INTEGRATED CARE DC TA PROGRAM WEBINAR SERIES

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HMA INTEGRATED CARE DC

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Thursday, September 1, 2022

Time 12pm – 1pm EST

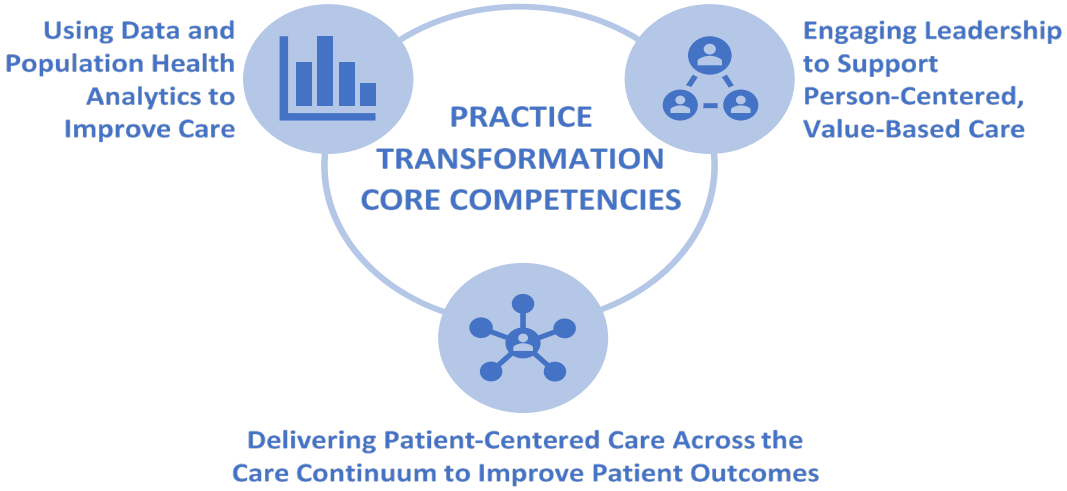
Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial 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:



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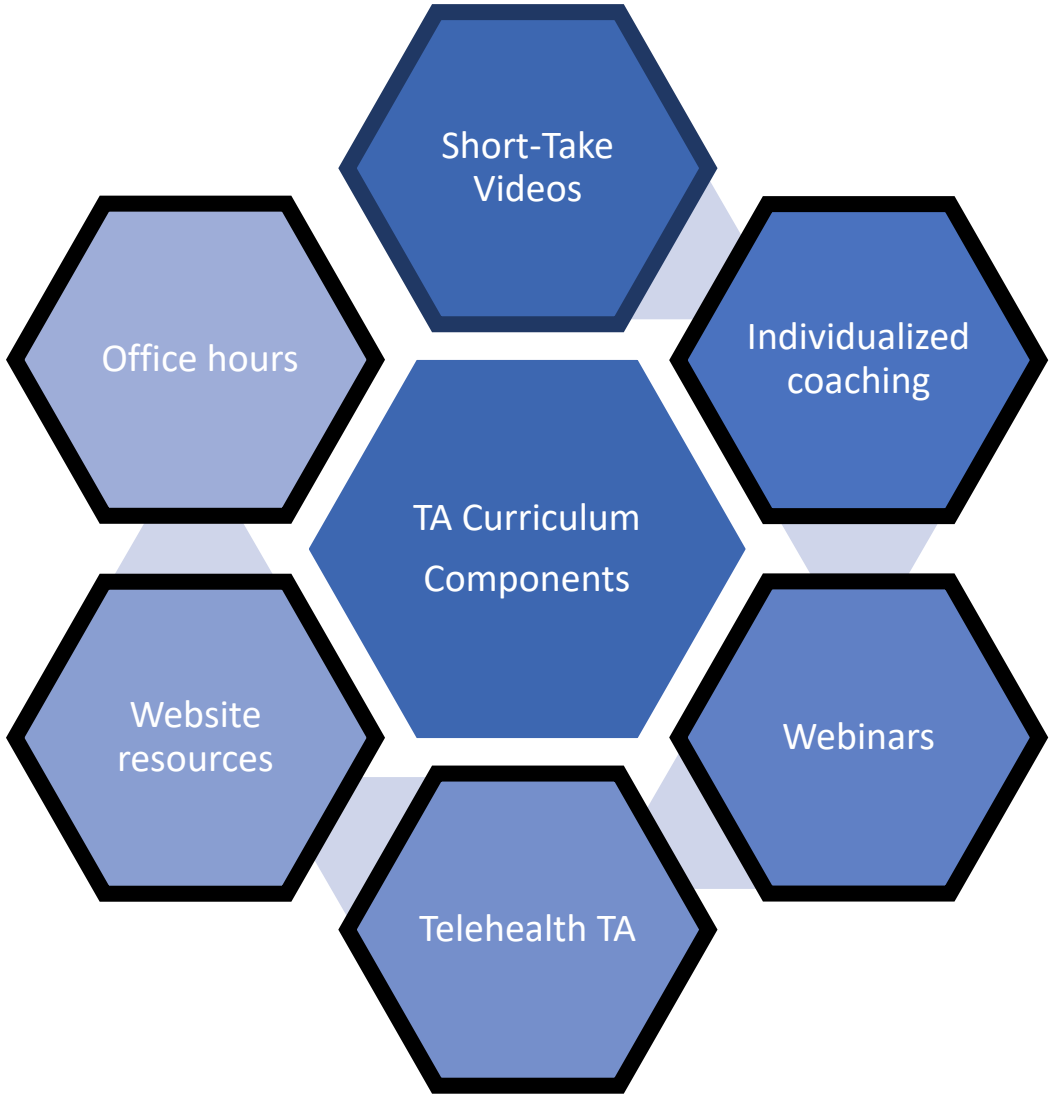
INTEGRATED CARE DC TECHNICAL ASSISTANCE

- 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.



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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/

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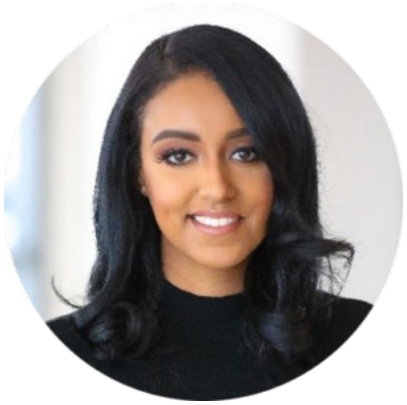

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Company	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures
Nature of relationship	N/A	N/A	N/A	N/A	N/A	N/A

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CONTINUING EDUCATION CREDITS

- 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 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.

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Agenda

Integrated Care DC TA Program Webinar Series

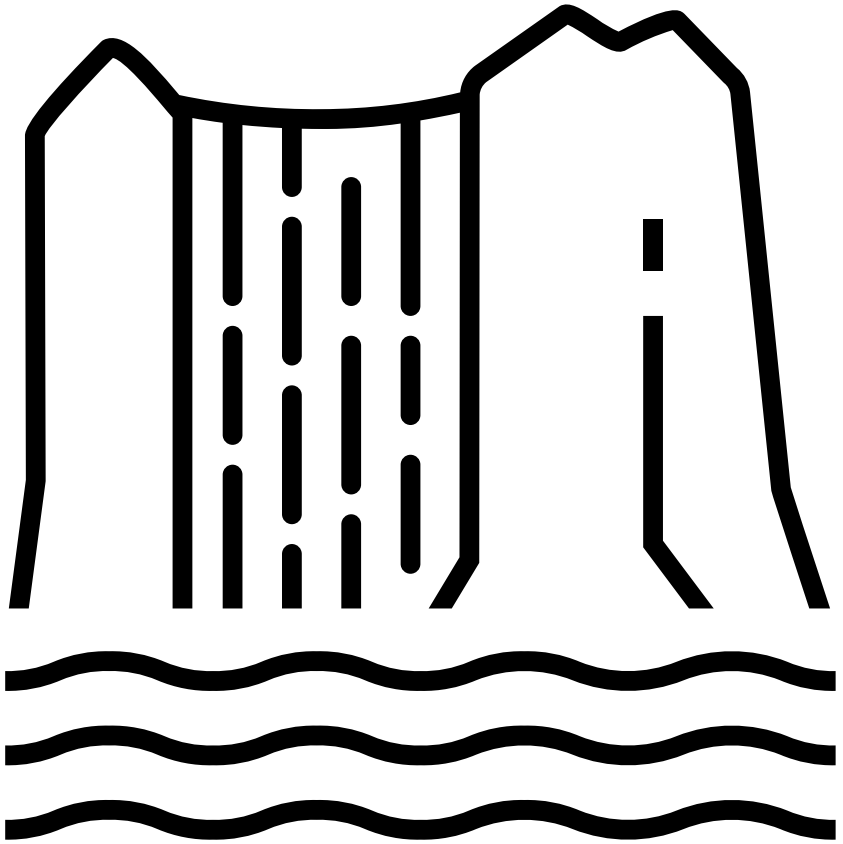
- Welcome and Program Announcements
- Introduction of CRISP DC HIE
- Identifying specific data elements in CRISP DC
- Best practices for using health information exchange
- Use of Electronic Notification Services (ENS) Alerts
- CRS Hospital Readmission Dashboard Overview
- Closing Remarks/Q&A

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
5. Identifying social determinants of health available in the DC HIE
6. Review the key features of the CRISP DC Consent Tool that enable compliant electronic exchange of behavioral health information

Image permitted by DC Department of Health Care Financ

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

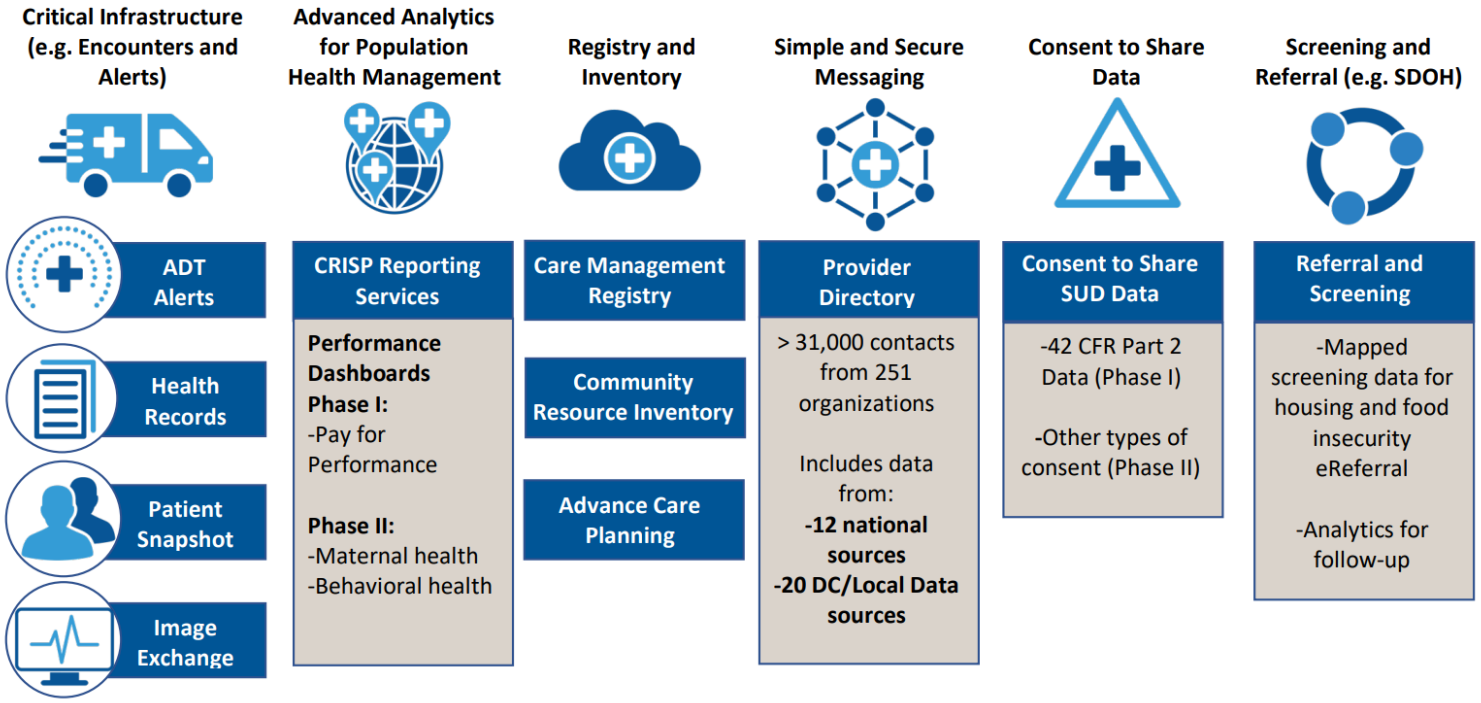
provides external connected systems information about patients while that patient is in-context in the external system.

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



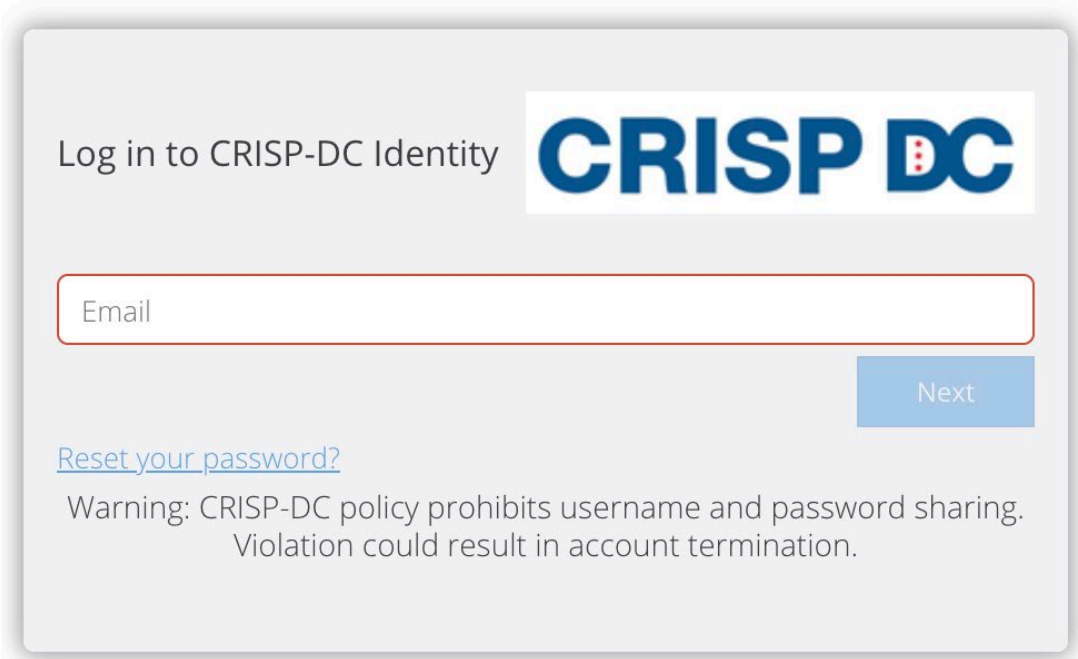
DCHA District of Columbia Hospital Association CRISP DC

Identifying Specific Data Elements in CRISP DC

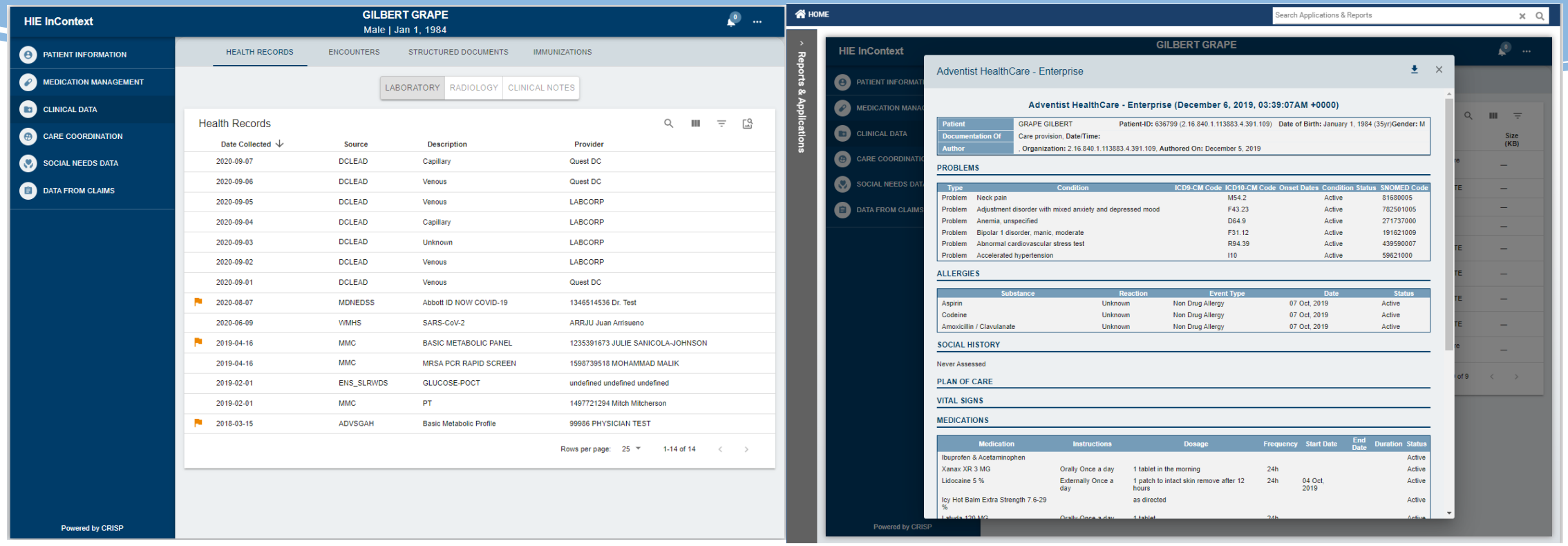
Where to Find Data Elements?

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

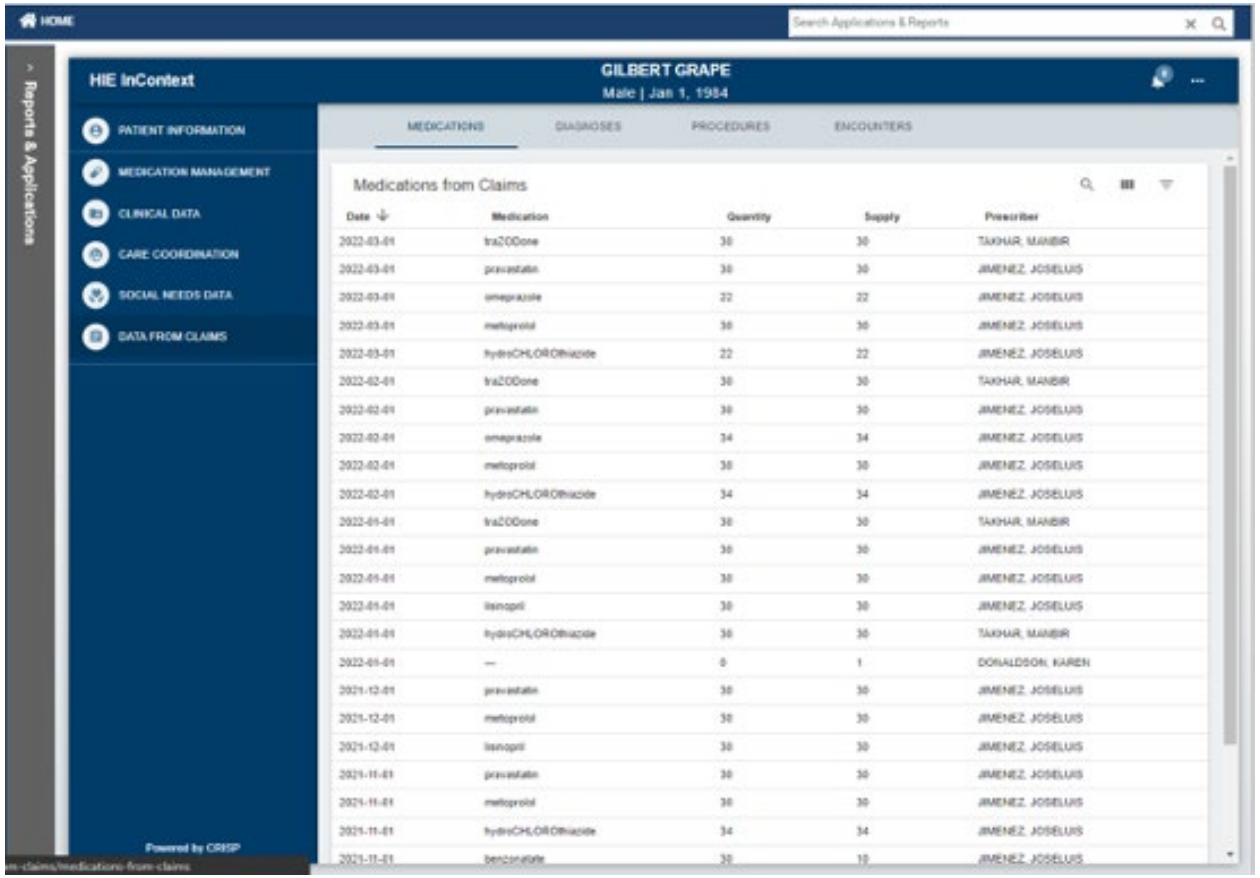


Critical Infrastructure: Clinical Data



- 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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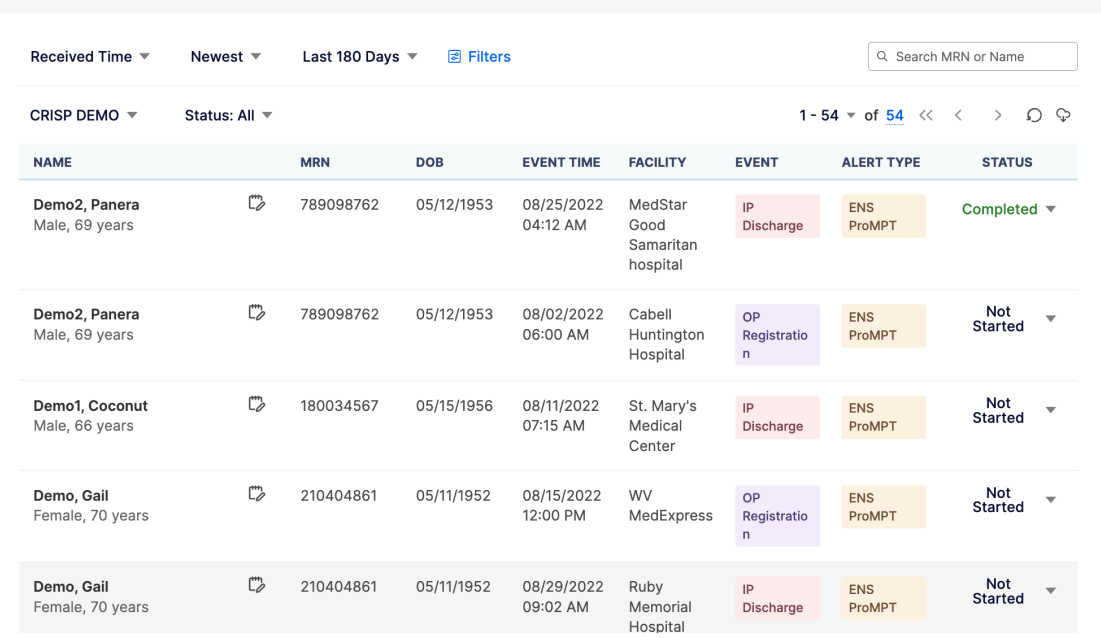
Use of Electronic Notification Services (ENS) Alerts

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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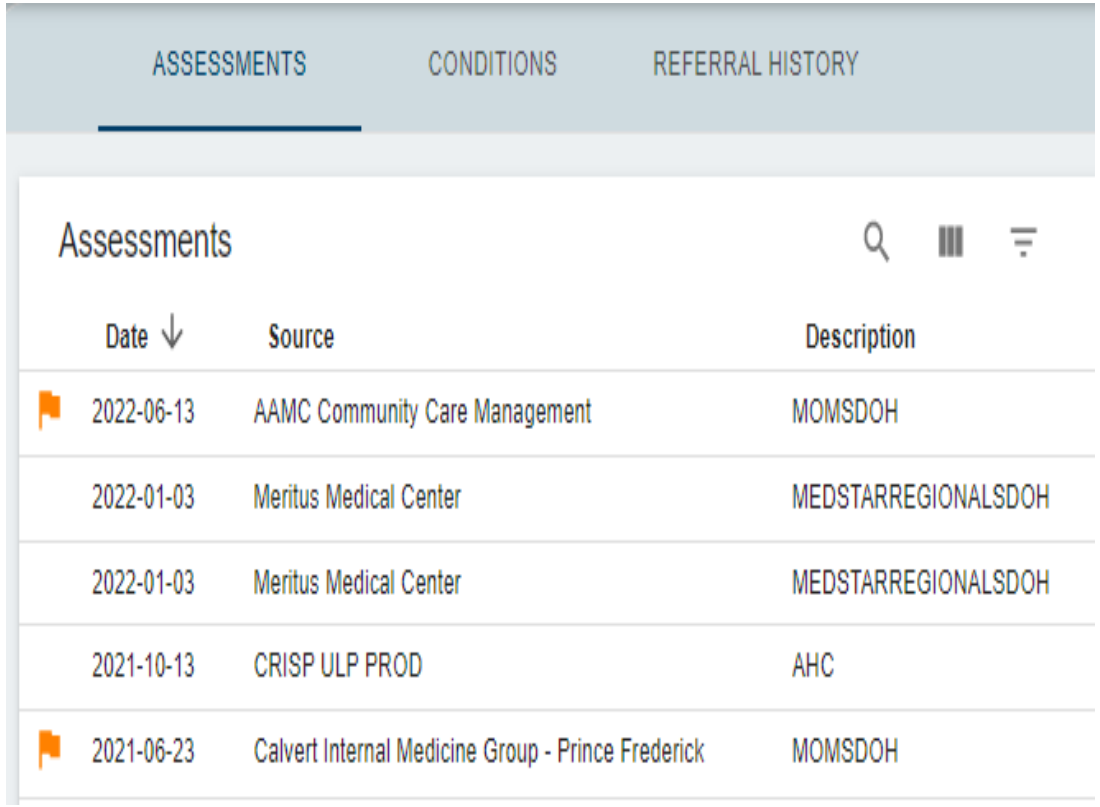
Social Determinants of Health Data via the DC HIE

Social Needs Data Tab: Assessments

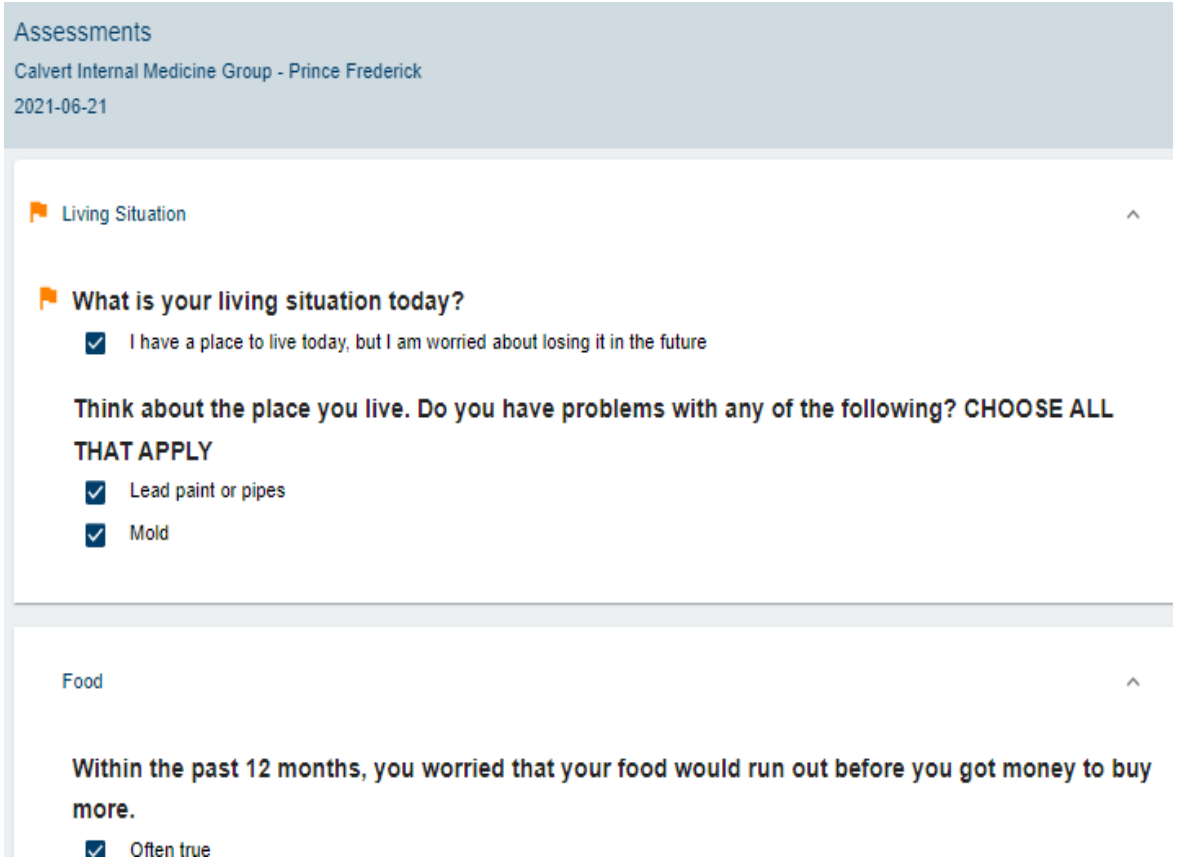
- DC HIE users can view assessments captured via an organization's EHR, the CRISP DC Direct Entry Screening Tool, or a third-party SDOH platform, such as FindHelp.
- Users can view the date the assessment was collected, the organization submitting the assessment, and the description of the assessment.



Social Needs Data Tab: Assessments

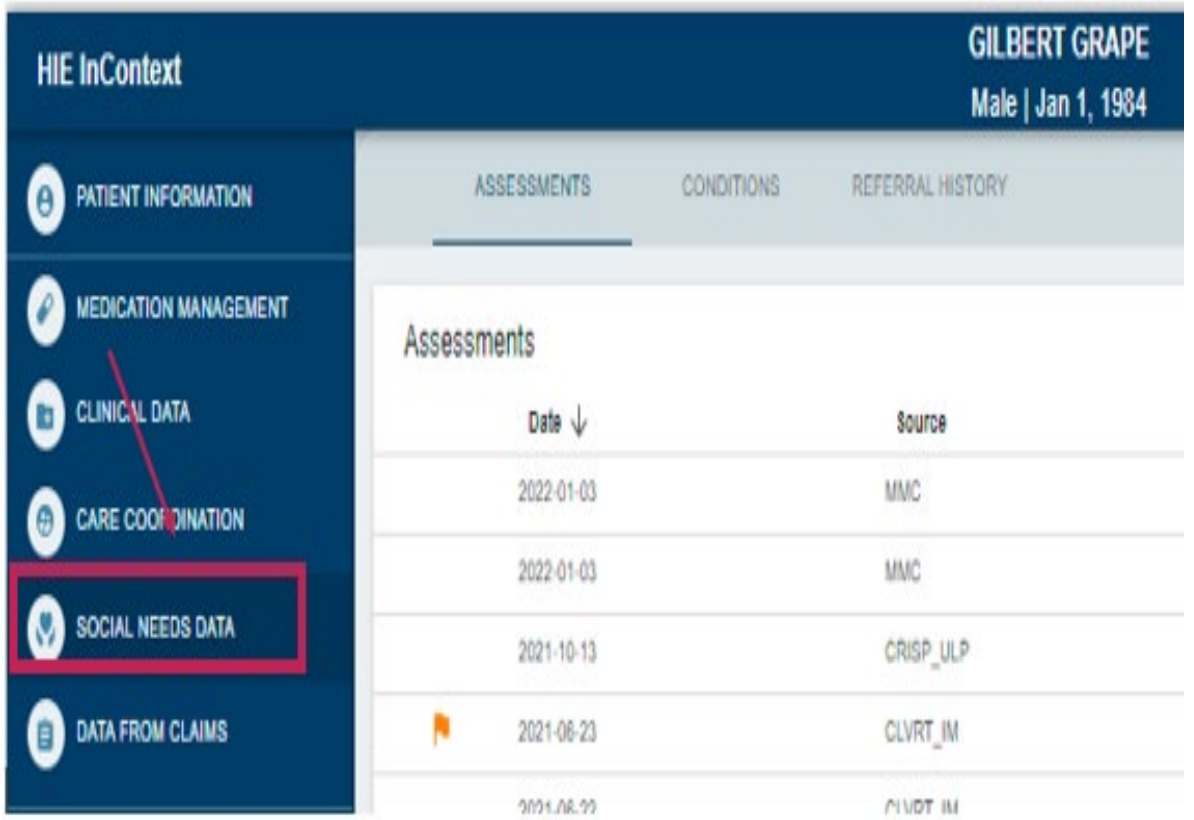
- When users click on a patient's assessment, they can view the full questionnaire. The questions are organized by SDOH domain, such as financial insecurity, food insecurity, housing transportation, etc.

- Answers in the questionnaire that are flagged as abnormal by the organization are indicated using the orange flag icon.



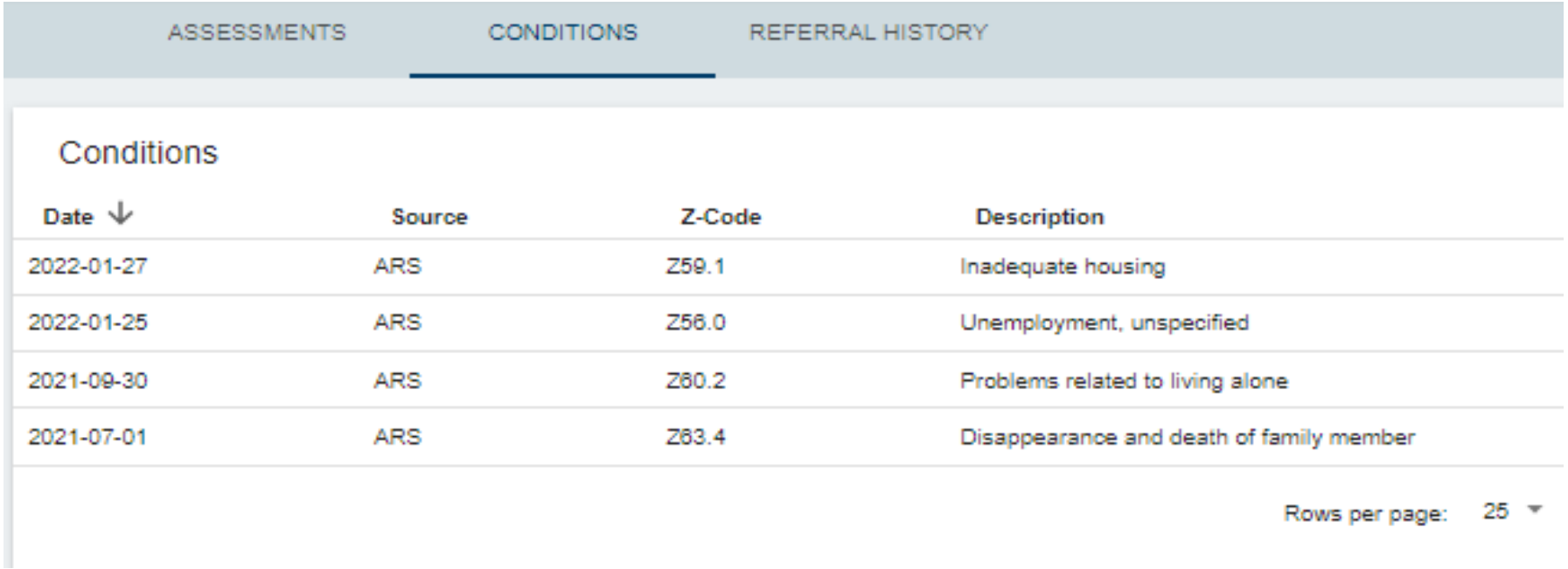
Social Needs Data Tab

- The CRISP DC HIE is displaying social needs data within the web-based DC Portal and the CRISP InContext App in the EHR.
- Through the social needs data tab, CRISP connected providers can view social determinants of health (SDOH) assessments, ICD-10 codes that reflect social conditions, and referral history for referrals captured in the CRISP DC Referral Tool and third-party SDOH referral platforms, such as FindHelp.



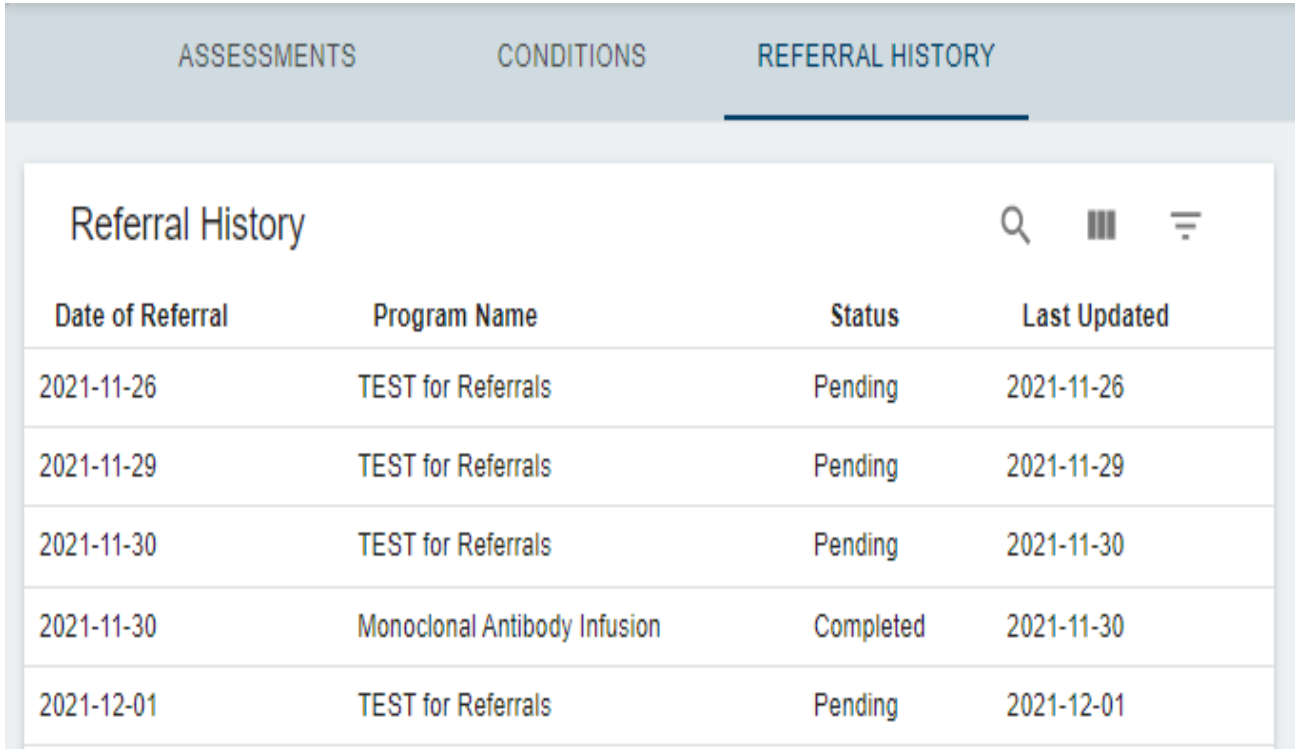
Social Needs Data Tab: Conditions

- DC HIE users can view ICD-10 codes (z-codes) reflecting social conditions in the Conditions subtab. Information such as the date, source, z-code, and z-code description, are made viewable.



Social Needs Data Tab: Referral History

- DC HIE users can select the Referral History subtab to view referral data captured using the CRISP DC closed-loop referral tool and third-party referral platforms that have opted to share referral data with the HIE, such as FindHelp.
- Users can view the date of the referral, program name, referral status, and the date the referral was last updated.

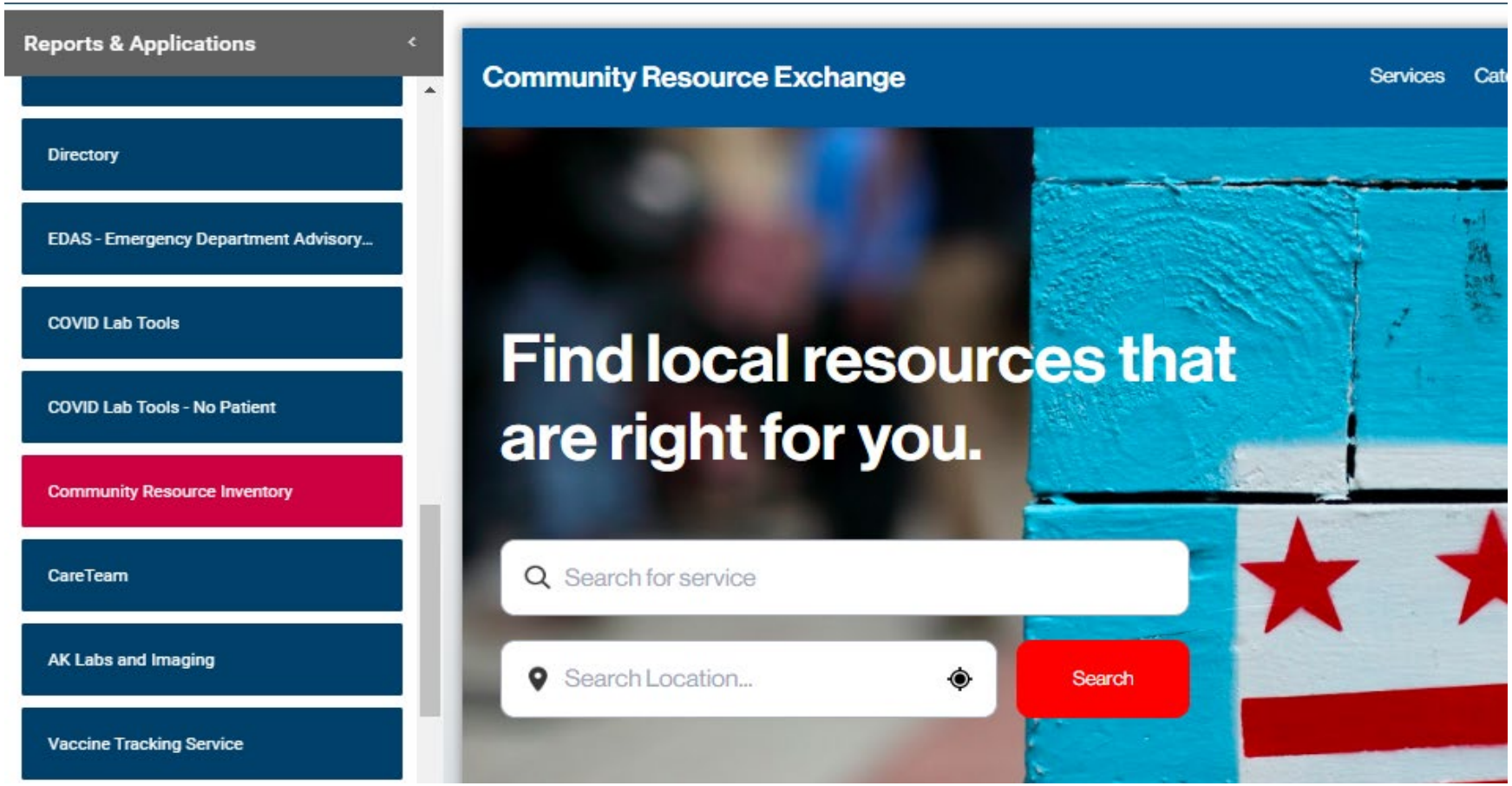


Social Needs Data Tab: Referral History

- The status of a referral is updated by the community-based organization, and includes pending, accepted, rejected, completed, and disenrolled.
- When the user clicks on a patient's referral, they can see additional information. This includes referral sender and referral recipient details, such as contact information and a program description.

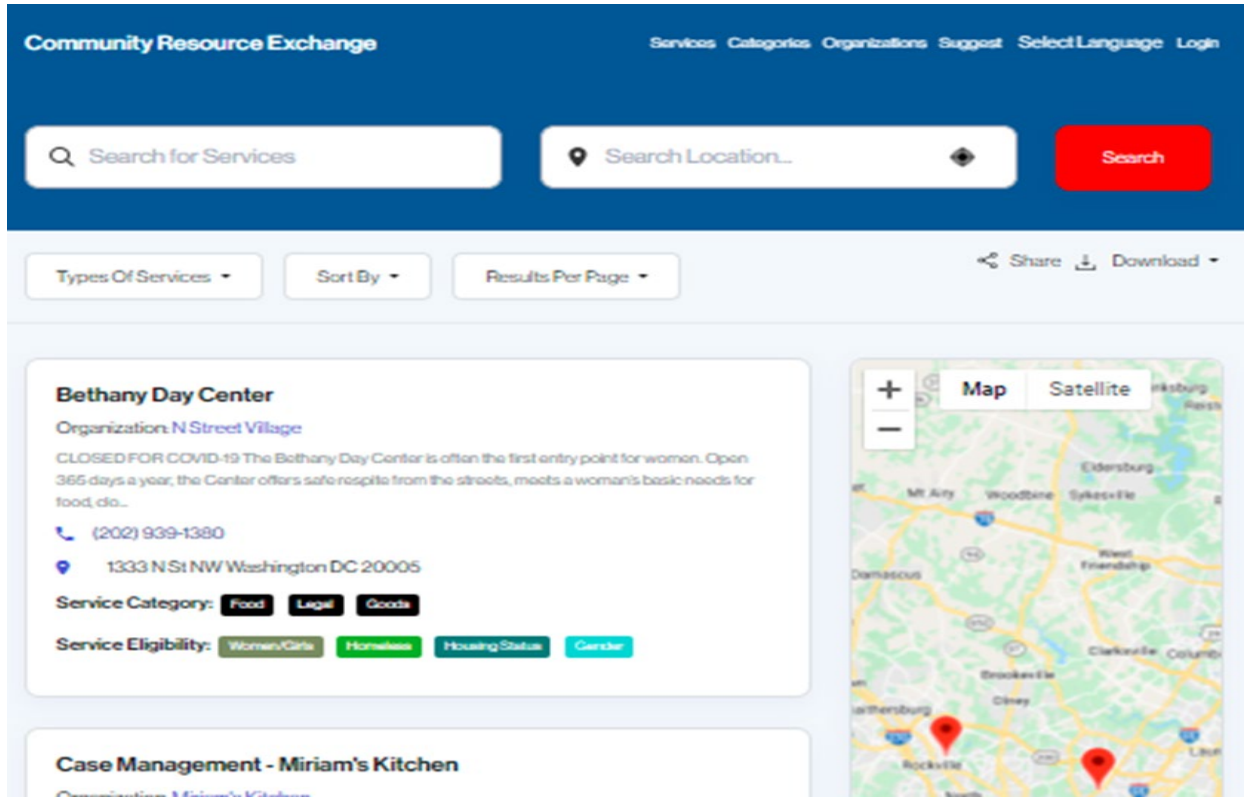
DC Community Resource Inventory

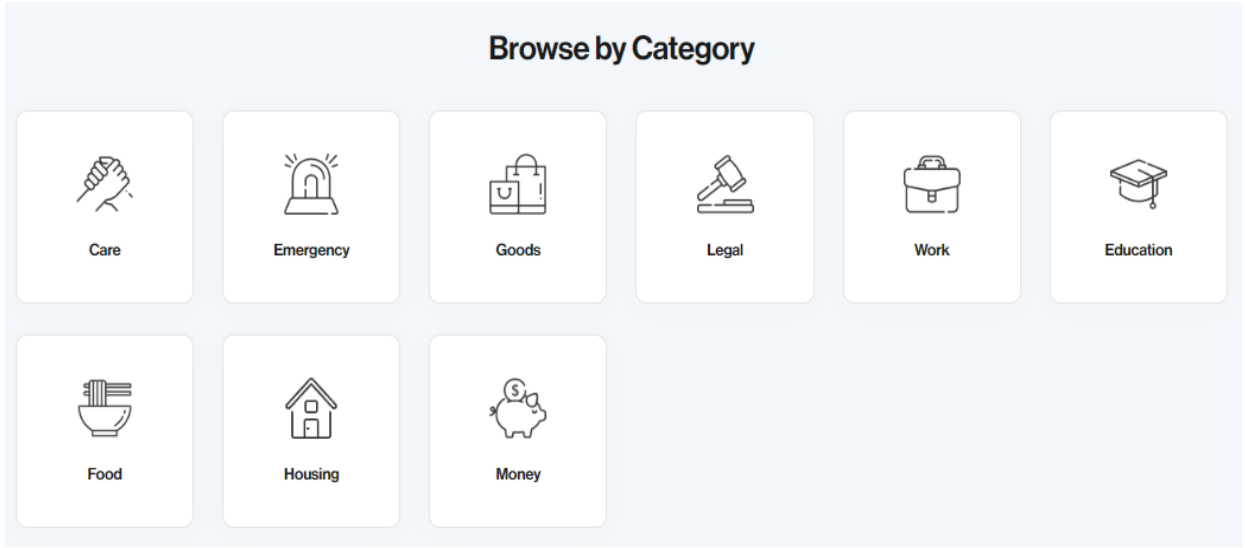
- The DC Community Resource Inventory is a District-wide publicly available directory of resources reflecting regional programs and organizations in the community. It is developed by the DC Primary Care Association and made viewable via a publicly accessible website and through the DC HIE.
- DC HIE users can use the CRI to understand the scope of services available in the District for referrals. Information such as organization address and contact information is included.



DC Community Resource Inventory

- Users can search for services using the search function, service category, or view a full list of organizations. The service eligibility tag can also be viewed to see if a patient is eligible for a certain program.





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Consent Tool to Share SUD Data with the HIE

Consent to Share SUD Data

- Developed in partnership with DHCF as a comprehensive, consent management solution to enable the compliant electronic exchange of patients' behavioral health information, including substance use disorder (SUD) data protected by 42 CFR Part 2, through the District of Columbia Health Information Exchange (DC HIE).
- Based on a patient's consent registration, this behavioral health data is shared with other members of the patient's care team through the DC HIE.
- CRISP DC piloted the configurable electronic consent management tool to initial user groups in the District beginning in April 2021 and released the tool to all clinical DC Portal users on July 1.

Pilot Phase:
April 2021-June 2022

Initial Pilot Release:

- Only available to register consents during in-person visits
- Providers must explain the consent process to their patients and attest to having done so within the tool
- The patient, or their legal guardian, may then provide their signature directly in the tool
- Patients can elect to share all SUD treatment information or only their care team's contact information

Updates Added in March 2022:

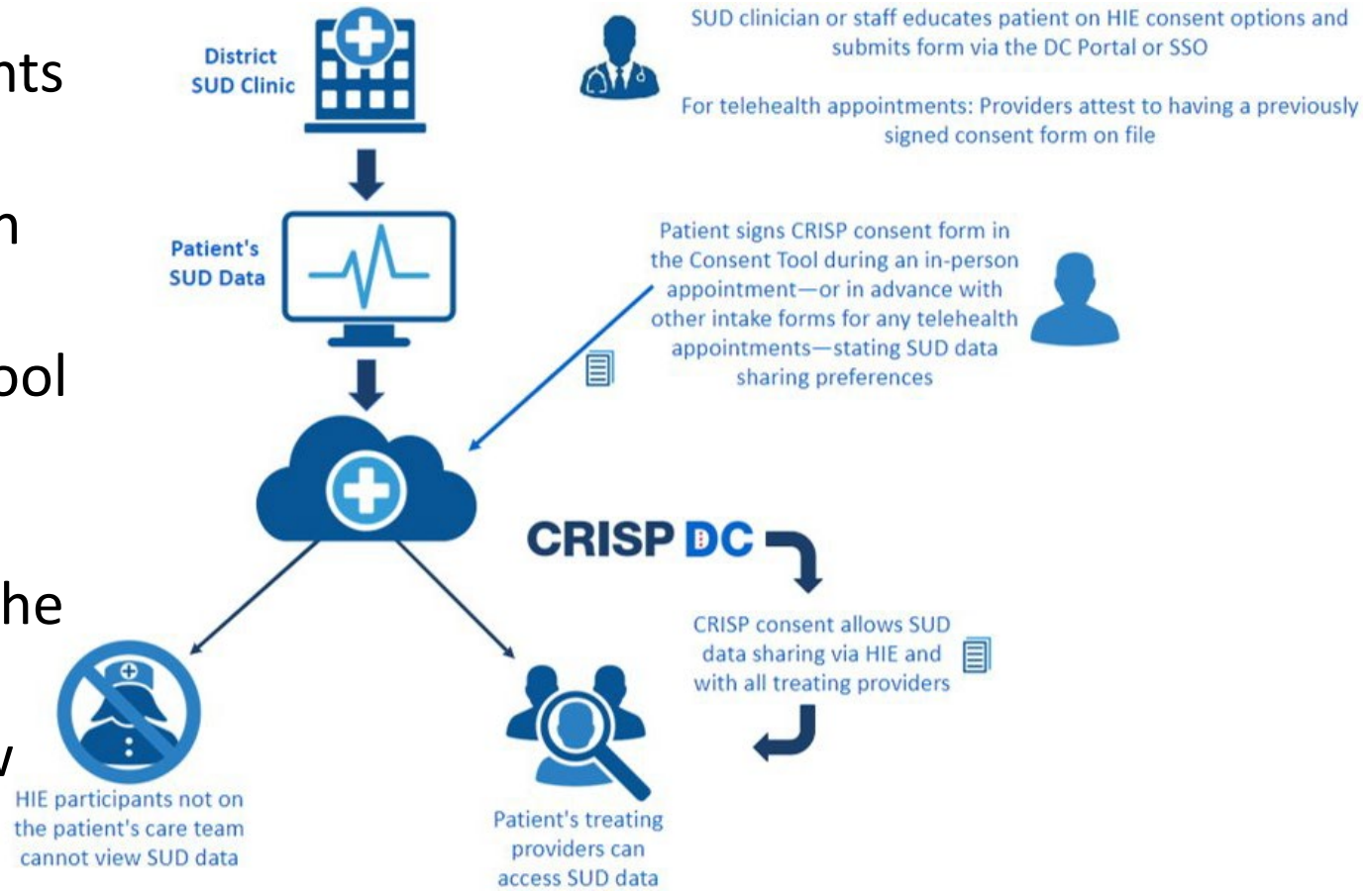
- Allows providers to register consents for telehealth patients
- Additional paper SUD form created to obtain patient's legal signature
- Form may be sent to patient in advance with other intake forms, allowing the patient time to review the details of this consent
- Patient returns form to provider and consent preferences are updated in CRISP as a data entry step

Pilot Group Results

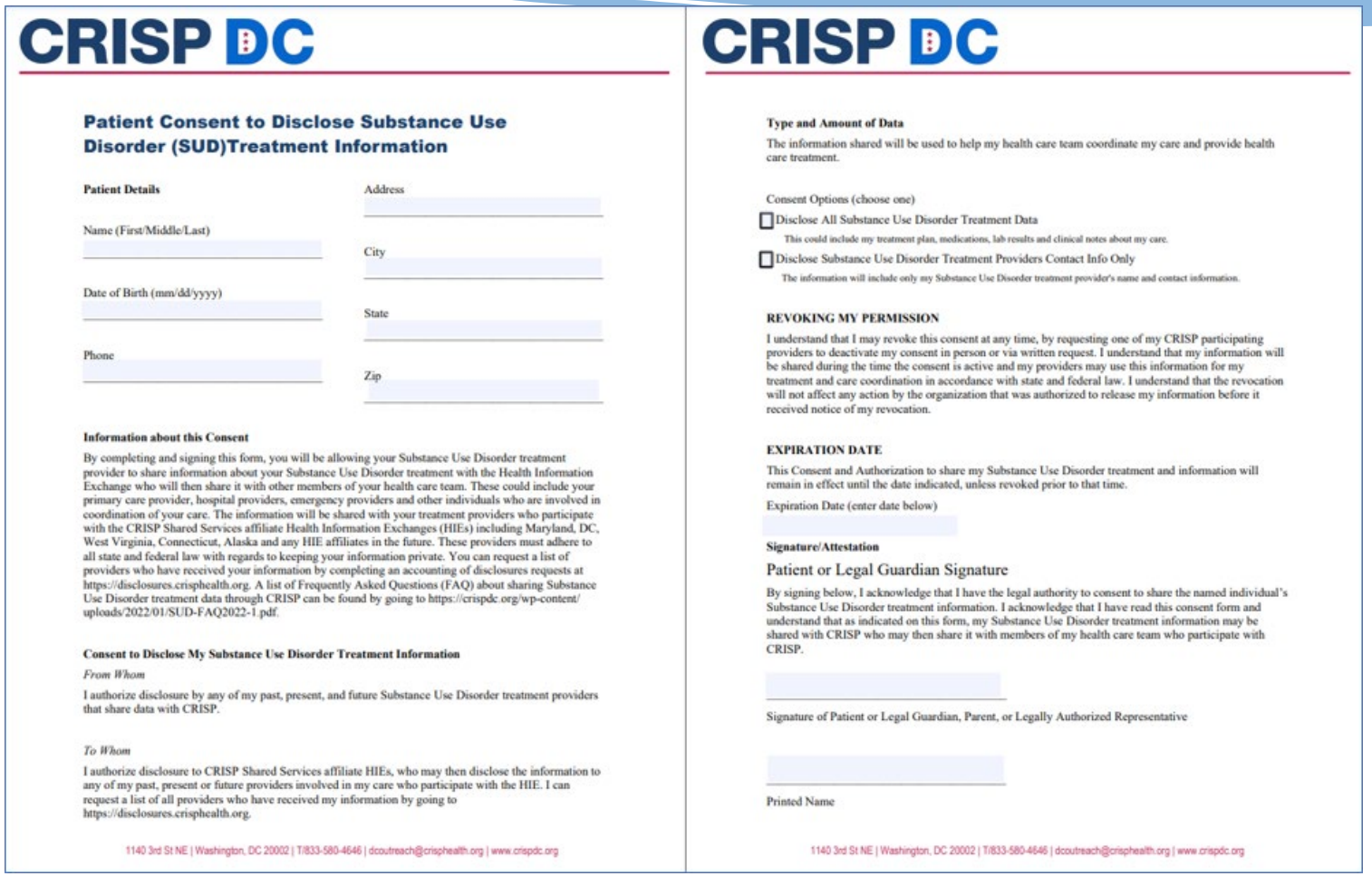
- **317** consents were registered across five organizations:
  - *MBI Health Services*
  - *RAP, Inc. (Regional Addiction Prevention)*
  - *Unity Health Care*
  - *McClendon Center*
  - *Medical Home Development Group*
- **More than 98%** of patients elected to share all their SUD treatment info - *(311 patients)*
- **Less than 2%** of patients chose to only share their care team's contact information - *(6 patients)*

SUD Data Flow from Providers to the HIE

1. SUD clinic sends patient's data to CRISP
2. SUD data is blocked until a patient consents
3. Provider educates patient on consent options and updates patient's designation in the DC Portal during in-person visit
4. Patient signs Part 2 form in the consent tool
   - Telehealth patients complete separate PDF before telehealth visit
   - Provider copies that information into the HIE once returned
5. Other members of the care team are now able to view patient's SUD data



SUD Consent Form for Telehealth Patients



CRISP DC

Patient Consent to Disclose Substance Use Disorder (SUD)Treatment Information

Patient Details

Name (First/Middle/Last)

Date of Birth (mm/dd/yyyy)

Phone

Address

City

State

Zip

Information about this Consent

By completing and signing this form, you will be allowing your Substance Use Disorder treatment provider to share information about your Substance Use Disorder treatment with the Health Information Exchange who will then share it with other members of your health care team. These could include your primary care provider, hospital providers, emergency providers and other individuals who are involved in coordination of your care. The information will be shared with your treatment providers who participate with the CRISP Shared Services affiliate Health Information Exchanges (HIEs) including Maryland, DC, West Virginia, Connecticut, Alaska and any HIE affiliates in the future. These providers must adhere to all state and federal law with regards to keeping your information private. You can request a list of providers who have received your information by completing an accounting of disclosures requests at https://disclosures.crisphealth.org. A list of Frequently Asked Questions (FAQ) about sharing Substance Use Disorder treatment data through CRISP can be found by going to https://crispdc.org/wp-content/uploads/2022/01/SUD-FAQ2022-1.pdf.

Consent to Disclose My Substance Use Disorder Treatment Information

From Whom

I authorize disclosure by any of my past, present, and future Substance Use Disorder treatment providers that share data with CRISP.

To Whom

I authorize disclosure to CRISP Shared Services affiliate HIEs, who may then disclose the information to any of my past, present or future providers involved in my care who participate with the HIE. I can request a list of all providers who have received my information by going to https://disclosures.crisphealth.org.

1140 3rd St NE | Washington, DC 20002 | T/833-580-4646 | dcoutreach@crisphealth.org | www.crispdc.org

CRISP DC

Type and Amount of Data

The information shared will be used to help my health care team coordinate my care and provide health care treatment.

Consent Options (choose one)

☐ Disclose All Substance Use Disorder Treatment Data

This could include my treatment plan, medications, lab results and clinical notes about my care.

☐ Disclose Substance Use Disorder Treatment Providers Contact Info Only

The information will include only my Substance Use Disorder treatment provider's name and contact information.

REVOKING MY PERMISSION

I understand that I may revoke this consent at any time, by requesting one of my CRISP participating providers to deactivate my consent in person or via written request. I understand that my information will be shared during the time the consent is active and my providers may use this information for my treatment and care coordination in accordance with state and federal law. I understand that the revocation will not affect any action by the organization that was authorized to release my information before it received notice of my revocation.

EXPIRATION DATE

This Consent and Authorization to share my Substance Use Disorder treatment and information will remain in effect until the date indicated, unless revoked prior to that time.

Expiration Date (enter date below)

Signature/Attestation

Patient or Legal Guardian Signature

By signing below, I acknowledge that I have the legal authority to consent to share the named individual's Substance Use Disorder treatment information. I acknowledge that I have read this consent form and understand that as indicated on this form, my Substance Use Disorder treatment information may be shared with CRISP who may then share it with members of my health care team who participate with CRISP.

Signature of Patient or Legal Guardian, Parent, or Legally Authorized Representative

Printed Name

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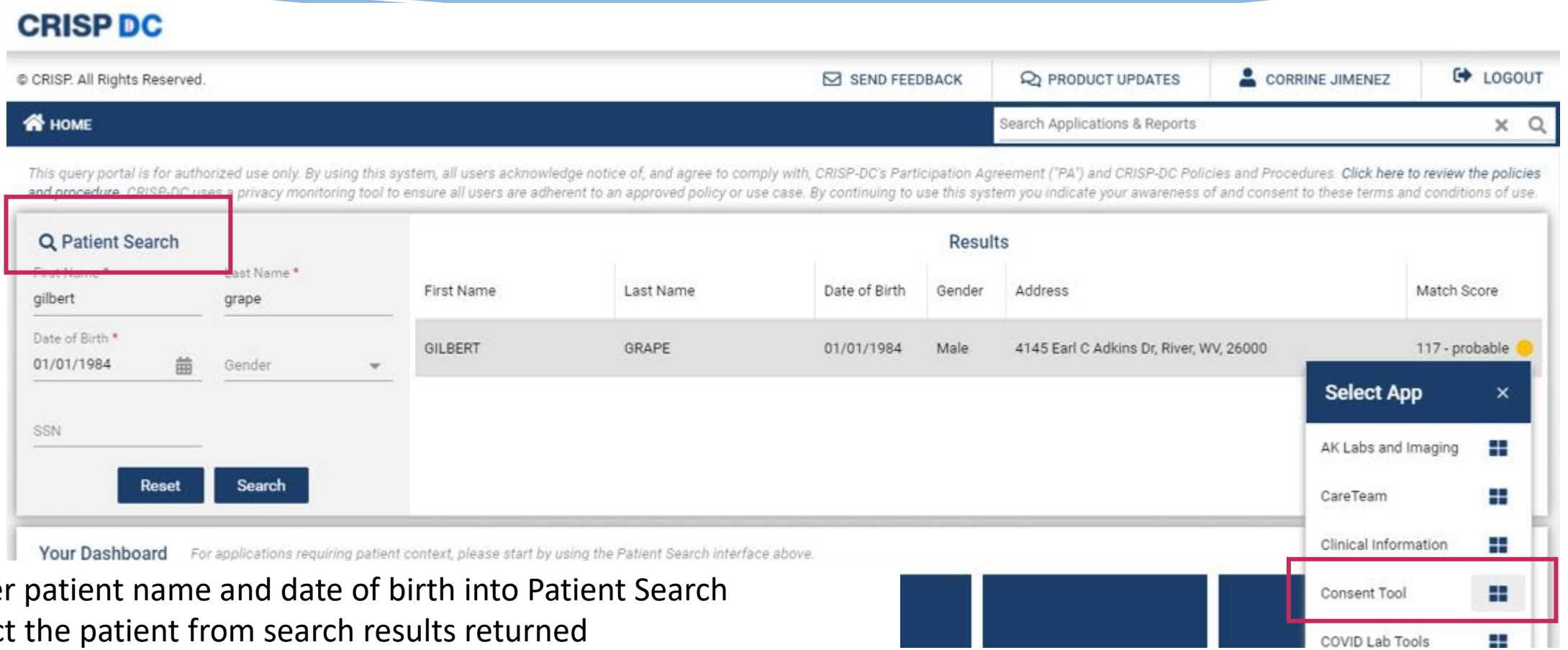
- Available here on the CRISP DC site
- Contains all the same fields as the Part 2 form in the consent tool
- Allows patient to select their level of data sharing and choose an expiration date
- Designed for use in a telehealth setting, but may be used in-person if the practice prefers
- All fields must be completed for provider to update the patient's designations in the HIE

How to Capture Patient's Consent: Search for a Patient



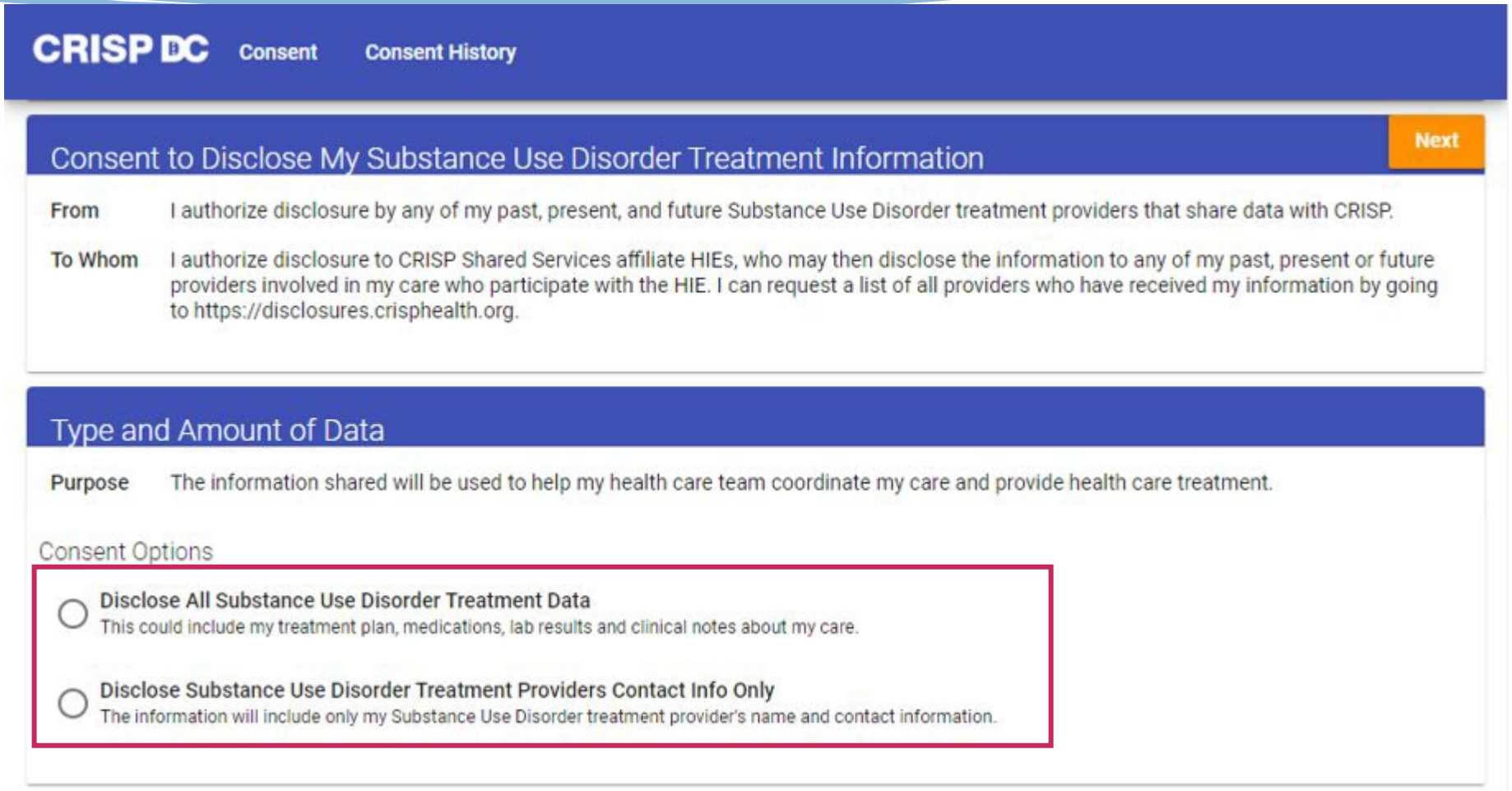
- Enter patient name and date of birth into Patient Search
- Select the patient from search results returned
- Click on the square icon next to the Consent Tool app

Step-by-step user guide is available here

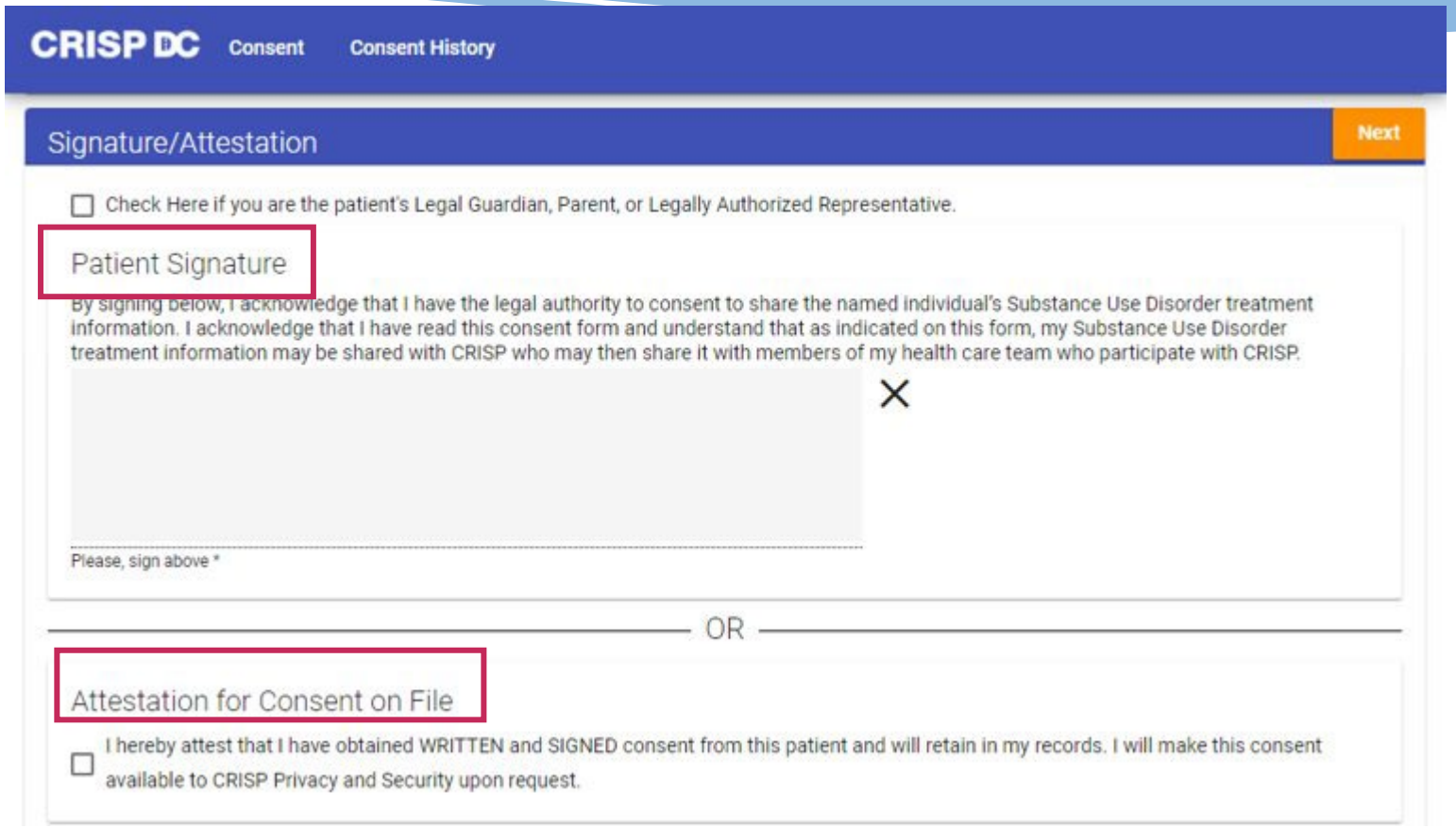
How to Capture Patient's Consent: Type & Amount of Data to Share

- Patients must decide whether they would like to share all their clinical SUD data with the HIE or only their care team's contact information
- Provider is required to select the option within the tool that corresponds to the patient's decision

Step-by-step user guide is available here



How to Capture Patient's Consent: Signature Portion



Step-by-step user guide is available here

For in-person registration:

- Patient enters electronic signature using a mouse, stylus pen, or finger via touchscreen/signature pad

For registrations of telehealth patients:

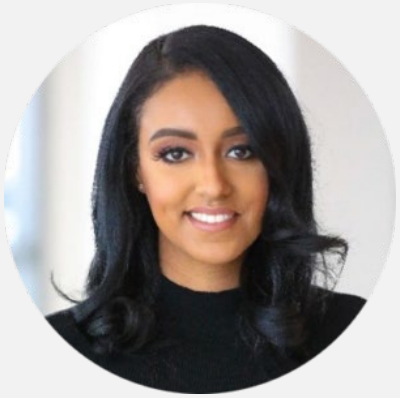
- Check the box under "Attestation for Consent on File."
- CRISP SUD Consent Form **must** be completed by the patient *before* provider attests

DCHA District of Columbia Hospital Association

CRISP DC

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 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/