CRISP: A Regional Health Information Exchange Serving Maryland and D.C.

Regional Partnership Webinar – Transformation Support
October 22, 2015
Agenda

- Purpose
- Regional Partner Liaisons
- CRISP Service Offerings
- Integrated Care Network Infrastructure
  - Ambulatory
  - Data Router
  - Reporting & Analytics
  - Care Management Software
- 3-Year Outlook
Regional Partnership Liaisons

- Regional Planning Community Health Partnership
- University of Maryland Upper Chesapeake and Hospital of Cecil County Partnership
- Howard County Regional Partnership for Health System Transformation
- Bay Area Transformation Partnership
- Southern Maryland Regional Coalition for Health System Transformation
- Nexus Montgomery
- West Baltimore Collaborative
- Trivergent Health Alliance
- Liaison for non-RP related initiatives with individual hospitals
Integrated Care Network Infrastructure
## CRISP Integrated Care Network Infrastructure Workstreams

### 1. Ambulatory Connectivity:
We are connecting with more practices, physicians, long-term-care facilities, and other health providers to the CRISP network.

### 2. Routing Data:
We are building a data router: including data normalization, patient consent management, patient-provider relationships – for sharing patient-level data.

### 3. Clinical Portal Enhancements:
CRISP will enhance the existing Clinical Query Portal with a care profile; a provider directory; information on other known patient-provider relationships; and risk scores.

### 4. Notification & Alerting:
CRISP will create new alerting tools so that notifications happen within the context of a provider’s existing workflow.

### 5. Reporting & Analytics:
We will expand existing CRISP reporting services and make them available to a wider audience of care managers.

### 6. Basic Care Management Software:
CRISP will support care management efforts throughout the state and region – through data feeds, reports and potentially a shared care management platform.

### 7. Practice Transformation:
CRISP will help providers to improve care delivery by training them on leveraging CRISP data and service, sharing best practices, and supporting collaborative partnerships.
Ambulatory Integration
The goal of Ambulatory Integration is to improve Care Coordination by making available clinical data from ambulatory encounters and improving the patient-provider attribution region-wide

- Maryland has 16,490 licensed physicians: 6,023 primary care physicians and 10,467 specialists
  - Based on Maryland Board of Physicians Licensure Data 2012-2013

Prioritization of Ambulatory Practices for Integrations:
- Collaborate with Regional Partnerships to identify (and outreach to) provider practices
- Practices participating/eligible for Medicaid EHR Incentive program as part of CRISP’s CQM initiative
- Practices that outreach to CRISP expressing interest to integrate
- Practices utilizing an EMR system from a vendor with whom CRISP has formally collaborated
Ambulatory Integration

Ambulatory Integration Strategy:

1. Collaborate with EMR vendors for global pricing and coordinated integration process
   - Global pricing
   - Coordinated integration efforts
   - Minimize interfaces with cloud-based vendors

2. Collaboration potential with 3rd party integrators (e.g. – EllKay, Caradigm, etc.)

3. Build Administrative networks with clearinghouses and potential payers for 837 claims data that can be translated to ambulatory encounter information

4. Direct to practice integration – work directly with the ambulatory practice and their EMR vendor rep to build integration with CRISP
Data Router
What is the Data Router?

**Key Functions include:**
- Consent management
- Data normalization
- Data routing
- Patient-provider relationships determination and management

**Data Router** - The router is a service that includes key functionality to support connectivity, consent management, data routing to other services or data consumers, and determine patient-provider relationships. These approaches may rely on connectivity through a health system, through a hosted EHR, directly to the practice, or via an administrative network.
Router Continued

- **Connectivity and Routing** — inclusive of a range of connectivity approaches including connections to practice through health systems, direct connectivity to EHRs, hosted EHR connectivity, and administrative network connections.

- **Data Normalization** — applications of message transformation and vocabulary mapping services to inbound data.

- **Relationship Determination** — patient to provider relationships could be established and maintained through a range of data types flowing through CRISP, for example by using administrative claim data and ENS subscription panels. Other tools to enable management of those relationships are also planned in order to facilitate program enrollment (and consent), such as CCM.

- **Consent Engine** — Engage patients and give them more granular choices on the flow of their data. The consent engine will serve as a gateway to determine if consent preferences should not allow a message to continue to flow or if the message should be sent to additional downstream systems.
Status of Data Router Implementation

• Architecture has been documented and agreed upon
• Development teams have been identified
• Final sign-off on router approach to be made by 10/24
• First phase will be to implement granular consent required for care coordination
  • Goal: 1/1/16
2015 CQ4 Router Goals

- Routing data from 40 total ambulatory practices to 2 care management programs
- Opt out for ambulatory data is more granular
- Opt out for ambulatory data submission is working
- 1,000 providers sending administrative data
- 500 ambulatory providers sending clinical data
Reporting & Analytics
CRISP Reporting Services (CRS)

- Reports generated from a collection of data sources to support quality improvement, strategic planning, financial modeling, and other activities.

- Primarily focused on hospitals, but expanding to public health departments, regional partnerships, and ambulatory providers.

- Allowable data use varies based on the amount of detail included; for example, patient-level detail in new Patient Hospital Utilization Dashboard (PaTH) is only permitted to be used for care coordination activities.
Population Health Dashboards

Hospitalizations by County with SHIP Disease Indicators - High Utilizers: 3 or More Visits
Total Hospitalizations for All Population
Payer: All Payer

SHIP Disease Indicators with Comparison to State

- No SHIP Indicator
- Any SHIP Indicator
- Mental Health
- Addiction
- COPD
- Diabetes
- Alzheimers
- Asthma
- Hypertension
- Dental

Measure Type
- Hospitalizations

Patient Measure Type
- Patients

Population Selection
- High Utilizers: 3 or More Visits

Zip or County
- County

Regional Partnership
- Bay Area
- Howard County
- Johns Hopkins
- Nexus/Montgomery
- Southern MD
- Trivergent
- University of MD Medical Center
- Upper Chesapeake & Union Hospitals
- None

Primary Payer Selection
- All Payer

Calendar Year
- 2014

SHIP Disease Selection (Map On...)
- All Population
- Any SHIP Indicator
Patient Total Hospitalizations (PaTH)

Bubble chart plots each patient by charges and visits at the user’s hospitals.

Patient Details table shows the visits and charges totals for selected patients.

Timeline view shows the progression of care for each patient by visit type and length of stay.

Filters pane limits the population shown in the bubble chart. Filters are the same as on the Summary tab.

Total number of patient and visits shown on bubble chart.

Totals at the user’s hospital on the Patient Details table.

Totals for all hospitals on the Patient Details table.

Link to additional notes.
Cross-Facility Patient-Level Data

Main table displays a list of visits for selected patient with detailed information for each visit. Filter and sort options show visits by Admit Date, Visit Type or Hospital.

More link provides diagnoses descriptions.

Conditions view lists all conditions for the patient.

Patient Total at This Hospital summarizes patient visits at the user’s hospital.

Patient Total at All Hospitals summarizes patient visits at all the hospitals.

Primary and secondary payers on the most recent visit.

Link to additional notes.

### Patient Total Hospitalizations - Patient Detail Sorted by Admit Date

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Care Alerts
• CRISP is working with the Bay Area Transformation Partnership to pilot a concept known as "Care Alerts."

• These are free text alerts presented in the context of a user's work flow that communicate the most critical piece of information on the patient in front of them.
“Mr X is a patient of Dr. Brown. He has frequent CHF exacerbations, often due to missed medication and/or physical exhaustion. If you feel he may be discharged after treatment in the ED (40 mg IV furosemide works well typically), securely text Dr. Brown at (XXXXXXXX) to plan follow-up in 1-2 business days.

His care manager is Jill Smith (contact information). If he needs to be admitted, please contact her for coordination of care.

Please note that Mr. X prefers low-cost medications and that his 3 cm RUL lung mass has been evaluated and found to be benign. His daughter Julie is health care POA and can be contacted at XXXXXXXXX. His MOLST is on record as is his Care Plan.”
CRISP Approach

• These alerts are being shared in standards based ways that CRISP already supports.
• It is important to CRISP and the ICN team that we provide as much information as is reasonable directly within the context of a user's workflow.
• If there are new types of data we can share through existing CRISP pathways we are eager to work with you on those sooner rather than later.
Care Management Software
Basic Care Management System

Planning phase activities:
• Conduct needs assessment through series of focus groups/interviews
• Conduct marketplace analysis of systems
• Participate in demos of care management systems

Goal:
• Determine if there is a need for CRISP to provide a basic care management system option. If yes…
  • What information/tools are most important?
  • What does the cost model look like?
  • What system(s) or data approaches can serve the identified needs?
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8. **Practice Transformation:** CRISP will connect with our ultimate customers through education, outreach and inclusion.
3-Year Outlook
CRISP’s ICN Infrastructure long-term (three-year) plan is still emerging, but has some basic characteristics:

- **Build Incrementally** – We will build on current capabilities to deliver additional value (e.g., Reporting & Analytics).

- **Leverage the Network Effect** – We will increase in value to our stakeholders and customers as we grow (e.g., Ambulatory Connectivity).

- **Demonstrate Value, then Scale** – We will pilot early and often to make sure what we deliver has value (e.g., Care Management Software).

- **Listen to the Voice of the Customer** – We will seek every opportunity to solicit feedback from those we serve – from early strategy to iterative enhancements (e.g., adding Patient and Caregiver Engagement).

- **Invest in Outreach** – We will invest in education and training of our customers to give them the best opportunity to effectively use our tools and services (e.g., Practice Transformation).

- **Be Good Stewards** – We will focus on world-class project management to make sure we are using the funds invested in CRISP thoughtfully and transparently.

- **Focus on Stakeholder Success** – We exist to improve healthcare performance and outcomes, not to compete or to pick winners in the healthcare marketplace.
The CRISP team and advisors are currently developing a three-year work plan and associated budget projections for our seven Integrated Care Network Infrastructure workstreams (plus #8: Patient & Caregiver Engagement).

Regional Partners do not need to build CRISP workstream contributions into their budgets, but should be aware of what we are planning to build and the expected timelines.