CRISP User Learning Collaborative: Post Acute

March 24, 2021
12:30pm – 1:30 pm
1. Welcome / Introductions

2. SNF to Hospital Transfer Form

3. Utilization of ULP Tools for COVID

4. InContext Update

5. Questions and Discussion
SNF to Hospital Transfer Form
• Broad agreement that SNFs have valuable information that should accompany patient upon transfer to acute hospital

• Collaborative efforts among SNFs and Hospitals developed a short SNF-to-Acute Transfer form, modeled on more comprehensive evidence-based INTERACT tools.
  • The Maryland form was shorter, making it more likely to be completed by SNFs
  • Common form, adopted by many hospitals, makes it easier for SNFs to complete a consistent and simple form

• Paper Form was adopted by many hospitals and SNFs, but rarely reached the Acute hospital with the patient
  • The paper form would “disappear” at any of several touch points during the transfer (i.e. ambulance companies, ED registrars, etc.)

• In the Fall of 2020, CRISP Developed On-Line Tool for SNFs to complete the form and store it on the ULP, making it more accessible to Acute hospitals in well used workflows.

• Now the tools are in place, we need to engage SNFs and Acute Hospitals to build awareness of the tools and take-up (COVID has made it challenging to focus attention in this area)
Sign into the Unified Landing Page, select resident in Patient Search, click on SNF Transfer Form.
Form:

**SNF TO HOSPITAL TRANSFER FORM**

**Nursing Supervisor Phone #:** ____________  **Main Line #:** ____________

**Patient Name:** ___________________________  **DOB:** ___________________________

**Patient Emergency contact name and number:** ___________________________

**Transfer Date:** ___________________________  **Primary Language:**  □ English  □ Other:

**Referring Clinical Provider:** ___________________________  **Telephone:** ___________________________

**What prompted transfer?**

- □ IV/PEG/Drain
- □ Fall with Injury Evaluation
- □ Cardiac/Respiratory Arrest
- □ Stroke-like Symptoms
- □ Abdominal Pain
- □ Chest Pain
- □ Syncope/Near Syncope
- □ Other:
- □ Shortness of Breath
- □ Altered Mental Status
- □ Other:
- □ Patient/Family Request:

**Interventions prior to sending to ED:**

**Vital Signs:** BP _______ HR _______ RR _______ Temp. _______ 02 Sat _______ Time Taken _______ (AM/PM)

**Co-morbidities:**  □ CHF  □ COPD  □ CKD  □ DM  □ Cancer (active treatment)  □ Dementia
- □ Psychiatric Condition
- □ Other:

**Allergies:**  □ None  □ Yes, please list: ___________________________

**COVID-19 Test History:**  □ Positive, ____________________________________________
- □ Negative, ____________________________________________
- □ Other:

**COVID-19 Vaccine History:**  □ Dose #1 ____________________________________________
- □ Dose #2 ____________________________________________
- □ Pfizer / Moderna / Other

**Is the Patient on Palliative/Hospice care?** [Please specified]

**Isolation Precautions:**

- □ MRSA
- □ VRE
- □ C. diff
- □ Other

**Baseline Mental Status:**

- □ Alert/Oriented
- □ Mild confusion
- □ Moderate/Severe confusion
- □ Minimally responsive/Unresponsive
- □ Other

**Baseline Functional Status:**

- □ Ambulates independently
- □ Ambulates with assistive device
- □ Ambulates only with human assistance
- □ Not ambulatory

What do you want the ED to do?

**SNF to ED TRANSFER CHECKLIST:** Print the following documents and include with this Transfer Form in the order listed. Send entire packet with the patient to the hospital.  □ MDLST  □ Facesheet

- □ X-Rays  □ Medication List  □ Lab Results  □ Care Plan Goals  □ SBAR  □ Other Info.

**Please note, our SNF facility can do:**  □ IV ABT/Fluids  □ EKGs  □ Blood Transfusion  □ Wound Care

- □ Wound Vac  □ X-Ray  □ Intravenous

**ED DOCUMENTATION**

**Date:** ____________  **Time:** ____________ (AM/PM)

**ED Contact:** ___________________________  **Telephone:** ___________________________

**Interventions completed in the ED:** [Brief progress notes]

**ED TO SNF TRANSFER CHECKLIST:**  □ Call SNF and/or SNF clinical provider for handoff

Complete ED Documentation section and make a copy of completed form for hospital records. Print the following documents, if applicable, and send to SNF with the original Transfer Form.

- □ Patient Instructions/AVS
- □ Physician Notes
- □ Labs
- □ Radiology Results

Updated 11/15/2021
Utilization of ULP Tools for COVID
Overview

- ENS Prompt
- Patient Snapshot
- Health Records
- COVID 19 Lab Tools
Patient Snapshot

Patient Name: Gilbert Gage  Gender: Male  Date of Birth: 01/01/1984  Date of Death: 01/23/2018

Care Alerts

- 02/26/2021: PON_PRM - On 2/8/2020, outreach was attempted to Gilbert unsuccessfully. Gilbert was enrolled in the diabetes prevention program on 10/1/2019 (OPI). Test Care Alert 1
- 02/24/2021: ENS_MAC - On 2/8/2020, outreach was attempted to Gilbert unsuccessfully. Test Care Alert 2
- 01/2021: TST4_PINGO - COVID Vaccination: This patient has received the FFR, COVID-19, mRNA, LNP-S, PF, 0.3mL vaccination on 01/07/2021 with lot number EL0149 at Walgreens R11160 - Beards Rd.
- 09/07/2020: DCHP_COVID19 - COVID-19 Virus Positive: This patient has had positive viral testing for SARS-CoV-2 on 2020-06-30 15:00:00 as reported by the Maryland Department of Health.
- 08/18/2020: DCHP_COVID19 - COVID-19 Virus Positive: This patient has had positive viral testing for SARS-CoV-2 on 2020-06-30 15:00:00 as reported by the Maryland Department of Health.

Advanced Directives and Medical Orders

- Combined Medical Power of Attorney and Living Will form: OHQA
- Do Not Resuscitate (DNR) card: OHQA
- Do Not Resuscitate (DNR) card: WVDOHLEG

Encounters From Claims

Event
<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Facility / Provider</th>
<th>Value / Ref. Range</th>
<th>Interpretation</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020-08-06</td>
<td>Abbott ID NOW COVID-19</td>
<td>Maryland National Electronic Disease Surveillance System</td>
<td>DETECTED</td>
<td>Abnormal</td>
<td>Final</td>
</tr>
<tr>
<td>2020-06-09</td>
<td>SARS-CoV-2</td>
<td>Western Maryland Health System</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>STAM Michael Stanko</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
COVID-19 Lab Order

Order COVID Test    Report Point of Care Test Results

Guidance And Advisories

This lab order form will allow your patient to be tested for COVID-19 at select sites throughout Maryland. Under the new Statewide testing strategies and with the greater availability of tests, COVID-19 testing at these sites will no longer be limited to testing symptomatic high-risk patients. We encourage you to additionally test patients who are asymptomatic and may have directly or indirectly come into contact with a person known or suspected of carrying the Covid-19 virus. This strategy will help to identify additional asymptomatic carriers in order to contain the spread of the virus.

Please confirm all patient information prior to submitting a lab order. Results delivery may be affected if there is inaccurate information in the order. Once this form is submitted, your patient will receive an email with a confirmation code. The code is required for scheduling the appointment. Your patient will have access to view all information included in your form submission below.

Click Here for more information regarding test order prioritization and screening. Contact CRISP Support at 877-952-7477 if you have issues regarding this form.

Patient Information

* First Name

Middle Name

* Last Name
HIE InContext

Application Overview

Spring 2021
Problem Statements:
  • I need to find data that does not exist in my EHR
  • I need information within my own EHR/workflow
  • I need to quickly get a complete, accurate, and up-to-date account of my new patients’ medical and non-medical history so I can best assess their current condition and plan appropriate care.

The Solution:
  • Embed an app within the EHRs with access to CRISP data
  • Combine data and design views that are useful and valuable to clinical users
Use Case Scenarios

As part of SNF admitting and intake processes, we need to know the patient’s medical history and most recent hospital visit information.

As a SNF provider, I need to understand the current medication list and prescriptions. I may need to prescribe a controlled substance, so the Prescription Drug Monitoring Program (PDMP) information is essential.

As a Social Worker, I need to know who is on the ‘Care Team’ (community care managers, PCP, Specialists, Hospice, etc.) for this patient, and how to reach them.

Coding and billing functions are informed by review of the patient medical record.
Assumptions
- Facility is connected to HIE
- Facility’s EHR is configured to communicate with InContext
- User has a role within the EHR that allows them access to InContext

Application Launch
*From within your own EHR*

*Click on the CRISP button*

*This launches the CRISP InContext application*

*If more than 1 patient is a possible match, select correct patient*

*Patient’s medical record is displayed*

*No separate login, no separate patient search!*
InContext: What data is available?

Patient Matching
Medication Management
  • PDMP Advisories
  • Medications
Clinical Data
  • Health Records: Encounters
  • Structured Documents (CCDs)
  • Immunizations
Care Coordination
  • Care Team
  • Advance Directives
Claims Data
Alerts
  • Care Alerts, Medication Alerts, Infection Control Alerts
Clinical Data: Health Records: Clinical Notes
### Clinical Data: Health Records: Labs

#### Health Records

<table>
<thead>
<tr>
<th>Date</th>
<th>Source</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020-02-13</td>
<td>KP</td>
<td>US PELVIS, NON-08</td>
</tr>
<tr>
<td>2019-04-16</td>
<td>MMC</td>
<td>BASIC METABOLIC PANEL</td>
</tr>
<tr>
<td>2019-04-16</td>
<td>MMC</td>
<td>MRSA PCR RAPID SCREEN</td>
</tr>
<tr>
<td>2019-03-12</td>
<td>SAH</td>
<td>BASIC METABOLIC PANEL</td>
</tr>
<tr>
<td>2019-02-01</td>
<td>ER/ICU</td>
<td>GLUCOSE-PDCT</td>
</tr>
<tr>
<td>2019-02-01</td>
<td>MMC</td>
<td>MRSA PCR RAPID SCREEN</td>
</tr>
</tbody>
</table>

*This data is used to monitor patient health and adherence to treatment plans. Please review this data regularly.*
### Immunizations

<table>
<thead>
<tr>
<th>Administered Date</th>
<th>Vaccine</th>
<th>Dosage</th>
<th>Administered Location</th>
<th>Source</th>
<th>Expiration Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020-01-30</td>
<td>Meningo Pneumococcal Conjugate</td>
<td>1.0 mL</td>
<td>IMM DUNN AVE HEALTH CENTER</td>
<td>IMM,NET</td>
<td>2020-05-06</td>
<td>Completed</td>
</tr>
<tr>
<td>2018-11-13</td>
<td>MMR</td>
<td>1.0 mL</td>
<td>IMM DUNN AVE HEALTH CENTER</td>
<td>IMM,NET</td>
<td>2020-10-01</td>
<td>Completed</td>
</tr>
<tr>
<td>2018-09-27</td>
<td>DTaP</td>
<td>—</td>
<td>—</td>
<td>IMM,NET</td>
<td>—</td>
<td>Completed</td>
</tr>
<tr>
<td>2016-09-27</td>
<td>Prevnar-23</td>
<td>1.0 mL</td>
<td>IMM DUNN AVE HEALTH CENTER</td>
<td>IMM,NET</td>
<td>—</td>
<td>Completed</td>
</tr>
<tr>
<td>2017-11-17</td>
<td>Influenza Type A (H1N1)</td>
<td>—</td>
<td>—</td>
<td>IMM,NET</td>
<td>—</td>
<td>Completed</td>
</tr>
<tr>
<td>1995-09-07</td>
<td>Hepatitis B</td>
<td>—</td>
<td>—</td>
<td>IMM,NET</td>
<td>—</td>
<td>Completed</td>
</tr>
</tbody>
</table>

**Rows per page:** 25 | **1 of 6**
Care Coordination: Care Team and Care Alerts

The image shows a screenshot of a healthcare management software interface. The interface includes sections for medication management, clinical data, care coordination, and data from claims. A care team section displays alerts and care team members. The care alerts include text from various sources such as ENS, JAM, and CRISP. The text of the alerts is not fully visible in the image.

Example alert text:
- ENS: Urgent Care Program: Transitional Care Program. End Date: Jul 01, 0000 12:00 a.m. Care Manager: Linda Jonas. Phone: 410.756.1234
- JAM: Medical
- CRISP: Urgent Care Program: Transitional Care Program. End Date: Jul 01, 0000 12:00 a.m. Care Manager: Linda Jonas. Phone: 410.756.1234

The interface also includes a care alert for HCCH (2019-10-18) from Mr. Apple's patient: "Please help as help you! We have been trying to reach the patient, who has been referred to us by their health insurance company. We are also using CARES, a local primary care office specializing in adults with a history of frequent ED/hospital visits. We provide care management, social work, behavioral health services, and transportation in addition to advanced primary care services. Help get this patient enrolled in HCCH CARES by calling one of us (Monday - Friday between the office hours of 9am - 5pm), and we will come to the patient's bedside as soon as possible. Thank you!"
Care Coordination: Advance Directives
Responsive Screen sizing

Content is resized and adapted to available screen size in order to accommodate multiple EHR systems and the manner in which they display external applications.
Questions?
Future Agenda Topics?
Thank you!

Reminder Next Meeting: June 2021