Department of Healthcare & Family Services

HealthChoice Illinois ADT

Accurate. Direct. Timely.

OVERVIEW & DEMO

March 26, 2021

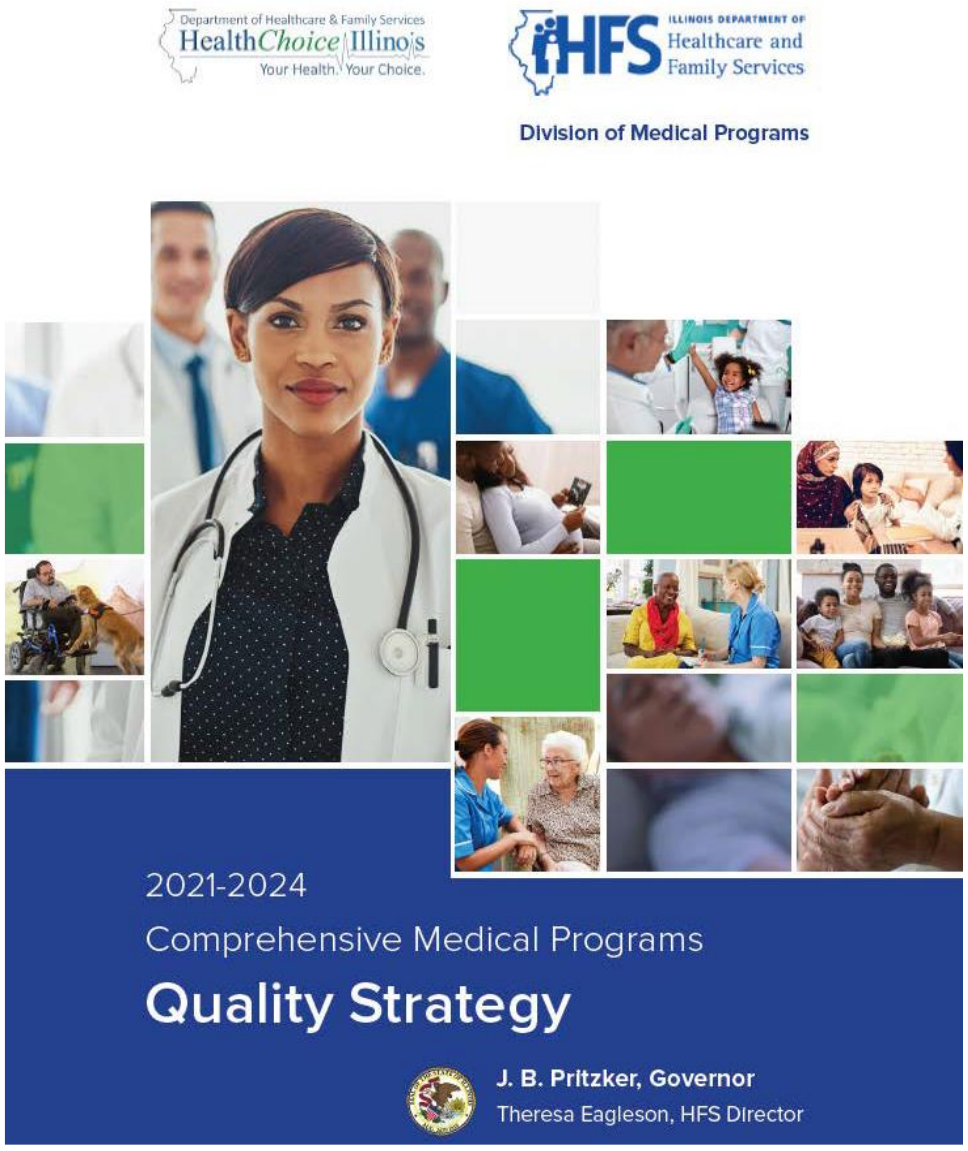
AGENDA

- INTRODUCTIONS
  - **Teresa Flesch**, Deputy Administrator of Operations for Medical Programs, HFS
  - **Stephanie Volante**, Director, Patient Financial Services, Health Policy & Finance, Illinois Hospital Association
  - **Laura Cedro**, PharmD, MPH, Senior Clinical Solutions Lead, Collective Medical Technologies
  - **Kary Nulisch**, General Manager, Collective Medical Technologies
- HEALTHCHOICE ILLINOIS ADT OVERVIEW
- TECHNOLOGY PLATFORM DEMONSTRATION
- HOSPITAL ONBOARDING PROCESS
- QUESTIONS AND NEXT STEPS

What is the HealthChoice Illinois ADT Project?

- The Illinois Department of Healthcare and Family Services (HFS) is launching **HealthChoice Illinois ADT**, a statewide data exchange platform that will deliver vital information to Illinois Medicaid providers in a timely and secure manner.
- The first phase of **HealthChoice Illinois ADT** will enable admission, discharge and transfer (ADT) notifications to be shared with Medicaid providers whose patients visit a hospital inpatient unit or emergency department.
- All hospitals that are enrolled in the IMPACT system to serve patients enrolled in Medicaid will be required to transmit ADT notifications for Medicaid enrollees in an HL7 format to **HealthChoice Illinois ADT** by September 30, 2021.
- Managed Care Organizations (MCOs) will subscribe to **HealthChoice Illinois ADT** to receive either "raw" ADT messages, or translated ADT notifications through the Collective Medical user portal, depending on their existing system capability to ingest ADT data.
- Illinois providers enrolled in the IMPACT system and engaged in care coordination services for persons enrolled in Medicaid are eligible to subscribe to **HealthChoice Illinois ADT** to receive ADT notifications for their patients.
- Future phases will enable sharing other types of data to support the goals of HFS' Comprehensive Medical Programs Quality Strategy.

Supporting HFS Quality Strategy



Goals

Better Care

1. Improve population health.
2. Improve access to care.
3. Increase effective coordination of care.

Healthy People/Healthy Communities

4. Improve participation in preventive care and screenings.
5. Promote integration of behavioral and physical healthcare.
6. Create consumer-centric healthcare delivery system.
7. Identify and prioritize reducing health disparities.
8. Implement evidence-based interventions to reduce disparities.
9. Invest in the development and use of health equity performance measures.
10. Incentivize the reeducation of health disparities and achievement of health equity.

Affordable Care

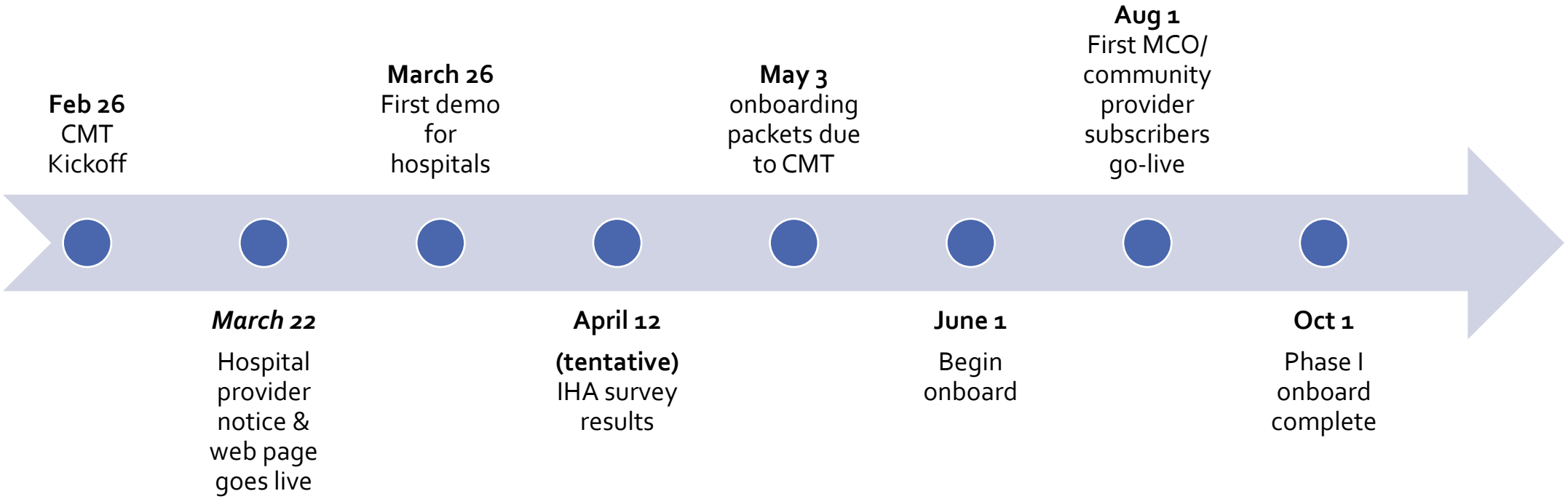
11. Transition to value- and outcome-based payment.
12. Deploy technology initiatives and provide incentives to increase adoption of electronic health records (EHRs) and streamline and enhance performance reporting, eligibility and enrollment procedures, pharmacy management, and data integration.

Objectives & Success Measures of HealthChoice Illinois ADT

- Hospitals contributing ADTs
- Quality of data in the ADTs
- Use of ADT messages by providers (subscribers)
- Impact on targeted HEDIS measures

Measure[1]	Measure Description
FUH - 7-Days	Percentage of Adults Age 21 and Older Hospitalized for Treatment of Mental Illness Receiving a Follow-Up Visit within 7 Days of Discharge
FUH - 30-Days	Percentage of Adults Ages 21 and Older Hospitalized for Treatment of Mental Illness Receiving a Follow-Up Visit within 30 Days of Discharge
IET - Initiation	Percentage of Adults Age 18 and Older with a New Episode of Alcohol or Other Drug Dependence Who: Initiated Treatment within 14 Days
IET - Engagement	Percentage of Adults Age 18 and Older with a New Episode of Alcohol or Other Drug Dependence Who: Initiated Treatment and Had Two or More Follow-up Visits within 30 Days
PCR-HH	For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Draft Timeline



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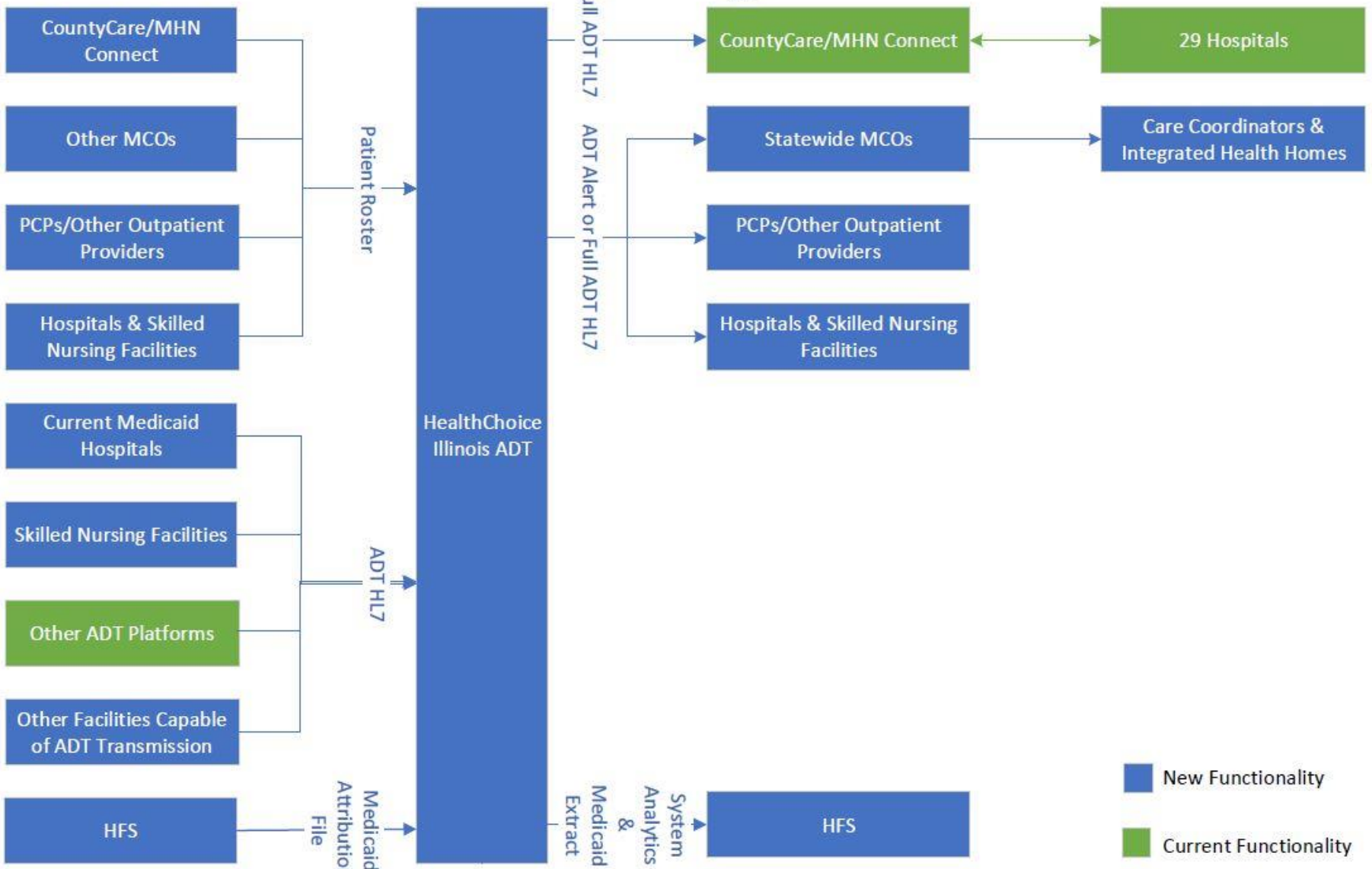


Collective Medical Technologies

OUR MISSION

Collective improves health outcomes and lowers cost by placing the right insights in front of each stakeholder along a patient's journey to inform and encourage the right action for the patient

About Collective

Collective Medical operates the largest and most sophisticated care collaboration network in the US

61 Million+
patients supported by the network

375 Million+
acute and sub-acute encounters—recorded, analyzed, and for which notifications have been sent

1000+
ADT feeds gathered from hospitals, health systems, and HIEs nationwide

2500+
entities contributing continuity of care documents (CCD), claims data, and prescription information

20,000+
ED Providers interact with the Collective Platform daily

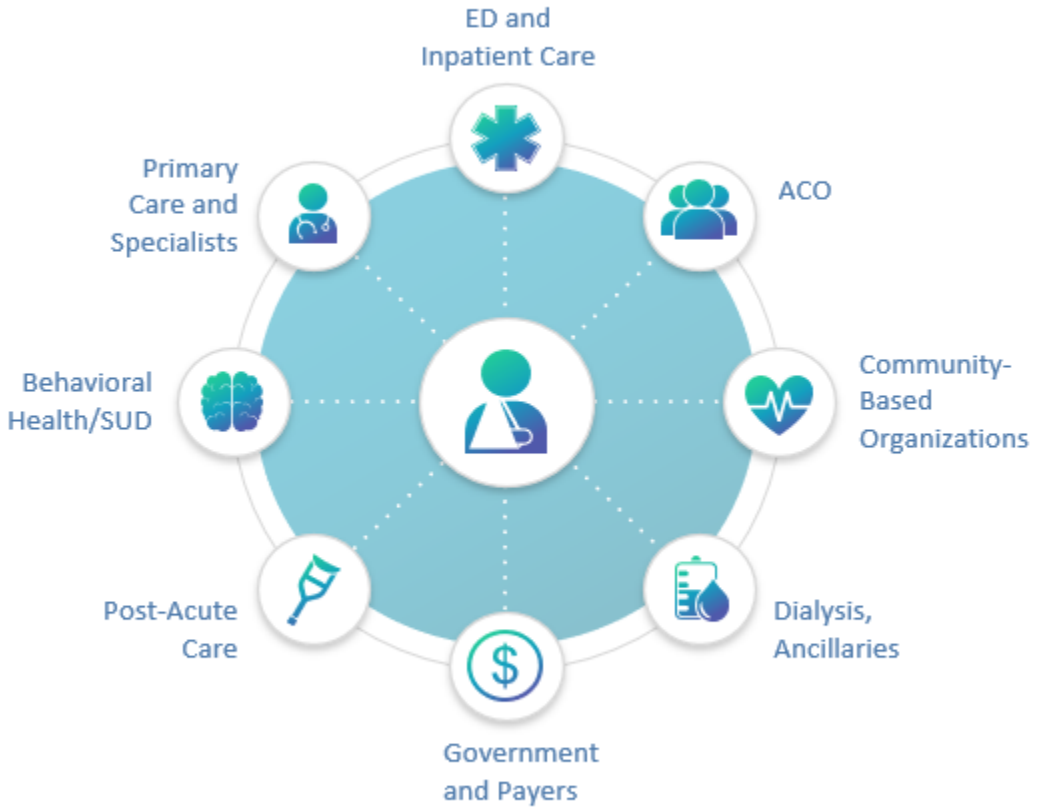
Endorsed by:

HITRUST CSF Certified

American College of Emergency Physicians
ADVANCING EMERGENCY CARE

What is Collective Medical?

Collective is a care coordination solution that gets the right information to the right person at the point of care.



A NETWORK

Collective is a network of hospitals, emergency departments, primary care, specialists, behavioral health providers, post-acute care providers, and health plans across the United States, sharing important patient information at the time of care

A PLATFORM

Collective is a platform that intelligently connects each member of a patient's care team for seamless collaboration at the right time and through the best medium

A COMMUNITY

Collective is a community of providers in the care of patients—especially those with complex medical needs—in your communities and across the country.

Building strong communities to support patients

IMPORTANT, COMMODITIZED

Data aggregation

- Move data from Point A to B
- Can be sourced by Collective (largest network in the US), from HIEs, trust frameworks (e.g., Carequality), or even private vendors such as PP, Ai, or ELLKAY

HCA

velatura

collectivemedical

Providers

ELLKAY

PATIENTPING

carequality

Ai

Data manipulation / Insight generation

- Insight extraction and generation; Collective drives deterministic and ML-based risk models to anticipate avoidable risk and opportunities for proactive patient engagement (e.g., ED high utilizers, overdose risk, complex obstetric, etc.) and can also work with third parties (e.g., the payer, Nuna, others to incorporate risk-stratified patient-specific insights, risk scores, etc.)

NUNA

abacus insights

collectivemedical

COLLECTIVE'S KEY DIFFERENTIATOR

Insight Sharing

- Best-in-class last-mile workflow integration (i.e. we need x user to modify y behavior to impact z outcome; so we need a data to generate b insights to populate c notification delivered via d pathway at e frequency with f context to g recipient)
  - EMR integration, fax, printer, DIRECT, email, SMS, mobile app, pop health, SMART on FHIR, Vocera, TigerText, etc.
- Not data consumption for consumption's sake, but pushing key insights, 1:1, as a function of risk by making it usable, relevant, timely, and deliverable to focus the provider's attention

Landmark

Aledade

CITYBLOCK

collectivemedical

Supporting Medicaid programs across the US

Washington Outcomes

According to The Brookings Institution, in a review of Washington State's ER is for Emergencies program, use of Collective as part of the program resulted in the following:[5]

- 9.9 percent overall reduction in Medicaid-related ED encounters
- 24 percent decrease in opioid prescriptions written in the ED
- 14.2 percent reduction in low-acuity ED visits
- 10.7 percent decrease in ED visits among high utilizers
- $34 million in savings during the program's first year of operation

Oregon Outcomes

Sharing patient information across the care continuum, and ensuring that providers have access to the insights they need to make more informed care decisions, has helped decrease potentially unnecessary ED utilization in Oregon. Through collaboration managed by HIT Commons, potentially avoidable **ED visits from patients with patterns of high utilization decreased 10.9 percent** from 2017 to 2019.[6]

Care collaboration has also led to faster patient follow-up after discharge. One organization, which historically had difficulty getting timely notifications when mental health clients were discharged from the hospital, was able to successfully implement a workflow that resulted in **almost all of its patients receiving follow-up care within seven days of discharge.**[7]

10% drop in total Medicaid ED visits year-over-year

70% reach for Medicaid member engagement

11% reduction in ED visits for patients with high utilization patterns

50% reduction in 30-day readmission rates

Virginia Outcomes

With updated demographic information and real-time notifications, member engagement improved across all MCOs. For UnitedHealthcare of Virginia, Medicaid member **engagement rates increased from 30 percent to 70 percent.**

New Mexico Outcomes

By engaging members in moments of crisis, peer support specialists can help guide members towards long-term solutions. This support has led to a **70 percent decrease in ED visits** and a **50 percent decrease in 30-day readmission rates** among members participating in the program.[11]

Illinois HFS – Care Collaboration and Coordination Across Settings

1 MCO Care & Utilization Optimization

Enables MCOs to identify patients with high or rising patterns of acute care services, chronic disease, behavioral health issues, and collaborate with providers in real time to put patients on the best path forward.

2 Hospitals and Emergency Departments

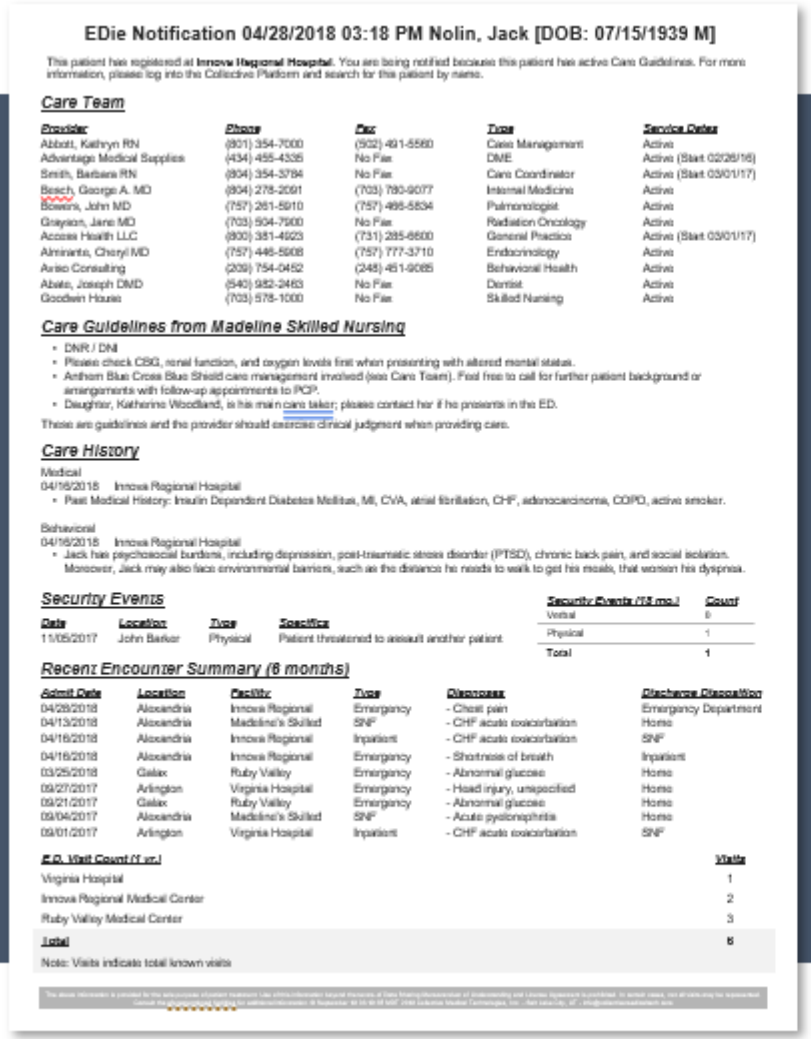
Alerts emergency department staff and providers to patient specific risk factors as soon as a patient registers, stand on the shoulders of other care team members to efficiently take the right action for the individual patient

3 Participating Community Providers and Health Homes

Ambulatory and Clinic providers made aware of how and when attributed patients are interacting with the healthcare system, and can follow-up rapidly after discharges and ED encounters to provide transitional care management and better maintain longitudinal care.

Care collaboration is enabled when disparate nodes are connected on a common platform

Bi-directional Communication MCO and Provider Network



EDie Notification 04/28/2018 03:18 PM Nolin, Jack [DOB: 07/15/1939 M]

This patient has registered at **Innova Regional Hospital**. You are being notified because this patient has active Care Guidelines. For more information, please log into the Collective Platform and search for this patient by name.

Care Team

Provider	Phone	Fax	Type	Service Dates
Abbott, Kathryn RN	(801) 354-7000	(502) 491-5560	Case Management	Active
Advantage Medical Supplies	(434) 455-4335	No Fax	DME	Active (Start 02/26/16)
Smith, Barbara RN	(804) 354-3784	No Fax	Care Coordinator	Active (Start 03/01/17)
Besch, George A. MD	(804) 278-2091	(703) 780-9077	Internal Medicine	Active
Bowers, John MD	(757) 261-5910	(757) 466-5834	Pulmonologist	Active
Grayson, Jane MD	(703) 504-7900	No Fax	Radiation Oncology	Active
Access Health LLC	(800) 381-4923	(731) 285-6600	General Practice	Active (Start 03/01/17)
Almirante, Cheryl MD	(757) 446-5908	(757) 777-3710	Endocrinology	Active
Aniso Consulting	(209) 754-0452	(248) 451-9085	Behavioral Health	Active
Abate, Joseph DMD	(540) 952-2463	No Fax	Dentist	Active
Goodwin House	(703) 578-1000	No Fax	Skilled Nursing	Active

Care Guidelines from Madeline Skilled Nursing

- DNR / DNI
- Please check CBG, renal function, and oxygen levels first when presenting with altered mental status.
- Anthem Blue Cross Blue Shield care management involved (see Care Team). Feel free to call for further patient background or arrangements with follow-up appointments to PCP.
- Daughter, Katherine Woodland, is his main care taker; please contact her if he presents in the ED.

These are guidelines and the provider should exercise clinical judgment when providing care.

Care History

Medical
04/16/2018 Innova Regional Hospital
- Past Medical History: Insulin Dependent Diabetes Mellitus, MI, CVA, atrial fibrillation, CHF, adenocarcinoma, COPD, active smoker.

Behavioral
04/16/2018 Innova Regional Hospital
- Jack has psychosocial burdens, including depression, post-traumatic stress disorder (PTSD), chronic back pain, and social isolation. Moreover, Jack may also face environmental barriers, such as the distance he needs to walk to get his meals, that worsen his dyspnea.

Security Events

Date	Location	Type	Specifics
11/05/2017	John Barker	Physical	Patient threatened to assault another patient

Security Events (18 mo.)	Count
Verbal	0
Physical	1
Total	1

Recent Encounter Summary (6 months)

Admit Date	Location	Facility	Type	Diagnoses	Discharge Disposition
04/28/2018	Alexandria	Innova Regional	Emergency	- Chest pain	Emergency Department
04/13/2018	Alexandria	Madeline's Skilled	SNF	- CHF acute exacerbation	Home
04/16/2018	Alexandria	Innova Regional	Inpatient	- CHF acute exacerbation	SNF
04/16/2018	Alexandria	Innova Regional	Emergency	- Shortness of breath	Inpatient
03/25/2018	Galax	Ruby Valley	Emergency	- Abnormal glucose	Home
09/27/2017	Arlington	Virginia Hospital	Emergency	- Head injury, unspecified	Home
09/21/2017	Galax	Ruby Valley	Emergency	- Abnormal glucose	Home
09/04/2017	Alexandria	Madeline's Skilled	SNF	- Acute pyelonephritis	Home
09/01/2017	Arlington	Virginia Hospital	Inpatient	- CHF acute exacerbation	SNF

E.D. Visit Count (1 yr.)	Visits
Virginia Hospital	1
Innova Regional Medical Center	2
Ruby Valley Medical Center	3
Total	6

Note: Visits indicate total known visits

Authoring Care Plans

Targeted specifically toward physicians, particularly in the emergency department

Delivered in real-time to the point of care, directly integrated into existing workflows

Contains curated, easy to consume, actionable information designed to aid in addressing acute episodes

Insights

COLLECTIVE ACO | ST. FRANCIS HOSPITAL

Care Coordination:

Collective ACO provides care coordination support for Ramesh- see details in Care Teams above for direct contact number which is staffed 24 hours a day for patient needs.

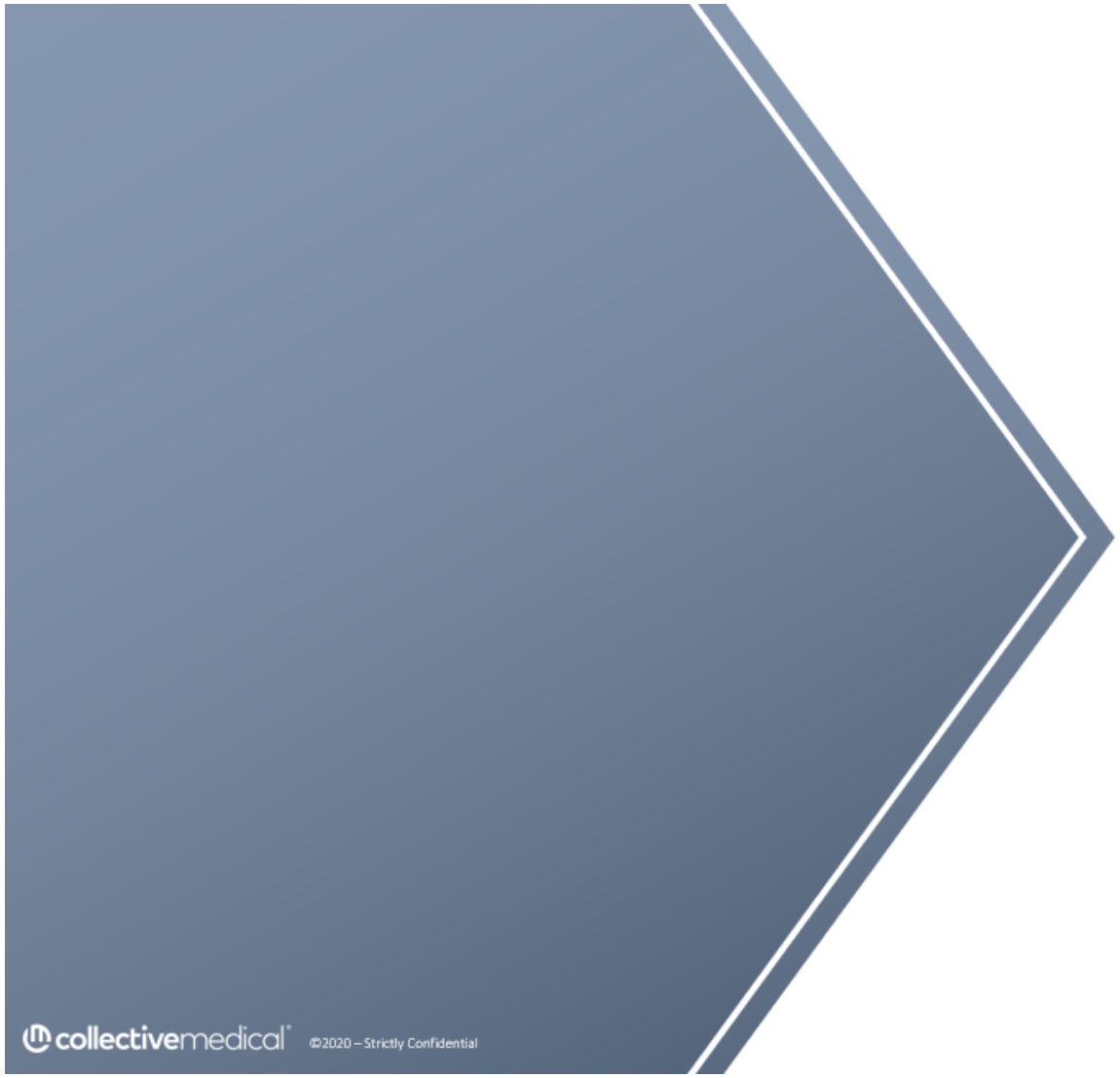
Please contact directly for assistance with transitions of care and authorizations for SNF, HH, DME or Specialty Care

Cardiology Referral approved through 6/2020-12/2020 for Dr. James River

- Ramesh has only attended 1 outpatient cardiology since initial authorization

These are guidelines and the provider should exercise clinical judgment when providing care.

Emergency Department Optimization



Emergency Department Optimization

Key risk factors are highlighted at the top, namely Security and Safety Events

Enables more informed decision making with easy to consume, summarized Care Histories, including medical and surgical, infections, chronic conditions, substance use, behavioral, social, and radiation

Provides a summary of Recent Encounters, including location, encounter type, and diagnoses / chief complaint

A link to the patient's aggregate profile on the platform to contribute and access attachments (e.g., Advanced Directives)

COLLECTIVE NOTIFICATION 04/10/2019 14:12 TYLER, BILL MRN: 202589839

You are being notified because this patient has a **Security and Safety Event, Insights,** and **>5 ED Encounters in 12 Months**

Security and Safety

Date	Location	Type	Specifics
3/12/2019 14:32	Sisters of Mercy	Physical	• **Details:** Patient struck case manager with hands and feet

Security Events (18 mo)	Count
Physical	1
Total	**1**

Care Insights from New Horizons BH Clinic

Last Updated: 3/1/19 10:34

- Provide a low stim environment in the ED; does not respond well to hallway treatment
- Consider an involuntary psych hold; has never admitted psych inpatient voluntarily
- Seroquel dispensed daily at ACT facility; ACT team travels to pt's homeless camp to dispense meds if pt no shows
- Reasonable and redirectable when medication-compliant, with only intermittent mild psychotic features
  - Decompensates quickly after missing meds
  - Sever psychotic episodes have included paranoia, pressured speech, anxious, auditory hallucinations, labile mood—known to have physically aggressive behavior towards staff
- Escalates in response to security/police; advise having security out-of-view
- ED can D/C pt to ACT team; if no psychosis. ACT will admit to NHBHC transitional housing unit (2-week respite bed providing meds onsite until further stabilized)

Care Coordination

1. Enrolled w/ the VBHC Assertive Community Treatment (ACT) team for SPMI
2. Please call the 24/7 crisis line—503-555-6666
3. ACT is available for real time telephonic coordination and can also travel to the ED to help with D/C
4. ACT can help assess for psych admission vs D/C

These are guidelines and the provider should exercise clinical judgment when providing care.

Care History

Substance Use / Overdose

12/6/2018 New Horizons BHC
- Intermittent alcohol abuse; typically leads to missing meds and further decompensation

Behavioral

2/15/19 New Horizons BHC
- Dx of Schizoaffective Disorder
- 6 prior psych admissions in the past 3 years; has required an involuntary psych hold
- Frequently verbalizes assaultive ideation, primarily in response to paranoid delusions

Social

1/2/19 New Horizons BHC
- Homeless since age 14
- No family supports: parents also have SUD; older brother is incarcerated
- Lives alone in a homeless camp in the city park; refuses to stay in shelters d/t paranoia
- Has been trying to apply for disability benefits but has been denied on first application; pt is a SNAP beneficiary

Recent Encounters

Date	Facility	City, State	Type	Diagnoses or Chief Complaint
3/12/2019	Sisters of Mercy	San Jose, CA	Emergency	• Headache
2/23/2019	Sisters of Mercy	San Jose, CA	Emergency	• Lower Back Pain
2/25/2019	Ruby Valley	Palo Alto, CA	Emergency	• Headache
1/18/2019	Covington Hospital	Coyote, CA	Inpatient	• Generalized Abdominal Pain

E.D. Encounter Count (12 mo)	Encounters
Sisters of Mercy	8
Covington Hospital	3
Ruby Valley Medical Center	2
Total	**13**

Care Team

Provider	Type	Phone	Fax
Erin Shah, MD	Psychiatry	(206) 555-1213	(206) 555-1212
David Smith, LCSW	Counselor	(206) 231-3125	(206) 231-3126
Laura Kowalski	Act Team	(534) 555-9513	(734) 555-2121

Collective Portal

For more information visit: https://demo.ediecareplan.com/patient/355

Care Guidelines eliminate duplicative case management resource expenditure by clearly enabling a single lead case manager to "quarterback" the patient's care management activities, which leads to a common care guidelines across stakeholders

Identifies providers on the patient's Care Team

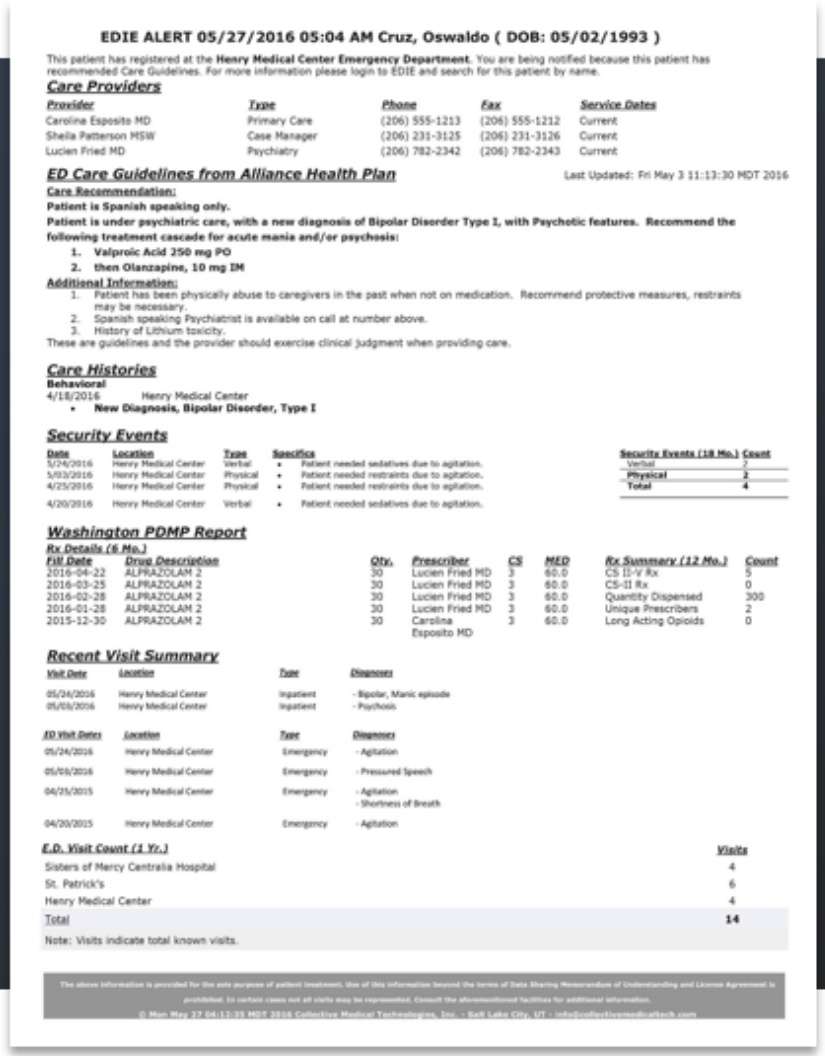
Collective Notification Workflow

< 1 Second			< 1 Minute	Ongoing
Patient presents at hospital check-in	Hospital EHR immediately, automatically alerts Collective	Patient identified; visit history aggregated	Provider notified if encounter meets criteria	Providers take action to influence care outcome
• Patient checks in with hospital registration • Hospital records core identification and demographic info	• Collective is directly integrated with the hospital EHR—no additional data entry required • Patient registration data immediately sent from hospital to Collective	• Collective identifies patient (even if key information missing from patient's hospital record) • The Collective platform cross-references patient with prior ED and inpatient visit history across systems	• If visit triggers the organization's established criteria, Collective notifies the end-user • Notifications contain visit history, diagnoses, prescriptions, guidelines, and other clinical data	• Provider has the information in hand before they see the patient • Patient-provider information asymmetry is closed; able to make informed care decision • Additional members of the patient's care team are notified in order to proactively engage

Notifications: When does the ED receive them?

Standard ED Notification Criteria

1. Patterns of high ED utilization
2. Patients traveling to multiple EDs
3. Care Plans available
4. History of Safety & Security Events
5. History of Sepsis Diagnosis



EDIE ALERT 05/27/2016 05:04 AM Cruz, Oswaldo (DOB: 05/02/1993)

This patient has registered at the **Henry Medical Center Emergency Department**. You are being notified because this patient has recommended Care Guidelines. For more information please login to EDIE and search for this patient by name.

Care Providers

Provider	Type	Phone	Fax	Service Dates
Carolina Esposito MD	Primary Care	(206) 555-1213	(206) 555-1212	Current
Sheila Patterson MSW	Case Manager	(206) 231-3125	(206) 231-3126	Current
Lucien Fried MD	Psychiatry	(206) 782-2342	(206) 782-2343	Current

ED Care Guidelines from Alliance Health Plan Last Updated: Fri May 3 11:13:30 MDT 2016

Care Recommendation:

Patient is Spanish speaking only.

Patient is under psychiatric care, with a new diagnosis of Bipolar Disorder Type I, with Psychotic features. Recommend the following treatment cascade for acute mania and/or psychosis:

1. **Valproic Acid 250 mg PO**
2. **then Olanzapine, 10 mg IM**

Additional Information:

1. Patient has been physically abuse to caregivers in the past when not on medication. Recommend protective measures, restraints may be necessary.
2. Spanish speaking Psychiatrist is available on call at number above.
3. History of Lithium toxicity.

These are guidelines and the provider should exercise clinical judgment when providing care.

Care Histories

Behavioral

4/18/2016 Henry Medical Center

- **New Diagnosis, Bipolar Disorder, Type I**

Security Events

Date	Location	Type	Specifics
5/24/2016	Henry Medical Center	Verbal	• Patient needed sedatives due to agitation.
5/03/2016	Henry Medical Center	Physical	• Patient needed restraints due to agitation.
4/25/2016	Henry Medical Center	Physical	• Patient needed restraints due to agitation.
4/20/2016	Henry Medical Center	Verbal	• Patient needed sedatives due to agitation.

Security Events (18 Mo.)	Count
Verbal	2
Physical	2
Total	4

Washington PDMP Report

Rx Details (6 Mo.)

Fill Date	Drug Description	Qty.	Prescriber	CS	MED
2016-04-22	ALPRAZOLAM 2	30	Lucien Fried MD	3	60.0
2016-03-25	ALPRAZOLAM 2	30	Lucien Fried MD	3	60.0
2016-02-28	ALPRAZOLAM 2	30	Lucien Fried MD	3	60.0
2016-01-28	ALPRAZOLAM 2	30	Lucien Fried MD	3	60.0
2015-12-30	ALPRAZOLAM 2	30	Carolina Esposito MD	3	60.0

Rx Summary (12 Mo.)	Count
CS II-V Rx	5
CS-II Rx	0
Quantity Dispensed	300
Unique Prescribers	2
Long Acting Opioids	0

Recent Visit Summary

Visit Date	Location	Type	Diagnoses
05/24/2016	Henry Medical Center	Inpatient	- Bipolar, Manic episode
05/03/2016	Henry Medical Center	Inpatient	- Psychosis

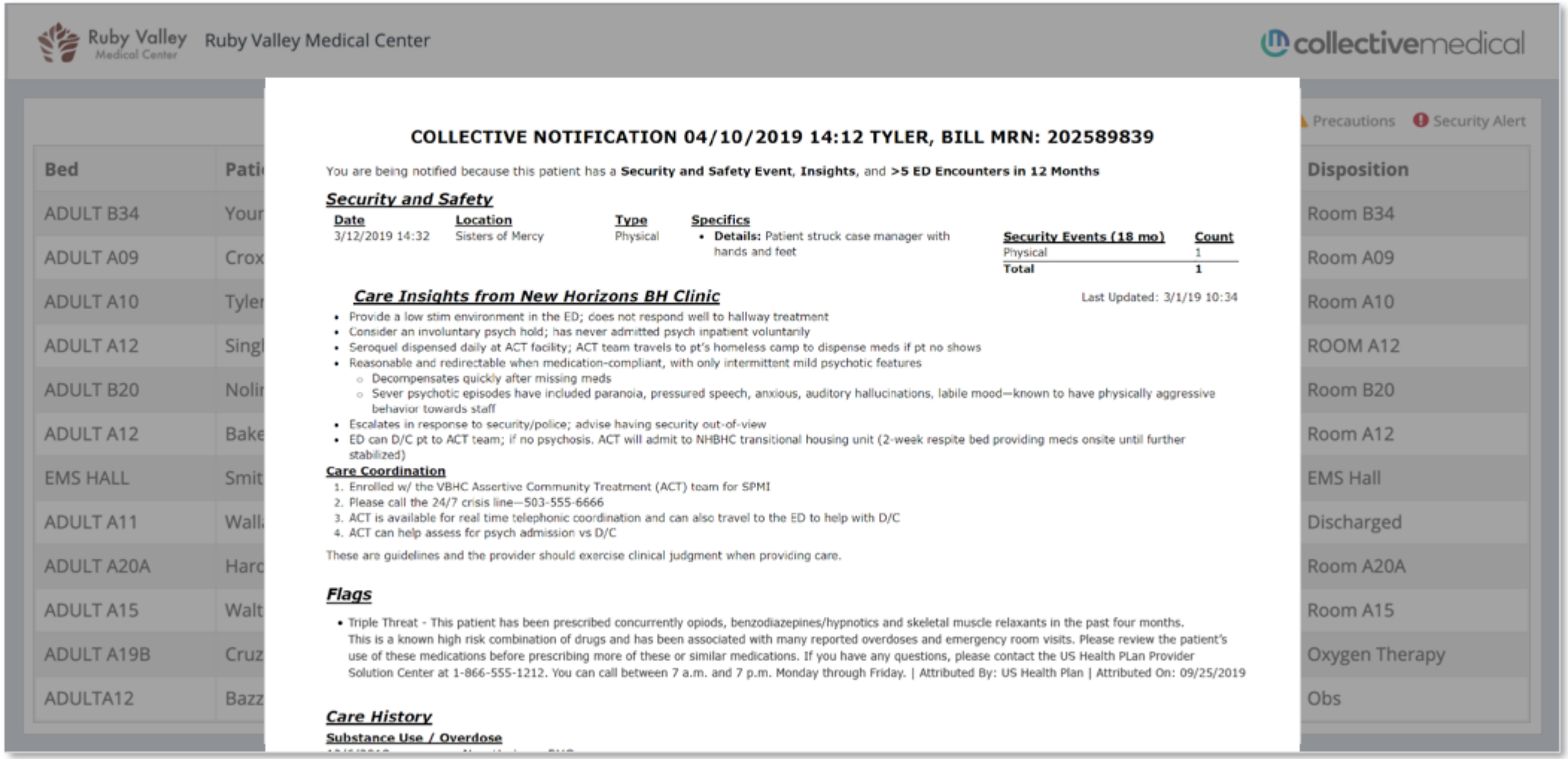
ED Visit Dates	Location	Type	Diagnoses
05/24/2016	Henry Medical Center	Emergency	- Agitation
05/03/2016	Henry Medical Center	Emergency	- Pressured Speech
04/25/2015	Henry Medical Center	Emergency	- Agitation - Shortness of Breath
04/20/2015	Henry Medical Center	Emergency	- Agitation

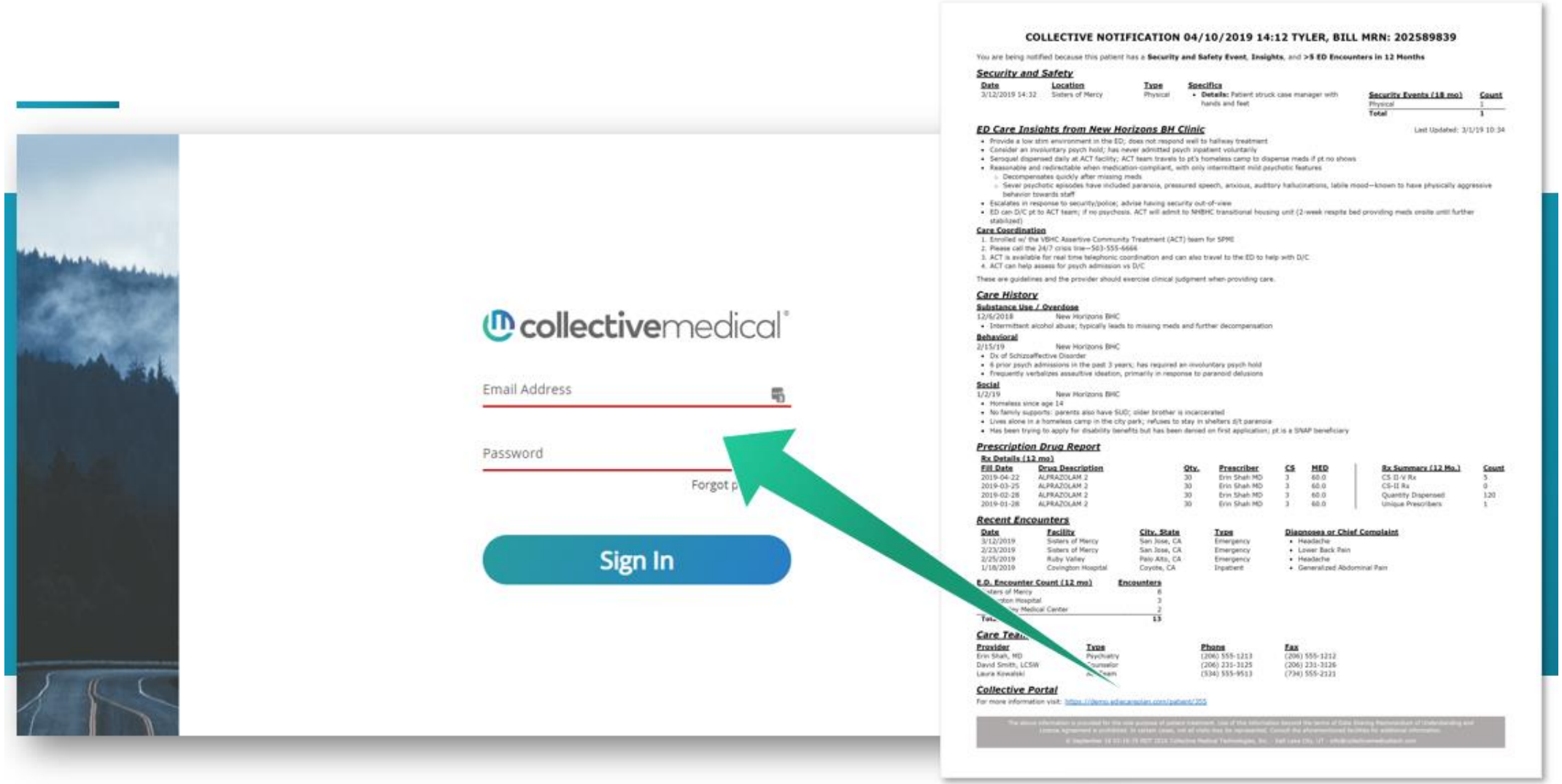
E.D. Visit Count (1 Yr.)	Visits
Sisters of Mercy Centralia Hospital	4
St. Patrick's	6
Henry Medical Center	4
Total	14

Note: Visits indicate total known visits.

Emergency Department Track Board Example

Clicking on any of the alert icons accesses critical clinical context on the patient




collectivemedical
Email Address
Password
Forgot p
Sign In
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Date
Location
Type
Specifics
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1
Total
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Reasonable and redirectable when medication-compliant, with only intermittent mild psychotic features
Decompensates quickly after missing meds
Sever psychotic episodes have included paranoia, pressured speech, anxious, auditory hallucinations, labile mood—known to have physically aggressive behavior towards staff
Escalates in response to security/police; advise having security out-of-view
ED can D/C pt to ACT team; if no psychosis. ACT will admit to NHBHC transitional housing unit (2-week respite bed providing meds onsite until further stabilized)
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Social
1/2/19 New Horizons BHC
Homeless since age 14
No family supports: parents also have SUD; older brother is incarcerated
Lives alone in a homeless camp in the city park; refuses to stay in shelters d/t paranoia
Has been trying to apply for disability benefits but has been denied on first application; pt is a SNAP beneficiary
Prescription Drug Report
Rx Details (12 mo)
Fill Date
Drug Description
Qty.
Prescriber
CS
MED
2019-04-22 ALPRAZOLAM 2 30 Erin Shah MD 3 60.0
2019-03-25 ALPRAZOLAM 2 30 Erin Shah MD 3 60.0
2019-02-28 ALPRAZOLAM 2 30 Erin Shah MD 3 60.0
2019-01-28 ALPRAZOLAM 2 30 Erin Shah MD 3 60.0
Rx Summary (12 Mo.)
Count
CS II-V Rx 5
CS-II Rx 0
Quantity Dispensed 120
Unique Prescribers 1
Recent Encounters
Date
Facility
City, State
Type
Diagnoses or Chief Complaint
3/12/2019 Sisters of Mercy San Jose, CA Emergency Headache
2/23/2019 Sisters of Mercy San Jose, CA Emergency Lower Back Pain
2/25/2019 Ruby Valley Palo Alto, CA Emergency Headache
1/18/2019 Covington Hospital Coyote, CA Inpatient Generalized Abdominal Pain
E.D. Encounter Count (12 mo)
Encounters
6
3
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Care Team
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Type
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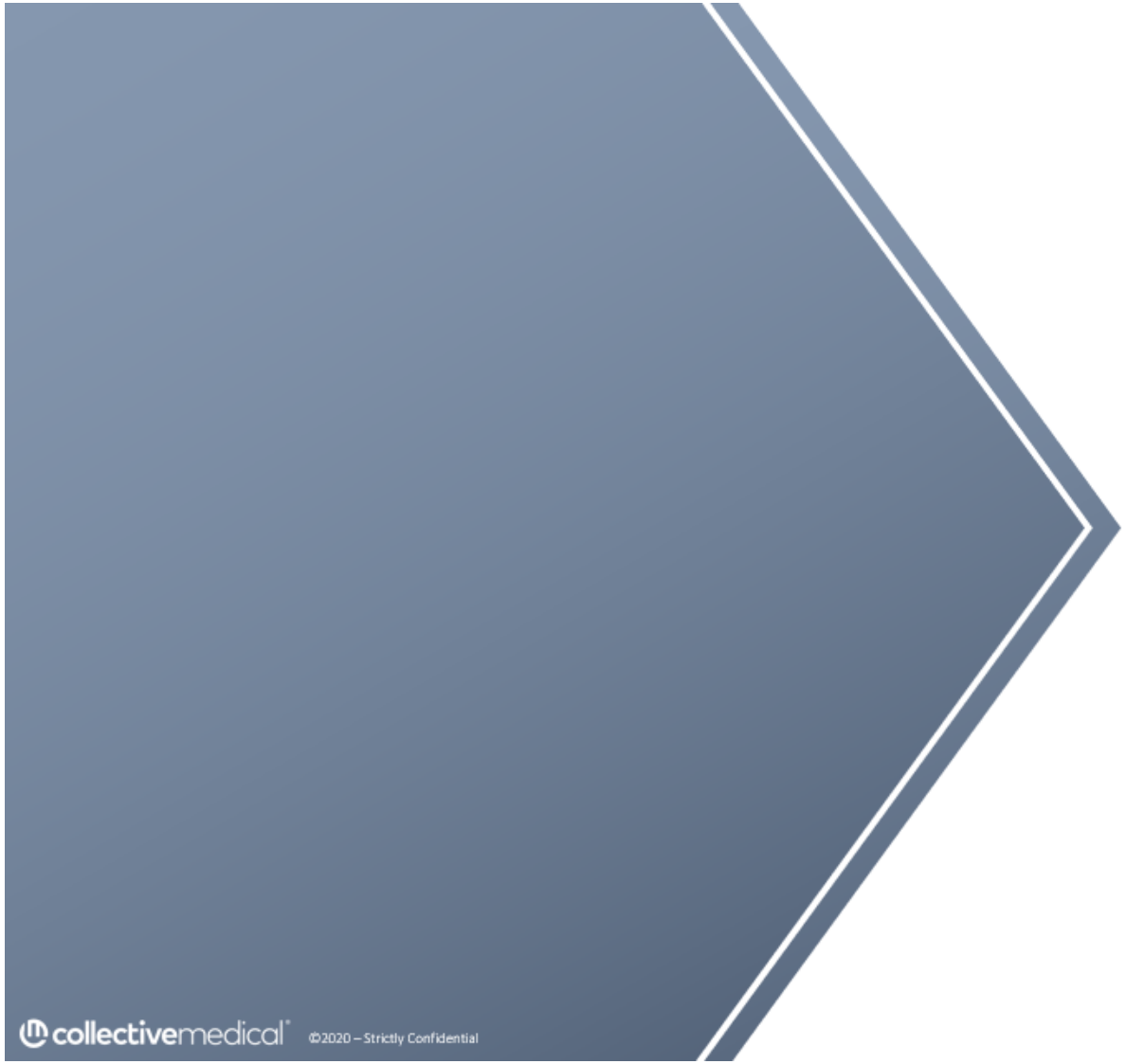
Collective Portal
For more information visit:

CMT Implementation Process



CMT Implementation Process

The Implementation Process

Technical Implementation

Steps:

1. Identify technical resources for project
2. Establish Secure Connectivity (.5 – 1.5 hours)
3. Outbound ADT Interface (.5 – 1.5 hours)
4. Return Notifications to / EMR (project specific)
   - EMR read receipts (click rates)
5. Single Sign On
6. Historical Encounter Data (3 – 6 hours)

Clinical Implementation

Steps:

1. Identify clinical resources for the project
2. Determine your facility's goals and identify workflows
3. Identify additional team members or facilities to engage within the implementation
4. Establish reporting metrics
5. Train all members of your team according to your goals
6. Begin using the platform and iterate workflows for optimization

Technical Implementation – Establish Connectivity

Determine the appropriate way to connect your ADT feed to the Collective Medical database:

- HL7 over REST (preferred)
- VPN

Technical Implementation – Outbound ADT Interface

ADT outbound

- Standard ADT feed to send HL7 to Collective Medical
  - Emergency
  - Inpatient
  - Observation
  - Pre-Admit
  - Outpatient (optional)
- Can often be cloned feed if available

ADT Mappings

- Translation of values around PV1 segment, as well as others

Technical Implementation – Historical File

Historical File – provides historical context, allowing criteria to trigger on day 1

- 12 – 24 months of historical encounter data
- Validation File - 1 week after go-live

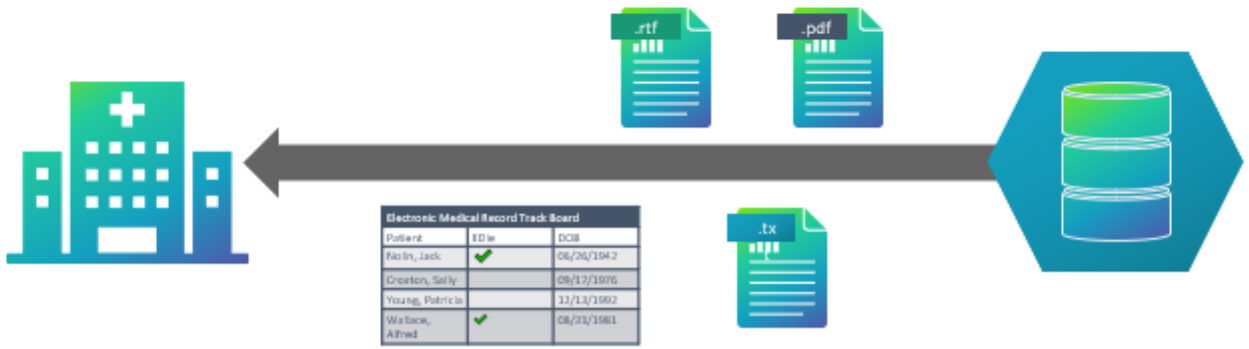
Technical Implementation – Notifications

Integrate Collective Notifications into your EMR track board

Notification types

- ORU (PDF/RTF)
- MDM (PDF/RTF)
- Plain Text

Store Collective Notification ID that is sent within HL7 message



Technical Implementation – Data Quality Review

After processing data for 6 weeks, Collective Medical will perform a data quality review. We request support from your team to address data points/fields that can be improved.

- This process is designed to help us ensure we are getting the best data we can from hospitals. As we continually improve our platform and release new functionality, we want to make sure that all hospitals (and the rest of our network) can benefit from the full functionality.

- While our initial quality check will catch many common issues, we do not have enough data history to tell the whole story. By reviewing after 6 weeks, we'll have a larger window to evaluate.

Clinical Implementation – Identify Clinical Goals

Articulate Your Goals

Discuss with your Implementation Specialist the goals you have within your facility / organization and how Collective can help you best achieve them.

Review Clinical Onboarding Forms

- User Account Form
- Notifications Criteria Form
- Notifications Routing Form
- Verification of Primary Contacts
- Review metrics reporting and parameters

Clinical Implementation – Training and Activation

Provide Training to your Team

Schedule and attend one or more training sessions depending on your facility's needs, ensuring that everyone who will access or use the Collective Platform understands their role and responsibilities as they pertain to your established goals.

Go-Live

Activate notifications and grant users access to your portal

Clinical Implementation – Training and Activation

Schedule Periodic meetings with your Client Success Specialist

- 1 week
- 1 month
- 3 month

Look for Areas of Improvement

- Identify potential room for improvement
- Adjust workflows accordingly to get the most out of the Collective Platform
- Look for ways to improve care as identified within your facility
- Look for inter-facility improvement opportunities

Implementation Timeline – Key Milestones

	Key Milestones	Start Date	End Date
1	Project Kickoff Call— Weekly Project Meeting	Today	
2	Connectivity: VPN/REST		
3	ADT Feed/Messages • Test • Mappings • Prod		
4	EMR Integration • EDie Return Message • EMR Build • Configure Icon • Validation		
5	Historical Files Submitted • SFTP		
6	SSO/Active Directory (Optional)		
7	Identify Clinical Goals/Set-Up Initial Users		
8	Complete trainings and go-live. Plan check-in point to review notification and clinical workflow updates have been successful.		

Onboarding Packet

Each hospital will receive an onboarding packet to help expedite the process. The packet includes:

- The paperwork that will need to be signed such as:
  - An MSA that defines the general terms and conditions
  - A BAA that defines all of the data sharing and HIPAA related items
  - An SOF that defines the solution you are receiving, term, etc.
- An FAQ document about the program that can be distributed across your facility
- White papers on how using this technology has positively impacted patient care at a statewide and facility level
- The VPN connection form that helps define the first step of the IT process

Questions and Next Steps

Please look out for the IHA survey next week and respond to it as soon as possible.

Additional information and periodic updates will be posted to:

https://www.illinois.gov/hfs/healthchoiceadt/Pages/default.aspx

THANK YOU