MARYLAND COMMISSION ON AGING
MEETING MINUTES
June 18, 2025
10:00 AM – 12:00 PM (Hybrid)

Commission Members Present (*virtual):
Rose Maria Li, MBA, PhD (Chair)
Mae Anne Beale
Paula Blackwell, MBA, MHA
John G. Haaga, PhD
Roseanne Hanratty, MSPH, MA
*The Honorable Benjamin F. Kramer
Jay S. Magaziner, PhD, MSHyg.
George Rebok, PhD
*David Roth, PhD
Allen Y. Tien, M.D.
Diane L. Ty, MBA

Commission Members Absent:
Barry Robert Liden, Esq.

Maryland Department of Aging (MDoA):
Secretary Carmel Roques (Non-Voting Representative)
Deputy Secretary Jennifer Crawley
*Andrew Baker, Planning, Policy, and Engagement Coordinator
*Jonathan Jenkins (JJ), Senior Call Check Administrator
Andrea Nunez, Legislative Director
Lisa O'Connor, Executive Assistant to the Deputy Secretary
Isabella Shycoff, Division Director, Housing Services
Barbara Sigler, Communications Director
Chelsea Wheeler, Supportive Communities Program Manager
Liz Woodward, Assistant Secretary, Planning

Members of the Public:
Sandy Morse
Darlene Palmer, MS, MPA
Ella Blue, RLA
*Estelle Brooks
*William Davies
*Leigh Anne Eagle, MAC
*Paula Erdie*Diamon Halliburton
*Kelly Hay, MITRE
*Mike Kavounis, RLA

*Emily Kraus, MITRE
*Tori Mudd
*Michelle Nnorom, CRISP-MD
*Warren Wilson

Welcome and Introductions:
Dr. Rose Li recognizes three members who will be completing their terms: Jay Magaziner, George Rebok, and David Roth, and the reappointments of John Haaga, Barry Liden, and Allen Tien and welcomed newly appointed members Mae Anne Beale and Darlene Palmer.

Secretary Roques reiterates the purpose and goals of the Department to receive and distribute federal and state funds, plan for the well-being of older adults and their care partners, create policy and develop legislation, and advocate for the wellbeing of older adults in Maryland. The Commission is here to support the Department in these efforts. Secretary Roques is actively seeking ways to structure the Department's work to allow the Commissioners to actively engage with the Department.

- **Deputy Secretary Jennifer Crawley provided the following updates:**
    - April report from AARP highlights that Medicaid is relied upon by hundreds of thousands of older adults in Maryland, including for home and community-based services to promote independence, nursing home care, long term care, assistance with paying Part B premiums, and more.
    - Federal actions like the One Big, Beautiful Bill Act will impact Marylanders through reductions in Medicaid and Older Americans Act Funds, Medicare, and other safety net programs such as SNAP.
    - The Department is monitoring the situation very closely as there is going to be a domino effect. If Medicaid is cut, the State needs to look at how to remedy the deficit.
    - The Department has been leading biweekly meetings with the aging services network to build awareness and provide guidance on scenario planning. Senator Alsobrooks has been an ally in navigating this fluid and dynamic situation.
      Secretary Roques provided follow-up comments:
    - The Administration for Community Living (ACL) was dismantled, and in the latest iteration we've seen, ACL will be an entity inside of the U.S. Department of Health and Human Services. This is very helpful for communication, and it looks like our partner agency at the federal level will stay intact.
    - Please refer to the department's website and follow https://aging.maryland.gov/lrm/Pages/LRM.aspx for a one-page informational document that can be distributed: https://aging.maryland.gov/SiteAssets/Pages/LRM/LRMSummary508c.pdf

Approval of Minutes
Minutes for the April 16, 2025 meeting were unanimously approved.

Community and Clinical Data Initiative (CODI)
Presenters: *Liz Woodward, Assistant Secretary, Planning, MDOA; Kelly Hay, Emily Krause, MITRE; Leigh Anne Eagle, MAC*

- CODI is a national effort with Maryland as one of the pilot sites over the last two years lead by MITRE, a not-for-profit established in 1958 to serve solely in the public interest with the goal of bridging gaps between the government and private sector to promote health.
- CODI aims to connect community and clinical data to understand the impact of social services on health. The initiative involves significant participation from area agencies on aging and other partners.
- The Administration for Community Living (ACL) provided funding for this project, which funds services and supports provided by states and networks of community-based programs.
- The Chesapeake Regional Information System for our Patients (CRISP-MD) is the Health Information Exchange (HIE) and Health Data Utility (HDU) for the state and is also a partner in this initiative.
- The project addresses challenges around the fact that the current health data ecosystem is siloed and often disconnected from clinical data, making it difficult to get a complete picture of an individual's health. The purpose of this project is to help integrate the data and bring it together to understand the combination of clinical care and programs received by individuals in the community. This will allow us to track outcomes and communicate impact of services and identify areas for improvement.
- The CODI model is publicly available and open source.
- CODI implementation benefits community based organizations (CBOs) that can measure and advocate for programs and services, health information exchange to link individuals across diverse data sources, healthcare providers to understand services that are reaching patients and the resulting outcomes and allow policy makers to improve health through strategic investment.
- The Maryland pilot began in 2023 with a focus on health promotion and social drivers in older adults. Participants in the pilot included CRISP, MAC, Meals on Wheels, and MITRE.
- Maryland's CODI design moves community data to a place where it can be connected to clinical data. The technical approach involves CBOs extracting social needs and service data from their systems, sending the data to CRISP to link individuals with the clinical repository. CODI will compute clinical and quality of life outcomes and the amount of services received and outcomes.
- CBO data shared with CRISP include person rosters, programs, enrollments, organizations, and delivery events.
- CBOs will gain the ability to measure dose of services, diabetes prevalence, diabetes control, and hypertension prevalence.
- The CBO implementation process includes working with HIE to determine data format and extraction. The HIE processes all of those files and makes the data available for querying outcome measures.
- Now, CBOs and AAAs can extract and share data with HIEs. There are tools inside of CRISP to understand how clinical outcomes differ in people who received services. A Maryland-specific information GUIDE document has been provided.
- Interested AAAs should consider sharing data, review CODI resources, and contact CRISP to discuss data sharing, explore information systems that hold the data, and can contact MAC to learn more about their experience.

Longevity Ready Maryland (LRN)

- Longevity Ready Maryland is a cross-agency activity aimed at preparing Maryland for longer lives by building a longevity ecosystem to help guide state aging policies and priorities.
- The initiative focuses on understanding the impact of social services on health overall and moving that work upstream.
- It connects extremely well to the priorities of the state agency around understanding the data, making data-informed decisions, and affording health care.
- The initiative is part of the broader effort to ensure affordable healthcare systems in Maryland.
- MDOA has collaborated with the Department of Human Services to work with the technology agency for the state to become part of a universal benefit assessment tool and benefit enrollment tool, aimed at streamlining the process of accessing benefits called My Maryland Benefits. The goal is to combine the benefits through the Older Americans Act into this process in a universal application.
- Commissioners were asked to review background materials and comment on shared priorities with five Maryland Departments (Health; Human Services; Housing & Community Development; Service and Civic Innovation; and Planning).

    - **Health** – *Jay Magaziner, Rosanne Hanratty*
        - There is a tremendous amount being done and the data system that's being really refined will be a great resource for access to information and evaluation. One of the biggest challenges in health is the individual getting their initial point of care. When they have an incident, they may go to the emergency room and it is the transition between that point of care and every point of care they need to get back; the transitions between all of these different programs is one of the most challenging things individuals have to face. How do we get it down to the individual, making it so they can get the care and services they need, including transitions between providers?
        - It is good to see that the coordination with MDH especially on the state health improvement plan. However, if funding is eliminated, where does that leave Maryland Access? Part of this gets back to CODI and the data we would be able to get from providers matching them to CBOs. It appears that most data are coming from hospital discharge, though there would be some outpatient data as well. Is the MDH primary care model still in existence? That model did link primary care providers feeding their data into CRISP. Is that part of any of the initiatives under discussion?
        - There seems to be a group of older adults who might be overlooked, e.g. older adults taking care of disabled adult children. How will older adults be impacted by cuts to developmental disabilities programs for their adult children? Will these older adults become more isolated trying to take care of their disabled child?
        - The ACL has funded the Department's Aging and Disability Resource Center (ADRC) work for over a decade. Most of the funding comes from state funds or federal financial participation and the future of that appears uncertain. the Department received this grant for a two-year period, so that is potentially one of those discretionary funds in question.
        - There are agencies that have funding streams and programs that overlap with the Department's work. It's very important to have staff who can actually

participate actively with other agencies that are focused on the things that the Department does not do, but are very important.

- **Housing and Community Development** – *George Rebok, John Haaga*
  - Housing is a complex, multifaceted problem with far reaching consequences. It is a crisis that is only going to get worse with rent inflation. We're still trying to catch up from the pandemic in terms of housing availability and demand is going to outpace supply for the next several years. One notable statistic is the 101% increase in homelessness among 65+ individuals. What aren't we doing in terms of early identification and avoiding foreclosures? The housing crisis is not just with older adults, it is a multigenerational crisis. There are a lot of options, including intergenerational alliances in cohousing, but people aren't always aware of them. There's also the need to integrate wraparound services with housing to keep people in their homes and community living in place.
  - This is exactly what the department should be doing – collaborating with the bigger departments and housing is an excellent model. Evidence-based programs like CAPABLE are important because it is a lot cheaper to fix a staircase than deal with a broken hip. It is absolutely correct to have our emphasis be on keeping elderly people aging in place. There is a battle going on now concerning zoning and "the missing middle" in housing. It is often framed as affordable housing posing a threat to the value of single-family homeowners. But more housing options could also be seen as more options for older people to stay in their neighborhoods, near their children and grandchildren, churches and other institutions they love. More choice for older people need not mean lower house values. More attention needs to be given to the interests of older adults.
  - Sec. Roques expressed interest in trying to promote small, assisted living as a growth industry in Maryland, and welcomed suggestions for gaining more traction on that. She has been talking to the small business administration about the opportunity to address the lack of assisted living or congregate housing in Maryland.

- **Human Services** -- *Paula Blackwell, Diane Ty*
  - We all know that social isolation and loneliness is a huge risk factor for dementia.
  - Data from the American Community Survey indicate that 27% of Marylanders live alone, with almost 40% of Marylanders aged 60+ live alone.[1]
  - Under priority challenges and streamlining access to public benefits and services, the Medicare managed plans are an opportunity as well as the SNAP beneficiaries, but also AARP Foundation is active in this space (as possible source of grant funding).
  - RubyWell is a startup helping families find support through Medicare's Home Health benefits, where care partners can get trained and paid to care for their loved one. They are piloting in Pennsylvania right now. The data initiative is very important and a big part of the GUIDE model for the intervention. There is also the opportunity to engage former caregivers in volunteering and running care support groups.

[1] https://dhcd.maryland.gov/Documents/Research/Housing-Needs-Assessment/Report-3-v0627-SHNA-2025.pdf

- The ability to collaborate and partner with organizations is important for identifying gaps and ensuring that we are leveraging resources across agencies.

- Service and Civic Innovation – *Mae Beale, Rose Li*
  - By 2030, one in four Marylanders will be over 60 and whether or not they are working, they want to utilize their skills and talent and be stakeholders in the process. Service is important because it helps build strong communities and gives older adults personal growth and a purpose. Civic innovation is really critical because it is a way to help solve public problems. It encourages public participation and helps us improve.
  - Maryland Corps says it includes adults up to age 70, but there is no age limit; that's just the oldest volunteer they currently have. Younger age volunteers are not emphasized here. In Maryland, students must complete 75 hours of Student Service Learning (SSL) before graduating high school (and 260+ hours earns a certificate for Meritorious Service at graduation). It would be good if the department could do more to advertise opportunities for younger people to introduce them into the aging field. Younger people using digital tools can help do a lot of organizing.
  - There are so many research projects that are looking for the older adult perspective. It is expensive to do focus groups, so if there is a way to connect those older adults who are very articulate and able to participate, that would be a good way to broaden the volunteer experience.
  - Having older adults help kids become better readers is a way to keep seniors engaged. ExperienceCorps is an evidence-based approach based on research funded by the National Institutes of Health. Perhaps there are ways to work with the Department of Education to encourage counties to pursue this opportunity.

- **Planning** – *David Roth, Allen Tien*
  - Let's shift the concept from elderly people being a cost to being an asset to communities. Instead of the term "aging in place," use of "elders at home" connotes older adults as an asset to the community with so much experience and knowledge. We can generate some economic activity and address the homeless problem with universal basic income. There is a whole area of thought and potential applications, policy, and investment. Economists say that universal basic income would triple our economy because you're accelerating its hyper local increase. So there are some more things to think about.
  - Developments in the education space are analogous in multiple important aspects to the longevity ecosystem that the Department is leading with the Longevity Ready Maryland plan. Many of the issues are the same set of issues, which we can think of as problem patterns for which we have solution templates, avoiding the delays and costs of reinventing solutions. All these things in the report have been worked through and are operational.
  - In education settings, the Multi-Tier System of Supports (MTSS) Framework model offers a strong solution template, spanning Universal Prevention, Early Intervention, and Treatment. It's an education space concept that has emerged over the past couple of decades. MTSS used to be focused on learning disability, and has evolved with a major focus on behavioral health and K12 students. Tier one is universal prevention; Tier two, early intervention; Tier 3, referral to treatment and shared multidisciplinary care plans.

- On the assisted living quality issue, there's so much that's available. A key option is to include video cameras with programs, with an Artificial Intelligence (AI) engine, enabling efficient observation that can be used to assure that people are doing the right thing very efficiently and just to build on that.
- The Longevity Ready Maryland document is an excellent document, but it only refers to the longevity ecosystem. Dr. Tien shared a couple of advances in terms of scientific models that might be helpful for capturing a broader context. One is called Energy Network Science (ENS) from a paper published by five ecosystem biologists; the lead author, Brian Fath, is at Towson University.[2] They developed their ENS model to look at biological ecosystems, and realized it could apply to social and economic systems more broadly. There are four main concepts under which they develop 10 principles. The really important part of this is that the 10 principles are measurable. Another important part to the ecosystem is participation; everyone wants participation of all the different stakeholders. There's another really good model called Biopsychosocial Technical Systems Theory developed by Alan Card at the University of California, San Diego. It involves bringing employees into the governance process to participate and then measure that part. It's a really powerful model to help us consider how we organize participation within the context of biopsychosocial issues and factors, then come up with what we're going to do and how we're going to measure it. And then create that improvement cycle -- an area not mentioned in the LRM document. There's a lot of available and ongoing work with implementation science and improvement science, and another area of work combining implementation and improvement science. And again, it all depends on having the data right as part of this process, to look at what we're doing and involvement.

Q&A (summary)

- **Q:** What about federal discretionary grants, like the Alzheimer's grant and so on?
- **A:** State grants, that is the dementia care grant we received this year, those are level funded and moving along. Federal discretionary awards are still level funded in the latest iteration of the budget documents. Those are back in and hope they will stay. We also applied for and received a few grants for family caregiving and navigating benefits. Our strategy has been to look to philanthropy and other discretionary grants.

- **Q:** This information is very much focused on the individuals who are already enrolled in services. Would you be able to give a geographic breakdown within the county level?
- **A:** CODI can be useful if organizations are screening for social needs and sharing that data with CRISP; there could be uses to combine that data with geography to look at what the biggest needs and specific populations are in a specific county. The health department that covers these counties could use these outcome measures to calculate the burden of chronic conditions in a specific county to better understand the diseases and social needs driving health concerns in that community.

- **Q:** This would be limited to those who are actually served, so we would not know about the individuals who are not served. From the Census, we would know the base population and the proportion of people who are served. It is another piece of the bigger

[2] Fath BD, Fiscus DA, Goerner SJ, Berea A, Ulanowicz RE. 2019. Measuring regenerative economics: 10 principles and measures undergirding systemic economic health. *Global Transitions*, Vol 1: 15-27.

picture, and we need to think about the group not being served. Is there a plan for education around how to make use of this data?

- **A:** There is a huge educational component to assist with interpretation of the data. It is straightforward for CBOs to look at data from their own organization. It is more challenging to combine and interpret data from across CBOs as the data that comes from these systems can be very diverse.

- **Q:** CRISP has hospital and outpatient data for physicians' offices. Is it possible to distinguish between for example, a discharge from the hospital and services from the CBO? Is it possible to look at outpatient providers and match what the CBOs are doing?
- **A:** Patient matches in certain situations may be more outpatient information because providers share that information with CRISP. Since we are getting all of that hospital data, our focus has been on looking at discharge information as well as related costs, and we can look at both pre- and post-intervention. We are currently working with social services to receive SNAP data in CRISP, so we will be able to match some of that data as well.

- **Q:** Some of the information and programs that are available do not always reach the people who actually need services. They probably feel depressed, lonely, and isolated.
- **A:** We talk about this at the agency. One of the strategic changes we made is how we have begun to take a hyper-local approach to funding CBOs that are closer to the people. We recognize that there is a whole cohort of people who do not access services; identifying and funding hyper-local organizations will help to close the gap and build up resiliency in these communities.

- **Q:** Is there any information about the availability of the caregivers or care partners or social networks, given the increasing number of older adults who are living alone? Is there a way to potentially target the people living alone because they may not have the same resources socially to know to reach out for needed services.
- **A:** The State Department of Health is working on a dashboard to do some mapping work to see where there is a need and identify different hot spots. We are trying to innovate on program delivery, including working with Villages and trying to identify neighborhoods with particular needs.

Action Items:

- MDOA (Liz Woodward) will provide information to Commissioners about the GUIDE Model, Clinical Judgement Action Model (CJAM), and list of abbreviations/acronyms
- If anybody would like to make a public comment, please email lisa.oconnor@maryland.gov.

Adjournment
The meeting was adjourned at approximately 12:05 PM.

Next Meeting
September 17, 2025