HealthChoice Illinois ADT

Clinical Collaboration Group

Collaborate to Improve Patient Outcomes

August 08, 2024

HFS
Illinois Department of
Healthcare and Family Services

Agenda

- Introductions
  - **Dana Wilson**, PMP, Program Manager, HFS, Division of Medical Programs, Program & Policy Coordination, Federal Health Information Planning
  - **Nancy Sehy**, BSN, RN, CHPCA, Sr. Clinical Solutions Lead, PointClickCare
  - **Patrick Dombrowski**, Executive Director, Collaborative Bridges Healthcare Transformation Collaborative
- HealthChoice Illinois ADT Program Updates
- Technical Advisory Committee (TAC) Updates
- Exploring Additional Data Segment Needs and Solutions
- Burden Reduction through Bi-Directional Communication
- Future Communication Plans and Onboarding Support
- Platform Updates and New Features
- Open Discussion and Q & A
- Next Steps / Upcoming CCG Events

One company. One mission.

Combining the strengths of two leaders in care.

PointClickCare®

Nation's Largest Post Acute Care EHR

Network Coverage

2.3+ million LTPAC admissions processed in 2018
750 million medications administered monthly
1.7 million patient records managed daily
15,000+ skilled nursing facilities

Shaping & Enabling Value Based Care

collectivemedical®

Leading Real-time Care Coordination Network

Deep and Broad Data Sets

2,700+ hospitals & >6,200 total nodes
Data ingestion & normalization, insights and notifications
Last-mile workflow integration
8 real-time care coordination programs

Largest Senior Care EHR + the Most Expansive Care Collaboration Network in the Country

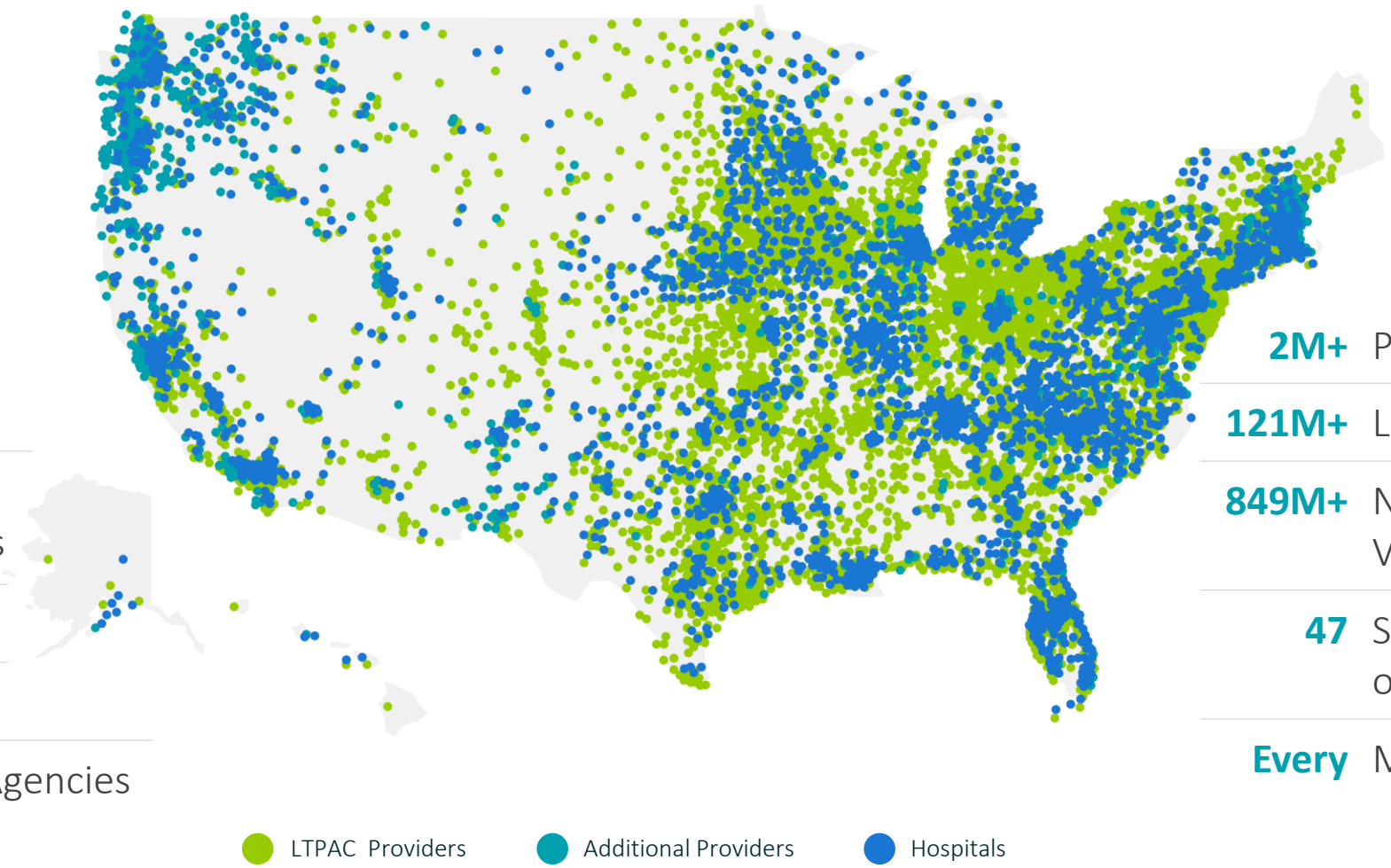
27,000+ Senior Care facilities

2,800+ Hospitals and Health Systems

3,600+ Ambulatory

48% US Hospitals

75+ State & Govt. Agencies



2M+ Patient Records

121M+ Lives

849M+ Network Patient Visits

47 States Connected on the Network

Every Major US Plan

Program Updates

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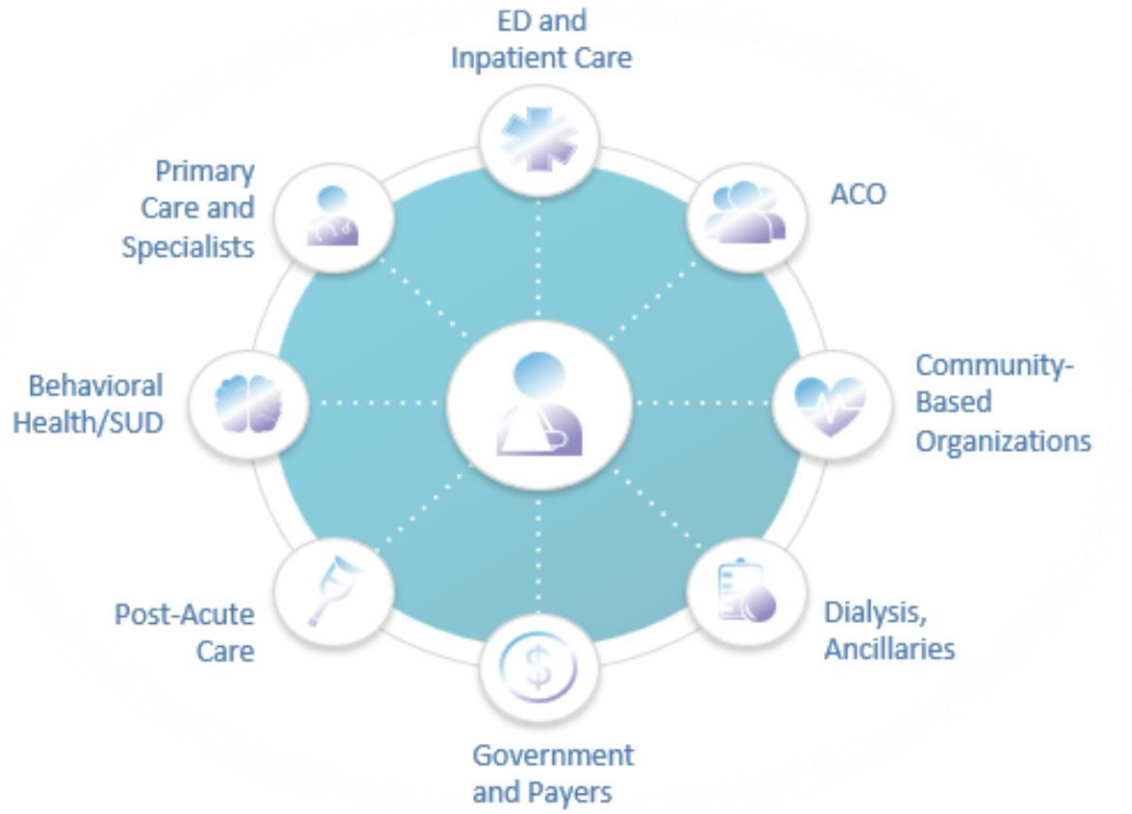
HealthChoice Illinois ADT Program Goals

1. Improve Care Coordination
2. Real-time ADT Alerts
3. Reduce Hospital Readmissions
4. Support MCO Operations
5. Enhance Provider Communication
6. Achieve High Data Quality
7. Utilize Reporting for Insights
8. Support Interoperability Legislation



Connected Facilities

957 Medicaid Facilities Transmitting Data

Type	Sending Live Data
Hospitals	194
ICFDD (Intermediate Care Facility/Developmental Disabilities)	31
SLF (Supportive Living Facilities)	108
SMHRF (Specialized Mental Health Rehabilitation Facilities)	18
SNF (Nursing Facilities)	606

673 Medicaid Ambulatory & Community Providers

Type	Subscribing
Certified local public health department	7
Community Health Agencies - In home	3
Community Mental Health Provider	346
Department of Alcohol and Substance Abuse Provider	87
Family Support Program	5
Federally Qualified Health Centers	169
Healthy Kids (EPSDT) screening clinics	1
Home Health Agencies - In Home	4
Home Nursing Agency	1
Hospice	3
Integrated Health Home	7
Rural Health Clinics	4
Waiver service provider--Elderly (DOA)	27
School Based / Linked Health Clinic	1
Behavioral Health Clinic	8

Numbers as of 08/08/2024

https://hfs.illinois.gov/healthchoiceadt/participants.html

Improved Data Quality

Emergency Room

Segment/Field	%	2021	2022	2023	2024	Diff.
Chief Complaint	95%	30	35	34	35	↑ 5%
Diagnosis Code	90%	73.5	62.75	65.25	66.5	↓ 7%
Discharge to Location	95%	0	6.5	12.5	17	↑ 17%
Discharge Date	95%	88	79.5	80	80	↓ 8%
Insurance Name	95%	42	83	93	97.5	↑ 55%
Insurance Plan ID	95%	31	61.75	70.75	76.5	↑ 45%
Group Number	95%	17.5	29	34	37	↑ 19%
Effective Date	95%	59	53.5	61.25	70	↑ 11%
Policy Number	95%	40.5	78.25	85.75	90.5	↑ 50%
Race	95%	72	73.25	76	73	↑ 1%
Telephone Number	50%	61.5	96	96.5	98	↑ 36.5%
Email	50%	17	30.25	31.75	36	↑ 19%
Language	95%	72	72.25	76	75.5	↑ 3.5%
Marital Status	95%	71.5	72.5	74.75	71.5	0%
Ethnicity	95%	67	68.5	70	68	↑ 1%

Inpatient

Segment/Field	%	2021	2022	2023	2024	Diff.
Chief Complaint	95%	36	28	31.25	37	↑ 1%
Diagnosis Code	90%	78	70.75	73.75	77	↓ 1%
Discharge to Location	95%	1	8.75	14.75	20.5	↑ 19.5%
Discharge Date	95%	90.5	82	83.75	83	↓ 7.5%
Insurance Name	95%	39.5	84.75	91.5	96	↑ 56.5%
Insurance Plan ID	95%	31.5	67	74.25	80	↑ 48.5%
Group Number	95%	19	35	39	42.5	↑ 23.5%
Effective Date	95%	31.5	63.25	69	76	↑ 44.5%
Policy Number	95%	38	80.5	84.75	89	↑ 51%
Race	95%	62.5	74.75	77.25	75	↑ 12.5%
Telephone Number	50%	69	96.25	97	98.5	↑ 29.5%
Email	50%	17	33.25	34.75	40	↑ 23%
Language	95%	63.5	74.25	77.5	77	↑ 13.5%
Marital Status	95%	62.5	70.25	72.25	71	↑ 8.5
Ethnicity	95%	58.5	70.25	72.25	71	↑ 12.5%

Technical Advisory Committee Updates

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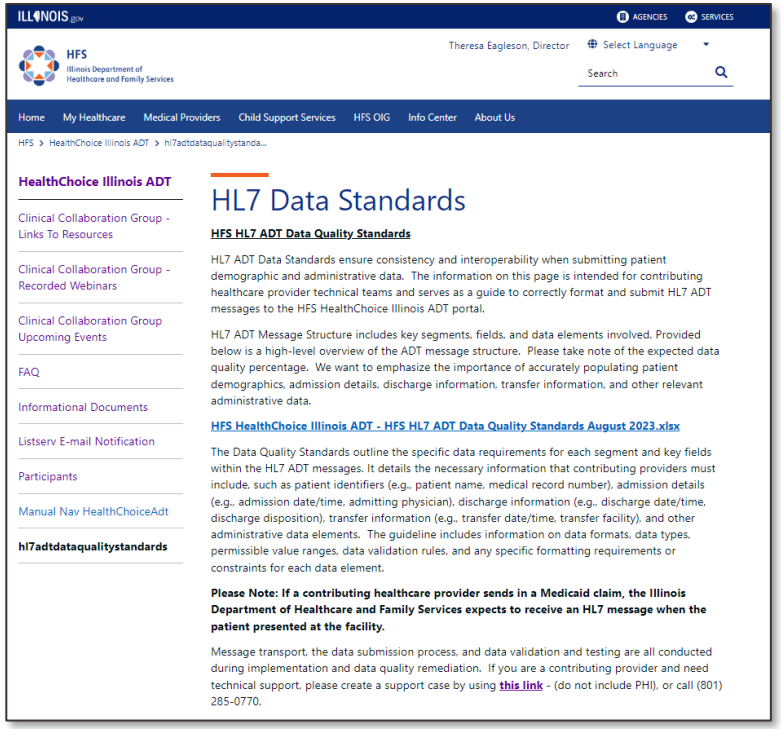
HFS HL7 ADT Data Quality Standards
Recommendation by IDPH and the Technical Advisory Committee



[HFS HealthChoice Illinois ADT – HFS HL7 ADT Data Quality Standards August 2023.xlsx]

Segment	Segment Description	Field	SubField	Description	Length	Field Type	HL7 Std Required1	HL7 Std Repeatability	CMT Standard Specs (R=Required, MR=Matching Required, CR=Conditionally Required, SS=Strongly Suggested, S=Suggested, O=Optional)	New Report Column Name(s)	Expected Data Quality %
MSH	*Message Header*	4		Sending Facility	##	String	O	N	R	Sending Facility Name; Sending Facility Identifier; Sending Facility CMT ID; Sending Facility Address	100%
PID	*Patient Identification*		3.1	Id Number	15	String	R	N		Recipient ID	95%
PR1	*Procedures*	2		Procedure Coding Method	3	IS (Coded Value for User Defined Tables)	B	N			
PR1	*Procedures*	3		Procedure Code	##	CE - Coded Element	R	N			
PR1	*Procedures*	4		Procedure Description	40	String	B	N			
PR1	*Procedures*	5		Procedure Date/Time	26	TS - Time Stamp	R	N			
PR1	*Procedures*	11		Surgeon	##	XCN - Extended Composite ID Number and	B	=			
PR1	*Procedures*	15		Associated Diagnosis Code	##	CE - Coded Element	O	N			
PID	*Patient Identification*		5.1	Family Name	194	FN - Family Name - FN.1 Surname, 50, R, St	O	N	R	Last Name	95%
PID	*Patient Identification*		5.2	Given Name	30	String	O	N	R	First Name	95%
PID	*Patient Identification*		5.3	Second And Further Given Names or Initials Thereof	30	String	O	N	S	Middle Name	
PID	*Patient Identification*	7		Date/Time of Birth		Date (YYYYMMDD)	O	N	R	Member DOB	95%
PID	*Patient Identification*	8		Administrative Sex	1	IS (Coded Value for User Defined Tables)	O	N	MR	Member Gender	95%
PID	*Patient Identification*	10		Race	##	CE - Coded Element	O	=	SS	Race	95%
PID	*Patient Identification*		11.1	Street Address	184	SAD - Street Address	O	N	MR	Member Street Address	90%
PID	*Patient Identification*		11.2	Second line of address	120	String	O	N	CR	Member Street Address Second Line	
PID	*Patient Identification*		11.3	City	50	String	O	N	MR	Member City	90%
PID	*Patient Identification*		11.4	State or Province	50	String	O	N	MR	Member State	90%
PID	*Patient Identification*		11.5	Zip or Postal Code	12	String	O	N	MR	Member Zip Code	90%
PID	*Patient Identification*		13.1	Telephone number	199	String	O	N	MR	Member Telephone Number	50%
PID	*Patient Identification*		13.4	Communication Address (Email)	199	String	O	N	.	Member Email	50%
PID	*Patient Identification*	15		Primary Language	##	CE - Coded Element	O	N	SS	Language	95%
PID	*Patient Identification*	16		Marital Status	##	CE - Coded Element	O	N	SS	Marital Status	95%
PID	*Patient Identification*	22		Ethnic Group	##	CE - Coded Element	O	=	SS	Ethnicity	95%
PID	*Patient Identification*	29		Patient Death Date and Time	26	TS - Time Stamp	O	N	CR	Member Deceased Date	
PID	*Patient Identification*	30		Patient Death Indicator	1	ID (Coded Value for HL7 Tables)	O	N	CR	Member Deceased	
PV1	*Patient Visit*	2		Patient Class	1	SI - Sequence ID	O	N	R	Major Type; Visit Type	90%
PV1	*Patient Visit*		3.4	Facility	##	HD - Hierarchic Designator - HD.1 Namesp	O	N	CR	Visit Facility Identifier; Visit Facility Name; Visit Facility CMT ID; Visit Facility Address	90%
PV1	*Patient Visit*	7		Attending Doctor	##	Extended Composite ID Number and Name	O	=	.	Visit Attending Physician	90%
PV1	*Patient Visit*		7.1	Identifier	15	String	O	N	SS	Attending Doctor Identifier	90%
PV1	*Patient Visit*		7.2	Family Name	194	FN - Family Name - FN.1 Surname, 50, R, St	O	N	SS	Attending Doctor Family Name	90%
PV1	*Patient Visit*		7.3	Given Name / First Name	30	String	O	N	SS	Attending Doctor Given Name	90%
PV1	*Patient Visit*		7.4	Middle Name	30	String	O	N	O	Attending Doctor Middle Name	
PV1	*Patient Visit*		7.9	Assigning Authority	##	HD - Hierarchic Designator - HD.1 Namesp	O	N	SS	Attending Doctor Assigning Authority	

Data Quality and Completeness Progress

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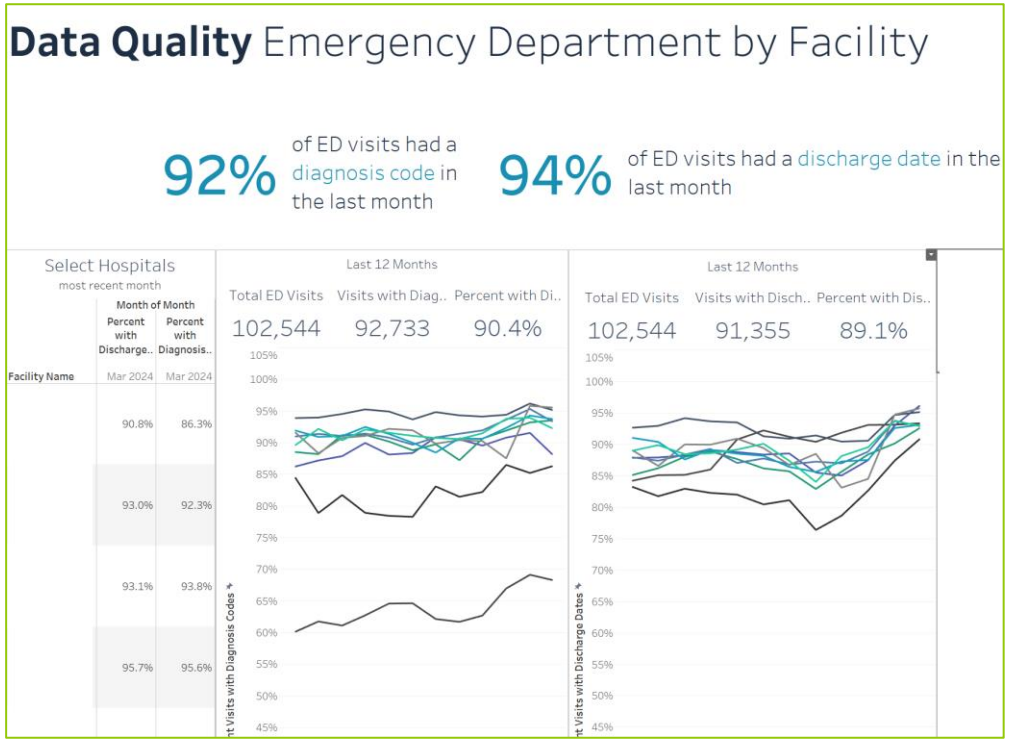
Data Quality Improvement Project

Focus During Onboarding

- Work with Data Senders to establish data quality standards
- Emphasis on ADT fields that support Care Collaboration

Ongoing Review and Maintenance

- Support teams flag performance changes and perform regular outreach when feeds go down or feed quality dips
- Customer Success teams engage with customers regularly to ensure understanding of importance of Data Quality



Data Quality Improvement Project

Areas of Focus

- Feedback from TAC + MCO partners helped HFS develop list of important ADT fields of focus
- Fields included important care coordination elements like chief complaint, diagnoses, and care team

Early Progress + Feedback

- Focused on health systems to begin with
- Five groups completed and awaiting claims review
- Time consuming process; scheduling and data transfer challenges

Known Issues and Challenges

- Hospital Awareness
- Resourcing and scheduling
- Multiple data hops/areas for failure

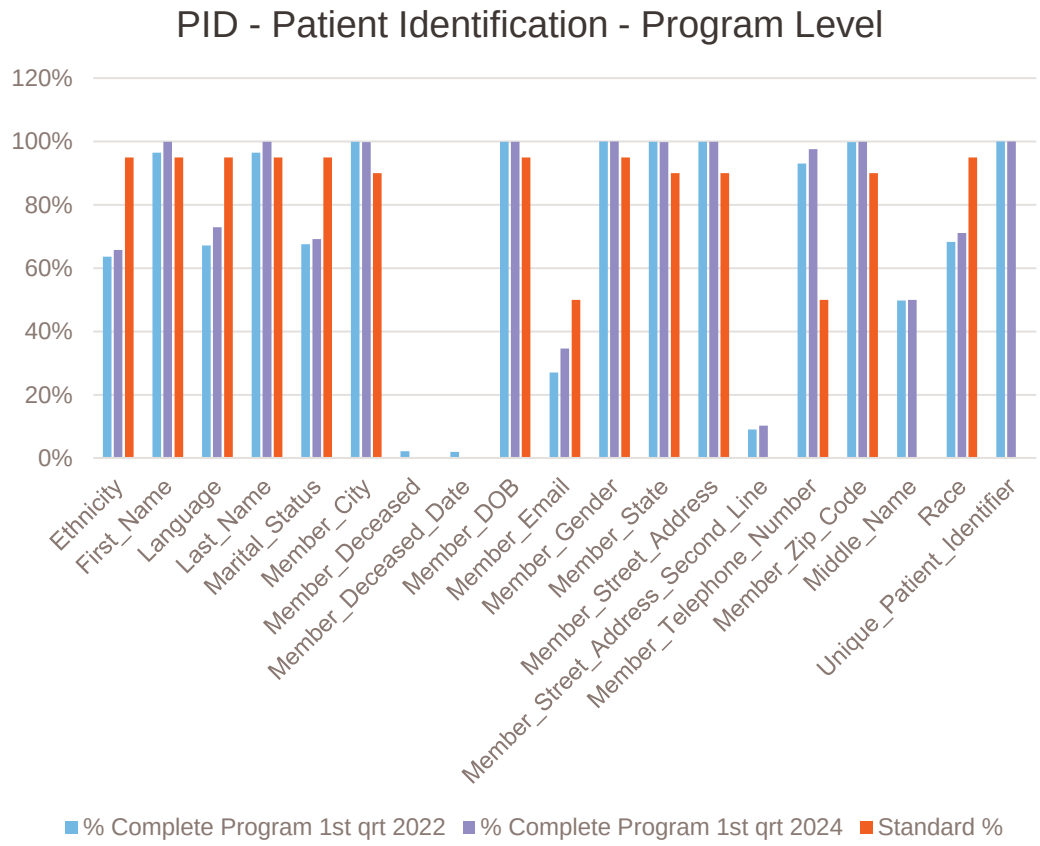
Reason for Optimism

- Project team has uncovered numerous previously unknown barriers to successful data transmission; already showing vast improvement in many important fields

PID - Patient Identification

0%-5% improvement
over 5% improvement
Meet Program Standard

	Entire Program % Complete		Pilot Program % Complete		Program Standard %
Name	1st qrt 2022	1st qrt 2024	1st qrt 2022	2nd qrt 2024	
Total Unique Encounters	486,113	451,696	22,028	28,045	
Ethnicity	64%	66%	13%	59%	95%
First_Name	96%	100%	100%	100%	95%
Language	67%	73%	13%	58%	95%
Last_Name	96%	100%	100%	100%	95%
Marital_Status	68%	69%	13%	55%	95%
Member_City	100%	100%	100%	100%	90%
Member_Deceased	2%	0%	1%	0%	
Member_Deceased_Date	2%	0%	1%	0%	
Member_DOB	100%	100%	100%	100%	95%
Member_Email	27%	35%	18%	57%	50%
Member_Gender	100%	100%	100%	100%	95%
Member_State	100%	100%	100%	100%	90%
Member_Street_Address	100%	100%	100%	100%	90%
Member_Street_Address_Second_Line	9%	10%	7%	10%	
Member_Telephone_Number	93%	98%	91%	99%	50%
Member_Zip_Code	100%	100%	100%	100%	90%
Middle_Name	50%	50%	31%	38%	
Race	68%	71%	13%	59%	95%
Unique_Patient_Identifier	100%	100%	100%	100%	



PV1 and PV2 - Patient Visit

0%-5% improvement
over 5% improvement
Meet Program Standard

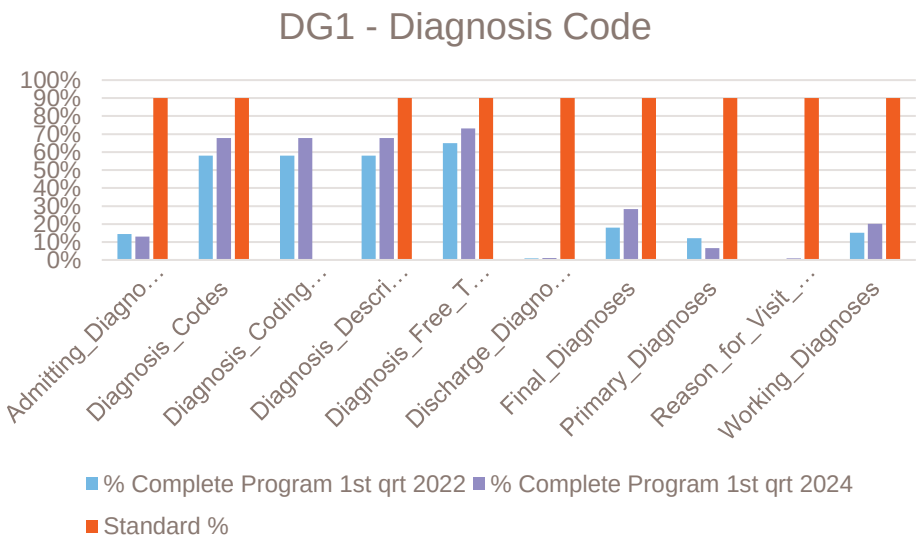
	Entire Program % Complete		Pilot Program % Complete		Program Standard %
Name	1st qrt 2022	1st qrt 2024	1st qrt 2022	2nd qrt 2024	
Total Unique Encounters	**486,113**	**451,696**	**22,028**	**28,045**	
Admit_Date	100%	100%	100%	100%	100%
Admit_Source	100%	100%	100%	100%	90%
Admitting_Doctor_Assigning_Authority	8%	12%	0%	23%	
Admitting_Doctor_Family_Name	22%	21%	2%	23%	90%
Admitting_Doctor_Given_Name	22%	21%	2%	23%	90%
Admitting_Doctor_Identifier	22%	21%	2%	23%	
Admitting_Doctor_Identifier_Type_Code	4%	2%	0%	0%	
Admitting_Doctor_Middle_Name	10%	9%	1%	12%	
Attending_Doctor_Assigning_Authority	32%	46%	10%	70%	
Attending_Doctor_Family_Name	80%	87%	75%	70%	90%
Attending_Doctor_Given_Name	79%	87%	75%	70%	90%
Attending_Doctor_Identifier	80%	90%	75%	70%	90%
Attending_Doctor_Identifier_Type_Code	19%	18%	10%	8%	
Attending_Doctor_Middle_Name	42%	48%	4%	44%	
Consulting_Doctor_Assigning_Authority	3%	3%	0%	10%	
Consulting_Doctor_Family_Name	7%	5%	0%	10%	
Consulting_Doctor_Given_Name	7%	5%	0%	10%	
Consulting_Doctor_Identifier	7%	5%	0%	10%	
Consulting_Doctor_Identifier_Type_Code	2%	0%	0%	0%	
Consulting_Doctor_Middle_Name	4%	0%	0%	0%	

	Entire Program % Complete		Pilot Program % Complete		Program Standard %
Name	1st qrt 2022	1st qrt 2024	1st qrt 2022	2nd qrt 2024	
Total Unique Encounters	**486,113**	**451,696**	**22,028**	**28,045**	
Discharge_Date	74%	80%	74%	73%	95%
Discharge_Disposition	100%	100%	100%	100%	95%
Discharge_Disposition_Raw	67%	76%	69%	73%	95%
Discharged_To_Location	0%	15%	0%	71%	95%
Major_Type	100%	100%	100%	100%	100%
Referring_Doctor_Assigning_Authority	6%	7%	0%	1%	
Referring_Doctor_Family_Name	22%	20%	3%	1%	50%
Referring_Doctor_Given_Name	22%	20%	3%	1%	50%
Referring_Doctor_Identifier	22%	20%	3%	1%	50%
Referring_Doctor_Identifier_Type_Code	4%	2%	0%	0%	
Referring_Doctor_Middle_Name	12%	11%	1%	1%	
Visit_Account_Number	100%	100%	100%	100%	100%
Visit_Attending_Physician	82%	86%	75%	69%	90%
Visit_Billing_Account_Number	98%	96%	100%	100%	100%
Visit_Facility_Address	100%	100%	100%	100%	100%
Visit_Facility_CMT_ID	100%	100%	100%	100%	100%
Visit_Facility_Identifier	0%	100%	100%	100%	100%
Visit_Facility_Name	100%	100%	100%	100%	100%
Visit_Type	100%	100%	100%	100%	100%
Chief_Complaint	33%	32%	17%	86%	95%

DG1- Diagnosis

0%-5% improvement
over 5% improvement
Meet Program Standard

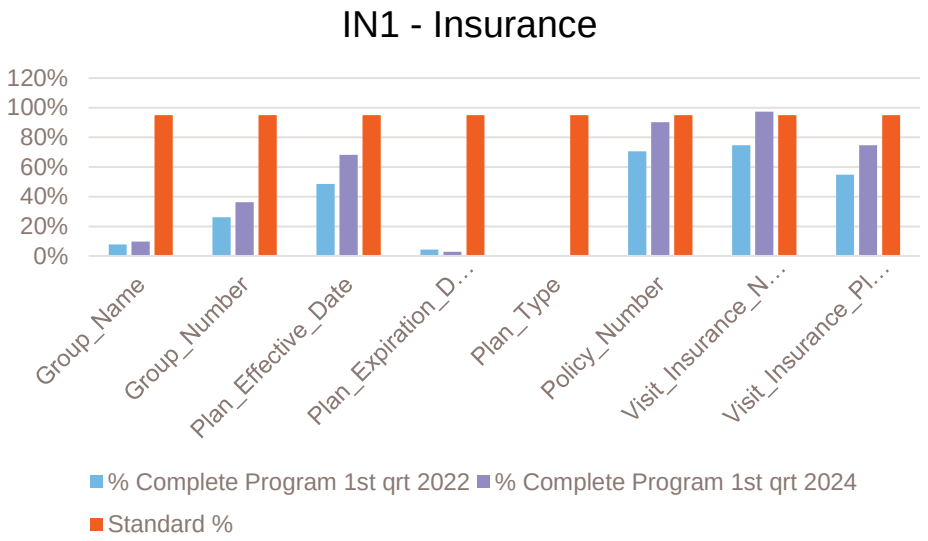
	Entire Program % Complete		Pilot Program % Complete		Program Standard %
Name	1st qrt 2022	1st qrt 2024	1st qrt 2022	2nd qrt 2024	
Total Unique Encounters	**486,113**	**451,696**	**22,028**	**28,045**	
Admitting_Diagnoses	14%	13%	15%	2%	90%
Diagnosis_Codes	58%	68%	82%	86%	90%
Diagnosis_Coding_Method	58%	68%	82%	86%	
Diagnosis_Description	58%	68%	82%	86%	90%
Diagnosis_Free_Text	65%	73%	82%	100%	90%
Discharge_Diagnoses	1%	1%	0%	0%	90%
Final_Diagnoses	18%	28%	0%	83%	90%
Primary_Diagnoses	12%	7%	0%	0%	90%
Reason_for_Visit_Diagnoses	1%	1%	0%	0%	90%
Working_Diagnoses	15%	20%	11%	0%	90%



IN1 - Insurance

0%-5% improvement
over 5% improvement
Meet Program Standard

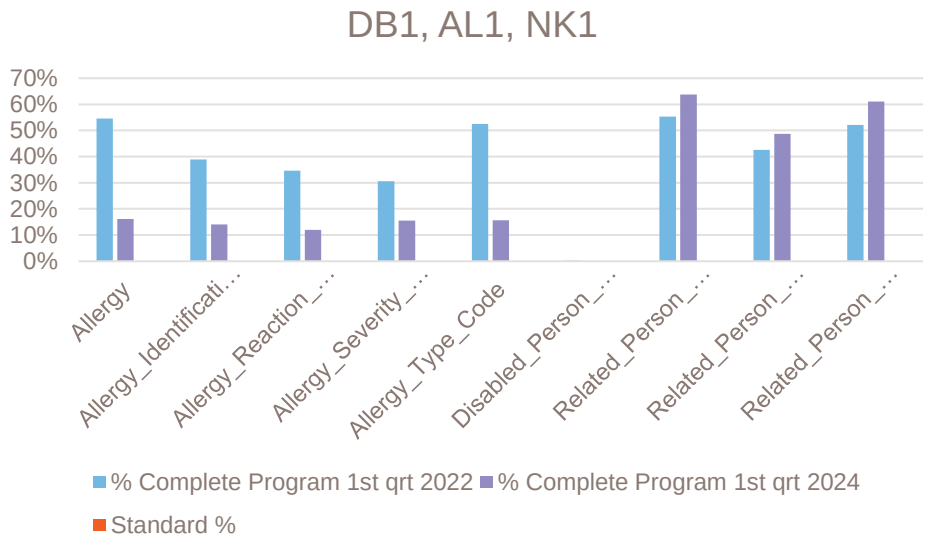
	Entire Program % Complete		Pilot Program % Complete		Program Standard %
Name	1st qrt 2022	1st qrt 2024	1st qrt 2022	2nd qrt 2024	
Total Unique Encounters	**486,113**	**451,696**	**22,028**	**28,045**	
Group_Name	8%	10%	3%	0%	95%
Group_Number	26%	36%	10%	34%	95%
Plan_Effective_Date	49%	68%	19%	100%	95%
Plan_Expiration_Date	4%	3%	0%	0%	95%
Plan_Type	0%	0%	0%	0%	95%
Policy_Number	71%	90%	100%	100%	95%
Visit_Insurance_Name	75%	97%	100%	100%	95%
Visit_Insurance_Plan_ID	55%	75%	2%	97%	95%



DB1, AL1, NK1- Disability, Patient Allergy Information, Next of Kin

0%-5% improvement
over 5% improvement
Meet Program Standard

	Entire Program % Complete		Pilot Program % Complete		Program Standard %
Name	1st qrt 2022	1st qrt 2024	1st qrt 2022	2nd qrt 2024	
Total Unique Encounters	486,113	451,696	22,028	28,045	
Allergy	55%	16%	38%	23%	
Allergy_Identification_Date	39%	14%	31%	22%	
Allergy_Reaction_Code	35%	12%	12%	21%	
Allergy_Severity_Code	31%	15%	14%	23%	
Allergy_Type_Code	53%	16%	38%	21%	
Disabled_Person_Code	0%	0%	0%	0%	
Related_Person_Name	55%	64%	14%	90%	
Related_Person_Phone_Number	43%	49%	14%	90%	
Related_Person_Relationship	52%	61%	14%	90%	



Exploring Additional Data Segment Needs and Solutions

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Exploring Additional Data Segment Needs

Key Points for Discussion:

1.Current Data Ingestion Methods:

1. Review of current data ingestion methods and their effectiveness.

2.Potential for CCD and National Network Subscriptions:

1. Evaluating the benefits and challenges of obtaining data through CCDs and national networks.

3.Future Data Infrastructure Requirements:

1. Identifying necessary infrastructure developments to support additional data types (Labs, Imaging, Rx, Scheduling, Physician Notes, Billing Data).

4.Stakeholder Needs and Preferences:

1. Gathering feedback on the data needs of various stakeholders and their preferred methods of data ingestion.

Burden Reduction through Bi-Directional Communication

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Open Discussion: Burden Reduction Opportunities

Focus Area – ED Optimization in Hospitals

Bi-Directional Integration or Trackboard

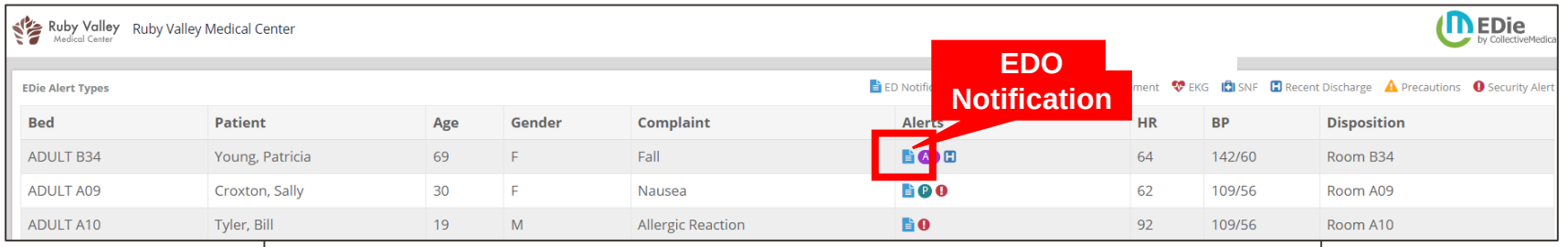
- Early adopters proving out value of ED Optimization tool
- Now – new interest due to Data Quality Improvement efforts + full Acute Facility connectivity
- Key Benefits – Burden Reduction through streamlined inclusion of important care collaboration data into ED workflows

Open Discussion: Burden Reduction Opportunities

- Previous Topics

- Prior authorization for LTC stays
- Bed availability for SNFs
  - DCFS state law
- Compliance with federal or state reporting mandates, e.g.,
  - Electronic notification requirement (CMS Interoperability and Patient Access Final Rule)
- Medicaid unwinding/redetermination (renewal outreach)
- Disease and public health monitoring
- Notice of admission (NOA)

ED Track Board Integration



Available for:

- Epic
- Cerner
- Meditech (and Sunrise and Expanse)
- AthenaHealth
- Allscripts
- CPSI
- T Systems
- Others -**Any**- PCC will work with you

NOTIFICATION 8/14/2023 12:53 Walters, Noel MRN: 34340371

Criteria Met

- 5+ ED Visits in 12 Months
- History of Sepsis
- Security and Safety Care Guidelines

Security and Safety

Date	Location	Type	Specifics
6/29/23 1:51 AM	Memorial Health Ctr	Physical	Patient physically assaulted a care provider, staff or patient
		Details:	Assaulted a physician- hit, slapped, and bit.

Security Events (18 Mo.)	Count
Physical	1
Total	**1**

Care Insights - Social Determinants of Health

Last Updated: 6/20/2023 1:10 PM Eden Health Department Senior Services

- Pt is enrolled with a discharge van services through Medicaid. Please call 123-456-7890 for transportation needs.
- Pt lives alone independently but is supported by her local pastor Richard at New Hope Church, 235-568-5455.
- Please do not call pt's daughter Jane Smith, as she neglects pt and steals her meds; pt has a safe and reliable friend named Derek James who has previously assisted pt temporarily post hospital: 555-537-3865

Flags

- History of Sepsis - Patient has received a diagnosis of Sepsis from an acute or post-acute setting. | Attributed By: Ruby Valley Med Ctr | Attributed On: 7/27/2023

Recent Emergency Department Visit Summary

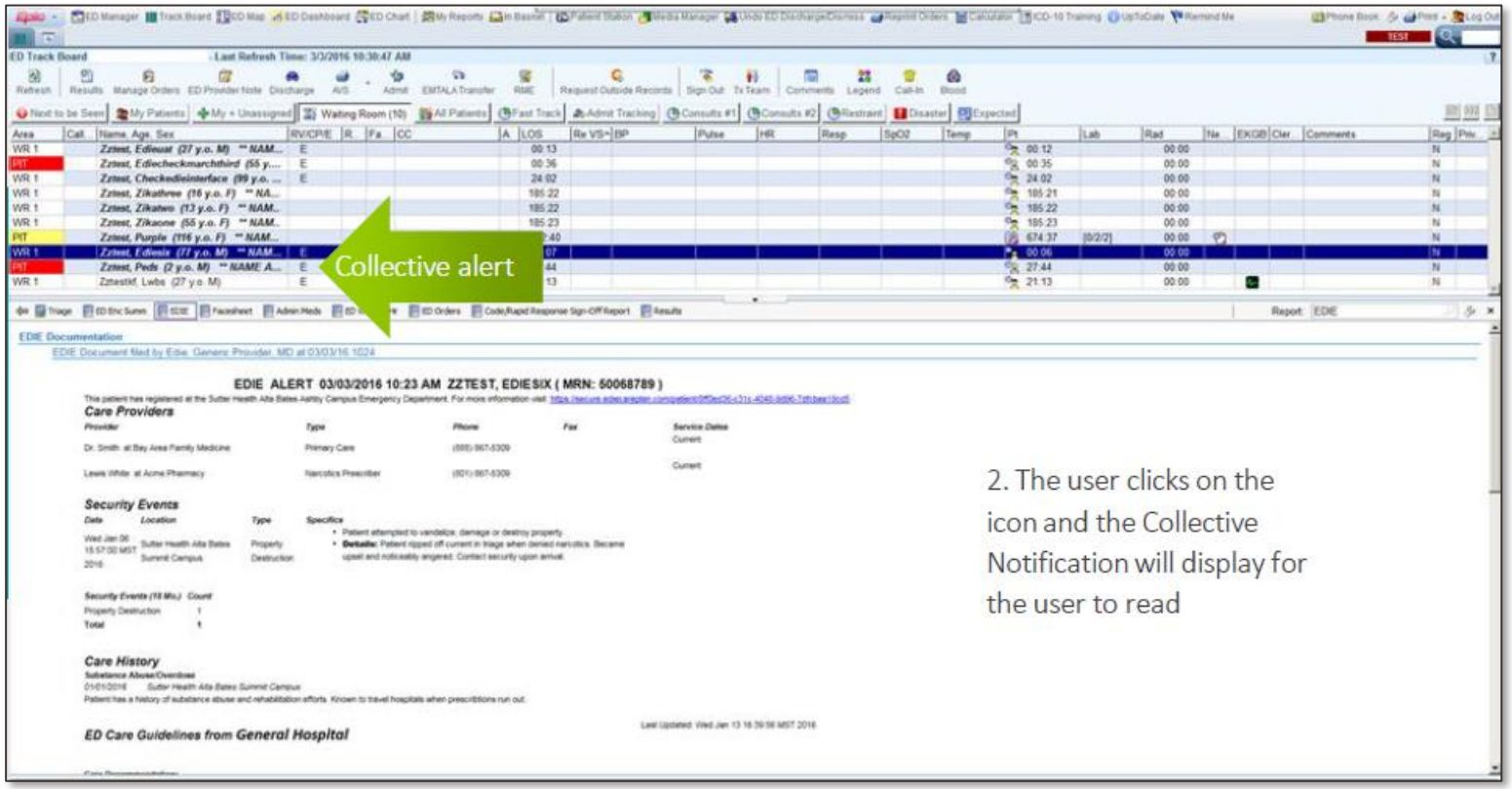
Admit Date	Facility	City, State	Type	Diagnoses or Chief Complaint
Mar 14, 2023	Ruby Valley Medical Ctr	Grand Rapids, MI	Emergency	Altered Mental Status ; UTI
Apr 3, 2023	Eden Health Center	Traverse City, MI	Emergency	Dizziness; Syncope
May 24, 2023	County Memorial	Detroit, MI	Emergency	Hallucinations; Agitation
Jun 17, 2023	St. Elizabeth Hospital	Ann Arbor, MI	Emergency	Chest Pain
Jul 14, 2023	Eden Health Center	Traverse City, MI	Emergency	Generalized Abdominal Pain; ESRD
Jul 27, 2023	Ruby Valley Medical Ctr	Grand Rapids, MI	Emergency	Shortness of Breath; Fever; Sepsis
Aug 4, 2023	Eden Health Center	Traverse City, MI	Emergency	Hallucinations; Agitation

SMART on FHIR Option

for select EHR systems

- EHR System Compatibility
- SMART App Authorization
- Launching the SMART App
- Contextual Patient Data
- Secure Data Exchange
- Care Collaboration and
- Coordination
- Continuity of Care

1. An icon will display in the ED's track board to indicate there is a Collective Notification for that patient



2. The user clicks on the icon and the Collective Notification will display for the user to read

SMART on FHIR

Available for:

- Epic
- Cerner

Through the App Orchard/Marketplace

- Accessible within EMR by those health system staff who are outside of the ED, such as Case Managers and Care Coordinators
- SMART on FHIR (SoF) App is a way to embed third-party content directly into an Electronic Health Record.
- This means that information provided from the PCC Network can be accessed directly from select EHRs, rather than having to access the PCC Platform directly.
- The PCC SMART on FHIR app provides intelligent alerts, risk analysis, and other concise actionable information from the PCC network and presents it to the care provider directly within their workflow in their EHR.
- The app reduces or eliminates the need for double documentation in care collaboration work streams by saving documented Care Insights simultaneously to Epic or Cerner EHRs as well as to the PCC network of participants.

Future Communication Plans and Onboarding Support

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Provider Notice
FQHC, CMHC, CHC, SUPR

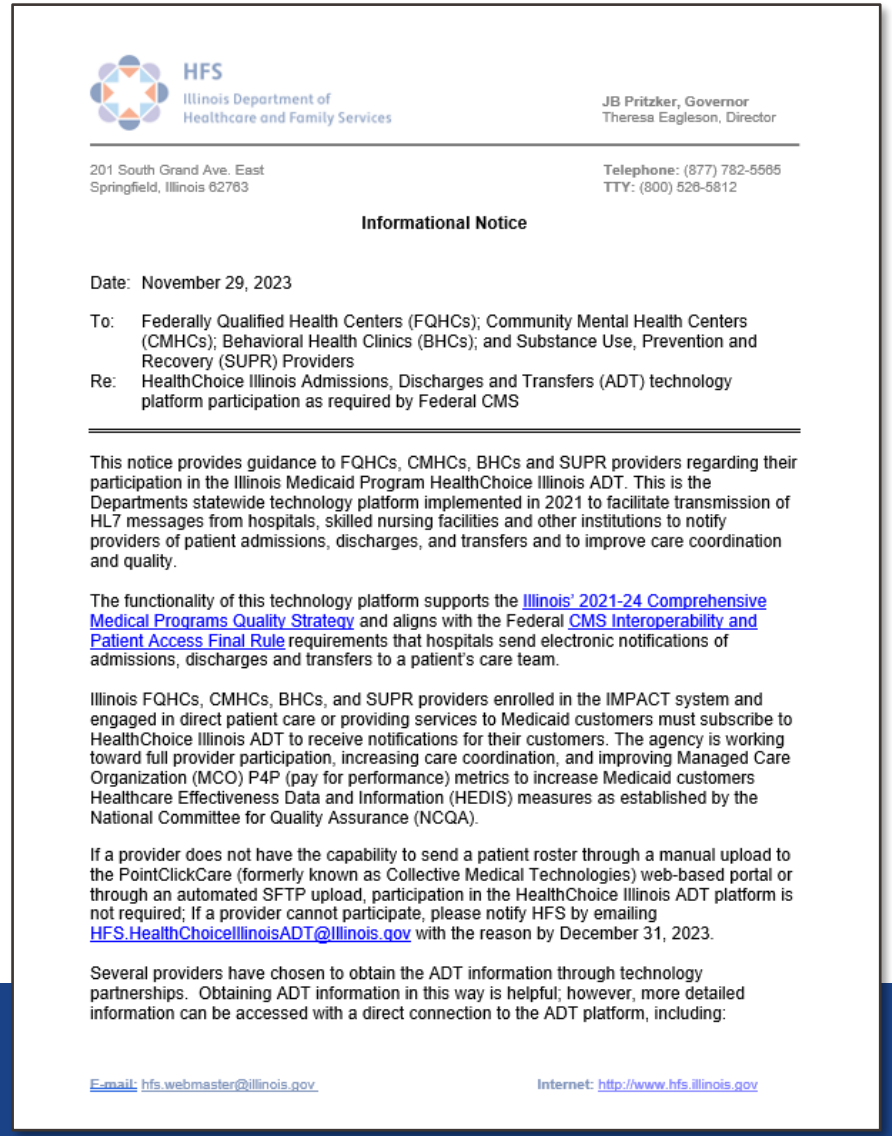
- Overview of provider notices to FQHCs, CMHCs, BHCs, and SUPR Providers
- Future communication plans and onboarding support
- Key goals and supports provided by the technology platform

Key Points:

- Subscription requirement for Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), Behavioral Health Clinics, and Substance Use, Prevention, and Recovery (SUPR) Providers

- Alignment with Illinois' 2021-24 Comprehensive Medical Programs Quality Strategy and Federal CMS Interoperability and Patient Access Final Rule

- Goals: Full provider participation, increased care coordination, improvement of MCO P4P metrics, enhancement of Illinois HEDIS measures



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Illinois Department of
Healthcare and Family Services

JB Pritzker, Governor
Theresa Eagleson, Director

201 South Grand Ave. East
Springfield, Illinois 62763

Telephone: (877) 782-5565
TTY: (800) 526-5812

Informational Notice

Date: November 29, 2023

To: Federally Qualified Health Centers (FQHCs); Community Mental Health Centers (CMHCs); Behavioral Health Clinics (BHCs); and Substance Use, Prevention and Recovery (SUPR) Providers

Re: HealthChoice Illinois Admissions, Discharges and Transfers (ADT) technology platform participation as required by Federal CMS

This notice provides guidance to FQHCs, CMHCs, BHCs and SUPR providers regarding their participation in the Illinois Medicaid Program HealthChoice Illinois ADT. This is the Departments statewide technology platform implemented in 2021 to facilitate transmission of HL7 messages from hospitals, skilled nursing facilities and other institutions to notify providers of patient admissions, discharges, and transfers and to improve care coordination and quality.

The functionality of this technology platform supports the Illinois' 2021-24 Comprehensive Medical Programs Quality Strategy and aligns with the Federal CMS Interoperability and Patient Access Final Rule requirements that hospitals send electronic notifications of admissions, discharges and transfers to a patient's care team.

Illinois FQHCs, CMHCs, BHCs, and SUPR providers enrolled in the IMPACT system and engaged in direct patient care or providing services to Medicaid customers must subscribe to HealthChoice Illinois ADT to receive notifications for their customers. The agency is working toward full provider participation, increasing care coordination, and improving Managed Care Organization (MCO) P4P (pay for performance) metrics to increase Medicaid customers Healthcare Effectiveness Data and Information (HEDIS) measures as established by the National Committee for Quality Assurance (NCQA).

If a provider does not have the capability to send a patient roster through a manual upload to the PointClickCare (formerly known as Collective Medical Technologies) web-based portal or through an automated SFTP upload, participation in the HealthChoice Illinois ADT platform is not required; If a provider cannot participate, please notify HFS by emailing HFS.HealthChoiceIllinoisADT@Illinois.gov with the reason by December 31, 2023.

Several providers have chosen to obtain the ADT information through technology partnerships. Obtaining ADT information in this way is helpful; however, more detailed information can be accessed with a direct connection to the ADT platform, including:

E-mail: hfs.webmaster@illinois.gov

Internet: http://www.hfs.illinois.gov

Let’s Stay Up To Date

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PointClickCare®

Notify HFS and PCC of Changes

- Name of facility/entity
- Ownership of facility/entity
- EMR change, new add-ons or versions, anything that may affect Feed/File/Data- we can then validate quality of data and ensure it is flowing correctly and we are receiving all.

HFS IMPACT Provider Enrollment: https://impact.illinois.gov/

General Questions: IMPACT.Help@Illinois.gov

Having Trouble Loggin In: IMPACT.Login@illinois.gov

PCC Support: support@collectivemedicaltech.com

Providers – How to Request Custom Reports; Uses for Scheduled Reports

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PointClickCare®

Scheduled Reports

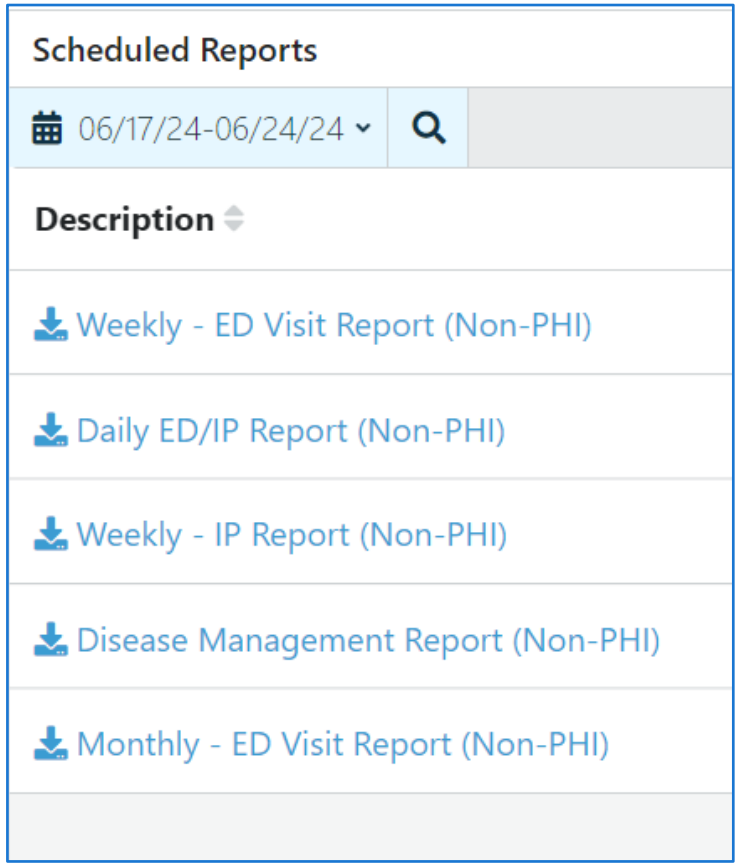
Available Reports

Hospitals :

- Custom, create with demographic, encounter info, utilization info, diagnosis-specific focus, and more

Ambulatory :

- Acute Encounters of Census (active patients)



Scheduled Reports Overview

Scheduled Reports FAQ

If you'd like to request a Custom Scheduled Report, please email Laney.Smith@PointClickCare.com to request a form.

PointClickCare

Portal Updates

HFS
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PointClickCare®

None as of now

DID YOU KNOW? The PCC Network platform is Single-Sign-On Compatible! This can streamline your work and help encourage and facilitate your staff’s ease of access.

Healthcare Transformation Collaboratives

Collaborative Bridges HTC

Patrick Dombrowski, Executive Director

HFS
Illinois Department of
Healthcare and Family Services

PointClickCare®

Healthcare Transformation Collaboratives

Setting the Stage

HTC
Healthcare Transformation Collaboratives

The goal of Healthcare Transformation Collaboratives is to reorient our healthcare delivery system in Illinois around people and communities. There are four major components in the Transformation Plan.

COMMUNITY NEEDS

Focus on community needs, for all levels of healthcare with an emphasis on addressing social and structural determinants of health.

SPECIALIZED APPROACHES

Tailor solutions to meet the unique needs of individuals.

HEALTH AND WELLNESS

Improve health and wellness for individuals and communities.

SUSTAINABLE INVESTMENTS

Invest in projects that improve outcomes, decrease disparities, and are sustainable over time.

HFS
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HTC Healthcare Transformation Collaboratives

COLLABORATIVE BRIDGES OVERVIEW:

Helping change the way behavioral health services are delivered for Chicago West Side residents, through a provision of community-based and wrap-around service delivery immediately upon discharge from hospital settings.

HTC Partnership with: Managed Care Organizations, Healthcare and Family Services, Hartgrove Hospital, Humboldt Park, Health, Community Counseling Centers of Chicago, Habilitative Systems, Inc, Bobby E Wright CMHC, and community stakeholders.

- Multi-disciplinary staffing comprised of peer engagement specialists, care coordinators, therapists, substance abuse counselors and discharge coordinators (modeled on Community Support Team philosophies of care.)
- Low barrier service delivery focused on people, where they live, and when there are stabilizing from a behavioral health hospitalization.
- Immediate support in filling medication, bridge therapy supports, transportation, and finding shelter at discharge.
- Ongoing support in crisis stabilization and recovery, connection to long term community supports, and warm linkage to preventative health, economic supports, and other Social Determinant of Health needs.
- Blended hospital and community staffing and workflows to ensure uninterrupted and immediate transitions of care.
- Paradigm shift to engagement focused service delivery, utilizing staff with lived experience to promote recovery services and after care community services, as well as, ongoing focus on barriers to recovery.

DRIVERS
WHY COLLABORATIVE BRIDGES IS NEEDED

300% Increased rate of suicide completion the week after a hospital discharge

33% People hospitalized psychiatrically are re-hospitalized within a year.

25% Hospital discharges connected to aftercare support.

25 years People with severe mental illness die 25 years earlier

17 years Life expectancy gap for between residents of West Side vs. downtown

66% Of premature deaths are due to treatable medical conditions

IMPACT
THE SUCCESS OF COLLABORATIVE BRIDGES MODEL

9% People served through Collaborative Bridges Model have been re-hospitalized

72% Hospital discharges connected to aftercare support.

100% Clients in care receive a warm linkages to providers to address SDOH

100% People in care can receive treatment until connected to long-term providers.

OUR VISION AND MODEL

In-Patient Mental and Behavioral Health Hospitalization

Long-term, out-patient care plus community-based support for SDOH

Part of the Illinois Healthcare Transformation Collaboratives

HTC
Healthcare Transformation Collaboratives

"Collaborative Bridges is funded by the Illinois Department of Health and Family Services' Healthcare Transformation Collaboratives (HTC).

The historic, equity-driven Healthcare Transformation Collaboratives are designed to create partnerships and bring entities together to find innovative ways to bridge gaps in the healthcare delivery system and increase access to quality healthcare services in underserved communities across Illinois, evolving treatment systems to ensure holistic treatment that focus on social drivers of health and community-based interventions."

WE KNOW...

- Reaching someone as they experience adverse stress is critical to avoiding deeper trauma and chronic mental health needs.
- Low rates of follow-up care after hospitalizations, coupled with high rates of rehospitalization immediately after psychiatric hospitalization, indicate a need for comprehensive post-hospitalization care rooted in person-centered, community-based care.
- 50% of health outcomes are directly impacted by Social Determinants of Health needs such as housing instability, food insecurity, economic insecurity, transportation, and community safety.

WE ARE...

- Providing immediate crisis stabilization and medication management services at discharge and providing support to address underlying stressors and barriers to recovery.
- Improving success of hospital discharge plans and preventing rehospitalizations by ensuring integration of care model that supports community stabilization and provides immediate therapy supports.
- Creating a network of community social service and healthcare providers to address the whole health needs of those we serve.
- Reducing stigma and shame through utilizing peer recovery models of care focused on root causes of mental health and substance use needs.

INTEGRATIVE APPROACH TO CARE THROUGH PARTNERSHIP WITH POINT CLICK CARE

Collaborative Bridges' partnership with Point Click Care facilitates:

- Evolution from triage oriented fragmented systems of care to one that is recovery oriented and supports clinical throughline.
- Identification to MCO's and 3rd party organizations of individuals enrolled in Collaborative Bridges services.
- Improved ability to address engagement barriers through continually updated phone numbers and addresses, and hospital engagement.
- Ongoing reports to identify individuals referred that have chronic hospital utilizations and assessment of risk.
- Real time updates to program staff when individuals have acute care needs.

Open Discussion and Q & A

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Survey Questions

Do you have additional questions and would like to discuss? Please indicate here, and we will contact you.

Yes

No thanks

What would you like to see/learn more about in an upcoming CCG? We would love to hear from you.

Indicate

Save the Date for Upcoming CCG Events

HFS
Illinois Department of
Healthcare and Family Services

Save The Date for the last CCG of 2024!

2024 Clinical Collaboration Group Webinars – All provider types

Thursday, November 7, 2024; 12pm – 1:00pm
Register Here

2025 Dates Coming Soon – Will be shared at our November CCG!

Topics including:

- Workgroup recommendations
- New Provider Notices
- Regional Collaborations
- Collaboration success stories
- Platform enhancements
- And more!

Missed the last CCG? All CCG slide decks and recordings from prior webinars can be found here:
https://hfs.illinois.gov/healthchoiceadt/clinicalcollaborationgrouprecordedwebinars.html

Resources

State HFS Website: HealthChoice Illinois ADT HFS Program Email: HFS.HealthChoiceIllinoisADT@Illinois.gov

Collective Medical/PointClickCare Customer Community Site: https://community.collectivemedical.com/

Collective Medical Support Email: support@collectivemedicaltech.com

Let's Get Engaged!

Want an in-person visit or virtual meeting with PointClickCare to help your team learn how to best use the platform?
A walk-through of the Network platform and its functions/features?
Click here to schedule a call to discuss your needs and get answers to your questions!

Click Here

Initial Steps to Sign Up

1. Ambulatory provider customers begin the subscription process by completing a brief HFS survey to receive an HFS onboarding packet

https://www.surveymonkey.com/r/8T87FTX

2. Complete HFS onboarding packet and email to HFS:

HFS.HealthChoiceIllinoisADT@Illinois.gov