Maternal Health Advisory Group

June 17th, 2025

Today's Agenda

Welcome – 5 min

Provider Incentive Program – 10 minutes

TMaH & Improving Data Infrastructure – 5 minutes

Digital Health: DC HIE 101 – 15 minutes

Discussion and Next Steps – 25 minutes

TMaH Award Required Notice

This project is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $17,000,000 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Provider Incentive Program

(10 minutes)

Provider Incentive Program for TMaH

- **Overview:** Eligible prenatal care providers can receive incentive payments (up to ~$46k) for completing milestones in calendar years 2025 and 2026

- **Milestones:** Eligible providers will complete seven milestones that aim to:
  - Strengthen capacity to implement TMaH whole-person care requirements
  - Provide information to support the development of the TMaH payment model
  - Prepare providers for value-based payment arrangements, including a focus on improving digital health infrastructure

- **Provider Eligibility**: Providers who deliver prenatal care services to Medicaid beneficiaries; DHCF identified 28 organizations that include:
  - Medicaid-enrolled physician groups and FQHCs that provided prenatal care services to >75 beneficiaries in FY24
  - Medicaid-enrolled doulas or doula groups
  - Providers under contract with a District MCP to deliver value-added prenatal care services

Milestones Aim to Strengthen Readiness and Infrastructure to Implement TMaH

Milestone	Overview of Requirements
Year 1	
Milestone 1: Engagement in TMaH	• Incentive program participation agreement • Non-binding Letter of Intent to participate in TMaH • Inventory of organization's perinatal services
Milestone 2: Whole Person Care	• Inventory of organization's approach to addressing barriers to care/whole-person care
Milestone 3: Digital Health Assessment	• Digital health needs assessment
Year 2	
Milestone 4: Digital Health Connectivity	• Digital health connectivity activities according to assessed level
Milestone 5: TMaH Payment Model	• Cost survey and organizational questionnaire
Milestone 6: Integrated Care Team	• Participation in quality improvement and integrated care technical assistance activities
Milestone 7: Digital Health Data Sharing	• Participation in digital health technical assistance activities

Provider Incentive Program Next Steps

- **CMS Approval:** DHCF is awaiting final approval for the program from CMS
  - DHCF will finalize program requirements, templates based on CMS approval

- **DHCF Outreach:** DHCF identified providers that meet service requirements and are eligible to participate in the program, based on review of claims data
  - In the coming weeks, DHCF will reach out to eligible providers to share more information about the program

- **Program Launch:** The program is anticipated to launch in late Summer 2025

TMaH & Improving Data Infrastructure

(5 minutes)

TMaH Leverages Data to Improve Care Delivery and Quality

- **Enhancing Care Coordination and Care Delivery**
  - Enable data sharing among OB/GYNs, midwives, primary care, and specialists
  - Closed Loop referrals to link with needed services from community-based organizations
  - Increase use of remote monitoring tools and virtual visits to manage care

- **Identifying Risk and Personalizing Care**
  - Identify high-risk pregnancies early
  - Support clinical decision-making and population health
  - Ensure referrals to specialists, behavioral health, and social services are completed and confirmed

- **Improving Quality and Accountability**
  - Enable real-time sharing of maternal health data across providers and settings
  - Monitor key maternal and infant health metrics (e.g., preterm birth, maternal morbidity)
  - Use dashboards and data tools to analyze trends across populations and care settings

TMaH Milestones for Improving Data Infrastructure for Maternal Care

CMS-Identified Problem	Proposed TMaH Solution
Outdated data collection methods; limited information-sharing among providers, community-based organizations, and other agencies	**Enhance data collection, exchange, and linkage through improvements in electronic health records and health information exchanges**

TMaH Milestones:

- Vital records linkages: Link mother-infant Medicaid IDs with vital records data
- Programmatic alignment: Identify beneficiaries who are using services such as WIC/SNAP; address cross-program enrollment gaps
- Patient safety: Enhance data collection processes to monitor hospital AIM patient safety bundle outcomes
- Screening and referrals: Identify data collection processes and establish bi-directional referral pathways between providers and CBOs

Digital Health: DC HIE 101

(15 minutes)

What is an HIE?

- ***Health Information Exchange (HIE)*** is the movement of health information electronically across multiple organizations

- An ***HIE entity*** is an entity that creates or maintains infrastructure that provides organizational and technical capabilities in a system to enable the secure, electronic exchange of health information among participating organizations not under common ownership

- HIE users can view the same content through the same interface, but for different panels – depending on which population they serve

- HIEs support the ability to view data at individual-level, panel-level, and in the aggregate from disparate data sources

- HIEs can promote transparency across entities involved in an individual's care delivery

CRISP DC is the Designated DC HIE

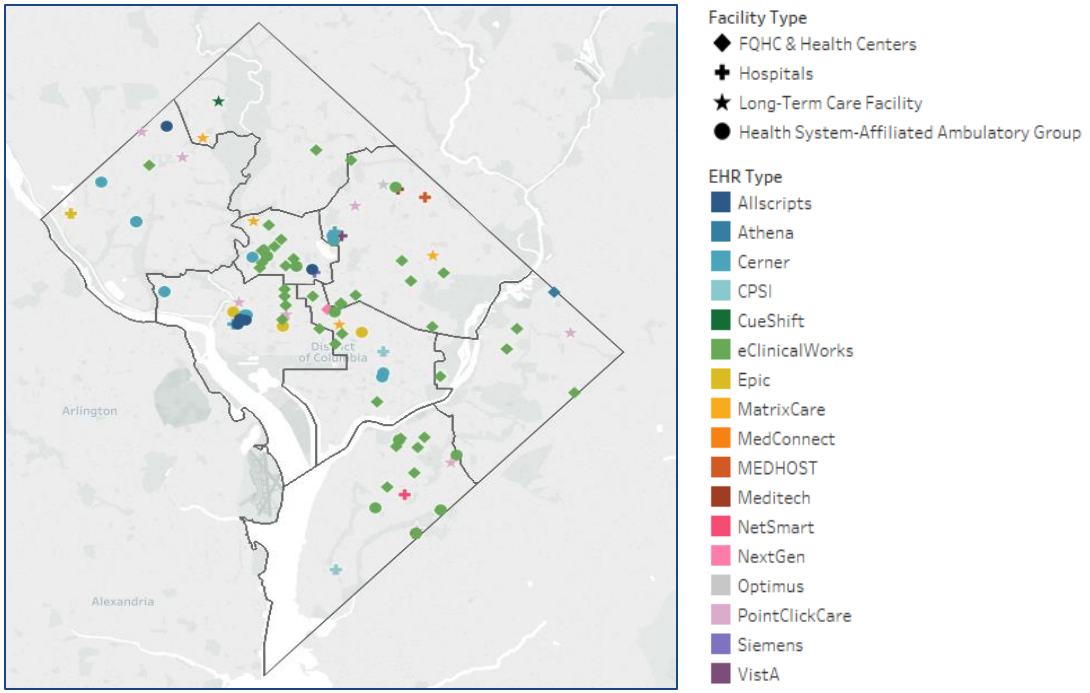
- CRISP DC's designation status is conferred by DHCF

- DHCF is responsible for:
  - Funding: Facilitating funding to support health IT projects that directly support Medicaid providers
  - Strategizing: Developing digital health strategies for the District that are responsive to the complex health care needs of a diverse population
  - Regulating: Regulating the DC HIE

- The CRISP DC supports the HIE infrastructure and services that facilitate the secure, electronic exchange of health information among the District Registered HIE entities and participating organizations in the District

The District has significant variation in Health IT systems

- The District is a microcosm of the US in the large variation of health IT vendors and companies operating in the health care system.
- Over 20 different EHR systems are in use in the District
- Over 60% of the market uses eClinicalWorks, including Federally Qualified Health Centers
- **A disconnected health system leads to fragmented and uncoordinated care**



Six Core Capabilities Comprise the DC HIE Infrastructure and Enable Access via User-Facing Tools

Critical Infrastructure (e.g. Encounters and Alerts)	Consent to Share Data	Registry and Inventory	Simple and Secure Messaging	Screening and Referral (e.g. SDOH)	Advanced Analytics for Population Health Management
					
Encounter Notifications	eConsent	Care Management Registry	Provider Directory	LinkU/HIE Integration & Exchange	PopHealth Analytics
Health Records		Advance Care Planning			
Patient Snapshot					
Image Exchange					

What Kinds of Data Flow Through the HIE to Support Those Core Capabilities?

- ***Admissions, discharge, and transfer data*** from hospitals is used to send notifications to providers when a patient has an encounter

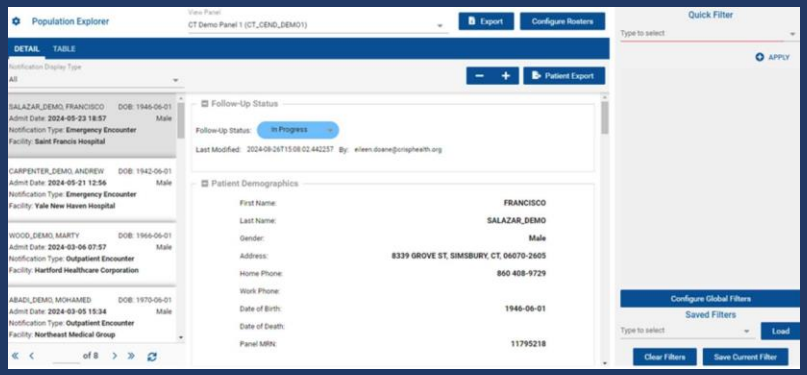
- Both ***claims and clinical data*** (including labs, medical imaging, visit summaries, and more) are shared by providers and viewable through the HIE at both the individual and population health level

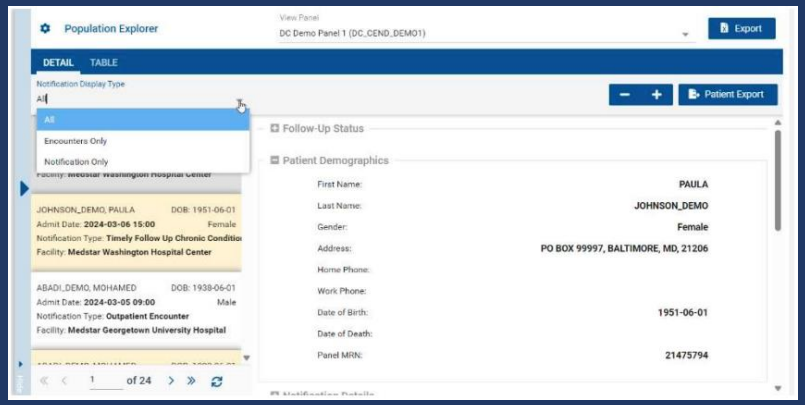
- ***Social needs screening data***, including assessments, z-codes, and referral information, is ingested by the HIE and consolidated in the Social Needs tab

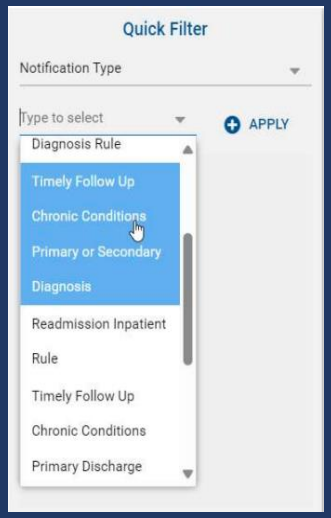
How can Maternal Health Providers Use the Encounter Notifications Tool in DC HIE?

Encounter Notifications

- *Enable real-time encounter and other alerts by matching an organization's roster (or panel) with admission, discharge, and transfer (ADT) data*
- ***Population Explorer** and **Advanced Filter Builder** can automate ED admission or discharge alerts for groups of patients (for ex., in a maternal health care coordination program) or diagnoses (for ex., preeclampsia)*



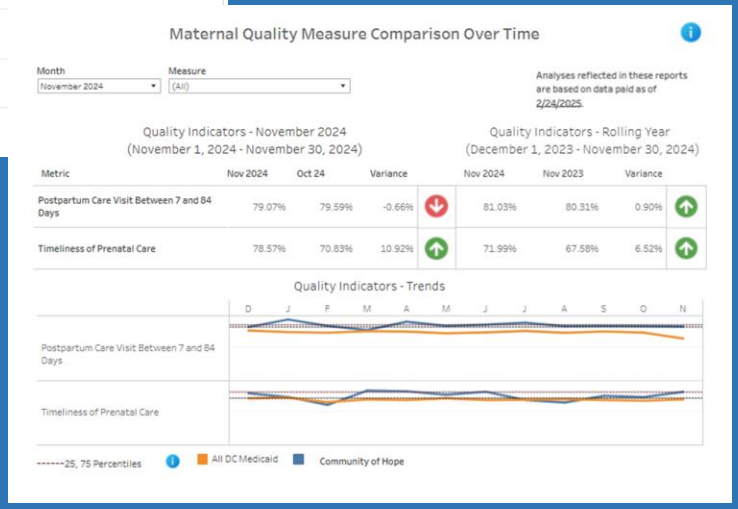




How Can Maternal Health Providers Use the PopHealth Analytics Tool in DC HIE?

PopHealth Analytics

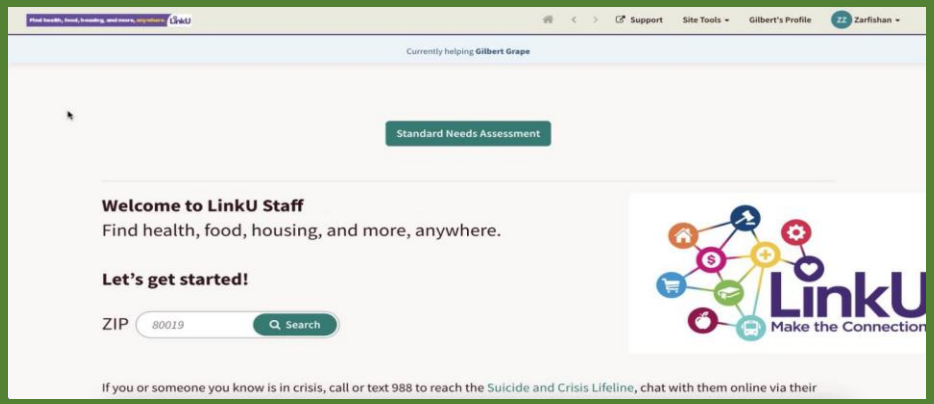
- *Provides population-level and panel-level reports by combining clinical and administrative data*
- *With the **Maternal Quality Measure Comparison Report**, providers can explore trends and performance rates for Postpartum Care and Prenatal care measures and identify opportunities for improvement*

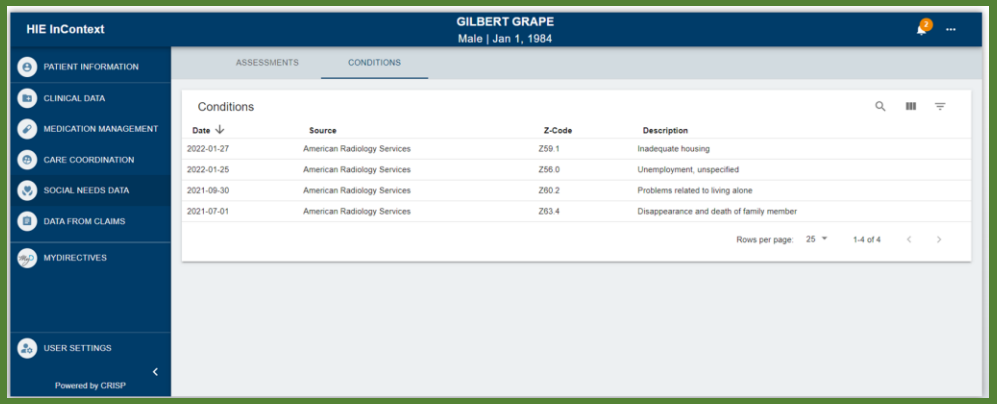


How Can Maternal Health Providers Use the LinkU/HIE Integration via the DC HIE?

LinkU/HIE Integration

- *Allows users to single sign on (SSO) to DC Health's instance of Findhelp, LinkU—a comprehensive social care platform connecting individuals to community resources and support services*
- *Providers can use LinkU to conduct social needs screenings, search for resources, and send closed-loop referrals, as well as view social needs data shared from other providers via the Social Needs Tab in the HIE.*





For More DC HIE Information and Engagement Opportunities

- **DC HIE Access:** If you're a Medicaid provider organization and would like access to the CRISP DC HIE, please email dcoutreach@crisphealth.org or go here for more info on how to get started

- **Trainings:** If you're interested in learning more about the HIE and its tools, join our Upcoming Webinars - CRISP DC - DC Designated Health Information Exchange

- **Use Cases:** We also work with stakeholders to generate new ideas for how to use the HIE to improve care. More info on submitting a DC HIE Use case can be found here
  - An HIE use case is a narrative that describes how the HIE will be used to accomplish a specific goal and helps communicate the functional requirements and intent of the proposed idea

Discussion and Next Steps

(25 minutes)

Breakout Group Discussion

Group 1:	Group 2:	Group 3:
PopHealth	LinkU	Encounter Notifications

Discussion Questions:

- How are you currently using, or how would you hope to use, this HIE tool to provide or coordinate care?
- What barriers have you encountered with getting started or while using the tool, and what resources are needed to alleviate those challenges?
- What are some additional opportunities for the HIE to play in improving maternal health care?
- How might this tool be used to address a care gap, support care transitions, or public health monitoring?

Report Out: (5 minutes)

Next Steps

Next Meeting

- Maternal Health Advisory Group will convene next on July 15th, 11am-12pm
- July Focus: Managed Care

Subsequent Meetings:

- Every 3rd Tuesday from 11am-12pm (monthly)

Stay in Touch

- Send questions or requests to dhcf.maternalhealth@dc.gov
- Meeting materials at https://dhcf.dc.gov/page/transforming-maternal-health

Background Info

The District Must Meet Milestones for 10 Key Care Elements by End of Year 3

Pillar 1 Access, Infrastructure & Workforce	Pillar 2 Quality Improvement & Safety	Pillar 3 Whole Person Care Delivery
• Increase access to the midwifery workforce • Increase access to birth centers • Cover doula services • Improve data infrastructure • Develop payment model	• Support implementation of AIM patient safety bundles • Support "Birthing-Friendly" hospital designation	• Increase risk assessments, screenings, referrals, and follow-up for perinatal depression, anxiety, tobacco use, substance use disorder, and health-related social needs (HRSN) • Increase home monitoring of diabetes and hypertension • Develop health promotion and disease prevention plan

The District Can Elect Up To 8 Optional Care Elements; Milestones TBD

Pillar 1 Access, Infrastructure & Workforce	Pillar 2 Quality Improvement & Safety	Pillar 3 Whole Person Care Delivery
• Cover certified midwives (CMs) and certified professional midwives (CPMs) • Cover perinatal community health workers (CHWs) • Create regional partnerships in rural areas • Extend Medicaid eligibility to 12 months postpartum	• Promote shared decision-making	• Expand group perinatal care • Increase use of home visits, mobile clinics, and telehealth • Expand oral health care