HFS

Department of Healthcare & Family Services

HealthChoice Illinois ADT

Accurate. Direct. Timely.

OVERVIEW FOR LONG TERM CARE PROVIDERS

June 16, 2021

AGENDA

- INTRODUCTIONS
  - **Mark McCurdy**, Bureau Chief, Long Term Care, HFS
  - **Laura Zaremba**, Principal, Health Management Associates
  - **Kathleen Williams**, Post Acute Account Executive, Collective Medical Technologies
  - **Kary Nulisch**, General Manager, Collective Medical Technologies
- HEALTHCHOICE ILLINOIS ADT OVERVIEW
- TECHNOLOGY PLATFORM DISCUSSION
- 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 Medicaid admission, discharge and transfer (ADT) notifications to be shared with Medicaid providers whose patients visit a hospital inpatient unit or emergency department.
- **The second phase will enable Medicaid ADT notifications to be shared with Medicaid providers whose patients receive care from a long term care provider**.
- All long-term care providers that are enrolled in the IMPACT system to serve Medicaid customers and have EHR systems capable of transmitting ADT notifications in an HL7 format will be required to transmit those notifications for Medicaid customers to **HealthChoice Illinois ADT** by December 31, 2021.

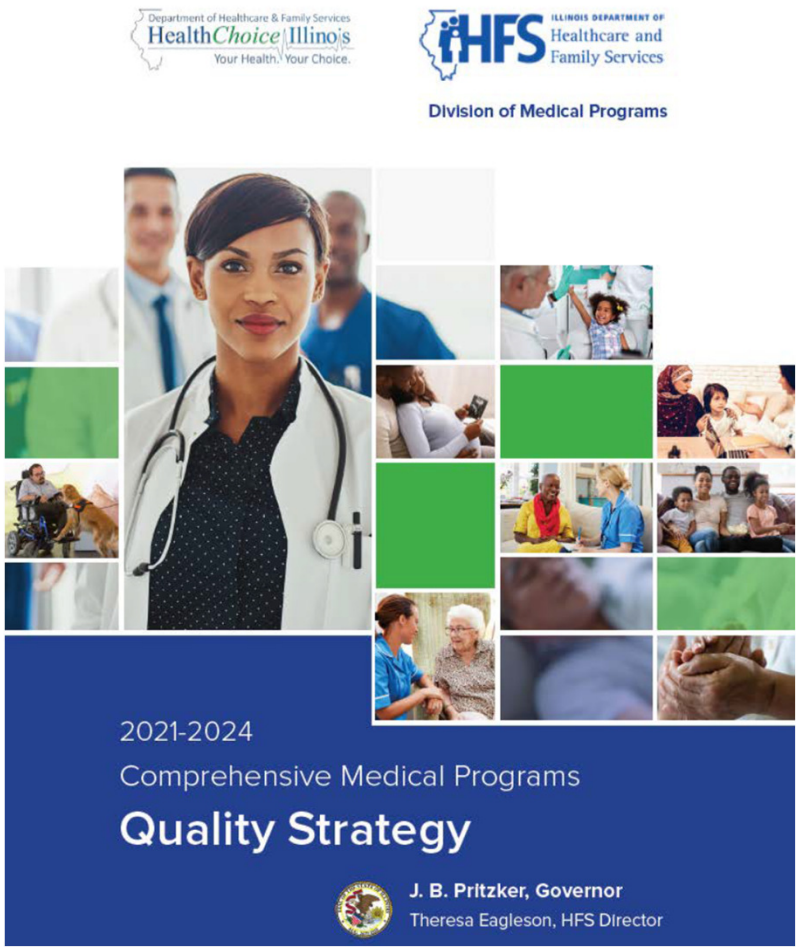
What is the HealthChoice Illinois ADT Project? (2)

- Onboarding to the **HealthChoice Illinois ADT** system does not replace the requirements for long term care providers to submit admission and discharge notifications for Medicaid payment and eligibility purposes to the MEDI portal.

- Managed Care Organizations (MCOs) will subscribe to **HealthChoice Illinois ADT** to receive the ADT notifications for their Medicaid enrolled members.

- 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 Medicaid ADT notifications for their patients.

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

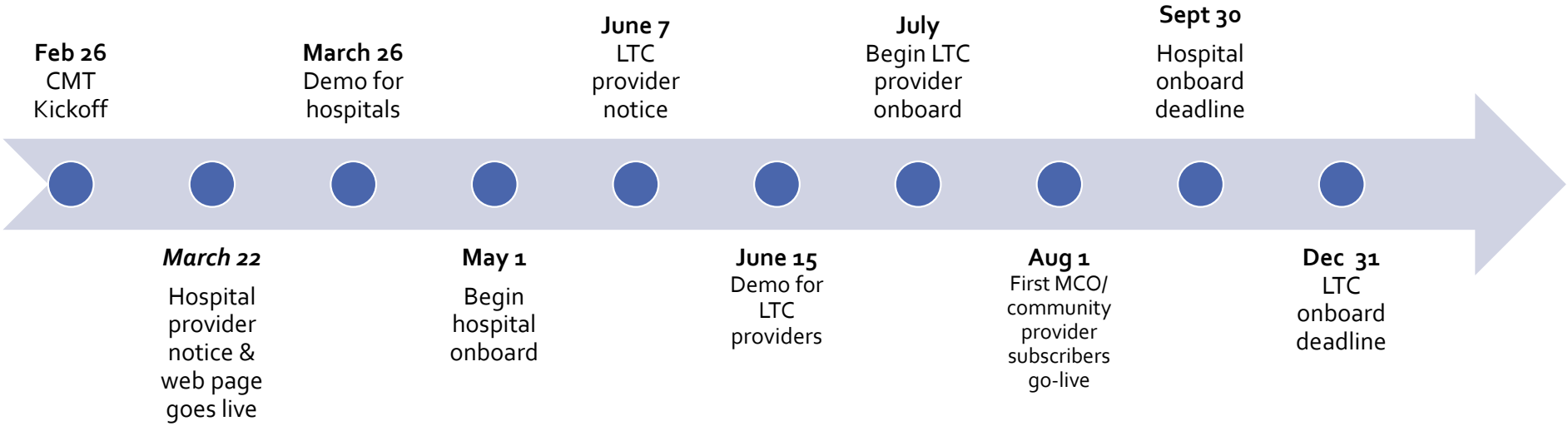
11. Transition to value- and outcome-based payment.
12. Deploy technology initiatives and provide incentives to increase adoption of electronic health records (EHRs) and streamline and enhance performance reporting, eligibility and enrollment procedures, pharmacy management, and data integration.

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.

Project Timeline



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.

Current State & Challenges: Post Acute

Market Broadly Adopted EMRs Over the Past 0 – 5 Years

- Emphasis on replacing paper
- Security
- Efficiencies
- Tangible ROI

Minimal Standardization

Fee for Service Model Generated Data Silos

Shift to Value Based Care

- Heightened focus on clinical outcomes
- A need to be identified as a quality provider within hospital networks and ACOs
- Shared responsibility for residents discharged back into the community
- A focus on preventing potentially avoidable rehospitalizations

The Cost of Poor Communication

~20%
Medicare beneficiaries hospitalized >1x/yr

~75%
of all hospital readmissions are potentially avoidable

$12 Billion
avoidable spend/yr

~35%
are discharged to post-acute care (PAC)

~40%
do not successfully transition from SNF to home

Identification

ED Optimization (ED as porch to health system)

Notifications to ED Providers for ED/In-Patient visits

Shared platform for ED care coordination information; integrated with existing IT infrastructure

- High utilization / complex ED patients

Specific User Base (ED Physicians & Care Managers)

Focused Population (High Utilization / Complex ED Patients)

Prevention

Collective Platform for Post-Acute (Population-centric, community-wide)

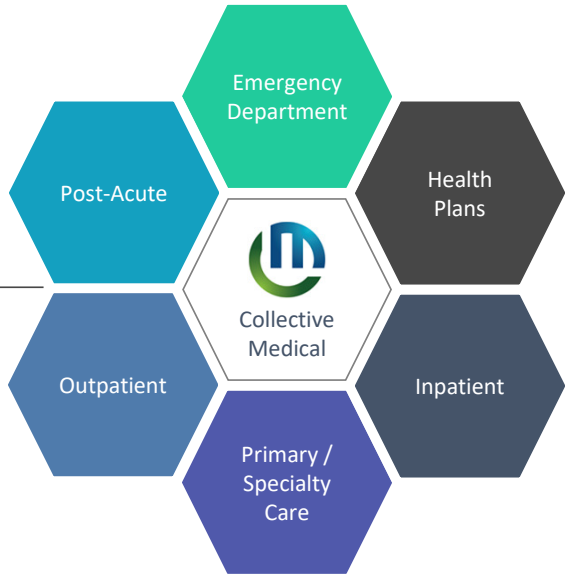
Notifications to multiple parties across ED/ In-/Out-patient visits

Shared platform for care coordination information; complementary service to ED Optimization; integrated with existing IT infrastructure

- High utilization / complex ED patients

Broad User Base (Primary / Specialty Care, ACOs, Post-Acute. Health Plans, Care Coordinators, Social Workers, others)

Entire Population (Active patient population or member base)

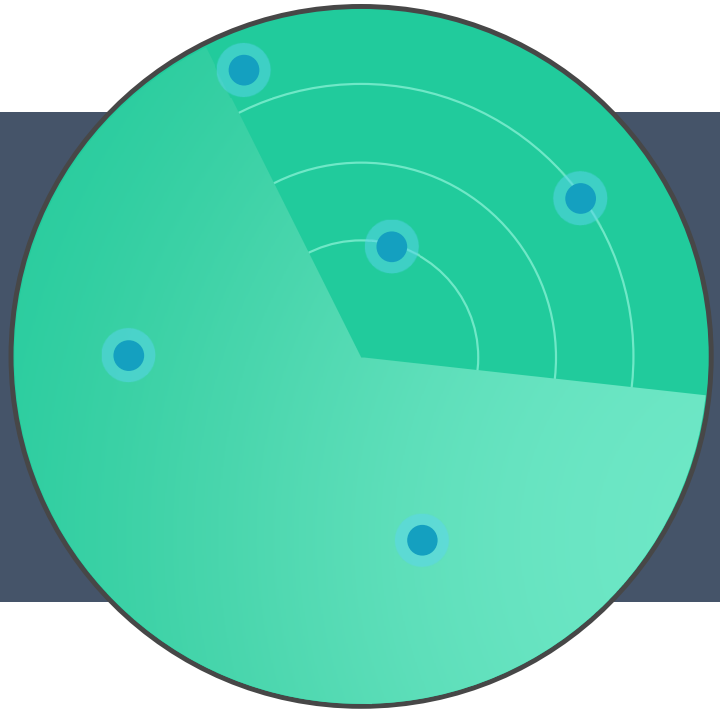


Collective has been proven to help post-acute understand…

- Where are my residents/patients across the healthcare continuum and why?
- Which new and current residents are at risk of avoidable future-state acute risk?
- Who is/should be on the care team and how do we engage them?
- How do we enable the care team to collaborate in order to mitigate the risk?

Think About Us This Way…

Real-time situational awareness and air traffic control for your most complex patients



Workflow Integration – Post-Acute Example

Patient Transferred to Post Acute Facility

Immediate

Basic demographic information and triage details about the encounter are entered into the facility's EMR

EMR Sends Patient Data to Collective

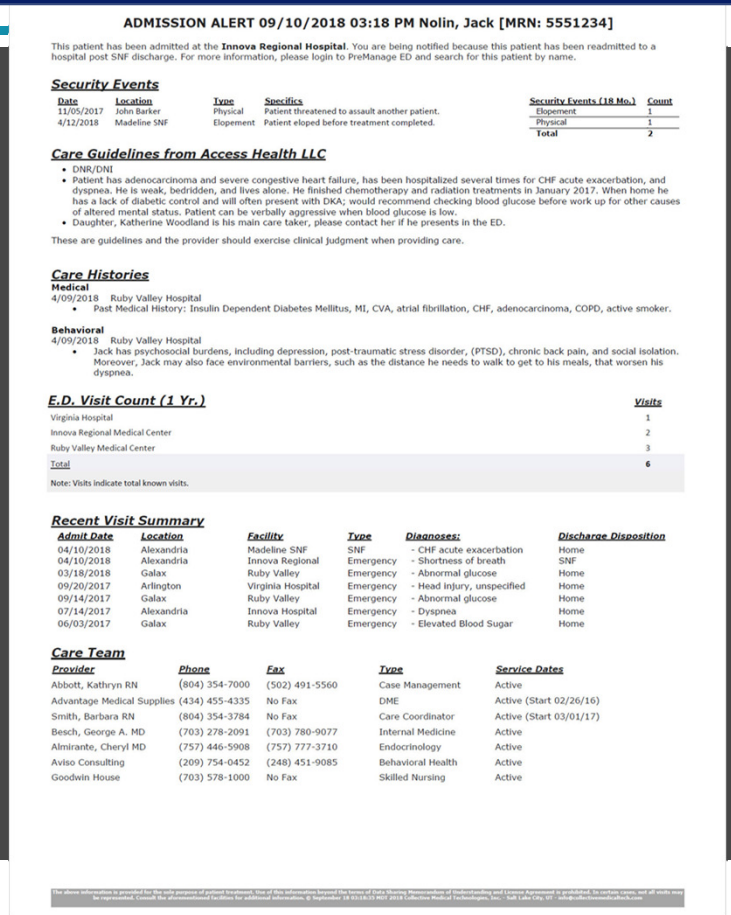
Less than two (2) minutes

Collective identifies the patient and cross-references new encounter information with prior care records from all entities on the Collective Network

PAC Staff Notified if Visit Meets Criteria

Ongoing

Notifications contain relevant, actionable information about the patient, allowing the provider to positively influence patient care outcomes



ADMISSION ALERT 09/10/2018 03:18 PM Nolin, Jack [MRN: 5551234]

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Security Events

Date	Location	Type	Specifics
11/05/2017	John Barker	Physical	Patient threatened to assault another patient.
4/12/2018	Madeline SNF	Elopement	Patient eloped before treatment completed.

Security Events (18 Mo.)	Count
Elopement	1
Physical	1
Total	**2**

Care Guidelines from Access Health LLC

- DNR/DNI
- Patient has adenocarcinoma and severe congestive heart failure, has been hospitalized several times for CHF acute exacerbation, and dyspnea. He is weak, bedridden, and lives alone. He finished chemotherapy and radiation treatments in January 2017. When home he has a lack of diabetic control and will often present with DKA; would recommend checking blood glucose before work up for other causes of altered mental status. Patient can be verbally aggressive when blood glucose is low.
- 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 Histories

Medical

4/09/2018 Ruby Valley Hospital

- Past Medical History: Insulin Dependent Diabetes Mellitus, MI, CVA, atrial fibrillation, CHF, adenocarcinoma, COPD, active smoker.

Behavioral

4/09/2018 Ruby Valley 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 to his meals, that worsen his dyspnea.

E.D. Visit Count (1 Yr.)

	Visits
Virginia Hospital	1
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Total	6

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The Collective Platform…

…facilitates collaboration using common care guidelines which are shared across stakeholders, enabling consistent care interventions across the care continuum.

…eliminates duplicative case management resource expenditure by clearly enabling a single lead case manager to “quarterback” the patient’s care management activities.

iHFS

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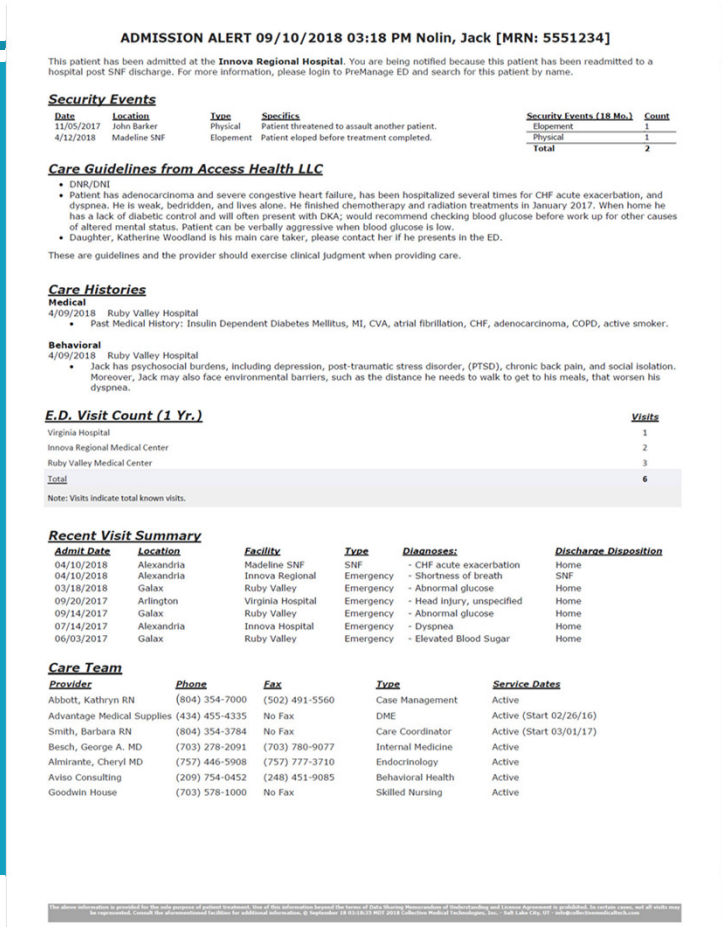
Post-Acute Notification Criteria



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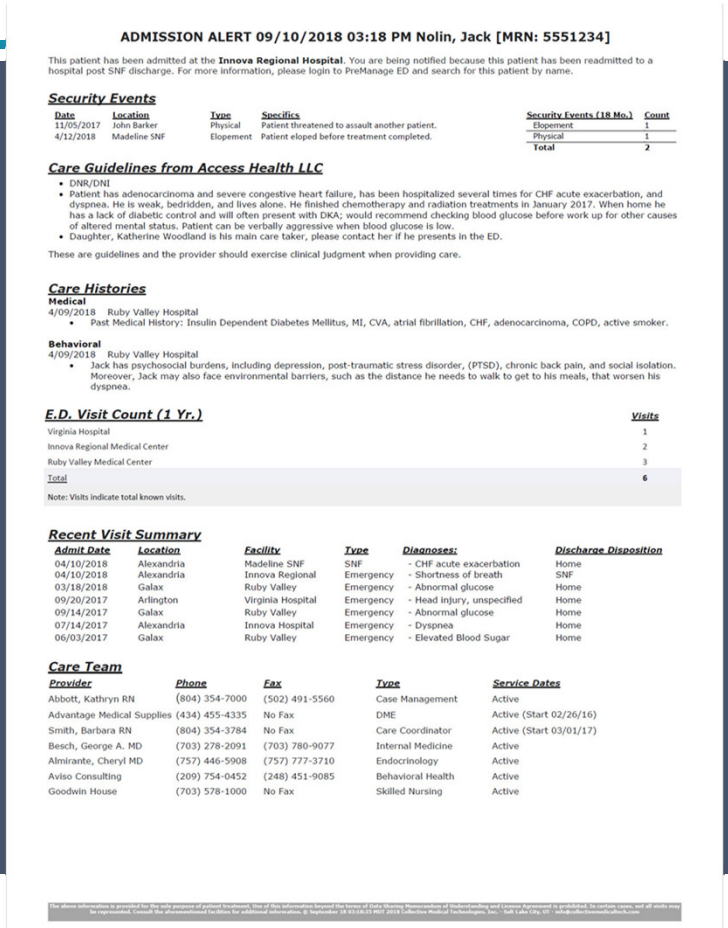
What Makes Notifications Special?

- Only sent when there's a good reason—based on custom criteria
- Filled with actionable information
- Consumable within 60 – 90 seconds
- Received any way you'd like—including printer, email, text, etc.

Post-Acute Notification Criteria



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Care Guidelines from Access Health LLC

- DNR/DNI
- Patient has adenocarcinoma and severe congestive heart failure, has been hospitalized several times for CHF acute exacerbation, and dyspnea. He is weak, bedridden, and lives alone. He finished chemotherapy and radiation treatments in January 2017. When home he has a lack of diabetic control and will often present with DKA; would recommend checking blood glucose before work up for other causes of altered mental status. Patient can be verbally aggressive when blood glucose is low.
- 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 Histories

Medical
4/09/2018 Ruby Valley Hospital
- Past Medical History: Insulin Dependent Diabetes Mellitus, MI, CVA, atrial fibrillation, CHF, adenocarcinoma, COPD, active smoker.

Behavioral
4/09/2018 Ruby Valley 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 to his meals, that worsen his dyspnea.

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.

Recent Visit Summary

Admit Date	Location	Facility	Type	Diagnoses:	Discharge Disposition
04/10/2018	Alexandria	Madeline SNF	SNF	- CHF acute exacerbation	Home
04/10/2018	Alexandria	Innova Regional	Emergency	- Shortness of breath	SNF
03/18/2018	Galax	Ruby Valley	Emergency	- Abnormal glucose	Home
09/20/2017	Arlington	Virginia Hospital	Emergency	- Head injury, unspecified	Home
09/14/2017	Galax	Ruby Valley	Emergency	- Abnormal glucose	Home
07/14/2017	Alexandria	Innova Hospital	Emergency	- Dyspnea	Home
06/03/2017	Galax	Ruby Valley	Emergency	- Elevated Blood Sugar	Home

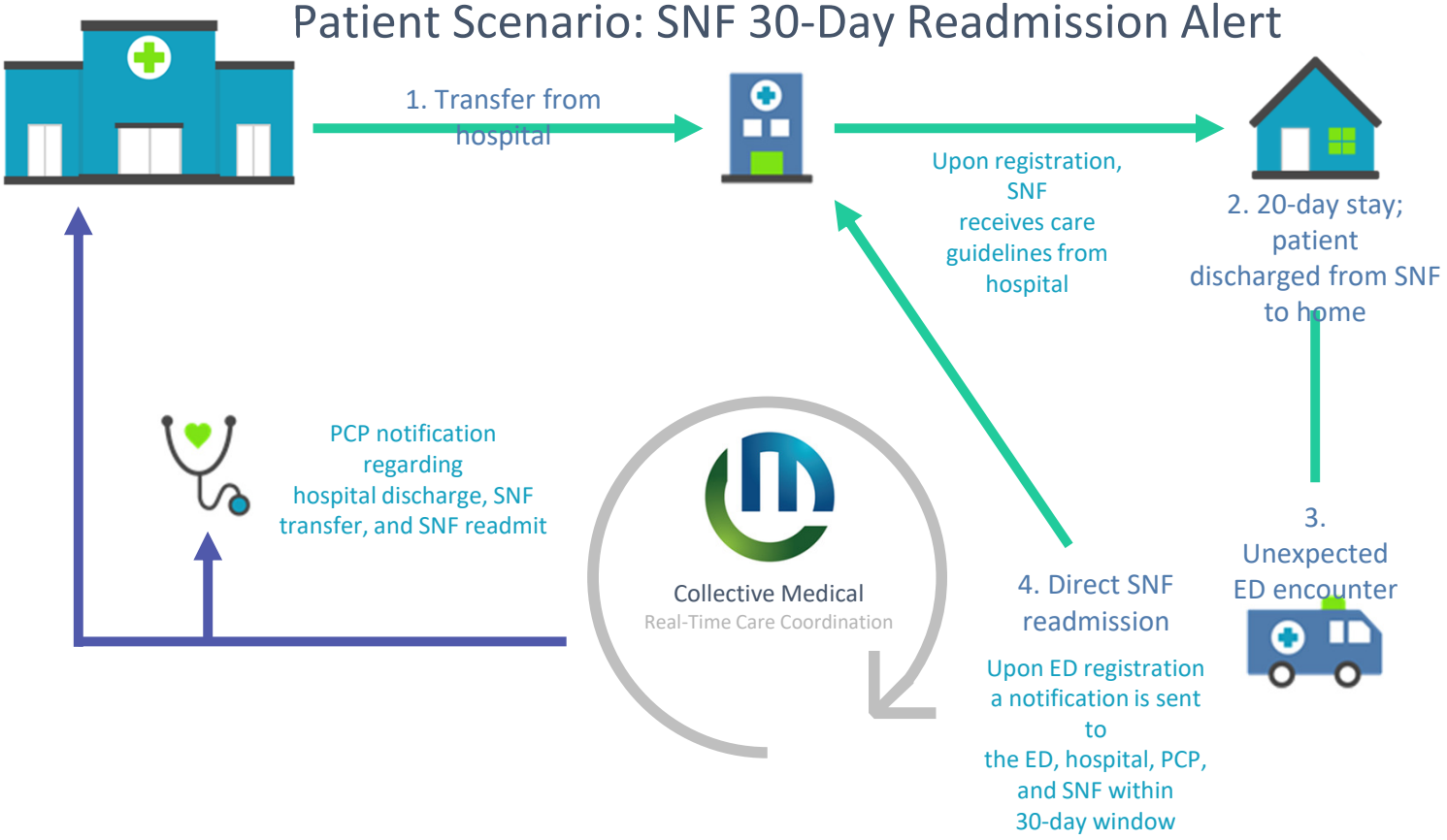
Care Team

Provider	Phone	Fax	Type	Service Dates
Abbott, Kathryn RN	(804) 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	(703) 278-2091	(703) 780-9077	Internal Medicine	Active
Almirante, Cheryl MD	(757) 446-5908	(757) 777-3710	Endocrinology	Active
Aviso Consulting	(209) 754-0452	(248) 451-9085	Behavioral Health	Active
Goodwin House	(703) 578-1000	No Fax	Skilled Nursing	Active

What Causes Notifications to Send?

1. Readmissions
   hospital encounter within 30 – 90 days of SNF discharge
2. High-Utilization
   3 ED encounters within 6 months
3. Complex Patients
   Insights entered into the network
4. Security or Safety Concerns
   Events entered into the network

Patient Scenario: SNF 30-Day Readmission Alert



Marquis Companies set up a pilot program to use this exact process within three of their facilities.

Readmissions were consistently reduced by 60% after only six months

- The facilities started with an average readmission rate as high as 19%
- From April to October of 2018, that rate was reduced to only 6.3%

The Implementation Process: PointClickCare (PCC)

Technical Implementation

Steps:

1. **Self Service Activation**
   - This will initiate the integration for PCC. Done in your PCC portal.
2. **Data Feed Authorization**
   - PCC authorizes your facility and sends Collective Medical an email
3. **Test Data Feed**
   - PCC begins sending Collective Medical messages to the data base to correct mapping
4. **Live Feed**
   - When the test feed has been found to connect properly and the information in messages has been verified as processing into the database, PCC and Collective will coordinate to begin processing live data
5. **Data Live**
   - Once data is flowing to the Collective application you can move to Clinical Implementation and training
6. **Historical File**
   - Send as a flat file to Collective Medical containing 12 – 24 months of historical data
   - Setup and drop via SFTP, email needed to set up. Send in CSV, Tx

Clinical Implementation

Steps:

1. **Review Clinical Onboarding Forms**
   - User Account Form
   - Notification Destination Form
   - Verification of Primary Contacts
2. **Determine your facility's goals and identify workflows**
3. **Training and Activation**
4. **Iteration and Optimization**

The Implementation Process: MatrixCare

Technical Implementation

Steps:

1. Building the Interface
    - Collective Medical and MatrixCare
2. We validate the interface and get approved
3. Once it is validated customers will have to sign an agreement
3. Data feed authorization

Clinical Implementation

Steps:

1. Review Clinical Onboarding Forms
    - User Account Form
    - Notification Destination Form
    - Verification of Primary Contacts
2. Determine your facility's goals and identify workflows
3. Training and Activation
4. Iteration and Optimization

The Implementation Process: Patient File

Technical Implementation

Steps:

1. **Patient Eligibility File**
   - Provides essential information so we can identify and track your patient population(s), this file will need to be updated by your facility at regular intervals
   - Accepted Formats: .csv .txt with tab or pipe delimiter
   - Via portal upload
   - Via SFTP – determine which SFTP site will be used to send ongoing eligibility files to Collective Medical ADT Mappings
2. **Patient File Validation, Configuration, and Processing**
   - File is analyzed manually and processed if sufficient Historical File
3. **Auto Processing**
   - When second file is received, and headers are consistent we can set to auto process
4. **Historical File**
   - Send as a flat file to Collective Medical containing 12 – 24 months of historical data

Clinical Implementation

Steps:

1. **Review Clinical Onboarding Forms**
   - User Account Form
   - Notification Destination Form
   - Verification of Primary Contacts
2. **Determine your facility's goals and identify workflows**
3. **Training and Activation**
4. **Iteration and Optimization**

Questions?

Onboarding Packet

Each long term care provider will receive an onboarding packet to help expedite the process. The packet includes:

- The appropriate paperwork that will need to be signed.
- 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

Questions and Next Steps

Please complete the survey as soon as possible:

https://www.surveymonkey.com/r/3D6C265

Additional information and periodic updates will be posted to:

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

THANK YOU