eHEALTHDC
A DISTRICT OF COLUMBIA PRIMARY CARE ASSOCIATION PROGRAM

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

DCPCA
DISTRICT OF COLUMBIA PRIMARY CARE ASSOCIATION

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

July Learning Community:

Enhanced Care Coordination

eHealthDC Learning Community Objective

The eHealth DC Milestone 8 learning communities are designed to promote knowledge sharing amongst participants and will require ongoing interaction and active participation among attendees.

Learning Community Expectations

- **Full Participation** (Required): Attendees are required to be present for the entire duration of the Learning Community. Note that facilitators will be soliciting reactions and responses to discussion topics from all participants.

- **Interactive Contribution** (Required): Actively contribute to the Learning Community through chat or audio interactions. Your insights and questions contribute to the collective learning experience.

- **Camera Presence** (Strongly Encouraged): We encourage attendees to turn on their cameras for a more interactive and engaging experience. While it's not mandatory, having your camera on enhances the sense of community and connection.

How to Engage

- Use **CHAT** to share comments and questions with group

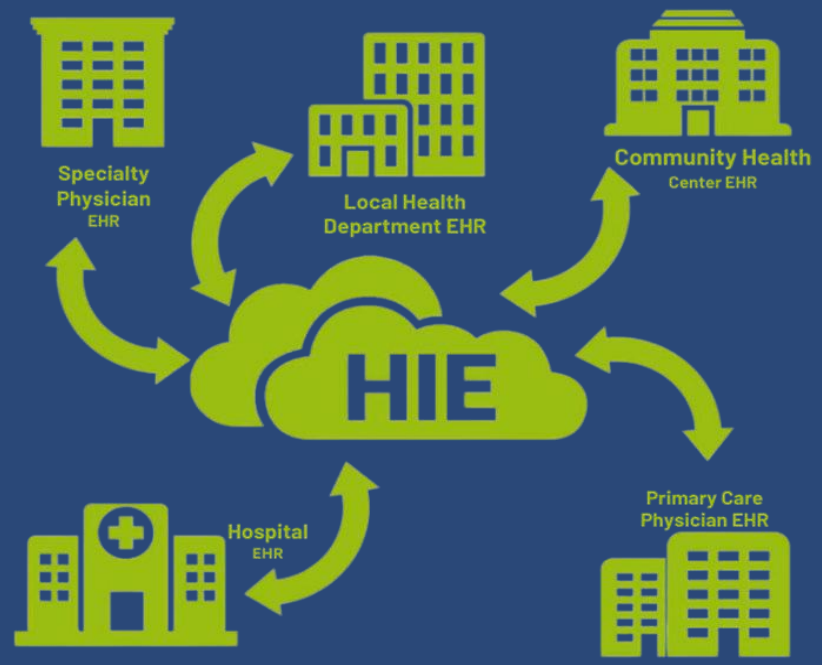
- Use **RAISE HAND** function to be queued up for commenting/ unmuting and share your comments with the group

Agenda

- Welcome and Objectives
- Fostering Collaboration: What can you send outbound from your EHR to the HIE?
- Refining Referrals: Utilizing Care Alerts and the Provider Directory
- Registering Part 2 Consent: Understanding the value of Registering Part 2 Consent via the CRISP DC Consent Tool
- Cohort Specific Breakout Room Sessions
- Wrap Up, Milestone 8 Announcements & Resources

Fostering Collaboration

What can you send outbound from your EHR to the HIE?

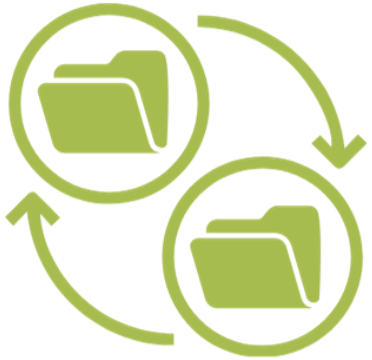


What can you send outbound from your EHR to the HIE?

- The HIE enables organizations to establish care team relationships and communicate actionable information related to their patient population.
  - **Care Team Relationships**
    - Care Managers
    - Care Programs
  - **Care Alerts**
    - Communicate important events or changes in a patient's condition
  - **Health Related Social Needs**
    - Z-Codes capture information related to social determinants of health
      - Problems related to housing and economic circumstances
        - Z59.0-Homelessness
        - Z59.01-Sheltered Homelessness
        - Z59.02- Unsheltered Homelessness
        - Z59.41-Lack of adequate food
        - Z59.81-Housing instability
        - Z59.86-Financial insecurity
        - Z59.82-Transportation insecurity

Transmission of Pertinent Patient Details

- CRISP-DC Participants can utilize their Patient Panel or ADT Connectivity to establish care team relationships
    - Care Managers
    - Care Programs
    - Primary Care Provider
- ADT Connectivity enables organizations to leverage Auto-Subscription which automatically updates an organization's patient panel. Auto-Subscription is only available for non 42-CFR Part II attested organizations
- Organizations that attested to providing Substance Use Disorder Treatment services would need to submit manual patient panels to establish care team relationships
- Health Related Social Needs Z-Codes can be contributed via ADT and CCD Data feeds. There are also manual approaches CRISP-DC has created to support sharing of Health Related Social Needs Screening



Refining Referrals

Utilizing Care Alerts and the Provider Directory

Care Alerts Overview

- **Care alerts are free-text electronic notes** used to communicate actionable, 'need-to-know' information **for high-risk patients** to all care team members at the point of care
- **Structure of Care Alerts**: While being brief, consider which of these are most crucial:
  - Key Health Concerns
  - Key Issues
  - Actions for Consideration
  - Barriers to Care
  - Contact Information for Key People
  - Enrollment in any Care Programs
- **Sending Care Alerts**:
  - Care alerts can be sent manually via Patient Panels in ***column AQ (Care_Alert)*** and must include appropriate Assigning Authority Code in ***column AR (Assigning_Authority_Code)***
  - Alternatively, Care Alerts can be shared through Continuity of Care Document (CCD) integrations
    - Care alerts should be documented in the Problem List Section, specified by LOINC code 11450-4

Care Alerts Use Pre-Worksheet Results

13. How often does your organization utilize the Care Alerts feature within CRISP's Clinical Information App Care Coordination tab?

More Details

Always (daily)	3
Sometimes (1-3 times within 2 ...	12
Rarely (monthly)	8
Never	5
Unsure	12

Care Alerts Scenario: Contributing Care Alerts

C	D	E	F	G	H	I	J	K	L	M	N
ent_ID	First_Name	Middle_Name	Last_Name	Name_Suffix	Address_1	Address_2	City	State	Zip	Birthdate	Gender
999999	Gretchen		Martin_Demo		33 main st	apt 45	baltimore	MD	21230	6/1/2002	F
000000	Jane	K	Doe		34 main st	apt 46	baltimore	MD	21230	12/31/1900	F

AM	AN	AO	AP	AQ	AR
DirectEmail	DocHaloID	Follow Up Date	Appointment Missed Date	Care_Alert	Assigning_Authority_Code
abc@ainq.direct.org	123456			**Patient is experiencing Homelessness (Z59. 00). Please contact our Licensce Clinical Social Worker Jane Smith at jane.smith@abcclinic.org or 202-111-1234**	**ENS_CRISP**
def@ainq.direct.org	456789			**Patient currently has 2 or more chronic conditions and is eligible for comprehensive care management, care coordination, Health Promotion, and Comprehensive Transitional care/follow-up. Please our care manager at 202-123-1235**	**ENS_CRISP**

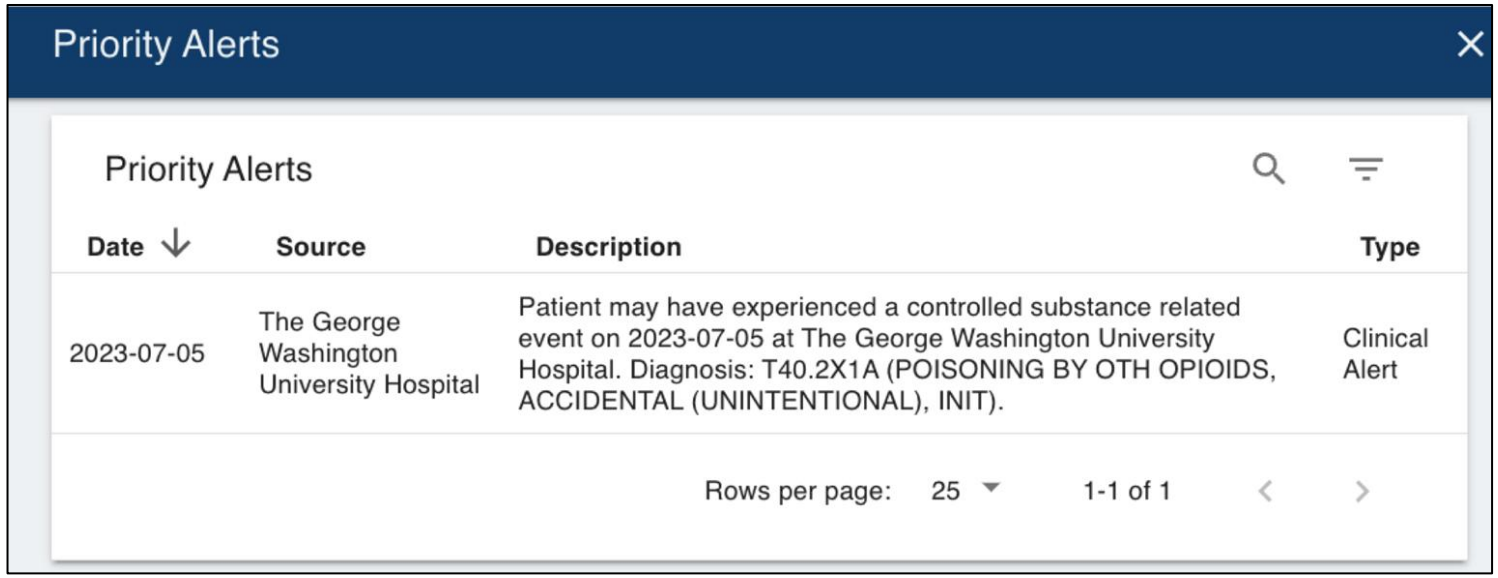
AQ: Care_Alert

AR: Assigning_ Authority_Code

1. Care Coordinators work with their clinical team to identify High Risk Patients that require enhanced Coordination
2. Care Managers work with with their organizations panel manager to add care alerts in their patient panel
3. The organization uploads their panel, enabling CRISP to process and display contributed care alerts within the Clinical Information app

Care Alerts Scenario: Retrieving Care Alerts

Screenshot of Care Alert displayed in Clinical Information App



3. A Care Coordinator monitoring a recent discharge searches for the patient within the Clinical Information App

4. The care coordinator finds a priority alert contributed by a local hospital

5. After reviewing the priority alert, the care coordinator can determine appropriate steps for follow up and or referral

Care Alerts: Next Steps

1

Schedule a meeting with CRISP DC by contacting dcoutreach@crisphealth.org

- CRISP DC's Account Managers will respond and coordinate a meeting

2

CRISP DC's Account Managers will review options for submitting Care Alerts via:

- Manual Patient Panel Entry
- Automated submission via CCD integration

3

CRISP DC's Account Managers discuss how care alerts are processed and how to resolve issues

Provider Directory Overview

- **What is the goal or purpose of the Provider Directory?**
  - The goal of the provider directory is to enhance care patient care coordination and ensure smooth transitions of care across the District and beyond
- **How do I use it?**
  - Free Text- CRISP DC Users can look for other organizations or practitioners by
    - Name, specialty, zip-code
  - Structured Search
    - Refine query in more detail, such as to yield all cardiologists in a specific zip-code, i.e “Cardiology 20020”
- **What is the best way to manage personal data?**
  - The directory is being constantly updated from multiple data feeds
  - CRISP-DC participants can manage their own information within the Provider Directory Application

Provider Directory Use Pre-Worksheet Results

15. How often does your organization utilize the CRISP Provider Directory in CRISP?

More Details Insights

Always (daily)	1
Sometimes (1-3 times within 2 ...	9
Rarely (monthly)	16
Never	5
Unsure	9

Provider Directory Demo

Registering Part 2 Consent (eConsent)

Understanding the value of registering Part 2 Consent via the CRISP DC Consent Tool

Provider eConsent Use Pre-Worksheet Results

16. My organization has consented to patients sharing their substance use disorder data with their other care team members through the DC HIE.

More Details

Yes	8
No	16
Unsure	16

Value of Registering Part 2 Consent

- The CRISP DC Consent Tool allows for the release of 42 CFR Part 2 covered data from the DC HIE's sensitive data repository.
- Non-SUD providers may not have full insight into their patient's health record without registering a Part 2 consent.
- Registering a Part 2 consent for your patient allows you and other members of the patient's care team to see data related to the patient's SUD treatment within CRISP DC.
- The registered Part 2 Consent offers the patient's care team a more holistic view of the patient's health record, as well as assisting with enhanced care coordination.

District Priorities for Addressing Opioid Crisis

- Live Long DC is the District of Columbia's plan to reduce opioid use, misuse, and related deaths.
  - From 2017 to 2022, approximately 72% of all fatal opioid overdoses occurred among adults between the ages of 40–69 years old, and such deaths were most prevalent among people ages 50–59 (30%).
  - From 2017 to 2023, opioid-related fatal overdoses were most prevalent in Wards 5, 6, 7, and 8, with Ward 8 experiencing the most deaths.
  - Long Live DC's opioid strategy areas include Prevention and Coordination, Harm Reduction, Treatment, and Recovery.

CRISP-DC Organizations can contribute to these coordinated community efforts to address the opioid crisis, by registering Part 2 consents within the HIE Portal.

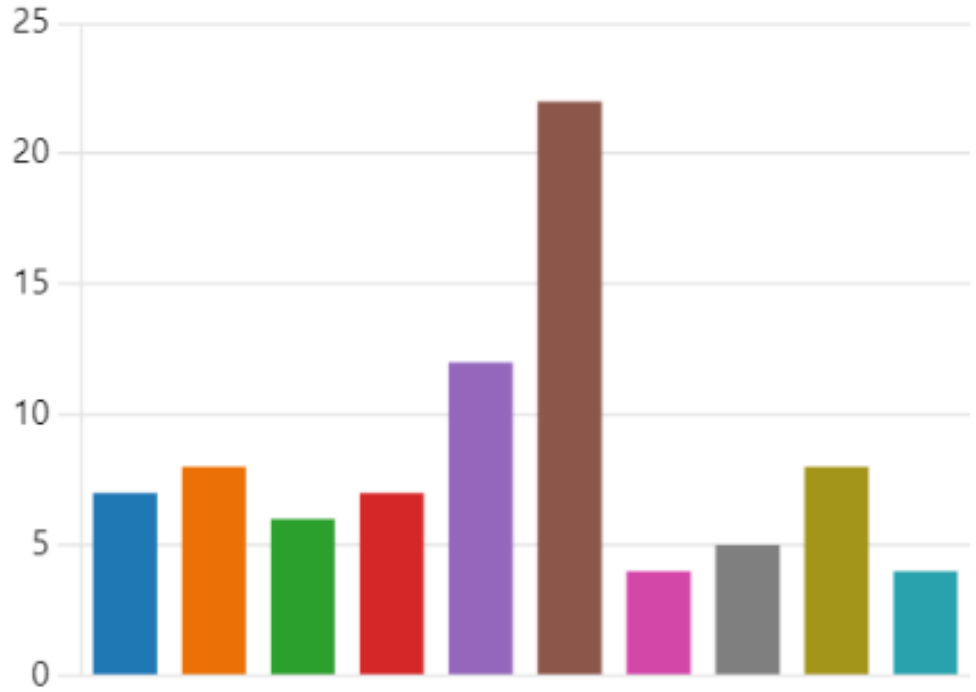
Breakout Session

Pre-Worksheet Results

7. My organization is currently sharing the following with the HIE. (check all that apply)

More Details

Care Alerts	7
Care Plans	8
Members of Care Team	6
Patient Appointment Information	7
Progress Notes	12
Patient Panel	22
Referrals	4
Therapy Notes	5
None	8
Other	4



Pre-Worksheet Results

8. What roles are included as part of your organization's care team that facilitates care coordination/care transition? (check all that apply)

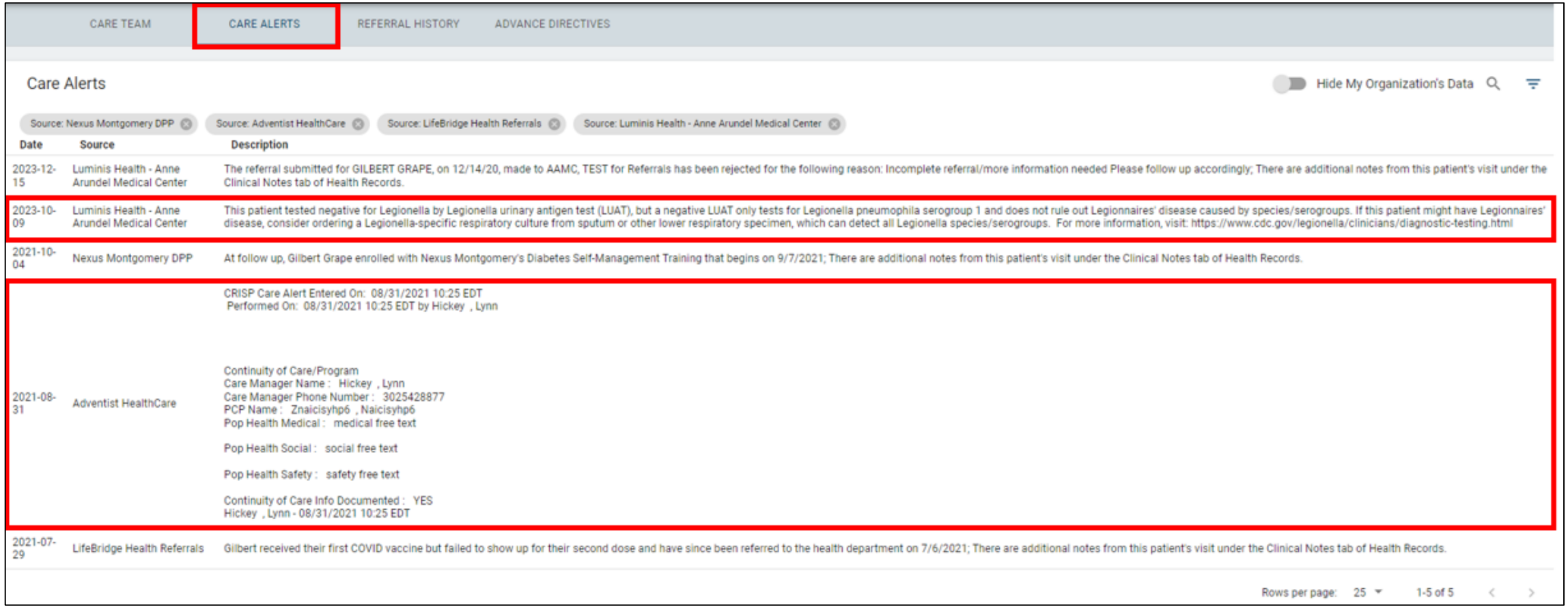
More Details

Care Coordinator	21
Care Manager	20
Peer Navigator	8
Social Worker	16
Other	10

How would you define a high-risk patient for whom you would create a care alert?

What information would be relevant to pull from a care alert based on your role (as a care team member, provider, QI specialist, etc.?)

Breakout Room Discussion: Care Alert Examples



CARE TEAM | CARE ALERTS | REFERRAL HISTORY | ADVANCE DIRECTIVES

Care Alerts

Hide My Organization's Data

Source: Nexus Montgomery DPP | Source: Adventist HealthCare | Source: LifeBridge Health Referrals | Source: Luminis Health - Anne Arundel Medical Center

Date	Source	Description
2023-12-15	Luminis Health - Anne Arundel Medical Center	The referral submitted for GILBERT GRAPE, on 12/14/20, made to AAMC, TEST for Referrals has been rejected for the following reason: Incomplete referral/more information needed Please follow up accordingly; There are additional notes from this patient's visit under the Clinical Notes tab of Health Records.
2023-10-09	Luminis Health - Anne Arundel Medical Center	This patient tested negative for Legionella by Legionella urinary antigen test (LUAT), but a negative LUAT only tests for Legionella pneumophila serogroup 1 and does not rule out Legionnaires' disease caused by species/serogroups. If this patient might have Legionnaires' disease, consider ordering a Legionella-specific respiratory culture from sputum or other lower respiratory specimen, which can detect all Legionella species/serogroups. For more information, visit: https://www.cdc.gov/legionella/clinicians/diagnostic-testing.html
2021-10-04	Nexus Montgomery DPP	At follow up, Gilbert Grape enrolled with Nexus Montgomery's Diabetes Self-Management Training that begins on 9/7/2021; There are additional notes from this patient's visit under the Clinical Notes tab of Health Records.
2021-08-31	Adventist HealthCare	CRISP Care Alert Entered On: 08/31/2021 10:25 EDT Performed On: 08/31/2021 10:25 EDT by Hickey , Lynn Continuity of Care/Program Care Manager Name : Hickey , Lynn Care Manager Phone Number : 3025428877 PCP Name : Znaicisyhp6 , Naicisyhp6 Pop Health Medical : medical free text Pop Health Social : social free text Pop Health Safety : safety free text Continuity of Care Info Documented : YES Hickey , Lynn - 08/31/2021 10:25 EDT
2021-07-29	LifeBridge Health Referrals	Gilbert received their first COVID vaccine but failed to show up for their second dose and have since been referred to the health department on 7/6/2021; There are additional notes from this patient's visit under the Clinical Notes tab of Health Records.

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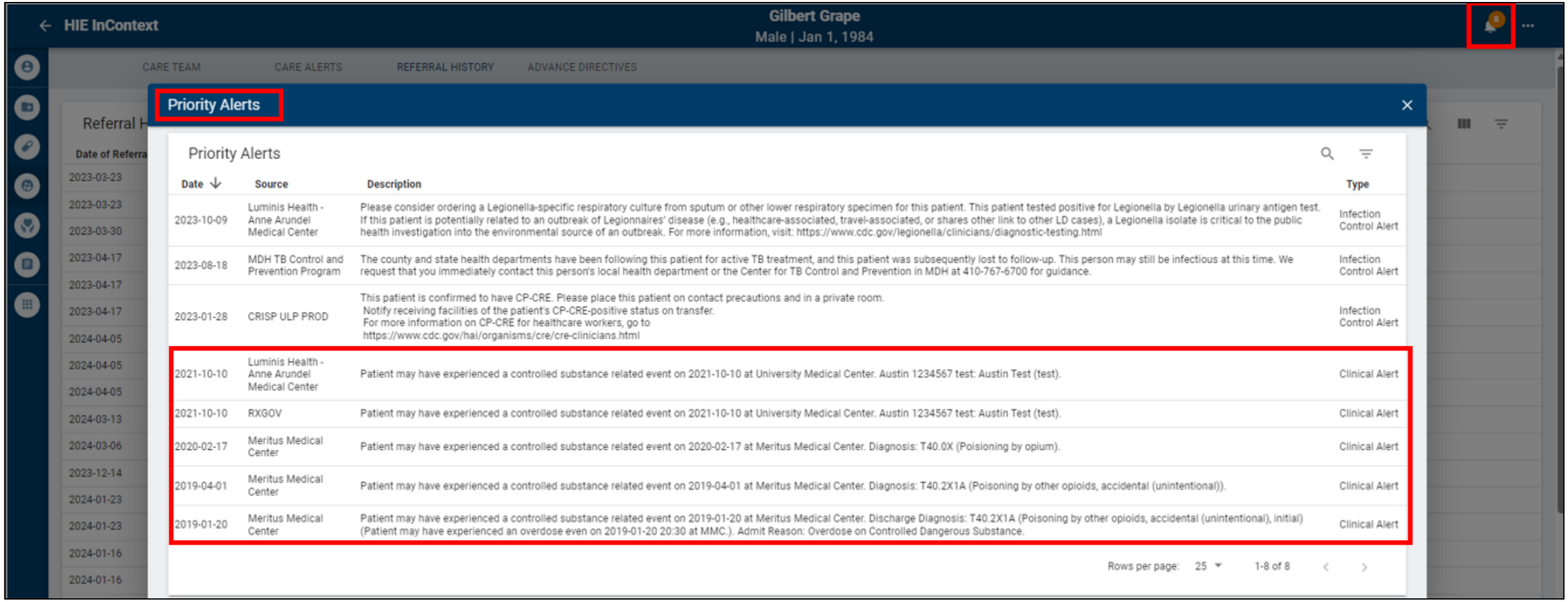
Breakout Room Discussion: Priority Alert Examples



What challenges or barriers might your agency be experiencing with registering Part 2 consent?

If you are a non-SUD provider, how does your agency approach a patient in obtaining a Part 2 consent?

Return to Main Session

Additional Resources

- Reach out to CRISP DC Team regarding implementing Care Alerts.
  - 1:1 support available
  - Email: dcoutreach@crisphealth.org

- Additional CRISP-DC Resources
  - Care Alerts
    - Care Coordination Overview
  - Provider Directory
    - Provider Directory Demo
    - Provider Directory Overview

UPDATE: LinkU Announcement

What's new?

- CRISP DC users will be provided a username and login to LinkU to access via the web-based CRISP DC Portal or SSO in the InContext App, which will allow them to:
  - Conduct a ***social needs screening assessment***
  - Send ***closed-loop referrals*** to community based organizations
  - Search for ***community resource information*** available in the District

How is this solution different than the existing social needs tools available in CRISP DC?

- The main difference is users will now be able to complete the above-mentioned actions solely by using LinkU, which contains a robust directory, a built-in screening assessment, and various organizations across social domains that accept referrals. All data collected in LinkU will be displayed in the Social Needs Tab in CRISP DC for all members of a patient's care team to view.

When will LinkU become available?

- CRISP DC plans to sunset the CRISP Referral Tool by **June 18, 2024.**

How can I participate in CRISP DC's social needs data sharing efforts at this time?

- Organizations can still participate in social needs data sharing efforts by reaching out to **CRISP DC Project Lead, Abby Lutz**, at abby.lutz@crisphealth.org

Where can I go for the most up-to-date information?

- Users will be notified of LinkU updates via CRISP DC communication emails and CRISP DC Newsletter.

Announcements/ What's Next

What's Next:

- All attendees & primary contact of your organization will receive:
  - a copy of today's presentation and copies of additional resources
  - instructions on how to submit the post-learning community worksheet
- The post-learning community worksheet, **must be submitted by Friday, July 19 at 11:59 pm** for Milestone 8 credit

REMINDER: Register for August Learning Communities!

Date	Learning Community Topic
Friday, July 26	Enhancing Care Coordination
Friday, August 16	Using Population Health to Advance Care Coordination
Friday, August 23	Using Population Health to Advance Care Coordination

Questions?