Using CRISP Encounter Notification Service (ENS) and Smart Alerts to Identify Populations and Streamline Patient Outreach and Care Coordination
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<th>Time</th>
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<td>Introduction</td>
<td>CRISP</td>
<td>1:30p-1:35p</td>
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<td></td>
<td>Kevin Phillip, Project Manager</td>
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<td>Vocabulary</td>
<td>Cindy Gingrich, MSIM, PMP - Account Executive, CRISP</td>
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<td><strong>FEATURED SMART ALERTS</strong></td>
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<td>Identifying High Utilizer Patients</td>
<td>Johns Hopkins Health System</td>
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<td>Diane Lepley RN, MSN - Sr. Director Care Coordination Health Policy and Outcomes</td>
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<td>Pamela Mercer - Sr. Director Quality and Transformation</td>
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<td>Identifying Patients with Prediabetes</td>
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<td>Timely Follow-up Certain Chronic Conditions</td>
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<td>Cindy Gingrich, MSIM, PMP - Account Executive, CRISP</td>
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<tr>
<td>Timely Follow-up after Diabetes related Hospital or ED visits</td>
<td>UM Center for Diabetes and Endocrinology</td>
<td>2:15p-2:25p</td>
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<td>Toshunia Robinson, MSN, RN – Nurse Manager</td>
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Types of Encounter Notifications

- ADT - Admission/Discharge/Transfer Messages - Patients moving into or out of hospitals, Emergency Departments, Skilled Nursing Facilities, etc.
- COVID Test Results
- Death Notifications
- Etc.

Delivery Methods

- ENS PROMPT
- Files (.csv)
- HL7
- DIRECT (secure email)
- EHR Inbaskets
Vocabulary - ENS PROMPT
Vocabulary - What is a SmartAlert?

- Patient demographics (e.g., age, zip code)
- Past encounters
- Payer status
- Diagnoses (ICD-10 codes)
- Free-text analysis on chief complaints
- Lab, CCD-A, and other structured values

One single, highly actionable alert

Smart Alert = uses logic applied to panels and/or data sources to create targeted encounter notifications for patients who meet criteria.
Vocabulary - BLIND PANELS

- A panel of patients who meet certain criteria, that sits in the background (not visible to users)

- Aid in pre-calculating patients who meet certain criteria for faster response time

- Today’s examples of Smart Alerts that use Blind Panels:
  - High Utilizer Smart Alert
  - Potential Prediabetes Smart Alert
Use Case: Identifying Potentially Prediabetic Patients (Pilot)

Maryland (Statewide)

If person is >=18 years
And they do not have Diabetes
And If their Lab and/or ICD 10 Codes indicate Prediabetes

Prediabetes Blind Panel (monthly updates)

Pilot: April / May 2022 – UMMC and Midtown
Overview: HSCRC Regional Partnership meeting on 4/26

Use Cases
1) Hospital Health Worker (CHW) uses Ambulatory panels to see ENS notifications for patients who may have Prediabetes (Pilot)

2) Panel with patients admitted to the hospital – Identification of Inpatients (and/or ED) who may have Prediabetes (Pilot pending)

3) Using an ENS panel of patients, create a report containing patients who are potentially prediabetic (Future)
**Smart Alerts: Timely Follow-up**

**Purpose:** Using visit-level discharge diagnoses (ADT data) to identify patients who meet certain chronic condition-based criteria (list of ICD-10 codes)

- QBR Timely Follow-up of Acute Exacerbations of Certain Chronic Conditions = Limit my ENS notification list to patients whose IP/ED/Obs visits were related to any CHF, COPD, CAD, Asthma, Diabetes. Arrange follow-up within recommended timeframes (7, 14, 30 days)

- Limit my ENS notification list to patients whose visits (encounters) were related to their Diabetes (list of ICD-10 codes)
Prerequisite for Timely Follow-up Smart Alert Use

Is CRISP receiving discharge diagnoses data (ICD-10 codes) when the patient is discharged or within 24 hours of the discharge?

The timeliness and accuracy of hospital charting of discharge diagnoses determines whether PCP/Specialist support staff can effectively use Timely Follow-up Smart Alerts.
ENS Smart Alerts:
Timely Follow-up for Acute Exacerbations of Certain Chronic Conditions

Statewide Integrated Health Improvement Strategy (SIHIS)

Care Transformation Domain
Timely Follow-up for Inpatient, ED or Observation Discharges with diagnoses associated with these six (6) chronic conditions

- Hypertension: Within 7 days of the date of discharge
- Asthma: Within 14 days of the date of discharge
- Heart Failure: Within 14 days of the date of discharge
- Coronary Artery Disease: Within 14 days of the date of discharge
- Chronic Obstructive Pulmonary Disease: Within 30 days of the date of discharge
- Diabetes: Within 30 days of the date of discharge