

# HIE Services: Moving From Volume to Value

April 20, 2018

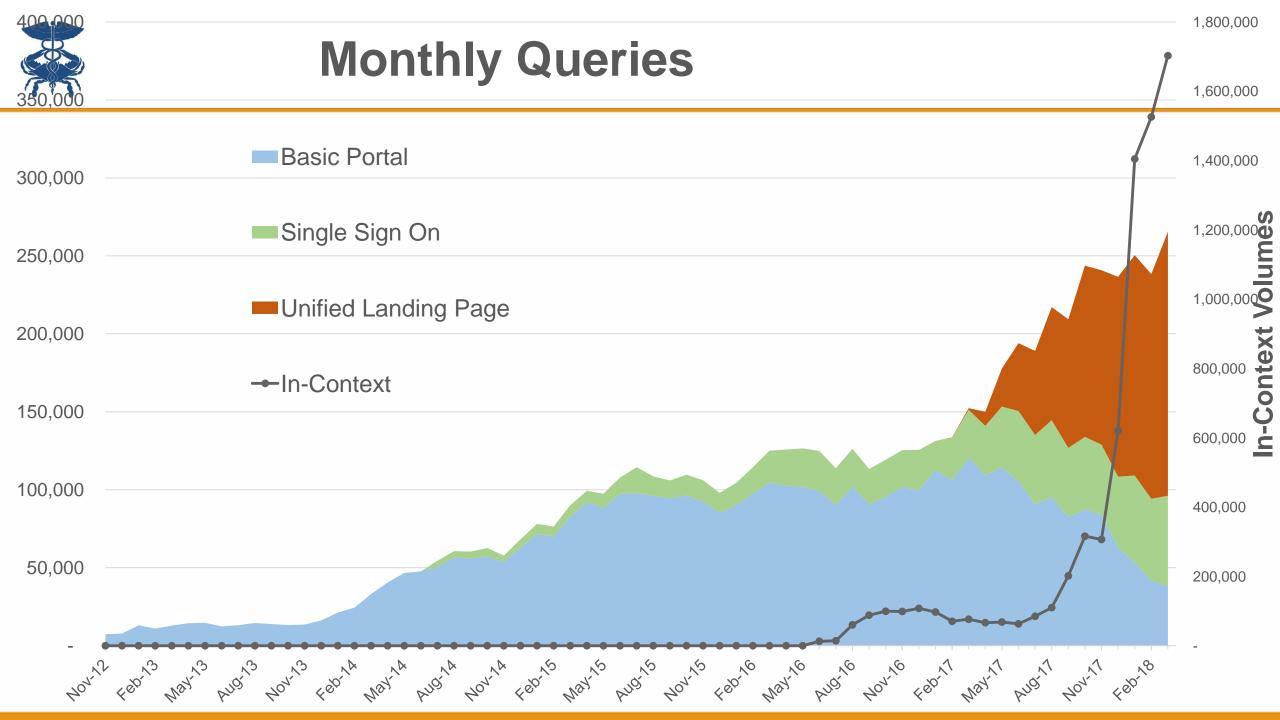
7160 Columbia Gateway Drive, Suite. 230 Columbia, MD 21046 877.952.7477 | info@crisphealth.org www.crisphealth.org



Regional Health Information
Exchange (HIE) serving Maryland and the District of Columbia, and collaborating with Delaware, Northern Virginia, Pennsylvania, and West Virginia

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

Data source or attribute	#
Live hospitals	91
Live clinical data feeds	261 (lab, rad, ADT, CCD)
Live ENS practices	+1,000
Long-term and post- acute care facilities	205
Standalone labs and radiology centers	16
Unique patients in index	+16 million
Patient searches	+400,000/mo
Encounter alerts sent	+2,500,000/mo



#### **CRISP - ENS® Utilization**

4,000,000





#### 1. POINT OF CARE: Clinical Query Portal & In-context Information

- Search for your patients' prior hospital records (e.g., labs, radiology reports, etc.)
- Monitor the prescribing and dispensing of PDMP drugs
- Determine other members of your patient's care team
- Be alerted to important conditions or treatment information

#### 2. CARE COORDINATION: Encounter Notification Service (ENS)

- Be notified when your patient is hospitalized in any regional hospital
- Receive special notification about ED visits that are potential readmissions
- Know when your MCO member is in the ED

#### 3. POPULATION HEALTH: CRISP Reporting Services (CRS)

- Use Case Mix data and Medicare claims data to:
  - o Identify patients who could benefit from services
  - Measure performance of initiatives for QI and program reporting
  - Coordinate with peers on behalf of patients who see multiple providers
- **4. PUBLIC HEALTH SUPPORT:** Partnerships with Maryland MDH, District of Columbia DHCF, and West Virginia through the WVHIN
- PROGRAM ADMINISTRATION: Technical and administrative support for Care Redesign Programs





# **User Stories**



### Sample User Story: Post-Acute Collaborative

"Our community has a partnership consisting of multiple hospitals and skilled nursing facilities. The hospital discharge planners and post-acute providers agreed to communicate at the time of a patient transfer. The SNFs that are able to also agreed to coordinate their short-term rehab patients' return home."

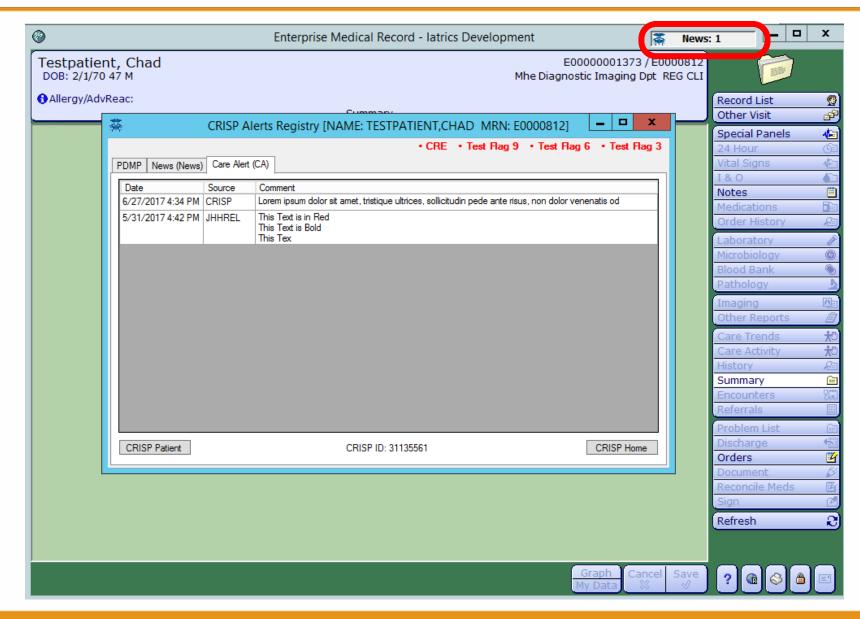


### Sample User Story: Post-Acute Collaborative

- Standard process for patients going from the hospital to the SNF
  - Discharge Planner uses **DocHalo** to text the SNF designee (varies by facility) to describe patient, indicate any key complications
  - Discharge planner also enters the key complications into EHR as a Care Alert
- If SNF residents have to return to the hospital, the SNF texts the ED physician on-call
  - As a fallback, the care alert, subscribers, and prior visits are available through
     CRISP InContext
- When residents leave the SNF, they are added to a panel for 90-days
  - ENS alerts give SNFs have more transparency into utilization post-discharge
  - If a patient goes to the ED, the SNF can text or call and share relevant information that may avoid a readmission



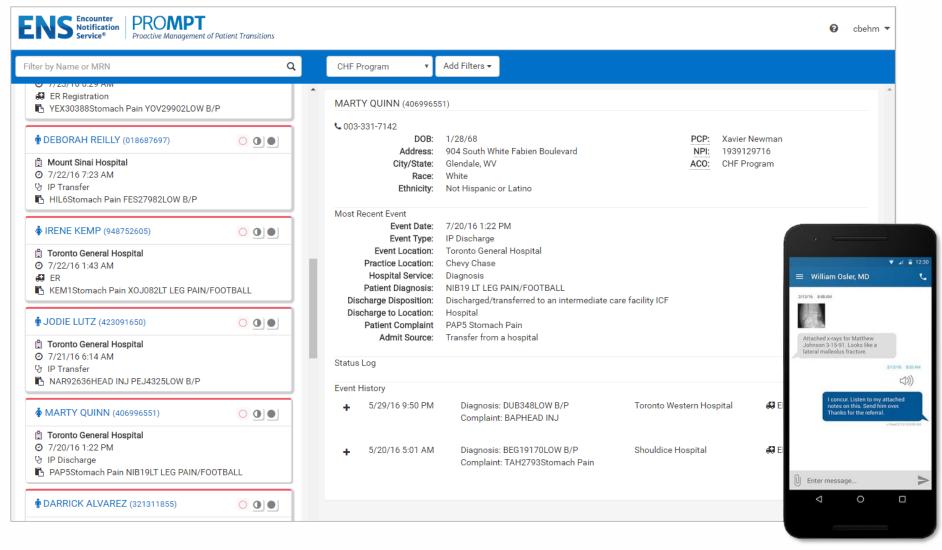
Critical data available at the point of care through API, FHIR, or CCDA; singlesign-on to patient record





#### **Encounter Notification Service**

Real-time or batch alerts to appropriate providers based on treatment and care management relationships





### Sample User Story: Longitudinal Coordination

"My hospital refers patients to a third-party care coordination entity. When we see patients are potentially eligible for support, we notify our partners. They engage the patients to describe the program and enroll them in services. Patients are typically managed for 90-120 days, depending on their situation."

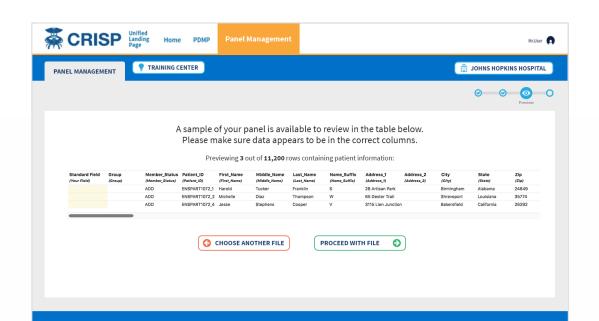


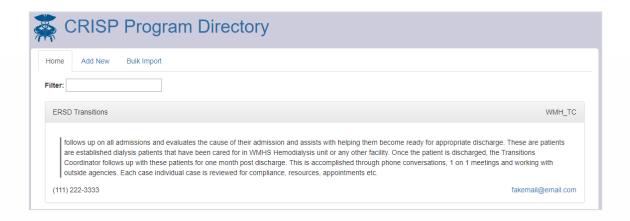
### Sample User Story: Longitudinal Coordination

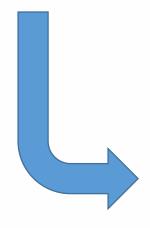
- CRISP Reporting Services created a panel of patients that would be eligible for the program if they had a hospital visit
  - ENS alert triggers for ED care managers to enroll patients
  - Care managers mark patients yellow in PROMPT
- Care coordination team reaches out to patients for long-term support
  - Write care alerts about specific patient needs
  - Submit new panels with program information
- If any of the newly enrolled patients are readmitted, the hospital sees the relationship
  - Program information is available at the point of care
  - Care coordinator reaches out, or can visit patients using PROMPT Census view

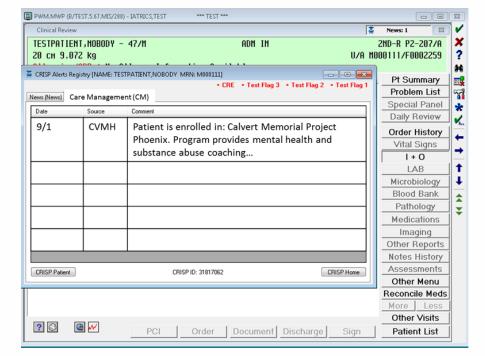


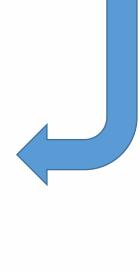
- Patient panels submitted manually or automatically in ADT feeds can include care program data such as care teams, contact information, and program enrollment
- Program metadata, without PHI, can be submitted to CRISP to show services available to all patients enrolled in that program, ACO, or payer plan
  - Information can include services offered, 24hr support numbers, regions served, and other similar information
- CRISP matches patients to panels to a program directory in real-time to display comprehensive information







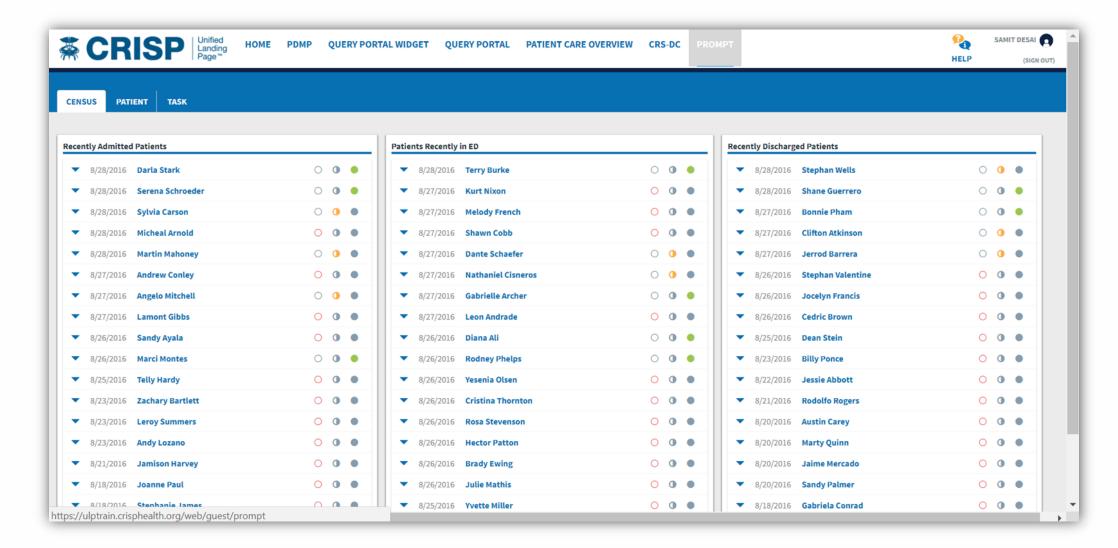








#### **PROMPT Census View**





### Sample User Story: High-Needs Beneficiaries

"I work for a Managed Care Organization. We have a program to support high-needs individuals by connecting them to their assigned primary care providers. It is frequently difficult to contact these beneficiaries and, when we do, they often need support navigating the health care system."

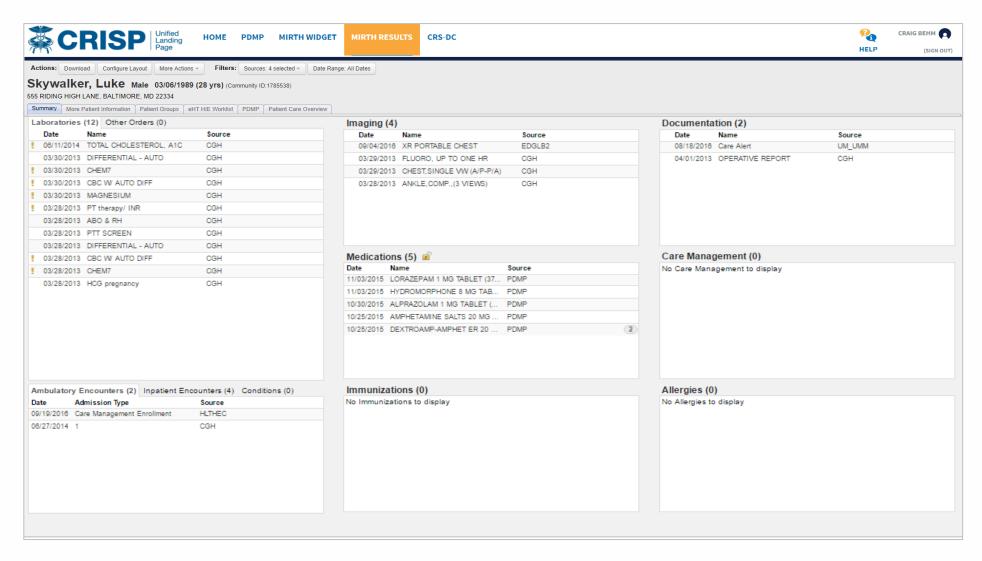


### Sample User Story: High-Needs Beneficiaries

- The Payer submits 2 panels:
  - Panel 1 is beneficiaries who are assigned but unseen by primary care provider
  - Panel 2 is beneficiaries above a specific risk score
- ENS messages come in for all patients
  - Panel 1 goes to PCP to trigger a transitional care visit
  - Panel 2 goes to Care Manager who will visit the ED
- Practice and care manager both go into CRISP Unified Landing Page to view discharge summaries, lab results, and other information



Manual patient search to view Prescription Drug Monitoring Program, labs, radiology results, recent encounters, and documents



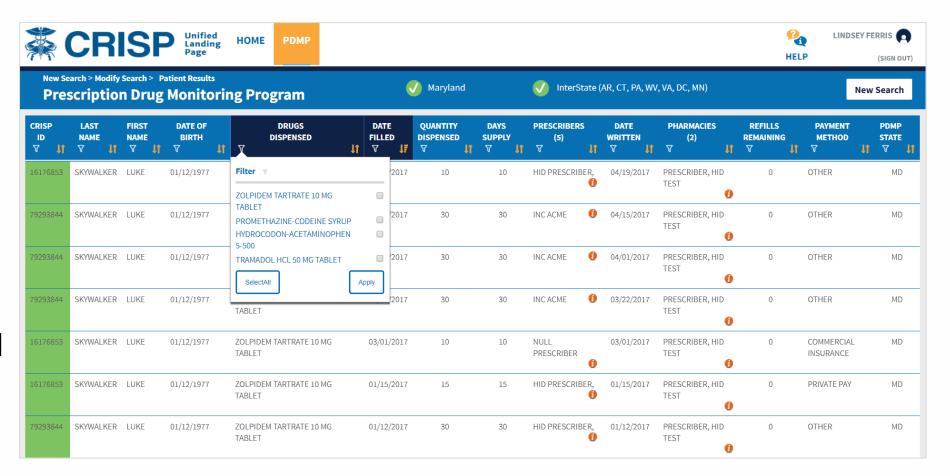


# **Additional Information**



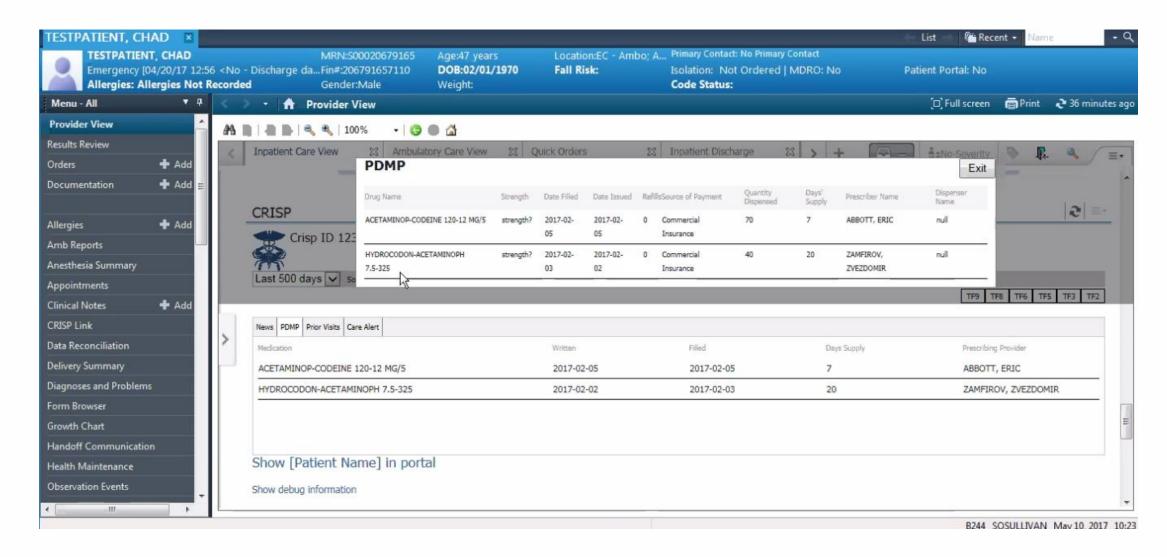
#### Prescription Drug Monitoring Program

PDMP data is available in the portal as well as the Unified Landing Page for Pharmacy users; additional features include sorting and multiple patient selection

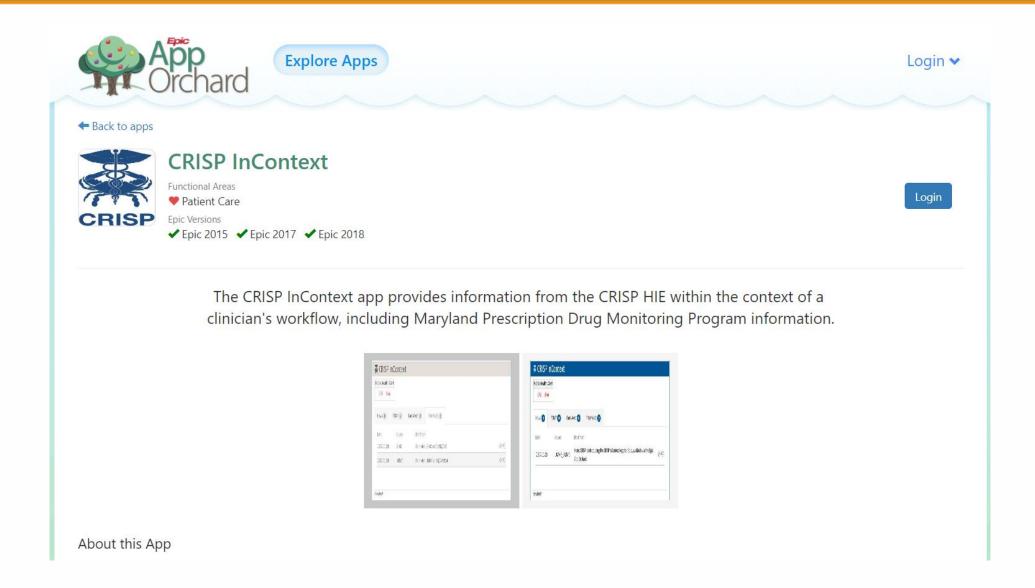




#### **CRISP In-Context**

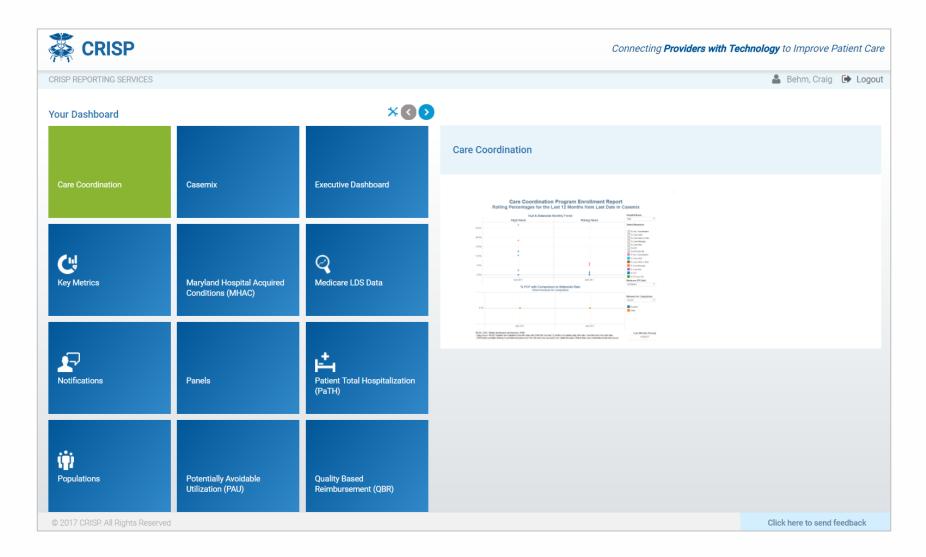


# Epic App Orchard





Dashboards from casemix and Medicare data to support high-needs patient identification, care coordination, and progress reporting





### **Questions and Discussion**

**Brandon Neiswender** 

VP & COO

Office: 443.285.0162

Cell: 410.804.6155

Email: Brandon.Neiswender@crisphealth.org