CRISP
Chesapeake Regional Information System for our Patients

Clinical Reporting: Skilled Nursing Facility Length of Stay (LOS)

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CLINICAL REPORTING: SKILLED NURSING FACILITY LENGTH OF STAY (LOS)

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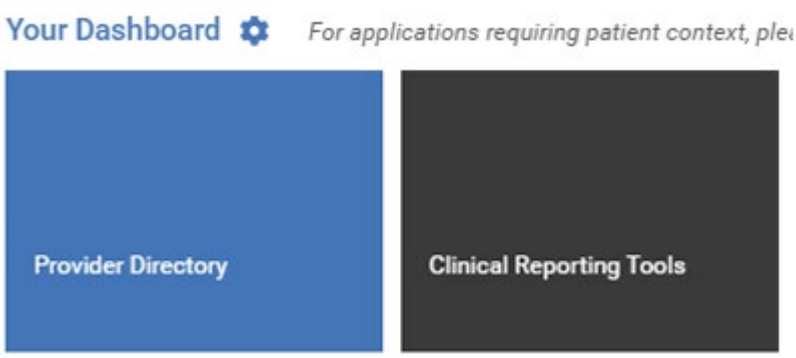
Overview

Clinical Reporting is a CRISP HIE Portal application that delivers curated, dynamic reports and dashboards built on real-time clinical data — developed in direct partnership with state agencies, hospitals, primary care practices, and public health stakeholders across Maryland. Unlike claims-based reporting, Clinical Reporting draws from HIE clinical data sources including ADTs, laboratory results, demographic data, SDOH assessments, and shared patient panels — giving organizations a more complete, timely picture of their patient populations. The dashboards offer insights into population health, quality of care, readmissions, health disparities, and value-based care outcomes, helping teams track care patterns, identify gaps, and support data-driven strategies to improve health outcomes.

How to Access Clinical Reporting

Users can access Clinical Reporting directly from their HIE Portal dashboard by clicking on the "Clinical Reporting" tile. If the tile is not available on their dashboard, users should contact their organization's HIE Administrator.



Clinical Reporting Dashboards

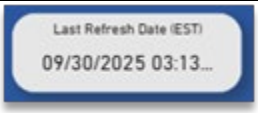
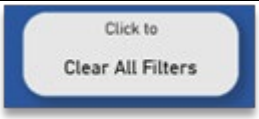
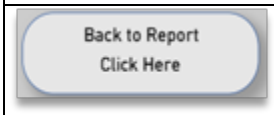
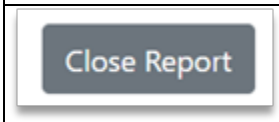
On the landing page, users can choose from a variety of reporting suites and individual reports, designed to help more effectively manage patient populations. Click the "Clinical Reporting Dashboards" button to access the IMHS Perinatal Referral Dashboard (see below).

Report Overview

The **Skilled Nursing Facility Length of Stay (LOS)** Dashboard provides an interactive view of post-acute care utilization by analyzing Skilled Nursing Facility stays following hospital discharge. The dashboard enables users to monitor SNF utilization, evaluate length of stay trends, examine hospital-to-SNF care transitions, and identify patients with overlapping hospitalizations or chronic conditions that may influence post-acute care needs

Through interactive filters, visualizations, and patient-level details, users can explore SNF length of stay across facilities, analyze utilization patterns over time, and identify opportunities to improve discharge planning, care coordination, and transitions of care.

The Navigation Buttons

	The **Last Refreshed Date (EST)** displays the most recent data refreshed date. Data is updated daily and includes a two-year look back from the current date.
	The **Clear All Filters** resets all drop-down filters that have been applied within the report. This button does *not* reset filters applied by clicking directly on or within the charts.
	The **Notes and Definitions** button opens a data dictionary with key terms, definitions, and guidance to help users better understand and navigate specific areas of the dashboard.
	The **Back to Report** button, located at the top right corner of the Notes and Definitions page, returns the user directly to the dashboard.
	At the bottom of the screen, the **Close Report** button exits the report entirely. This button is conveniently available once the dashboard is opened, providing a consistent way to exit at any time.

Tips for the User Guide

Filters:

All filters can be used individually or in combination to refine the report and focus on specific patient populations, geographic regions, or other characteristics.

Interactive Features:

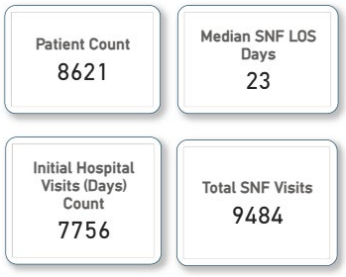
Many charts within the dashboard are interactive. Selecting a value such as county, status, or type will filter the associated visualizations to display related data. To remove a selection, click the selected value again or use the report's **"Clear All Filters"** functionality to reset the dashboard to default.

Data Disclaimer

Data displayed within Clinical Reporting is sourced from:

- Participating organizations sharing Patient Panels, Admission, Discharge, Transfer (ADT) feeds, Continuity of Care Documents (CCDs), Lab Values, Referrals and more.
- Completeness and timeliness of data vary by organization.
- Reports reflect available data and may not represent the full population.
- Certain data (e.g. opt-outs, 42 CFR Part 2) is excluded.

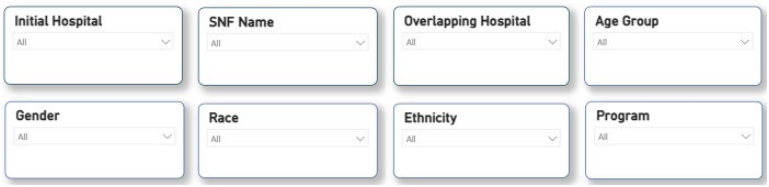
Navigating Charts and Reporting Tables



Patient Count: The number of identifiable patients within a panel as of the most recent refresh date.
Median SNF LOS Days: The median number of days spent in a Skilled Nursing Facility (SNF) during the selected reporting period. The LOS includes continuous SNF visits.

Initial Hospital Visits (Days) Count: Total number of initial hospital visits used as the starting event for SNF length of stays analysis.

Total SNF Visits: Total number of Skilled Nursing Facility (SNF) visits identified within the selected reporting period and applied filters.



Initial Hospital: Filters by the hospital associated with the patient's initial hospital visit.

SNF Name: Filters results by Skilled Nursing Facility (SNF) name

Overlapping Hospital: A hospital visit that takes place during a SNF visit.

Age Group: Filters patients by age categories

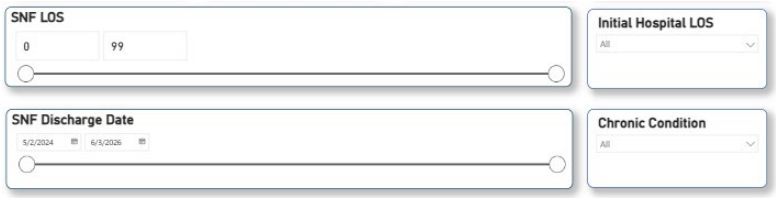
Gender: Filters patients by reported gender.

Race/Ethnicity: Reflects the patient's most frequently reported response for race/ethnicity based on ADTs. For example, if a patient is recorded as "Hispanic" five times and "non-Hispanic" once, the patient will be categorized as "Hispanic."

Program: Filters by patients participating in specific reported program(s) identified from attributed patient panel.

Navigating Charts and Reporting Tables

SNF LOS: Filters for specific length of stay range based on the number of days spent at a Skilled Nursing Facility.



Initial Hospital LOS: Identifies 3 patient groups of the SNF visits population: patients who didn't have a prior hospital visit to their SNF visit, patients who had a prior hospital visit under 3 days, and patients who had a prior hospital visit 3 days or greater.

SNF Discharge Date: Filters visualizations and data to one or more selected quarterly reporting period(s).

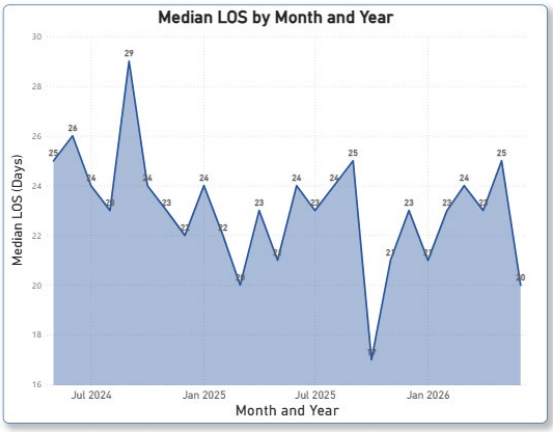
Chronic Condition: Displays the most prevalent chronic conditions within the patient population. Displays a summary of the top 10 most prevalent chronic conditions within the patient population among the following list of conditions:

- Alzheimer's
- Asthma
- Breast Cancer
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Colorectal Cancer
- Depression, Bipolar, or Other Depressive Mood Disorders
- Diabetes
- Endometrial Cancer
- Heart Failure and Non-ischemic heart disease
- Hyperlipidemia
- Hypertension
- Ischemic Heart Disease
- Lung Cancer
- Non-Alzheimer's Dementia
- Obesity
- Prostate Cancer

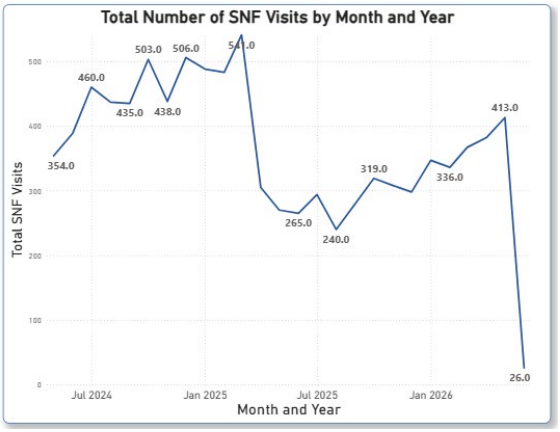
Patients are identified as having a chronic condition if they have received a diagnosis within the past two years, based on data from ADTs and CCDs.

Charts and Potential Insights

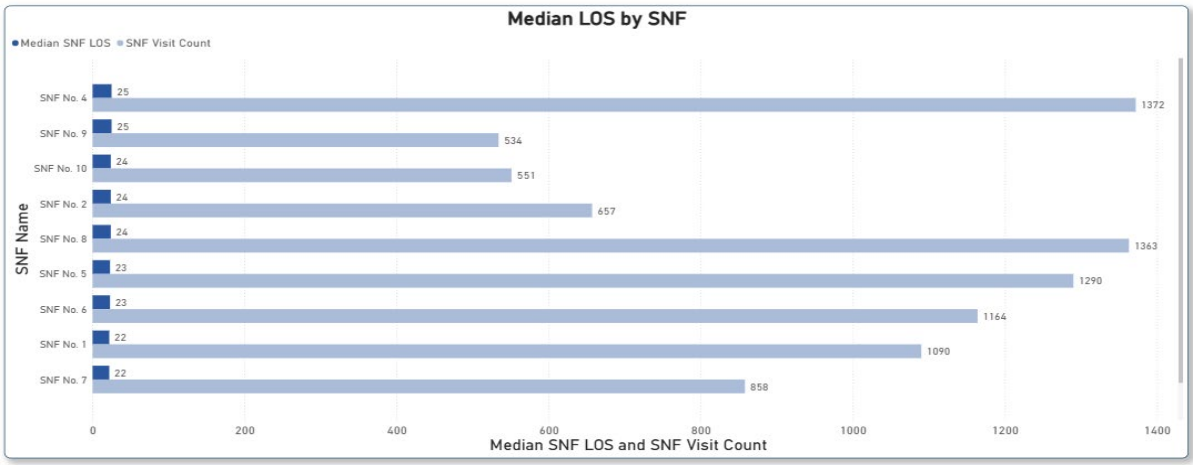
Median LOS by Month and Year: Displays the median Skilled Nursing Facility (SNF) length of stay, by month and year based on the selected filters. This chart can help users identify higher lengths of stay periods, monitor changes in median LOS over time to identify trends, and assess opportunities to improve discharge planning and post-acute care efficiency.



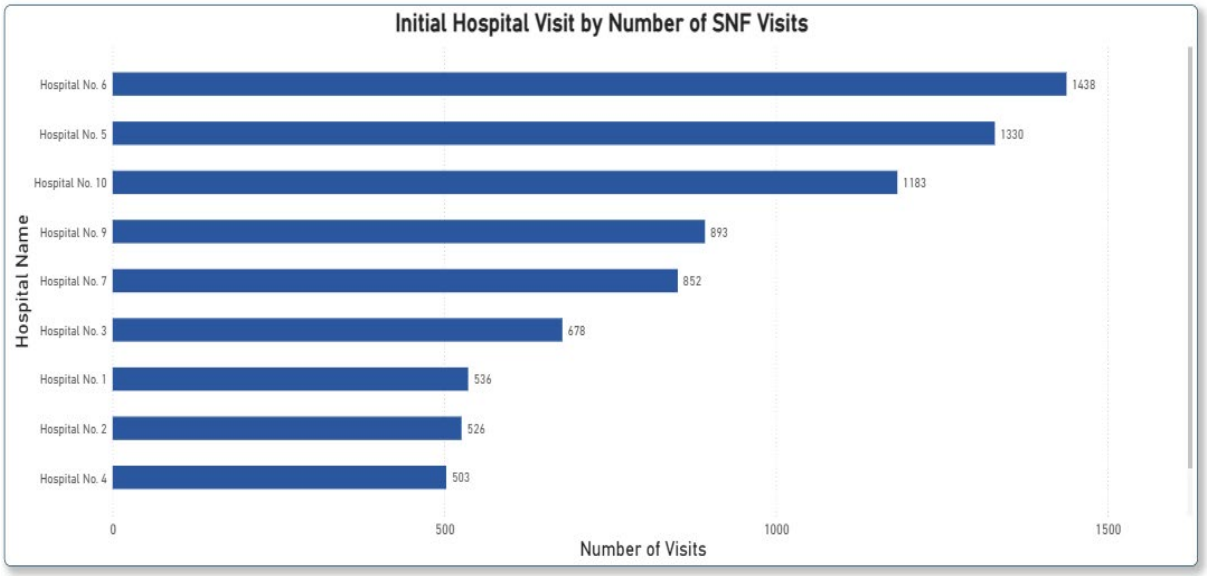
Total Number of SNF Visits by Month and Year: Displays the total number of SNF visits by month and year. This chart shows SNF utilization by SNF visit and tracks SNF utilization trends over time. Users can quickly identify fluctuations in post-acute care demand and support operational planning and resource allocation.



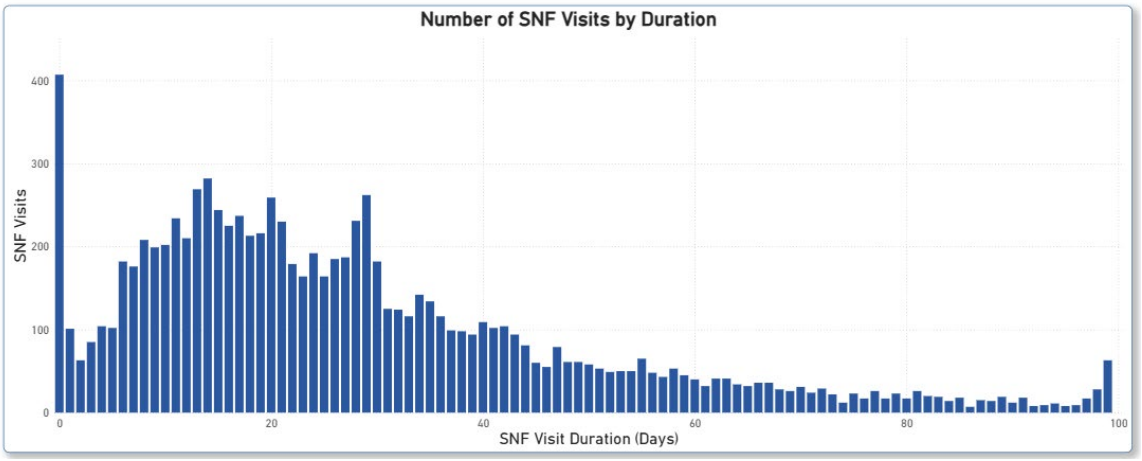
Median LOS by SNF: Displays the median SNF length of stay, in days grouped by SNF. Users can identify SNFs with higher lengths of stays, compare performance across SNFs, and evaluate utilization patterns that may warrant further review or collaboration with post-acute care patients.



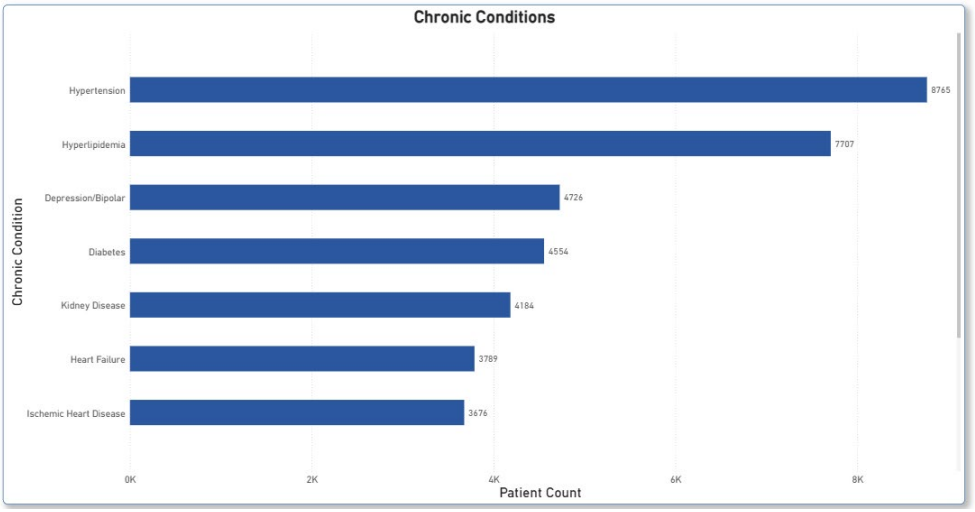
Initial Hospital Visit by Number of SNF Visits: Displays the number of initial hospital visits associated with corresponding SNF visits counts. This chart provides insight into hospitals with high SNF visit rates and helps users understand the relationship between hospitalizations and subsequent SNF utilization. Identified populations with multiple SNF stays can benefit from enhanced discharge planning interventions, care coordination, or transitional care services.



Number of SNF Visits by Duration: Displays the distribution of SNF length of stays by visit count. Identify the frequency of short, medium, and long duration SNF stays to better understand utilization patterns, monitor extended stays, and evaluate opportunities to improve transitions of care.



Chronic Conditions: Displays the number of unique patients associated with selected chronic condition categories. Patients may be represented in multiple categories if they have more than one chronic condition. The most common chronic conditions among patients utilizing SNF services can be easily identified to support risk stratification efforts and prioritize care management resources for populations with complex clinical needs.



Patient SNF/Hospital Visit Patient Detail Table:

Patient SNF/Hospital Visit

Patient ID	Initial Hospital Patient Class	Initial Hospital Name	Initial Hospital Admit Date	Initial Hospital Discharge Date	Initial Hospital Discharge Dx Description	SNF Name	SNF Admit Date	SNF Discharge Date	SNF LOS (Days)	SNF Discharge Disposition	Overlapping Hospital Name	Overlapping Hospital Admit Date	Overlapping Hospital Discharge Date
AbbottDEMO, Melanie | F | 1939-12-25	I	Hospital No. 6	05/20/2025	05/27/2025	Diagnosis 5	SNF No. 4	05/27/2025	06/03/2025	6				
AbbottDEMO, Melanie | F | 1949-10-20	I	Hospital No. 5	01/16/2026	01/27/2026	Diagnosis 2	SNF No. 5	01/27/2026	02/26/2026	29				
AcevedoDEMO, Sherry | F | 1938-08-20	I	Hospital No. 7	04/29/2024	05/18/2024	Diagnosis 1	SNF No. 8	05/18/2024	07/01/2024	44				

Patient ID: Using pipe delimiters, including the patient's full name| gender| DOB. For example, John Doe| M| 2001-09-16.

Initial Hospital Name: Name of the facility associated with the initial hospital stay.

Initial Hospital Admit Date: Date the patient was admitted to the hospital that initiated the subsequent skilled nursing facility admission.
Initial Hospital Discharge Dx Description: Description of the primary diagnosis associated with the initial hospital discharge.
SNF Name: Name of the Skilled Nursing Facility where the patient received post-acute care.
SNF Admit Date: Date the patient was admitted to the Skilled Nursing Facility.
SNF Discharge Date: Date the patient was discharged from the Skilled Nursing Facility.
SNF LOS (Days): Total Number of days between the SNF admission date and SNF discharge date.
SNF Discharge Disposition: Patient disposition recorded at discharge from the Skilled Nursing Facility (e.g., home, hospital transfer, deceased).
Overlapping Hospital Name: Name of a hospital associated with an encounter that overlaps with the SNF visit.
Overlapping Hospital Admit Date: Admission date of the overlapping hospital encounter occurring during the SNF visit.
Patient Class: Displays the visit classification associated with the encounter as IP, ED or OBS.

Note: Overlapping hospital encounters are identified during an active SNF visit. These encounters are displayed to support analysis of care transitions and potential disruption in post-acute care.