INTEGRATED CARE DC TA PROGRAM WEBINAR SERIES

HMA INTEGRATED CARE DC

PRESENTED BY:
Elizabeth Mulugeta
Ronald Emeni and
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Thursday, August 25, 2022

Time 12pm – 1pm EST

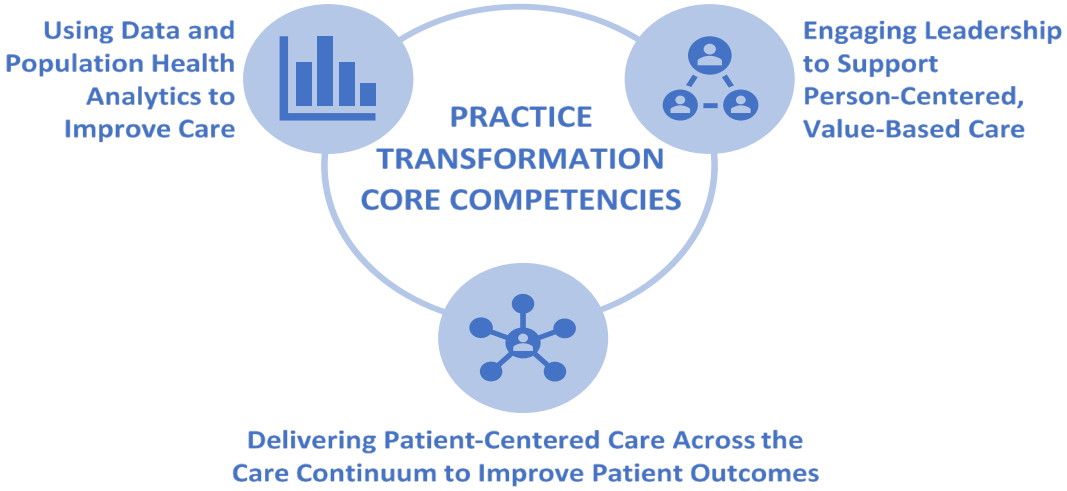
Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,616,075.00 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS, or the U.S. Government.

WHAT IS INTEGRATED CARE DC?

- Integrated Care DC is a five-year program aimed to enhance Medicaid providers' capacity and core competencies to deliver whole person care for physical, behavioral health, SUD and social needs of beneficiaries.

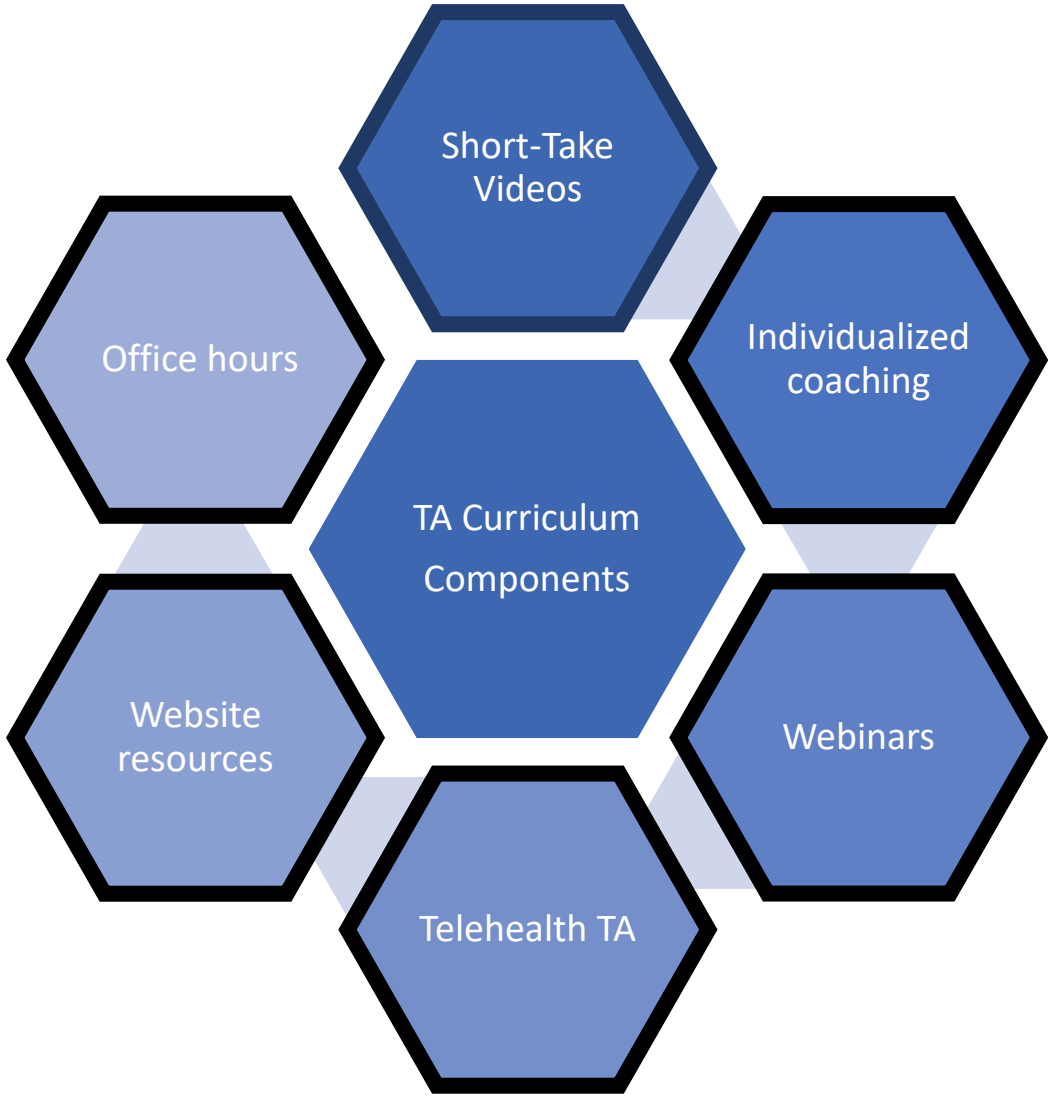
- Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). Health Management Associates will provide the training and technical assistance.

The goal is to improve care and Medicaid beneficiary outcomes within three practice transformation core competencies:



INTEGRATED CARE DC TECHNICAL ASSISTANCE

- The program offers several components of coaching and training. Material is presented in various formats. The content is created and delivered by HMA subject matter experts with provider spotlights.
- All material is available on the project website: Integratedcaredc.com
- Educational credit is offered at no cost to attendees for select elements.



INTEGRATED CARE DC UPDATES

Are you receiving our Integrated Care DC Newsletters?

Check your inbox at the beginning of the month for the Monthly Newsletter and around the 15th for the Mid-Month Update.

Got ideas?

Take this short survey to share suggestions and requests for trainings.
https://www.integratedcaredc.com/survey/

PRESENTERS

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Project Manager

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Founder of Innovation Horizons

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Outreach Manager

Faculty	**Elizabeth Wolff, MD, MPA** **CME Reviewer**	**Shelly Virva, LCSW, FNAP** **CE Reviewer**	**Elizabeth Mulugeta** **Presenter**	**Ronald Emeni** **Presenter**	**Gregory Downing** **Presenter**
Company	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures
Nature of relationship	N/A	N/A	N/A	N/A	N/A

HMA discloses all relevant financial relationships with companies whose primary business is producing, marketing, selling, re-selling, or distributing health care products used by or on patients.

CONTINUING EDUCATION CREDITS

- Health Management Associates, #1780, is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved as ACE providers. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. Health Management Associates maintains responsibility for this course. ACE provider approval period: 09/22/2021 – 09/22/2022. Social workers completing this course receive 1 continuing education credits.
- To earn CE credit, social workers must log in at the scheduled time, attend the entire course and complete an online course evaluation. To verify your attendance, please be sure to log in from an individual account and link your participant ID to your audio.
- Application for CME credit has been filed with the American Academy of Family Physicians. This session is approved by AAFP for up to 1 AMA Level 1 CME credit.
- **If you would like to receive CE/CME credit, the online evaluation will need to be completed.** You will receive a link to the evaluation shortly after this webinar**.**
- Certificates of completion will be emailed within 10-12 business days of course completion.

Agenda

Integrated Care DC TA Program Webinar Series

- Welcome and Program Announcements
- Introduction of CRISP DC HIE
- Identifying specific data elements in CRISP DC
- Best practices for using health information exchange
- Use of Electronic Notification Services (ENS) Alerts
- CRS Hospital Readmission Dashboard Overview
- Closing Remarks/Q&A

Objectives

1. Define the role of CRISP DC and how hospitals can access the system

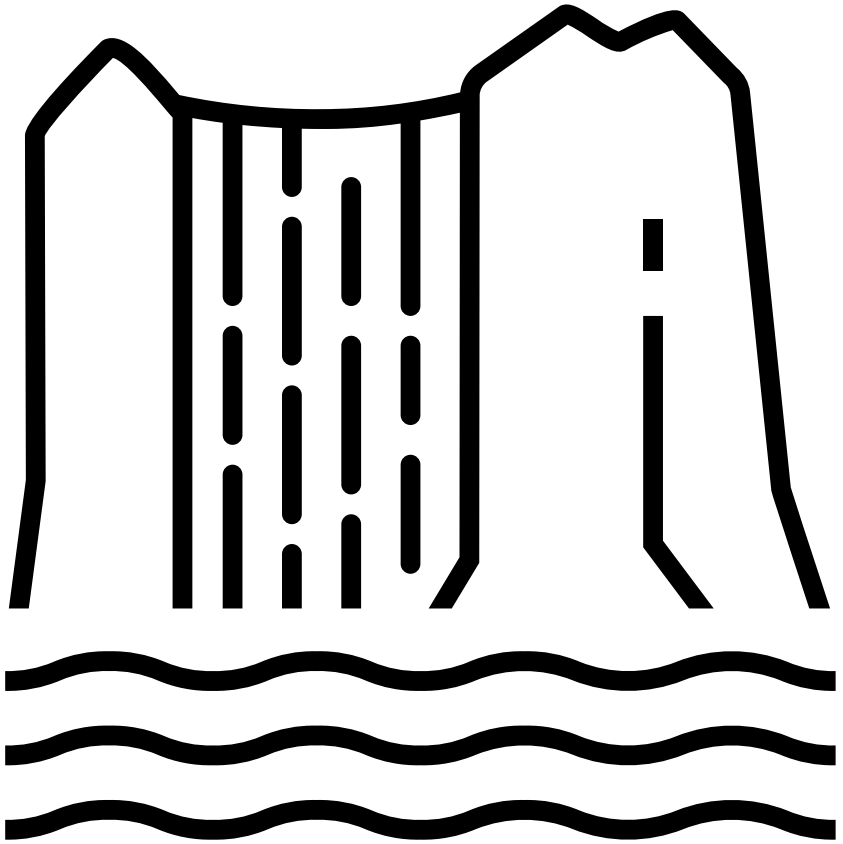
2. Explain where care teams can look for specific data elements

3. Outline 2-3 best practices for using health information exchange to improve care coordination

4. Provide instructions on how to use electronic notification services (ENS) alerts

Image permitted by DC Department of Health Care Finance

Chatterfall



Interoperability is the ability of different information systems and software applications to communicate and exchange data?

a. TRUE
b. FALSE

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CRISP DC

Role of CRISP DC

Introduction of CRISP DC HIE

The CRISP DC HIE is a way of instantly sharing health and social determinants information among doctors' offices, hospitals, labs, radiology centers, community-based organizations and other healthcare entities.

As the the designated health information exchange (HIE) serving the District of Columbia.
CRISP's main goal is to deliver the right health information to the right place at the right time to enable safe, timely, effective, equitable, and patient-centered care. CRISP is committed to ensuring that District partners are securely sharing data to facilitate better patient care, reduce costs, and improve overall health outcomes.

District-Wide Data Sharing for Whole Person Care

1,400,000+
Patients Served Through the HIE

12,500+
DC Healthcare Professionals Utilizing the HIE

900+
Organizations Accessing and Contributing Data

CRISP DC Tools and Products

1. **Encounter Notification Service (ENS) Alerts**
   - Allows providers, care managers and others with a treatment relationship to be notified when patients are hospitalized in most of the region's hospitals

2. **Clinical Data - Health Records, Encounters, Structured Documents, Immunizations, Imaging Worklist**
   - Search for your patients' prior hospital records (e.g., labs, radiology reports, other dictated reports)

3. **Data from Claims**
   - This section will provide all data received from Claims. This includes Medications, Diagnoses, Procedures, and Encounters.

4. **Social Needs Data**
   - **Assessments** - Provides questions and patient responses to structured social determinant of health questionnaires.
   - **Conditions** - a list of social needs related conditions to ICD-10 codes (Z55-65) the patient has received.
   - **Referral History** - Displays referrals to organizations that address the patient's social needs.

CRISP DC Tools and Products

VIA WEB

Navigate to

PORTAL.CRISPDC.org

In-Context

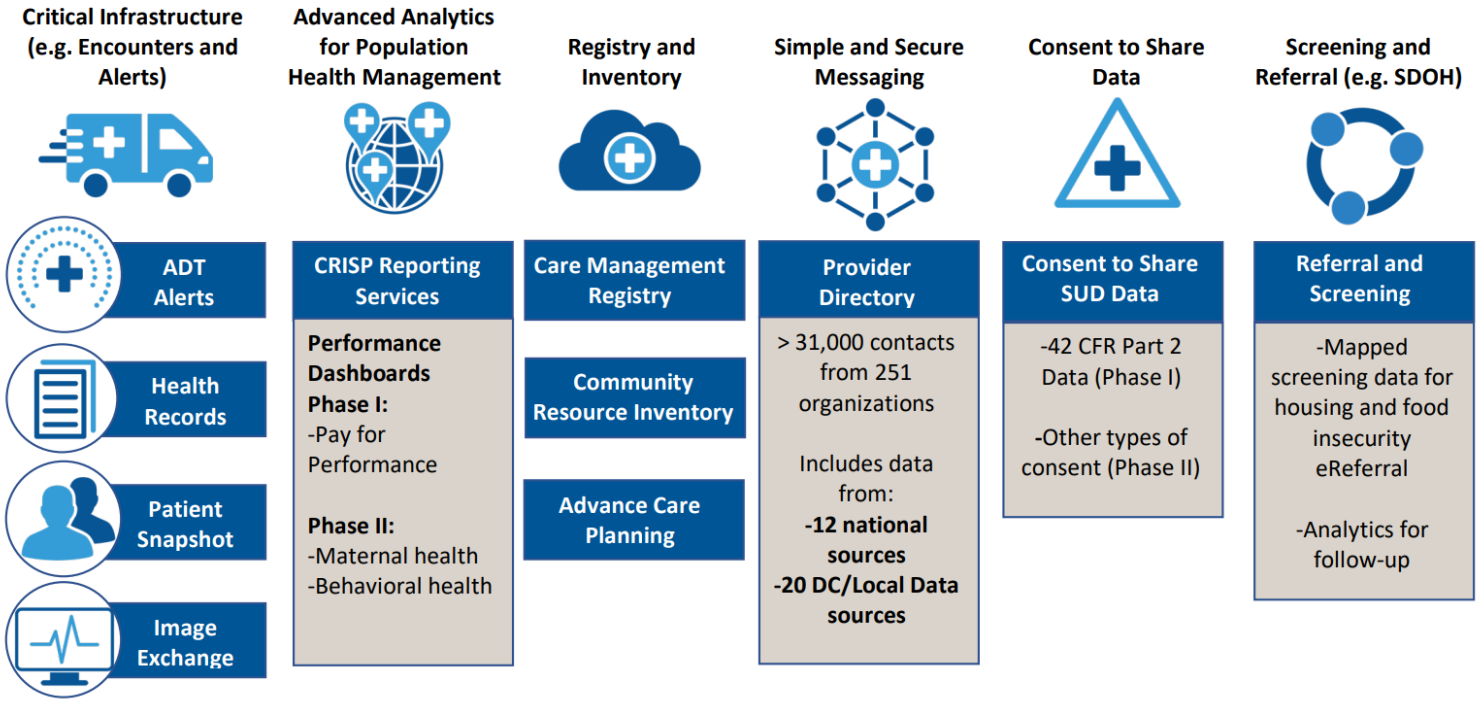
provides external connected systems information about patients while that patient is in-context in the external system.

Single Sign On (SSO)

Launch CRISP InContext from EHR

CRISP DC Core Capabilities

The DC HIE is a Health Data Utility with Six Core Capabilities for Providers



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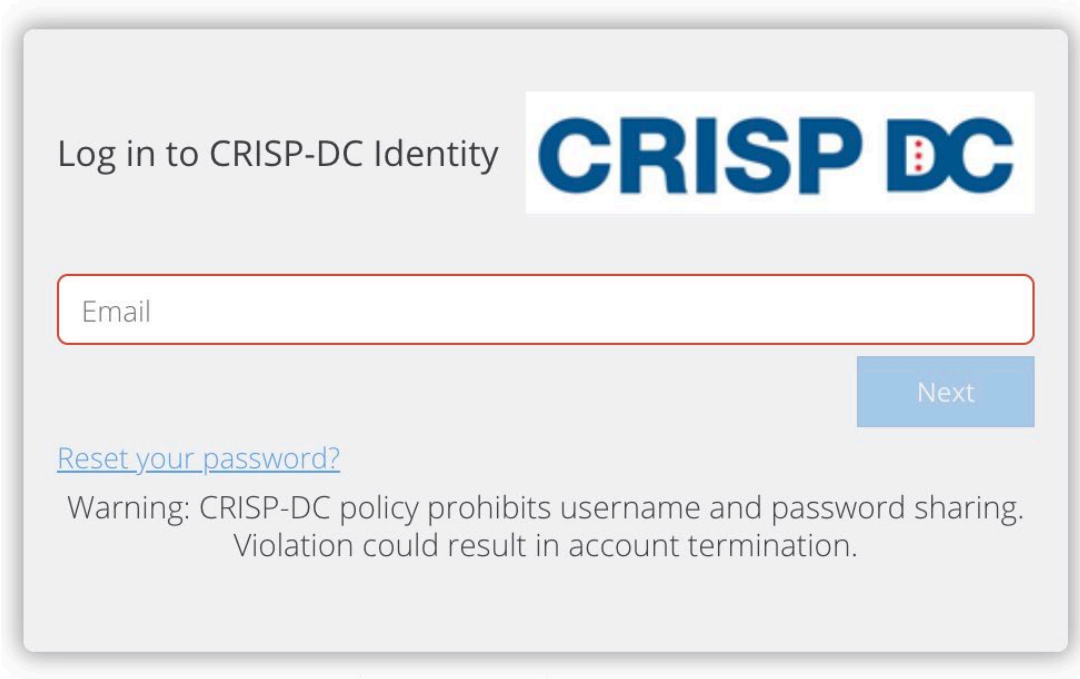
Identifying Specific Data Elements in CRISP DC

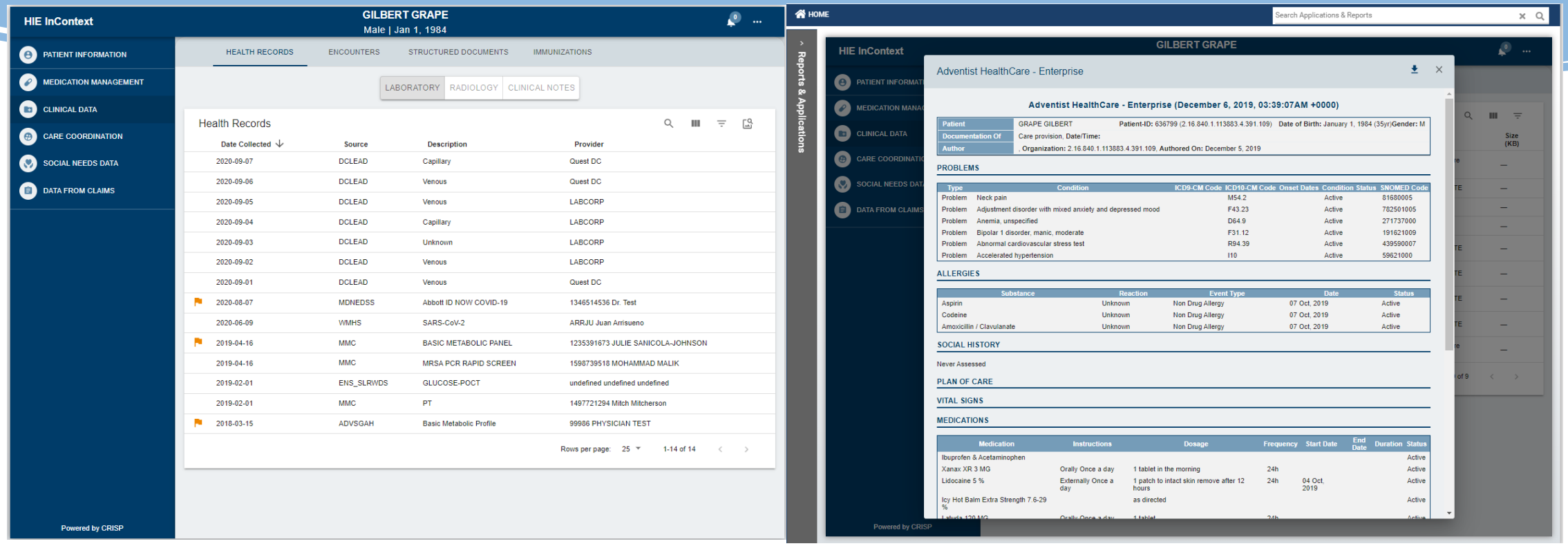
Where to Find Data Elements?

Data Element	Data Type	Where to find
Reason for Visit	ADT	ENS PROMPT
Discharge Diagnosis	ADT	ENS PROMPT
Lab Results	ORU	Clinical Data
Allergies	CCD	Structured Documents/Clinical Notes
Vital Signs	CCD	Structured Documents/Clinical Notes
Medications	CCD	Structured Documents/Clinical Notes
Discharge Appointment*	CCD	Structured Documents/Clinical Notes
Discharge Medications	CCD	Structured Documents/Clinical Notes
Immunizations	ORU	Immunizations

Let's Get Started! - Overview

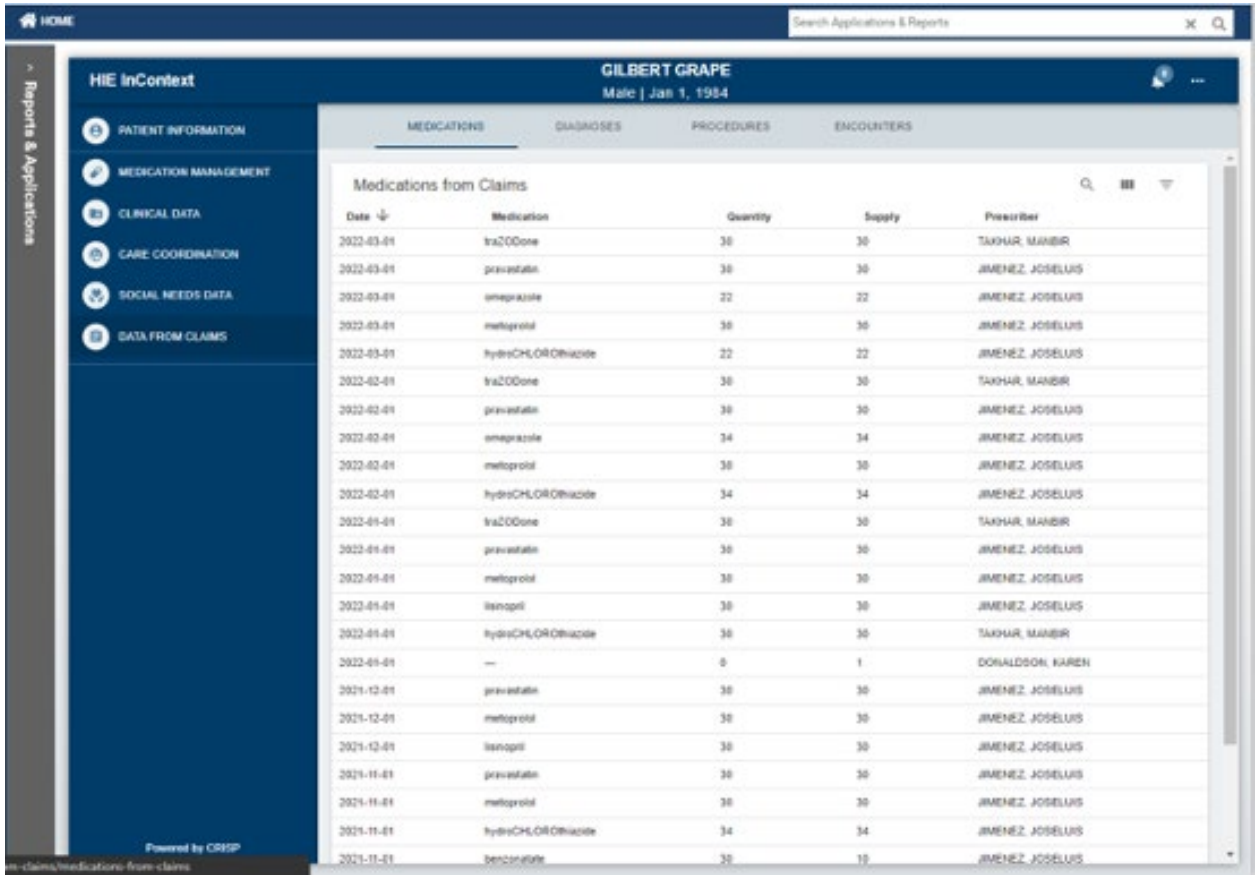


Critical Infrastructure: Clinical Data



- Search for your patients' prior hospital records (i.e. labs, radiology reports, etc.)
- Determine other members of your patient's care team
- Users can view clinical notes such as Discharge Summaries, Clinical Notes, Operative reports, Ambulance Run Sheets, and more
- Review structured documents from outpatient facilities including all of the Federally Qualified Health Centers in DC

Critical Infrastructure: Data From Claims



- Review historically data from claims
- Medications with Quantity, Supply, and Prescriber
- Diagnoses with Condition and date recorded
- Procedures with the description, source, and date
- Encounters with the source, claim type, reason and date

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Best Practices For Using Health Information Exchange

Transitions of Care Use Cases For Outpatient Behavioral Health Providers Using CRISP

- The purpose is to demonstrate the utility of hospital discharge data in CRISP by Outpatient Behavioral Health Providers (OBHPs)
- Pilot studies were conducted with 3 hospital systems and 2 behavioral health networks
- Using a quality improvement format, discharge notifications were made to OBHP and access to discharge information in CRISP was used in patient follow-up
- Several use cases of common clinical scenarios were developed for education and training purposes to identify potential opportunities for use of CRISP-enabled access to hospital discharge data for improved care coordination

Scenario: Accessing Clinical Discharge Diagnosis

- An OBHP was notified by a hospital discharge coordinator that their patient, Marina, was discharged after a 5-day hospital stay and was instructed to have a follow up within 1 week.
- The provider logs into CRISP and reviews Marina's discharge information and notes that she had been admitted with fever and pneumonia but that she also had been without her anxiety medications for several weeks.
- The provider then looks to see the medication list and notes that Marina was discharged on oral antibiotics and a prescription for a new anxiolytic medication that she had not been on previously.
- The OBHP arranges for an appointment the following day.
- The Provider then enters the discharge diagnosis information into OBHP clinic records and makes note of a few questions to address regarding the new diagnosis and medications with Maria for her clinic visit.

Scenario: Medication Needs Following Discharge

- Chui was recently discharged from hospital admission following a traumatic encounter in his homeless shelter. He has a history of chronic depression and had missed an appointment to OBHP a month ago.
- Upon notification of the discharge the OBHP clinical social worker (CSW) began assessing new housing options and noted he did not have his medications.
- The clinic intake staff supervisor logged into CRISP and saw that Chui was discharged on two medications for his depression and anxiety. The OBHP was notified and the CSW was able to obtain a prescription refill from a local pharmacy.
- The OBHP also coordinated with CSW to arrange for a follow up visit the following week for medication review.

Scenario: Closing Follow-up Appointment Gaps Following Repeated Hospital Visits

- Shaya is a long-time patient at a behavioral health clinic with persistent problem with recurrent headaches.
- At her next appointment, her OBHP greets Shaya and asks about a recent ED visit for her symptoms.
- The provider inquired about what actions were taken at the ED and Shaya noted that she could not remember.
- The provider looks up Shaya's hospital encounter data in CRISP and finds that there have been 3 ED visits at different facilities in the last several months with similar symptoms.
- With the last two encounters, the hospital ED provider recommended an outpatient neurology appointment but there was no documented followup appointments made.
- The provider reviewed the laboratory test and vital signs data in CRISP, then facilitated the scheduling of a visit with a neurology clinic for 3 days and reviewed the plan with Shaya.

Scenario: Missed Clinic Appointments

- Giselle is a longtime senior patient at the local behavioral health clinic. She has diabetes.
- Yesterday, Giselle did not appear for her scheduled appointment and a call placed by the clinic manager to her mobile phone went unanswered.
- The clinic manager logs into CRISP and notes that Giselle was admitted a week ago as an inpatient at a local acute hospital with diabetic coma. She had fallen at home and had fractured her shoulder and was transferred to a skilled nursing facility (SNF) 2 days ago.
- The clinic manager entered notes from CRISP into her chart and contacted the SNF where it was noted that Giselle would be coming home soon and in need of supportive care there.
- The clinic manager discussed with the hospital arranged for a discharge coordination call and began preparations for visiting nurses, home meals, and a virtual clinic follow-up the day after her arrival at home.

Next Steps

- Continued feedback from hospital discharge coordinators and OBHP intake staff and providers on utility of CRISP data
- Facilitate education and training of CRISP discharge data access by providers at additional hospitals and clinics
- Longer term: assess the impact of discharge data access on readmissions and ED visits

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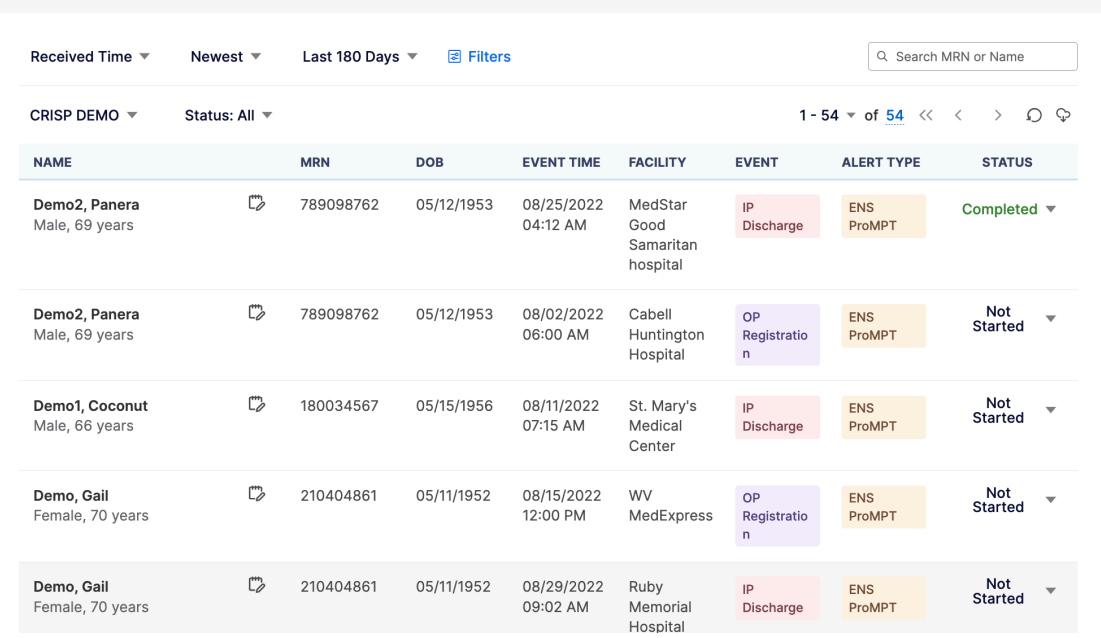
Use of Electronic Notification Services (ENS) Alerts

What is ENS Prompt?

ENS (Encounter Notification System) is designed to provide real-time notifications for treatment, quality improvement, and care coordination purposes when patients have specific encounters, such as hospital admissions or discharges, or specific criteria are met, such as a diagnosis being recorded.



NAME	MRN	DOB	EVENT TIME	FACILITY	EVENT	ALERT TYPE	STATUS
Demo2, Panera Male, 69 years	789098762	05/12/1953	08/25/2022 04:12 AM	MedStar Good Samaritan hospital	IP Discharge	ENS ProMPT	Completed
Demo2, Panera Male, 69 years	789098762	05/12/1953	08/02/2022 06:00 AM	Cabell Huntington Hospital	OP Registration	ENS ProMPT	Not Started
Demo1, Coconut Male, 66 years	180034567	05/15/1956	08/11/2022 07:15 AM	St. Mary's Medical Center	IP Discharge	ENS ProMPT	Not Started
Demo, Gail Female, 70 years	210404861	05/11/1952	08/15/2022 12:00 PM	WV MedExpress	OP Registration	ENS ProMPT	Not Started
Demo, Gail Female, 70 years	210404861	05/11/1952	08/29/2022 09:02 AM	Ruby Memorial Hospital	IP Discharge	ENS ProMPT	Not Started

ENS Prompt Key Features

- ENS Alerts live within PROMPT for 6 months
- ENS alerts are a combination of patient panel attributes and sender ADT message attributes
- Custom filters available
- Patient workflow status indicators
- Download results up to 500 rows

ENS Prompt Connected Sites

CARE COORDINATION: Encounter Notification Service (ENS)

•CRISP currently receives information pertaining to **ER visits and inpatient admissions** in real-time from acute care hospitals in the region.
•All Maryland acute care hospitals
•All D.C. acute care hospitals
•All Delaware acute care hospitals (in partnership with DHIN)
•17 Northern Virginia acute care hospitals (in partnership with ConnectVA)
•Most West Virginia acute care hospitals

•If you send us a list of patients, we can send you an alert:
•When your patient encounters at a hospital
•When your patient re-admits at another hospital
•When your patient is discharged or passes away
•When your patient is transferred to rehab or long term care

How Does ENS Prompt Work?

1.  A patient goes to the hospital → 

2. 

At registration the hospital asks the patient for basic information (name, DOB, etc.) and the reason for the visit. The registrar enters that information into an Electronic Medical Record.

3.  When the registrar has completed entering the information, and pushes 'save', a copy of that information is immediately sent to CRISP → CRISP

4. CRISP A facility who has submitted a patient panel to CRISP that includes this patient receives a real-time or batch notification that the patient has been to the hospital. → 

5.  The facilities that submitted patient panels to CRISP may also consult ENS Prompt for the patient's discharge disposition and location, and the Patient Care Overview for important details about the patient's prior hospitalizations and care coordination activities. → 

Who Uses ENS Prompt?

Currently, participants may not know when one of their patients is admitted to a hospital, or alternatively, they may find out well after the admission and/or have incomplete data. ENS messages will serve to initiate a process for coordinating care and/or providing follow up care after specific encounters.

Case Manager

Care Coordinator

Medical Assistant

Healthcare Provider

How to Leverage ENS Prompt?

ENS Prompt Filters

Filtering: Enables users to arrange data using general categories such as, demographic information, facility type, patient classification, diagnostics, event type, and various subgroups for providers. The selected category is further refined using the following fields.

a) **EVENT TYPE:** There are several options when filtering for ADT encounters in ENS. The event type filter quickly allows you to filter for Admissions, Discharges, Transfer, Registrations.
b) **PATIENT CLASS:** Users can filter for emergency room, inpatient, outpatient and ambulance encounters.
c) Combine multiple additional filters based on patient complaint, diagnosis code, discharge disposition and more.
d) Users can manage ENS notification internally by utilizing the status fields (not started, in progress, completed)

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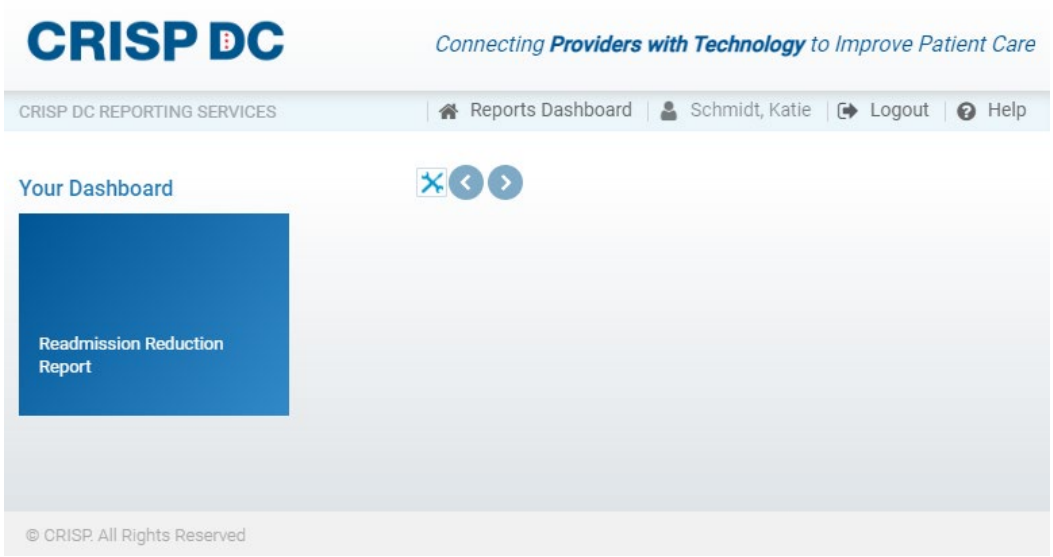
CRS Hospital Readmission Dashboard Overview

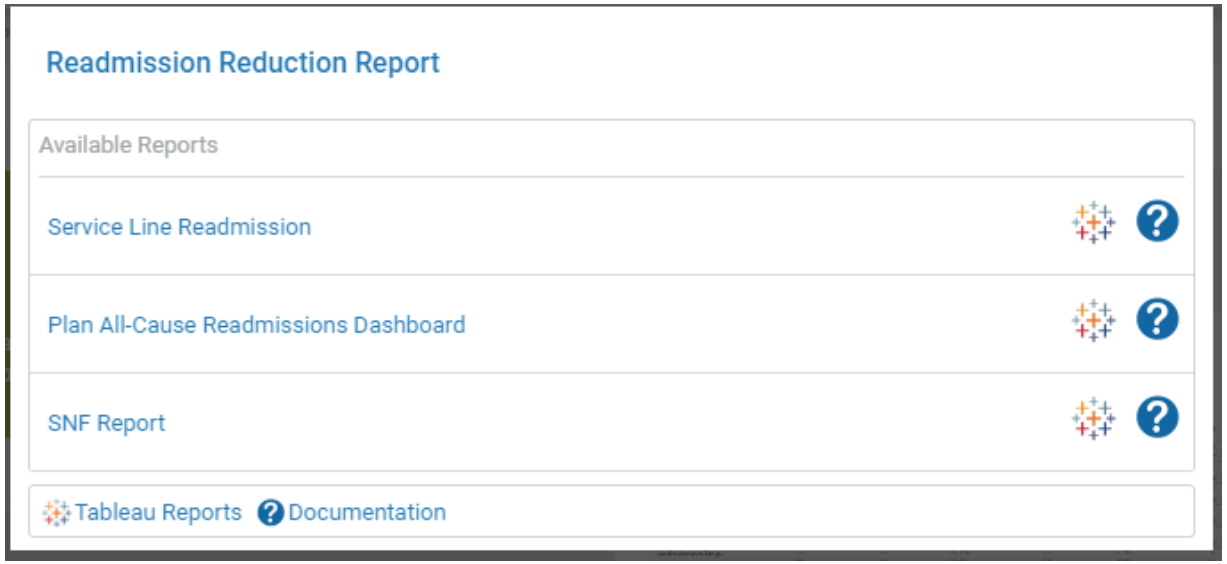
Current Data in the Reports

- DC Medicaid and Alliance Members
- Medicaid and Alliance Claims data coming directly from DHCF bi-weekly
- Data available from November 2018 to present
- Note: All data in this presentation is demo data and does not include PHI (and therefore can be shared with others)

Accessing the Reports

- Navigate to reports.crispdc.org
- Select “Readmission Reduction Report” Suite
- Select report of interest from the pop-up window





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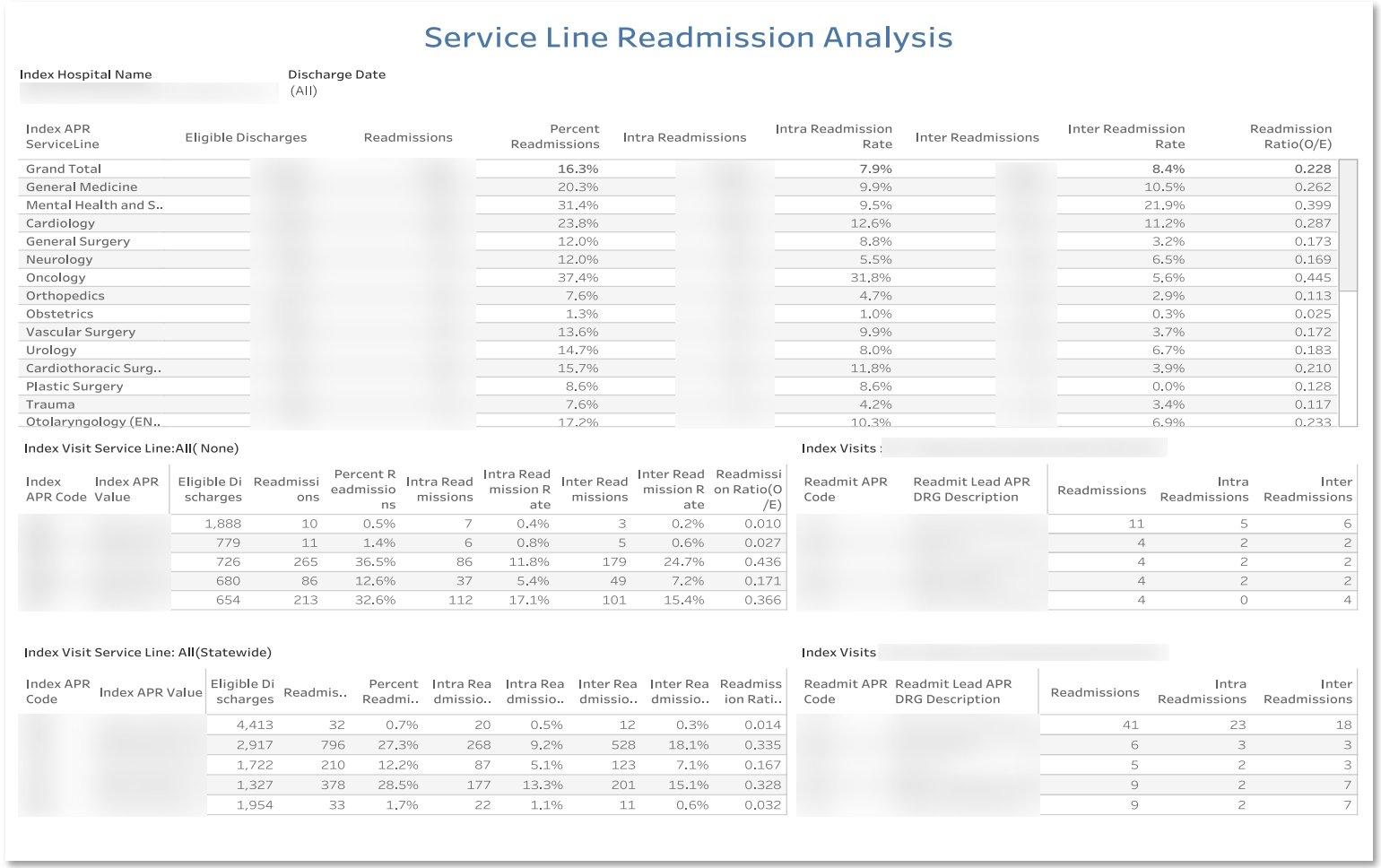
Hospital Readmission Reports

Service Line Readmission Report

- High-level overview of readmissions by APR DRG Service Line.
- Select an APR DRG Service Line on the top chart to show index visit APR DRGs making up that data point.
  - Select index APR DRGs (left chart) to view the readmission APR DRGs on the right charts.
  - Note: The first APR DRG chart is specific to your hospital and the bottom is a reference for the full DC Medicaid population.



Service Line Readmission Analysis

Index Hospital Name

Discharge Date
(All)

Index APR ServiceLine	Eligible Discharges	Readmissions	Percent Readmissions	Intra Readmissions	Intra Readmission Rate	Inter Readmissions	Inter Readmission Rate	Readmission Ratio(O/E)
Grand Total			16.3%		7.9%		8.4%	0.228
General Medicine			20.3%		9.9%		10.5%	0.262
Mental Health and S..			31.4%		9.5%		21.9%	0.399
Cardiology			23.8%		12.6%		11.2%	0.287
General Surgery			12.0%		8.8%		3.2%	0.173
Neurology			12.0%		5.5%		6.5%	0.169
Oncology			37.4%		31.8%		5.6%	0.445
Orthopedics			7.6%		4.7%		2.9%	0.113
Obstetrics			1.3%		1.0%		0.3%	0.025
Vascular Surgery			13.6%		9.9%		3.7%	0.172
Urology			14.7%		8.0%		6.7%	0.183
Cardiothoracic Surg..			15.7%		11.8%		3.9%	0.210
Plastic Surgery			8.6%		8.6%		0.0%	0.128
Trauma			7.6%		4.2%		3.4%	0.117
Otolaryngology (EN..			17.2%		10.3%		6.9%	0.233

Index Visit Service Line:All(None)

Index APR Code	Index APR Value	Eligible Discharges	Readmissions	Percent Readmissions	Intra Readmissions	Intra Readmission Rate	Inter Readmissions	Inter Readmission Rate	Readmission Ratio(O/E)
		1,888	10	0.5%	7	0.4%	3	0.2%	0.010
		779	11	1.4%	6	0.8%	5	0.6%	0.027
		726	265	36.5%	86	11.8%	179	24.7%	0.436
		680	86	12.6%	37	5.4%	49	7.2%	0.171
		654	213	32.6%	112	17.1%	101	15.4%	0.366

Index Visits

Readmit APR Code	Readmit Lead APR DRG Description	Readmissions	Intra Readmissions	Inter Readmissions
		11	5	6
		4	2	2
		4	2	2
		4	2	2
		4	0	4

Index Visit Service Line: All(Statewide)

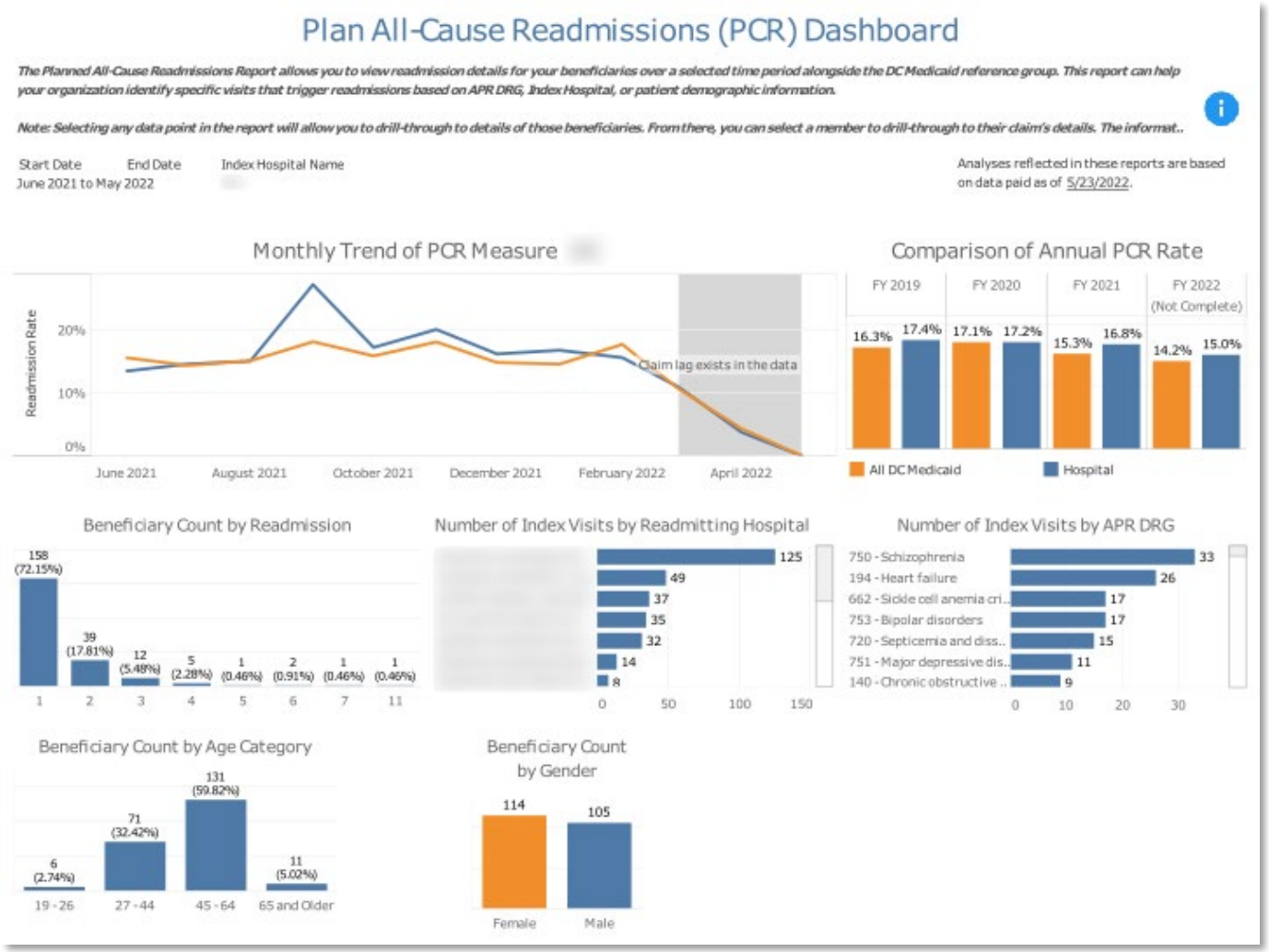
Index APR Code	Index APR Value	Eligible Discharges	Readmis..	Percent Readmi..	Intra Readmissio..	Intra Readmissio..	Inter Readmissio..	Inter Readmissio..	Readmission Rati..
		4,413	32	0.7%	20	0.5%	12	0.3%	0.014
		2,917	796	27.3%	268	9.2%	528	18.1%	0.335
		1,722	210	12.2%	87	5.1%	123	7.1%	0.167
		1,327	378	28.5%	177	13.3%	201	15.1%	0.328
		1,954	33	1.7%	22	1.1%	11	0.6%	0.032

Index Visits

Readmit APR Code	Readmit Lead APR DRG Description	Readmissions	Intra Readmissions	Inter Readmissions
		41	23	18
		6	3	3
		5	2	3
		9	2	7
		9	2	7

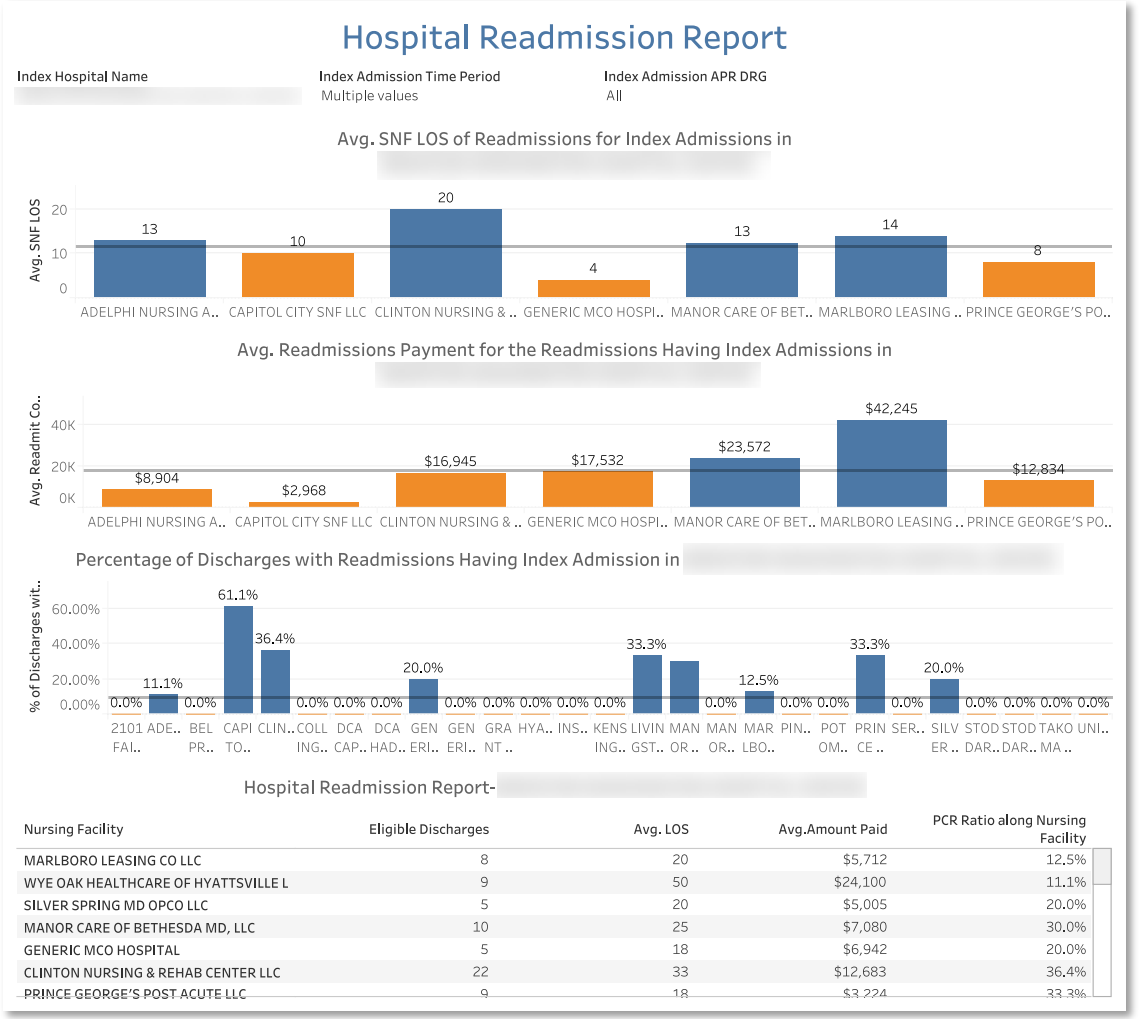
Plan All-Cause Readmissions (Hospitals)

- Track your beneficiaries' readmissions by:
  - Date
  - APR DRG
  - Readmitting hospital
  - Demographic information
- Reference Groups available for performance comparison
- Filterable on any report selection.
- Drill-throughs to Beneficiary- and Claim-level details.



SNF Readmissions Report

- View average LOS for SNFs that have readmissions along with the average readmission payment amount by facility
- Percent of readmissions by facility and an overall view by facility is available in a table
- Report is filterable by:
  - Index admission time period (calendar year)
  - Index admission APR DRG



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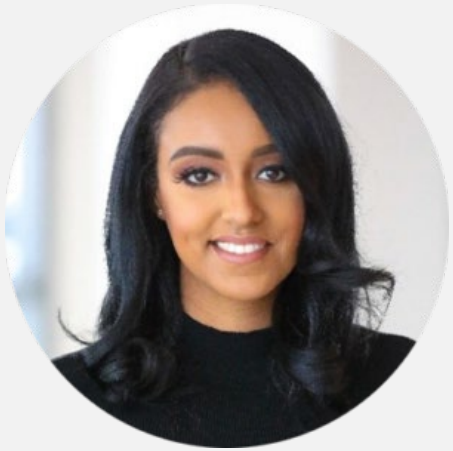
Q&A

Contact Us



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Evaluation Polling Question

As a result of this webinar, I understand:

a. How to build a business case for integrate care.
b. Ways to develop enhanced referrals.
c. Methods to implement measurement-based care.
d. Key elements of high functioning teams.

Reference List

- For CRISP DC related inquiries please contact outreach at dcoutreach@crisphealth.org.
- For support contact support@crisphealth.org or call 833.580.4646.
- Visits crispdc.org for more information about CRISP DC

Wrap Up and Next Steps

- Please complete the online evaluation! **If you would like to receive CE or CME credit, the evaluation will need to be completed.** You will receive a link to the evaluation shortly after this webinar**.**

- The webinar recording will be available within a few days at: https://www.integratedcaredc.com/learning/

- For more information about Integrated Care DC, please visit: https://www.integratedcaredc.com/