Using CRISP Encounter Notification Service (ENS) and Smart Alerts to

Identify Populations and

Streamline Patient Outreach and Care Coordination

CRISP

7160 Columbia Gateway Drive, Suite 100
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

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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

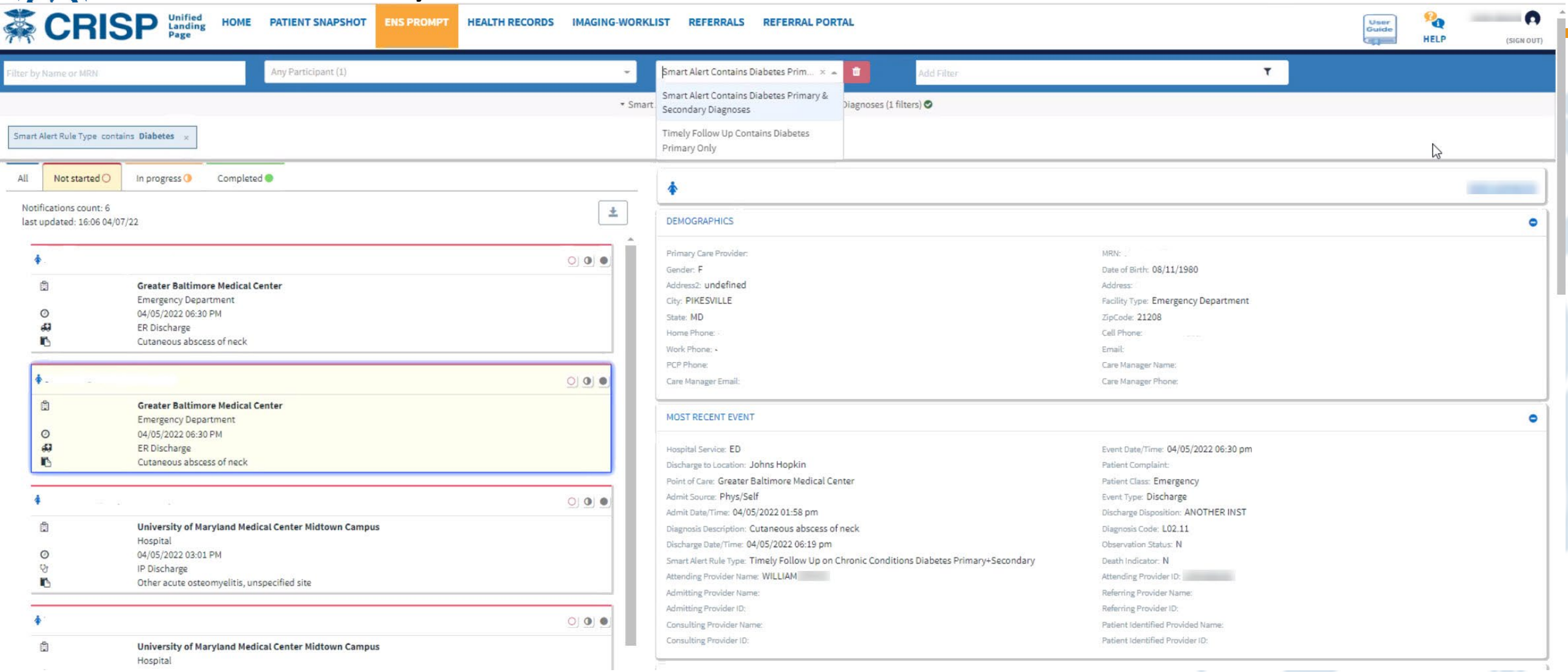
Types of Encounter Notifications

- 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

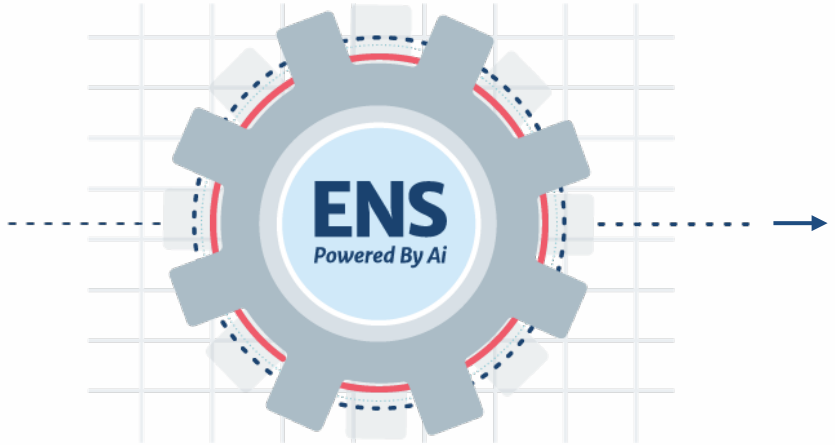
- ENS PROMPT
- Files (.csv)
- HL7
- DIRECT (secure email)
- EHR Inbaskets

Vocabulary - ENS PROMPT



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

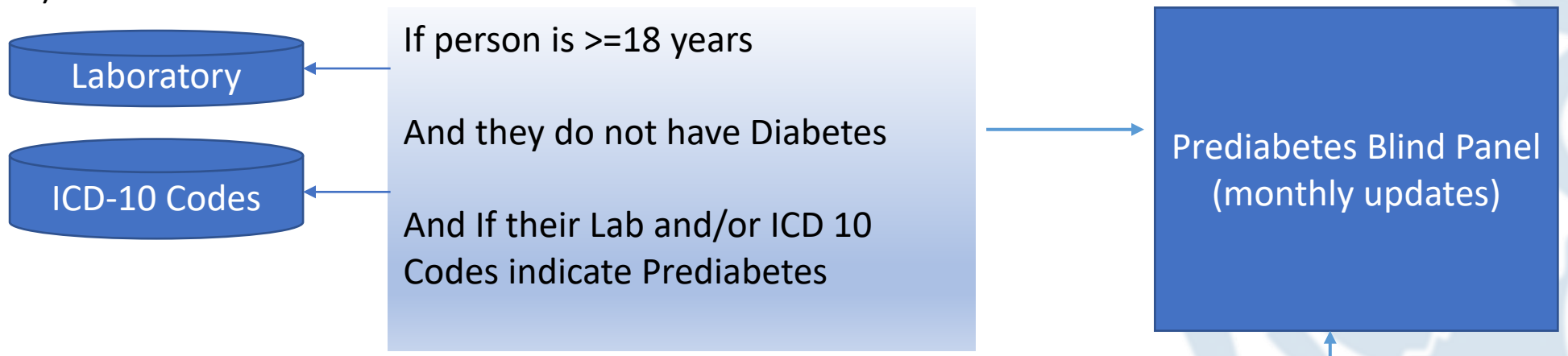
Smart Alert = uses logic applied to panels and/or data sources to create targeted encounter notifications for patients who meet criteria.

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