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Helping Healthcare Providers Adopt
Digital Health Technologies and Achieve
HIE Connectivity in the District

ARPA Home and Community Based Services (HCBS) Digital Health Technical Assistance (TA) Program

Care Coordination

February 20, 2024

How to Engage

- Use **Chat** to share questions and comments with the group

- Use **Raise Hand** function to be queued up for commenting / unmuting and share your comments with the group

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Key Learning Objectives

1. Gain insights into the importance of care coordination
2. Develop the knowledge and skills necessary to effectively coordinate care
3. Learn how your EHR and the DC HIE support care coordination

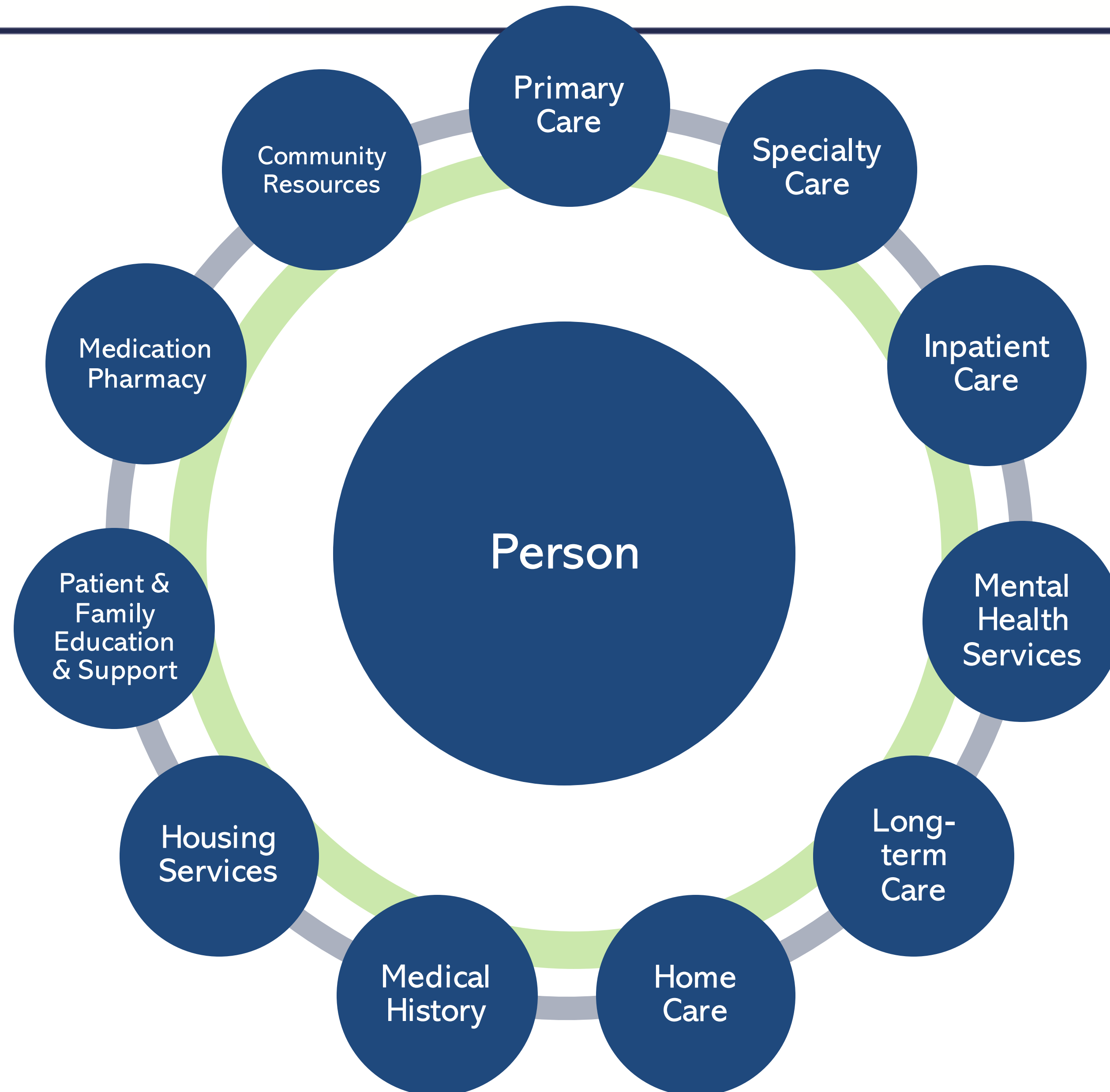
What is Care Coordination?

Agency for Healthcare Research and Quality (AHRQ) --

"Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care."

https://www.ahrq.gov/ncepcr/care/coordination/atlas/chapter2.html

Care Coordination Ring



6 Cs of Health and Social Care

Northern Healthcare – a UK independent provider of supported living services for individuals due to a mental health diagnosis, learning disability or autism

Perspectives on Care Coordination

- **Person/Family:**
  - Ensure the person's needs and preferences are met across all care areas
  - Smooth transitions between different care settings

- **Service Provider (Medical, Behavioral, Disability, Long Term, Housing):**
  - Person-centered team-based care
  - Smooth transitions to and from different care settings

- **Systems (Government Agencies, Insurers (Accountable Care Organization (ACO)):**
  - Manage care activities and resources efficiently and effectively
  - Smooth transitions between care settings to avoid gaps in care and duplicative services

The goal of care coordination is to facilitate the appropriate and efficient delivery of services both within your organization and across systems

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Why is Care Coordination Important?

- Address Housing Insecurities
- Reduce Hospital Readmissions
- Reduce Medication Errors
- Manage Chronic Diseases
- Assist with Self-Care

Quality of Life

- Reduce Missing Information
- Reduce Missed Appointments
- Timely Follow-Up Appointments
- Address Other Risk Factors
- Increase Access to Services

Gaps in Care

- Reduce ER visits
- Reduce unnecessary hospitalizations
- Eliminate duplicative testing
- Reduce utilization costs
- Use resources efficiently and effectively

Cost Savings

What percentage of older adults (>50 years old) perceived poor care coordination?

a) **10-15%**

b) **40-45%**

c) **70-75%**

d) **90-95%**

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What percentage of older adults (>50 years old) perceived poor care coordination?

a) 10-15%

b) 40-45%

c) 70-75%

d) 90-95%

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Challenges with Care Coordination

Missing Information

Fragmented Communication

Challenges

Siloed Systems

Lack of Resources

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Social Determinants of Health (SDOH)

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Social Determinants of Health

Z59

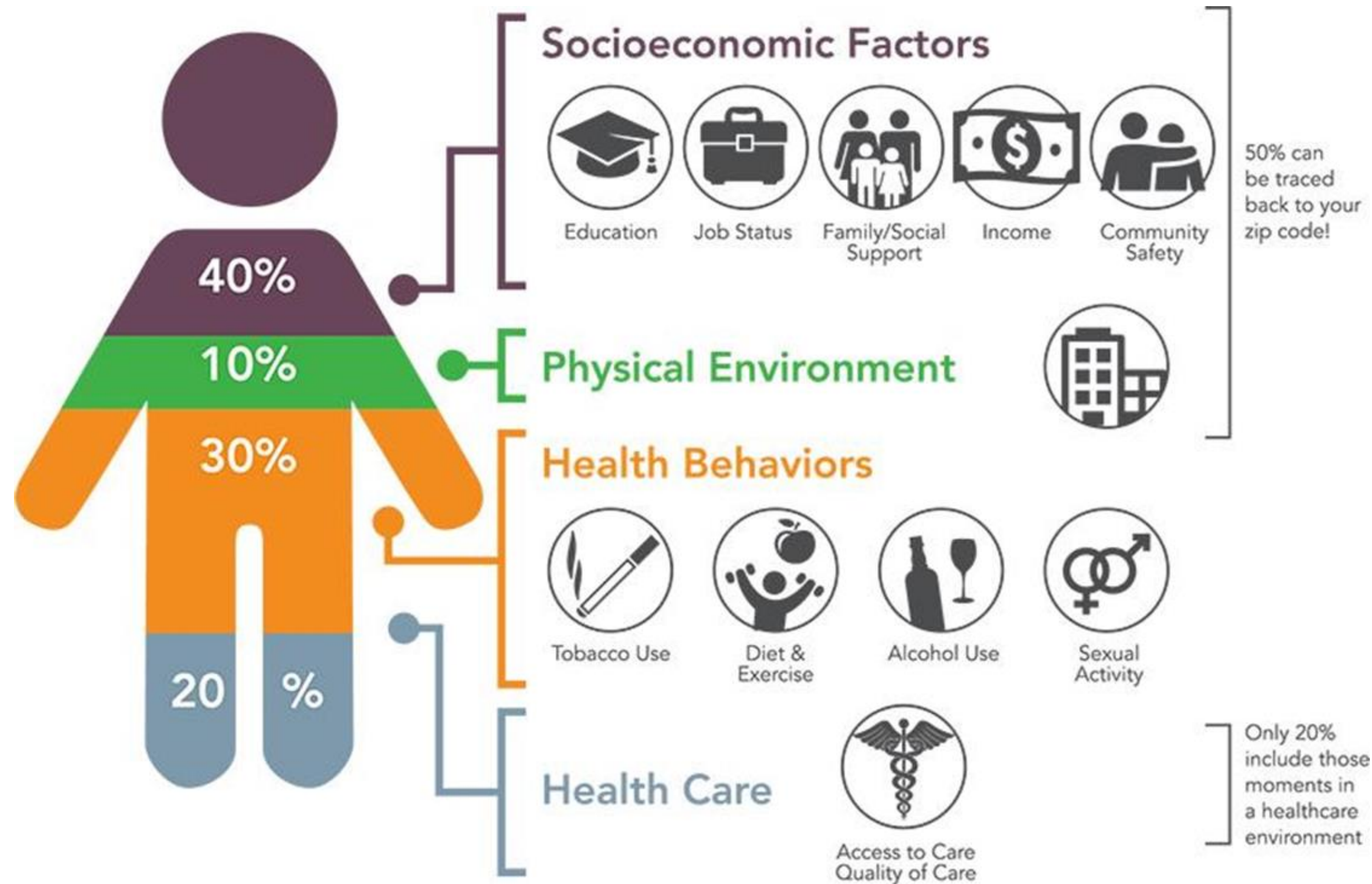
Z55

Z56

Z59.4

Z75

SDOH



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

DC Health Information Exchange (HIE) Snapshot

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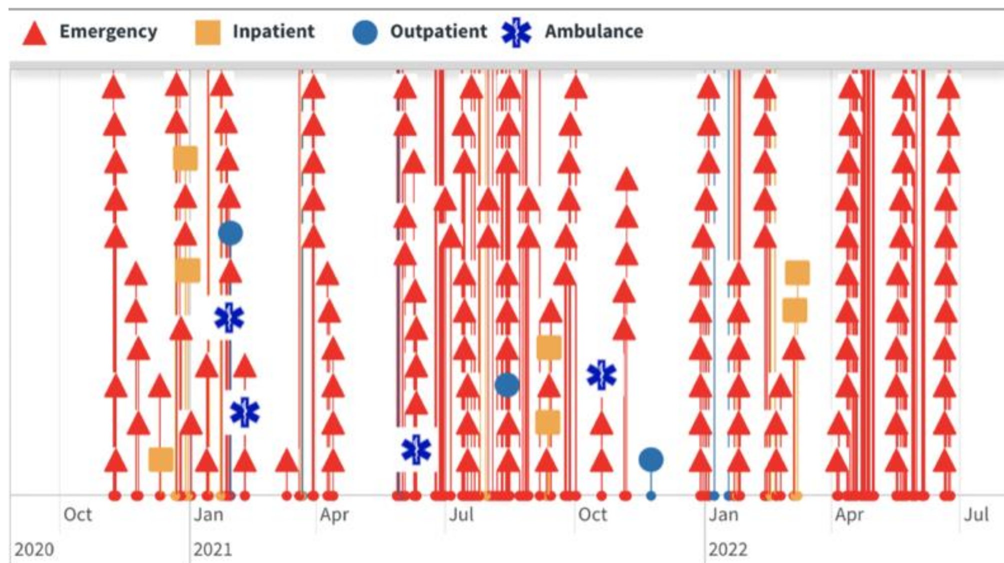
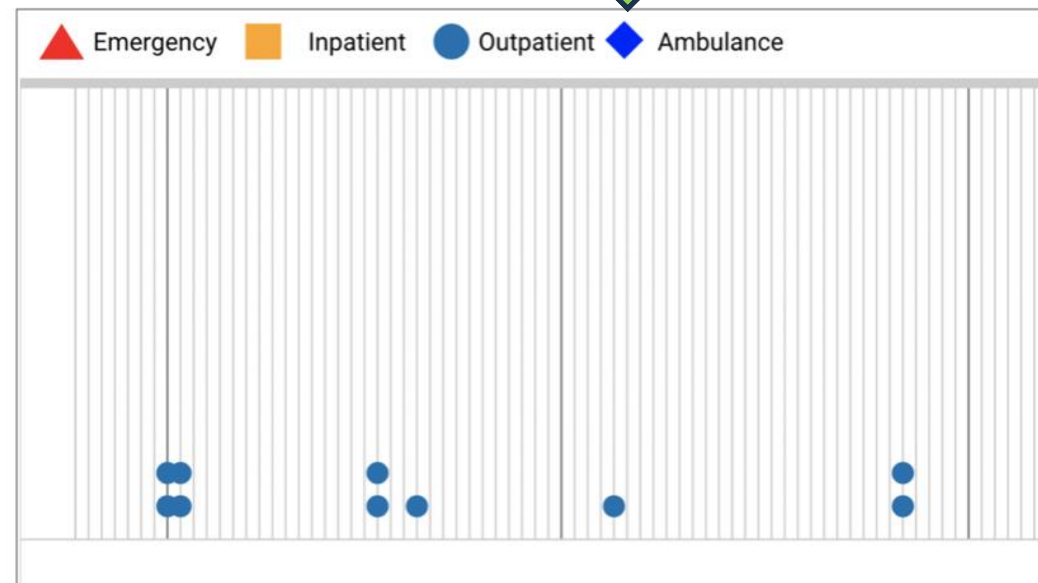
DC HIE Patient Snapshot



No care coordination
- Increased ER visits
- Increased costs
- Poor health outcomes

Care coordination - connected with appropriate resources and services
- Decreased ER visits
- Decreased costs
- Improved health outcomes



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Steps to Achieve Care Coordination

Teamwork

Integrated Care Approach

Continuity of Care

Information Technology (IT) Supported Care Coordination

Care Coordination

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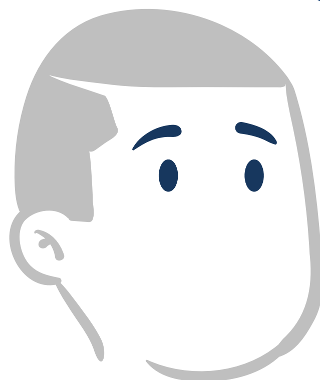
Case Study: Ms. Jane

Jane is a 45-year-old with a history of substance abuse and recent homelessness.

Goal: To achieve sobriety and secure stable housing.

Case Study: Mr. Lee

I hope I can stay in my home.



Mr. Lee is a wheelchair bound 75-year-old with advanced Alzheimer's disease.

Goal: To maintain the highest possible quality of life in a safe, familiar environment.

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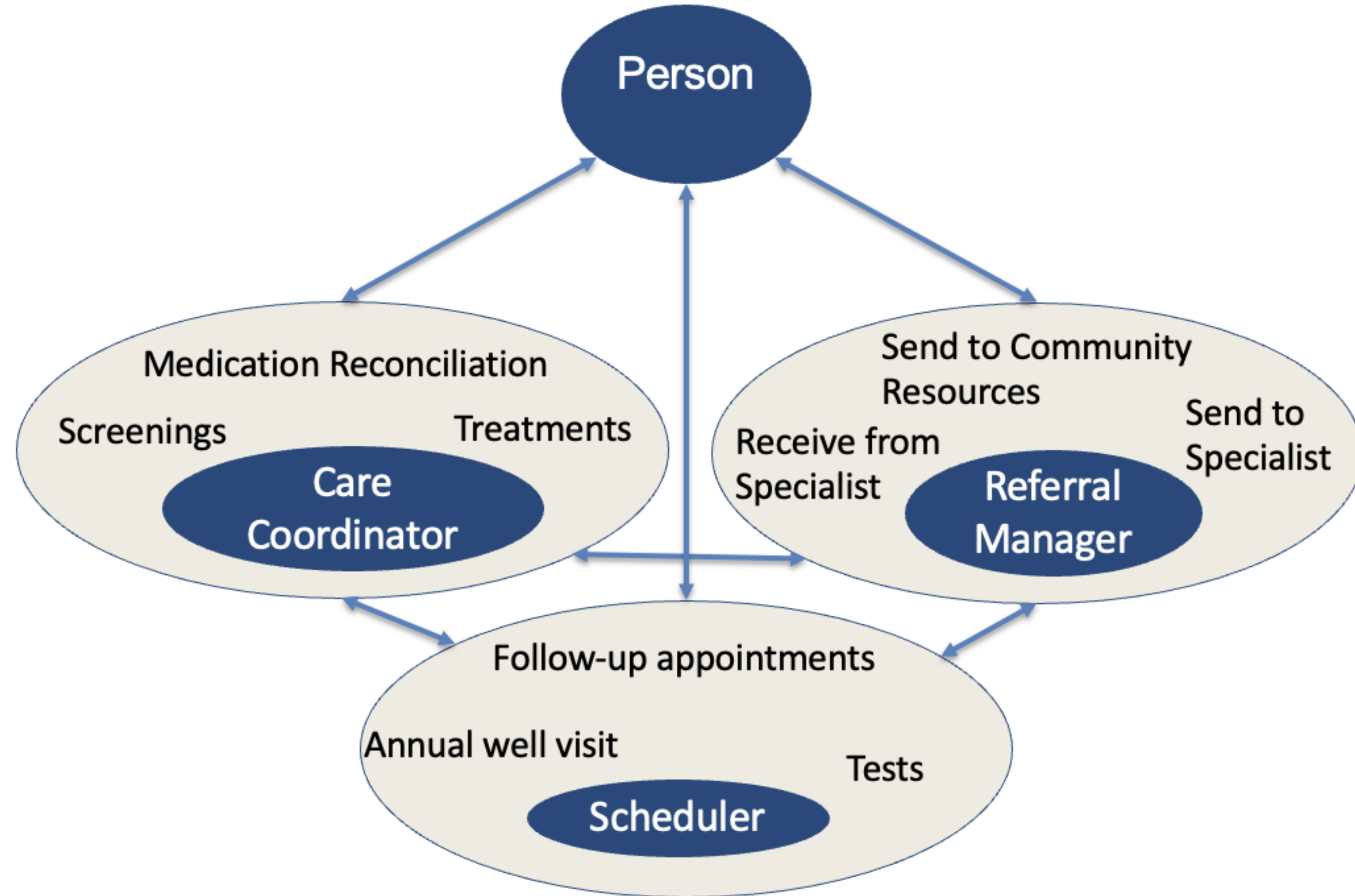
Teamwork

Monitor, Follow-Up & Respond to Change

How Care Coordination is Implemented

Organization Playbook:

Team Huddle



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How Care Coordination is Implemented

Care Plan

Care Alerts

Direct Messaging

Decision Support Tools

EHR

Data

HIE

Encounter Notifications

DC CRISP Encounter Notification System (ENS)

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HIE ADMINS | SEND FEEDBACK | PRODUCT UPDATES | | LOGOUT

HOME | Search Applications & Reports

Reports & Applications

- 2023 eCQMs
- ENS PROMPT
- HIE Admin Tool
- Referral Portal
- Directory
- Community Resource Inventory
- PopHealth Role Manager
- PopHealth

Notifications

New Alerts

Received Time | Newest | Last 90 Days | All Filters | Search MRN or Name

Status: All | 1 - 100 of

Name	MRN	Event Time	Facility	Patient Class	Event Type	Alert Type	Status
Female, 52 years		01/27/2024 10:18 PM	Mercy Medical Center	Emergency	Discharge	ENS ProMPT	Not Started
Male, 25 years		01/27/2024 10:08 PM	UM UMMC Midtown Campus	Emergency	Discharge	ENS ProMPT	Not Started
Male, 62 years		01/27/2024 10:07 PM	MedStar Washington Hospital Center	Emergency	Registration	ENS ProMPT	Not Started
		01/27/2024	Johns	Emergency	Discharge	ENS	Not Started

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DC CRISP Encounter Notification System (ENS)

AdvancedMD EHR & PM | Home | Chart | Modules | Reports | Tools | Admin | Web Links | Help | Back to Classic

Patients | Dashboard | × CIE Inbound

Inbound Clinical Information Exchange 131

Filter by: Source Provider or patient name

Date	Source		DOB	Sender	Type
11/30/2023 04:22 PM			09/09/1951		
11/30/2023 04:22 PM			09/09/1951		
11/30/2023 10:23 PM			09/09/1951		
12/01/2023 05:49 AM			09/09/1951		
12/01/2023 05:49 AM			09/09/1951		
12/04/2023 09:47 AM			07/30/1953		
12/04/2023 01:04 PM	CRISP ENS Encounter Notification	,		ens@ens.hdirect.net	Direct
12/29/2023 05:39 AM	CRISP ENS Encounter Notification	,		ens@ens.hdirect.net	Direct
01/01/2024 08:38 AM	CRISP ENS Encounter Notification	,		ens@ens.hdirect.net	Direct
01/03/2024 04:15 PM	CRISP ENS Encounter Notification	,		ens@ens.hdirect.net	Direct
01/07/2024 02:04 PM	CRISP ENS Encounter Notification	,		ens@ens.hdirect.net	Direct
01/08/2024 02:07 AM	CRISP ENS Encounter Notification	,		ens@ens.hdirect.net	Direct
01/08/2024 04:47 PM			01/20/1926		
01/09/2024 01:50 AM			01/06/1945		
01/10/2024 11:31 PM	CRISP ENS Encounter Notification	,		ens@ens.hdirect.net	Direct
01/11/2024 08:13 AM	CRISP ENS Encounter Notification	,		ens@ens.hdirect.net	Direct
01/12/2024 01:43 AM			06/30/1955		
01/12/2024 10:00 AM					
01/13/2024 06:47 AM	CRISP ENS Encounter Notification	,		ens@ens.hdirect.net	Direct
01/14/2024 01:19 AM	CRISP ENS Encounter Notification	,		ens@ens.hdirect.net	Direct
01/19/2024 04:42 PM			06/30/1955		
01/19/2024 06:27 PM			09/28/1953		
01/20/2024 01:55 AM			05/08/1966		
01/20/2024 09:14 PM	CRISP ENS Encounter Notification	,		ens@ens.hdirect.net	Direct
01/21/2024 03:37 AM	CRISP ENS Encounter Notification	,		ens@ens.hdirect.net	Direct
01/24/2024 01:11 PM			11/09/1966		
01/25/2024 01:23 PM	CRISP ENS Encounter Notification	,		ens@ens.hdirect.net	Direct
01/26/2024 08:38 PM			09/09/1951		

Open | Dismiss

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Continuity of Care

Facilitate Transitions

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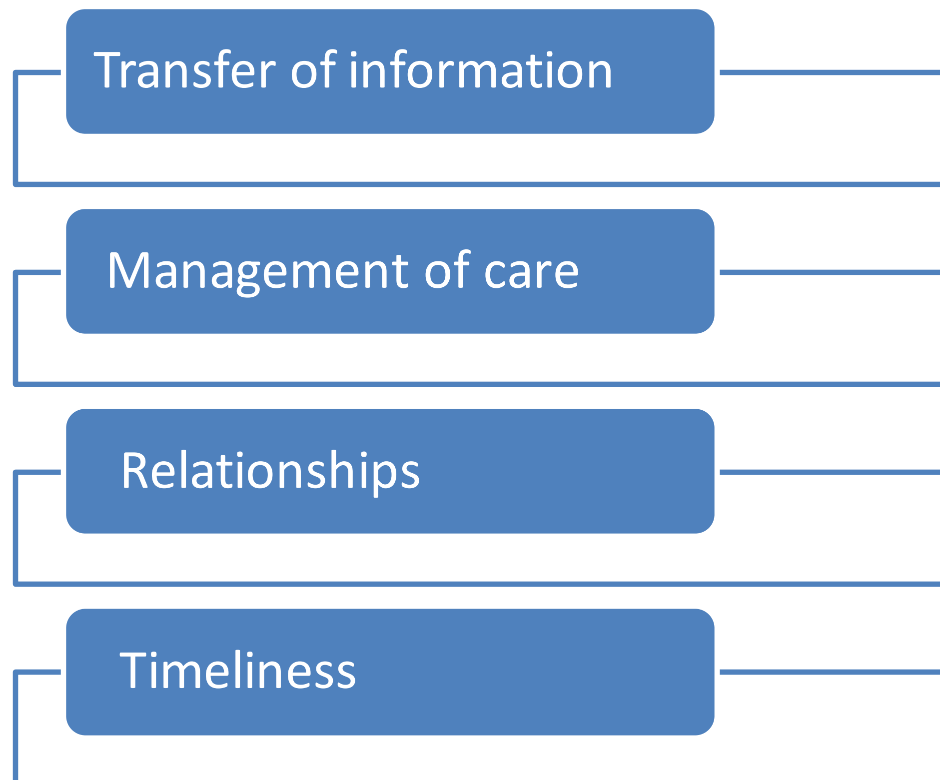
Continuity of Care

Consistent and cohesive provision of services to individuals over time that emphasizes the seamless transition between different providers, settings, and levels of care to ensure comprehensive, consistent and uninterrupted care as needed



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Transitions

AHRQ --

*"Transitions occur when information about or accountability for some aspect of a patient's care is transferred between two or more health care entities **OR** is maintained over time by one entity. "*

Between entities of the healthcare system.

Over time.

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Care Transitions

Transitions between entities

- Among members of one care team
- Between care teams
- Between caregivers
- Across care settings

Transitions over time

- Between episodes of care
- Across lifespan
- Across trajectory of illness and changing levels of coordination need

DC Department of Disability Services

Transition of Care Guide

A Guide for Community Support Providers to Facilitate Safe Transitions from the Hospital or Long Term Care Facility to Home

The following questions are provided to assist community support providers, service coordinators, and health care decision makers in obtaining the information needed to promote safe health care transitions from the hospital or long term care facility to the home setting for individuals with developmental disabilities.

- **Health Conditions**
- **Discharge Instructions**
- **Medications**
- **Home Staffing Needs**
- **Follow-Ups**
- **Behavioral Supports**

https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/Transition%20of%20Care%20Guide_1.pdf

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DC HIE ENS Notification

| Male |

ED Patient Summary

Provider: MedStar Washington Hospital Center

Date Collected: 2024-01-26

Follow Up Instructions
You must call each Provider to make/verify your appointment.
PHYSICIAN/PROVIDER DETAILS
Please follow-up with your Methadone Clinic to do graduate decrease in methadone dosing. If you are unable to work with the Methadone Clinic, then go to PIW. If neither of these options work, you can contact MWHC Pyschiatry or Unity Health Care. When: Within 1 to 2 days

Psychiatry(Outpatient) When: Within 1 week
Address: 216 Michigan Ave. NE
Washington DC 20017
(202)877-6333(Ph)
Comments: Call for followup appointment

Unity Health Care When: Within 1 week
Address: no address

(202)469-4699(Ph)
Comments: Call for followup appointment

Referral for Transition of Care

AdvancedMD EHR & PM   Home   Chart   Modules   Reports   Tools   Admin   Web Links   Help   Back to Classic

Patients   Dashboard   × CIE Outbound

Generate Outbound Clinical Document

Patient search: **Search** 3 patients in selection list.

Select Patient:

Send to: *No Destination Selected*

CDA Typ ✓ - - -   Start Date   End Date 01/28/2024

- Referral/Transition of Care
- VDT Ambulatory Summary
- Clinical Summary

Please select a provider or leave blank to only print the document and select a CDA type

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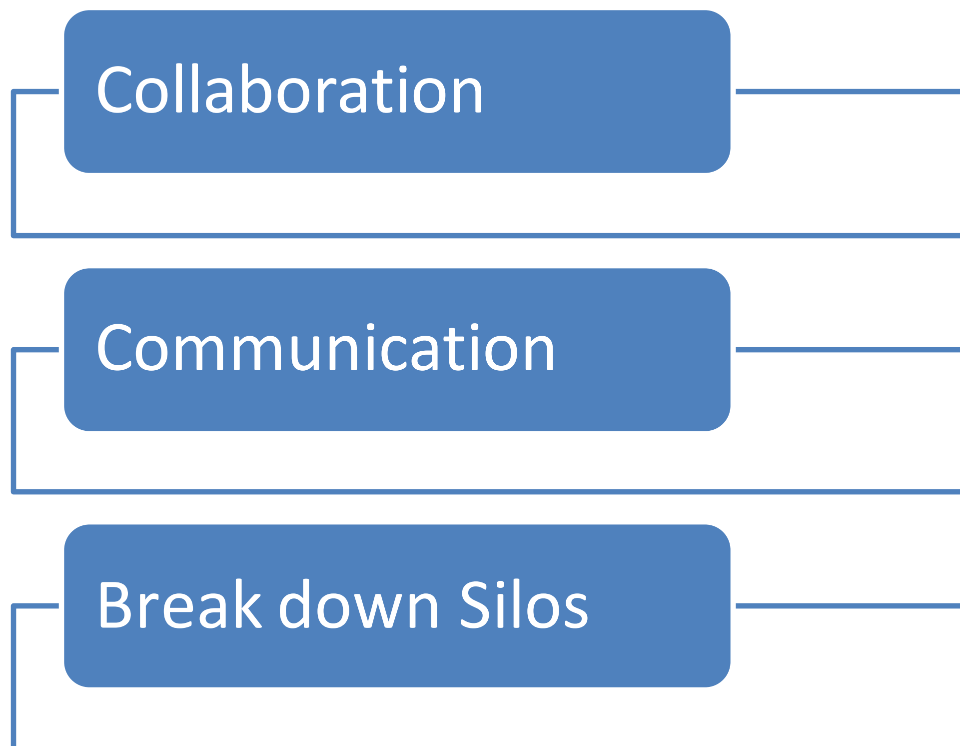
Integrated Care Approach

Integrated Care Approach

Comprehensive approach to whole person care across the spectrum of services to provide more coordinated, patient-centered and effective care that addresses the complex needs of individuals across their continuum of care



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2024 CMS Innovation in Behavioral Health (IBH) Model

Innovation in Behavioral Health (IBH) Model: Delivering Coordinated, Whole-Person Care 2024-2032

Julia's Journey with IBH

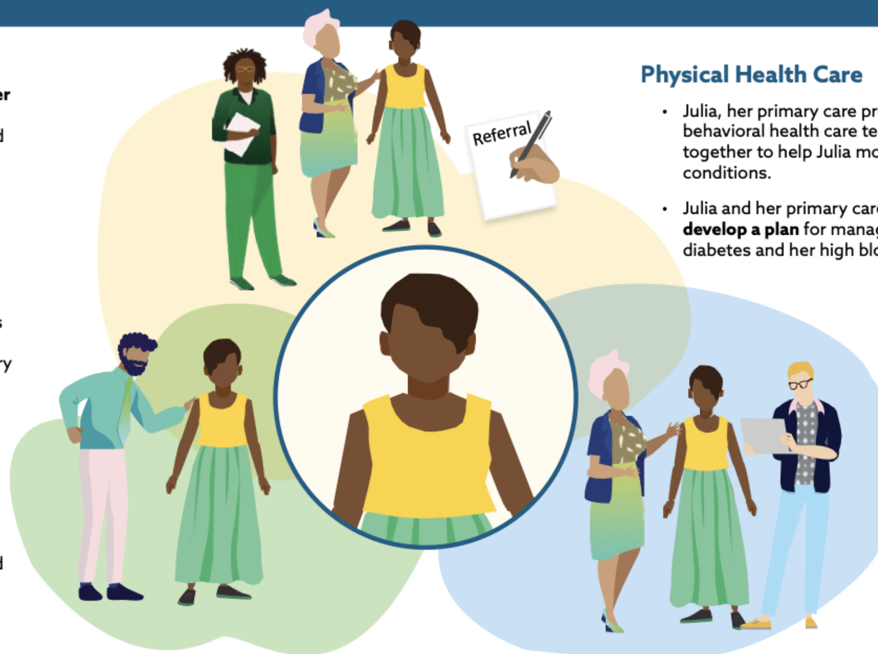
Julia is living with bipolar disorder and opioid use disorder, high blood pressure, and diabetes. She has a trusted relationship with her behavioral health provider, who is participating in the IBH Model. As part of IBH, her behavioral health provider puts together a care team to address Julia's behavioral, physical, and social needs.

Behavioral Health Care

- Julia visits her **behavioral health provider** and they talk about how managing her bipolar disorder, opioid use disorder, and diabetes has become overwhelming.
- Her behavioral health provider performs a routine physical health screening and assesses health-related social needs such as food security, employment and housing status.
- Her behavioral health provider convenes a **care team** that includes a case manager, peer-support advocate, primary care provider, and a community social services organization. Julia and her care team create a plan that fits Julia's needs and preferences.

Community Support

- A community organization assists with Julia's health-related social needs by helping her sign up for a healthy food program to better manage her diabetes and high blood pressure.
- Julia's case manager also helps to connect her with resources.



Physical Health Care

- Julia, her primary care provider, and behavioral health care team work together to help Julia monitor her conditions.
- Julia and her primary care provider **develop a plan** for managing her diabetes and her high blood pressure.

Julia's Outcomes under the IBH Model

Julia has a care plan that fits her needs and preferences. As a result, she feels less overwhelmed. She feels respected and heard by her care providers. She is eating healthier, feels more confident in managing her bipolar disorder and opioid use disorder, and her diabetes and high blood pressure are now under control.

https://www.cms.gov/priorities/innovation/innovation-models/innovation-behavioral-health-ibh-model

DC Community Resource Inventory (CRI)

The DC Community Resource Inventory (CRI) is a District-wide, publicly available directory that provides information about regional health, human, and social programs and organizations in the community that are available to District residents.

https://dc.openreferral.org/

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CRI Categories

Browse by Category

Care

Emergency

Goods

Housing

Money

Work

Education

Food

Health

Legal

Transit

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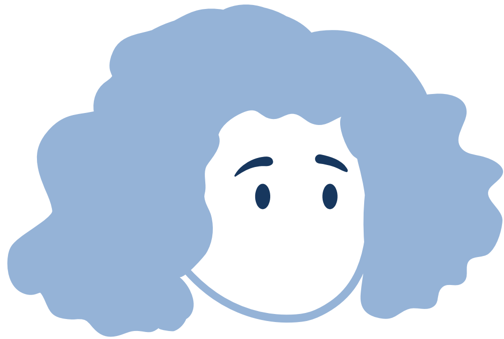
Integrated Care Planning: Ms. Jane

Welcome!
How can we help?



PLAN

- Enroll in a residential treatment program for substance abuse
- Schedule counseling sessions for behavioral health support
- Connect with a local housing authority to secure long-term housing
- Connect with a job support program for employment and/or training

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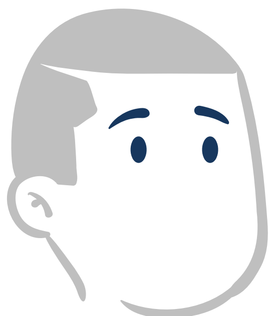
Integrated Care Planning: Mr. Lee

I am here to help you with your daily activities.



PLAN

- Connect with In-home support services
- Enroll in an adult day care program that specializes in dementia care
- Connect family caregivers to support groups and respite care services

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Information Technology (IT) Supported Care Coordination

Consent to Share Information in CRISP

- DC is an **opt-out** district
- Check EHR settings to ensure data is being sent to the HIE
  - Some EHRs have a workflow that require staff to 'activate' sending data to the HIE at the patient level
  - Other EHRs can be defaulted to send patient data to the HIE
- Most agencies are connected and sending data to the HIE automatically, **UNLESS** there is 42CFR Part 2 Sensitive Data
  - 42 CFR part 2 data is sent to CRISP's sensitive repository until the provider completes the **Consent Tool within CRISP** which requires consumer consent
  - A patient can ask a provider or care team member to disable their consent to share data to the HIE at any time

What is 42 CFR Part 2?

- 42 CFR Part 2 is a federal regulation that was created to protect a patient's SUD treatment data.
  - It ensures patient confidentiality while also creating ways for their data to be exchanged to enhance overall care.
- "Part 2" refers to federally assisted programs who provide SUD treatment and meet the definition of a "program" under 42 CFR 2.11
  - This regulation protects information, in any form, that could directly or indirectly identify a patient has having sought or received SUD treatment from a Part 2 program.
  - **NOTE**: Not all SUD treatment providers will fall under this definition. SUD provider ≠ Part 2 provider

CRISP Consent Tool for 42CFR Part 2 Data Sharing

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CRISP DC

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Search Applications & Reports

This query portal is for authorized use only. By using this system, all users acknowledge notice of, and agree to comply with, CRISP-DC's Participation Agreement ("PA") and CRISP-DC Policies and Procedures. Click here to review the policies and procedure. CRISP-DC uses a privacy monitoring tool to ensure all users are adherent to an approved policy or use case. By continuing to use this system you indicate your awareness of and consent to these terms and conditions of use.

Patient Search

First Name *

Last Name *

Date of Birth *

Gender

SSN

Reset

Search

Search Results

First Name	Last Name	Date of Birth	Gender	Address	Match Score
			Male		

Select App

Clinical Information

Consent Tool

Referrals

Snapshot

For applications requiring patient context, please start by using the Patient Search interface above.

CRISP Consent Tool for 42CFR Part 2 Data Sharing

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HOME | Search Applications & Reports

Reports & Applications

- 2023 eCQMs
- ENS PROMPT
- HIE Admin Tool
- Snapshot
- Referral Portal
- Directory
- Community Resource Inventory
- PopHealth Role Manager
- PopHealth
- Consent Tool

CRISP DC | Consent | Consent History

Patient Consent to Disclose Substance Use Disorder (SUD)Treatment Information

Next

Patient Details

Name (First/Middle/Last)
Date of Birth (mm/dd/yyyy)
Address
City
State
Zip
Phone

Information about this Consent

By completing and signing this form, you will be allowing your Substance Use Disorder treatment provider to share information about your Substance Use Disorder treatment with the Health Information Exchange who will then share it with other members of your health care team. These could include your primary care provider, hospital providers, emergency providers and other individuals who are involved in coordination of your care. The information will be shared with your treatment providers who participate with the CRISP Shared Services affiliate Health Information Exchanges (HIEs) including Maryland, DC, West Virginia, Connecticut, Alaska and any HIE affiliates in the future. These providers must adhere to all state and federal law with regards to keeping your information private. You can request a list of providers who have received your information by completing an accounting of disclosures requests at https://disclosures.crisphealth.org. A list of Frequently Asked Questions (FAQ) about sharing Substance Use Disorder treatment data through CRISP can be found here and at https://crispdc.org/consent/.

Consent to Disclose My Substance Use Disorder Treatment Information

What should I see in the HIE?

Clinical Summary (December 27, 2023, 1:20:10PM -0500)

Patient	Date of Birth: N (38yr)Gender: F Patient-ID:
Race	White
Ethnicity	Not Hispanic or Latino
Language Communication	, no information, preferred: no
Contact Details	Home Primary: 7
Documentation Of	Care provision, **Date/Time:** from June 20, 2018, 6:09:54PM -0400 to December 27, 2023, 1:20:10PM -0500, **Performer:**
Author	CDA Document Generator, **Organization** 1 3), **Authored On:** December 27, 2023, 1:20:10PM -0500

What should I see in the HIE?

Table of Contents

- Conditions or Problems
- Medications
- Medications Administered
- Allergies, Adverse Reactions, Alerts
- Results
- Plan of Care
- Procedures
- Vital Signs

Conditions or Problems

Problem Name	Problem Code	Onset Date	Status	Entry Date	Provider	Comment	Standard Description	Annotate
HEAD LICE	81000006 (SNOMED CT)	2023/12/25	Active	2023/12/25			Pediculosis capitis	
INSOMNIA	193462001 (SNOMED CT)	2022/02/20	Resolved	2022/02/20			Insomnia	
SUICIDAL IDEATION -- SUICIDE PRECAUTION	R45.851 (ICD-10-CM)	2023/08/15	Resolved	2023/08/15			Suicidal ideations	

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What should I see in the HIE?

Medications

Medications Administered

Allergies, Adverse Reactions, Alerts

Allergy Name	Reaction Description	Start Date	Severity	Status	Provider
NKDA		2018/06/20	Mild		[redacted]

Results

Date	Name	Value	Unit	Range	Flag	Description
HIV Screening: HIV Questions/Pre/Post						
2018/06/20	HIVRAPIDRSLT	Negative				HIV 1+2 Ab [Presence] in Unspecified specimen by Rapid immunoassay
Transfer: Intrasystem Transfer Screening Form						
2018/06/20	RPR TITER	pending				rapid plasma reagin antibody titer

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What should I see in the HIE?

Plan of Care

Procedures

Code	Procedure Name	Date	Entry Date
012005	RPR	2023/11/29	2023/11/29
183194	Chlamydia / Gonococcus, NAA	2023/11/29	2023/11/29
139900	2019 Novel Coronavirus (COVID-19), NAA	2023/08/03	2023/08/03

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Uploading Patient Panels to the HIE

- Patient Panel uploads ensure the HIE has the most up-to-date information on an organization's patient/client population
  - Ensure your organization has a process in place to regularly remove patients that have been discharged from your care or are inactive to keep your panels up to date
  - Keeping patients on your panels/not discharging them from care in a timely manner will cause providers to keep seeing ENS notification in the HIE about them when they are no longer being treated there
- SUD and MHRS + SUD orgs still must manually upload panels
- Patient panels must be sent to CRISP every 90 days
  - CRISP offers an auto-subscription service that automatically pull these panels into the HIE from your EHR

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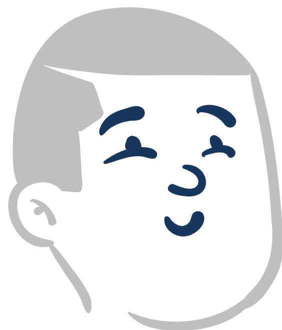
Outcomes: Ms. Jane and Mr. Lee

OUTCOME

After 6 months, Ms. Jane successfully completed the rehabilitation program, moved into stable housing and found part-time employment. Regular check-ins and adjustments to her care plan were crucial in addressing emerging challenges and supporting her recovery journey.



OUTCOME

Home Support Services allowed Mr. Lee to remain in his home, surrounded by familiar settings and faces. His participation in a specialized dementia day program helped slow the progression of his symptoms and allowed needed respite for his caregivers.

Questions?

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Upcoming eHealthDC Trainings

Training (All occur 12 PM – 1:30 PM ET)	Date	Training Type
Security and Privacy	Friday, March 15, 2024	EHR
Best Practices for Improving EHR Data Quality	Friday, March 22, 2024	EHR
Best Practices for Improving EHR Data Quality	Tuesday, March 26, 2024	EHR
eHealth DC Learning Community	Thursday, March 28, 2024	EHR

Training (All occur 12 PM – 1:30 PM ET)	Date	Training Type
I’m Connected to the HIE, Now What?	Wednesday, March 13, 2024	HIE
PopHealth/Analytics	Tuesday, March 19, 2024	HIE
Social Needs Screening Tool	Wednesday, March 27, 2024	HIE