Management Training
Luke Skywalker	M	1977-01-22	Janelle Thomas	2024-01-22 10:42:27 AM	Pending	2024-01-22 10:42:27 AM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	F	1984-01-01	Janelle Thomas	2024-01-19 03:38:35 PM	Pending	2024-01-19 03:38:35 PM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	F	1984-01-01	Janelle Thomas	2024-01-19 03:36:11 PM	Pending	2024-01-19 03:36:11 PM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	F	1984-01-01	Janelle Thomas	2024-01-19 10:58:20 AM	Pending	2024-01-19 10:58:20 AM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	F	1984-01-01	Janelle Thomas	2024-01-19 10:32:10 AM	Pending	2024-01-19 10:32:10 AM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	M	1984-01-01	Nick Ramsing	2024-01-17 12:13:44 PM	Enrolled	2024-01-17 12:15:32 PM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	F	1947-09-30	Janelle Thomas	2024-01-11 03:09:45 PM	Pending	2024-01-11 03:09:45 PM	Test Organizations	PIMR
Gilbert Grape	M	1984-01-01	Nick Ramsing	2024-01-11 12:20:11 PM	Enrolled	2024-01-11 12:22:00 PM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	M	1984-01-01	Nick Ramsing	2024-01-11 11:50:38 AM	Pending	2024-01-11 11:50:38 AM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	F	1947-09-30	Janelle Thomas	2024-01-08 09:57:32 PM	Enrolled	2024-01-22 02:17:27 PM	Test Organizations	Monoclonal Antibody Infusion
Gilbert Grape	F	1947-09-30	Janelle Thomas	2024-01-08 05:24:07 PM	Pending	2024-01-08 05:24:07 PM	Test Organizations	Diabetes Self-Management Training

Items per page: 25 26 – 37 of 37

Filter

- [x] Pending
- [x] Accepted
- [x] Enrolled
- [ ] Rejected
- [ ] Completed

Maryland Model Program Participants

Episode Care Improvement Program (ECIP):
15 Hospitals participated in ECIP for CY2023, and the unduplicated count of care partners was **4,764** individual clinicians & **9** facilities.
The total amount of hospital incentives awarded since program inception is **$9,025,347.**

Episode Quality Improvement Program (EQIP):
CRISP supports specialty practice and other provider participation in bundled care arrangements. In CY2023, there were **2,733** care partners participating across **64** EQIP entities

Care Transformation Initiatives (CTIs):
All but 2 MD Hospitals are participating in at least one CTI, and in total, **107** participant elected CTIs cover **263,907** episodes. CRISP Care Transformation Profiler allows hospitals to view all CTIs statewide and to monitor progress.

MD Primary Care Program (MDPCP):
48 practices joined in 2023, and 154 practices graduated to Track 3. Currently there are more than 500 primary care practices participating in the program

Broad Alignment for TCOC Activities

Care Coordination Tools	Population Health Reports	Program Performance Reports
• Pertinent treatment information at the point of care (clinical, SDOH, care alerts) • Notifications to allow timely follow up after discharge and transitional care • Close loop referrals • Patient identification for care management interventions	• Key trends and descriptive statistics for patient population • Study of directional data for specific populations and geographies • Patient identification for care management interventions • Intervention tracking	• Key metrics for programs such as MDPCP, MPA, EQIP, CTI, ECIP • Results and opportunities for quality improvement related to HSCRC payment methodologies
Program Administration	**Quality Reporting**	**Learning System**
• Support participants with program enrollment and related requirements • Technical assistance for providers • Promote policy transparency and coordination with stakeholders	• Annual MDPCP eCQM reporting • Hospital Quarterly eCQM collection in partnership with HSCRC • Ambulatory eCQM data collection in partnership with MDPCP	• Educational webinars • White papers • Learning collaboratives • Website resources • Annual summit

Public Health: Health Data Utility

The General Assembly passed HB1127 in 2022 requiring the State-Designated HIE (CRISP) to operate as a Health Data Utility (HDU). Purposes include:

1. The collection, aggregation, and analysis of clinical information, public health data, and health administrative and operations data to assist the Department, local health departments, the Commission, and the Health Services Cost Review Commission in the evaluation of public health interventions and health equity;
2. The communication of data between public health officials and health care providers to advance disease control and health equity; and
3. The enhancement and acceleration of the interoperability of health information throughout the State.

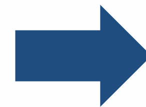
Source: https://mgaleg.maryland.gov/2022RS/bills/hb/hb1127T.pdf

Key Pillars of a Health Data Utility

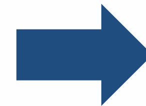
Services

- **Enrich Data**
  - Link disparate data sets
  - Use multiple sources to fill gaps
  - Improve data feeds
  - Surface key insights
- **Distribute Information**
  - Create visualizations
  - Control access levels
  - Push individual clinical records
  - Share analytic files
- **Enable Interventions**
  - Flag patients at the point of care
  - Notify appropriate end users
  - Share relationships between organizations

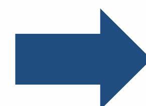
Value



All data becomes more useful when it is linked, normalized, deduplicated, and cleansed within a single analytics engine



User experience is enhanced and usage increases when a single entity is responsible for governance and distribution



Alignment between population level reports and actionable individual experiences is more likely to result in positive change

Near-term HDU Activities

- Leverage **existing data feeds** for multiple use cases
  - Hospital HL7 can be aggregated for public health dashboards – Ex. Respiratory disease
  - Medicaid claims can be shared at the point of care
  - Send immunizations to payers in bulk , alleviating the need for individual queries
- Support collaborative governing bodies to **share ideas**, best practices, and recommendations
  - Groups that don’t routinely interact get the opportunity
- Launch pilots by leveraging existing infrastructure and staff; expand or stop based on **real-world results**
  - Push suspected overdose events to a local health department to try new outreach programs
  - Try sending referrals from primary care practices to community-based organizations

HIE – MDH Collaboration Success Stories

School Immunizations

- Sent bulk immunizations to 2 county school systems, adding efficiencies to a process that required manual, individual querying to confirm student immunization records. One school system reported decrease in staffing needs from 10 to 2 FTE.

Cancer Registry

- The MD Cancer Registry is required to send tumor abstracts for all cancer cases who died to CDC. CRISP was able to send encounter information for folks the Registry was missing, and they were able to reach out to those providers to get missing information. Using CRISP supplied data, the team was able to reduce the rate of missing in half, from 3% to 1%

Cryptosporidium

- On 9/28, Baltimore City announced that levels of a microscopic parasite (Cryptosporidium) was found in reservoir. MDH requested data to help assess their baseline data. On 10/3, CRISP provided positive labs data and total tests to MDH to compare against their numbers. MDH reported that there were no additional cases identified by CRISP that were missing from their eLR feeds, providing additional confidence in required reporting.

Pregnancy and HIV

- MDH had concerns they weren't identifying all HIV positive pregnancies and infants as soon as they could be. CRISP sends pregnancy indicator in HIV positive individuals to MDH for outreach and checking. We were able to identify 4 infants exposed to HIV that were previously unknown to MDH.

Privacy & Security

Opt-out model gives patients the right to block electronic access to their information shared through the HIE

- All participating providers must update Notice of Privacy Practices and make patient education materials available
- If a patient opts out, no information will be available through the portal and notifications about hospitalizations for this patient will be blocked
- EXCEPTION: By Maryland law, opt-outs do not apply to PDMP and this data will still be visible in a patient's record

Annual audits and reports as required by State Designation Agreement, regulations, and best practices

- SOC 2 Type 2
- HIPAA & COMAR Compliance
- Cybersecurity & Social Engineering Testing

Adhering to industry best security standards

- EHNAC HIE accredited since Feb. 2017
- HITRUST certificated since Nov. 2017

Continuous privacy monitoring

- Protenus software monitors query activity to identify potentially suspicious activity outside of a permitted use case

Resources

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

Public Health Infrastructure

CRISP helps state and local systems coordinate with each other within the states, enhance the data with up-to-date demographic information, add clinical data, help communicate between states, and distribute data to downstream users.

Selected recent successes

- Secure shared COVID reporting portal for analytics
- Scalable contact tracing workflow for COVID and MPOX
- Centralized surge response through bed occupancy
- COVID state reporting
- Vaccination data to providers and downstream users (such as Baltimore City Schools for school readiness)
- Interoperability between health and other sectors
- EMS data at the point of care

Maryland Model, MDH, & Medicaid

CRISP helps MDH work with, support, and benefit from the Total Cost of Care Model through statewide reporting, actionable data for public health program enrollment, and inclusion of Medicaid data in Model measures and tools.

Selected recent successes

- Shared reporting for Model population health goals (diabetes, opioids, maternal and child health)
  - Severe Maternal Morbidity
- Provide actionable data to public health to enroll patients in public health programs linked to state goals (asthma home visiting program, pre-diabetes alerts)
- Follow-up after hospital discharge measure for both Medicaid and Medicare

Health Equity/Social Determinants of Health

CRISP is enhancing the focus on health equity through enhancing data with race/ethnicity, and building an interoperable SDOH suite of tools to help providers support their patients with social needs and connect with community providers.

Selected Recent Successes

- Race/Ethnicity enrichment for COVID testing, immunizations, etc.
- SDOH referrals between clinicians and community organizations
- Interoperability with third-party social needs vendors
- Social needs clearly visible in portal (assessments, z-codes)

Behavioral Health

CRISP continues to focus on behavioral health both from a point of care perspective but also as an HDU in partnership with MDH to support various initiatives

Selected Recent Successes

- Non-fatal overdoses displayed at the point of care, and also routed to LHDs for follow up and connections to care
- SUD consent tool allows for providers to complete consent and view available SUD data (Care Team, Clinical Documents)
- DORM initiative – data management and linkage
- PDMP - Continued support of MD program (User facing tools + backend analytics, provider insights, etc.)
- Maternal Opioid Misuse (MOM) model – federal pilot program ended but we are supporting continuation at the local level

Public Health: Maryland Department of Health Collaborations

Prescription Drug Monitoring Program

- PDMP data available to providers and dispensers along side clinical data
- Close partnership with Behavioral Health Administration to support the continued development of the program and services
- Maryland Mandatory Registration and Use

Population Health Reports

- Geographic mapping for public health officials of hospital encounters, and when married to HSCRC claims data, specific conditions

Meaningful Use

- CRISP facilitates public health reporting and attestation for hospitals and providers

Support of State Medical Examiner and Fatality Review Teams

- CRISP serves as a source of clinical information in death investigations

Disease Investigation

- Public Health Investigators utilize CRISP for Reportable Disease Investigation
  - Demonstrably more efficient and richer data source for hospital-reported conditions than previous methodology
- HIV Care Reengagement
  - Alert DHMH when HIV positive individuals encounter health system
  - Reconnect individuals to treatment and individuals who never learned status

Oz System

- Newborn alerting, to facilitate mandatory hearing screening

CAliPR

- Clinical Quality Measure calculation tool for Medicaid Eligible Professionals and Hospitals, using EMR data to automate selected CQMs

ImmuNet Registry

- MDH ImmuNet registry data available in CRISP Clinical Portal

Public Health Dashboard Details

- Data Sources
  - **Claims** - HSCRC All-Payer Hospital Claims (referred to as the Casemix Data) for IP, OP, ED, Obs visits.
    - Refreshed monthly
  - **County/Zip Code** - values pulled from the HSCRC Casemix data.
    - Denominators derived from the American Community Survey
  - **Conditions** – Defined by ICD-9/10 Codes or CMS Chronic Condition Warehouse (CCW)
  - **Prevention Quality Indicators (PQIs) –** AHRQ methodology
  - **Readmissions** – HSCRC's Readmission Reduction Incentive Program (RRIP) definition of readmissions
  - **Service Lines** – 3M APG-DRG Grouper (IP &Obs >24Hrs.) & EAPG (OP & ED)

*More specific details can be found in the Public Health Dashboard User Guide

Summary Tab

The Summary Tab can be used by users to select primary population of interest using the available filters. This tab is a quick way for users to view population demographics and brief utilization statistics.

Refresh | Revert | Pause | Help | Print | Excel

Reports

Summary | Populations Compare | Service Line | Trend | Utilization Map | Excess Map

Public Health Dashboard

Summary

Review Maryland's hospital utilization by demographics. Select pie chart sectors or blue bars and other charts will update to the selected sector.

Race

White 46% 4,617,217
African American 43% 4,271,431
Native Hawaiian or other Pacific Islander 0% 23,976

African American | Native Hawaiian o... | American Indian, E... | Other | Asian or Pacific Isl... | White | Biracial

Gender

Unknown 0% 669
Male 44% 4,392,054
Female 56% 5,594,124

Female | Male | Unknown

Payer

Commercial and Other 34% 3,435,604
Medicare FFS 21% 2,127,650
Medicare MCO 2% 210,743
Self-Pay and Charity 7% 730,136

Medicare FFS | Self-Pay and Charity | Medicaid FFS | Commercial and Ot... | Medicare MCO | Medicaid MCO

Conditions

Condition	%
None	41.0%
Acquired Hypothyroidism	2.3%
Acute Myocardial Infarcti..	0.7%
Alcohol Overdose	0.0%
Alcohol Related SUD	3.5%
Alzheimer's Disease	0.4%
Alzheimer's Disease and R..	2.5%
Anemia	8.4%
Anxiety	8.3%
Any Mental Health Conditi..	24.3%
Any Overdose	1.4%
Any Substance Use Disord..	17.0%
Asthma	8.4%
Atrial Fibrillation	4.7%
Benign Prostatic Hyperpla..	1.8%
Cataract	0.0%
Chronic Kidney Disease	8.8%
Chronic Obstructive Pulm..	6.0%
Colorectal Cancer	0.6%
Depression	7.8%
Diabetes	13.1%
Endometrial Cancer	0.2%
Fall	2.1%
Female / Male Breast Canc..	1.2%
Heart Failure	4.8%
Hip/Pelvic Fracture	0.3%

0 | 5,000,000
Visits Total

Age Group

Age Group	%
0-4	9.0%
5-9	3.4%
10-14	3.1%
15-17	2.5%
18-24	9.3%
25-29	8.1%
30-34	7.7%
35-39	6.6%
40-44	5.3%
45-49	5.8%
50-54	6.7%
55-59	6.7%
60-64	5.8%
65-69	5.0%
70-74	4.3%
75-79	3.7%
80-84	3.0%
85+	4.0%
NA	0.0%

0 | 500,000 | 1,000,000
Visits Total

Hospital

Hospital	%
Anne Arundel Medical Cen..	4.4%
Johns Hopkins Hospital	4.4%
Holy Cross Hospital	3.8%
UM-Baltimore Washingto..	3.6%
St. Agnes Hospital	3.6%
Medstar Franklin Square	3.5%
Peninsula Regional Medic..	3.4%
Howard County General H..	3.2%
University Of Maryland M..	3.2%
Frederick Health Hospital,..	3.1%
Sinai Hospital	3.0%
Shady Grove Adventist Ho..	2.9%
Meritus Medical Center	2.6%
Mercy Medical Center	2.6%
Greater Baltimore Medica..	2.5%
Johns Hopkins Bayview M..	2.5%
UM-Upper Chesapeake Me..	2.5%
Medstar Union Memorial ..	2.2%
Northwest Hospital Center	2.2%
UM-Charles Regional Medi..	2.1%
UM-St. Joseph Medical Ce..	2.1%
Medstar St. Mary's Hospit..	2.0%
Medstar Harbor Hospital ..	2.0%
Medstar Good Samaritan	1.9%
Carroll Hospital Center	1.9%
Medstar Southern Maryla..	1.9%

0 | 500,000
Visits Total

Utilization

Visit Type: (All)
Month of Discharge Date: January 2016 – December 2019
Conditions: (All)
Hospital Name: (All)
High Need (Last 12 mo): (All)
Payer: (All)
Service Line: (All)
Prevention Quality Indicators: All Patients

Demographics

Age Group: (All)
Race: (All)
Ethnicity: (All)
Gender: (All)

Geography

Zip:
County: (All)

Data Available Through January 2020

- Demographics displayed:
  - Race
  - Gender
  - Age

- Hospital Utilization displayed:
  - Payer
  - Conditions
  - Hospital

Data Available through indicator

Utilization Map

The Utilization Map allows user to visualize trends by zip or county to identify areas most impacted by the measure and filters selected. The chart below the map populates with data from the measure selected by the zip or county. Users can use the excel download icon to export the data table into an excel workbook.

Refresh | Revert | Pause | Help | Print | Excel

Summary | Populations Compare | Service Line | Trend | Utilization Map | Excess Map

Public Health Dashboard

Utilization Map

The utilization map allows you to visualize various quality, financial, and utilization measures by county or zip code for your population of interest. For example, you can visualize the ED encounters per 1000 for pediatric asthma by zip code to identify areas that are most impacted.

Georgraphy: County

Measure: Visits

Visits 52,245 – 1,912,394

Delaware

© 2020 Mapbox © OpenStreetMap

	Visits	Patients	Charges	Population	Selected Measure Visits
State	9,986,847	3,371,083	$44,723,746,881	5,773,552	9,986,847
Allegany County	140,764	44,678	$678,100,828	75,087	140,764
Anne Arundel County	901,743	346,942	$3,975,078,319	537,656	901,743
Baltimore City	1,912,394	503,210	$8,709,557,071	620,961	1,912,394
Baltimore County	1,460,738	538,998	$8,162,352,971	805,029	1,460,738
Calvert County	163,363	61,008	$555,573,707	88,737	163,363
Caroline County	65,079	22,827	$278,724,358	33,066	65,079
Carroll County	221,041	91,502	$1,296,600,400	167,134	221,041
Cecil County	179,238	58,717	$713,144,893	101,108	179,238
Charles County	252,375	94,851	$805,477,339	146,551	252,375
Dorchester County	98,065	25,433	$352,074,887	32,618	98,065
Frederick County	350,556	144,056	$1,594,795,694	233,385	350,556
Garrett County	55,406	17,688	$136,730,831	30,097	55,406
Harford County	393,900	149,406	$2,017,804,015	244,826	393,900
Howard County	330,444	155,301	$1,732,732,082	287,085	330,444

Utilizaition
- Visit Type: (All)
- Month of Discharge Date: January 2016 – December 2019
- Conditions: (All)
- Hospital Name: (All)
- High Need (Last 12 mo): (All)
- Payer: (All)
- Prevention Quality Indicators: All Patients
- Service Line: (All)

Demographics
- Age Group: (All)
- Race: (All)
- Ethnicity: (All)
- Gender: (All)

Geography
- Zip
- County: (All)

Data Available Through January 2020

Alyssa Lord, MA, MSc
Deputy Secretary of Behavioral Health
Maryland Department of Health

Baltimore City
Central Maryland

Alyssa Lord is the Deputy Secretary for Behavioral Health at the Maryland Department of Health (MDH). She brings more than 20 years of experience in community and population health. Ms. Lord has focused her efforts on working collaboratively across local, city, state, and federal entities to improve the health outcomes across the lifespan.

Prior to joining MDH, Ms. Lord served in a number of leadership positions that combined direct service, advocacy, policy, and strategy in New York and New Jersey. Most recently she was Vice President, Healthcare Strategy at a large ($120 million+) housing, healthcare, and workforce development nonprofit where she was responsible for setting the vision for healthcare, behavioral health, and substance use services for homeless and unstably housed New Yorkers. In previous positions she led the implementation of care coordination services for clinically, behaviorally and socially complex Medicaid, dually enrolled, and special needs plans beneficiaries. She was also responsible for establishing a university-community partnership in West Philadelphia that led to the implementation of a school-based health center/federally qualified health center and the development of an innovative health careers curriculum for middle and high school students.

Ms. Lord earned Master's degrees from New York University and the London School of Economics.

MARYLAND DEPARTMENT OF HEALTH/Behavioral Health’s Vision and Priorities

Alyssa Lord, MA MSc

Commission on Public Health
March 6, 2024

Behavioral Health Continuum of Care

Prevention/Promotion				Primary Behavioral Health/ Early Intervention		Urgent/Acute Care		Treatment / Recovery	
Promotion	Universal Prevention	Selective Prevention	Indicated Prevention	Outpatient Care	Intermediate Care	Urgent/ Crisis Care	Acute Treatment	Long-Term Treatment	Recovery Supports

Data / Quality / Health Equity / Workforce Initiatives

Behavioral Health Continuum of Care for Children and Adolescents

Draft - 9.5.23

Prevention/Promotion				Primary Behavioral Health			Urgent/Acute Care		Treatment / Recovery	
Promotion	Universal Prevention	Selective Prevention	Indicated Prevention	Outpatient Care	Intermediate Community Care	Intensive Community Based Care	Urgent/ Crisis Care	Acute Treatment	Sub-Acute Intervention	Recovery Supports
• General Outreach • Pop Specific Outreach • Comms Campaigns	• ACE Awareness • Social and Emotional Learning modules • School-Based Services (Tier 1)	• Good behavior game • SBIRT • Harm Reduction • Early childhood MH consultations w/ brief treatment	• SBIRT • Home Visiting • Mental Health First Aid • TAY • Early childhood MH consultations w/ brief treatment • DHS Prevention	• Community-Based Services • Case Mgmt • MH Client Support Services • Drug Court • Outpatient Detox • MAT • Brief intervention - PCP • School-based care	• Youth PRP • Youth TBS • DDA Youth Community Supports Services	• Partial Hospitalization • Intensive outpatient (IOP) • Intensive in home supports (EBPs) under 1915i	• 988 Hotline • Urgent Care Services • Crisis Stabilization Centers • Mobile Crisis Teams • Res Crisis • STOP • Respite	• ED • Inpatient • Inpatient Detox (ASAM 4.0, 3.7-D)	• ASAM 3.5/3.7 • Intensive in-home supports (EBPs) under 1915i • MAT	• State Care Coor. • MDRN • START • Family Peers • Adolescent Clubhouse • Recovery schools
			• SATS (TCA) • Targeted Case Management			• ACT • MHSS / MRSS • Safe Stations		• Targeted Case Management • Res. Treatment		
			• BHIPP • EPSDT • EMR embedded screening • FEP							

BHA Focus Areas

Prevention/Promotion:
- Suicide Prev/Problem Gambling
- Veteran's Services
- Peer Services

Primary BH/Early Intervention:
- BH Children's Strategy

Urgent/Acute Care:
- Mobile Crisis/Crisis Stabilization Center Regulations

Treatment/Recovery:
- RRP, ALU Bed Expansion
- Housing/Wrap Around Supports

Policy/Planning:
- Licensing/Accreditation
- Provider Quality / Monitoring
- State BH Strategic Plan
- Planning/Grants

Operations:
- Shared Services (HR, Fiscal, Procurement)

Medical Director:
- Resident Grievance System Expansion/Regulations

BHA Focus Areas – Strategic Priorities Q2-Q4 CY 2024

Workforce:

- MDH Focus

Inter-Agency Collaboration:

- Partnerships with DHS / DJS/ MSDE

Value-Based Purchasing:

- Drafting Framework

CCBHCs:

- Awaiting Federal NOFO

School-Based Health Services:

- Recent NOFO

Outcomes:

- Alignment with the Governor's Office on Performance Improvement

Technology Enhancements:

- National Landscape
- Apps, Bed Registries, Telehealth Services

Thank You