

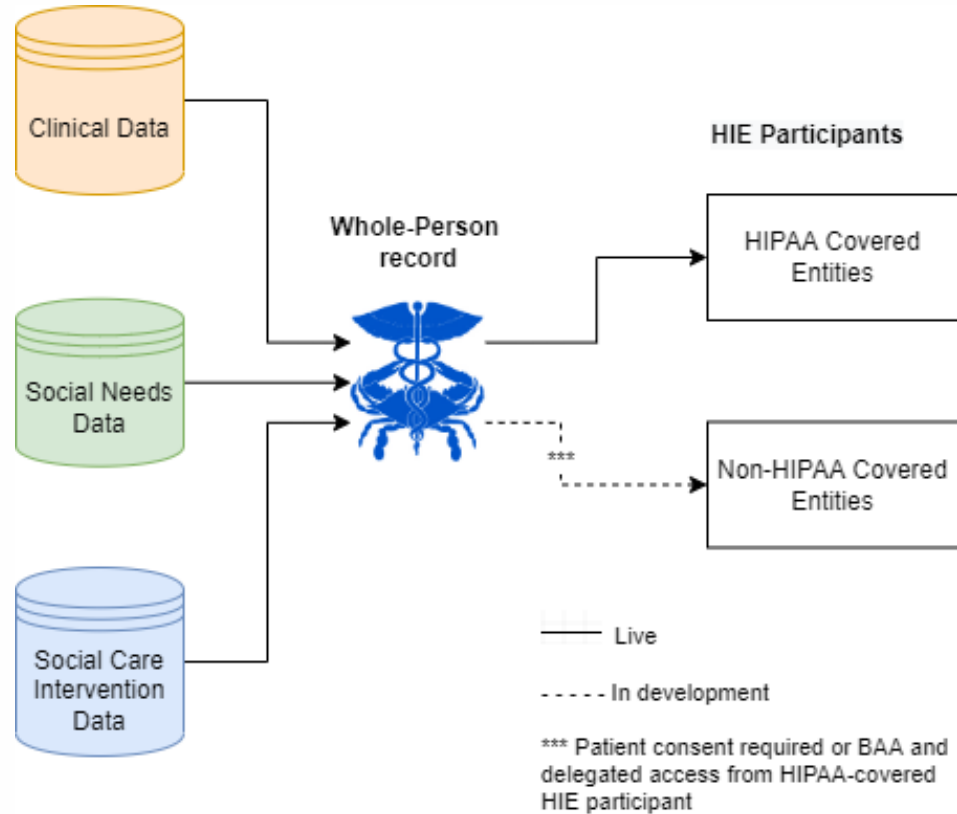
# CRISP Bulk Referrals

10480 Little Patuxent Parkway, Suite 800  
Columbia, MD 21044  
877.952.7477 | [info@crisphealth.org](mailto:info@crisphealth.org)  
[www.crisphealth.org](http://www.crisphealth.org)



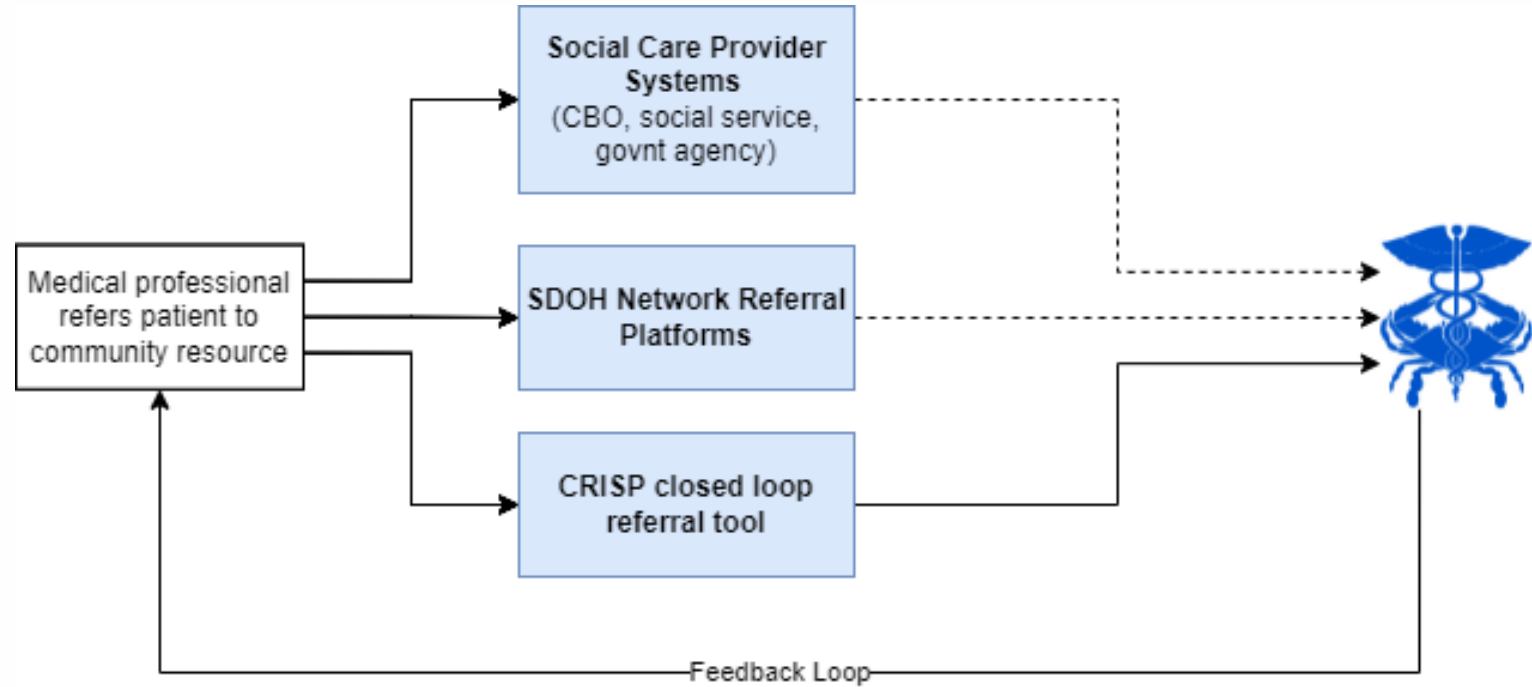


# Whole Person Record

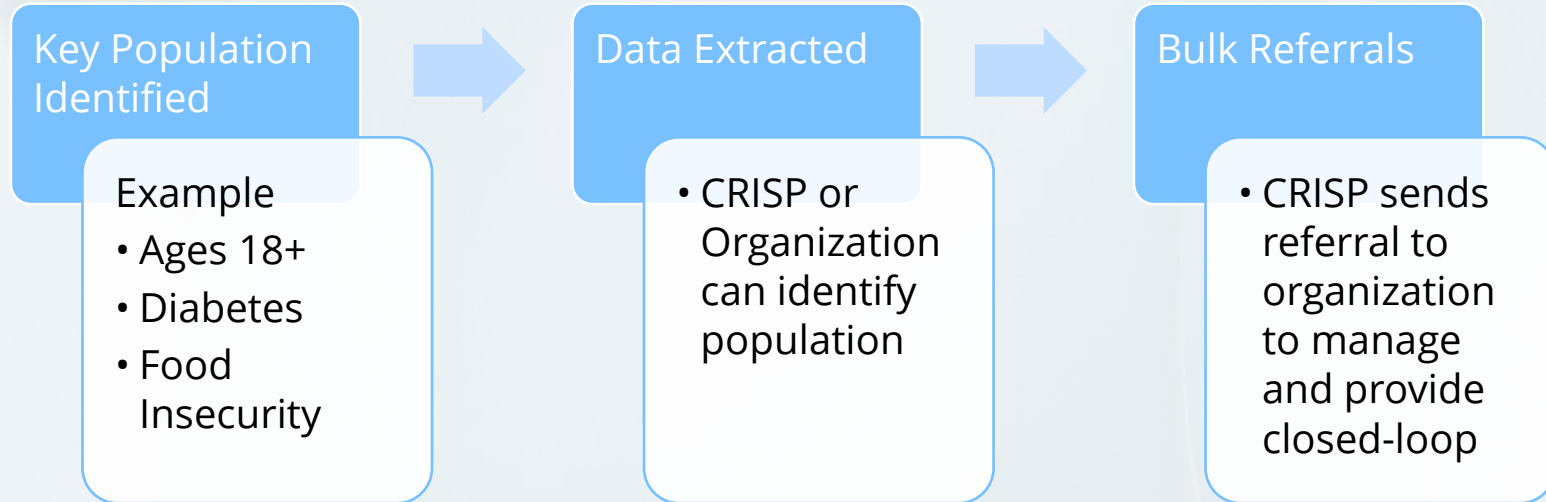




# Addressing Social Needs



# • Bulk Referrals





# CBO Workflow- "Manage Referral" Tile

## CBO WorkList

Select Referrals to Download

Download Worklist



Name	Gender	Date of Birth	Referring Provider	Referral Date ↓	Referral Status	Last Updated	Organization	Program Name
GILBERT GRAPE	M	1984-01-01	Janelle Thomas	2026-02-26 11:31:02 AM	Pending	2026-02-26 11:31:02 AM	Test Organizations	FIMDH (Food is Medicine MDH Requirements)
ANNA CADENCE	F	1981-11-16	Janelle Thomas	2026-02-24 04:12:07 PM	Pending	2026-02-24 04:12:07 PM	Test Organizations	FIMDH (Food is Medicine MDH Requirements)
GILBERT GRAPE	M	1984-01-01	Alex Jones	2026-02-24 12:09:58 PM	Pending	2026-02-24 12:09:58 PM	Test Organizations	FIMDH (Food is Medicine MDH Requirements)



# CBO Feedback to Referring Entity

Back to Worklist

Journal Information

Date	Status	Journal	Person who made entry
2026-02-09	Pending	Referral Created	System

Items per page: 10 1 - 1 of 1

Create new journal

Status  
Pending

Date  
2/26/2026

Journal

Submit Journal

Referral Decision

Date  
2/26/2026

Accept Reject



# Journal Examples

## Journal Information

Date	Status	Journal	Person who made entry
2026-02-26	Rejected	Patient Unreachable	Michelle Nnorom
2026-02-26	Pending	Outreach #3 - No Answer, reject referral	Michelle Nnorom
2026-02-26	Pending	Outreach #2- No Answer	Michelle Nnorom
2026-02-26	Pending	Outreach #1- No Answer	Michelle Nnorom
2026-02-02	Pending	Referral Created	System

Patient  
Declined

## Journal Information

Date	Status	Journal	Person who made entry
2026-02-26	Completed	YES - Desired outcomes achieved: Pt received all meals	Michelle Nnorom
2026-02-26	Enrolled	Pt is enrolled in services will receive 3 meals a week for 6 weeks.	Michelle Nnorom
2026-02-26	Accepted	Referral Accepted	Michelle Nnorom
2026-02-26	Pending	Called pt and they are interested in services	Michelle Nnorom
2026-01-15	Pending	Referral Created	System

Items per page: 10 1 - 5 of 5 < > >>

Patient  
Accepted



# Addressing Social Needs – Feedback Loop

← HIE InContext

PATIENT INFORMATION

MEDICATION MANAGEMENT

CLINICAL DATA

CARE COORDINATION

SOCIAL NEEDS DATA

DATA FROM CLAIMS

MY PATIENT SUMMARY

APPS

USER SETTINGS

Powered by CRISP Shared Services

← HIE InContext

GILBERT GRAPE

Male | Jan 1, 1984

CARE TEAM

CARE ALERTS

REFERRAL HISTORY

ADVANCE DIRECTIVES

Referral History

Date of Referral	Source	Program Name	Status	Last Updated ↓
2024-02-26	CRISPReferralUI	Weight Loss Program	Disenrolled	2024-05-24
2024-05-09	CRISPReferralUI	Weight Loss Program	Completed	2024-05-24
2024-05-16	CRISPReferralUI	Able Bodied Transport	Pending	2024-05-16
2024-05-16	CRISPReferralUI	Transportation ServeU	Pending	2024-05-16
2024-05-16	CRISPReferralUI	Transportation ServeU	Pending	2024-05-16
2024-05-16	CRISPReferralUI	Able Bodied Transport	Pending	2024-05-16
2024-02-27	CRISPReferralUI	Skilled Nursing service	Disenrolled	2024-05-15
2024-05-15	CRISPReferralUI	CT Meals on Wheels Partner Program	Pending	2024-05-15

Referral Status	Meaning
Pending	Initial and default status (awaiting a decision)
Accepted	Referral has been accepted by the organization
Rejected	Referral has been rejected by the organization
Enrolled	Patient has been enrolled into the program
Disenrolled	Patient has been disenrolled from the program
Completed	Referral activities and lifecycle has been completed

GILBERT GRAPE | Male | Jan 1, 1984

Referral History

Weight Loss Program

Date Updated: 2024-05-24

Referral Sender

Referral Recipient

Journal Entries



# Closing the Food Insecurity Gap for Patients:

## Automated Risk Detection and Referral to Community-Based Food Services

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**Meals on Wheels of Central Maryland**

**Moveable Feast**

**Maryland Food Bank**

**University of Maryland Medical System**

**CRISP**

**May 19, 2026**

**CRISP Annual Summit 2026**



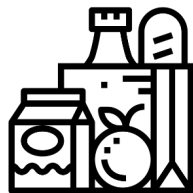
# Food Insecurity – The Challenge

Food insecurity impacts approximately 1 in 3 Maryland residents<sup>1</sup>

## CHALLENGES

### Food insecurity is difficult to measure<sup>2</sup>

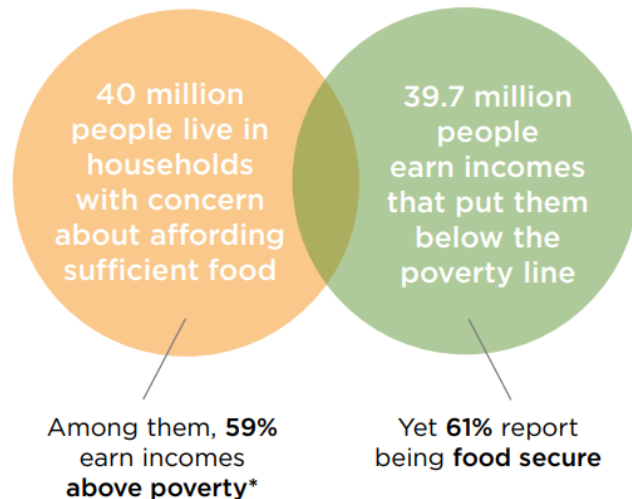
- Can be a temporary situation
- Rely on individuals to report that they are food insecure



### Food insecurity is not always associated with poverty<sup>3</sup>

- Low income does not necessarily mean food insecure
- Not low income does not necessarily mean food secure

Food insecurity and poverty are not always experienced by the same families<sup>3</sup>



\*Among food insecure households whose income is known.

1. <https://mdfoodbank.org/hunger-in-maryland/>

2. Edin, K., et al. SNAP food security in-depth interview study. U.S. Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis, 2013

3. [https://hungerandhealth.feedingamerica.org/wp-content/uploads/2018/10/Food-Insecurity-Poverty-Brief\\_2018.pdf](https://hungerandhealth.feedingamerica.org/wp-content/uploads/2018/10/Food-Insecurity-Poverty-Brief_2018.pdf)

# Motivation for Food Insecurity Algorithm

## Self-Reporting of Social Drivers of Health (SDOH) Initiative

Starting in January 2024, CMS requires SDOH screening and reporting for hospitalized patients

1. **Food insecurity**
2. Interpersonal safety
3. Housing insecurity
4. Transportation insecurity
5. Utilities

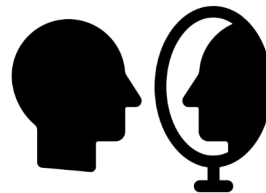
**CMS.gov**



## Why does self-reporting not tell the whole story?

Food insecurity is often under-reported in surveys due to:

- Patient recall<sup>1</sup>, perceptions and cultural ideals<sup>2</sup>
- Self-perceptions and social stigma<sup>3,4</sup>
- Incomplete understanding of the benefits of available services<sup>3</sup>



**Goal: Identify UMMS patients at risk of food insecurity to refer to appropriate Food Access & Support Services Team (FASST) Partners**



1. Livings, Michelle S., et al. "Food Insecurity Is Under-Reported in Surveys That Ask About the Past Year." American Journal of Preventive Medicine, vol. 65, no. 4, Oct. 2023, pp. 657–66.
2. Fong, K., et al. "The Cost of Free Assistance: Why Low-Income Individuals Do Not Access Food Pantries." The Journal of Sociology & Social Welfare, vol. 43, no. 1, 2016.
3. Kissane, R. J. "Poor women's moral economies of nonprofit social service use: Conspicuous constraint and empowerment in the hollow state." Sociological Perspectives, vol. 55 no. 1, 2012, pp. 189-211.
4. El Zein, et al. "Why Are Hungry College Students Not Seeking Help? Predictors of and Barriers to Using an On-Campus Food Pantry" Nutrients, vol. 10, no. 9, 2018, pp.1163.

# Food Access & Support Services Team (FASST)

FASST is a collective of community-based organizations:  
**Meals on Wheels of Central Maryland, Moveable Feast  
and Maryland Food Bank**, in partnership with the  
University of Maryland Medical System and CRISP.

FASST delivers a streamlined referral and payment system,  
facilitating access to nutrition and support services that  
have been **proven to improve health outcomes and  
reduce healthcare expenses.**



Meals on Wheels of Central Maryland, Moveable Feast,  
and Maryland Food Bank



**FASST launched in 2022 and is currently winding down  
Year 4 of the 4-year grant with the University of Maryland Medical System**

# FASST Food Service Offerings



**Two ready-to-eat nutritious meals daily** that meet two thirds of the RDA for adults 60 years of age and over.

Services include:

- Daily home-delivered meals with a health and safety check.
- A comprehensive in-home assessment of nutrition, health, social and housing needs, including social isolation screening.
- Support services.



Home-delivered, medically tailored meals and nutrition services with weekly deliveries consisting of **12 medically tailored entrees**, a bag of fresh produce, and supplements as indicated by nutrition assessment.

Services include:

- Approximately 50-60% of weekly nutrition needs.
- Monthly visits with a Registered Dietician Nutritionist for assessment, counseling, and coaching.



Direct shipping biweekly of Back Up Boxes, which contain **enough food for 25 nutritious meals**.

Choice of:

- Diabetes-Friendly
- Healthy

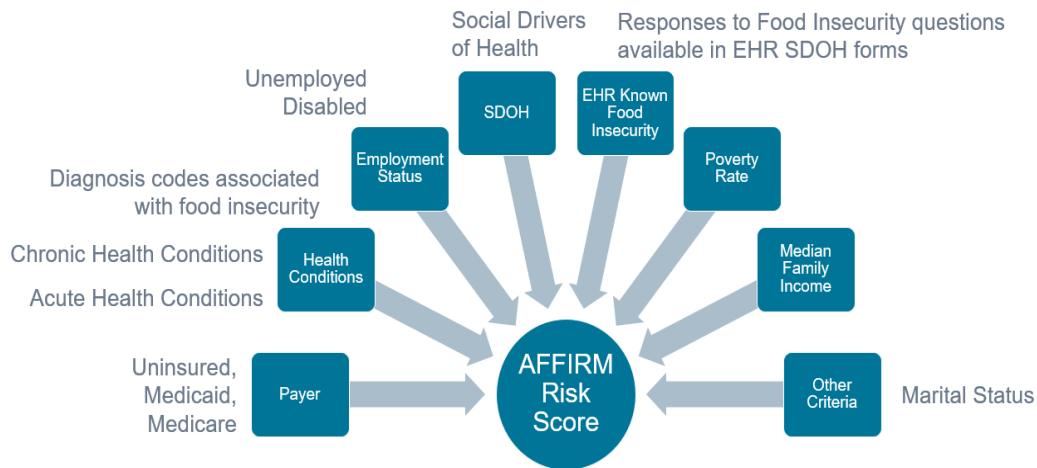
Contents are selected using Supporting Wellness at Pantries methodology, with appropriate measures of nutrients and limitation of saturated fat, sodium and sugars.



# UMMS Food Insecurity Risk Algorithm – AFFIRM

## Assessment For Food Insecurity Risk Measures

- *AFFIRM* is an AI-based algorithm developed by UMMS that automatically predicts a patient's risk of food insecurity
- By using objective patient-level data, *AFFIRM* leverages a large scope of available information to help identify food insecurity indicators



**AFFIRM applies to ALL patients** with hospital encounters at UMMS



and harnesses **patient-specific clinical data** and **publicly available population/community level data**

to identify patients **at risk of food insecurity**

**AND**



UMMS sends **referrals daily** to FASST Partners



tailored to each organization's scope of eligible populations

# FASST Referral Process

UMMS

AFFIRM Scores are generated daily for all adult hospital patients. Scores above a threshold are assessed for eligibility and shared with CRISP daily.

CRISP

CRISP sends the referrals to the FASST partner that patients have been matched with

FASST

FASST partners contact to enroll the patients.  
If a patient enrolls, they receive 90 days of no-cost meals  
FASST partners update referral status in CRISP

CRISP

CRISP sends enrollment statuses back to UMMS for analysis weekly

Enrollees (patients) complete surveys upon program enrollment and again at completion to assess pre/post intervention data

Surveys assess food and financial security, healthy days, medication compliance and patient satisfaction with the program

Surveys administered by third-party evaluator Sharp Insight

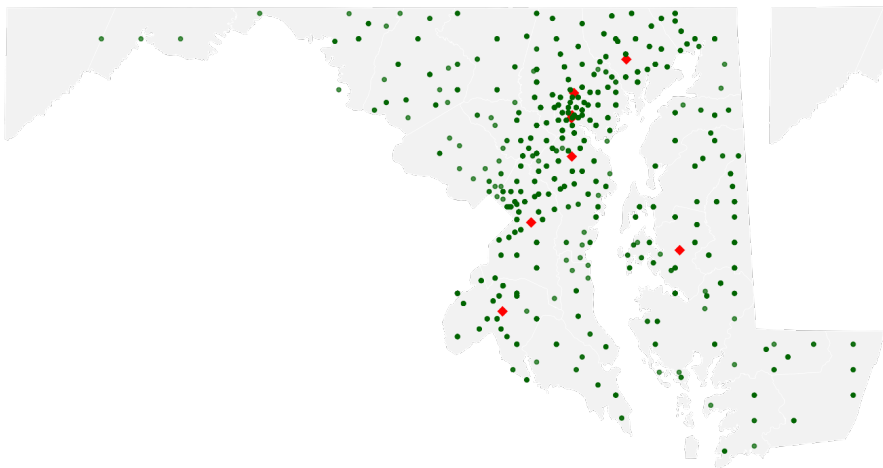


# Geographic Distribution of FASST Enrollees

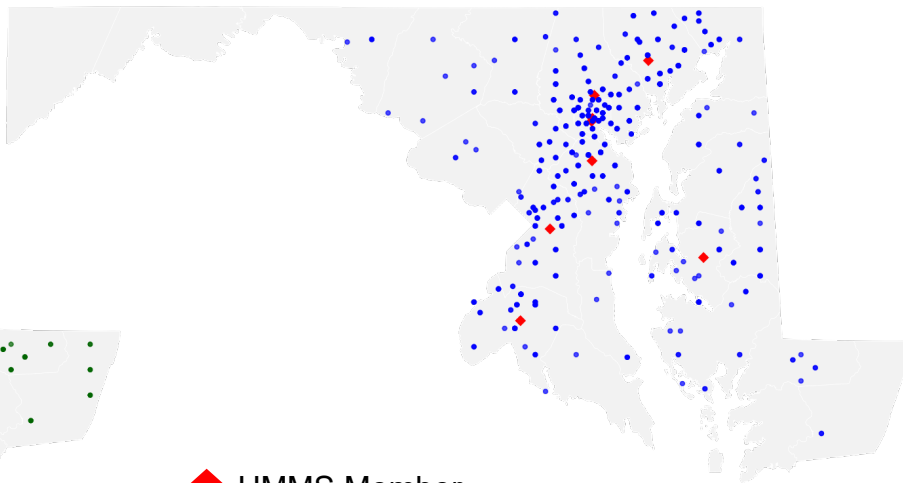
Maryland Patients Referred from 08/01/2023 - 05/01/2026

Patients are referred from UMMS Member Organizations  
across Central, Southern and Eastern Maryland

**All Referrals**  
(n = 11,198)



**Enrolled**  
(n = 2,416)

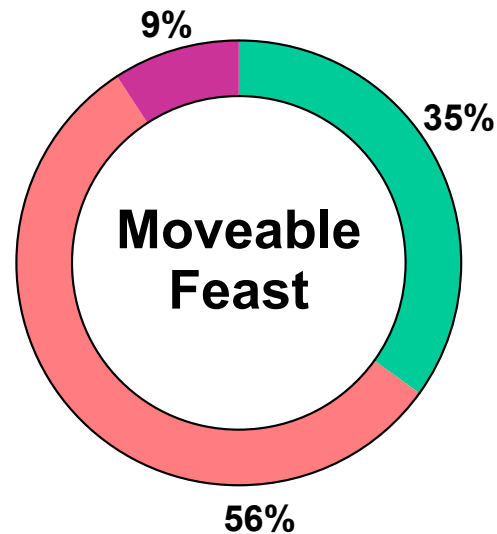
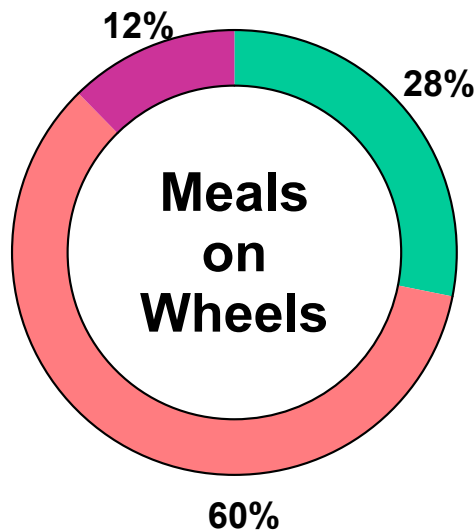
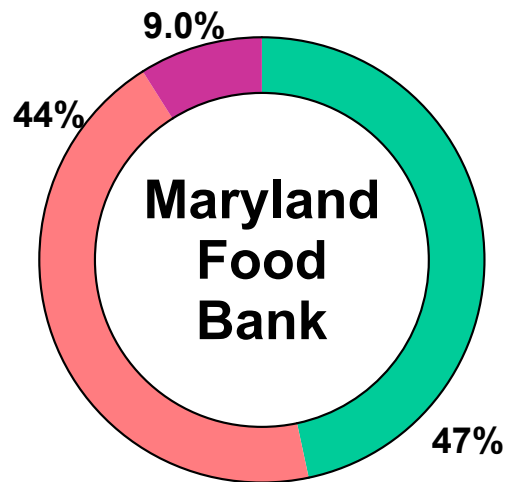


- ◆ UMMS Member
- Organizations
- AFFIRM Referred Patients  
FASST Enrolled Patients



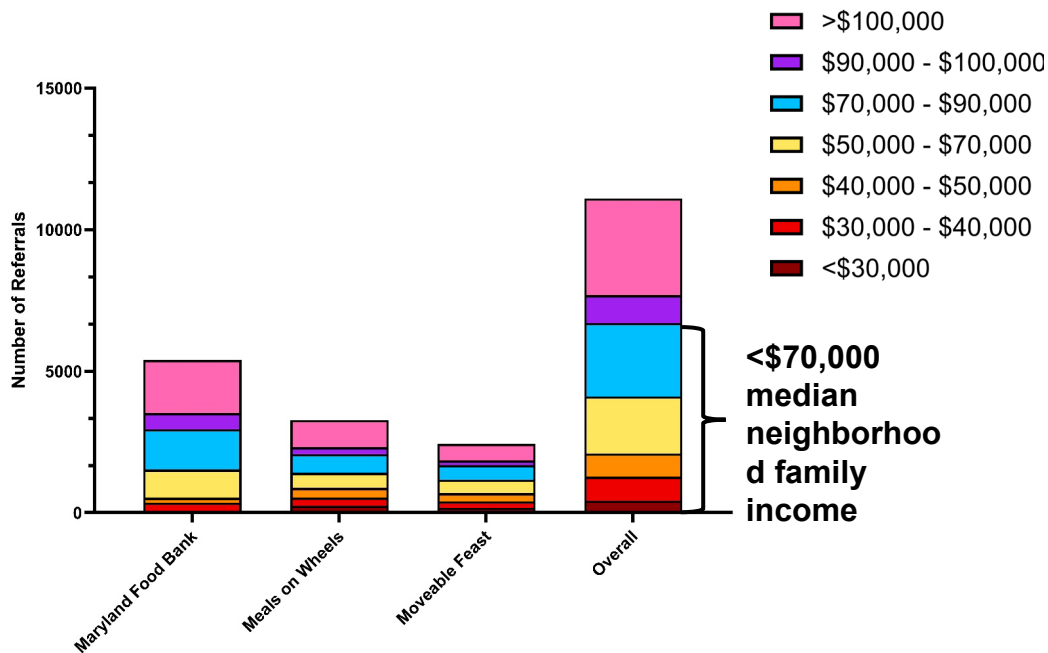
# Type of Hospital Encounter that Generated Referrals

Most referred patients had a **Hospital Stay**

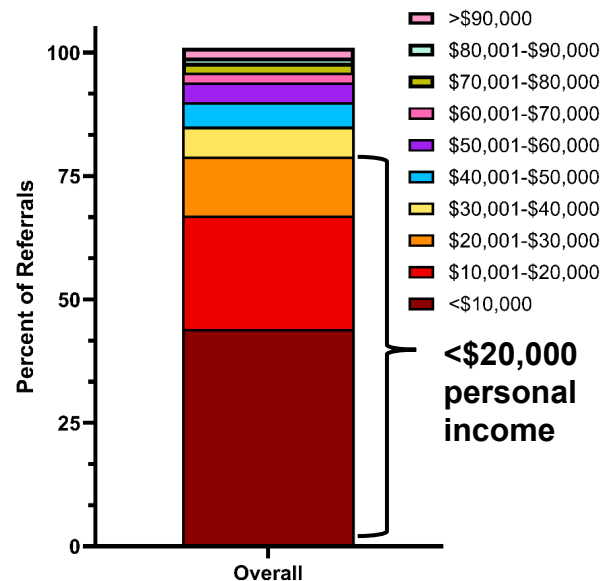


# Median Family & Personal Income Distributions

Most referred patients live in an area where the **Neighborhood Median Family Income** is **<\$70,000** with many **<\$50,000**



Most enrolled patients have a **Personal Income** of **<\$20,000** with many **<\$10,000**



# Results and Impact of FASST

For Meals on Wheels, Moveable Feast and Maryland Food Bank

3,281 Patients Referred  
& Contacted from  
08/01/2023 - 05/01/2026



**2,416** food insecure households  
provided 90 days of no-cost meals



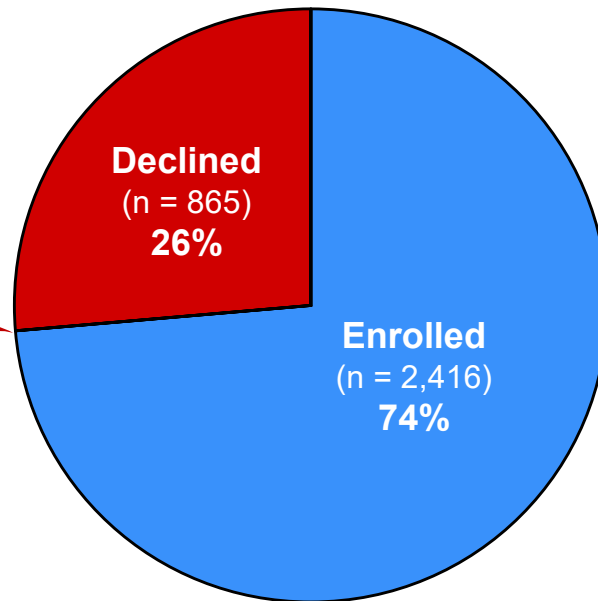
**74%** enrollment rate among  
contacted patients  
compared to historical rates of 7%

**540**

referrals per month  
in the past year to  
food-based CBOs  
(MOW, MF, MFB)

## Reasons for Declining Program

Already receiving  
services, feeling like  
others needed the  
food more, and not  
being interested in  
such a program



# Challenge Contacting the Patients

## 58% contact rate among patients referred for food support

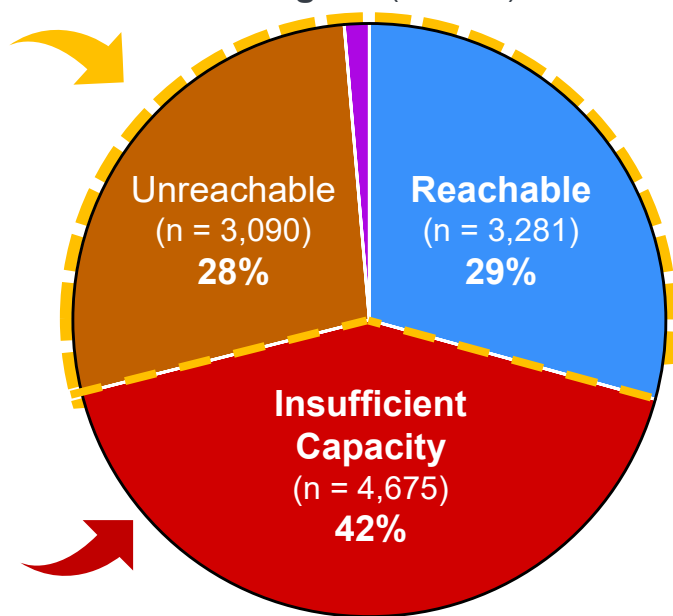
Among those that were contactable:

- 29% were reachable (answered phone)
- 28% were unreachable due to not answering phone, disconnecting the call or having an out of service phone number
- 1% were ineligible

## 42% not contacted due to insufficient capacity of food service providers

Challenges with reaching patients meant that maintaining full program enrollment required more referrals than available capacity, and at other times, referrals exceeded the **budget limits** for monthly enrollment

11,198 Patients  
Referred from  
08/01/2023 -  
05/01/2026



# FASST Program Success Factors

AFFIRM algorithm is highly accurate in identifying patients at risk of food insecurity

**10,000+** automated referrals generated so far for FASST Partners

**2000+** patients enrolled FASST program over the past 3 years

**74%** of patients who connect with FASST teams enroll in FASST program compared to 7% historically

**99%** of the time a referred patient was eligible for the FASST program

High Volume of Referrals!

Met FASST Program Goal!

Suitable Referrals!

High Match for FASST Program Eligibility!



# Areas of Focus

## Relationship Management

- Actively manage relationships with healthcare partners through regular planned communication
- Build a system to close the loop on referrals that includes status updates, outcomes, and feedback to the sender
- Prepare for multilevel service coordination, as referral follow-up often reveals additional needs

## Operational Infrastructure

- Build an internal triage system for referrals by first piloting on a small scale and being prepared to ultimately scale intake and report workflows
- Define clear eligibility requirements and automate screening where possible
- Integrate technology where possible to minimize manual entry and errors
- Expect inconsistencies in data and be prepared for duplicates and additional validation of potentially out-of-date information

## Performance & Sustainability

- Expect declines and drop-off, even when referrals are high quality
- Refine outreach strategies and set realistic limitations on contact attempts to prevent staff burnout
- Track metrics beyond referrals received (contact rate, engagement rate, service completion, outcomes)



# FASST Program Impact on Patients

"The program showed me how to eat a balanced meal with diabetes."

- Survey Respondent, 2025

"I had a medical problem and went to the hospital and [was] out of work for some weeks. Coming out of the hospital, they recommended the [FASST] program. It was helpful because I did not have to pay and food came to my door."

- Survey Respondent, 2025





# Bulk Referrals for Medically Tailored Meals

May 19, 2026



# Funding Source: Population Health Improvement Fund (PHIF)

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- **AHEAD State Agreement:** Requires creation of the PHIF.
- **Legislative Authority:** Established by HB 1104 as a special, nonlapsing fund that supports investment to reach population health targets under AHEAD and any successor models.
- **Governance:** MDH and HSCRC jointly administer the Fund
  - HSCRC Commissioners voted (Dec. 2024) for a one-time, statewide adjustment of \$25 million in CY 2025, designed to advance Maryland's population health goals. This investment was structured outside of hospitals' existing rate structures to avoid any reduction in hospital resources.
  - Allowed to accept funds from public and private sources

# PHIF 2026 Plan

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## Launch 2 pilot FIM initiatives:

- 1) *Medically tailored meals*** (MTMs) for high-risk patients: generate short-term savings and demonstrate value of FIM in MD. *Launched on April 27.*
- 2) *Place-based produce prescriptions*** (Produce Rx): build FIM capacity and prevent chronic disease in ENOUGH communities. *Subcommittee supporting RFA development; RFA anticipated in early summer.*

# Why MTMs?

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- There is a lot of food-related work already occurring in Maryland and many different interventions are needed to make a difference on food insecurity and nutritional quality.
- MTMs were selected as an intervention for the PHIF based on:
  - Alignment with AHEAD
  - Current insurance reimbursement practices in other states
  - Available evidence on likelihood of seeing short-term health outcome improvements and healthcare savings that can justify larger investments into Food Is Medicine in the future

# Patient Eligibility Criteria for MTMs

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- **Clinical Criteria:** 2 or more hospital visits with diabetes as a primary or secondary diagnosis or diabetes PQI event
- **HRSN Criteria:** Barrier to healthy eating identified in screening (conducted either by healthcare provider or MTM provider)
- **Residency Criteria:** Residents of Prince George's, Baltimore City, Baltimore County, Dorchester, Somerset, or Allegany
  - Jurisdictions selected based on: regional diversity; food insecurity rate; rates of PQI and 2+ hospitalization for diabetes; cost of care for high acuity diabetic patients
  - May add more jurisdictions, depending on enrollment rates, over the course of the pilot

# Referral Pathways

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- Moveable Feast and Food & Friends are HIPAA covered entities.
- **Bulk referrals:** patients who meet the clinical and residency criteria are identified via their hospital utilization data (case mix). The contact info for these patients is sent from CRISP to the implementing nonprofits. The nonprofits reach out to the patients, screen them for the HRSN criteria, and then start delivering services.
- **Provider referrals:** providers complete a brief form in CRISP that affirms that a patient meets the criteria, and the form is sent directly to the nonprofit.

# Evaluation

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- Working with Dr. Seth Berkowitz
- Quantitative evaluation of healthcare utilization, healthcare spending, and clinical outcomes (enrolled patients vs. comparison group)
- Will also track those who decline services.

# Path to Sustainability

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- Pilot large scale MTM intervention with concurrent evaluation to demonstrate impact on health outcomes and cost savings in MD.
- Build MTMs into routine healthcare, through payer reimbursement.
  - ILOS (target 2027-28)
  - MCO contracts
  - Commercial reimbursement
  - AHEAD outcome credits and MAHA adjustment