



**District of Columbia Medical Care Advisory Committee
Health System Re-Design Subcommittee**

July 7, 2021
4:00-5:00pm

Meeting Minutes

- 1. Welcome** (T. Smith - 5 minutes)
 - a. **Attendees:** Mark LeVota, District of Columbia Behavioral Health Association, Tommy Zarembka - Food & Friends, Josh Kauffman, AmeriHealth Caritas DC, Alec McKinney, JSI, Mark Rodriguez, HSCSN, Akeisha Guy, DBH, Rachelle Toman, MedStar Health, Terri Spencer, DBH Adult Services, Cheryl Fish-Parcham, Families USA, Dena Hasan, DHS, Anna Dunn, HSCSN, DHCF Staff
- 2. Report out from the Subcommittee recommendation to full MCAC** (T. Smith - 5 minutes)
 - a. Discuss next steps and timeline to report back (tabled for September)
- 3. 2022 State Medicaid Health IT Plan** (D. Soyer, A. Kinney - 45 minutes)
 - Focus group to provide feedback and inform the 2022 District of Columbia State Medicaid Health IT Plan (SMHP).
 - Overview of SMHP project purpose, approach, and timeline
 - Discuss and reflect on District's progress to date on HIT / HIE initiatives since the creation of the [2018 SMHP Health IT Roadmap](#)
 - Discuss stakeholder priorities for the next few years to enhance the use of health IT and HIE in the District.
 - **Notes:** Health homes uses CRISP for tracking EMS alerts hospitalizations and readmissions. Teams have also been using measures and vitals. Worked with Team

Enlightened to train providers on how to use CRISP. Panels specific to health homes are available to receive specific alerts daily. CRISP doesn't have a reminder for updating the panel – so teams may forget to update and end up getting locked out of system.

Technical difficulties occur often.

- Health centers use CRISP to respond to patient ER or hospitalization – ED and inpatient notification, reporting, COVID vaccine.
- AmeriHealth and HSCSN uses CRISP for ED and inpatient notification, ED Reporting, Covid vaccine reporting
- DBH is trying to figure out how better to use for clients who may be eligible for the new Transition Planning Benefit. There are some unique eligibility issues with this group, so we are not there yet.
- Population health analytics – Suggest to make available aggregate data for utilization trends for different service types or perhaps the most common diagnosis types that lead to hospitalization. Let providers compare themselves to other providers to in an anonymous way. Allow them to also do drill down into their own patient panels.
- Behavioral health providers have challenges feeling comfortable with sharing out mental health clinical data with other providers. How can we incentivize that?
- Cross-sector data sharing has challenges, but CBOs are interested in data for their clients in the aggregate and specifically.
- Population health – filtering is burdensome – ensure that the information is presented in a straightforward manner.
- Many of the measures are not actionable, but by using CRISP in a sophisticated way. Making specifications for measures publicly available. Streamline number of measures, but also provide support within the HIE for providers to be able to track those measures.
- Ongoing training with providers would be great.
- Many organizations need to understand what they need beyond CEHRT to be successful for their specific business
- Interoperability – SSO, InContext in eMR adds huge value to clinicals; Technical Assistance -Team Enlightened TA; COVID Use Cases promoting.
- Give flexibility to folks; don't limit to a single platform
- Enable granular consent management
- Inconsistent legal interpretation of policies

4. Next meeting (scheduled for September 1 at 4p) (O. Enyia – 5 min)

- Call for agenda items
 - Discuss subcommittee ideas and goals regarding the HER (20 minutes)
 - [NCQA HEDIS Report](#) (stratification of key outcome measures by race/ethnicity)
 - Potential Microsoft Teams to Webex transition this Fall