Care Alert Sprint: Introductory Webinar
December 14, 2016
Supplemental Questions

Q: Can you provide references to research of communities that have shared care alerts or care plans and shown improvements in care?

A: Care alerts were recommended by an MHA workgroup based on hospital pilots within Maryland and programs such as Whole Person Transitional Care from AHRQ. Care alerts or care plans on their own should not be expected to directly result in measurable impact on utilization; rather, this is a tool which will contribute to better care management across providers, settings, and time.

Q: Is the goal to create care alerts for all high-needs patients or just Medicare fee-for-service beneficiaries with 3 or more bedded stays in the previous 12-months?

A: The goal of the sprint is specifically focused on writing and sharing care alerts for 25% of the Medicare fee-for-service beneficiaries with 3 or more bedded stays. Hospitals may have a broader definition of high-needs patients, and are encouraged to consider how care alerts may benefit that population as well. Hospitals and their community partners may be using care plans rather than care alerts; these would also satisfy the goal.

Q: Is the target to create 5,000 care alerts or to have 5,000 patients with alerts?

A: There are approximately 20,000 Medicare fee-for-service beneficiaries who have had 3 or more bedded care stays in the prior 12-months. The goal of the sprint is 25% of those individuals to have care alerts or care plans shared in CRISP, which is 5,000 people.

Q: Do care alerts or care plans from non-hospital sources, such as payers or community providers, count towards the goal?

A: Yes. This is a population-based target, so Medicare beneficiaries with a care alert or care plan in CRISP will count regardless of the source. The sprint is intended to help Maryland hospitals achieve a goal and hospitals would benefit from identifying, mobilizing, and collaborating with all relevant stakeholders who may be able to provide a care alert or care plan.

Q: Technical integrations may be required to move care alerts or care plans into CRISP. Is there funding for these efforts?

A: CRISP has resources to support integrations which will allow this data to be shared in a safe, efficient way. Many pathways to collect this data, including through existing interfaces or in standard clinical document types, have been developed. Contact Craig Behm (craig.behm@crisphealth.org) if you would like to discuss solutions to share this data effectively.

Q: When I try to download the data from the CRISP Medicare FFS High Utilizer report, the crosstab option is not able to be selected.

A: To download data within the dynamic reports, users must select the table within the report they would like to download. In the Medicare FFS High Utilizer report, first left click any row of patient data to highlight it. The crosstab option will then be available.

Q: Are patients with only 1 or 2 bedded care encounters with my hospital included in my Medicare FFS High Utilizer report? If so, do I need to create care alerts or care plans for those individuals as well?

A: The patients within each hospital's report are based on whether a patient has had any type of visit within that hospital during the prior 12-months. CRISP is not applying any type of assignment methodology. This does not mean you need to develop a care alert for every patient in your report. We invite you to review the list, quantify the number of patients, sort them according to your priorities (number of visits, presence on a provider's panel, total charges, etc.) and work from that basis. We stand by to assist you in your analysis and planning efforts to best identify how to get started with a list that makes sense for you, and encourage hospitals to collaborate where there is overlapping utilization.

Q: If a patient has several bedded events at multiple hospitals, how can the hospitals communicate regarding who will develop the care alert or care plan?

A: There are likely multiple ways based on your region and the local circumstances of providers. One recommendation would be to form an ad hoc cross-hospital coordinating committee for the purposes of this sprint. Additional options will be addressed in the "how to" webinars in January.

Q: Who are the CRISP points of contact for each hospital?

A: Hospitals may contact Craig Behm (craig.behm@crisphealth.org) to find out who the best contact is based on their specific requests.