



CRISP

Using CRISP Encounter Notification Service
(ENS) and Smart Alerts to
Identify Populations and
Streamline Patient Outreach and Care
Coordination

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AGENDA	PRESENTERS	Time
Introduction	CRISP Kevin Phillip, Project Manager	1:30p-1:35p
Vocabulary	Cindy Gingrich, MSIM, PMP - Account Executive, CRISP	1:35p-1:40p
FEATURED SMART ALERTS		
Identifying High Utilizer Patients	Johns Hopkins Health System Diane Lepley RN, MSN - Sr. Director Care Coordination Health Policy and Outcomes Pamela Mercer - Sr. Director Quality and Transformation	1:40p-2:10p
Identifying Patients with Prediabetes Timely Follow-up Certain Chronic Conditions	Cindy Gingrich, MSIM, PMP - Account Executive, CRISP	2:10p-2:15p
Timely Follow-up after Diabetes related Hospital or ED visits	UM Center for Diabetes and Endocrinology Toshunia Robinson, MSN, RN – Nurse Manager	2:15p-2:25p



Vocabulary - Encounter Notification Service (ENS)

ENS
PANELS

Ambulator Practice

Dr. Smith
Dr. Monsanto

Patient / Office or
Patient/Provider List

Health Systems

All patients who
are discharged from Inpatient

Patient/Hospital
Attribution

Programs

Patient / Program
Attribution

Skilled Nursing Facilities

Patient / SNF
Attribution

Community Based
Organizations

Patient / CBO
Attribution

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

Filter by Name or MRN Any Participant (1) Smart Alert Contains Diabetes Prim... x Add Filter

- Smart Alert Contains Diabetes Primary & Secondary Diagnoses
- Timely Follow Up Contains Diabetes Primary Only

Diagnoses (1 filters)

Smart Alert Rule Type contains Diabetes x

All Not started In progress Completed

Notifications count: 6 last updated: 16:06 04/07/22

- Greater Baltimore Medical Center
Emergency Department
04/05/2022 06:30 PM
ER Discharge
Cutaneous abscess of neck
- Greater Baltimore Medical Center
Emergency Department
04/05/2022 06:30 PM
ER Discharge
Cutaneous abscess of neck
- University of Maryland Medical Center Midtown Campus
Hospital
04/05/2022 03:01 PM
IP Discharge
Other acute osteomyelitis, unspecified site
- University of Maryland Medical Center Midtown Campus
Hospital

DEMOGRAPHICS

Primary Care Provider:	MRN: .
Gender: F	Date of Birth: 08/11/1980
Address2: undefined	Address:
City: PIKESVILLE	Facility Type: Emergency Department
State: MD	ZipCode: 21208
Home Phone: .	Cell Phone: .
Work Phone: .	Email:
PCP Phone:	Care Manager Name:
Care Manager Email:	Care Manager Phone:

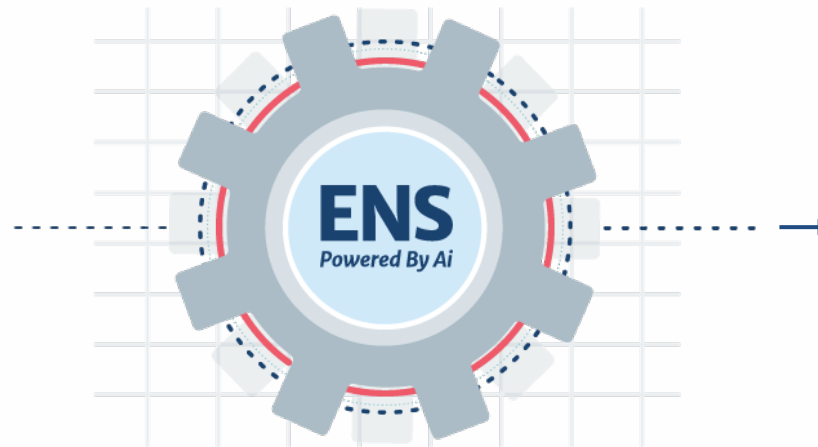
MOST RECENT EVENT

Hospital Service: ED	Event Date/Time: 04/05/2022 06:30 pm
Discharge to Location: Johns Hopkin	Patient Complaint:
Point of Care: Greater Baltimore Medical Center	Patient Class: Emergency
Admit Source: Phys/Self	Event Type: Discharge
Admit Date/Time: 04/05/2022 01:58 pm	Discharge Disposition: ANOTHER INST
Diagnosis Description: Cutaneous abscess of neck	Diagnosis Code: L02.11
Discharge Date/Time: 04/05/2022 06:19 pm	Observation Status: N
Smart Alert Rule Type: Timely Follow Up on Chronic Conditions Diabetes Primary+Secondary	Death Indicator: N
Attending Provider Name: WILLIAM	Attending Provider ID: .
Admitting Provider Name:	Referring Provider Name:
Admitting Provider ID:	Referring Provider ID:
Consulting Provider Name:	Patient Identified Provider Name:
Consulting Provider ID:	Patient Identified Provider ID:



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

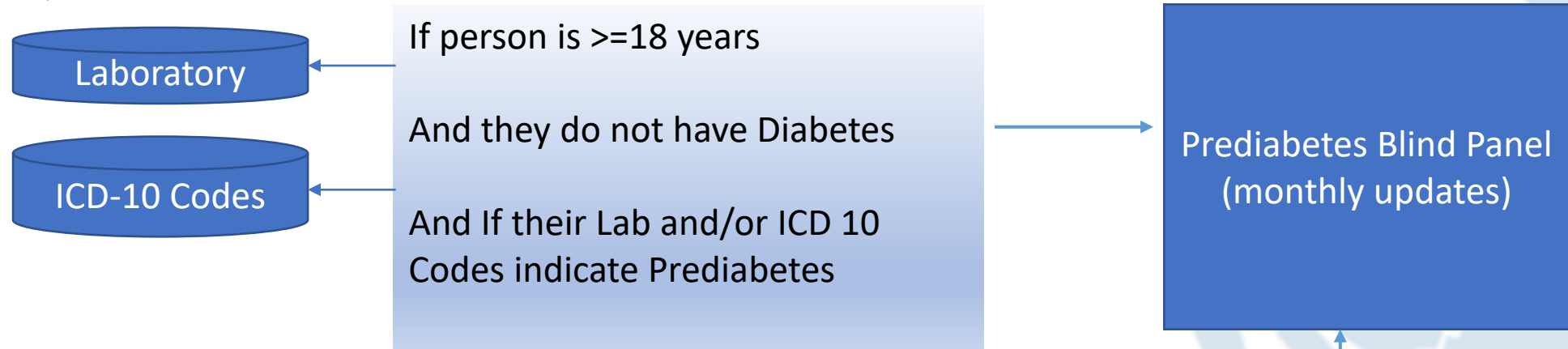
- A panel of patients who meet certain criteria, that sits in the background (not visible to users)
- Aid in pre-calculating patients who meet certain criteria for faster response time
- Today's examples of Smart Alerts that use Blind Panels:
 - High Utilizer Smart Alert
 - Potential Prediabetes Smart Alert





Use Case: Identifying Potentially Prediabetic Patients (Pilot)

Maryland (Statewide)



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