Best Practice: Care Alerts in Maryland's Health Information Exchange, Chesapeake Regional Information System for our Patients (CRISP)

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Abstract

Background and Aim: The Health Services Cost Review Commission (2016) has recommended working with CRISP to "exchange information regarding care coordination resources aimed at reducing duplication of resources, ensuring more person-centered approaches, and bringing additional information to the point of care." To address this initiative we worked with CRISP to implement care alerts. CRISP (2016) describes care alerts as two to three sentences that are "high priority care coordination information meant for the most complex patients who frequent hospitals and practices. Action-oriented, 'need to know' information that informs decision making and could assist in the prevention of unnecessary admissions and duplicated procedures." CRISP offered flexibility in how care coordinators and providers would receive the care alert information that would display on their site. This allowed us to define the best way for us to send them the information. This presentation outlines that approach. **Method**: Our requirements were for an easy to use, readily accessible documentation method. We desired a straightforward approach, utilizing processes already in place to promote a smooth implementation and increase the likelihood of success. Using existing documentation contained within the Continuity of Care Document, discharge routine, or other care management documents was considered, but ultimately rejected due to additional interface costs and the cumbersome process of isolating the pertinent information. After collaborating with CRISP, a physician champion, and our care management team we created two separate document templates for care manager and physician content. A change was needed to make the care managers' workflow similar to the providers' so that all care alert documents would file in the same location. This meant we could leverage our existing interface that sends transcription reports to CRISP. They could then use the report type value we provide in the message to identify the care alert messages and pull the text to display as care alerts in CRISP. After 3 weeks of defining requirements, developing templates, testing, and demonstrating success CRISP has used our experiences to formulate a best practice approach to care alerts for hospitals using the same EMR. **Lessons Learned**: 1) Leverage existing processes; 2) Create a process that is not burdensome to end users; 3) Focus on requirements. Keeping the purpose of care alerts in mind became increasingly important. We found the content could easily grow as we expanded to a wider group of users. **Implications**: Care alerts have the potential to be a valuable tool in addressing readmissions for high utilization patients and could have a positive impact on our patients. Future opportunities include expanding usage to primary physicians and hospitalists, and increasing the patient population beyond high utilizers. CRISP also has the ability to house more comprehensive documentation such as care plans, for which we can utilize this same process.