HEALTH MANAGEMENT ASSOCIATES

CRISP DC

Leveraging current and new opportunities to access and share data

Million Hearts Learning Collaborative

May 18, 2022

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PRESENTERS

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CRISP DC

www.crispdc.org

Aida Semere
Project Manager - CoRIE (SDOH)
Aida.Semere@crisphealth.org

Corrine Jimenez
Project Manager - Cancer Screening, Consent, Provider Directory
Corrine.Jimenez@crisphealth.org

Elizabeth Mulugeta
Project Manager
Elizabeth.Mulugeta@crisphealth.org

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AGENDA AND LEARNING OBJECTIVES

- Welcome and Introduction
- Update from CRISP DC
  - Learn about the portal interface
  - Discuss the status of CoRIE and the closed-loop referral tool
  - Understand what tools are coming soon, including consent management
- Discuss questions, share challenges and experiences

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POLLING QUESTIONS

Optimizing CRISP DC Clinical Infrastructure

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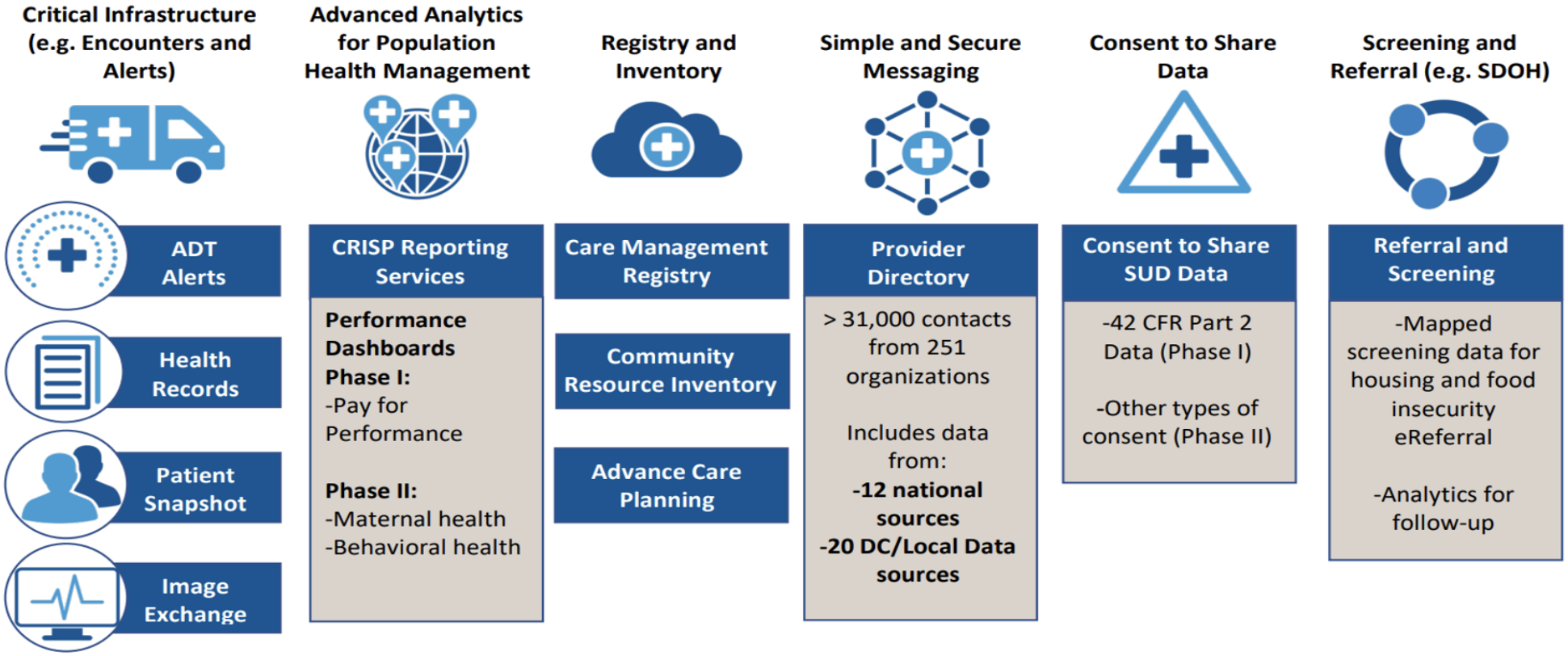
The DC HIE is a Health Data Utility with Six Core Capabilities for Providers



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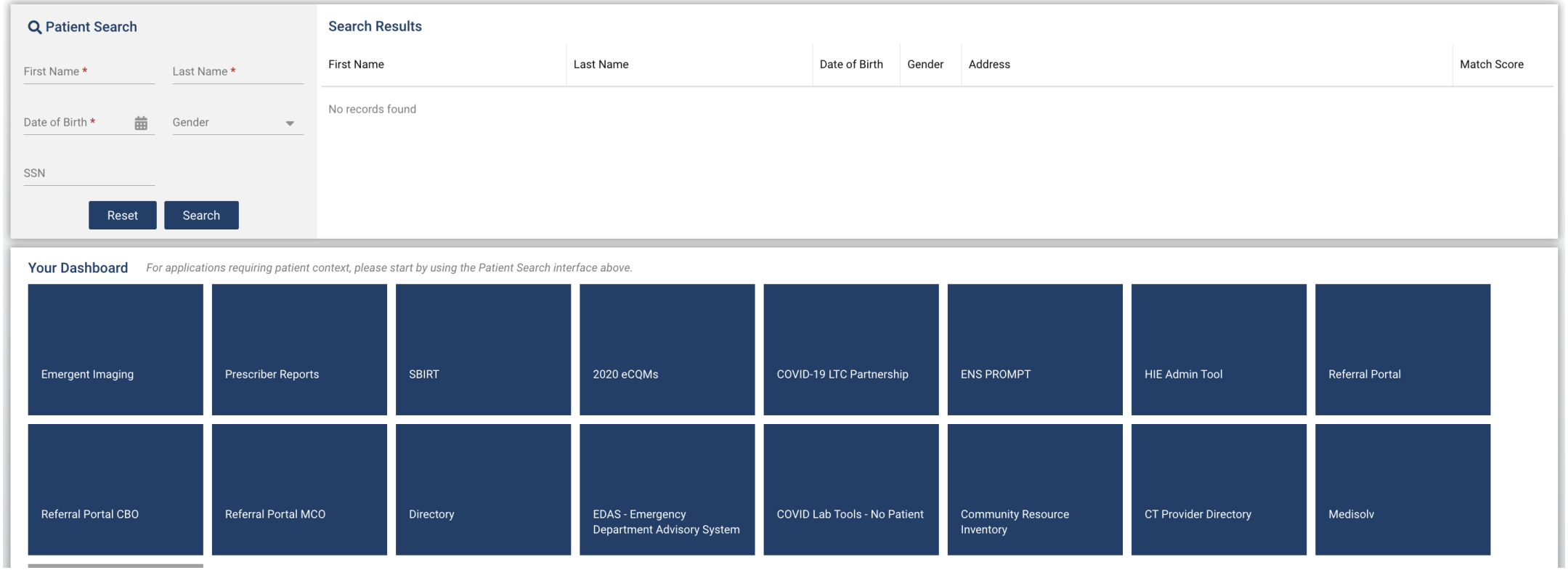
CRISP DC

CRISP DC Portal



POINT OF CARE: **Clinical Information App & In-context Information**

- Search for your patients' prior hospital records (i.e. labs, radiology reports, etc.)
- Determine other members of your patient's care team
- Be alerted to important conditions or treatment information

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CRISP DC Critical Infrastructure: Clinical Data

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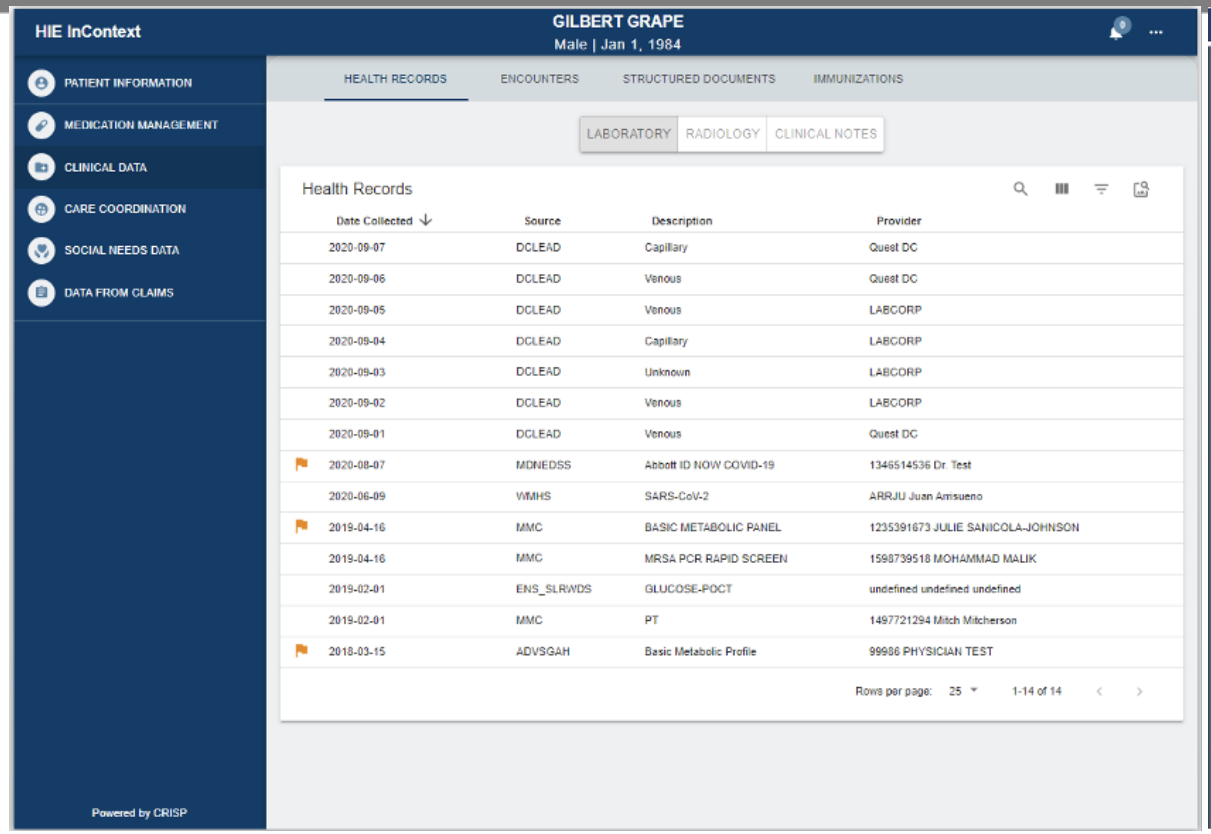

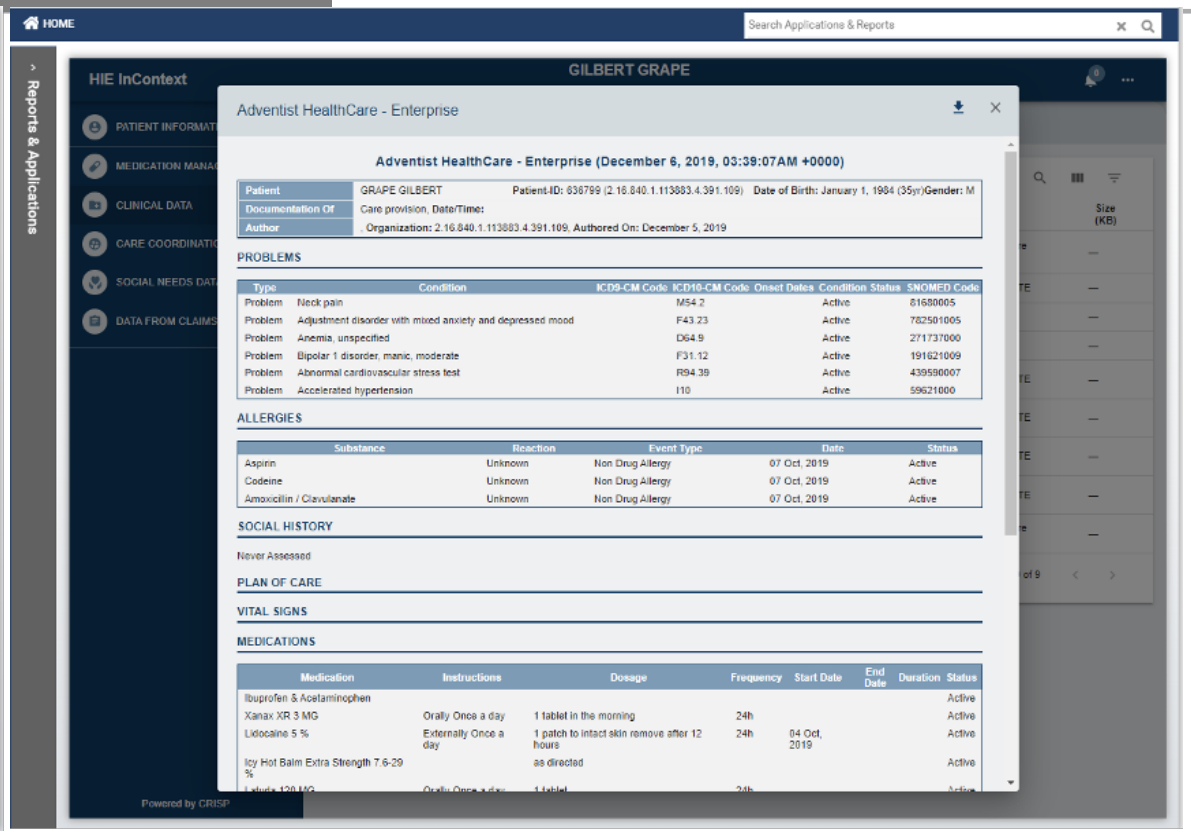

- Access to radiology and lab results from connected hospitals. Save costs by reducing duplicative services
- View clinical notes such as discharge summaries, clinical notes, ambulance run sheets, and more
- Review structured documents from outpatient facilities, including all DC Federally Qualified Health Centers

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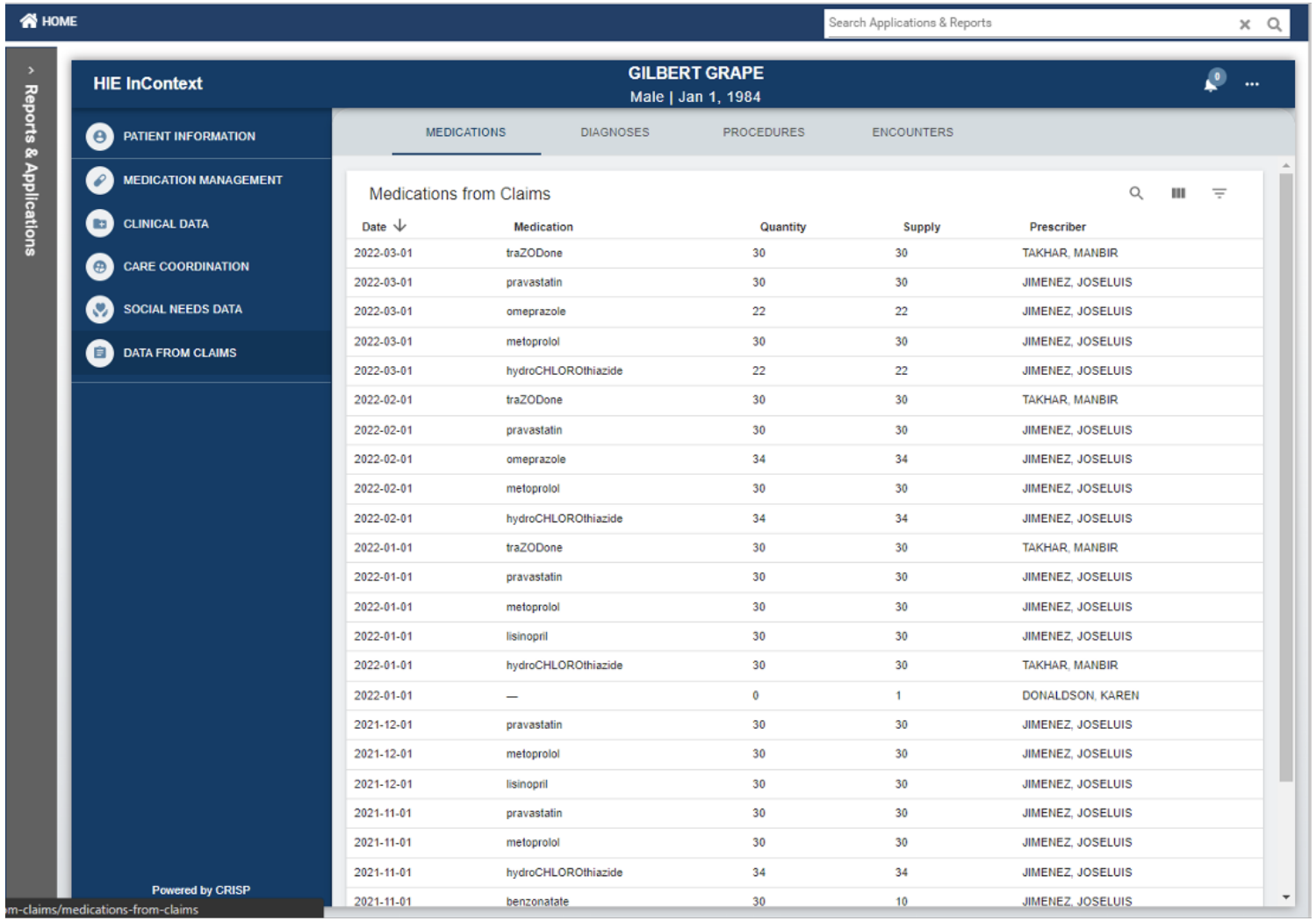
CRISP DC Critical Infrastructure: Data From Claims



Review historically data from claims:

- **Medications** with Quantity, Supply, and Prescriber
- **Diagnoses** with Condition and date recorded
- **Procedures** with the description, source, and date
- **Encounters** with the source, claim type, reason and date

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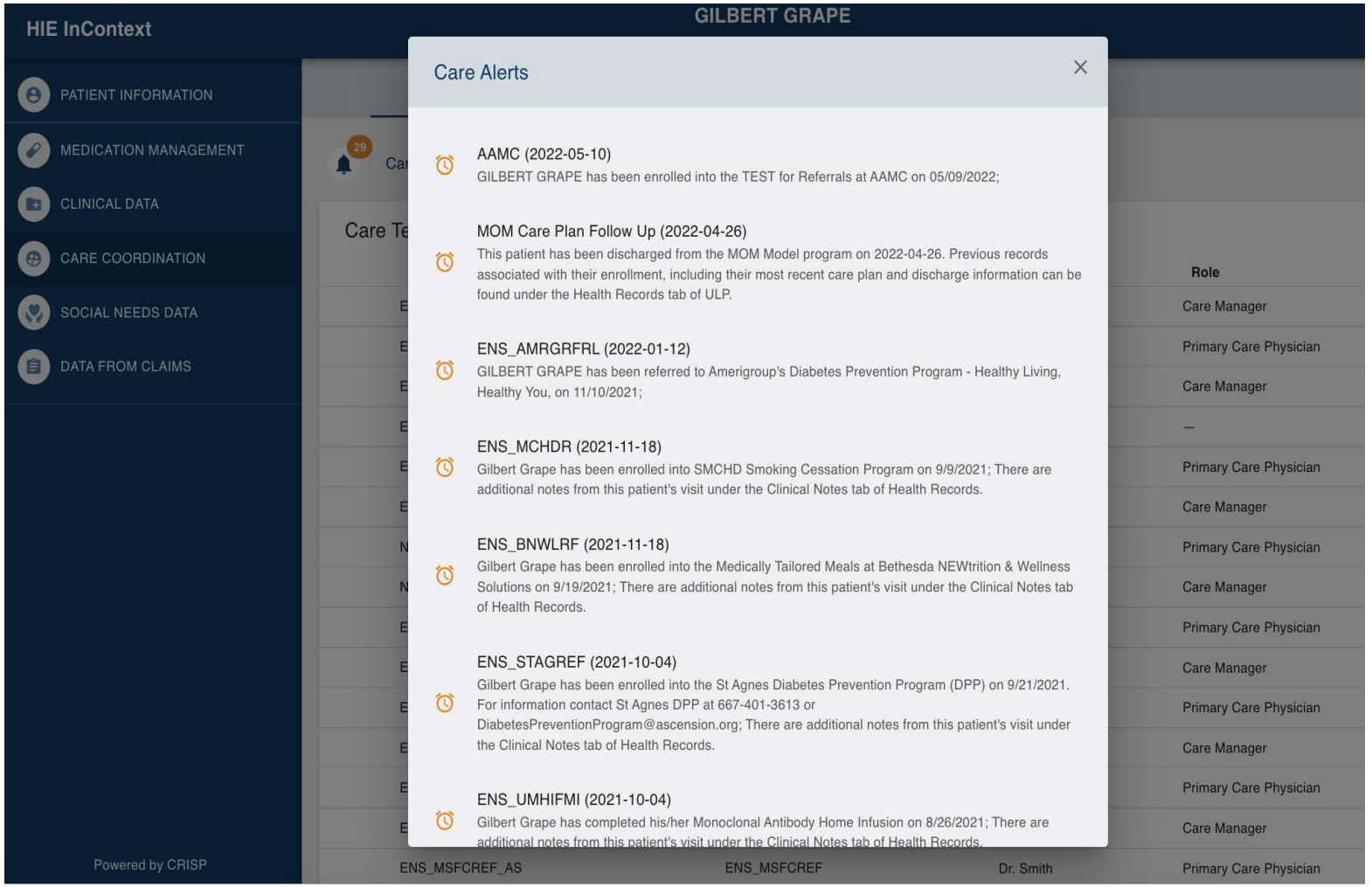
CRISP DC Critical Infrastructure: Care Coordination



Review Care Coordination:

Care Team

Provides a list of organizations that are currently subscribed to receiving information about the patient.

Care Alerts

High priority care coordination information meant for the most complex patients who frequent hospitals and practices. These are generally written by physicians or care managers who have previously seen the patient.

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CARE COORDINATION: Encounter Notification Service (ENS)

CRISP currently receives information pertaining to **ER visits and inpatient admissions** in real-time from acute care hospitals in the region.

- All Maryland acute care hospitals
- All D.C. acute care hospitals
- All Delaware acute care hospitals (in partnership with DHIN)
- 17 Northern Virginia acute care hospitals (in partnership with ConnectVA)
- Most West Virginia acute care hospitals

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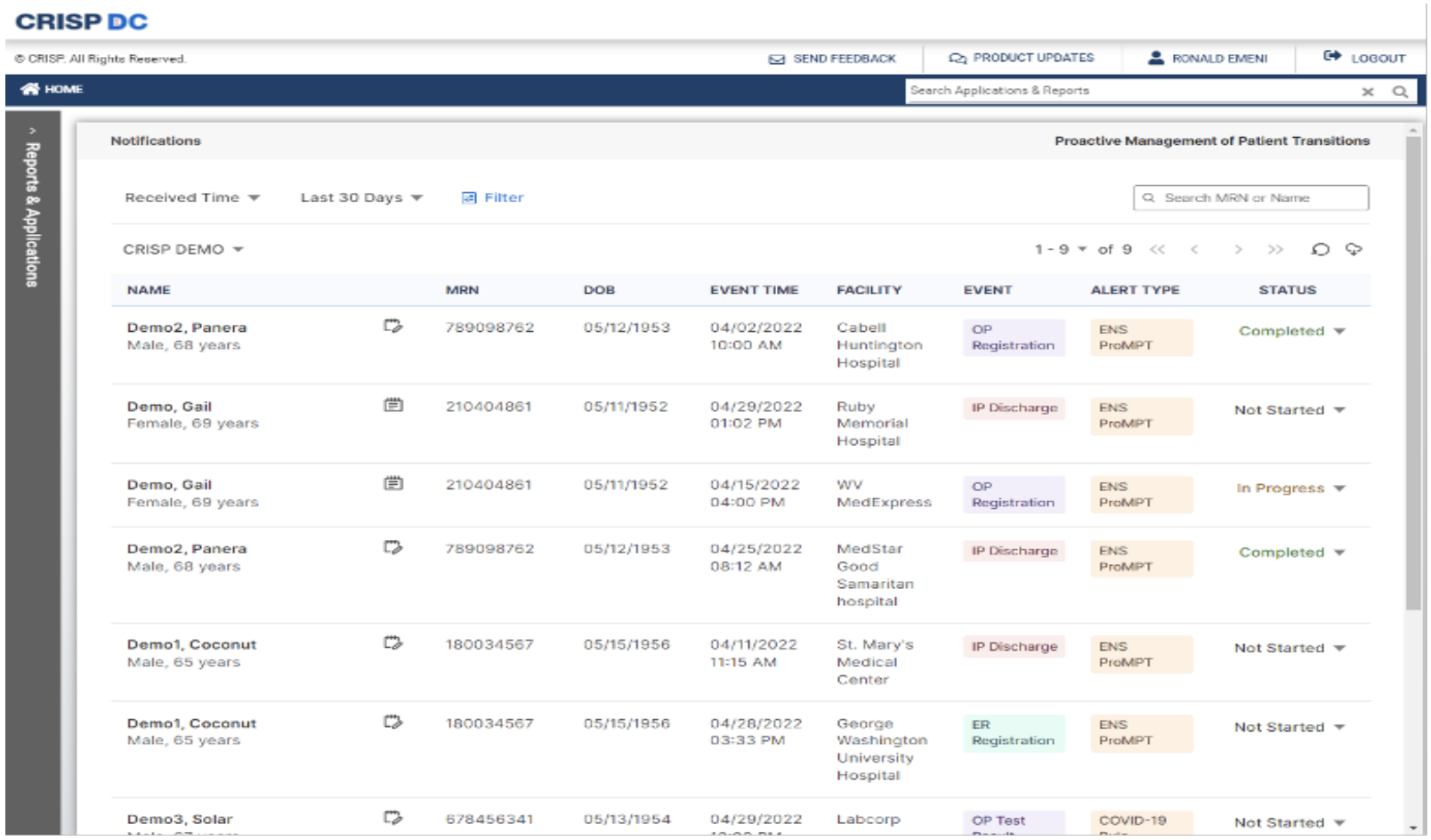
CRISP DC Critical Infrastructure: Encounter Notification Alerts



Review Encounter Notifications:

- Be notified when your patient is hospitalized in any regional hospital
- Receive special notifications regarding ED visits that are potential readmissions
- Create additional filters based on patient complaints, diagnosis codes and discharge dispositions

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Community Resource Information Exchange (CoRIE)

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What is the Community Resource Information Exchange (CoRIE) Initiative?

CoRIE is a Partnership

- DHCF, CRISP DC, DC Primary Care Association, and DC Hospital Association are collectively known as 'CoRIE Partners'
- Committed to supporting and sustaining technical solutions and enabling coordinated whole person care across health, human, and social service providers in the District.

CoRIE is a set of 3 technical functionalities to address SDOH

- Screening for social risks and share dispositions
- Lookup resources through a centralized community inventory (CRI)
- Refer to appropriate community and support services
- Together these 3 functionalities enable data sharing among health system stakeholders to address individuals' social needs.

CoRIE is a Vendor Agnostic Approach

- Enables screening and referral information to be shared and displayed regardless of how it was collected
- Ensures care partners can view the same information via DC HIE regardless of the vendor platform they use

CoRIE is an Interoperable System within the DC HIE

- Digitally connects care partner, including health and social service providers, through the DC HIE health data utility
- Provides shared services across the region
- Fosters a culture of shared responsibility for ensuring the availability and quality of actionable information

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Community Resource Information Exchange (CoRIE)

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CoRIE is designed to enable social needs screening and referral through DC HIE infrastructure *without* requiring a single District-wide platform

Providers, MCOs, and health system stakeholders use different systems to:

- Collect social needs information from patients
- Make referrals to community services

CoRIE allows 4 pathways to capture and share SDOH screening and referral data with care partners through the DC HIE

Choose 1 of 4 pathways to capture and share SDOH screening and referrals

Each pathway contributes data to the DC HIE

DC HIE Users can view screening and referrals from each pathway in the social needs tab

1. Use 3rd Party SDOH Network Platforms (findhelp, mahmee)
   - Vendor integration with CRISP enables transmission of screening and referral data
2. Use an EHR (eClinicalWorks, Epic, Cerner, Other EHRs)
   - CSV files containing referral data
   - CSV files containing screening data elements
   - Z-codes extracted from CCDs reflecting screening dispositions
3. Use CRISP DC Direct-entry Screening Tool to capture SDOH screening/assessment
   - Screening and assessment data elements

CRISP DC Social Needs Tab

- DC HIE users can view referral history made in non-DC HIE systems
- DC HIE users can view conditions based on extracted z-codes
- DC HIE users can view assessments captured via the CRISP DC Screening Tool or third-party platform

4. Use CRISP DC Referral Tool to send referral to CBO

CRISP DC Referral Tool

CBOs can

- Receive referrals for services
- Communicate with referring provider
- Close the loop

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CRISP DC Closed-Loop Referral Tool

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CoRIE Referral Tool	Accomplishments	FY22
FindHelp mahmee **Referral History from 3rd Party Network Platforms and other sources**	• Two (2) 3rd party vendors (FindHelp, Mahmee) signed agreements to display referral data • FindHelp will share referral history starting with MedStar Regional hospitals	• Continue the technical integration with FindHelp to enable third-party MedStar Regional referrals to be added to the CRISP HIE and viewable at point of care. • Engage and implement technical integrations with other third-party SDOH network platforms to make screening and referral data available within the CRISP HIE

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Referral Tool
	• Initial pilot conducted with Gerald Family Care in late 2020.
	  • More than 70 referrals sent to Giant Nutrition for *Virtual Services for Heart Health, Prediabetes and Diabetes, and Healthier You.*
	  • Ability to tracking follow-up to nutritional counseling services and view follow up notes
	• Closed loop referral tool went live and in use by CRISP clinical users and community-based organizations
	  • 12 healthcare organizations are making referrals to CBOs
	  • 18 DC CBO programs available to receive and close loop on referrals
		• Expand userbase to enable more CBOs to receive and respond to referrals through the free CRISP DC referral tool
		• Onboard more DC HIE user healthcare organizations make referrals to CBOs
		• Engage directly with DC CBOs, coalitions, and agencies to onboard more CBOs across various SDOH domains (food, transport, housing, legal, etc.) to the CRISP referral tool
		• Enable CBOs to make referrals in Fall 2022

CRISP DC **Social Needs Tab** • Referral History Subtab	• CRISP Referral History Subtab built under Social Needs Tab and available to DC HIE users	• Social Needs Tab, Referral History Subtab data to be made available to all DC HIE users

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CRISP DC Closed-Loop Referral Tool (Referring Provider View)

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CRISP Program Referral

Guidance And Advisories

Due to extremely limited supply, referrals for monoclonal antibody treatment have been paused to allow for treatment to older adults in skilled nursing facilities. Please consider an alternative therapeutic for high-risk patients such as Paxlovid or Molnupiravir.

Patient Information

* First Name	Middle Name	* Last Name
Gilbert		Grape

* Date of Birth (Format MM/DD/YYYY)	Primary Language	Gender
01/01/1984		

* Home Address 1	* Phone Number	* Type
4145 Earl C Adkins Dr	678-595-4587	

Home Address 2	Alternate Phone Number	Type
	999-999-9999	

* City	* State	* Zip	Email
River	WV	26000	

Patient Vitals

BMI	HbA1c	Blood Pressure

Cholesterol	Fasting Glucose	Allergies ⓘ

Referral Program

* Organization: The YMCA of Metro Washington

* Programs:
- Blood Pressure Self-Monitoring
- Cooking and Nutrition classes
- Diabetes Prevention Program
- Medical Nutrition Therapy

* Please enter all relevant information that you would like relayed to the accepting provider below:

Example: Luke Skywalker is a 44 y.o. male who presented to ABC Family Practice and qualifies for enrollment into a DPP. Per most recent encounter on 4/1/19, BMI is 32, HbA1c level is 6.2. No previous diagnosis of DM1 or DM2. Counseled patient on lifestyle changes including healthy eating habits and fitness regimens.

Choose Files No file chosen

Referring Physician

◯ I am referring this patient myself ◯ I am referring this patient on behalf of a physician

Submit Clear ☐ Patient Agreement ?

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CRISP DC Closed-Loop Referral Tool (CBO and Referring Provider View)

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Filter by Status: Pending (+1 other)

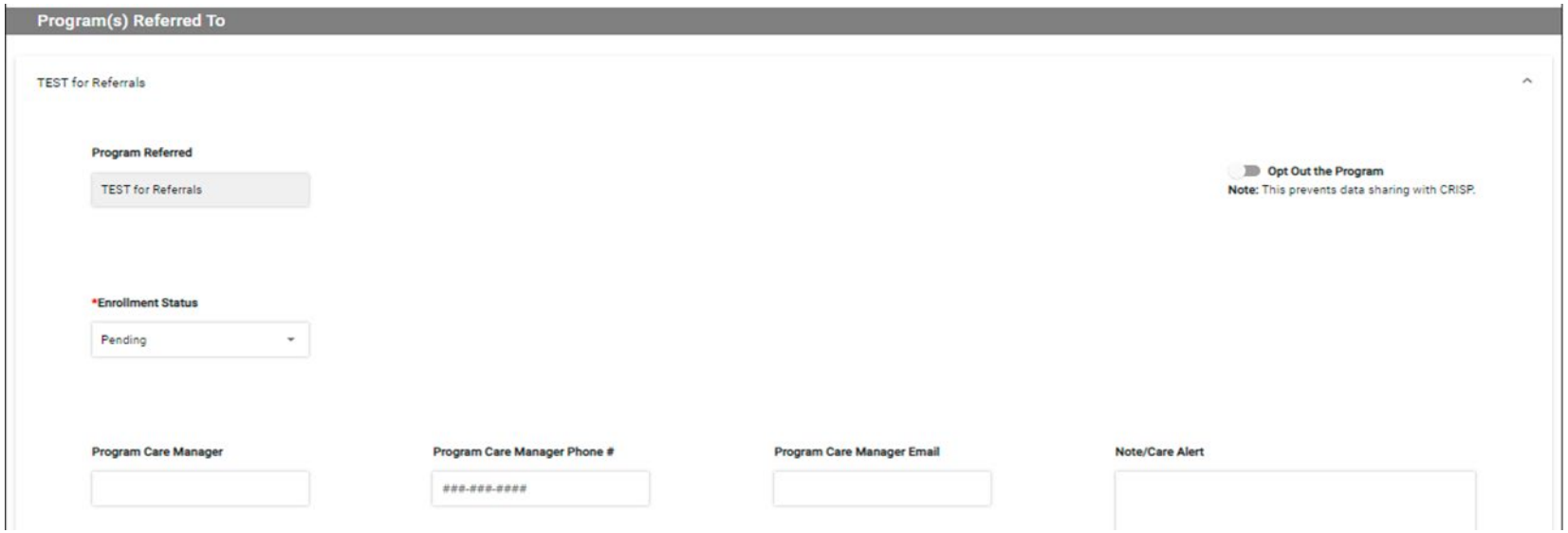
Referrals Overview

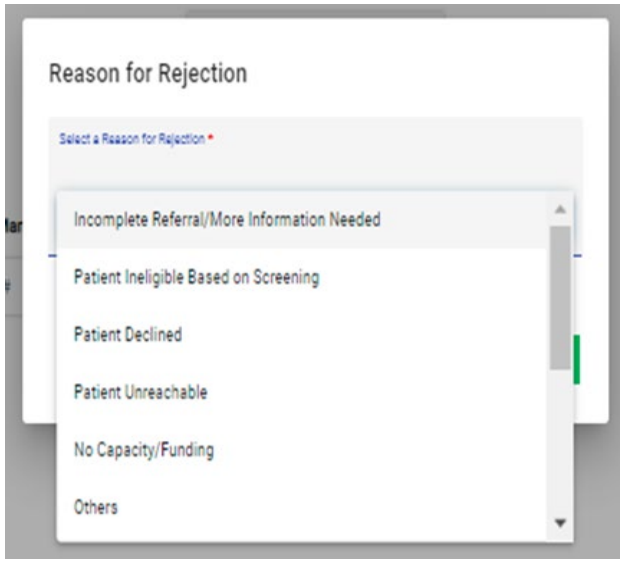
Look up Referral: ymca

Name (last, first)	Gender	DOB	CBO	Ref. Date	Referral Status	Accepted Date	Programs
GRAPE, GILBERT		Jan 1, 1984	The YMCA of Metro Washington	Jan 28, 2022	Pending		0 / 0 / 1
GRAPE, GILBERT		Jan 1, 1984	The YMCA of Metro Washington	Apr 22, 2021	Accepted	Apr 22, 2021	0 / 0 / 1
GRAPE, GILBERT		Jan 1, 1984	The YMCA of Metro Washington	Apr 21, 2021	Accepted	Apr 22, 2021	0 / 0 / 1

Export to Excel | Reports

Items per page: 25 | 1 – 3 of 3





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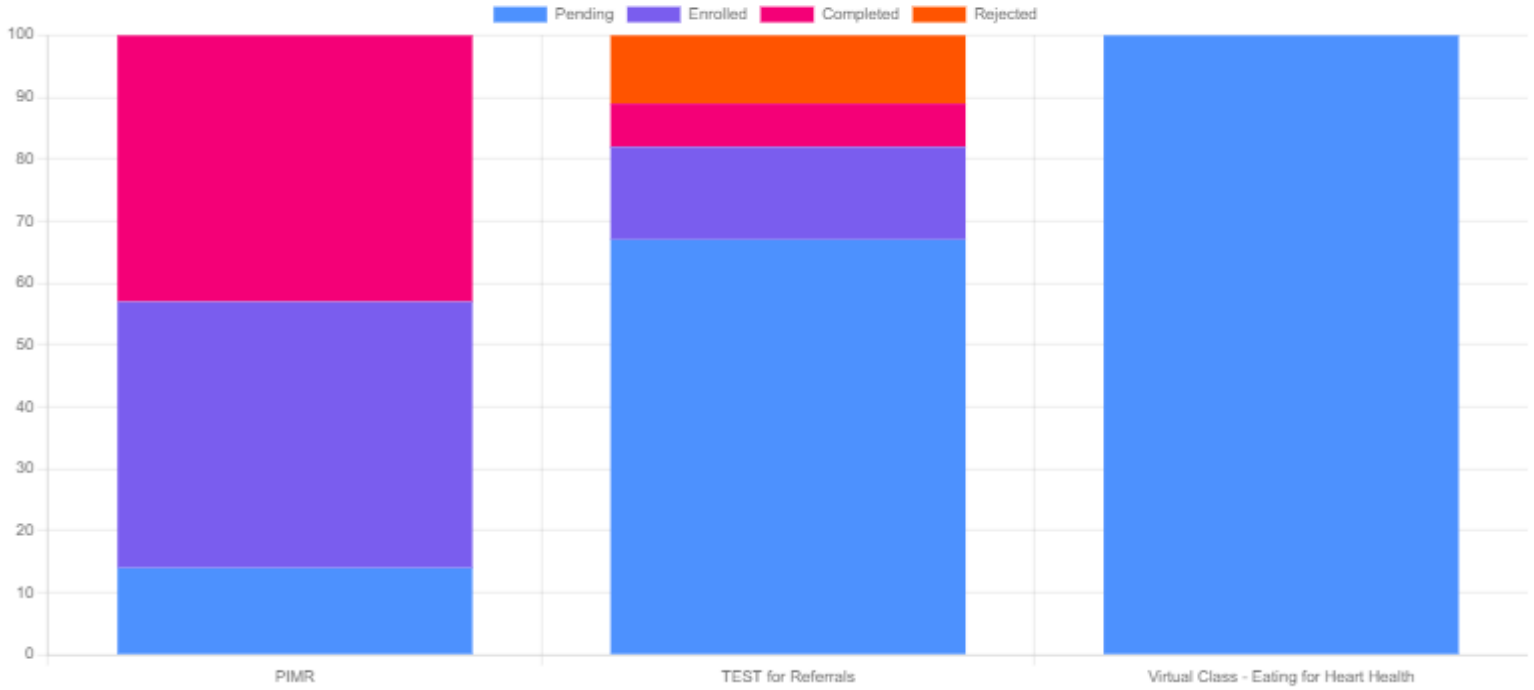
CRISP DC Closed-Loop Referral Tool (CBO and Referring Provider View)

Reports

Back to Referrals

Enrollment Outcome | Calendar Year | 01/01/2022 | 12/31/2022 | Submit



Id	Full Name	Referrer	CBO Notes	Created	Referral Program ID	Enrollment Status	Reject Reason	Program Name	Outcome Achieved	Response Time (Days)
4015	Gilbert Grape		TEST.	2022-02-25	8773	Completed		PIMR	✖	0

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Display of CRISP DC Referral Data

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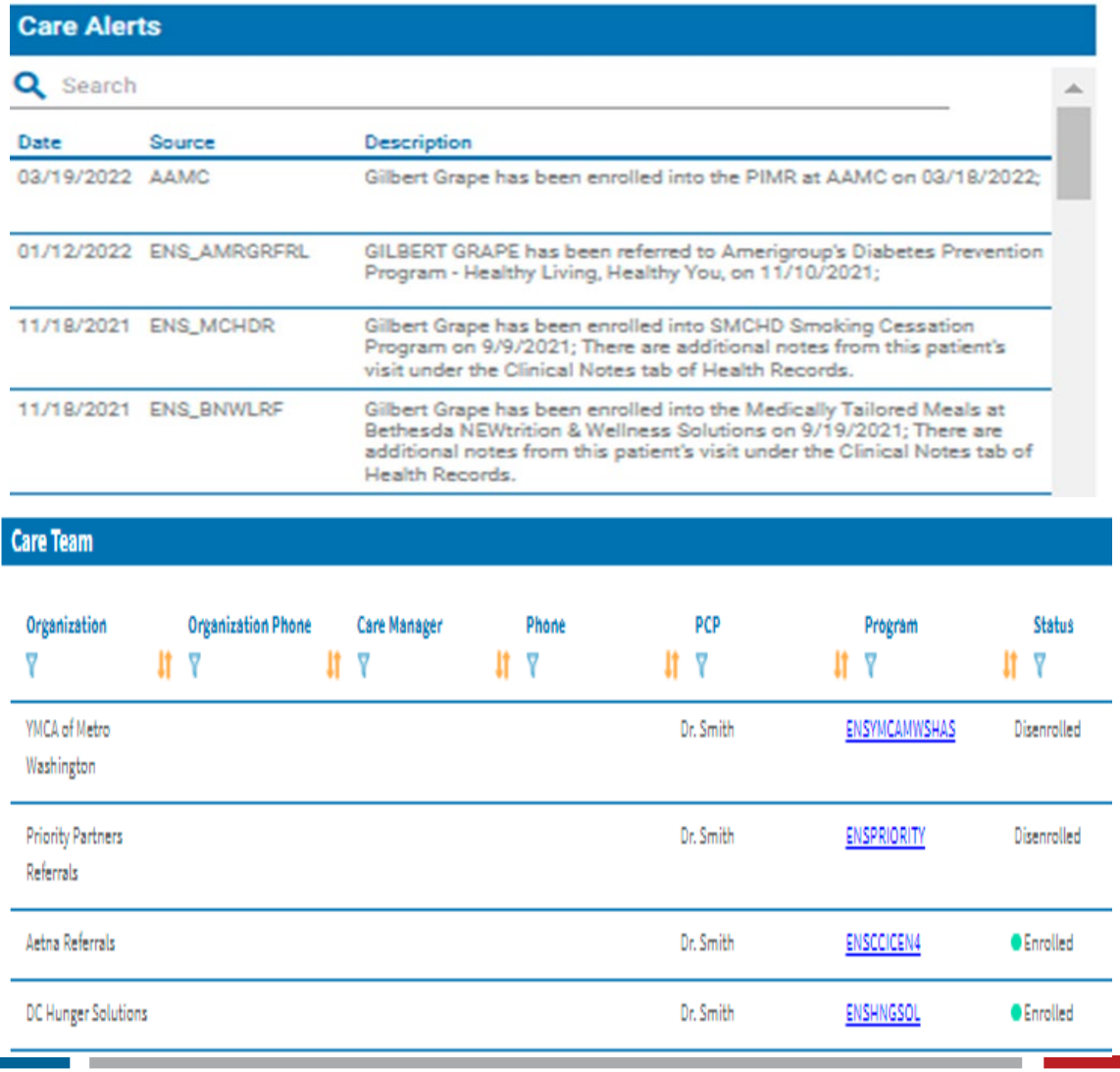

Care Alerts

Search

Date	Source	Description
03/19/2022	AAMC	Gilbert Grape has been enrolled into the PIMR at AAMC on 03/18/2022;
01/12/2022	ENS_AMRGRFRL	GILBERT GRAPE has been referred to Amerigroup's Diabetes Prevention Program - Healthy Living, Healthy You, on 11/10/2021;
11/18/2021	ENS_MCHDR	Gilbert Grape has been enrolled into SMCHD Smoking Cessation Program on 9/9/2021; There are additional notes from this patient's visit under the Clinical Notes tab of Health Records.
11/18/2021	ENS_BNWLRF	Gilbert Grape has been enrolled into the Medically Tailored Meals at Bethesda NEWtrition & Wellness Solutions on 9/19/2021; There are additional notes from this patient's visit under the Clinical Notes tab of Health Records.

Care Team

Organization	Organization Phone	Care Manager	Phone	PCP	Program	Status
YMCA of Metro Washington				Dr. Smith	ENSYMCAMWSHAS	Disenrolled
Priority Partners Referrals				Dr. Smith	ENSPRIORITY	Disenrolled
Aetna Referrals				Dr. Smith	ENSCCICEN4	Enrolled
DC Hunger Solutions				Dr. Smith	ENSHNGSOL	Enrolled

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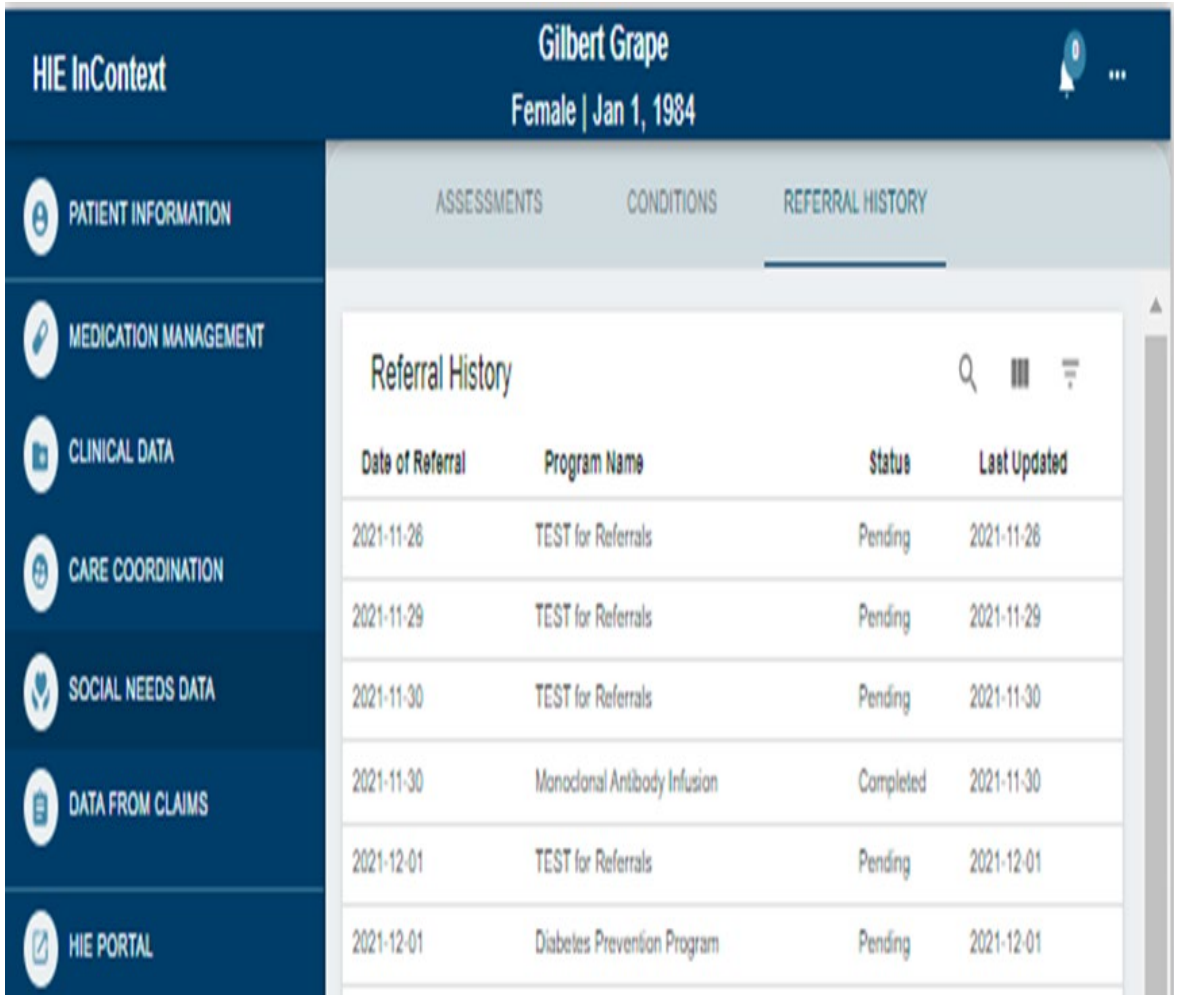
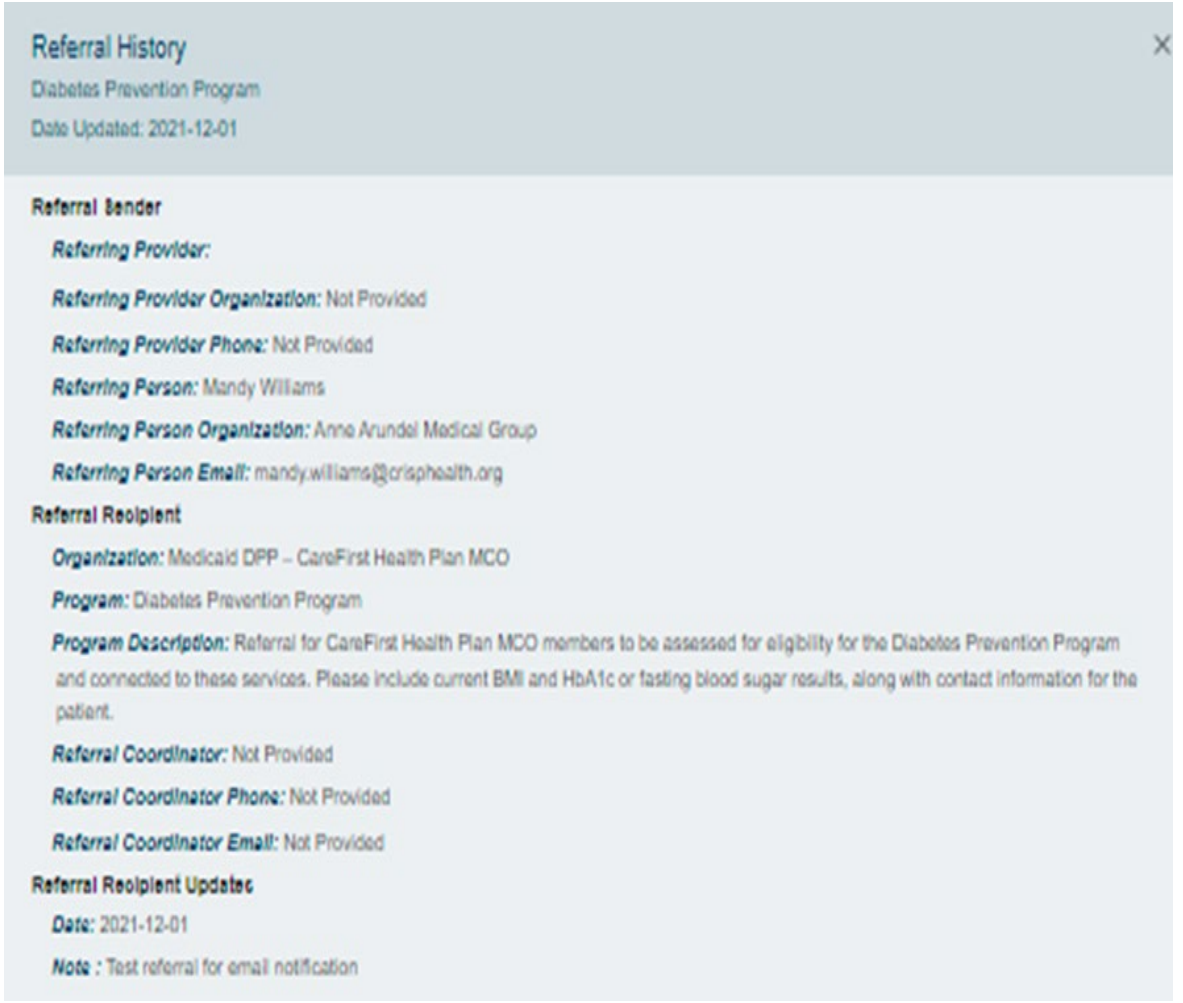
Display of CRISP DC Referral Data





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CRISP DC has the following CBOs and programs available for referrals on the closed-loop referral tool:

Giant Food Nutrition:

- 6 Steps to a Healthier You Webinar (Virtual Class)
- Eating for Heart Health (Virtual)
- Eating for Prediabetes and Diabetes (Virtual)
- Healthy Meal Planning (Virtual)
- Mindful Eating (Virtual)
- Virtual Consultation (English and Spanish)
- Virtual Store tour

Bethesda NEWTrition & Wellness:

- Diabetes Prevention Program
- Diabetes Self-Management & Education Program
- Medical Nutrition Therapy

DC Hunger Solutions

- SNAP Assistance
- WIC Assistance

Sorogi

- DPP
- Diabetes Self-Management and Education Program
- Remote Patient Monitoring Program
- Self-Measured Blood Pressure Program

YMCA of Metro Washington

- Blood-pressure Self Monitoring
- DPP
- Cooking and Nutrition Classes
- Medical Nutrition Therapy

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How to access the CRISP DC Closed-Loop Referral Tool

If your organization would like to:

- Access the closed-loop referral tool as a healthcare organization who wants to make referrals
- Onboard your CBO and its programs to the referral tool
- Recommend community-based organizations (CBOs) whose programs could be on the closed-loop referral tool

Please reach out to Aida Semere, CRISP DC Referral Tool Project Manager **(aida.Semere@crisphealth.org)**, who will work with your organization to onboard and train your staff and assist with the onboarding process for adding CBO programs onto the closed-loop referral tool.

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CRISP DC Consent Management Solution Overview

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- The CRISP DC Consent Tool is a platform for providers and staff to register patient consents to share 42 CFR Part 2-protected data.

- **What is my patient consenting to?**
  - To allow their Substance Use Disorder (SUD) treatment provider to share information about their SUD treatment with the DC Health Information Exchange (HIE).
  - The HIE will then share it with other members of the patient's health care team who participate with CRISP HIEs
    - Including Maryland, DC, West Virginia, Connecticut, Alaska and any HIE affiliates in the future
  - The pilot of the consent management tool began in April 2021:
    - 11 initial sites have been trained and credentialed to access the tool
    - 316 consents have been registered to date
    - <**2%** of consents registered have elected to share only their care team information, >**98%** have elected to share all of their SUD treatment data
  - CRISP DC is prepared to make this tool available to all clinical users of CRISP by July 2022

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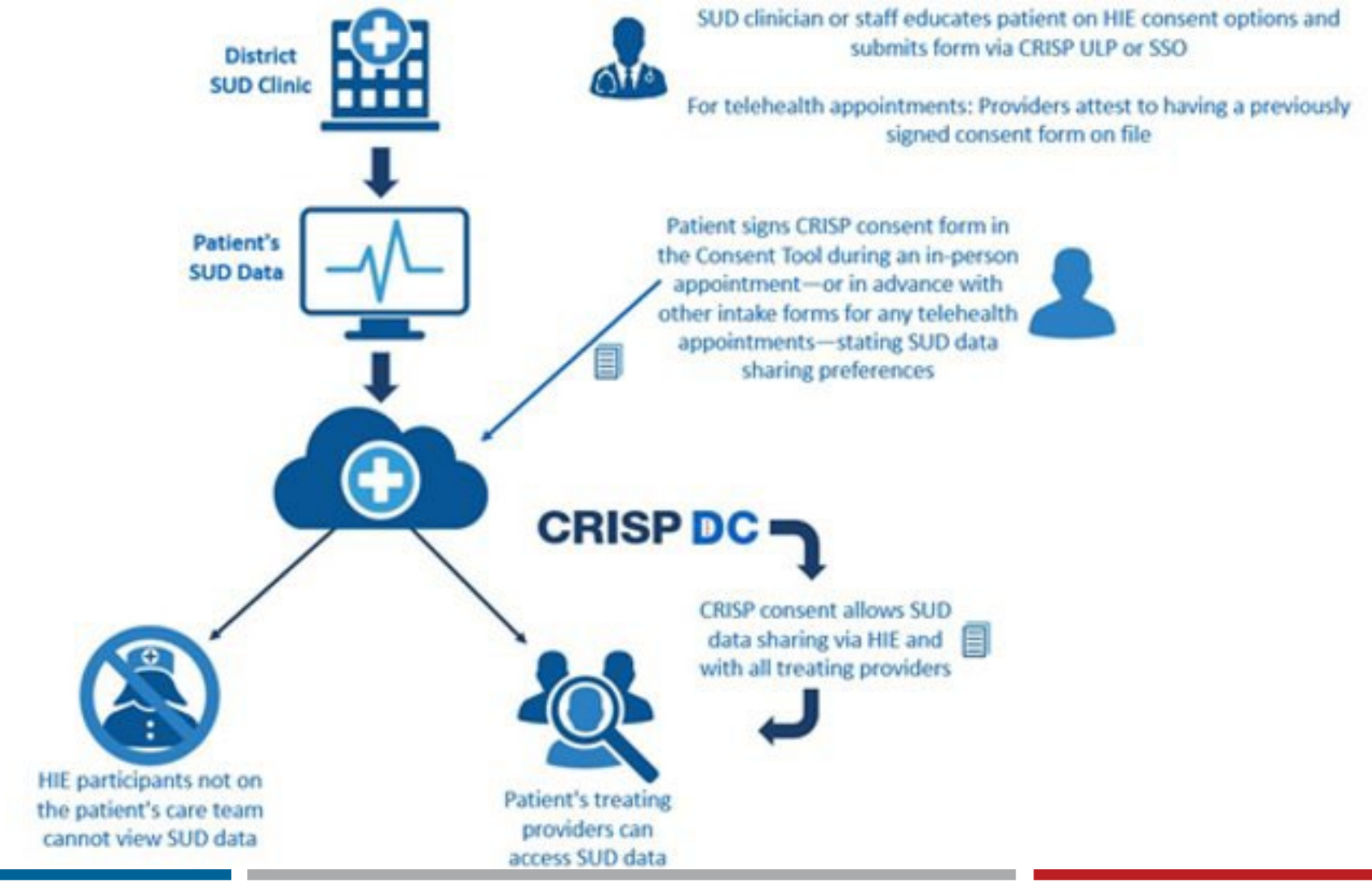
CRISP DC

SUD Data Flow from Providers to the DC HIE



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What features are available in the consent tool?

- Easy integration into existing workflows and clinical systems
- Electronic signatures for patients to opt-into sharing their 42 CFR Part 2 protected data
- Attestation button allowing providers to register patient's consent that has been captured outside of the tool, either electronically or on paper (intended for telehealth patients)
- Flexible expiration dates for consent registration, with a default expiration date of one year from registration date
- Provider and payer specific forms with multiple patient consent options to share all of their SUD treatment data (treatment plan, medications, lab results, clinical notes) or only the care team's contact information

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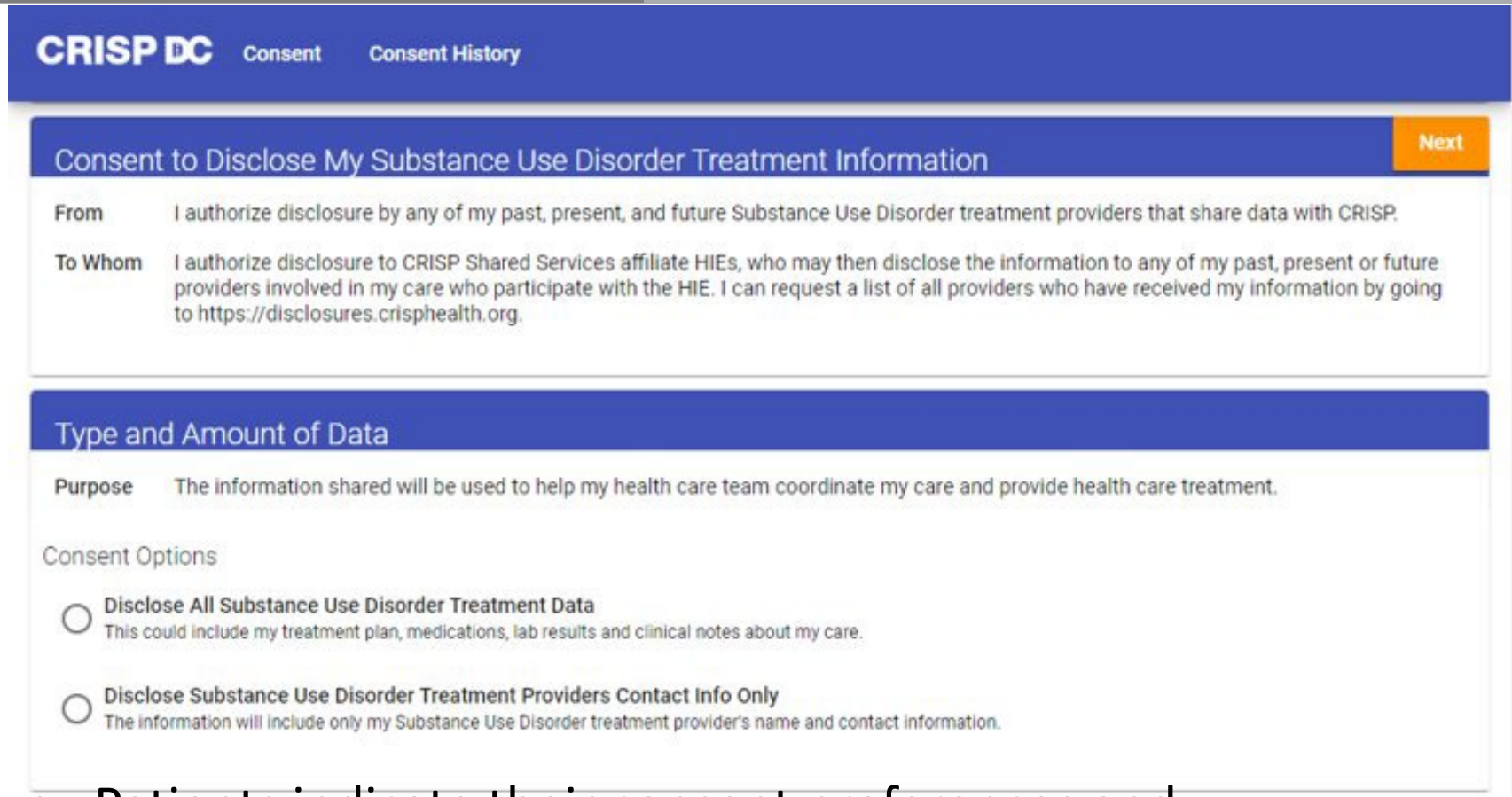
How will providers access the tool and register consents?

- Providers can search for a patient, then launch the consent tool through the DC Portal

- Providers must attest to providing patient education and verifying patient identity before submitting the consent and the patient may revoke their consent at any time



- Patients indicate their consent preferences and electronically sign the form or submit an additional paper form, for telehealth visits

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Discussion

QUICK EVALUATION POLL

1. To what extent did the session meet the stated objectives? (1-not at all to 5-met all objectives)
   - Learn about the portal interface.
   - Discuss the status of CoRIE and the closed-loop referral tool.
   - Understand what tools are coming soon, including consent management.
   - Discuss and address grantee questions, challenges, and opportunities for improvement and implementation.

2. How would you rate the session overall? (from 1-5, where 1 is poor and 5 is excellent)

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- ✓ One on one coaching, team/clinic trainings, evaluation plan and CIP updates
- ✓ Recorded trainings and tools: https://livingwell.dc.gov/page/clinical-partners
- ✓ Other questions or ideas? Please reach out:
  - Mary Kate Brousseau – mbrousseau@healthmanagement.com
  - Mobile: (541) 231-3717

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CONTACT US

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CRISP DC

www.crispdc.org

Aida Semere
Project Manager - CoRIE (SDOH)
Aida.Semere@crisphealth.org

Corrine Jimenez
Project Manager - Cancer Screening, Consent, Provider Directory
Corrine.Jimenez@crisphealth.org

Elizabeth Mulugeta
Project Manager
Elizabeth.Mulugeta@crisphealth.org

Ronald Emeni
Outreach Manager
Ronald.Emeni@crisphealth.org

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