

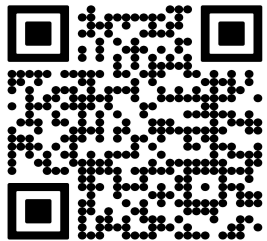
[●REC] THIS WEBINAR IS BEING RECORDED [●REC]



Clinical Information and Population Explorer

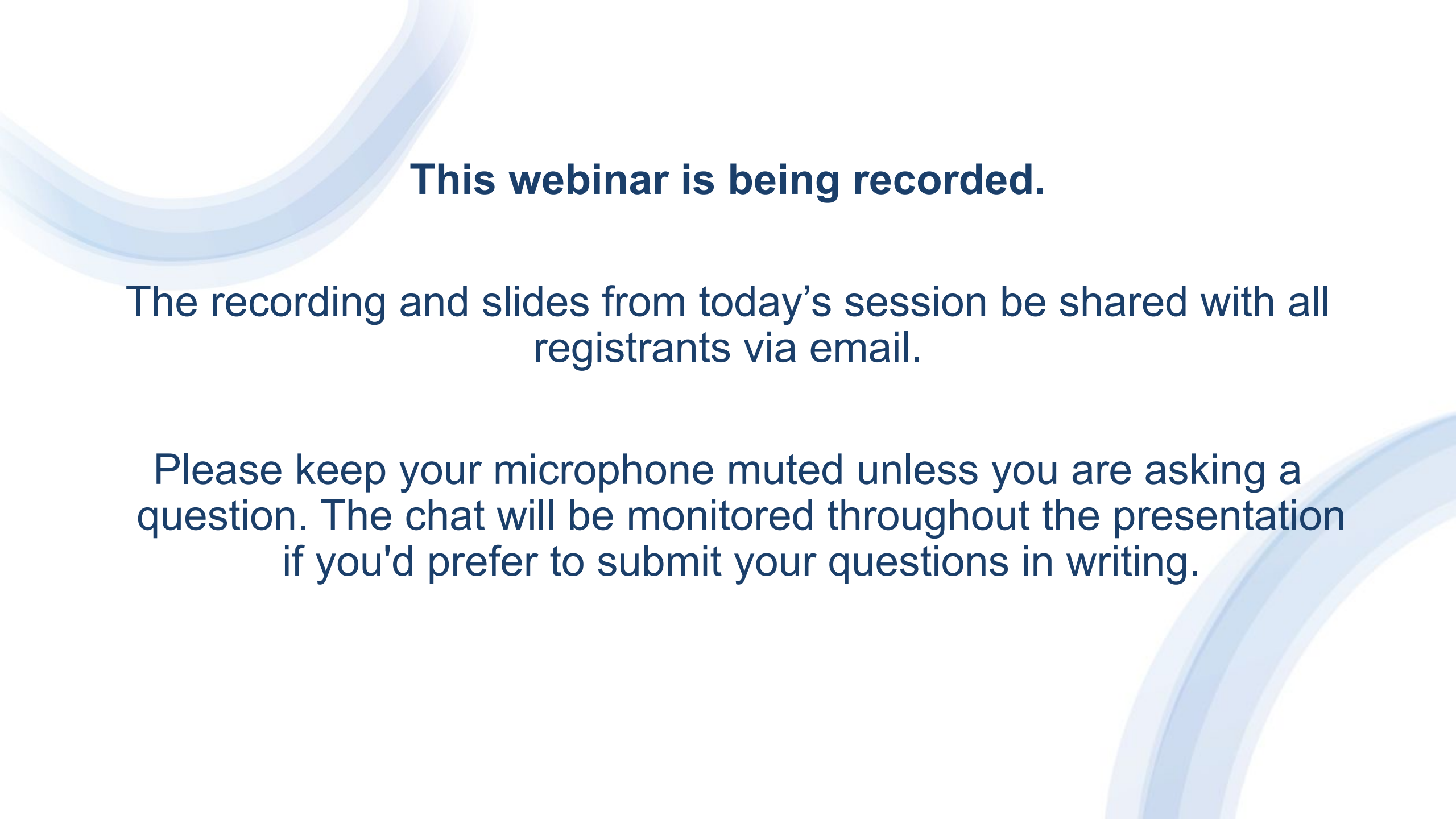
Learning community

April 17th, 2026



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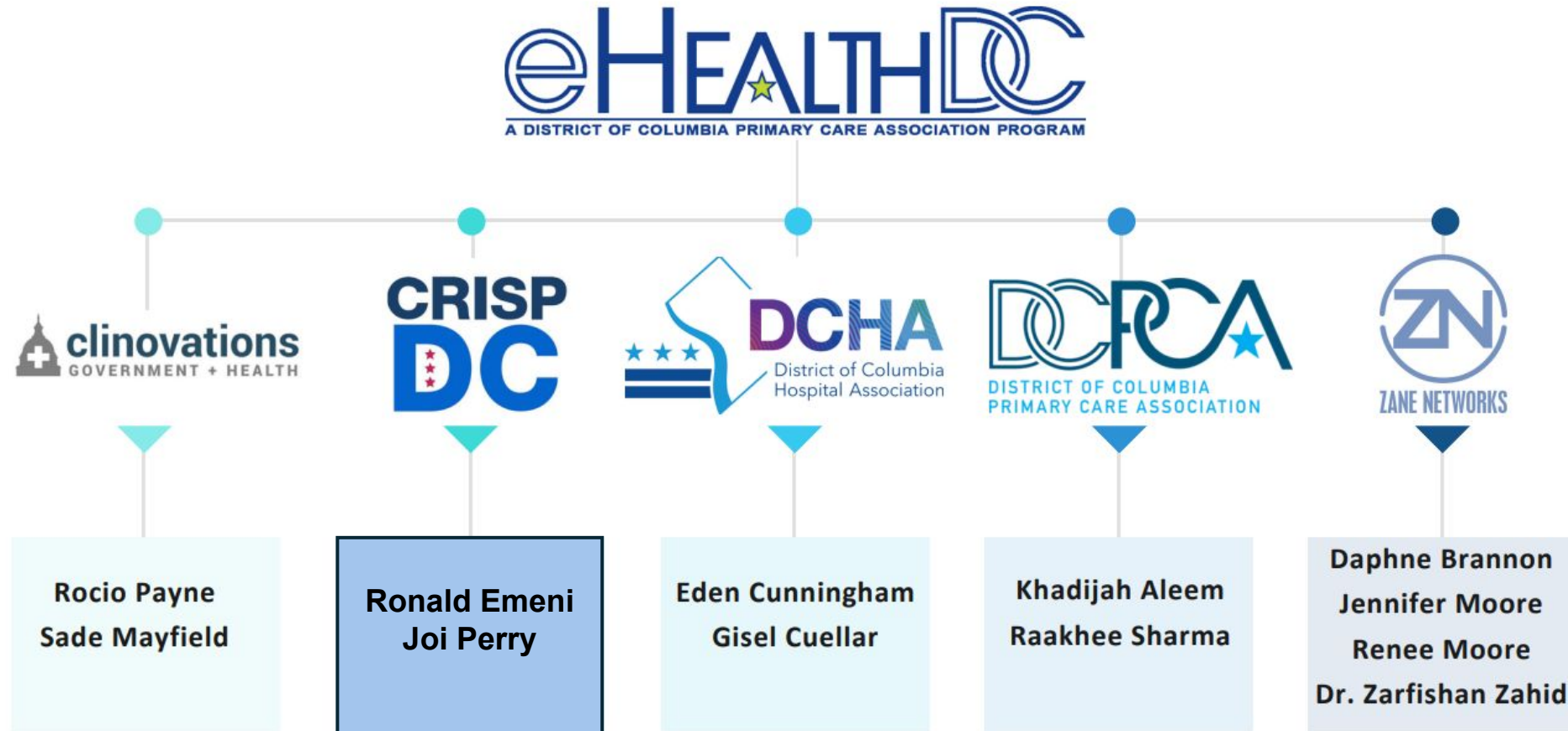
This webinar is being recorded.

The recording and slides from today's session be shared with all registrants via email.

Please keep your microphone muted unless you are asking a question. The chat will be monitored throughout the presentation if you'd prefer to submit your questions in writing.



Improving Care in the District through Collaborative Efforts



CRISP DC and eHealthDC are partnering to provide tailored technical assistance for various CRISP DC tools, including the CRISP Population Explorer and Clinical Information App. For support or inquiries, the technical assistance team is available via email at dcoutreach@crisphealth.org.

Announcement: New TA Opportunity!

***New Free Technical Assistance Opportunity for Ambulatory and Hospital Organizations focusing on
1) EHR Data Quality and Workflow Optimization and 2) HIE Tools Adoption***



eHealthDC is the District's Digital Health Technical Assistance Collaborative, made up of regional health leaders including the DC Primary Care Association (DCPCA), Clinovations, CRISP DC, DC Hospital Association

Through this new Digital Health TA Program funded by DHCF, eHealthDC will provide free, tailored technical assistance to help improve EHR data quality, boost interoperability, and integrate CRISP DC HIE tools into daily workflows.



Fill out an Interest Form or reach out to contact@e-healthdc.org and we'll be in touch!



Today's Agenda



Introduction & Learning Objectives

What you'll be able to do after today's session

5 min



Webinar: Clinical Information and Population Explorer

Overview of CRISP-DC's Critical Infrastructure

25 min



Live Demo: Clinical Information App and Population Explorer

Real-time demonstration with your actual panel data

20 min



Q&A + Next Steps

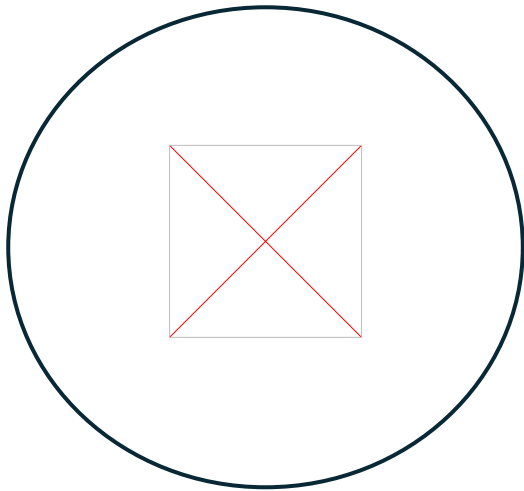
Open questions and opportunities for engagement

10 min



Learning Objectives

**By the end of
this session,
you will be able
to:**



1. CRISP-DC Health Data Utility



2. Types of Data, Local-Regional-National Data



3. Modalities of Access and Locating Clinical Data



4. Overview, benefits, and key features of Population Explorer



5. Real world use cases for Population Explorer





CRISP DC, Inc. is a Standalone 501c3, Non-Profit Corporation

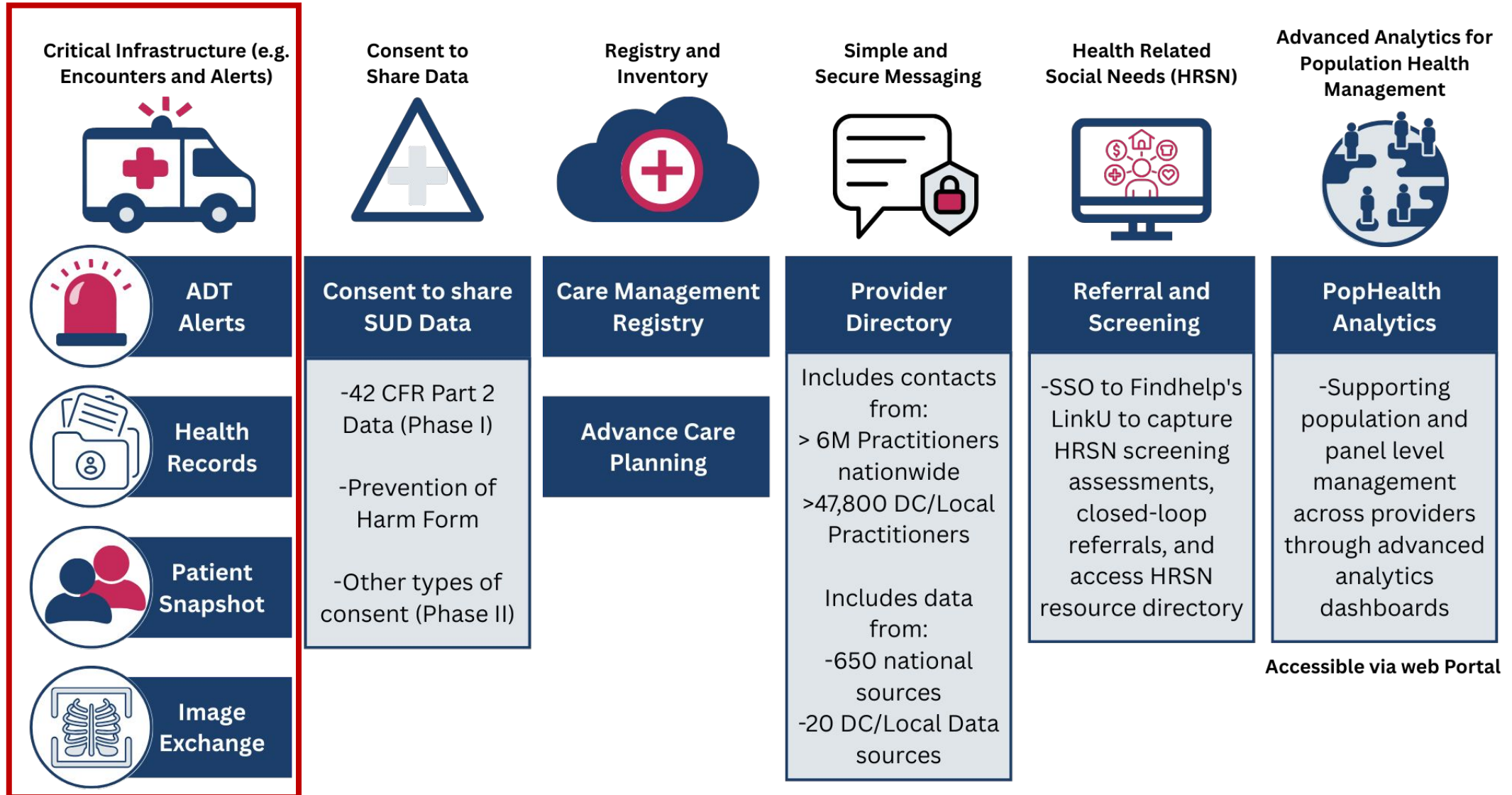
- **CRISP DC provides health information technology solutions** allowing healthcare organizations and community-based organizations to instantly connect and access tools that enable safe, timely, effective, equitable, and patient-centered care to improve health outcomes.
- **CRISP DC is the Designated HIE for the District of Columbia** by the DC Department of Health Care Finance (Medicaid) and the HIE Policy Board.
- **CRISP DC has a robust team that is dedicated to serving the District HIE users**
- **CRISP DC is an affiliate to CRISP Shared Services (CSS)**, a technology vendor that provides our infrastructure and allows us to easily coordinate with neighbor HIE entities such as Maryland and Virginia



App Engagement
58,000+
clicks/month in
the application

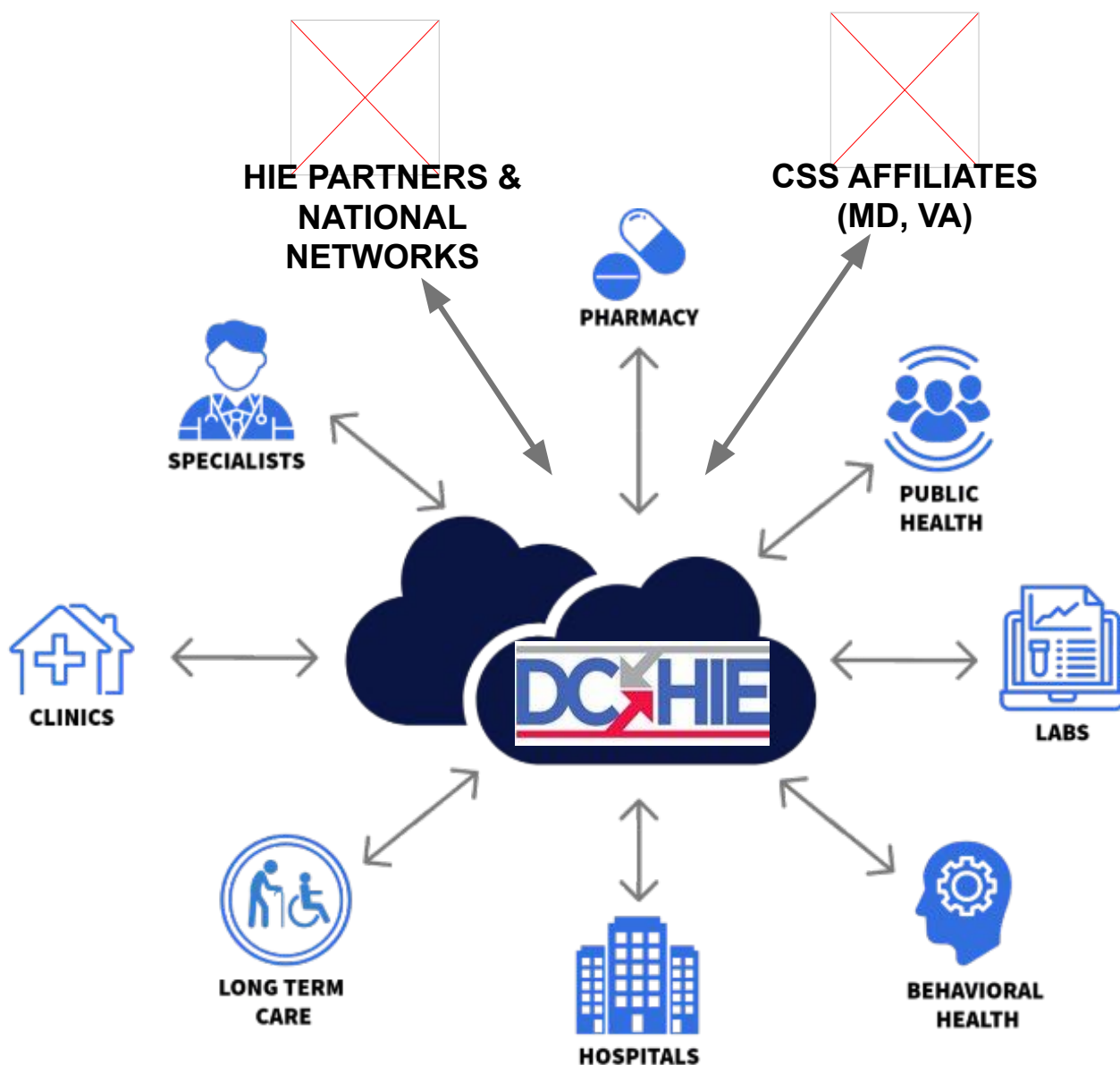
1,093 Participating Organizations
with over **17,000 Users**

The HIE is a Health Data Utility with Six Core Capabilities for Providers





Sources and Types of Data



ADTs (Admission, Discharge, Transfer)

- Typically received within 15 minutes of the encounter, powering CRISP's Event Notification System (Population Explorer)
- Admit Reason and Diagnosis Codes

CCDs (Visit Summaries)

- Medications, Immunizations, Allergies, Problems, Vital Signs, Procedures

ORUs (Observational Result)

- Laboratory and Test Results, Imaging Studies, Medical Interpretations

Image Exchange

- Radiology and Cardiology imaging modalities, including: x-rays, CT scans, MRI, ultrasound, PET-CT, cardiac angio



Locally Managed Health Data Utility, Regional Data Sharing

- Northern Virginia connectivity conversations include, Arlington County FEMS, Inova, and numerous ambulatory providers.
- CRISP DC is working a public list of area National Network participants to continue to target data capture for those organizations that are not connected directly to CRISP DC or its CSS partner
 - CRISP DC is building the infrastructure to support queries for Veterans Affairs and Northern Virginia hospitals and ambulatory organizations
- Data that is **not** available from National Networks:
 - Medical Imaging
 - Substance Use Disorder Data
 - Findhelp and other Health Related Social Needs, Screening, Referral and Resource Inventory Data
 - Provider Directory
 - Advance Care Planning
 - Comprehensive Care Team Including Care Managers and Managed Care Organization
 - Population Health Reports
 - Claims Data



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Data that is not available from National Networks:

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- Comprehensive Care Team Including Care Managers and Managed Care Organization
- Population Health Reports
- Claims Data

Participating in CRISP is **NOT** “One Size Fits All”

Ways to PARTICIPATE in the HIE



Accessing
CRISP to VIEW
Data



Sharing Clinical
Data Through
the HIE

Optional/Not Required to Access CRISP to View Data

Ways to ACCESS the HIE



Portal
Webpage

App
Embedded
into EMR

Single Sign
On from EMR
to Portal
Webpage



Accessing Clinical Information

HIE Portal

HOME 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.

Q Patient Search

First Name * Last Name *
gilbert grape

Date of Birth * 01/01/1984 Gender

SSN

Reset Search

Search Results

First Name	Last Name	Date of Birth	Gender	Address	Match Score
GILBERT	GRAPE	01/01/1984	Male	4145 Earl C Adkins Dr, RIVER, WV, 26000	117 - probable

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

Clinical Information	PMP	Snapshot	CareTeam	Screening	Create Referral	MyDirectives for Clinicians
Consent Tool	PopHealth Role Manager	PopHealth	Directory	HIE Admin Tool	Panel Processor	User Guide & Help

Population Explorer

View Panel
CRISP-DC - Demo CEND Panel (CRISPDG_CEND)

Export

Wilson, DEMO, Ashley DOB: 1961-01-01 Admit Date: 2025-09-18 10:00 AM Female Notification Type: Outpatient Encounter Facility: CRISP-DC - Demo Hospital Source

Irwin, DEMO, Veronica DOB: 1961-01-01 Admit Date: 2025-07-14 01:45 PM Female Notification Type: Outpatient Encounter Facility: CRISP-DC - Demo Hospital Source

Luna, DEMO, Nicholas DOB: 2001-01-01 Admit Date: 2025-07-14 08:00 AM Male Notification Type: Outpatient Encounter Facility: CRISP-DC - Demo Hospital Source

Mora, DEMO, Tami DOB: 1970-01-01 Admit Date: 2025-07-14 08:00 AM Female Notification Type: Outpatient Encounter Facility: CRISP-DC - Demo Hospital Source

Luna, DEMO, Nicholas DOB: 2001-01-01 Admit Date: 2025-07-10 09:00 AM Male Notification Type: Outpatient Encounter Facility: CRISP-DC - Demo Hospital Source

Optional/Not Required to Access CRISP to View Data

InContext

Patient Hub TEST, Caspian May 8, 2006 (18 yo M) Acc No. 190033

35 Jolley Drive, Bloomfield, CT 06002
860-874-3092 (P) | 860-874-3092 | 860-555-5555
cmanliguis@pmmhartford.com | 05/08/2006
Account No: 190033 | Messenger Enabled: Yes
Web Enabled: Yes | Healow Tracker Data: No | eEHX Status: GO

Advanced Directive :
Insurance : ACADIA INSURAN
Last vMsg : 03/26/2024 , 10:0
PCP : FEINGOLD, DAVI
Rendering Pr
Default Facility :

Billing

Patient Balance : \$0.00
Pt Coll. Balance : \$0.00
Account Balance : \$0.00
Collection Status :
Assigned to :

Structured Data

current smoker

Labs DI
Actions Tel Enc
Docs P2P

Apps

Search Search by App Name or Description Favorite Apps

CRISP

Bumped Apps: NONE Case Manager Hx:

New Appointment

Medical Record
Problem List
eClinForms >>

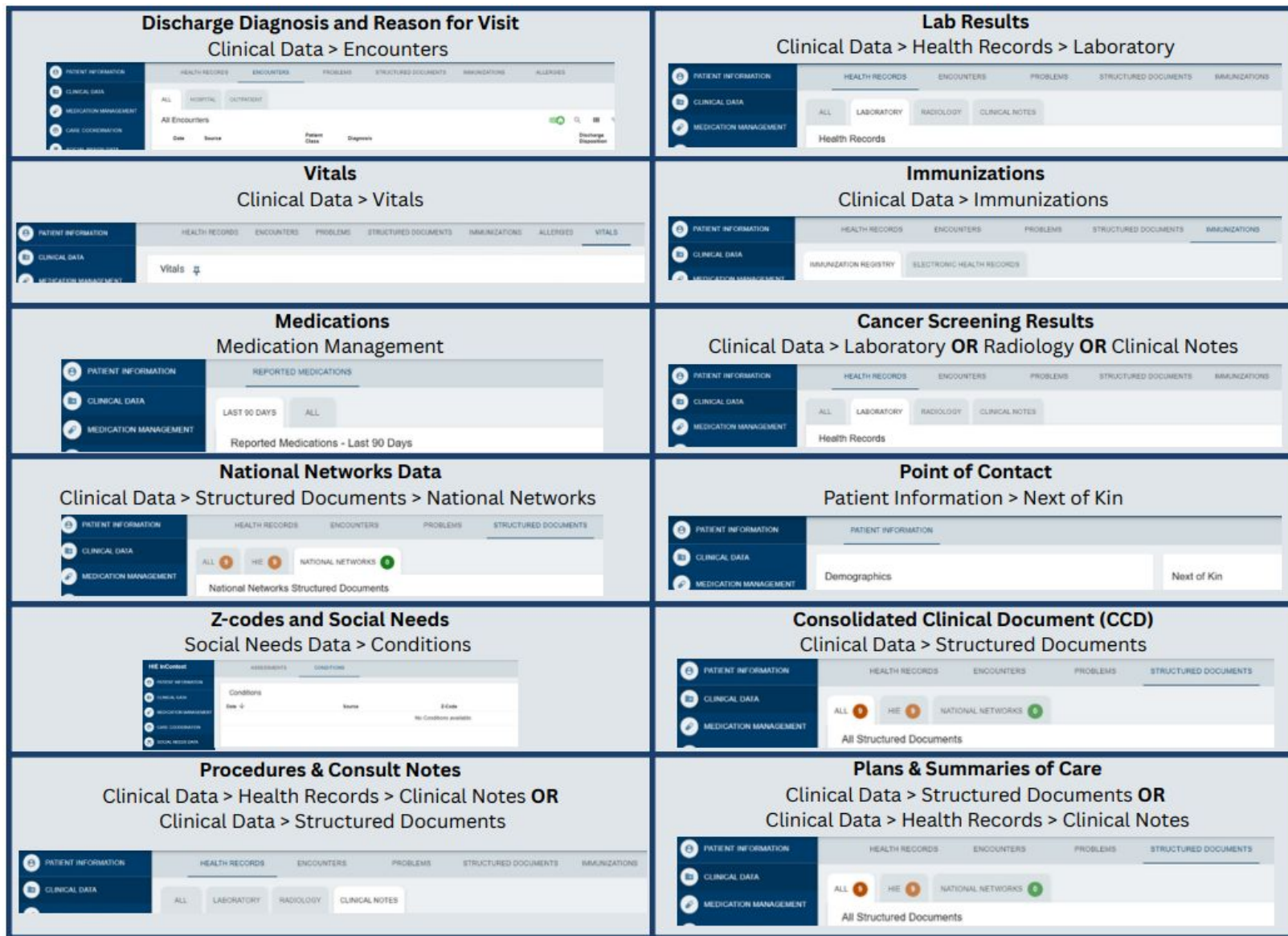
Patient Docs Action New
Devices Logs New
Consult Notes Letters >> Send
Blow sheets Print Labels Mess
eEHX

Available: Epic, ECW, Athena, Cerner, PointClickCare

Locating Data in the CRISP DC HIE

Tip Sheet

- Visit Summaries
- Vitals
- Medications
- Lab Results
- Immunizations
- Cancer Screening Results
- Procedures and Consult Notes
- Social Needs and Z-Codes
- Care Plan
- National Networks and HIE Partners



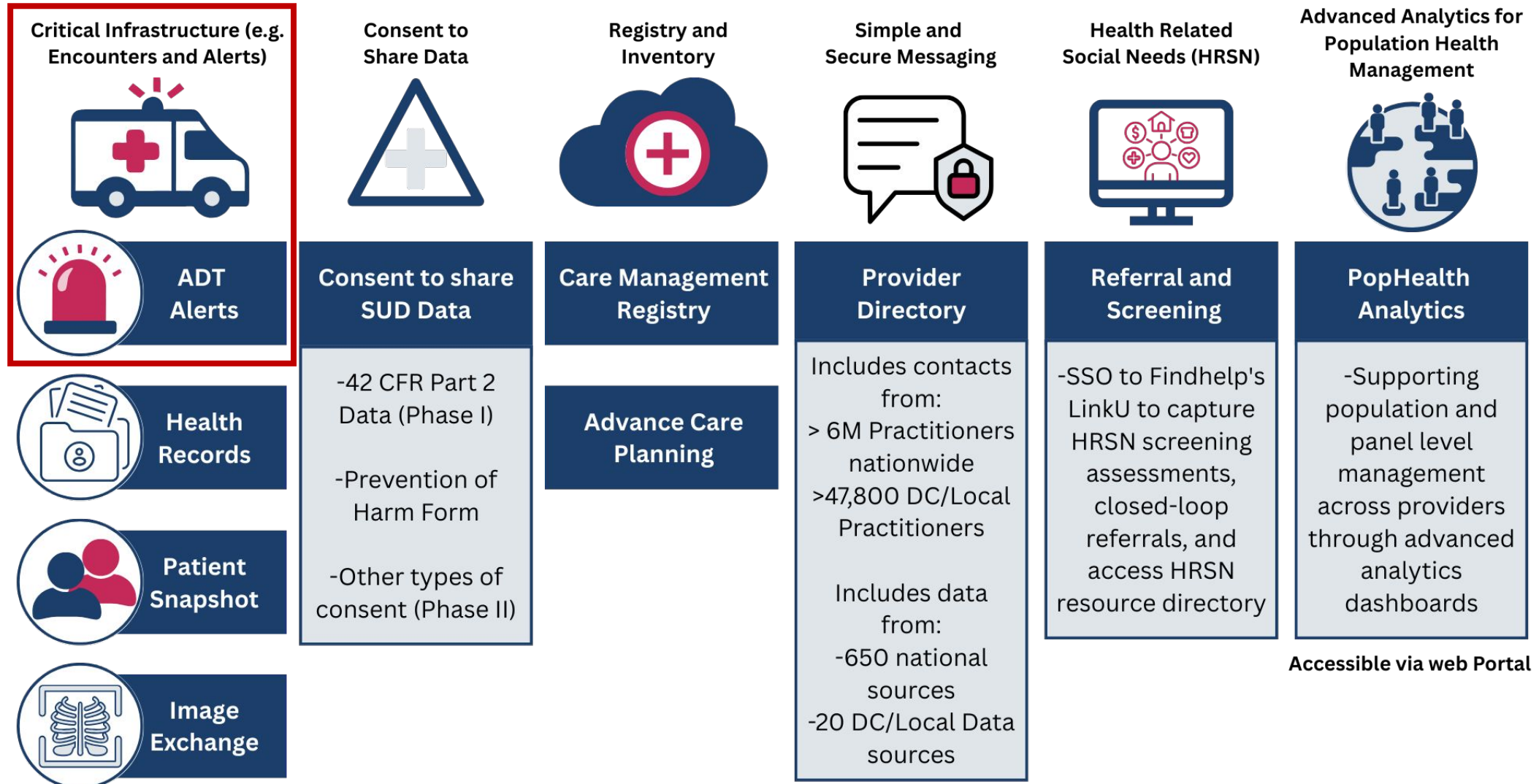
The following table summarizes the navigation paths shown in the screenshots:

Data Type	Navigation Path
Discharge Diagnosis and Reason for Visit	Clinical Data > Encounters
Lab Results	Clinical Data > Health Records > Laboratory
Vitals	Clinical Data > Vitals
Immunizations	Clinical Data > Immunizations
Medications	Medication Management
Cancer Screening Results	Clinical Data > Laboratory OR Radiology OR Clinical Notes
National Networks Data	Clinical Data > Structured Documents > National Networks
Point of Contact	Patient Information > Next of Kin
Z-codes and Social Needs	Social Needs Data > Conditions
Consolidated Clinical Document (CCD)	Clinical Data > Structured Documents
Procedures & Consult Notes	Clinical Data > Health Records > Clinical Notes OR Clinical Data > Structured Documents
Plans & Summaries of Care	Clinical Data > Structured Documents OR Clinical Data > Health Records > Clinical Notes

Introduction to Population Explorer

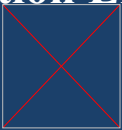
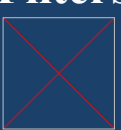
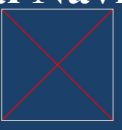
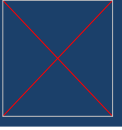
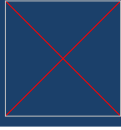
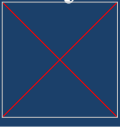
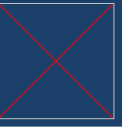
Leveraging CRISP-DC's Critical Infrastructure for real-time Care Coordination

The HIE is a Health Data Utility with Six Core Capabilities for Providers



Population Explorer & CEND Overview

Population Explorer and CEND (CRISP Encounter Notification Delivery) are two CRISP tools that deliver real-time encounter insights to support care coordination and clinical decision-making.

Population Explorer 	Export Encounters 	Filters 	Portal Navigation 
Review encounter history	Download encounter summaries	Apply custom filters	Move between related apps
CEND Delivery 	Real-Time Alerts 	Delivery Options 	Reliable & Fast 
Routes alerts into Pop Explorer	Instant ADT updates	Sends alerts to EHR/secure inbox	Built for accuracy



Why do I need it?

Save Time and Stay Focused

- Eliminates the need for multiple systems, allowing users to quickly access critical information and focus on what matters most – your patients.

Spot Opportunities for Improved Care

- Identify gaps, trends, and follow-up needs with ease, helping users prioritize high-impact interventions and reduce avoidable hospitalizations.

Simplify Your Workflow

- Offers a user-friendly interface that makes navigating and understanding patient data simple, efficient, and effective.



Key Features within Population Explorer

Launch with Context

Navigate from an individual encounter into the Clinical Information App

Follow Up Status

Establish internal workflows to track care coordination progress

Filter Creation

Sort encounters by care setting, patient complaint, primary diagnosis codes and more

Preventive Screening

Validate Patients screened for Colorectal and Breast Cancer

Export Data

Build reports used to support daily workflow for care coordination or population health/qualitative improvement initiatives



Population Explorer Layout

CRISP DC
© CRISP. All Rights Reserved.

MY HIE ADMIN(S) | SEND FEEDBACK | PRODUCT UPDATES | RONALD EMENI | LOGOUT

HOME | Search Applications & Reports

Population Explorer

DETAIL | TABLE

View Panel

DC Demo Panel 1 (DC_CEND_DEM01)

Download

Quick Filter

Diagnosis Codes

Input Value

This field is required

Saved Filters

Type to select

Apply

Clear Filters

Save Current Filter

MALONE_DEMO, MARGARET | DOB: 1942-03-23 | Gender: Female | Encounter Type: Outpatient | Event Time: 2024-02-29 14:56

MALONE_DEMO, MARGARET | DOB: 1942-03-23 | Gender: Female | Encounter Type: Outpatient | Event Time: 2024-02-29 14:56

GROVE_DEMO, YVETTE | DOB: 1935-07-01 | Gender: Female | Encounter Type: Inpatient | Event Time: 2024-02-29 09:14

GROVE_DEMO, YVETTE | DOB: 1935-07-01 | Gender: Female | Encounter Type: Inpatient | Event Time: 2024-02-29 05:37

JOHNSON_DEMO, PAULA | DOB: 1967-09-15 | Gender: Female | Encounter Type: Outpatient | Event Time: 2024-02-29 04:21

Patient Demographics

First Name:

Last Name:

Gender:

Date of Birth:

Address:

Home Phone:

Work Phone:

Selected Encounter Details

Point of Care:

Event Date / Time:

Encounter Type:

Page 1

1. View Panel- Organization's Panel populating encounter alerts
2. Detail & Table View- switch between excel like "Table" view or "Detail" view to select individual encounter alerts
3. Quick Filter- Slice list of encounter alerts by 5 key categories

Filter Toolkit in Population Explorer

35+ available filters across 5 key categories: designed to support every step of care coordination

				
Encounter Details	Patient Details	Clinical Data	Utilization Metrics	Care Team & Panel
Encounter Type, Patient Class, Admit Date/Time, Encounter Date, Discharge Date/Time, Facility	Patient Name, Date of Birth, Insurance Type, MRN, Panel MRN, Primary Care Provider	Diagnosis Code, Diagnosis Description, Primary Diagnosis Code, Patient Complaint, Discharge Disposition	ER Last 30/60/90/180 Days, Inpatient Last 30/60/90/180 Days, OBS & Outpatient Visit History	Care Manager, Care Program, ACO, Risk Score 1 & 2, Group, Practice, Follow Up Status, NPI

Filters can be combined using AND logic in Quick Filter, or with complex Boolean logic (AND/OR/NOT) in the Advanced Filter Builder.



Real-World Use Cases

From Quality Measure to Filtered Patient List

Three quality measures actionable today in Population Explorer

01

Transitions of Care

Post-discharge follow-up

02

**Plan All-Cause
Readmissions (PCR)**

30-day readmission prevention

03

Non-Emergent ED (NED)

Reducing avoidable ED visits

Transitions of Care

What Is It?

The Transitions of Care (TRC) measure evaluates the quality of care transitions across four domains:

- Notification of inpatient admission
- Receipt of discharge information
- Patient engagement after discharge
- Medication reconciliation post-discharge

Source: NCQA HEDIS, CMS Star Ratings

Why It Matters

14%

All cause average hospital readmission rate in Washington DC

7-14 days

follow-up window targeted by NCQA for TRC measure compliance

¹ Definitive Healthcare, Average hospital readmission rates by state

² Health Affairs, Medicaid Readmissions Study, 2022

USE CASE 01

Filter Recipe: Transitions of Care

Goal: Identify patients discharged from inpatient or ED in the last 7 days who need follow-up within the TRC window

1

Encounter Type

Captures hospital admits and ED discharges

Inpatient OR Emergency

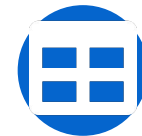


2

Patient Class

Confirms active inpatient or emergency status

Inpatient OR Emergency



3

Discharge Date/Time

Targets the critical TRC follow-up window (NCQA: < 7 days)

Yesterday, Last 3 Days, Last 7 Days



4

Follow Up Status

Surfaces patients with no outreach yet initiated

Not Started



Pro Tip: Use Advanced Filter Builder to combine Inpatient OR Emergency encounter types in a single filter — Quick Filter applies all criteria as AND.

Plan All-Cause Readmissions (PCR)

What Is It?

The PCR measure tracks 30-day all-cause readmissions for Medicaid beneficiaries following an acute inpatient stay.

It is used by:

- DC Medicaid Managed Care Plans
- CMS Quality Rating System
- NCQA HEDIS measurement set

High PCR rates signal gaps in post-discharge care coordination and transitions of care processes.

Source: NCQA HEDIS PCR Measure, CMS Core Measures

Why It Matters

\$16,000

Average cost of 30-day all-cause adult hospital readmission

30 days

measurement window — every day of delay in outreach increases risk

-7.55%

30-Day Readmission deterioration between Amerihealth and Medstar MCO

¹ Systemic Review and Meta-Analysis of the Financial impact of 30-day Readmissions

² Medicaid Managed Care Performance Report Jan 2023-Dec 2023

Filter Recipe: 30-Day Readmission Prevention

Goal: Surface patients with recent inpatient discharge + prior utilization history suggesting high readmission risk

1

Encounter Type

Focus only on acute inpatient stays per PCR definition

Inpatient



2

Discharge Date/Time

Aligns exactly to the PCR 30-day measurement window

Last 30 Days



3

Inpatient Last 30 Days

Flags patients with a PRIOR admission — highest readmission risk

Greater Than: 0



4

Diagnosis Code

Targets highest-risk chronic populations (HTN, DM, COPD)

Chronic condition ICD-10 codes
(e.g., I10, E11.9, J44.1)



Pro Tip: Upload a bulk list of chronic condition ICD-10 codes via the AFB Submission Template — no manual entry needed. Save as 'Active Public' to share with your full care team.

Non-Emergent ED (NED) Use

What Is It?

The NED measure monitors emergency department visits for conditions that could have been treated in a lower-acuity outpatient setting.

Key signals:

- Repeated ED visits (ER Last 30/60/90 days)
- Low-acuity patient complaints
- Lack of a primary care follow-up

Addressing NED use supports:

- HEDIS Utilization of the ED measure
- DC Medicaid value-based care goals

Why It Matters

1-3

of all ED visits nationally are for non-emergent conditions treatable in primary care settings²

**\$1,500-\$
3,000**

average ED visit cost vs. \$150-\$250 for equivalent urgent care visit²

¹ JAMA Network Open (2022)

² UHC Consumer Cost Guide (2026)

USE CASE 03

Filter Recipe: Non-Emergent ED Reduction

Goal: Identify high-frequency ED users presenting with non-emergent complaints who need redirection to primary care

1

Encounter Type

Isolates ED visits only — the target population for NED

Emergency



2

ER Last 30 Days

Flags patients with 2+ recent ED visits — highest NED risk

Greater Than: 1



3

Patient Complaint

Low-acuity chief complaints that could be managed in primary care

e.g., 'headache', 'cough',
'back pain', 'fever'



4

Follow Up Status

Prioritizes patients with no prior care team outreach

Not Started



Pro Tip: Add the Risk Score filter to layer in your plan's risk stratification — prioritize the highest-risk, highest-frequency ED users first for care manager outreach.

Filter Cheat Sheet

Key filters for each quality measure — ready to apply in Population Explorer

Quality Measure	Primary Filters	Supporting Filters	Filter Method
Transitions of Care	Encounter Type (Inpatient/ED) Discharge Date/Time (Last 7 Days)	Follow Up Status Patient Class	Quick Filter or AFB
PCR 30-Day Readmissions	Encounter Type (Inpatient) Discharge Date/Time (Last 30 Days)	Inpatient Last 30 Days > 0 Diagnosis Code (chronic)	Advanced Filter Builder
Non-Emergent ED	Encounter Type (Emergency) ER Last 30 Days > 1	Patient Complaint Follow Up Status	Quick Filter or AFB

Also worth knowing:

Risk Score 1 & 2 | Care Program | Insurance Type | Primary Care Provider | Discharge Disposition | ACO | Death Indicator



Live Demo

Population Explorer in Action

20 minutes | Follow along using your own panel